Certificate of Need

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Key questions: CON

1. What problem are we trying to solve?
2. Will CON repeal address this problem?
3. What critical purpose does CON serve?
4. What happens if we get CON wrong?
   - To our health care system
   - To our state budget
5. Given other factors in the market, is now the time to repeal CON?
6. What information would we need to make this decision?

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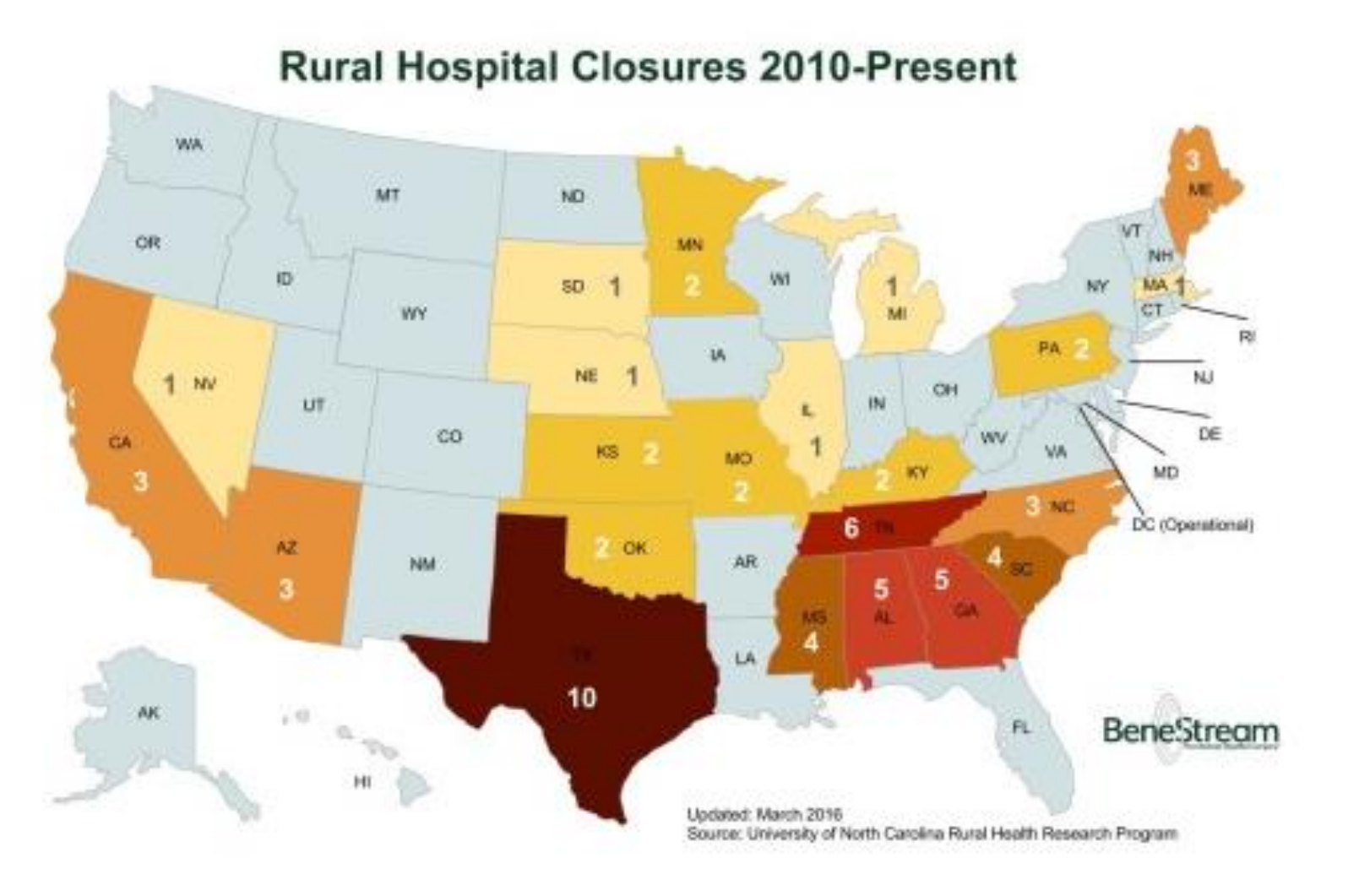
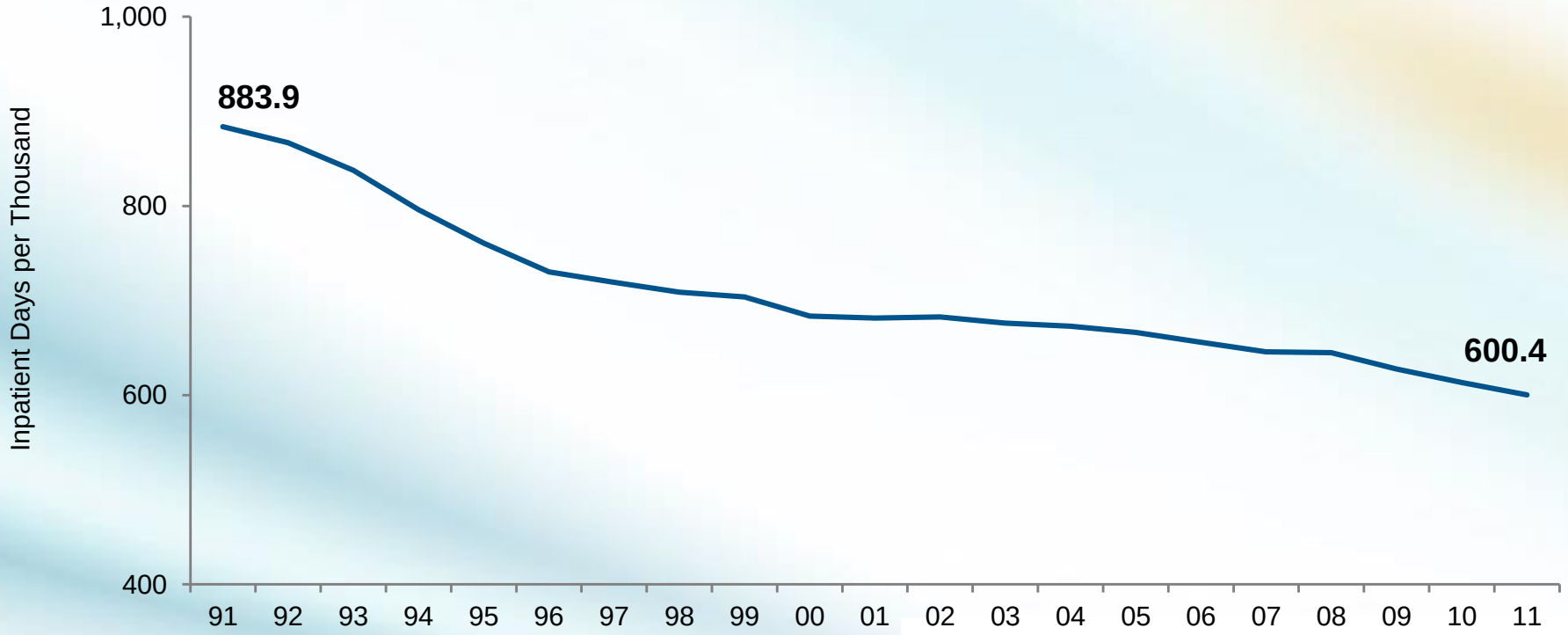
Alaska hospital market

Profitable few, but marginal many



Lower inpatient use

Inpatient Days per 1,000 Persons, 1991 – 2011



Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2011, for community hospitals. US Census Bureau: National and State Population Estimates, July 1, 2011.
Link: http://www.census.gov/popest/data/state/totals/2011/index.html.

Medicare cuts

Cuts Enacted (2010-2026): Legislative	
ACA Marketbasket Cuts	($344,831,800)
Sequestration	($105,309,100)
Medicare DSH Cuts	($94,317,900)
ATRA Coding	($39,036,900)
Bad Debt at 65%	($3,195,800)
MACRA Post Acute MB Cut	($1,818,700)
Total Legislative Cuts	**($588,510,200)**
Cuts Enacted (2010-2026): Regulatory	
Coding Cuts	($222,386,500)
LTCH SN Adjustment	($32,598,700)
Total Regulatory Cuts	**($254,985,200)**
Quality Based Payment Reform (2010-2026)	
Quality	($13,082,900)
Total Cuts Enacted	**($856,578,300)**

These cuts will cost Alaska hospitals $856 million over 15 years.

15-Year Medicare Cut Analysis, DataGen, February 2017.

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Medicaid cuts

- Inflationary adjustments frozen, last two years
- FY18 Administrative cuts:
  - 5% inpatient and outpatient hospital rate reduction, starting July 1
- Senate DHSS reduction, could mean additional cuts on top of 5% rate reduction
- *For our high-Medicaid providers, these cuts are approaching the point where financial viability is in question*
- Especially vulnerable: inpatient residential psychiatric treatment for adolescents, skilled nursing facilities, Critical Access Hospitals (<25 beds)

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Goal of CON program

For proponents of repeal: to restrain the growth of health care costs

- Competition reduces prices and will thus lower overall costs in the health care market
- Thus, increasing competition through CON repeal will lower prices and restrain the growth of health care costs

We must add to that analysis:

- Impact of CON on quality
- Impact of CON on access to care for underserved populations
- Use of CON as a tool for public accountability and transparency

Competition is occurring

1. CON has not limited small outpatient imaging or surgery centers in most markets due to the physician office exemption, lax enforcement, and ability to move facilities
2. CON has limited high-cost, capital intensive surgery centers, expensive hospital expansions
3. CON has limited SNF development
   - Mat-Su Valley CON
   - 90% Medicaid

Does CON repeal address our cost problem?

Primary factors driving health care costs:

1. Fee-for-service system, which rewards volume of procedures, incentivizing overtreatment
2. Prescription drugs
3. New medical technology, and our use of new medical technology
4. Aging population
5. Unhealthy lifestyles
6. High administrative costs
7. Service provider consolidation (not much of a factor in Alaska)

Mack, M. (2016). What drives rising health care costs? *Government Finance Review.* 26-32.

What factors are driving health care costs?

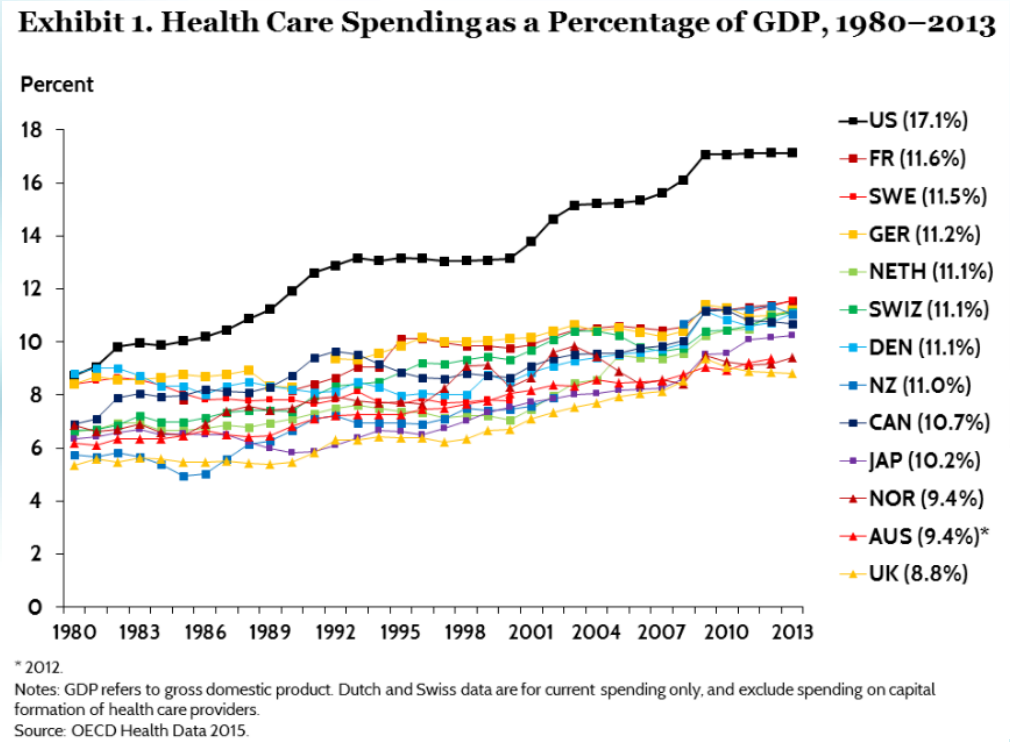
Lack of competition in the health care market is not commonly cited as a driver of health care costs.

"… choice and competition have no proven track record of cost control in medical care either in the United States or elsewhere."

Elhauge, E. (2010). The Fragmentation of U.S. Healthcare: causes and solutions. New York, New York, Oxford University Press.

A global perspective

- High U.S. healthcare costs attributed to higher prices and greater use of medical technology.
- Other countries have far greater controls on utilization of high-priced medical technology.
- Higher costs have not led to better outcomes.



The Commonwealth Fund, U.S. Healthcare from a Global Perspective

Use of medical technology

Exhibit 5. Diagnostic Imaging Supply and Use, 2013

	Magnetic resonance imaging		Computed tomography		Positron emission tomography	
	MRI machines per million pop.	MRI exams per 1,000 pop.	CT scanners per million pop.	CT exams per 1,000 pop.	PET scanners per million pop.	PET exams per 1,000 pop.
Australia	13.4	27.6	53.7	110	2.0	2.0
Canada	8.8	52.8	14.7	132	1.2[a]	2.0
Denmark	–	60.3	37.8	142	6.1	6.3
France	9.4	90.9	14.5	193	1.4	–
Japan	46.9[b]	–	101.3[b]	–	3.7[b]	–
Netherlands	11.5	50.0[b]	11.5	71[b]	3.2	2.5[a]
New Zealand	11.2	–	16.6	–	1.1	–
Switzerland	–	–	36.6	–	3.5	–
United Kingdom	6.1	–	7.9	–	–	–
United States	35.5	106.9	43.5	240	5.0[a]	5.0
OECD median	11.4	50.6	17.6	136	1.5	–

[a] 2012. [b] 2002–2009. [c] 2009–2012.
[d] Current spending only; excludes spending on capital formation of health care providers.
[e] Adjusted for differences in the cost of living.
[f] Numbers may not sum to total health care spending per capita due to excluding capital formation of health care providers, and some uncategorized spending.
Source: OECD Health Data 2015.

Health care vs. a normal market

Normal Competitive Market	Health Care
Many buyers and sellers	Few sellers
Firms can freely enter and exit the market	Barriers to entry: high capital costs, licensing restrictions
Perfect information	Information is asymmetric. The agent (e.g. provider) has access to more information than the consumer, and makes decisions on the consumer's behalf.
Buyers pay the cost of what they consume	Third party payers insulate buyers from the full cost of their choices.
If buyers can't pay, they don't get a service	Emergency Medical Treatment and Active Labor Act (EMTALA)

It is well-established that health care is not a normal market. Different assumptions thus yield different outcomes than in a normal market.

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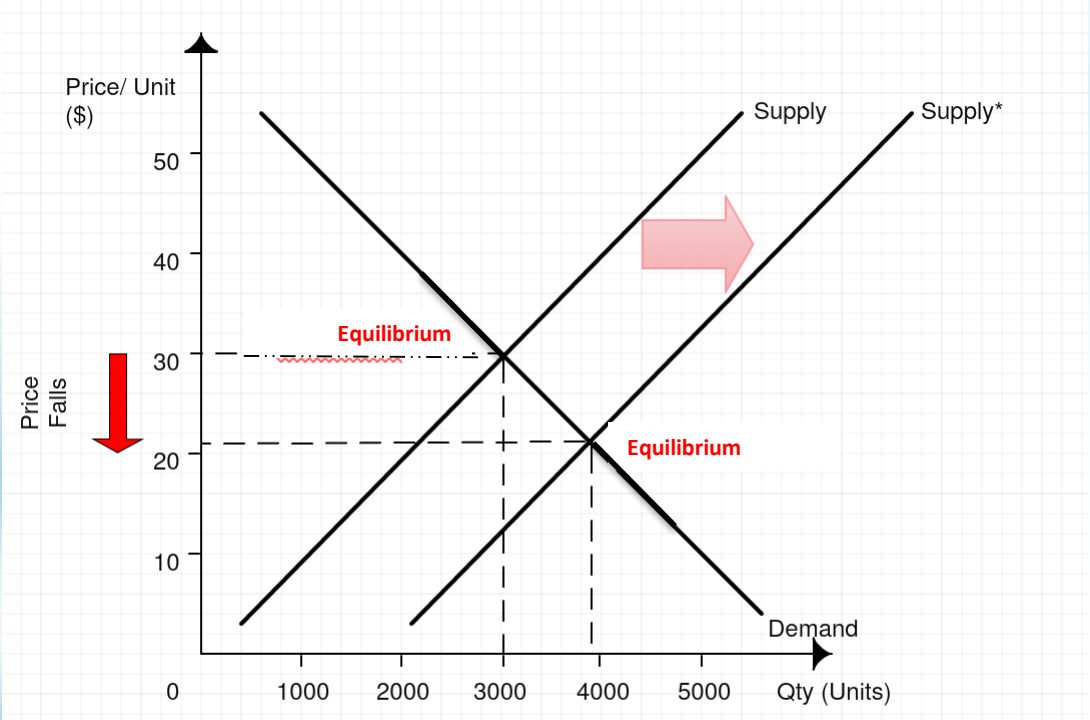
Increased supply means increased quantity



Impact of Increase in Supply with no change in Demand

This is what CON repeal proponents believe will happen:

- Supply increases
- Price falls
- Quantity increases

"Note, however, that one need not assume SID (supplier-induced demand) to predict aggregate demand increases in response to increased competition. A simple market supply and demand model predicts this."

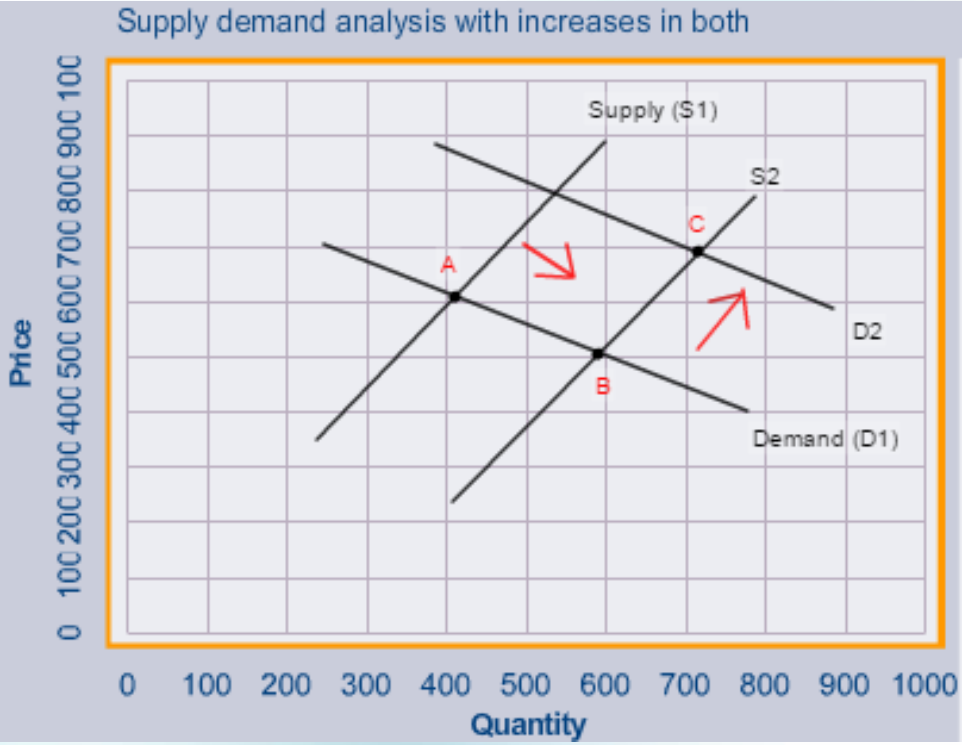
– Folland, S., Goodman, A. C., & Stano, M. (2013). *The Economics of Health and Health Care* (7th ed.). Upper Saddle River, NJ: Prentice Hall.

A Starbucks on every corner means we drink a lot more coffee.

Competition and health care markets

- Under most normal markets, competition reduces per unit cost and increases the quantity purchased.
- Health care is NOT a normal market.
- One reason is that providers impact demand, an observation strongly supported by economic studies.
- Competition will lower prices if the impact is only on supply. If demand also increases, competition can actually raise prices.
- How does this happen?

Competition can increase prices!



Original price	$600 (Point A)
Original quantity	400 (Point A)
Original total cost (PxQ)	$240,000
Price after supply and demand increases	$700 (Point C)
Quantity after supply and demand increases	700 (Point C)
New total cost	$490,000
Net effect	**Increased total cost by $250,000 and per unit cost by $100.**

Under certain circumstances, competition can <u>increase volume and</u> price, leading to higher costs for the individual and for the health care system.

What does the literature say on CON?

You can find a study to support your view:

1. Difficulty in comparing between states and in isolating which variables drive cost. (e.g. California a non-CON state with a high penetration of managed care)
2. Some studies support that CON reduces the rate of growth of acute care (hospital)services.
3. Little evidence that overall costs are reduced.
4. Evidence suggests that CON helps maintain the financial viability of safety net hospitals and ensure care for the indigent.
5. CON has a positive impact on quality of care in some targeted instances.

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A few studies to note:

Lorch, S.A., Maheshwari, P., & Even-Shoshan, O. (2012). The impact of Certificate of Need Programs on Neonatal Intensive Care Units. *Journal of Perinatology 32, 39-44.*

"Conclusion: There has been an erosion of CON programs that oversee NICUs. CON programs are associated with more efficient delivery of neonatal care."

Lucas, F.L. Siewers, A., Goodman, D.C., Wang, D., & Wennberg, D.E. (2011) New cardiac surgery programs established from 1993 To 2004 led to little increased access, substantial duplication of services. *Health Affairs.*

"We observe that certificate-of-need requirements may help avoid unnecessary duplication of services by preventing new programs from opening in close proximity to existing ones."

Hellinger, F.J. (2009). The effect of Certificate-of-Need laws on hospital beds and healthcare expenditures: an empirical analysis. *The American Journal of Managed Care, 15(10), 767-744.*

Conclusion: Certificate-of-need programs have limited the growth in the supply of hospital beds, and this has led to a slight reduction in the growth of healthcare expenditures.

Cost: "… it is clear that the evidence on cost-containment is weak, but the evidence suggests that the CON process does affect spending patterns." (p. i)
Quality: "… the area where CON can directly influence quality is narrow." (p. ii)
Access: "The remaining argument, maintenance of access, particularly for the underserved deserves careful consideration." (p. ii)

"The traditional arguments for CON are empirically weak… However, given the potential for harm to specific critical elements of the health care system, we would advise the Illinois legislature to move forward with an abundance of caution. *Nontraditional arguments for maintaining CON deserve consideration, until the evidence on the impact that specialty hospitals and ambulatory surgery centers may have on safety net providers can be better quantified." (p. iii)*

An Evaluation of Illinois' Certificate of Need Program

By
Al Dobson, PhD
W. Pete Welch, PhD
David Bender, Kristina D. Ko, Namrata Sen,
Audrey El-Gamil, Terry West, and Ted Kirby

The Commission on Government Forecasting and Accountability

February 22, 2007

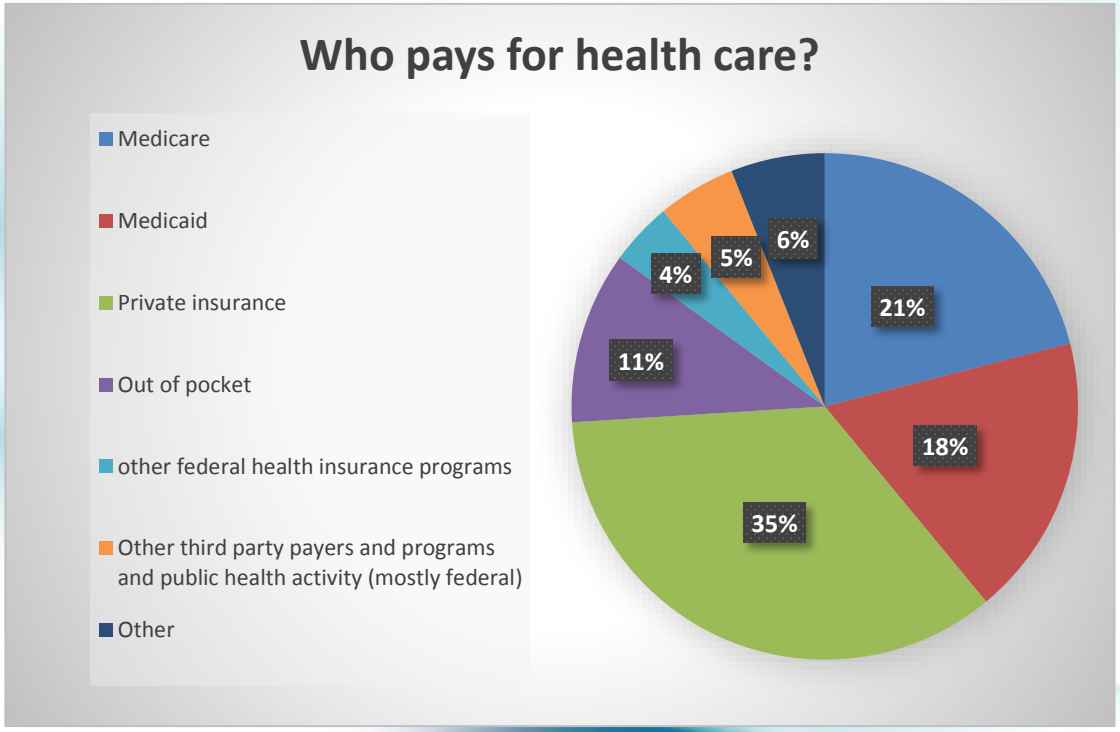
The Lewin Group

Benefits of CON

1. Promotes and ensures access for underserved populations
2. May prevent oversupply of services, equipment and facilities
3. May restrain oversupply of facilities, which can lead to overutilization of services (supply-induced demand)
4. May protect high-volume procedures that affect quality (e.g. NICU)
5. Provides a vehicle for health care cost transparency and public input into the health planning process
6. Manages major capital expenditures, protecting Medicaid budget

Health care and the public interest

- Government plays a significant role in both the financing and regulation of health care.
- Intent of CON law should be to ensure that health care services operate in a manner fully consistent with the public interest.
- State of Alaska: Medicaid pays a capital rate, budget implications!



EMTALA and the free market

- Emergency Medical Treatment and Active Labor Act (EMTALA)
- Uncompensated care

Uncompensated Care at Alaska Hospitals				
2011	2012	2013	2014	2015
$ 85,047,723	$ 90,025,771	$ 94,475,540	$ 89,001,149	$ 72,594,126

CON: a hospital perspective

Hospitals subsidize many services that do not generate revenue or where revenue doesn't cover costs. Examples:

- Sexual assault response (forensic nursing)
- Subspecialty services for children
- Homeless services (medical respite)
- Primary care (Mountain View, senior clinics)
- Community health (school programs, etc.)

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CON: a hospital perspective

- Hospitals also must maintain infrastructure and staffing for 24-hour emergency services.
- *These services are provided because hospitals have positive margins on other services.*
- CON repeal (and loopholes in the CON law) allows profitable services and payers to be stripped out of hospitals, leaving hospitals with fewer resources to provide needed community services.

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It's about what we value….

- What is the value of the community services, like forensic nursing and senior care clinics, that hospitals subsidize in the community?
- What is the value of having certain specialty services in the community (e.g. pediatric cardiology, pediatric oncology)?
- What services do you want available in your hospital if you or a family member have a medical emergency?
- What is the value of rural hospitals?

… and who gets care

CON laws can protect access to care for:

- The poor
- The very sick
- Those who do not have commercial insurance (Medicare, Medicaid, uninsured)
- Rural areas
- Urban neighborhoods with high populations of uninsured

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A path forward…

- Loopholes and lack of enforcement in current CON law make it dissatisfying for many of our members
- Appropriate to have a conversation about whether the law is working as intended and how it could be strengthened/changed
- Alaska's unique provider environment must be considered
- We recommend:
  1. The conversation be informed by data
  2. The issue be addressed with a stakeholder group to ensure that all perspectives are heard