

**MINUTES**  
**STATE COMMISSION ON THE EFFICACY OF CON**  
Sanders Fireplace Room at the Capitol Education Center  
180 Central Avenue, Atlanta, Georgia

September 13, 2005; 1:00 pm

**Daniel W. Rahn, MD, Chair, Presiding**

**MEMBERS PRESENT**

Melvin Deese, MD  
Donna Johnson, Esq.  
Robert Lipson, MD  
Dan Maddock  
Ronnie Rollins  
Joseph "Rusty" Ross, Esq  
Representative Austin Scott

**MEMBERS ABSENT**

Jeff Anderson  
Senator Don Balfour  
Tim Burgess

**GUESTS PRESENT**

Bill Lewis, Lewis Consulting  
Brian Looby, Medical Association of Georgia  
Billy Barron, GAA  
Brian Hudson  
Bryan Fiveash, Fiveash-Stanley, Inc.  
C. Hayslett, GA. Alliance of Community Hospitals  
Christi Carmichael, Emory Healthcare  
Clay Campbell, Archbold Medical Center  
Clint Austin, GHA  
Cynthia George, Phoebe Putney Health System  
Don Fears, DeKalb Medical Center  
Dodie Putnam, Hospital Corporation of America  
Deborah Kolb, Mitretek  
Fred Watson, Georgia Healthcare Association  
Genia Ryan, Georgia Assisted Living Federation of America  
Helen Sloan, Nelson Mullins  
Holly Bates Snow, Georgia Hospital Association  
Jill Fike, Senate Research Office  
Julie Windom, GA. Alliance of Community Hospitals  
Jimmy Lewis, Hometown Health, LLC  
John Parker, Esq., Georgia Alliance of Community Hospitals  
Judy Adams, Georgia Assoc. for Home Health Agencies  
Jason Broee, Children's Healthcare of Atlanta  
Jerry Usry, Phoebe Putney Health System

**STAFF PRESENT**

Doris Berry  
Neal Childers, JD  
Richard Greene, JD  
Matt Jarrard, MPA  
Julie Kerlin  
Victoria Kizito, JD  
Brigitte Maddox  
Robert Rozier, JD  
Virginia Seery, PhD  
Stephanie Taylor

Jeffrey Baxter, Nelson Mullins  
Jon Howell, GHCA  
Joy Davis White, Rockdale Medical Center  
Kim Menefee, WellStar Health System  
Kent Lederman, Morgan Healthcare Consulting  
Kevin Rowley, St. Francis Hospital  
Leo Reichert, Parker Hudson  
Larry D. Lloyd, Innovative Consultants  
Lawrence J. Myers, Smith Morre LLP  
Leah Fressell Watkins, Powell Goldstein  
Lisa Robinson Norris, The Strategy House  
Linda Simmons, Symbion Healthcare  
Marge Coggins, HBO  
Marvin Noles, Medical Center of Central Georgia  
Monty Veazey, Georgia Alliance of Community Hospitals  
Scott Maxwell, Mathews & Maxwell  
Sharon Cooper (State Representative)  
Sheila Humberson, Troutman Sanders  
Stan Jones, Nelson Mullins  
T. Chambliss, Georgia Alliance of Community Hospitals  
Tom Bauer, Georgia Assoc. of Homes & Services for the Aging, Inc.  
Tony Strange, Georgia Assoc. Home Health Agencies  
Traci Bone, Holland & Wright  
Travis Lindsey, Resurgens  
Walter Coffey, Georgia Assoc. of Homes & Services for the Aging, Inc.  
Webb Cochran, Tenet

## **WELCOME AND REVIEW OF COMMITTEE'S CHARGE**

Dr. Rahn called the meeting of the State Commission on the Efficacy of Certificate of Need Program (Commission) to order at 1:05 pm. He welcomed members and guests and reiterated that the Commission was created for the purpose of studying and collecting information and data related to the effectiveness of the Certificate of Need (CON) program in Georgia. He said that the Commission, among other things, is asked to determine whether the CON program impacts access to high quality healthcare services for the citizens of Georgia in the most cost effective and efficient manner.

## **APPROVAL OF MINUTES OF AUGUST 8<sup>TH</sup> MEETING**

Dr. Rahn noted that the minutes of the draft minutes of the August 8<sup>th</sup> meeting were mailed to members in advance of the meeting. He called for a motion to accept the minutes of the August 8<sup>th</sup> meeting. Dr. Deese asked that additional portions of his dialog with Mr. Dwozan during the Stakeholder Question and Answer portion of the meeting be included in the minutes. Members voted unanimously to accept the minutes, pending the addition of this additional language.

Dr. Rahn welcomed and recognized State Representative Sharon Cooper, who chairs the House Committee on Health and Human Services and thanked her for attending today's meeting.

## **STAKEHOLDER PRESENTATIONS**

Dr. Rahn welcomed four stakeholder organizations to present before the Commission. He noted that presenters would be asked to provide testimony in the order that is stipulated on the agenda (alphabetical order, by organization). He said that questions and answers would be held at the end of all presentations.

Copies of all testimonies were distributed to Commission members at the onset of the meeting and appear as Appendix A. The following persons and organizations presented testimony before the Commission:

- Georgia Assisted Living Federation of America  
Genia Ryan, Executive Director
- Georgia Association for Home Health Agencies, Inc,  
Judy Adams, Executive Director
- Georgia Association of Homes and Services for the Aging, Inc.  
Walter Coffey, President
- Georgia Healthcare Association  
Fred Watson, President

## **STAKEHOLDER'S QUESTION & ANSWER SESSION**

- *Note: Summary of the Q&A session for purposes of the meeting minutes is done using audiotape recording. The recording of this session was very poor and in most cases, inaudible.*

- *Note: Judy Adams, Executive Director, Georgia Association for Home Health Agencies, Inc (GAHHA), provided testimony before the Commission. Tony Strange, Director, Region I (GAHHA) fielded questions during the Question & Answer portion of the meeting.*

**Dr. Deese :** (directed to Mr. Watson) Should the CON capital restrictions be removed?

**Mr. Watson:** Yes, that would be good. The industry is currently using the Dodge Construction Formula that was developed in 1982 (based on construction costs at that time). The formula has not been increased since that time even though the buildings have deteriorated. If a nursing facility is torn down or is replaced then the facility is rebased at the current Dodge Construction reimbursement. As a result there is an increase in property reimbursement however it is still not enough to pay for the cost of the building. If there is a debt on the old building, there would not be enough to pay for both buildings. Many states (i.e. Alabama) have adopted a fair market renovation system where the reimbursement formula is based on a current appraisal of the property.

**Dr. Deese:** (directed to Mr. Watson) do all of the members that you represent hold a CON?

**Mr. Watson:** Yes, all nursing homes require a CON.

**Dr. Deese:** (directed to Mr. Watson). You stated that you would like to continue with CON but would also like flexibility within the program to expand the umbrella of CON. You would like the protection of CON but you would like to add home care services. Also, you don't want any limitations on relocation. Is that an accurate summary of your recommendation?

**Mr. Watson:** It is not what our typical member would like but it is what the consumer would like. We would like to meet the needs of the consumer and the consumers would like more homecare-based services. The capital restrictions should be removed. Also, in the next ten years, we expect that there will be a need for additional nursing home beds. Nationwide the utilization of nursing home beds is going down but within certain ethnic groups, utilization is actually going up. As we get older, 85years and older, there are more chronic illnesses so there is a 50% chance that people over 85 years of age will spend some time in a nursing home. That is the fastest growing segment of the nursing home population. The Association believes that there will be a need and that it is prudent for the Department and the Commission, in the next five years, to start studying where, how much and what types of beds we will need here in Georgia.

**Dr. Deese** (directed to Ms. Ryan): How does CON help to deliver services to patients?

**Ms. Ryan:** CON actually increases provider costs. CON application costs are passed on to patients. There is no government reimbursement for these services; No Medicare or Medicaid reimbursement. CON protects existing markets though it doesn't affect the profitability of the market. (Other portions of her response were inaudible)

**Mr. Maddock:** (directed to Ms. Ryan) what percentage of your facilities statewide is profit vs. not-for-profit entities?

**Ms. Ryan:** The association has both large and small, for-profit and not-for-profit facilities. (Other portions of her response were inaudible).

**Representative Scott:** (directed to the Department) Ms. Ryan said that in 1994, four CONs were approved. How many were denied?

**Robert Rozier:** There have been no denials of CONs for personal care homes in the last 5 years because there has been a calculated need for this service.

**Representative Scott:** Are there other areas where no CONs have been denied or is this area unique?

**Dr. Rahn:** Perhaps we could ask the Department to provide a summary of the number of applications for each area, including the number of denials and approvals.

**Representative Scott:** The Department should also provide information regarding the length of time that it takes between the time of application and the actual ground breaking.

**Dr. Deese:** (directed to Tony Strange) why is the current CON process superior to licensure?

**Tony Strange:** CON is important particularly when you examine the experiences of such states as Florida and Tennessee which saw the number of facilities quadruple. CON requires an investment in the community. In Atlanta, home care providers may drive 2.5 miles between patients while in other parts of the state they may travel as much as 28 miles. As a general rule, providers do NOT migrate to rural areas because the costs to provide care to patients in rural areas tend to be higher. Up until 2004 CMS had recognized this and had added a 5% "rural add-on" reimbursement rate however in 2004 that was eliminated further. There is an economic difference in providing care in a home setting than in an institution.

**Dr. Deese:** (directed to Mr. Strange) Are you in favor of keeping CON?

**Tony Strange:** I am absolutely in favor of continuing the CON program in Georgia.

**Dr. Deese** (directed to all panel members): Does each of your industries come under the auspices of CON?

**Fred Watson:** Yes, nursing homes are regulated by CON. Nursing homes are probably the most heavily regulated industry in the United States. Joint Commission Accreditation is a voluntary process for nursing homes. If you are accredited by Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) you do not get deemed-status from the federal regulations as hospitals do. Nursing Homes are regulated by state, local, and federal government. Approximately 15% of Georgia's nursing facilities have voluntary JCAHO accreditation.

**Tony Strange:** Yes, home health agencies are regulated by CON and seek JCAHO accreditation on a voluntary basis. Approximately 80% of our members are accredited by JCAHO.

**Walter Coffey:** Yes, continuing care retirement communities (CCRCs) are regulated by CON and are heavily regulated.

**Genia Ryan:** Yes, personal care homes are regulated by CON.

**Dr. Deese:** My feelings about CON are well-known.

**Representative Scott:** How does restriction of providers help consumers?

*Responses were inaudible.*

**Rusty Ross:** (to all panel members) What would happen if CON went away in Georgia?

**Fred Watson:** We would expect to see an increase of facilities in high population areas while facilities in rural areas would go out of business. State budget could not be sustained. Many states without CON have put a moratorium on nursing home beds.

**Representative Scott:** (directed to Fred Watson) Why should there be a CON threshold?

**Fred Watson:** Without a threshold, the state could not afford the cost of these services.

**Donna Johnson:** Who are the patients in nursing homes?

**Fred Watson:** Patients in nursing homes are usually aged, blind and/or disabled.

**Rusty Ross:** (to Ms. Ryan) What would happen to personal care homes if CON went away?

**Genia Ryan:** There would likely be innovative providers and decreased costs. Administrative costs are passed on to consumers.

**Rusty Ross:** Is CON prohibiting innovation currently?

**Genia Ryan:** No, it is not. The increases in costs arise from market analysis and other CON application fees

**Dr. Deese** polled panel members (stakeholders) and asked whether they are in favor of continuing CON.

**Panel Response:** All panel members voted unanimously in favor of continuing CON.

**Dr. Lipson** asked panel members whether they operate in a free-market.

**Fred Watson:** The nursing home industry is very heavily regulated.

**Walter Coffey:** Continuing care retirement communities are very heavily regulated. These communities are also regulated by the Office of Insurance Commissioner.

**Tony Strange:** Home health services operate in a free market.

**Genia Ryan:** Personal care homes are appropriately regulated.

Dr. Rahn thanked the panel for their presentation at today's meeting. He encouraged panel members to provide any additional references, studies or other materials that would be helpful to the Commission in the decision-making process.

## **OTHER BUSINESS**

### **A. General surgery Request**

Dr. Rahn indicated that there have been five requests from general surgeons to make presentations before the Commission related to general surgery and other regulations surrounding ambulatory surgical services. He said that in preparation for this discussion he wanted to be sure that everyone understood the issues surrounding general surgery, including the reasons that the Commission has received these requests.

Dr. Rahn stated that regulations for ambulatory surgery centers fall into two categories; one that is statutorily based and another that falls under CON Rule. The regulation that is statutorily-based allows single-specialty surgical practices to develop ambulatory surgical centers under a category that requires a Letter of Nonreviewability (LNR). There is a specified list of specialties that fall under this single-specialty classification. The other regulation which governs the establishment of ambulatory surgery is a CON Rule. This rule governs the establishment of multi-specialty ambulatory surgical services. Under current CON Rule, general surgery is classified as a multi-specialty service and a CON must be submitted. He said that there has been lots of discontent with the statute that created the LNR process and the CON Rule surrounding ambulatory surgery. He solicited guidance from Commission members regarding these requests to present before the Commission and he asked Richard Greene and Neal Childers to provide the Commission with an update regarding the legal issues surrounding ambulatory surgical services and general surgery.

Mr. Greene summarized the work of the Ambulatory Surgical Services TAC noting that the TAC held five meetings and a public hearing during CY 2003 and developed a set of Proposed Draft Rules which were slated to be presented to the Health Strategies Council at their November 2003 meeting. He said that the TAC Chair had received a wide range of input from the Department, providers, and other constituents indicating that there were areas of concern. The TAC Chair

agreed not to seek approval of the Rules from the Council at the November 2003 meeting and instead sought the Council's input and agreed to have the TAC reexamine those specific areas that needed additional work.

Mr. Greene said that several of the issues that were brought before the TAC required confirmation regarding what the TAC or the Health Strategies Council could do by rule versus what could be done by statute. He said that there had been a lot of confusion because many people were of the opinion that the Health Strategies Council could make recommendations to the General Assembly or to the DCH Board regarding changes to state statutes. He clarified that the functions of the Council are set out in statute and the Council does not have statutory authority to comment on or make recommendations about changes to state statutes. He emphasized that the Council is authorized to make changes to the Department's rules and regulations as they relate to CON.

Neal Childers noted that the Department forwarded the TAC's Draft Proposed Rules to the Office of the Attorney General (OAG) and asked that they provide some legal guidance. The Department recently received an opinion from the OAG which made five (5) specific recommendations. (See Appendix B)

Dr. Rahn summarized that the Department of Community Health stipulated a list of specialties that would be classified as single-specialties for purposes of the administration of the LNR process. He indicated that there has been a point of contention and disagreement about this list. He said that general surgery is a clinical specialty which has training programs and other requirements including residency training programs as a specialty. The Department has classified this service for purposes of this administrative process, as a multi-specialty service. The Commission has received five requests from general surgeons to present before the Commission, including the following:

- Chris Smith, MD, President , Georgia Chapter of Society of General Surgeons
- Thomas Gadacz, MD, Georgia Chapter, American College of Surgeons
- John Bagnato, MD, Officer, Georgia Chapter, Society of General Surgeons
- Harold L. Kent, MD, Brunswick, GA
- John Price Corr, Jr., MD, Albany, GA, Georgia Chapter of Society of General Surgeons

Dr. Rahn also added that there was a request from Jimmy Lewis, President, Home Town Health, LLC to present before the Commission.

Dr. Deese requested information about the membership of the Health Strategies Council. Dr. Rahn indicated that the Council is a 27-member body, appointed by the Governor. He agreed to provide a membership list of the Council at the next meeting. Mr. Greene noted that the membership list also could be downloaded from the Department's website.

Commission members agreed that they would like to hear from general surgeons at the next meeting. They recommended that speakers tailor their presentations to address issues specific to general surgery and LNR issues.

Representative Scott indicated that the issue regarding general surgery is one of the key reasons that the Commission was established.

Commission members recommended that in the interest of time invitations should be extended to Drs. Smith & Gadacz to present before the Commission and other physicians would be encouraged to submit written comments. Additionally, Commission members made the following requests:

- A presentation from the Department detailing the LNR and CON processes, including an explanation of their differences.
- Requests for information regarding Mandamus actions.

#### **B. Information from Dept of Justice/Federal Trade Commission**

Dr. Rahn reminded members that the following materials are included in their packets:

- List of Consultants, provided by U.S. Dept. of Justice
- Baughcum, Alan, "*Notes for Georgia CON Commission*", Economic Analysis Group, Antitrust Division, U. S. Dept. of Justice, 8/3/05

#### **C. Health Strategies Council Requests**

Dr. Rahn said that the Health Strategies Council (HSC) has several technical advisory committees which meet to develop new and revised state health plans. He said that at present there is one TAC namely, Inpatient Physical Rehabilitation Services TAC whose work is in progress and another Psychiatric & Substance Abuse Inpatient Services TAC, which expects to be convened in the near future. An Ad Hoc Committee on Indigent & Charity Care has been put on hold.

Dr. Rahn summarized the work flow of the Council and its TACs noting that TACs develop draft planning documents and present them to the Council for approval. The Council then votes to send these draft documents back to the TAC for further work or sends the draft documents to the DCH Board, for issuance for public comments.

Dr. Rahn indicated that the Ambulatory Surgical Services TAC held its last meeting in 2003 and presented its draft Rules to the Council at its November 2003 meeting for review and input. He said that at that time the Department and the public had identified several areas of concern and the draft Proposed Rules were sent to the Office of the Attorney General (OAG) for legal guidance. The OAG has provided some guidance to the Department and the TAC.

Dr. Rahn said that the Council did not want to recommend that the Ambulatory Surgical Services TAC be reconvened to develop recommendations that might potentially overlap the Commission's work. He said that Council members suggested that the Commission provide guidance to the Council regarding whether the TAC should be convened or whether they should wait until the Commission makes some specific recommendations about issues surrounding general surgery. The Commission voted unanimously to allow the Ambulatory Surgical Services TACs and all other TAC's to continue their work.

## **OTHER BUSINESS**

Dr. Rahn thanked all members for their participation in this meeting and their engagement in this process. The next meeting is scheduled for **Monday, October 24, 2005 at 1:00 pm at Sanders Fireplace Room/Capitol Education Center, 180 Central Avenue, Atlanta.**

There being no further business, the meeting adjourned at 3:45 pm.

Minutes taken on behalf of Chair by Stephanie Taylor.

Respectfully Submitted,

Daniel W. Rahn, MD  
Chair

**MINUTES**  
**STATE COMMISSION ON THE EFFICACY OF CON**  
Sanders Fireplace Room at the Capitol Education Center  
180 Central Avenue, Atlanta, Georgia

**APPENDIX A**  
(Stakeholder Presentations)



Georgia Assisted Living Federation of America  
Georgia Association For Home Health Agencies, Inc.  
Georgia Association of Homes & Services for the Aging, Inc.  
Georgia Healthcare Association



**Georgia-ALFA**  
*The State Affiliate of the  
Assisted Living Federation of America*

September 13, 2005

Daniel W. Rahn, MD, Chair  
The State Commission on the Efficacy of the Certificate of Need Program  
State of Georgia

Dear Chair Rahn and Commission Members:

Thanks for the opportunity to provide an update on the assisted living industry and to present Georgia-ALFA's position on current Certificate of Need plans and rules that govern the development of personal care homes in Georgia.

Georgia-ALFA, the state affiliate of the Assisted Living Federation of America (ALFA), is a non-profit trade association incorporated in 1998 representing Georgia's senior living industry and the growing population it serves. Members range from freestanding assisted living residences (licensed personal care homes) to retirement campuses where assisted living may be a component.

While Georgia-ALFA membership is diverse, our mission is shared by all. Georgia-ALFA wants to insure the right of every Georgia senior who needs daily assistance to receive quality care in a choice-driven, dignified, safe and clean residential environment. We believe that our senior residents should feel like they are living "in their own home," not in an institution. Georgia-ALFA represents roughly 200 for-profit and not-for-profit providers of assisted living serving over 10,000 consumers.

**OUR RECOMMENDATION**

Georgia-ALFA was part of the committee that drafted the current Personal Care Home Component Plan and Rules in August 2001. While we would prefer to have the market drive the process, we recognize that we, in fact, operate under the CON process. We've monitored the process over time and will continue to do so. At this time, we recommend no changes to the Certificate of Need plans and rules.

**ADDITIONAL BACKGROUND INFORMATION**

**CON APPROVALS**

The current methodology still demonstrates the need in all planning areas. In 2003, four CONS were approved, in 2004 ten CONS were approved, and three CONS are pending for 2005. Most of these were from existing providers wanting to expand.



## **Georgia-ALFA**

*The State Affiliate of the  
Assisted Living Federation of America*

### **CAPITAL**

We expect continued growth in assisted living both here in Georgia as well as throughout the country. Funding is still tight for new investors. Mergers and consolidations will continue. Some who invested in the business when funding was plentiful have decided they want out. As a result, we're seeing good properties sold at attractive prices and acquired by experienced owners from professionally managed companies.

### **OCCUPANCY**

Occupancy rates are good throughout the state. Results from a recent survey of Georgia-ALFA members indicate that occupancy rates are generally running in the low to mid 90s, up from high 80s and low 90s in 2004.

### **STAFFING**

Staffing continues to be a challenge for the industry. Employee turnover remains one of the toughest nuts to crack in assisted living, especially when it comes to recruiting and retaining the best and the brightest frontline employees.

### **GENERAL LIABILITY INSURANCE**

While the rising cost of insurance continues to be a challenge, we are beginning to see some stabilization as additional carriers are entering the Georgia market. Providers are still able to find coverage. However, professional liability premiums are running over \$300-\$400 per licensed bed in Georgia.

### **RISK MANAGEMENT PROGRAMS**

Providers have been able to control costs by instituting risk management programs. Some insurance companies provide a credit at the end of each year for implementing risk management programs. The maximum credit we've seen is five percent. Implementing risk management programs has the added benefit of helping staff members protect our residents by providing better quality of care.

### **WORKER COMPENSATION**

The cost of worker compensation coverage is continuing to increase as medical costs increase. One insurance company will insure small businesses if premiums don't exceed \$50,000. In the assisted living industry, that means a company with three or four communities. For mid-size companies, obtaining coverage is more difficult. As a result, many of our members have found some relief in outsourcing some of the HR functions. In doing this, worker compensation coverage is included.

### **PROPERTY INSURANCE**

Last year, we saw property premiums coming down. However, we feel sure that Hurricane Katrina is going to have an impact on future premiums probably starting as early as next year.



**Georgia-ALFA**

*The State Affiliate of the  
Assisted Living Federation of America*

**CONCLUSION**

As indicated above, we recommend no changes to the Certificate of Need plans and rules at this time.

On behalf of Georgia-ALFA, I'm available to assist in any way that would help the Commission in carrying out its responsibilities by producing results that will benefit Georgia's senior citizens.

Sincerely,

**Genia Ryan**

Genia Ryan, CAE  
Executive Director/CEO

The State Commission of Efficacy of the Certificate of Need Presented by  
Georgia Association for Home Health Agencies, Inc.

September 13, 2005

The Georgia Association for Home Health Agencies, Inc., (“GAHHA”) is a non-profit organization, founded in 1979, to represent home care providers who are Medicare certified and licensed by the State of Georgia. It advocates statewide, region-wide and nationally for Georgia homecare providers. As you may know, homecare providers in Georgia provide a full range of professional homecare services to patients in their homes under the direction of the patient’s physician. These services include, skilled nursing, physical, occupational and speech therapy, home infusion, medical and social services and home health aide services.

GAHHA appreciates the opportunity to submit our written comments to the State Commission on the Efficacy of the Certificate of Need Program (the “Committee”) and to make a presentation to it. We understand that the Commission’s mandate is to conduct a comprehensive review of the Certificate of Need (“CON”) Program, including the effectiveness of the program in accomplishing its original policy objectives and to determine if any changes are needed in order to achieve those policy objectives. We hope that our material and presentation helps you with that task.

GAHHA’s Position on CON

GAHHA fully supports the CON Program. GAHHA believes that it has served the original purpose set forth in the CON statutes. It ensures “that adequate healthcare services and facilities are developed in an orderly and economical manner and are made available to all citizens and that only those the healthcare services found to be in the public interest shall be provided in this state.” OCGA §31-6-1. In essence, we believe that the CON Program has ensured high quality homecare services and at the same time ensured broad financial access to healthcare for all Georgians, regardless of their economic status. We do not believe that any major changes need to be made to the CON Program.

Any modification to the specific CON rules can be handled through the rule making process. Indeed, GAHHA supports ongoing review of those rules by the Health Strategies Council and the various Technical Advisory Committees appointed by the Council. The legislature recognized that over time that the CON Program might have to adapt to changing circumstances. As a result, it gave the State Health Planning Agency, now the Department of Community Health (“DCH”), a broad mandate to regulate the process. The legislature also built in a continuing review process by creating the Health Strategies Council. The Council’s purpose is to adopt a Component Plan for each type of service and make recommendations to DCH about its rules. The provider community and other interested parties have the opportunity to participate at various times throughout the process before rules are changed or new ones adopted. The rule changes and new rules can (and have) come from various sources including the DCH staff, members of the Technical Advisory Committees and the providers subject to those rules.

Other states have suffered adverse consequences as a result of changing or abolishing CON. The disastrous effects of repealing CON are illustrated by what occurred in Texas and Tennessee. In both of those States, the number of home health agencies quadrupled immediately after CON was abolished. Because of the dramatic increase in the number of providers, the State of Tennessee could not handle the increased administrative process. It imposed a moratorium on the addition of new agencies. As you may know, this problem was addressed in a letter from Claude Vickers, former Georgia State Auditor of the Department of Audits, dated February 18, 1997 to the Department of Medical Assistance. A copy is attached to this paper. There have been some changes involving home health since 1997, but the ultimate adverse impact of abolishing CON would be the same.

If home health agencies are not required to go through the CON process, there will be an exponential increase in the number of agencies in Georgia. That increase will dramatically increase the administrative burden and costs to regulate those agencies. There are currently approximately 100 home health agencies in the State of Georgia. If CON is abolished for home health agencies, Georgia could literally have 400 agencies in the State of Georgia overnight. This could result in having to quadruple the budget and manpower of regulatory and licensing agencies. Of course, it would also dilute the overall quality of services by allowing inexperienced, undisciplined and unqualified home health providers to provide services.

GAHHA wants to address briefly the report by the Federal Trade Commission and the Department of Justice in July 2004 titled "Improving Healthcare: A Source of Competition." The underlying theme of that paper is that competition should be permitted to service in the healthcare industry without regulation. However, the healthcare industry, particularly home health, does not act in a traditional commercial manner.

The vast majority of the patients in home health are over 65 and is covered by Medicare and/or Medicaid. As a result, there are a limited number of patients in the State of Georgia that actually qualify for home health services under those programs. The CON Program effectively prohibits the number of providers from getting out of balance with the number of patients. As set forth in the statute, the CON Program avoids the "unnecessary duplication of services".

The amount paid by Medicare and Medicaid is dictated by the healthcare governmental agency and not by market forces. The FTC's report is concerned that the CON prices can "actually drive up prices by fostering anti-competitive barriers." That is simply not correct. The amount paid to home health agencies is dictated by governmental agencies and not by market forces. With the advent of managed care, even the minimum number of private patients served by home health agencies are not governed by truly market forces. They are dictated by managed care contracts, which effectively cap the amount home health providers can be paid for their services.

In order to keep their finances balanced, home health providers must maintain a large volume of patients. If there are too many home health providers, some will wind up with high

cost, low payment patients. The agencies can provide high quality care to all of Georgia's patients only if they have the volume to balance the burden of low paying patients over all of their patients. The CON program helps maintains the appropriate balance by allowing only additional agencies when they are truly needed. In fact, under the CON home health rules, a new provider can be approved for a CON only when there is a need of at least 500 patients in the planning area and an existing provider expand only when there is a need of at least 250 patients in the planning area.

Also, the CON Program ensures that new providers will provide a high quality of care. In order to be approved for CON, there are certain minimal things that a provider must agree to do:

1. It must provide a community linkage plan, which demonstrates factors such as, but not limited to, referral arrangements with other providers in the healthcare system. It must work out arrangements with other related community services to show a continuity of care and coordinate an integrative system, which promotes continuity;
2. The applicant must provide a written statement of its intent to comply with all appropriate licensure requirements and operational procedures required by the Office of Regulatory Services of the Georgia Department of Resources;
3. An applicant for new or expanded home health agency, must show that it and its parent organization has no history of uncorrected or repeated rule violations or uncorrected standard deficiencies as identified by licensure inspections or other deficiencies noted by Medicare or Medicaid audits;
4. An applicant for new or expanded home health agency owned and operated by the applicant or its parent organization shall have no previous conviction of Medicare or Medicaid fraud;
5. An applicant must provide a written plan showing its ability to recruit, hire and retain the appropriate numbers of qualified personnel;
6. An applicant for a new home health agency shall provide evidence of their intent to meet the appropriate accreditation requirements of the Joint Commission for Accreditation of Healthcare Organizations (otherwise known as JCAHO);
7. An applicant for an expanded home health agency must provide documentation that it is fully accredited by JCAHO already; and
8. An applicant must show that it will assure access to services to individuals unable to pay and to all individuals regardless of payment source or circumstances.

All of these items create a minimum threshold for home health agencies to meet and to obtain a CON. Without CON, none of those requirements will be imposed upon home health agencies and the result will be in all likelihood a significant decline in the overall quality of services provided by home health providers in the State of Georgia.

## The Future of Home Health

The Federal Government has continually supported the provision of home health services to Medicare and Medicaid patients. We fully expect that the support will continue for the indefinite future so it is important that all home health agencies in the State of Georgia meet minimum requirements in order to be able to provide services to very needy people. The provision of home health services (like the provision of other healthcare services) is not a commodity like other things are in a typical free market system. We are dealing with real people with real problems and real diseases. It is important that the providers of those services to those people, who rely on them for a very long time are competent and committed to the provision of the highest quality services.

It has been widely reported that there is a significant shortage of qualified medical personnel in Georgia and nationally. We can only imagine what it would be like if the number of providers in Georgia quadrupled overnight from 100 to 400 in terms of recruiting and employing high-quality people. We would expect that the cost of recruiting qualified people would increase dramatically but at the same time there would be numerous provider providing sub-quality services without any real oversight to check on those services. That is not good for the State of Georgia, it is not good for Georgia citizens.

Thank you for giving us the opportunity to make this presentation to you today.



## DEPARTMENT OF AUDITS AND ACCOUNTS

254 Washington Street, S.W., Suite 214

Atlanta, Georgia 30334-8400

CLAUDE L. VICKERS  
STATE AUDITOR  
(404) 888-2174

February 18, 1997

Ms. Marjorie P. Smith, Commissioner  
Department of Medical Assistance  
2 Peachtree Street, N.W., Suite 27-100  
Atlanta, Georgia 30303

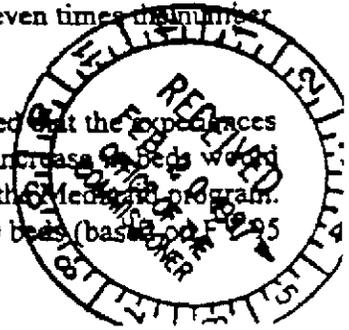
Dear Commissioner Smith:

You requested the fiscal impact of removing certificate of need requirements for certain health care providers in Georgia. It should be noted that the General Assembly has not asked us for a fiscal note on any particular piece of legislation and the contents of this letter are not applicable to any particular bill. However, in anticipation of a possible request for a fiscal note, we have done some research on the effects experienced in other states which removed CON requirements. This research has led us to draw some general conclusions as to the possible fiscal impact of the removal of certificate of need requirements in Georgia. The remainder of this letter presents those conclusions.

### *NURSING HOMES*

In those states in which the certificate of need (CON) for nursing homes was abolished, the effects were immediate and dramatic. Every state saw an increase in the number of available nursing home beds coupled with a decrease in occupancy rates. Taken either in concert or singly, both effects have a tremendous potential fiscal impact on the state's Medicaid budget. Looking at just the explosion of available beds yields confirming data. The State of Arizona abolished the CON program for nursing homes in 1982. During the period of 1982 to 1986, the number of nursing home beds grew by 5,878 or an average annual increase of 14%. In the state of Utah, the CON program was eliminated in 1984. During the three year period immediately following deregulation, 1,303 new nursing home beds were added to the system. Of these beds, 81% were added in one year - 1987. Kansas terminated the CON program for nursing homes in 1985. From 1980 to 1985, the period just prior to deregulation, nursing home beds increased by 569 beds or an average increase of 114 beds per year. Between 1985 and 1989, the three years following the removal of the CON, a total of 2,143 new beds were added or an increase of 714 per year; approximately seven times the number added under the CON program.

Should the CON program be removed in the State of Georgia, it is anticipated that the experiences detailed in other states would also occur to some degree in Georgia. The increase in beds would increase the number of patient days which would greatly impact the costs of the Medicaid program. A ten percent increase in Medicaid nursing home beds, approximately 4,100 beds (based on Feb 95



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numbers) would have a total fiscal impact of just over \$117 million dollars, of which Georgia would be responsible for approximately \$45 million (38%).

### ***HOME HEALTH***

Removal of the CON program for the home health industry proved to be so problematic for many states that moratoriums were instituted almost immediately. The most dramatic increases in the number of home health agencies occurred in Texas and Tennessee. In both states the number of home health agencies literally quadrupled over night. Tennessee officials report that they were unable to handle the increase in administrative procedures and thus sought a moratorium on the addition of new agencies. This moratorium remains in place and officials state that they do not plan to remove it in fear of a repeat of their earlier experience. Growth in the states parallels national health care expenditures for home health care. During the period of 1985 to 1990 (the years when most states removed the CON on this sector of health care), expenditures for home health care grew from approximately \$6 billion to over \$13 billion.

The Georgia State Health Planning Agency reports a cost avoidance in the home health care sector of health care of just over \$5 million for the period of 1990 to 1995. However, if the CON requirement is removed, it is anticipated that Georgia will experience an increase in the number of home health care agencies and a subsequent increase in the number of Medicaid recipients served just as in other states.

An increase of 50% in terms of the number of Medicaid recipients served by home health agencies would result in a cost of approximately \$9 million with the state share estimated to be \$3.2 million.

### ***HOSPITALS***

The most problematic of all health care sectors are hospitals. Removal of the CON program has had mixed effects in various states. In general, states without CONs report a concentration of new facilities and buildings in metro areas to the detriment of rural areas as well as a nationwide decrease in hospital bed occupancy rates.

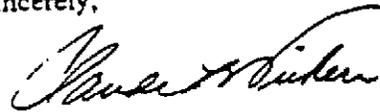
After the removal of the CON in Texas in 1985 on hospitals, in just one year, the number of psychiatric facilities jumped from 48 to 86 and the number of psychiatric beds jumped from 4,712 to 8,371. In 1989, when Virginia dramatically reduced the scope of its CON program, the number of MRIs in the state doubled from 38 in 1989 to 72 in 1991. In July 1992, Virginia reinstated CON review requirement for any capital expenditures exceeding \$1 million and for specified equipment like MRIs regardless of cost.

While it is anticipated that the removal of the CON program in Georgia would have the same adverse

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effects, it is impossible to predict with any degree of confidence the total fiscal impact this would have on the state's budget.

Sincerely,



Claude L. Vickers  
State Auditor

CLV/mp

POTENTIAL MEDICAID IMPACT OF ABOLISHING CERTIFICATE OF NEED (C.O.N.)

CATEGORY OF SERVICE	EXPECTED IMPACT
Inpatient Hospitals	<ul style="list-style-type: none"> <li>• Expansion of some technologies such as CT scans and MRIs.</li> <li>• Potential diffusion of high cost procedures (heart surgery, transplants, pediatric intensive care) in hospitals with low volume</li> <li>• Expansion of perinatal services without necessary neonatal supports for quality of care</li> <li>• Little increase in marginal cost from added beds</li> <li>• No <u>short term</u> cost increase from expanded beds or capital outlay due to established case rates.</li> <li>• Public hospitals may lose more profitable patients, would need more DSH funds.</li> </ul>
Home Health Agencies	<ul style="list-style-type: none"> <li>• The nursing home industry will enter the market with vigor</li> <li>• In a very competitive market, providers will push physicians to order more services, resulting in more cost.</li> </ul>
Nursing Homes	<ul style="list-style-type: none"> <li>• Rapid, dramatic growth in nursing home beds (as happened in Texas with repealed CON)</li> <li>• Increasing dominance of the industry by chains with capital for investment in beds and in community based services.</li> <li>• If both beds and patients increase, total costs will rise. If beds increase significantly more than patients, cost per patient will rise due to empty beds, and cost-based rates will increase.</li> </ul>
Ambulatory Surgical or Obstetrical Facilities	<ul style="list-style-type: none"> <li>• Growth in the number of facilities, with some potential for cost savings over inpatient care</li> <li>• Increase in workload, cost for standards and licensure, with possible quality problems resulting</li> </ul>
Inpatient facilities treating traumatic brain injury	<ul style="list-style-type: none"> <li>• Diffusion of service into facilities with low volume, risk of low quality</li> <li>• Rehabilitation providers would lease empty beds from hospitals, provide services there.</li> </ul>
Diagnostic, treatment and rehabilitation centers: <ul style="list-style-type: none"> <li>• Radiation therapy</li> <li>• Biliary lithotripsy</li> <li>• Surgery</li> <li>• Cardiac catheterization</li> </ul>	<ul style="list-style-type: none"> <li>• Expansion of facilities and services, with increased cost associated with equipment purchase</li> <li>• Risk of quality problems associated with low volume</li> <li>• Increase in workload, cost for standards and licensure</li> </ul>

**GEORGIA ASSOCIATION OF HOMES & SERVICES FOR THE AGING  
(GAHSA) COMMENTS TO THE STATE COMMISSION ON THE EFFICACY  
OF THE CERTIFICATE OF NEED PROGRAM**

Prepared for September 13, 2005 Commission Meeting  
Walter Coffey, President

The Georgia Association of Homes and Services for the Aging (GAHSA) is an association representing a diverse group of over 100 non-profit senior care providers (and quality-focused for-profit continuing care retirement communities) with distinct constituent groups: continuing care retirement communities, nursing homes, low-income senior and retirement housing, assisted living, hospital-based and community-based providers. Representing members for 32 years, GAHSA members serve over 124,000 older Georgians. Due to the very existence and nature of GAHSA's work, it is abundantly clear that GAHSA believes that seniors should have access to a full continuum of services in order to maximize independence and enhance quality of life. It is from this perspective that GAHSA offers the comments to the State Commission on the Efficacy of the Certificate of Need Program.

**Background:**

Georgia is a rapidly growing destination for retirees. Many parts of the state are aggressively marketing to the senior population with positive results. For example, Brooks, Lowndes, and Thomas Counties with the Triple Crown Hometown have made efforts to recruit seniors to South Georgia. With the recent hurricane seasons that have shown brutal outcomes in Florida more seniors are considering Georgia as a retirement destination. In addition, seniors are moving to the coast of Georgia, metro Atlanta, and the north Georgia mountains. This has produced greater interest in the development of Continuing Care Retirement Communities (CCRC) in our state.

Continuing care retirement communities (CCRCs) offer an innovative and independent lifestyle that is different from other housing and care options for older adults. Through long-term contracts that provide for housing, services and nursing care, usually all in one location, the CCRC continues to meet residents' needs in a familiar setting as they grow older.

Religious organizations, fraternal groups and other nonprofit agencies sponsor most CCRCs nationwide. These communities provide comprehensive residential and health care services. At the same time, they offer some distinct advantages including physical and financial security, independence and access to healthcare, companionship of friends and neighbors of similar age, access to community facilities, and privacy.

CCRCs are governed by state regulation in 33 states. Typically, as is the case in Georgia, CCRCs are classified as an insurance model and are governed by the state department of insurance or another similar entity. Each of the components making up a retirement community may also be subject to separate oversight: the housing units could be

regulated by the local government, the assisted living regulated by the state, and the nursing home part of the community governed by federal regulations.

The current Certificate of Need laws in Georgia have a limiting effect upon the development of CCRCs within the state. Other states have been progressive in encouraging the development of CCRCs which ultimately expands the economies in the locality in which they are located as well as throughout the entire state. If CON regulations were amended slightly to allow for a limited "open fill" of nursing facilities constructed as part of a CCRC (currently considered "sheltered beds"), CCRCs would be able to offer to their market the assurance of the nursing component being readily available and still protect the interest of stand alone nursing homes in the community.

Since CCRC regulations prohibit full service CCRC contracts from participating in the Medicaid program, amending the CON regulations to allow "outside" admissions or those residents not currently living on the campus of the CCRC would not in any way increase the Medicaid liability of the state nursing home expenses. The residents of such communities are covered through the population of the campus "self insuring" for future nursing home needs.

We feel that some needed changes to the Certificate of Need program that will enable it to more effectively dovetail into the Certificate of Authority Program for CCRCs administered by the Department of Insurance. GAHSA proposes the following changes in the CON regulations to support the growth of CCRC development and thus retiree relocation in and to the state of Georgia:

**Changes needed to support the development of CCRCs in Georgia:**

Regarding CCRC Sheltered Nursing Facility Beds

We suggest the following revision to Rule 111-2-2-.33(4)(c):

(c) Sheltered nursing facility beds approved under these Rules shall be used exclusively for persons who are residents of the CCRC, and who are a party to a continuing care contract with the facility or the parent organization and who have lived in a non-nursing unit of the CCRC for a period of at least 90 days. The following exceptions shall be allowed: (1) one spouse, sibling or parent may be admitted directly to the nursing unit at the time the other spouse or sibling moves into a non-nursing unit, or (2) a person who is a party to the continuing care contract may be admitted directly into the nursing unit when the medical condition requiring nursing care was not known to exist or be imminent when the individual became a party to the continuing care contract, or (3) a person who is not a party to a continuing care contract may be admitted directly into the nursing unit during the first seven (7) years after the date of the initial nursing facility license. Further, the facility may continue to admit persons who are not parties to continuing care contracts after its first seven (7) years of operations for such periods as approved by the Department after the Department considers the

financial impact on the CCRC and the impact on the contractual rights of the residents of the CCRC.

The basis for our suggestion is that maintaining occupancy in the nursing facility is crucial to the success of a CCRC. Being able to admit nonresidents directly into the nursing facility will offset the large costs incurred in operating the nursing facility and, in turn, maintain lower monthly service fees paid by CCRC residents. Outside private pay residents (including Medicare residents) provide a source of revenue that contributes towards the significant costs of providing skilled nursing care to the existing residents of the CCRC.

In general, CCRCs in Georgia are experiencing minimal usage of nursing home beds in the first few years of operation. Further, based on our member's experience, residents of a new CCRC will not fully occupy the nursing facility beds until the CCRC is 7 to 9 years in operation. In addition, admitting nonresidents to the CCRC nursing facility also provides an additional health care choice to seniors. We are not proposing that the CCRC participate in the Medicaid program.

There are other states where some of members conduct business that have similar requirements for admission of nonresidents to the CCRC nursing facility for a certain number of years after licensure. These CON programs have been very successful in those areas.

#### Post-Approval Requirements for CCRC Personal Care Home/Nursing Facility Development

Rules 111-2-2-.02(6) and 111-2-2-.04(2)(b) state that projects involving construction must submit the following documentation to the Department within 12 months of the effective date of the Certificate of Need:

1. the construction plans have been approved by the Department's architect;
2. the construction contract has been signed, specifically indicating beginning and completion dates; and
3. The construction materials and equipment are on the site and construction of the project has actually begun.

We would like to propose that these sections be revised or an additional section be added that would establish separate post-approval requirements for a CCRC personal care home/nursing facility development project. We suggest extending the term for completion of the items listed in 1, 2 and 3 above to 36 months for CCRC projects. This 36-month period would also need to be reflected in Rule 111-2-2-.02(7) – Extension of Time Periods.

The language as written in Rules 111-2-2-.02(6) and 111-2-2-.04(2)(b) is more reflective of building a freestanding nursing facility. For the development of a CCRC project, certain pre-sales must be met before construction can begin. Pre-sale goals vary

depending on long-term financing requirements and Certificate of Authority regulatory requirements, but typically run around 60 to 70 percent of the CCRC residences being reserved in advance. Depending on the size of the project, it can take up to 2 to 3 years before construction can begin. Because the personal care home and/or nursing facility is developed in conjunction with a CCRC, a 12-month time-frame for the items listed in 1, 2 and 3 above is not feasible for a CCRC project.

### **Regarding Nursing Homes & Personal Care Homes**

As noted earlier, GAHSA believes strongly in the need for a continuum of services. Therefore, we believe that Georgia needs to closely examine the current residential options for older Georgians.

GAHSA members participate in the national Quality First program as well as the Georgia quality initiative. We were pleased to work with other groups including Georgia Health Care Association, Alzheimer's Association, AARP, Ombudsman and Georgia Medical Care Foundation on this project. Likewise, we are pleased with the results of these initiatives.

Currently, Georgia has two options for long-term care residential settings. For those who need continuous medical supervision, nursing facilities are the residential option. For those who do not need medical supervision, personal care homes are available. For those consumers who need some intermittent nursing services, but not 24-hour medical supervision, no appropriate residential option is available. Several years ago, the Health Strategies Council of the then Georgia Department of Medical Assistance recommended adding another level of care.

At least ten states license facilities based on differing categories of care. Legislation is pending in the Georgia General Assembly to create an additional licensing level in Georgia's long-term care continuum. (It should also be noted that legislation could be framed to allow, or to preclude Medicaid reimbursement of services provided in this prospective new level of long-term care.)

Regarding nursing home beds, GAHSA feels that the need to create additional general nursing home beds should be evaluated from the perspective of the above discussed continuum of care. In addition, we agree with the Georgia Health Care Association that the state should assist in the development of incentives to allow providers to replace older facilities and allow for the relocation of beds or facilities in order to better serve older Georgians.

We appreciate the opportunity to participate in this process and are available to provide additional information if it is needed. Below, please notice a list of GAHSA member CCRCs and communities that provide all levels of care.

### GAHSA CCRC Members

- Brandon Wilde – Augusta
- Canterbury Court – Atlanta
- Carlyle Place – Macon
- Lanier Village Estates – Gainesville
- Lenbrook in Buckhead – Atlanta
- Marshes Edge on St. Simons Island (Under Construction)
- Marshes of Skidaway Island – Savannah (Under Construction)
- Park Springs - Stone Mountain
- Peachtree Hills Place, Atlanta (Under Development)
- Presbyterian Village – Austell
- Spring Harbor – Columbus (Under Construction)
- St. George Village – Roswell
- Talmage Terrace Retirement Community - Athens
- Wesley Woods of Newnan-Peachtree City

### GAHSA Multi-Level Communities

- Christian City – Union City
- The Presbyterian Home – Quitman
- Wesley Woods Center of Emory Healthcare – Decatur
- The Weinberg Campus – Atlanta

**Presentation  
To The  
State Commission  
On the Efficacy of  
The CON Program**

**By**

**Fred Watson, President**  
Georgia Health Care Association

**September 13, 2005 – 1:00 p.m.**

**Georgia Health Care Association  
160 Country Club Drive  
Stockbridge, Georgia 30281**

**678-289-6555 FAX 678-289-6400 email: [fwatson@gnha.org](mailto:fwatson@gnha.org)**

## **INTRODUCTION AND OVERVIEW**

The Georgia Health Care Association (“GHCA” or the “Association”) has served as the primary advocate for Georgia’s frail and elderly citizens since 1953 and currently represents over 95% of all the licensed skilled nursing facilities in the State. There are currently 372 facilities in the State of Georgia consisting of approximately 40,000 beds. In addition, at least one skilled nursing facility is located in almost every county in the State.

The Association and its members appreciate the opportunity to participate in the certificate of need review process that has been established by the Georgia General Assembly, the Division of Health Planning and the Health Strategies Council. It is important that there be open and thorough review of the regulatory process. In the past, the Department of Community Health (the “Department”) has shown a willingness to make adjustments and changes to meet the needs of the citizens of this State and the organizations that provide health care services.

## **POSITION ON CURRENT RULES AND METHODOLOGIES**

The Association has participated in the development of the current rules and methodologies established by the Department and **WE RECOMMEND NO MAJOR CHANGES AT THIS TIME FOR CON RULES GOVERNING SKILLED NURSING FACILITIES AND OTHER LONG TERM CARE PROVIDERS.** We believe the current process has served its purpose as illustrated by the following points:

- With few exceptions there is an adequate supply of skilled nursing beds across the state. The current average occupancy rate for skilled nursing facilities ranges from 87% to 90%. Only the preferred, high-quality homes have waiting lists and those are by consumer preference, not availability of beds.
- Georgia has embraced the concepts of the New Freedom Initiative and made significant regulatory and other methodology changes to promote home and community based services. As a result of these regulatory and methodology changes by the Department, skilled nursing facilities have actually served more patients per year (55,000), while the overall average occupancy rate has declined. This desired change has been driven by the development of home and community based programs, the SOURCE program, and additional personal care home beds.
- The Department, in conjunction with skilled nursing service providers, recently implemented a new acuity-based payment system for skilled nursing services. The patients that are now admitted to skilled nursing facilities are generally sicker, more frail and have shorter lengths of stay. Changing to an acuity-based system was driven by the desire to reduce unnecessary and inappropriate admissions to skilled nursing facilities. Evidence indicates the regulatory change is having the desired impact on

skilled nursing facilities and other long-term care providers. Accordingly, **WE RECOMMEND NO MAJOR CHANGES AT THIS TIME FOR CON RULES GOVERNING SKILLED NURSING FACILITIES AND OTHER LONG TERM CARE PROVIDERS.**

### **FLEXIBILITY NEEDED IN THE CURRENT SYSTEM**

**Integration:** Skilled nursing facility providers are diversifying their menu of services with many now providing home care, pharmacy and rehabilitation therapy services. In addition, some of the most successful SOURCE community-based providers in the State are operated by organizations that also provide skilled nursing services. This type of integration of a fragmented system is needed to save Medicaid and private health care dollars and provide better service for patients. Georgia skilled nursing service providers are participating in development of the Medicaid Modernization Plan currently being promoted by the Governor's office. Hopefully, the Modernization Plan and its related regulatory changes will make integration of the health care delivery system more achievable.

**Resource Utilization:** Skilled nursing facilities employ over 33,000 employees in the state and often are the sole and largest health care provider in many communities. Given the current local health care delivery system, the skilled nursing service providers are the most logical means to efficiently deliver health services in the local communities. The infrastructure, personnel and knowledge base is already in place. Accordingly, the regulatory process should encourage skilled nursing service providers to participate and partner with other providers to promote movement of patients from various levels of care. GHCA encourages this flexibility in the regulatory process to allow providers to provide the services without interruption of the flow of funding and certification.

**Modernization:** GHCA also believes the Department, through its policies, procedures and regulations should encourage maintenance of skilled nursing facilities. Likewise, to the extent health facilities are utilized by state beneficiaries, Department regulations and payment methodologies should include modernization incentives to encourage replacement of older facilities (some are as much as 40-50 years old). Additionally, GHCA promotes the elimination of 3 and 4-bedroom wards. However, there is a barrier that inhibits skilled nursing facilities from providing private-room accommodations. GHCA advocates modification of rules and regulations to allow skilled nursing facilities the flexibility to modernize physical plants.

**Relocation:** Georgia's population has grown substantially since adoption of the current CON legislation and accompanying rules and regulations. In addition to population shifts, other factors including economic, demographic and health care shifts within the state have affected the access to skilled nursing services in some areas. Accordingly, rules and regulations should also encourage reconstruction and relocation of some beds or facilities across county lines to better serve the community. Further, the three-mile limitation should be eliminated for replacement of facilities. The three-mile limit

prevents relocating skilled nursing facilities to locations more suitable and convenient for the elderly population.

## **FUTURE EXPECTATIONS AND DEMANDS**

**High-Quality Care:** Georgia's skilled nursing service providers recognize the need to continuously improve the quality of services and the quality of the environment that is expected by the public and paid for by Medicaid and Medicare. With that in mind the Association and the Department initiated a joint, state-wide Quality Initiative just two years ago. The goals of the Initiative were to: 1) improve clinical outcomes, 2) improve customer satisfaction, and 3) reduce employee turnover. After 24 months, 100% of all Georgia skilled nursing facilities are participating in the Initiative. All skilled nursing service providers pledged a commitment to quality improvement. Clinical data is collected from all skilled nursing facility providers each month. The clinical data is compiled and a monthly scorecard is produced each month for every facility. The results of the Initiative have been outstanding and Georgia is recognized as the only state in the nation with such a cooperative effort to improve quality care for its skilled nursing facility residents. The AARP, the Ombudsman, the Alzheimer's Association and many others have supported the Quality Initiative. Clinical data indicates that clinical outcomes have improved. Independent surveys indicate over 85% of all families are satisfied with the care delivered in skilled nursing facilities and would recommend the facility to others. The Association supports continued collaborative efforts and flexibility in regulations to meet the public's expectation of high-quality care.

**Bed Need:** In the future, as the population of Georgia grows and grows older, demographic data indicates that Georgia will need more skilled nursing facility beds. A recent newspaper article explained that 33% more beds will be needed in Veterans Administration facilities just to accommodate the needs of veterans. This figure is also indicative of the general population, especially considering that the over age 85 population is the fastest growing segment of the population and are most likely to need skilled nursing care. Under the current CON rules and regulations, care alternatives are developing in Georgia to meet the current market needs. Accordingly, it is not likely more beds will be needed in the near future. At the present time, and for the foreseeable future, skilled nursing facility beds are available throughout the state.

**Staffing:** The shortage of trained medical personnel is a well-documented concern. The cost of labor, benefits and other payroll related issues continue to rise. Georgia's public and private education system is moving to address the future needs of the medical community, including skilled nursing service providers. As indicated in the discussion of Resource Utilization, given the current local health care delivery system, the skilled nursing service providers are the most logical means to efficiently deliver health services in the local communities. Currently, there is a documented need to recruit 1,500 to 2,000 more nurses (LPN or RN) and 2,000 certified nursing assistants to meet current staffing needs of skilled nursing facilities.

**Payment for skilled nursing care:** GHCA recognizes that the public is demanding: 1) better accommodations 2) additional staff 3) more highly-trained staff to care for higher-acuity patients, and 4) better technology and infrastructure in the physical buildings. Given these expectations and demands, GHCA encourages the Commission, the Legislature and various regulatory agencies to provide rules and regulations that encourage private sector investment to replace, modernize and improve the aging skilled nursing facilities in the state. It is not possible under the current payment system. With the help of the federal match and an improved property payment system similar to other states, Georgia can create jobs, improve local economies and improve services for the patients who need our essential services. We ask the Commission to explore those possibilities further.

## **SUSTAINABLE RESOURCES**

**Diversion of Funds:** Adequate resources are required to keep skilled nursing service providers in operation and delivering care and services. Budget cutbacks have impacted skilled nursing facilities over \$300 million in the past three years and more significant reductions have been imposed for the current year. Skilled nursing service providers actually agreed and helped pass a "provider fee", legislation that requires skilled nursing facilities to pay \$9.00 per patient per day in fees. Skilled nursing facilities pay a total of \$100 million in provider fees to the State of Georgia each year which is used to generate \$160 million in additional federal matching funds for Medicaid. Unfortunately, the additional federal funds have not been utilized to pay for skilled nursing services.

Accordingly, none of the additional federal funds were used to modernize skilled nursing facilities, provide and pay for staff or meet the public's demand to provide high-quality services.

**Economic environment:** In the past 5 years, at least 75 skilled nursing facilities in Georgia have filed for bankruptcy protection and reorganization (20% of all skilled nursing facilities in the state). Presently, most of the bankrupt facilities have come out of bankruptcy and many have changed operators and owners. Unfortunately, the skilled nursing industry remains grossly undercapitalized and under funded while attempting to meet a rapidly changing market.

**Economic Impact:** Total skilled nursing facility expenditures amount to approximately \$1 billion dollars annually with approximately 1/3<sup>rd</sup> coming from Medicaid state funds. The economic impact of these payments in local communities is projected to be \$5 billion for the State. The cost containment payment system in Georgia has worked for over 20 years to reduce payment rates and the average payment to skilled nursing facilities in the state is approximately \$105 per patient per day. Presently, skilled nursing facilities are being paid based on operating costs that were incurred in 2001 and 2002. At \$105 per patient per day, Georgia is one of the most efficiently operated skilled nursing facility programs in the nation. Georgia's overall expenditures for skilled nursing care ranks in the bottom 5 in the nation.

## **CONCLUSIONS AND RECOMMENDATIONS**

**Conclusion:** GHCA recognizes Medicaid expenditures are growing and believes its member facilities have taken extraordinary steps to provide funding (example – provider fee). Further, skilled nursing facility providers have demonstrated: 1) a commitment to quality, 2) the ability to develop health care facilities and services in an orderly, economic and efficient manner, 3) the ability to discern new health service needs, and 4) the ability to address the needs in a manner that avoids unnecessary duplication of service, that is cost effective, and that is compatible with the health care needs of the various areas and populations of the state.

**Recommendation:** The Georgia Health Care Association respectfully recommends **NO MAJOR CHANGES AT THIS TIME FOR CON RULES GOVERNING SKILLED NURSING FACILITIES AND OTHER LONG TERM CARE PROVIDERS.**

Thank you for this opportunity and I will be happy to answer any questions.

**MINUTES**  
**STATE COMMISSION ON THE EFFICACY OF CON**  
Sanders Fireplace Room at the Capitol Education Center  
180 Central Avenue, Atlanta, Georgia

**APPENDIX B**

**Proposed Revisions to Draft Proposed Rules,  
Ambulatory Surgery Services  
(As recommended by Georgia Department of Law)**

**Summary of Law Department Review  
of  
TAC-Proposed Revisions to Ambulatory Surgery Services Rule**

As you are aware, the Department asked the Department of Law to review the TAC-proposed revisions to the ambulatory surgery services regulation. Staff at the Department of Law carefully reviewed the proposed revisions and provided feedback to the Department. The Department has summarized the Law Department's findings below.

**1. Exclusion of freestanding facilities remote from hospital campuses but owned by a hospital or billed under a hospital's provider number is in contravention of the CON Statute**

The CON Statute precludes defining the term, "part of a hospital," to include freestanding facilities integrated with and billed under a hospital's provider number if such facilities are not on a hospital's campus. The CON statute, at OCGA § 31-6-2(1), defines an "ambulatory surgical service" as a facility, which is not part of a hospital. The phrase, "not part of a hospital" refers to geographic location, and not just to ownership. Comparatively, other provisions within the statute use terms such as "owned by," "operated by," and "utilized by" certain entities or individuals. *C.f.* OCGA § 31-6-2(14)(G)(iii)(exempting from CON review ASCs that are "owned, operated and utilized by private physicians.") Furthermore, the statute clearly maintains that Certificates of Need are location specific and places particular emphasis on location throughout.

**Action Needed:** Freestanding facilities which are not located on a hospital's campus must be reviewed in the same manner as all other freestanding facilities. As the proposed revision provides to the contrary, it must be revised.

**2. Distinct criteria for replacement facilities is authorized as long as such distinctions have a rational basis**

As long as a rational basis for distinguishing criteria for replacement and new facilities is identified, replacement facilities may be reviewed under separate and distinct review criteria. Since the revisions were proposed, the Department has developed and promulgated several generally applicable rules regarding replacement facilities.

**Action Needed:** The component plan should be revised to identify a rational basis for distinct review criteria for replacement facilities. In addition, the proposed revisions must be revised to comport with the Department's current regulations regarding replacement facilities.

**3. Inclusion of rooms where surgical treatment is performed solely without anesthesia, with a level of anesthesia less than regional, or in an environment that does not meet the standards for operating rooms established by the Department of Human Resources is not authorized by Statute**

The CON statute, at OCGA § 31-6-2(1), defines an “ambulatory surgical service” as a facility, which provides surgical treatment performed under general or regional anesthesia in an operating room environment. The proposed revision’s definition of operating room may include rooms in which surgical treatment is performed without anesthesia or under minor or local anesthetics, such as endoscopies.

**Action Needed:** The proposed revision must be revised to exclude rooms that are used solely for surgical procedures not requiring anesthesia or requiring anesthesia at a level below regional. If a room will be licensed by DHR as an operating room it should be counted in the inventory of operating rooms, if it will not be so licensed, it cannot be counted in the inventory.

**4. The term “expansion” needs clarification to define the exact instances in which an application would be reviewed under the ASC rules and the general considerations as opposed to solely the general considerations**

The proposed revision states that a project would be reviewed under the ASC rule only when operating rooms are added and the cost exceeds the threshold. The revision does not clarify what would occur when operating rooms are added below the threshold or what would happen when the threshold is exceeded but no operating rooms are added. It is currently the practice of the Department to apply the ASC-specific rules whenever ORs are added regardless of cost.

**Action Needed:** The proposed revision should be modified to clarify when an ASC expansion project would be reviewed under the ASC rule and when it would be reviewed solely under the general considerations.

**5. Exhaustive lists of surgical specialties must provide rational bases for excluding non-included specialties or, in the alternative, a non-exhaustive listing should be employed along with regulatory criteria for determining a single specialty**

The CON statute does not specifically define “single specialty.” Therefore, it is within the Department’s authority to define this term (except for the inclusion of general surgery). The proposed revision employs an exhaustive listing of specialties which qualify as a single specialty. When certain items are excluded from an exhaustive list, administrative law requires that a reasonable basis for distinction be articulated.

**Action Needed:** The component plan must document a reasonable basis for the exclusion of specialties from an exhaustive list, or in the alternative, a non-exhaustive list should be employed. If a non-exhaustive list is employed, then the rule should specify objective criteria by which the Department can judge the eligibility of a specialty not specifically listed, e.g. by reference to a medical certification board.