HB 407

I have several observations on the report prepared by Information Insights regarding the Medicaid impact of eliminating CON requirements for ASCs in Fairbanks ("CON deregulation" hereafter).

1. We agree with the validity of the "Medicaid cost argument." Allowing an unneeded ASC[1] will definitely increase Medicaid spending.
2. The report explicitly acknowledges that the TVC ASC will initially simply move patients out of the local hospital. This is consistent with the State finding that there is no need for additional surgical capacity in the CON denial. This creates a costly "excess" of hospital capacity, unavoidably raising Medicaid payments to the hospital.
3. The report provides several different estimates of the magnitude of the negative impact this bill will have on Medicaid spending. This ambiguity requires clarification through additional research.
4. Much of the analysis rests on assumptions about future hospital pricing decisions. These are incorrect. The first pricing decision assumed is that the hospital will lower its prices for ambulatory surgery prior to the opening of the ASC. This is incorrect: even the report recognizes that this will have no impact on the diversion of TVC patients to the ASC.
5. The report makes no mention of ASC pricing decisions. In fact, the ASC in Anchorage has raised its rates, and there are no state constraints on rates currently in effect. Any assumptions about future savings based on rate-reduction are highly speculative.
6. Discussions of price changes are limited to assumed reductions in outpatient surgery. This ignores the increased costs to Medicaid that will occur if the hospital compensates for decreased Medicaid revenues in outpatient surgery by raising rates in other areas. The hospital can alter its rate structure to ensure that total Medicaid payments to it will remain constant. Recognizing this, all Medicaid payments to the ASC are incremental increases in Medicaid spending.
7. The report's end-state scenario of lower Medicaid costs is critically dependent on two alternative assumptions, both of which are highly questionable.

   The first is that the hospital might eventually backfill cases as the population increases and use-rates rise because of an aging population. This argument has several faults. First, outpatient surgical use-rates have not risen in recent years, they have declined. Second, it tacitly assumes that incremental increases in total surgical volume will be captured by the hospital through some unspecified mechanism. Third, it ignores the possibility that increases in surgical volume will be met by the expansion of physician-owned facilities. TVC could expand as readily as FMH could "backfill." More obviously neglected is the possibility of another rival ASC, even though this is exactly what Dr. McGuire is actively pursuing.

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[1] "Unneeded" because a CON application for it was denied and area surgical volume has decreased since that time.

Response by Mike Powers, FMH Administrator to analysis by Brian Rogers Re: Zero fiscal note

- The alternative critical assumption is that if hospital "backfill" fails to occur, the hospital will "re-assign" fixed outpatient surgery costs elsewhere. The report suggests that this could be accomplished by converting dedicated outpatient suites to inpatient use. This argument fails to recognize that FMH has no dedicated outpatient suites. All rooms are currently available to inpatients as well as outpatients and the State's need assessment finding no need for additional outpatient surgical capacity reflects this fact. More importantly, hospital operating rooms are highly isolated units. Excess surgical capacity cannot be inexpensively converted to another use. The report fails to recognize that the hospital will incur additional costs in dealing with any excess surgical capacity arising from CON deregulation; to which these additional costs will be entirely attributable. If incurred, these increased costs will unavoidably increase Medicaid payments to FMH.

In summary, the report recognizes that Medicaid payments will rise as patients are moved form the hospital to an unneeded ASC. The report's lower-cost end-state will probably never be reached. After certain increases in short-term Medicaid expenditures, potential long-term projected savings are built upon incorrect assumptions, the omission of potential areas of increased costs, and are highly speculative. Rather, it is highly likely that the costs of the initial patient diversion will be permanently incorporated in the subsequent payment structure; system-wide Medicaid costs will always be higher as a result of deregulation.

IMPACT OF STATE CERTIFICATE OF NEED PROGRAMS ON OUTCOMES OF CARE FOR PATIENTS UNDERGOING CORONARY ARTERY BYPASS SURGERY

REPORT TO THE FLORIDA HOSPITAL ASSOCIATION

PREPARED BY:

GARY E. ROSENTHAL, MD
MARY V. SARRAZIN, PHD
PROGRAM IN HEALTH SERVICES RESEARCH
DIVISION OF GENERAL INTERNAL MEDICINE
UNIVERSITY OF IOWA COLLEGE OF MEDICINE
IOWA CITY VA MEDICAL CENTER
IOWA CITY, IOWA

JANUARY 17, 2002

- First, the analysis was limited to Medicare beneficiaries and, thus, only includes roughly half of all patients undergoing CABG. However, it is likely that if patterns of care were different for Medicare patients, relative to other patients, these differences would be similar across states and would not bias study findings.

- Second, the relationships in this observational analysis represent associations—not necessarily cause and effect relationships. Thus, any associations between CON regulation and study outcomes may represent confounding due to other factors that may differ according to CON status. These factors may include: i) managed care penetration; ii) regional physician practice variation and/or differences in quality of care; iii) efforts to report and disseminate outcomes data to providers, purchasers, and the lay public; and iv) differences in patient preferences for care. Nonetheless, it would be nearly impossible and certainly not feasible to design a study in which states were randomized to implement CON or an observational study in which all possible confounding factors could be adjusted to isolate the true effect of CON regulation.

- Third, the analysis may also be confounded by regional differences in the use of PTCA. As an alternative treatment for coronary insufficiency, such differences in PTCA use may directly impact CABG utilization and lead to selection bias in analyses comparing in-hospital mortality. Indeed, the decline in the total numbers of CABG performed in all three groups between 1996 and 1999 probably reflects increasing utilization of PTCA. Thus, full understanding of CABG utilization patterns requires analysis of PTCA utilization rates, which are beyond the scope of the current analysis.

- Fourth, the development of risk-adjustment models based on administrative data is itself subject to limitations. Administrative data may be subject to wide variations across hospitals in the reliability of individual diagnosis codes, which are used to define risk-adjustment variables. The range of variables that can be used for risk-adjustment is also limited. For example, important prognostic variables, such as left ventricular ejection fraction, admission vital signs, and other admission physiological indicators cannot be ascertained from administrative data. Moreover, it is difficult to discern whether certain conditions that are identified were present prior to a patient's admission or if the diagnosis occurred after CABG and may represent a complication of the procedure. However, it should be noted that the risk-adjustment was constructed to minimize the use of variables that could represent complications.

- Lastly, the analysis used risk-adjusted mortality as an indicator of quality of care, but did not directly measure the process of care (e.g., technical skills of the surgeon, quality of post-operative care). Similarly, the study examined CABG utilization, but did not directly examine appropriateness of CABG in individual patients.

Conclusions

The current analysis, based on a complete sample of Medicare beneficiaries undergoing CABG during the years 1994 through 1999, found that CABG utilization may actually be somewhat lower in states with no CON regulations than in states with continuous CON regulation. In

addition, the analysis found only relatively small differences in the prevalence of individual risk factors and in the predicted risk of death (i.e., severity of illness).

In contrast, the analysis found that risk-adjusted mortality was 21% higher in states with no CON regulation, compared to states with continuous CON regulation. Based on an actual mortality rate of 44 deaths within 30 days or in-hospital per 1000 patients in states with continuous CON, the 21% difference in mortality would translate to 9 additional deaths for every 1000 patients undergoing CABG. In addition, the analysis found that average hospital volumes in states with no CON were substantially lower and that patients in such states were substantially more likely to undergo CABG in low-volume hospitals. The higher proportion of patients undergoing CABG in low-volume hospitals may underlie the higher risk-adjusted mortality in states with no CON. While the potential methodological limitations listed above need to be considered in the interpretation of these findings, this analysis would suggest that CON regulation is associated with better patient outcomes. Thus, repeal of CON regulations may have negative consequences on patient outcomes.

March 25, 2002

Representative John Coghill
State Capitol, Room 102
Juneau, AK 99801

Dear Representative Coghill:

The legislation set forth in HB 407 will eventually destroy the ability to provide the level of health care that Fairbanks Memorial Hospital now provides to the Fairbanks Community.

Programs such as mental health, Denali Nursing Center and many other services that Fairbanks Community Hospital now provides will not be provided because the real money producing services will have been cherry picked from the hospital by those who are only interested in making more money at the expense of the Fairbanks Community.

You do not see any of those people who want to change the CON language, as it is now, wanting to open a mental health clinic or a long term nursing facility because they know it does not make a profit.

The real issue is more profit in some ones bank account as opposed to the overall health care for the Fairbanks Community.

I sincerely wish you to not tamper with the CON language as it is now written.

Sincerely,

Dave Rasley

Dave Rasley

Cc: Senator Pete Kelly
Senator Gary Wilken
Senator Gene Therriault
Representative John Davies
Representative Jim Whitaker
Representative Hugh Fate
Representative Jeanette James
Representative Joe Hayes
Representative Fred Dyson, Chairman House HESS

March 25, 2002

Representative John Coghill
State Capitol, Room 102
Juneau, AK 99801
Phone: 907-465-3719
Fax: 907-465-3258

Dear Representative Coghill,

I urge you to delay all action for this session on Certificate of Need (CON) legislation. The CON has worked well for nearly 20 years and Fairbanks has benefited with outstanding health care. If you feel the CON needs attention, please bring the issue home and hold hearings this summer and fall so the people most impacted by HB 407 can be heard in the community you represent.

The changes in the CON will negatively impact Fairbanks Memorial Hospital (FMH). I sit on the board and Executive Committee for the FMH Foundation. We have provided services no one else would provide. We have provided cancer treatment and psychiatric care. We have not just provided the most profitable services that will be promoted in the future by those who will benefit from your proposed changes to the CON.

Thank you for your attention to my concerns. You can contact me days at 488-5104 or evenings at 457-6066, if you have questions. I truly believe the best interests of your constituents will be served by delaying all action on HB 407 this session.

Sincerely,

Jeff Cook ICT

Jeffrey J. Cook
458 Terrace Drive
Fairbanks, AK 99712

CC: Senator Pete Kelly
Senator Gary Wilken
Senator Gene Therriault
Representative John Davies
Representative Jim Whitaker
Representative Hugh Fate
Representative Jeanette James
Representative Joe Hayes
Representative Fred Dyson, Chairman House HESS

March 25, 2002

Representative John Coghill
State Capitol, Room 102
Juneau, AK 99801
Phone: 907-465-3719
Fax: 907-465-3258

Dear Representative Coghill,

I am writing to you regarding HB407 and would like to express my concerns related to the changes this bill would have on healthcare.

First of all, my concern relates to the elimination of the current CON. I feel that changing the CON as it currently exists would effect changes that would begin the deterioration of the Health Care System in Fairbanks as we know it today. My past experience of 15 years working as a physician in a heavily managed care environment has given me the opportunity to experience the unhealthy competition and declining quality of care that is produced ultimately from these changes.

Secondly, as Medical Director of Mental Health at Fairbanks Memorial Hospital, I feel strongly that for quality mental health care to continue to be delivered, we need the resources and financial support that HB407 threatens by virtue of the effect on overall funding for the hospital. Additionally, I feel that the statewide plan for the development of mental health beds is important to the development of a well-balanced mental health system throughout the state, and HB407 threatens this plan.

Finally, I feel that any legislative action that holds potential harm to healthcare throughout the state as HB407 does, requires careful consideration by those supporting the changes. Thank you for your consideration in this very important matter.

Respectfully,

R. Duane Hopson, MD
Medical Director of Mental Health
Fairbanks Memorial Hospital
1650 Cowles St.
Fairbanks, AK 99701
(907)458-5529

CC: Senator Pete Kelly
Senator Gary Wilken
Senator Gene Therriault
Representative John Davies
Representative Jim Whitaker
Representative Hugh Fate
Representative Jeanette James
Representative Joe Hayes
Representative Fred Dyson, Chairman House HESS

April 23, 2002

Representative Carl Moses
House Finance Committee
State Capitol
Juneau, AK 99801

Dear Representative Moses,

We are extremely concerned by the current Certificate of Need legislation that is being considered.

Fairbanks Memorial Hospital, owned by a non-profit volunteer community board and operated by a non-profit health system, has provided the Fairbanks community with exceptional health care for 30 years. Decisions have been made to provide health care based on community need not just health care that provides a profit. They have stepped up and provided mental health care beds and services, long term care nursing, routine nursing units and home health care to name a few services that are cross-subsidized by surgery, imaging, lab and pharmacy. The CON law has made this possible because other entities have not been able to "cherry-pick" the hospital. For-profit entities would not be interested in providing mental health beds, etc. but instead would only want those services that provide a profit. Doing away with the CON in Fairbanks could decimate a wonderful community hospital that has proven to care about, and step up to the plate, to meet the health care needs of this community over and over again.

No employee of the hospital, nor can any Board Member refer a patient to the hospital for services, however a physician can refer a patient to their own surgery center, imaging center, etc. so that they can personally gain by the referral. This is of grave concern to us and we would hope to you also.

The Certificate of Need insures that unnecessary facilities are not built. If unnecessary facilities were built there will be an even greater shortage of nurses and health care technical personnel to go around. It is already difficult for the hospital to compete for some of these positions because clinics can give them 8:00 to 5:00 shifts with weekends off and the hospital must be staffed 24 hrs. a day, seven days a week. Another area that would further hurt our community hospital.

The CON process has proven that health care costs can be less expensive with fewer options. Fairbanks Memorial hospital charges less for surgery procedures than the hospitals in Anchorage. Having more than one option in Anchorage did not create cheaper services.

The Fairbanks community needs the Certificate of Need to remain in place. Please do not tear apart our community hospital. If our hospital isn't or can't meet the health care needs of the community then through the current Certificate of Need process someone else can.

Sincerely,

Jim + Karen Holt

Jim E. and Karen A. Holt
1617 Madison Drive
Fairbanks, AK 99709
907-474-3874

Valley Hospital is legally and ethically bound to serve all patients that walk through our doors, regardless of ability to pay. Under EMTALA, Valley Hospital cannot turn anyone away or discharge him or her due to financial class. A "medical boutique" does not operate under the same regulations and may in fact limit customers of a particular payer status (Medicaid, Medicare or self-pay).

Valley Hospital is a private business, a not-for-profit enterprise, and receives no assistance from the Mat-Su Borough government, which has limited health powers as a second class borough. Valley Hospital competes directly with the Anchorage providers (Alaska Regional and Providence). Over 16,000 Valley residents commute to Anchorage for work Monday through Friday. Surveys conducted by Valley Hospital show that most of these commuters receive their healthcare in Anchorage and use Anchorage providers. Over the last five years, Valley Hospital has made between 1.5 and 2.5 million dollars in net revenues. As you can see, Valley Hospital is in a competitive environment.

At Valley Hospital, our board members and administrators take seriously the intent and spirit of the 501(c)3 code. We invest 10% of our net revenues in excess of expenses back into the Mat-Su Borough community through our Healthy Communities Program. This Healthy Communities Program makes small community grants to local organizations and funds programs throughout the Mat-Su Borough that help to raise health status of Valley residents. Nationwide, most hospitals invest less than one- percent back into the community, and Valley Hospital has been recognized for its leadership in this area.

In addition, Valley Hospital reinvests the remaining 90% of its revenues back into capital equipment, facilities and staffing to remain competitive and viable. Each year, Valley Hospital strives to donate one percent of its net revenues to charity care. This, coupled with uncollectible accounts, adds up to millions of dollars annually in unreimbursed care. This unreimbursed care totaled $3,974,000 in 2000 and $5,501,000 (unaudited) in 2001.

In summary, Valley Hospital supports keeping the Certificate of Need at a $1 million threshold for equipment and raising the CON to a $2 million threshold for building, so long as any bill altering the CON also supports the following criteria:

- All providers, <u>including private physicians</u>, must meet the terms of the CON.
- All providers must provide care for <u>all financial classes</u>, and their payer mix must reflect the payer mix of the locale within which they operate. (Note: the current CON bureaucracy at the State could track this.)
- <u>All expenditures</u>, whether they be for capital, equipment, operational lease, or bricks and mortar, must fall under this $2 million threshold.

With such great controversy over this proposed amendment to the CON, we recommend that the legislature establish a working group comprised of providers and legislators to examine the entire CON process. Valley Hospital remains willing to work with interested parties and the State of Alaska to improve the CON process in order that it respond to the evolving needs of the health care environment in Alaska.

VALLEY HOSPITAL

MEMO

4-23-02

TO: Representatives Eldon Mulder and Bill Williams, Co-Chairs
Members of House Finance Committee

FROM: George Larson, CEO
Valley Hospital Association

RE: Written Testimony for House Bill No. 407

For the record, Valley Hospital Association is against the proposed population delimiter in House Bill No. 407 and Senate Bill 256. Valley Hospital serves one of the only large communities in the state that would be affected by this proposed population delimiter for the Certificate of Need process.

Valley Hospital supports other measures in these bills, including the following:

- Leaving the CON at the $1,000,000 level
- Replacing facilities at the same site or in the same community as long as no new category of health services is provided and the existing facility is not used for other health services without a CON
- Adding time requirements and review standards for the CON department to process CON applications

We acknowledge the benefits of fair competition, and assert that this proposed delimiter does nothing to support a level playing field. We are particularly concerned about the establishment of "medical boutiques" (such as a free-standing imaging or surgery center) that limit services to those without third party insurance, thereby "cherry-picking" most of the paying customers. The demography and geography of Alaska limit the effectiveness of unregulated competition as a means of ensuring socially appropriate supply and demand of health care services.

To put this "cherry-picking" in perspective, the Mat-Su Borough has one of the highest rates of Medicaid patients, per capita, of any borough in the State of AK. Medicaid is the fast growing "payer segment," along with "self-pay"—those that do not have any insurance. In the last three months, Valley Hospital's "self-pay" financial class has doubled from eight percent to 12% of our payer mix. In the next five to 10 years, we expect our Medicare payer segment to double from six to 12 percent of our population. In Mat-Su, there are already private providers that do not accept or limit the number of Medicaid or Medicare patients that they see. Based on what is already happening, we cannot assume that these "medical boutiques" will treat patients in these payer groups that do not pay 100 cents on the dollar.

515 E. DAHLIA ST., P.O. BOX 1687, PALMER, AK 99645 (907) 746-8600

Missouri Certificate of Need

Why Employers and Labor

Want to retain it as a Cost Containment Tool

HB407, CON
House Finance Hearing/Teleconference
Tuesday, April 23, 2002 1:30

Submitted testimony:

On Teleconference: Out of State Expert Witnesses
- Carolyn Watts PhD Seattle, WA.
- Jay Kaplan, MD; Banner Health; Arizona
- Thomas R. Piper. Missouri Dept. of Health
- Dean Montgomery, HSA Northern Virginia
- Robert Caswell, Ohio State University; HS Mgt. & Policy

Teleconference: In State
- Mike Powers, FMH Administrator

Written Backup – Testimony: Opposed to HB 407
- Need for Regulation – State by State examples
  - Compiled by Mike Powers, FMH Administrator
- Market Forces in Health Care
  - By Robert Caswell, PhD
- St. Louis Area Business Health Coalition – Missouri CON Debate
- Missouri CON – Employers & Labor Want Cost Containment Tool
- Ohio After CON – Submitted by Robert Stetson Assoc.
- Richard Burger, M.D. – Fairbanks
- Richard Hattan, M.D. - Fairbanks
- Conrad G.B. Frank – Founding Member FMH Foundation
- Peter Marshall, M.D. – North Pole
- Harry Porter, FMH Foundation
- R. Duane Hopson, M.D. Medical Director of Mental Health, FMH
- Jeffrey J. Cook – FMH Foundation
- Dave Rasley – FMH Foundation
- Response to Brian Rogers Analysis re: zero fiscal impact to state
  - By Mike Powers, FMH Administrator

Carolyn A. Watts, Ph.D.
Health Economics and Policy
19920 174th Ave. N.E.
Woodinville, Washington 98072
(425) 402-8405

April 23, 2002

Mr. Chairman, and Members of the Committee:

I am a professor of health economics at the University of Washington. Thank you for the opportunity to speak with you today.

For the past 26 years, I have done research and taught in the area of health economics and health policy. I have written widely on issues involving the organization of health care markets, including several pieces on Certificate of Need, one for the Washington State Legislature.

The message I would like to deliver is that you need to proceed with extreme caution with this legislation as the stakes are very high, both for Alaska's Medicaid budget and for access to basic services such as obstetrics and prenatal care for the populations, particularly the low income populations, served by sole community hospitals.

As an economist, I believe in competition. However, competition delivers good results in markets that can support many buyers and sellers where all consumers can afford to pay their way. Competition at its best does a good job of catering to the desires of buyers with money. It does nothing for people without the ability to pay. This is not the situation in single hospital communities. Here patients have no alternative if the only hospital cannot survive financially because another provider has entered the market to do only the profitable services.

Competition can lower prices in some markets. However, the only prices that get lowered are for those consumers and services the sellers want to serve (at a profit). Sellers won't compete to serve Medicaid or charity patients – but competition will erode the ability of charitable hospitals to serve these patients if they take away the potential for cross subsidization.

The Alaska State budget is in trouble. Medicaid funds are in trouble. Cross subsidization of Medicaid and charity services with insurance funds paid for profitable services essentially allows the state to shift some of the financial burden of its Medicaid obligation to the private sector. Competition that lowers the prices of profitable services to insured patients benefits insurance companies at the expense of the state Medicaid budget. The

hospital's financial obligations around basic services such as obstetrics and prenatal care to low income Medicaid or uninsured patients will not be reduced as outpatient surgery centers and other niche providers enter the market. In the absence of funds generated through cross subsidization, the hospital will either have to raise its prices to Medicaid or fail financially, resulting in major access dilemmas not just for Medicaid patients but for all the residents of the community.

Finally, Certificate of Need does not prohibit competition It simply provides a structure and a public process through which competition can be monitored, guided, and shaped to be constructive rather than destructive. The free market, after all, brought us Enron.

I urge you to study this issue very carefully before you dismantle the public process that supports the health care infrastructure of Alaskan communities.

Thank you again for allowing me to share my thoughts on this matter.

Sincerely,

Carolyn A. Watts, Ph.D.
Professor

Certificate of Need Revisited

Certificate of Need programs can play an important role in managing health care, though not necessarily in the manner originally intended.

by Daniel N. Mendelson and Judith Arnold

The pressure of rising health care costs on state budgets, employer payrolls and American families has again brought health care cost control to the forefront of state regulatory agendas.

Tired of waiting for the federal response to the nation's health care ills, most states have begun to examine options for initiating reform. This has brought new scrutiny to state programs designed to contain costs, monitor quality and promote access to care. An increasing number of states are re-examining the effectiveness of their Certificate of Need programs and considering their role in the rapidly changing health care environment.

Certificate of Need (CON) is a regulatory review process that requires certain health care organizations, such as hospitals, nursing homes and physician groups, to obtain authorization from the state for major capital expenditures, the purchase of high technology equipment and the expansion of services.

The use of capital review programs at the state level began with voluntary state programs and accelerated with the passage of Section 1122 of the 1972 amendments to the Social Security Act, which stipulated that states must review all capital expenditures that exceeded $100,000, changed bed capacity or involved a "substantial change" in services. States not reviewing such expenditures were subject to a loss of Medicare capital reimbursement, federal Medicaid payments and payments through the Maternal and Child Health Program.

In 1974, the National Health Planning and Resources Act went further, requiring states to enact Certificate of Need to receive funds through the Public Health Service. While some states implemented CON to contain costs, improve access or monitor quality, others simply did so to conform with federal requirements.

Since the 1986 repeal of the National Health Planning and Resources Act, 12 states have repealed part or all of their CON or allowed it to sunset. Many of the states repealing CON substituted other regulation, especially for long-term care. The 38 remaining state programs vary widely with respect to the types of services reviewed, dollar thresholds for capital review, the quality of the State Health Plan stipulating program goals, the stringency with which regulations are enforced and in a variety of other ways.

This diversity provides the opportunity to compare a variety of approaches to capital review.

CON's Effectiveness In Acute Care

In the acute care sector, CON typically requires hospitals to file for review when expanding bed capacity or adding clinical services. State regulators thought that by controlling excess hospital capacity and limiting services, CON would moderate increases in health care costs, maintain access to care and promote quality. While CON programs have not met all of these expectations, they have achieved some modest successes that are often overlooked.

> Certificate of Need programs have not been successful in holding down hospital costs.

Acute Care Costs

CON programs have not been successful in holding down hospital costs. This conclusion is based on extensive empirical analyses of hospital costs between 1980 and 1989. Our findings concur with a number of studies conducted during the 1970s, concluding that the program did not decrease hospital costs during that time (Sloan, Steinwald 1980) (Policy Analysis, Inc., 1981), and two more recent studies that showed CON associated with modest increases in costs in the early 1980s. (Ashby 1984 and Federal Trade Commission 1988) These national results may not hold for a given state, since each program is unique. They do, however, hold in Ohio and Pennsylvania, two states analyzed in detail. (Lewin-VHI 1991 and Lewin-VHI 1992a)

Legislators also are frequently interested in whether costs increased in states that repealed CON. We have found no evidence of increased costs in the 12 states that repealed their CON programs. There was expansion of certain services in these states, as will be discussed in the following section. However, these results cannot be used to predict the potential consequences of repeal in other states since the regulatory, market and other circumstances in each state are unique.

What has hindered CON programs from successfully controlling acute care costs? There are four primary factors. First, CON targets only a small portion of a hospital's overall budget. Control of capital spending has no effect on cost increases caused by the rise in labor, hospital-specific inflation and innovative uses of surgical techniques.

Second, the program does nothing to affect the prices that a hospital can charge. Third, the health policy literature shows that reductions in hospital bed capacity (a major target of CON programs) do not usually reduce the use of services. (Friedman, Pauly 1983 and Schwartz, Joskow 1980) In fact, closing inexpensive community hospitals can actually add to costs, as patients go to more sophisticated and expensive sites for care. (Pauly, Wil-

	Open Heart Units/ Million	Organ Transplant Units/Million	Hospital-based Units/ Million	Total Units/ Million
Lagged Dependent	.543[a]	.409[a]	.477[a]	.639[a]
	(.036)	(.039)	(.043)	(.038)
Time	.006	.036[b]	−.012[a]	.00001
	(.006)	(.017)	(.003)	(.003)
R^2	.931	.750	.988	.981
R^2(C)	.922	.716	.986	.979
F	112	22	532	337
N	617	541	479	479

[a] Significant at the 1 percent level (two-tail test).
[b] Significant at the 5 percent level (two-tail test).
[c] Significant at the 10 percent level (two-tail test).

data to assess the impact of CON. Examining data through 1982, Lanning, Morrisey, and Ohsfeldt (1991) found that after controlling for the fact that per capita spending was significantly different in states which adopted CON early, CON was associated with a 20.6 percent *increase* in hospital spending and a nine percent increase in spending on other health care. The net impact was a 13.6 percent increase in per capita spending on personal health care services. Using data derived from the annual *Hospital Statistics* on per capita hospital spending through 1990 (AHA 1977–1994) and a method that accounted for endogeneity of CON, Antel, Ohsfeldt, and Becker (1995) reported that CON had no impact on this form of spending, although they found that section 1122 reduced hospital spending. Without controlling for the endogeneity of CON, the coefficient on the CON variable was negative but very small, with a t-ratio of −.47. Taking account of endogeneity, the coefficient on CON became positive and statistically significant at the 10 percent level. It is noteworthy that explicitly accounting for CON's endogeneity made it appear to perform *less* well. Salkever and Bice (1976) found no impact of CON on total hospital operating costs per capita. Likewise, an earlier study by the Federal Trade Commission found that CON had no impact on hospital costs, but also found that section 1122 had a negative influence (Sherman 1988). By contrast, in our study, neither mature CON nor section 1122 had an impact on this type of expenditure, although both were associated with lower growth in acute care spending.

required to outnumber provider members on local planning boards (Sloan 1988). Also, any Health Systems Agency plan that failed to address needs of low-income persons was subject to challenge at a public hearing.

There is a paucity of empirical studies of effects of CON on access to acute care services. One study conducted in Florida reported that a hospital's success in obtaining CON approval was consistently related to the amount of indigent care that it provided (Campbell and Fournier 1993). A study of California hospitals found evidence consistent with the hypothesis that hospital regulators reward large uncompensated care providers with profitable CON licenses, although no CON variables were actually used in estimating the amount of uncompensated care given by providers (Campbell and Ahern 1993).

Even though this information is suggestive, it is difficult to use it as a basis for continuing to support CON. First, it only applies to two states. Second, there must be more efficient ways to promote access than conferring monopoly franchises on facilities. Efforts to promote access are likely to be more productive if they are focused on primary care providers. Lack of adequate and timely primary care has been found to lead to a significant number of avoidable hospitalizations (Billings et al. 1993)

Earlier studies were more favorable than ours to other regulatory programs such as PPS and state hospital rate-setting relative to CON. It is not that CON has become more effective, but rather that the other programs became worse performers in terms of cost containment as the provider community became more familiar with them.

Conclusion

Our empirical analysis of effects of CON on costs revealed that, at best, CON has had a modest cost-containing influence on hospital and other acute care services. We found no evidence for a surge in acquisition of new facilities or in costs following removal of CON. States that lifted CON did not experience a rise in spending on hospital and physicians' services relative to those that retained it. The conclusion of lack of surge even holds for facilities such as ambulatory surgery units that have experienced substantial growth in recent years. It is doubtful that CON has had much of a positive or negative influence on quality of care. CON may have improved access, but the empirical evidence for this is quite meager.

Sectional for CSHB 407(HSS)
Version S

***Section 1.** (a)(1) This provision specifically provides that if a facility is operating under a certificate of need, that facility cannot, **for any amount**, construct a skilled nursing facility or psychiatric hospital, increase the bed capacity of a skilled nursing facility, nor convert a building or part of a building to a skilled nursing facility or psychiatric hospital. It also prohibits the conversion of adult psychiatric beds to psychiatric beds designated for care of a child under 21 years of age. This language requires a CON for skilled nursing facilities and psychiatric hospitals.

(a)(2) This provision stipulates that a skilled nursing facility or a psychiatric hospital wishing to add health services that would cost $1 million or more would have to apply for an additional CON to do so.

It also exempts from the CON provisions any health facility other than a skilled nursing facility or psychiatric hospital in an area with a population of 55,000 or more.

Section 2. Provides that a facility destroyed on site or demolished on site could be replaced without having to acquire a new certificate of need and provides that a facility could move to a new site without a new certificate of need as long as capacity and categories of services do not change.

Section 3. Requires the department to adopt regulations to set a time limit for the department to determine that an application is complete.

Section 4. Requires the department to set a time limit by which public hearings must be held.

Requires the department to approve or deny an application within 120 days of the date the department determined the application was complete.

Section 5. Places all certificate of need applications under the same standards of review that currently exist for nursing home beds. All CON's except nursing homes had a vague standard of review under AS 18.07.041. This change gives a more definitive standard for the applicants to follow.

Sections 6
Thru 10. Technical changes required under Section 5.

Section 11. Repeals the broad standard of review in AS 18.07.041 and repeals 18.07.031(b) which is now AS 18.07.031(a)(1)(C) and is expanding the restrictions to psychiatric hospitals.

Section 12. Applicability of new statute is limited to CON applications filed on or after the effective date.

Section 13. Has an immediate effective date.

Sectional for CSHB 407(HSS)
Version S

***Section 1.** (a)(1)(A) This provision specifically provides that if a facility is operating under a certificate of need, that facility cannot, **for any amount**, construct a skilled nursing facility or psychiatric hospital unless they are replacing or relocating a facility already covered under a CON.

(a)(1)(B) This provision specifically provides that if a facility is operating under a certificate of need, that facility cannot, **for any amount**, increase the bed capacity of a skilled nursing facility or psychiatric hospital, unless that increase is covered in the existing CON.

(a)(1)(C) This provision specifically provides that if a facility is operating under a certificate of need, that facility cannot, **for any amount**, convert a building or part of a building to a skilled nursing facility or psychiatric hospital, unless the conversion is covered under the existing CON.

(a)(1)(D) This provision specifically provides that if a facility is operating under a certificate of need, that facility cannot, **for any amount**, convert adult psychiatric beds to psychiatric beds designated for care of a child under 21 years of age.

(a)(1)(E) This provision specifically provides that if a facility is operating under a certificate of need, that facility cannot, **for any amount**, convert the existing use of any bed to a new use other than a psychiatric bed designated for the care of a child under 21 years of age if the existing use required a CON or if the facility is located in a community of 55,000 of less.

(a)(2) This provision stipulates that a skilled nursing facility or a psychiatric hospital wishing to add health services that would cost $1 million or more would have to apply for an additional CON to do so.

If a new health facility is to be built in a community of 55,000 of more and the facility will not be a skilled nursing facility or psychiatric, the facility can be built without a CON.

Section 2. Provides that a facility destroyed on site or demolished on site could be replaced without having to acquire a new certificate of need and provides that a facility could move to a new site without a new certificate of need as long as capacity and categories of services do not change.

Section 3. Requires the department to adopt regulations to set a time limit for the department to determine that an application is complete.

Section 4. Requires the department to set a time limit by which public hearings must be held.

Requires the department to approve or deny an application within 120 days of the date the department determined the application was complete.

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Section 13. Has an immediate effective date.

MHFRC **Missouri Health Facilities Review Committee**

www.health.state.mo.us/CON/Title.html 915G Leslie Blvd., Jefferson City, MO 65101 Voice: (573) 751-6403 Fax: (573) 751-7894

Patrick Brady, Chair
H. Bruce Nethington, Vice-Chair
Sen. Betty E. Sims
Rep. Thomas A. Villa
Sen. Mary Groves Bland
Rep. Jim P. Murphy
Mukamari A. Cunningham, M.D.
Ross P. Marine

April 23, 2002

House Finance Committee of the Alaska State Legislature

Dear Committee Members:

As the Director of the Missouri Certificate of Need (CON) Program and Information Coordinator for the American Health Planning Association, I am submitting this testimony to you in support of the continuance of Certificate of Need in Alaska. My points are brief and to the point as listed below.

For almost 18 years I have administered health planning and CON in Missouri, and I have seen it evolve and change in many ways:

1979 Original CON Law passed
1983 Establishment of the Nursing Home Moratorium established
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Hospitals were split for many years, but now united with business to reform CON. Proposed bills would cover both acute and long term care with zero thresholds for first-time services, but broaden flexibility for service expansion and replacement. The basic rationale is to protect established community services while restraining double-digit inflation in health care premiums and Medicaid costs. The impact of deregulation has been jolting in the number of new ambulatory surgery and diagnostic imaging centers, plus major hospital expansions. The fiscal impact cannot yet be measured accurately, but it could not come at a worse time with our state budget cuts of over $500 million and federal limitations on reimbursement.

Such funding problems are being experienced everywhere in our country. As I have monitored CON activities nationally over the last 13 years, and watched the demise of managed care, we have seen CON stabilize in 36 states and the District of Columbia. In Missouri we have streamlined our process, which appears to be a popular pattern in most CON states.

State oversight of health care persists because public funds pay for over two-thirds of health care services, and competition doesn't work in health care. Health care is part of the caring community, not a commodity . . . public/private partnerships with community health planning and oversight continues to be our best investment.

Sincerely,

Thomas R. Piper

Thomas R. Piper, Director
Certificate of Need Program

Missouri Certificate of Need -- Acute Care Facilities Reasons to Renew and Reform Programs

1. Healthcare cost are projected to rise 11% per year for all employers in 2001 according to the 2000 National Survey of Employer-Sponsored Health Plans by William M. Mercer. These increases are often in excess of 20% for small companies. This is no time to experiment with ending a program that is designed to hold cost down.

2. The potential consequences of ending CON are not well known; however, there is some evidence that Indiana and Ohio have seen significant growth in new excess hospital capacity especially cardiac surgery capacity after CON ended. In states without CON, facilities are built without the opportunity for community input, which CON provides. There is no evidence to date that ending CON has brought cost down in states that ended it.

3. The healthcare market does not respond fully to market incentives as in other industries. Hence, some level of regulation of supply may be needed. Many providers receive more than 50% funding from public sources. Many providers are not-for-profit. Third parties pay for care while individuals consume care. Many utilization decisions are made by providers not consumers.

4. Healthcare tends to be a supply driven industry. The supply of facilities has a direct effect on the rate of utilization. St. Louis already has higher utilization that most markets. Ending CON will only make our potentially high utilization problem worse without any plan for controlling this problem. For example, St. Louis has 58% more available beds per 1,000 population and 36% more hospital day use than a comparison group of regions cited in the *St. Louis Health Care – A Regional Comparison, Volume II Hospital Performance*, pg 10, dated December 1999 by the St. Louis Area Business Health Coalition. St. Louis already exceeds most U.S. regions in utilization of cardiac procedures. We are 50% higher for inpatient cardiac catheterization than for a comparison group of regions. (See page 12 of the above report)

5. Excess supply of beds in St. Louis is finally on the way down after years of resisting movement. Approximately one thousand excess beds were taken out of this area's almost 10,000 available beds in recent years while CON was in place. Ending CON can only serve to reverse this positive trend. St. Louis currently has approximately 3,000 excess available beds (*St. Louis Area Hospitals, Industry Financial and Statistical Overview*, St. Louis Area Business Health Coalition, August 2000).

6. SB235 improves the less than perfect current CON system. It eliminates from review most facility remodeling and replacement of equipment. It also eliminates from review small and moderate size facility building projects under 7 million dollars. It also allows for documented need for a competitive alternative as a valid reason to approve proposals for new facilities or expansions.

Examples of successful CON use in this region are:

1. The negotiation of common use of Gamma Knife technology by BJC and SLU hospital when only one was needed for the entire region.
2. The negotiation of quality and accountability standards tied to financial incentives as part of the women's hospital proposal in Chesterfield.
3. The negotiation of bed reductions as part of several campus renovation projects by hospital systems over the past several years.

Rev 4/3/01
STL BHC

Case Study: Ohio After CON

Ohio and Missouri are similar: both are medium-sized Midwestern states, both have a large amount of their population in urban centers, and yet both are agricultural throughout most of the land between the major cities

In Ohio, the state's CON law sunset in phases between 1995 and early 1998. The unanticipated results can be summarized in three ways:

1. Tremendous Proliferation of Niche Services

Ohio left in place a notification requirement for development of most health-care services. Based on compilation of this data by a respected Ohio law firm, the sheer number of services that have proliferated is staggering. Virtually all new development in Ohio carves out only the most "lucrative" of services from hospitals. Services over-developed in the state include:

- 14 new open heart programs and 8 new transplant programs (5 organ and 3 bone marrow/stem cell)
- 17 new cardiac catheterization programs (3 without open-heart support)
- 13 new radiation therapy programs for cancer treatment (5 at freestanding centers)
- 82 new MRI and CT units (estimated as two-thirds of 123 total new units)
- 133 new ambulatory surgery centers (ASC) ("the vast majority of the new ASCs are owned and operated" by niche players and "the majority of them seem to be developing in the affluent and growing suburbs and counties surrounding the metropolitan areas.")

This over-development drives up health-care costs through the addition of redundant overhead. Prevention of this is the reason CON was created more than twenty years ago. The Ohio Dept. of Health reported that the notices for just new facilities filed between January 1, 1997 and June 30, 1999 totaled over $694 million. (New facilities are surgery centers, hospitals, imaging centers, etc. Excluded are new machines added in existing locations.)

2. Services Are NOT Going Where Needed

If the tremendous proliferation of services in Ohio had gone to areas previously underserved, the figures above would be less conspicuous. ***But instead, services have gone to areas already well served by healthcare providers.*** Here is just one example:

- 73% of all new ambulatory surgery centers were constructed in the top 22 most affluent of Ohio's 88 counties, ranked by per capita income. In other words, nearly 3/4 of all new surgery centers were built in just the top 1/4 richest counties.
- In the bottom quarter of Ohio counties, only one new surgery center was built, representing just 3% of all new surgery centers constructed over the time of this study.

3. Hospitals are Closing or In Trouble

In Cincinnati, two urban hospitals "effectively closed" inner-city facilities and relocated to the suburbs. In Cleveland, two inner-city hospitals closed and its "largest and busiest public hospital," whose "heart and soul has always been care for the poor," saw a $21 million shortfall in 2000, only one year after laying off 190 employees.

VALLEY HOSPITAL

MEMO

4-23-02

TO: Representatives Eldon Mulder and Bill Williams, Co-Chairs
Members of House Finance Committee

FROM: George Larson, CEO
Valley Hospital Association

RE: Written Testimony for House Bill No. 407

For the record, Valley Hospital Association is against the proposed population delimiter in House Bill No. 407 and Senate Bill 256. Valley Hospital serves one of the only large communities in the state that would be affected by this proposed population delimiter for the Certificate of Need process.

Valley Hospital supports other measures in these bills, including the following:

- Leaving the CON at the $1,000,000 level
- Replacing facilities at the same site or in the same community as long as no new category of health services is provided and the existing facility is not used for other health services without a CON
- Adding time requirements and review standards for the CON department to process CON applications

We acknowledge the benefits of fair competition, and assert that this proposed delimiter does nothing to support a level playing field. We are particularly concerned about the establishment of "medical boutiques" (such as a free-standing imaging or surgery center) that limit services to those without third party insurance, thereby "cherry-picking" most of the paying customers. The demography and geography of Alaska limit the effectiveness of unregulated competition as a means of ensuring socially appropriate supply and demand of health care services.

To put this "cherry-picking" in perspective, the Mat-Su Borough has one of the highest rates of Medicaid patients, per capita, of any borough in the State of AK. Medicaid is the fast growing "payer segment," along with "self-pay"—those that do not have any insurance. In the last three months, Valley Hospital's "self-pay" financial class has doubled from eight percent to 12% of our payer mix. In the next five to 10 years, we expect our Medicare payer segment to double from six to 12 percent of our population. In Mat-Su, there are already private providers that do not accept or limit the number of Medicaid or Medicare patients that they see. Based on what is already happening, we cannot assume that these "medical boutiques" will treat patients in these payer groups that do not pay 100 cents on the dollar.

Valley Hospital is legally and ethically bound to serve all patients that walk through our doors, regardless of ability to pay. Under EMTALA, Valley Hospital cannot turn anyone away or discharge him or her due to financial class. A "medical boutique" does not operate under the same regulations and may in fact limit customers of a particular payer status (Medicaid, Medicare or self-pay).

Valley Hospital is a private business, a not-for-profit enterprise, and receives no assistance from the Mat-Su Borough government, which has limited health powers as a second class borough. Valley Hospital competes directly with the Anchorage providers (Alaska Regional and Providence). Over 16,000 Valley residents commute to Anchorage for work Monday through Friday. Surveys conducted by Valley Hospital show that most of these commuters receive their healthcare in Anchorage and use Anchorage providers. Over the last five years, Valley Hospital has made between 1.5 and 2.5 million dollars in net revenues. As you can see, Valley Hospital is in a competitive environment.

At Valley Hospital, our board members and administrators take seriously the intent and spirit of the 501(c)3 code. We invest 10% of our net revenues in excess of expenses back into the Mat-Su Borough community through our Healthy Communities Program. This Healthy Communities Program makes small community grants to local organizations and funds programs throughout the Mat-Su Borough that help to raise health status of Valley residents. Nationwide, most hospitals invest less than one- percent back into the community, and Valley Hospital has been recognized for its leadership in this area.

In addition, Valley Hospital reinvests the remaining 90% of its revenues back into capital equipment, facilities and staffing to remain competitive and viable. Each year, Valley Hospital strives to donate one percent of its net revenues to charity care. This, coupled with uncollectible accounts, adds up to millions of dollars annually in unreimbursed care. This unreimbursed care totaled $3,974,000 in 2000 and $5,501,000 (unaudited) in 2001.

In summary, Valley Hospital supports keeping the Certificate of Need at a $1 million threshold for equipment and raising the CON to a $2 million threshold for building, so long as any bill altering the CON also supports the following criteria:

- All providers, <u>including private physicians</u>, must meet the terms of the CON.
- All providers must provide care for <u>all financial classes</u>, and their payer mix must reflect the payer mix of the locale within which they operate. (Note: the current CON bureaucracy at the State could track this.)
- <u>All expenditures</u>, whether they be for capital, equipment, operational lease, or bricks and mortar, must fall under this $2 million threshold.

With such great controversy over this proposed amendment to the CON, we recommend that the legislature establish a working group comprised of providers and legislators to examine the entire CON process. Valley Hospital remains willing to work with interested parties and the State of Alaska to improve the CON process in order that it respond to the evolving needs of the health care environment in Alaska.

Health Systems Agency of Northern Virginia
7245 Arlington Boulevard, Suite 300
Falls Church, Virginia 22042
Phone: 703-573-3100 Fax 703-573-1276

April 23, 2002

House Finance Committee
Alaska State Legislature

Testimony, HB 407
Alaska Certificate of Need Program

Dean Montgomery
Executive Director, HSANV

Mr. Chairman, Members of the Committee,

I am Dean Montgomery, Staff Director of the Health Systems Agency of Northern Virginia (HSANV), a private non-profit corporation. HSANV does health services research and planning, under contract, for both public and private entities. We have conducted a number of CON and related planning studies in Virginia and elsewhere over the last two decades. I have more than 25 years experience in this field.

The merits, and necessity, of CON and related planning have been debated in Virginia, with varying degrees of intensity, every year since 1986. The Virginia experience may be instructive and of use as you consider changes to Alaska's program. After years of debate, most covered service in Virginia were deregulated in 1989. Among acute care services, planning controls were kept on only hospital beds, operating rooms and open-heart surgery. Following deregulation, there was an immediate proliferation of new services (notably, CT, MRI, radiation therapy, cardiac catheterization). The resulting increase in capital expenditures, and the sharp decrease in average program use/volumes and the associated revenue loss at established programs, led the state legislature to reimpose planning controls three years later, in 1992. Controls were reimposed on all of the services that had been deregulated in 1989. The excesses following deregulation were such that it took between 7 and 8 years for average program volumes to return to 1989 levels. Virginia has been a rapidly growing state during the last decade. Were this not the case, the negative effects of deregulation would have been even greater and longer lasting.

This experience notwithstanding, CON has been debated annually (during each general assembly session), since the reimposition of controls in 1992. To date there has been no significant change in the program, although there is a strong lobby in favor of the deregulation, particularly of

surgery centers, diagnostic imaging services, specialized cardiac services, cancer treatment centers, and similar services that can be operated profitably outside of community hospitals.

The CON debate has centered on three broad issues: (1) on the economic effects of deregulation, particularly for community hospitals, (2) on the access to care implications, especially for the medically indigent and Medicaid patients, and (3) on the quality implications, notably for specialized surgical and other tertiary care services.

To date (the 2002 general assembly session ended recently), the legislature has not deregulated again because the evidence and testimony indicate that:

- community hospitals would lose critical revenue from the loss of a large percentage of the services on which they make a profit (e.g., ambulatory surgery, diagnostic imaging, cardiac catheterization) and use to subsidize losses in necessary but unprofitable services;
- in some cases, and perhaps in many, the loss of this revenue would undercut the economic viability of the hospital upon which a community, or a specific population, is dependent;
- many community hospitals would be unable, or less able, to provide necessary emergency services and services to the medically indigent and to Medicaid patients, without a substantial increase in Medicaid payments;
- cost of deregulation to community hospitals is estimated, at minimum, to be tens of millions of dollars annually, and perhaps several hundred million, depending on the categories of services removed from regulation; and
- although there have been sustained negotiations over several years, to date the legislature has been unwilling or unable to appropriate monies or to increase Medicaid payments to offset a significant part of these losses to essential community hospitals, or to otherwise level the playing field (e.g., tax deregulated services) to offset the inherent advantages of proprietary ambulatory surgery centers and other diagnostic and treatment centers.

Conclusion

Virginia hospitals are highly dependent on ambulatory surgery and diagnostic imaging revenues to offset losses in a number of essential but unprofitable services they are required to provide. The same is true of most essential community hospitals elsewhere.

Deregulation should occur, if at all, only after careful study of the economic and service implications. The cost can be substantial, much higher than anticipated. These costs will necessarily be borne most heavily, if not entirely, by the poor, the medically indigent and the state.

Thank you for the opportunity to comment of the proposed changes to Alaska's certificate of need program. I hope it is no reflection on the value of my views and testimony, but I have not been compensated in any way for testifying.

MHFRC
Missouri Health Facilities Review Committee
www.health.state.mo.us/CON/Title.html 915G Leslie Blvd., Jefferson City, MO 65101 Voice: (573) 751-6403 Fax: (573) 751-7894

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Sincerely,

Thomas R. Piper, Director
Certificate of Need Program

Greater Fairbanks Community Hospital Foundation, Inc.

Owners of Denali Center, Fairbanks Memorial Hospital and Fairbanks Cancer Treatment Center

P.O. Box 71396
Fairbanks, AK 99707

(907) 458-5550
Fax: (907) 458-5551

March 25, 2002

Representative Joe Hayes
State Capitol
Juneau, AK 99801

Dear Representative Hayes,

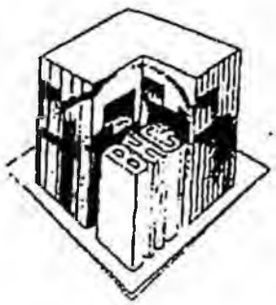
The movement in the state government to change the CON rules alarms me. We have operated as they are presently on the books since we began our community hospital. Reflect for a moment where we came from: 1967 flood, departure of the Sisters of Providence, creation of the Greater Fairbanks Community Hospital Foundation, various fund drives, constant building and changes to deliver the best hospital care at the least possible cost. We have done and are continuing to do the job for the Fairbanks community without cost to the state government. We are not receiving an appropriation from the state in 2002. We are not a part of any Senate or House appropriation bill.

Some legislators have expressed the feeling that they do not understand the hospital business. Give us credit for 30 + years of involvement on a daily basis at no cost to anyone gives us an understanding of our local hospital and healthcare needs. Kill those unwarranted CON bills.

Very truly yours,

Harry J. Porter

Harry J. Porter
Treasurer



ST. LOUIS AREA
BUSINESS HEALTH COALITION

8888 Ladue Road, Suite 280 St. Louis, MO 63124
(314) 721-7821 Fax (314) 721-6784 Email: stlbhc@aol.com

March 14 2001

The Honorable Lana Baker
Chairperson, House Social Services, Medical & The Elderly Committee
Missouri Representative Dist. 76
Capital Bldg, Rm. 313-2
Jefferson City, MO 65101

And

Members of the House Social Services, Medical & The Elderly Committee

RE: HB715 & HB680 Certificate of Need

Dear Representative Baker and Committee Members:

There is an emerging cost crisis in health care that threatens business in Missouri, the state budget and the family budget. We have now returned to double digit premium increases for large employers and over 20% per year increases for small employers are common. This trend will cause serious damage if not checked.

Every able-bodied cost containment tool is needed to fight this problem. The employers in our region believe one of those tools, while not without its flaws, is the State Certificate of Need (CON) Program. Much of that program concerning hospital facilities will sunset this year unless the legislature renews it. This is not the time to allow CON to sunset! We support HB715 and HB680 both in the Social Services, Medicaid and the Elderly Committee. We are asking that you vote in favor of both bills in committee so there can be house floor debate on CON soon.

Failure to act on CON this year will expose employers, consumers and the state to the real risk of an accelerated arms race in health care facility construction in Missouri. We are an organization of 42 of the major employer purchasers of health care in our region who purchase care for over 400,000 lives in this area. We believe the current CON sunset will make the serious inflation in health care even worse in this supply driven industry. The CON process is not perfect, but on balance does serve as a dampening influence on excessive health facility expansion. We know excess supply is a key driver in our health care premium inflation.

Most of the health bills you will likely see this year will increase cost to employers and consumers. This one may be the only one you will see that even has the potential to help hold cost down and should be seriously considered. Please listen to the voices of consumer and purchasers of health care on this issue. They are who CON is design to help. Thank you for your consideration.

Sincerely,

James C. Stutz
Executive Director

JCS:lr

Need for Regulation

Given the demise of centrally planned economics and the relative prosperity of the United States, one might expect Americans to be preaching to the world about the superiority of the system: mixed capitalism. Instead, the political flavor of the moment asserts the necessity to abandon what we have in favor of a purer, more rough-and-ready version of the market economy. The billboards on the road of this promised economic Utopia offer now familiar policy prescriptions for what ails America: privatization, deregulation, downsizing, shrinking entitlements, and lower taxes. The intellectual underpinning of this thrust is a nearly religious adherence to the belief that virtually all public-sector activity, including financial support for the poor, protection of union-labor rights, and even macroeconomic policies, does more harm than good. Adherents view the simplified models of laissez-faire economics as revealed wisdom about what sort of world their proposals would produce.

Faith in idealized market structures also has spawned a political jihad intent on stripping away the community and governmental safeguards against market abuse and imperfections -- safeguards that are central to the modern American system constructed during the Great Depression and after World War II. In addition, an overtly and proudly selfish ideology finances and propels the drive to cut taxes on the wealthy, punch holes in the social safety net, and "unchain" business from the shackles of regulation and litigation. The conservative catechism castigates those who would "reward need" by supporting public programs for the poor and, at its most radical, even rejects Adam Smith's conviction that the state must provide the bedrock of the educational and physical infrastructure of an industrialized society.

The extreme version of the current fundamentalist conservative economics seems to imply that there is no such thing as a market failure -- that in every circumstance the market will produce better results than alternatives. This view is not universal; in fact, the majority of scholars recognize that it carries an important point to the level of absurdity. The ravages of an unpoliced marketplace are well known. At a minimum, modern commerce and economic growth depend on clear rules of the game, enforceable contracts, independent courts, community infrastructure, and public investment, especially in education.

Foreward by Richard Leone to Everything for Sale by Robert Kuttner. University of Chicago Press1993.

Comments & Background - M Powers FMH.

Points for Public Testimony

I'm concerned that if the CON threshold is raised, it will open the floodgates for programs that aren't needed. There is a nationwide shortage of nurses and other health care personnel. I'm worried that the new services that would start up under a wide-open no-CON necessary policy like the one you're suggesting might be forced to skimp on the quality of their staff just to keep it open. There are pieces of medical equipment in this town that aren't open because the staff to run it can't be found. So the equipment sits idle. Somehow it's got to be paid for, and I worry that it's just driving up the cost of something else. In health care, I can't really choose what to buy and what not to buy, like picking out options on a used car. So I'm afraid that I'll end up getting something I may not really need just to pay for these kind of investments that go sour. Moreover, I don't want my insurance company to be manipulated into bailing out somebody's bad business decision. It's not a normal business. How can health care be cheaper in the long run if we let the providers themselves build facilities and buy equipment without showing somebody that they've done their homework and it's really needed? Maybe they just want it. And they're going to get all of us to pay for it.

Larger, busier programs usually have better outcomes. There is abundant literature on this for Cardiac Bypass. In most industries, it's also true that larger producers are both better and less expensive. By removing the CON requirement that sufficient need is present, you'd be artificially stimulating many small providers. By doing this, aren't we moving in the wrong direction? Shouldn't our efforts to obtain the economic advantages we see in other industries work in the direction of encouraging a smaller number of larger more efficient and more experienced providers? And then monitoring them to make sure that they are not abusing their leverage? The Federal government does this all the time in other industries. If we are interested in the health of the patients and the total cost to the system, that's what we would do. If we encourage a greater number of smaller providers we are only working in their narrow self-interest of the providers and not in the best interest of the patients. Raising the threshold too much, say over $2 million, will have the effect of diluting the quality of staff, diluting the patient and provider base needed to establish experience and a track record. That would not be in the interest of patients, and so I urge to re-consider your proposal to raise the CON threshold to such a dangerously high level.

I don't understand why the state wants to abdicate their role in helping communities develop workable health care plans. If a service can be shown to be needed, then a CON can be obtained. It doesn't give any preference to one applicant over another – each of the alternate proposals is evaluated and the best one is granted a CON and authorization to proceed. What's wrong with that? I don't see how that is anti-competitive. If health care worked like the market for hair spray or power tools, we wouldn't need the State to get involved. But we all know that patients and doctors aren't equal players in the marketplace the way a hardware store and a handyman are. If I need a power tool, I can shop around and get the prices and the features of the different models. I can decide

which ones best fit my needs. I can decide whether I want to drive farther to get a lower price, or order it through the mail and wait, or whatever. But when I go to the doctor, I don't know what I need. I don't know what I should pay. I don't know whether this hospital is better than that one, or this specialist is as good as the one down the street. I rely on my doctor to tell me. So I don't get to bargain in the marketplace the way I do with when I buy a power drill. And I don't want to. But I do know this. If there's no need for a facility, and yet a group of doctors wants to build it anyway, a red light goes off. I know that there's a potential conflict of interest there. If they tell me to go to their facility, how am I going to know that they're saying that because it's the best thing for me? Maybe it's the best thing for them. So if there's no need, then the community needs to able to say "no." And if there is a need, then we should be able to have a say in who gets to build it. But I don't want the doctors or the hospital to decide to build something and then to use me to fill it and to use my insurance company to make it pay. Regulation makes a lot of sense under these circumstances and I agree with the state's CON process the way it is now.

We're not talking about providers not being allowed to provide services that they can show are needed. The current rules let them do that already. We are talking about a proposal to allow providers to build facilities without having to show that they are needed. Now if everyone who wanted to use these places was acting on their own, I would say, let them have at it. But it doesn't work that way and it won't work that way. My insurance will pay, the State of Alaska will pay. The doctors will tell us where to go for services – we won't really decide for ourselves what's best, because we won't know. But it can't be cheaper to build a new facility just so you can leave the other one half-empty. The CON has never stood in the way of this community getting the health care it needs. But it has stood in the way of it getting infrastructure that we don't need. I think this is a good idea, and I'm against changing the CON law.

When the State of New Jersey looked at whether to get rid of CON, they decided not to. "Those Commission members who recommend that CN be maintained agreed that CN is required to:

- help maintain the volumes necessary to ensure services are delivered to each patient consistent with the highest possible quality standards;
- help maintain quality by enhancing staff skills, particularly as the state and nation move into an era of nursing and other staff shortages;
- maintain the financial viability of urban/inner city hospitals where many of the services under study are concentrated;
- maintain access to a variety of preventive and primary care services by enhancing the financial viability of urban/inner city hospitals through continuation of certificate of need for tertiary services that both attract professional staff and are generally well covered by third party payers

- maintain appropriate access to care for all residents through recommended CN process changes that will permit managed growth of services and facilities as population needs change;
- maintain, where appropriate, the system of regionalized services that are part of a formal, well-defined referral network where patients are placed according to acuity;
- maintain an appropriate rate of growth in the parts of the state budget that pay for health care services.

Source: Report of the New Jersey Certificate of Need Study Commission

I agree with their thinking on this. By raising the threshold to $10 million, you would be removing these assurances. I urge you to reconsider the effect that this uncontrolled situation might have on patients, providers, and the State budget.

New Jersey decided to keep a number of services under review for several reasons. Here is a sample of several of these services and the reasons they gave for keeping a CON process in place to review them:

1. **Cardiac Catheterization and Pilot Cardiac Catheterization:** A highly specialized service
   where quality is dependent on volume; pilot low risk catheterization process has shown that a number of programs failed to meet volume and normal study requirements, potentially negatively affecting quality.
2. **Cardiac Surgery:** a highly specialized service where quality is very closely dependent on
   volume; recommended for retention as a regionalized service by the American College of Cardiology; costly to initiate, particularly with shortages of nursing and other highly specialized staff; negative impact on urban/inner-city facilities where this service is concentrated.
3. **Nursing Homes (including general, pediatric, ventilator and behavioral beds):** Potential to undercut the state's priorities to promote community based services; potentially a large impact on the state budget; substantial majority of those speaking at the public hearings favored retention; costs are highly related to staffing and increased numbers of providers, especially in view of nursing and other staff shortages will exacerbate costs; highly staff sensitive, thus these shortages will negatively affect both quality of care and quality of life of residents.
4. **Assisted Living Residences and Programs and Comprehensive Personal Care Homes:**
   Potentially a large impact on the state budget should these services become a Medicaid entitlement; substantial majority of those speaking at the public hearing favored retention; costs and quality are highly related to staffing; particularly in view

of nursing and other staff shortages, costs may increase and both quality of life and quality of care deteriorate.

They were concerned with the likely impact on four areas:

1. concern that quality will deteriorate with numerous new providers, especially in view of looming nursing and other specialized staff shortages
2. that a highly specialized service where quality is dependent on volume would be compromised
3. that a program might be very costly to initiate, particularly with shortages of nursing and other highly specialized staff, yet not needed
4. its impact on the state budget

Source: Report of the New Jersey Certificate of Need Study Commission

I think that these concerns are identical to those we face here in Alaska. To eliminate CON review for these services, as your proposal would allow, would be a grave mistake.

CON Threshold Amount:

The $1,000,000 threshold was set in the early 80s. The National Bureau of Labor Statistics seasonally adjusted consumer price index in Dec 2001 stood at 177.3 with 1982-1984 equal to 100. Adjusting the original $1,000,000 for rising prices would mean setting it now at $1,773,000. How can you explain moving it up by a factor of 10 instead of a factor of 1.7 or even 2.0? It seems completely at variance with the original intent of the threshold. I urge you to be very careful in considering raising the threshold by anything over $2,000,000.

Central New York hospitals struggling to survive hard times

01/29/2002

"Five years after New York state stopped regulating hospital rates, Syracuse's four major hospitals are in "poor financial health," the Syracuse *Post-Standard* reports in a look at the impact of competition in the local health care market. Following the passage of the Health Care Reform Act in 1997, which abolished state-regulated rates, the city's hospitals became more competitive, investing in new services and buying up physician practices in order to capture market share. According to some local experts, this "wave of competition"—coupled with declining utilization rates, rising labor costs and stagnant population growth—has taken a financial toll on area hospitals. Says one official at University Hospital at SUNY Upstate Medical University, "All of us have tried to respond to competition by expanding and making investments in services... It looks like very few of those investments have paid off."

According to a recent report by Excellus, the parent company of BlueCross BlueShield of Central New York, hospital costs in the area now exceed both state and national averages.

Hospital per-member, per-month expenses in Central New York rose nearly 23% between 2000 and 2001. Meanwhile, since the state relaxed its regulations governing the creation of freestanding ambulatory centers, the region now boasts eight physician-owned for-profit outpatient facilities—further compromising hospital revenue, according to some hospital executives."

I'm concerned that your proposal will lead to the same sort of deterioration in Alaska, and I urge you to retain CON in its present form.

Idaho: Chicago, Ill.-based **National Surgical Hospitals** is considering opening a surgical hospital in Post Falls in partnership with up to 15 area physicians. However, CEO Joe Morris of nearby **Kootenai Medical Center** says that opening a for-profit surgical center 10 miles away from Kootenai could have a negative financial impact on the community hospital. He says the surgery center would force the hospital to raise rates, reduce services or seek a tax increase, which it has not done in eight years (1/20).

I think there is a real likelihood that same thing would happen here if we loosen up the system too much, as your proposal would do, and I urge you to reconsider.

By raising the threshold to $10 million, you will be eliminating CON review for all but the most expensive programs. These are the very programs where the planning is most likely to be the most thorough, and where consequently, the value of outside CON review the least valuable. We need to be concerned about the smaller programs, where a provider might be playing a hunch or making a bet. I think that the threshold should remain where it is, or perhaps lowered, so that we don't have providers spending money on things we don't need.

Ohio: When Cincinnati-based Christ Hospital opens a $67-million, four-story Heart Center of Greater Cincinnati in the first quarter of 2004, it will be the ninth hospital in the Tri-State area performing open-heart surgery. Late last year, Mercy Health Partner opened a new heart surgery unit at Mercy Hospital of Fairfield. Industry experts are concerned that the area has too many cardiac units and have called for the community to "come together and determine how many heart centers we can afford." "Not all of them will be first class," adds Leslie Miller, a VP at consulting firm Marsh USA (Tortora, *Cincinnati Business Courier*, 1/25).

Some categories of service should require a CON no matter what they cost. If there is unlikely to be sufficient volume to have a high quality program, then the residents of the State will suffer. How would competition handle this problem? We shouldn't be willing to wait until enough patients have bad outcomes for the word to get out to consumers to stay away from that facility.

I am in favor of a reasonable level of state oversight of the establishment of new programs. It should ensure that there is a good chance that the project can be built for a reasonable amount of money, that it can be staffed appropriately, that it is likely to have the volumes necessary to achieve economies of scale, and a likely prospect of producing good outcomes. The existing CON program does these things now, and I think it would

be a big mistake to try an untested experiment of allowing programs to spring up wherever providers think they can make some money. Raising the threshold to $10 million is too risky and extreme an experiment.

In 1999, the American Health Planning Association published a statement on health policy which states, in part:

"The reliance on market competition for 'healthcare reform' is a political and economic experiment which is resulting in dislocations throughout society. The challenge to public policy is to facilitate the development of a responsible marketplace, one in which the sought-after benefits of competition are realized. To achieve benefit from this process for all residents, it is necessary for legislators to take a more active role in shaping the transformation of the market. Government is obligated to exercise sound stewardship of the public's resources, much of which it controls as the primary payer of services. Healthcare is a social good like safety and education which, in a democratic society, requires intelligent government oversight in order to balance competing needs and priorities."

Intelligent oversight is provided by the CON process: it provides a forum for the public's involvement in decisions to expand capacity and to make major investments in healthcare technology. Where good planning can be demonstrated, CON is not an impediment. Where there is not good planning, CON provides a reasonable check on the unrestrained proliferation of unnecessary services. I am in favor of retaining the CON process as it is, perhaps expediting the review of some categories and raising the cost threshold by a reasonable amount to adjust for inflation. But to raise the threshold for review to $10 million would open the floodgates for projects that wouldn't have passed muster before.

"As long as providers do not bear the financial risk of additional health service volume (and they only truly bear such risk in reimbursement system in which they are paid a set amount per person served – a 'capitated' payment) their economic incentive will be to expand services. It is important, then, to provide 'extra-market' forces – capacity management – to assure that there is a balance between the public's need for health care services and the supply to meet those needs."

Source: Capacity Matters. The Finger Lakes Health Systems Agency, Rochester, NY June 2000.

I agree that health care is a very imperfect market where other controls are required. CON is one of them. Your proposal effectively abolishes CON for all but the very largest projects, and this is a mistake.

In a report just made available by the Florida Hospital Association, two researchers from the University of Iowa investigated the impact of CON on the risk of death from cardiac bypass surgery. The concluded that, "risk-adjusted mortality was 21% higher in patients

in states with no CON regulation, compared to states with continuous CON regulation... that 21% difference in mortality would translate to 9 additional deaths for every 1,000 patients undergoing CABG. In addition, the analysis found that average hospital volumes in states with no CON were substantially lower and that patients in such states were substantially more likely to undergo CABG in low-volume hospitals....this analysis would suggest that CON regulation is associated with better patient outcomes. Thus, repeal of CON regulations may have negative consequences on patient outcomes."

Source: Impact of Certificate of Need Programs on Outcomes of care for Patients Undergoing Coronary Artery Bypass Surgery: Report to the Florida Hospital Association. Gary E. Rosenthal, MD and Mary V. Sarrazin, PhD. Program in Health Services Research, University of Iowa College of Medicine January 17, 2002.

By raising the threshold to $10 million, you would be effectively eliminating CON. I ask that you reconsider your proposal in light of this new and importance evidence, and retain CON as it is, or require that new programs require a CON no matter how much or how little they cost.

"Competition in health care markets is not feasible due to uncertainty and informational asymmetries that are inherent in the nature of medical care... the effects of competition in health care crucially depend on the institutional structure. For instance... competition... may result in a wasteful medical arms race." [1]

The health care market is such that "increased supply can lead to higher prices, not lower, as the conventional model of competition would imply...where markets are imperfect and information is differentially costly for buyers and sellers, increased competition may well decrease economic welfare."[2]

In a review of court decisions in hospital merger cases, Gaynor and Vogt point out that in 4 of the 12 cases, hospitals mergers were allowed because courts found that they would reduce wasteful non-price competition. By contrast, in the presence of highly price-responsive managed care plans... competition may result in too low levels of quality, if inadequate information about quality is lacking." The authors conclude "much remains to be understood about competition and antitrust in health care."[3]

I urge to investigate this market more carefully and to reconsider eliminating CON controls.

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1 Gaynor and Vogt: Handbook of Health Economics

2 Gibson, Rosemary and John B. Reiss. (1983). "Health Care Delivery and Financing: Competition, Regulation, and Incentives" in *Market Reforms in Health Care*. Meyer, Jack, ed. The American Enterprise Institute for Public Policy Research, Washington, DC. Page 246.

3 Gaynor and Vogt: Handbook of Health Economics

Despite being a requirement of a competitive market, the high cost of entry and exit may present advantages in health care delivery. Several years ago, an Institute of Medicine Committee asserted that "since [not-for-profits] economic well-being has never been fully dependent on the generation of profits from operations, they have provided a degree of stability in the provision of needed services, rather than entering and leaving markets depending on profit opportunities."[4] In addition, "given the prevailing... structure in which...only a physician can admit a patient...it is also not clear what increased competition in the form of greater ease of entry into the market would bring about. It is likely, however, that the results would include more excess capacity and commensurably higher average costs."[5]

Your proposal to raise the CON threshold is contrary to these conclusions. Is there any reason why Alaska's health care situation is different from the rest of the country's, where CON is effective in curbing costs and helping to increase access? I ask you to reconsider your effort to change the CON law.

There exists a vast literature on health economics and the reasons why markets are not generally reliable in producing socially desirable outcomes. The *Handbook of Health Economics* runs to 1,996 pages. Therefore, I agree with Weisbrod when he concludes, "we should be cautious about relying heavily on competition ... to optimize the level and distribution of health care services."[6]

An additional reason for caution is that access to health resources is widely regarded as an important social good, and "a competitive model may create problems with respect to equal access to medical care."[7] Competitive markets depend, among other things, on pervasive profit-maximizing behavior. This leads some to conclude that access may suffer as a result of increased competition, becasue "if competition alone is to govern access to health care, many... rules that force providers to give 'free' care will have to be eliminated. Consequently, some beneficiaries of these rules may be denied access."[8] Agreeing with this conclusion, one panel of health care experts concluded that encouraging competition in health care is not a suitable objective for government policy. In their opinion, "*substantive goals regarding cost, quality, access, education, and*

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4 Committee on Implications of For-Profit Enterprise in Health Care. Institute of Medicine. (1986). *For Profit Enterprise in Health Care.* Bradford H. Gray, ed. National Academy Press. Washington, DC. Page 194.

5 Weisbrod, Burton A. (1983). "Competition in Health Care; A Cautionary View" in *Market Reforms in Health Care.* Meyer, Jack, ed. The American Enterprise Institute for Public Policy Research, Washington, DC. Page 66.

6 Weisbrod, Burton A. (1983). "Competition in Health Care; A Cautionary View" in *Market Reforms in Health Care.* Meyer, Jack, ed. The American Enterprise Institute for Public Policy Research, Washington, DC. Page 70.

7 Gibson, Rosemary and John B. Reiss. (1983). "Health Care Delivery and Financing: Competition, Regulation, and Incentives" in *Market Reforms in Health Care.* Meyer, Jack, ed. The American Enterprise Institute for Public Policy Research, Washington, DC. Page 245.

8 Gibson, Rosemary and John B. Reiss. (1983). "Health Care Delivery and Financing: Competition, Regulation, and Incentives" in *Market Reforms in Health Care.* Meyer, Jack, ed. The American Enterprise Institute for Public Policy Research, Washington, DC. Page 246.

research are more appropriate than a goal of creating fair competition between ... health care organizations." (italics original) [9]

I think that your proposal seems like a good idea at first glance but that it could have disasterous consequnces, particularly for the poor of Alaska. I ask that you withdraw your proposed amendment to the CON statute.

In examining questions of equality of access the health care under competition, Victor Fuchs from UCLA concludes that "the virtues of competitive markets are considerable, but it is questionable whether the transformation of the health care industry into an approximation of the used car industry represents social progress."[10]

Given the unique features of health c, trying to transforming the market to a competitive one is ill-advised. It will be difficult to attempt and probably impossible to achieve; and even if attained, it is doomed to fail in its primary goal: ensuring an equitable distribution of these socially important resources. I urge you to leave the CON process as it is.

Competitive markets, even for specific services, <u>will not be created</u> in Alaska by the addition of several new providers of services. The action of other factors make it impossible. And, since the introduction of the new providers into markets is likely to create excess capacity, it is also likely to result in higher prices rather than lower ones. We need a strong CON law in Alaska to provide a measure of discipline to the market. By loosing the standards, you will open the door to a host of problems. I urge you to consider strngthening the CON, lowering the cost threshold and making more projects reviewable instead of only a handful.

Arguing against reliance on markets, "adherents of the 'social good' view...point to some perverse effects of the marketplace—its stimulus to provide unnecessary services; its tendency to offer only those services from which, and to serve only those patients from whom, money can be made either directly or indirectly; its eagerness to duplicate services without respect to 'community need' if doing so serves competitive advantages; its alleged willingness to shade on aspects of quality when detection by customers is unlikely, as can happen in medical care, its emphasis on amenities, which are seen as the equivalent of packaging in other areas of merchandising."[11]

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[9] Committee on Implications of For-Profit Enterprise in Health Care. Institute of Medicine. (1986). *For Profit Enterprise in Health Care.* Bradford H. Gray, ed. National Academy Press. Washington, DC. Page 191.

[10] Fuchs, Victor R. (1986). *The Health Economy.* Harvard University Press, Cambridge, MA. Page 552.

[11] Fuchs, Victor R. (1986). *The Health Economy.* Harvard University Press, Cambridge, MA. Page 15.

Is this what we want? If not, then I ask you to reconsider your amendment.

"In a market comprising only profit-maximizing firms, increased competition will tend to promote allocative efficiency and low prices (if there are no dislocations resulting from informational, pricing or other sources of 'private market failure'). Will the same be true of markets dominated by governmental and private nonprofit firms?"[12] Weisbrod answers "we don't know." However, there is agreement that the pre-conditions for a competitive market which will result in allocative efficiency and low prices do not exist in health care, nor are they created by adding suppliers and facilities.

Given the uncertainty and riskiness surrounding your proposed amendment, I ask that you withdraw it from consideration.

Government policy must address issues of distributional equity and other concerns along side efforts to improve allocative and economic efficiency. Not-for-profit and governmental institutions are important in addressing these broader issues. Thus, "public concern is warranted about the continued vitality...of important not-for-profit...institutions—particularly those that are sole community providers."[13]

Attempts to substitute a bastardized form of competition for regulation will fail in lowering costs, increasing quality or increasing access. They may fail in only one or perhaps in all three. One thing is certain: we cannot afford to roll the dice with Alaska's fragile health care delivery system. I ask you to reconsider your amendment.

Competition can be good. It seems easy. This common view is mistaken. To make this case requires delving into the details of economics that we cannot attempt here. To summarize a complex story: competition only works when certain conditions can be met. Yet, "market failure [is] prevalent in the hospital industry"[14] and "some basic assumptions underlying economists' confidence in competition do not hold in much of the health care industry"[15] (emphasis added). It isn't a matter of saying, "competition won't work." It's that "you won't really have competition at all." Worse yet, while the

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[12] Weisbrod, Burton A. (1983). "Competition in Health Care; A Cautionary View" in *Market Reforms in Health Care.* Meyer, Jack, ed. The American Enterprise Institute for Public Policy Research, Washington, DC. Page 67.

[13] Weisbrod, Burton A. (1983). "Competition in Health Care; A Cautionary View" in *Market Reforms in Health Care.* Meyer, Jack, ed. The American Enterprise Institute for Public Policy Research, Washington, DC. Page 67.

[14] Eastbaugh, Steven R. (1992). *Health Economics: efficiency, quality, and equity.* Auburn House, CT. Page 65.

[15] Weisbrod, Burton A. (1983). "Competition in Health Care; A Cautionary View" in *Market Reforms in Health Care.* Meyer, Jack, ed. The American Enterprise Institute for Public Policy Research, Washington, DC. Page 62.

hoped-for benefits of competition evaporate, the negative consequences of a laissez-faire approach will be real— higher overall health care costs and hospitals with diminished capability to care for community's under-served -- where no "market" exists and where one will surely not be created.

Your amendment will fail to achieve its objectives, and I ask that you consider withdrawing it.

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37 states currently have CON. Others are considering strengthening it. In the lower 48, managed care has led many states to try to allow them to manage the marketplace instead of CON. But in Alaska we don't have managed care and it is doubtful we ever will. Your proposal won't create competition, and it might create chaos. I ask that you give your proposal more thought and withdraw it from consideration during the current session.

THE NEED FOR CARE IN USING MARKET FORCES IN HEALTH CARE

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School of Public Health
The Ohio State University
April 22, 2002

It is tempting to assume that the discipline of market forces might be just what is needed in order to achieve lower cost and greater efficiency in health care. As a health economist who has worked in this subject area for more than thirty years, I am certainly aware of the power of markets and the response of actors to incentives. In fact, the problem of markets in health care is frequently not what is imagined. It's not that "the laws of supply and demand don't apply in health care," or anything of that sort. Instead, the issue is that markets in health care tend to be enormously complicated, and imbued with all manner of moral and social considerations that are not terribly relevant if we are dealing with the market for, say, pizzas. In effect, the problem is not that markets don't work in health care—it's just that we may not like the results we get. Rather than try to elaborate all this theoretically, I will simply list a few points to illustrate the care that needs to be taken in considering public policy toward health care markets.

- Although we may like the idea of efficiency and low prices in health care, we simultaneously deplore the commercialization of relationships in health care. Most of us do not want to worry about whose interest the physician, hospital, etc. is considering in caring for us. We show in part by our behavior in purchasing insurance that we distinctly wish to avoid "calculatedness" in treatment decisions.

- Institutional providers, and particularly hospitals, frequently represent a long-standing pattern of investment by the community. These are not only businesses, they are community institutions in which we take pride and whose viability we have a shared interest in preserving.

- Price and cost are distinct concepts in economics. If resources are in use, there is a cost regardless of the price that can be recovered for their use. In health care this is particularly noticeable in so-called "option demand" areas, such as the emergency department, operating rooms, etc. The resources must exist in advance of the demand, so that the option is available when needed. It may, however, be difficult to recover the cost of these resources relying only on the price that can be charged to current users, and thus there need to be ways to share the cost among both current and potential users. A competitor bidding down the price doesn't make the cost go away. The cost is only removed if the resources themselves are removed, which could have an obvious impact on the community.

There are many more examples that could be given. The point, however, is straightforward: markets and the actors in them respond to the incentives they face. In complex markets such as those in health care, we need to exercise substantial caution in trying to apply concepts from simpler settings, or we may have consequences quite different than those that were intended.

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* Affiliation information for identification only. The opinions expressed here are in my capacity as a private citizen and are not an official position of The Ohio State University.

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April 22, 2002

Representative Bill Williams
Co-Chair House Finance
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907-465-3424
Fax: 907-465-3793

Representative Eldon Mulder
Co-Chair House Finance
State Capitol, Room 507
Juneau, AK 99801
907-465-2647
Fax: 907-465-3518

Dear Representatives Williams and Mulder:

This letter is to let you know my feelings regarding SB 256, HB 407 and HB 485. These bills propose changes to the Certificates of Need (CON) laws.

CON are essential to ensuring that the needs of a community are being met. By passing SB 256, HB 407 or HB 485, the Alaska State Legislature will be essentially eliminating the CON process for all but the most expensive programs. Because these programs are so expensive, they generally have more thought and planning. The smaller programs, less-expensive programs, are usually the programs most in need of these laws.

A meaningful CON process is critical to the reasonable and appropriate planning of health facilities and programs in Alaska. This state, from our experience, represents some of the most unique and challenging environments in which to build and maintain critical health access facilities.

I respectfully suggest that you take a very serious look at this current legislation and study the impact of this bill from a public policy, Medicaid expenditure, and a facilities planning perspective. Please bring into the equation the appropriate experts in Alaska and, perhaps across the nation to help resolve this issue in this fragile healthcare environment of Alaska.

Sincerely,

Conrad G.B. Frank

CC: House Finance Committee Members
Interior Delegation

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HONORABLE SENATOR GENE THERRIAULT
STATE CAPITOL, ROOM 121
JUNEAU, ALASKA 99801

DEAR GENE:

I understand that the legislature is considering several bills this year to either change or eliminate the certificate of need process for new health care related construction. As you know I have been a doctor in Fairbanks for nearly 27 years. I have always believed that our greatest health care asset in Fairbanks is our community hospital. Changing this law would be very bad for Fairbanks because it will likely lead to the construction within the next year of at least two free standing for profit outpatient surgi-centers. These will duplicate services already provided by FMH and take away resources from our hospital (by only serving paying patients - the ones who have good insurance) and will leave the hospital as the provider of last resort for indigent patients. Since there is only a finite amount of money available this will lead to increased costs and decreased quality of service at FMH.

Patient safety is also an issue. Occasionally patients have life-threatening adverse problems during even the most routine surgery. At the hospital, all advanced life saving services and equipment are immediately available. These facilities are very expensive and will never be available at outpatient surgi-centers. A patient in trouble will have to be transported to the hospital and precious minutes will necessarily be lost.

Another patient safety issue is peer review and quality of surgical staff. At Fairbanks Memorial we have an independent medical staff of doctors who are responsible for policing the individual doctors and acting to limit or deny privileges of those surgeons who don't meet high standards of quality in their work. Since the staff is representative of all the clinics in town, there are no financial incentives to allow substandard surgeons to continue operating. The two proposed surgi-centers will be owned and operated by small groups of doctors who are primarily motivated by profit. They will have strong financial incentives to keep the facility busy and very little incentive to police themselves and other affiliate surgeons.

For all of these reasons, I urge you to help defeat these proposed changes in the law. I would be very happy to speak with you further on this or provide more information if you desire.

SINCERELY,

PETER MARSHALL, M.D.

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April 19, 2002

Representative Bill Williams
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Representative Eldon Mulder
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Dear Representative Williams and Representative Mulder:

As a former Chief-of-the-Medical Staff at Fairbanks Memorial Hospital and a physician with over 20 years experience practicing medicine in Fairbanks, I would like to speak to the concerns I have with HB 407 and SB 256 which effectively eliminate the Certificate of Need program in Fairbanks. At one point in my career, I would have been in support of changing the Certificate of Need laws. But through my work as Chief of the Medical Staff at our local hospital, and as current Medical Director of Denali Center, I have come to gain a broader perspective on the importance of healthcare planning issues, particularly as they related to Medicaid expenditures. While I believe it is appropriate that Certificates of Need are being eliminated in many states where large populations and a choice of many facilities make competition work fairly well for the public, I believe that in Alaska and especially Fairbanks, there is good justification for continuing the Certificate of Need process for healthcare expenditure planning.

If the CON laws were to be changed, the public would be precluded from participating in important health planning decisions for this community. The Certificate of Need program is nothing more than a structured public process that requires businesses to demonstrate the value of adding important health services to a community, before adding redundant or duplicated programs and services to a community's health system. We all must be vigilant to ensure communities get the biggest bang for their healthcare dollar. Eliminating this important public process exposes a community to entities who will, under the guise of "competition," cherry pick profitable services from community agencies who provide an array of services – many of which will never pay for themselves but add to the health and well-being of a community. Services such as surgery and imaging are what pay for services no others will provide due to their cost, such as mental health, home care, cancer treatment, and neo-natal care.

Furthermore, unlike most supply and demand economic situations, it has been shown that healthcare expenditures often increase rather than decrease when new technologies and competitive facilities provide duplicate services. Proper public planning in a small community such as Fairbanks may actually reduce total healthcare expenses by matching the facilities with the true needs of the community. For example, I will suspect that the new MRI machine recently introduced at Tanana Valley Clinic will result in greater total expenditures for MRI scans in this community and NOT reduce those expenditures by competition because an increased number of MRI scans will be ordered (this would be an easy study for Medicaid to do over the next year).

Before such an important public process is eliminated, I urge you to carefully study this issue. Call in local and national experts and help craft a meaningful Certificate of Need law that balances the safety net local hospitals provide, against only the favorable aspects of competition that might be able to help control costs to the Medicaid program. Outright elimination of the Certificate of Need laws, I am convinced, will bring changes to our local health system that we are not prepared to accept, nor are willing to pay for.

Thank you for your thoughtful consideration of this important public policy issue. Be very careful of the unintended consequences inherent in the proposed legislation.

Sincerely,

Richard Burger, MD

Cc: House Finance Committee Members
Interior Delegation

March 25, 2002

Representative John Coghill
State Capitol, Room 102
Juneau, AK 99801
Fax:907-465-3258

Dear Representative Coghill:

I have been following the legislation proposing to change the Certificate of Need limitations to a higher limit. This started several years ago in Fairbanks with the attempt to place a for profit outpatient surgery center in Fairbanks. A lot of the testimony at hearings on this matter was very telling as to the true motives of the people involved. Although testimony centered on freedom of choice and lower cost, what I got out of the hearings was transfer of insured patients and well-heeled patients to the for profit center with overall costs for the community only increased. Excess capacity and profit motive would increase usage of the for profit outpatient facility leaving less remunerative care as a responsibility of Fairbanks Memorial Hospital.

I hear many positive comments about the not-for-profit community based medical care currently available in Fairbanks from patients who have had to deal with much more complex systems available in the lower 48 states. Patients in Fairbanks need not worry about the true motives of physicians when care is either recommended or discouraged. Physicians are not rewarded for recommending care at Fairbanks Memorial Hospital nor are they discouraged when care is ordered for underinsured or non-paying patients.

I feel that changing the CON limitations may be good for a few businesses and individuals but is not a good change for the community.

Sincerely,

Richard Hattan

Richard Hattan, MD
992 Willow Grouse Rd
Fairbanks, AK 99712

ALASKA STATE HOUSE OF REPRESENTATIVES

Interim Address:
119 N. Cushman, Suite 211
Fairbanks, AK 99701
(907)-456-5081
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(907)-465-3719
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State Capitol
Room 102

REPRESENTATIVE JOHN COGHILL

HB 407 Certificate of Need
Sponsor Statement

In trying to preserve the free enterprise system, I will do all that I can to protect our open market and the consumer's choice. This bill is an attempt to do this in the world of health care.

Under the current state statutes, if a health care provider in Fairbanks or the Mat-Su Borough wanted to build or supply services over $1 million dollars worth, they would have to obtain a Certificate of Need. In applying for that certificate of need they would have to prove to the government that a proposal would not adversely affect other health care facilities. This puts the government in charge of who can deliver health care in any area. I would rather see the customer and the health care providers have a greater choice in the market dynamics.

I don't believe that by eliminating the CON requirement for larger Alaskan communities there will be large influx of new medical facilities. This may have been true when the federal government subsidized CON programs, but the federal CON law was repealed in 1996. Since the repeal of the federal law, 14 states have repealed CON's. Another ten states have eliminated CON requirements for acute care facilities and additional nine states do not require CON's for ambulatory surgical centers.

More ambulatory surgical centers in Fairbanks would not, in my opinion, mean less business for existing facilities. It could mean however, more choices in providers and that fewer Fairbanksans may have to travel to Anchorage or the lower forty-eight for a medical procedure.

According to the attached *Heartland* article, in 1996 the Federal Trade Commission estimated that CON regulations increased the cost of hospital care nationwide by more than $1.3 billion annually.

This legislation will encourage competition in the larger Alaskan communities where the population would support competition while protecting the fragile balance of health care services in the smaller Alaskan communities.

Representative_John_Coghill@LEGIS.state.ak.us

WHAT IS THE RIGHT POPULATION NUMBER?

U.S. Census provides extended information for communities 25,000 and over	25,000
125% of Federal Level standard conversion for poverty level for medical assistance	31,250
150% of 125% level of poverty level for medical assistance	46,875
175% of 125% level of poverty level for medical assistance	54,688
200% of 125% level of poverty level for medical assistance	62,500

ORGANIZED BOROUGH POPULATIONS

Anchorage Borough	260,283
Fairbanks North Star Borough	82,840
Matanuska-Susitna Borough	59,322
Kenai Peninsula Borough	49,691
Juneau Borough	30,711
Ketchikan Gateway Borough	14,070
Kodiak Island Borough	13,913
North Slope Borough	7,385
Northwest Arctic Borough	7,208
Aleutians East Borough	2,697
Haines Borough	2,392
Lake Peninsula Borough	1,823
Bristol Bay Borough	1,258

Statement of Revenues and Expenses — Providence Alaska Medical Ctr

	1998	1999	2000	2001	2002	2003	2004
REVENUES							
Gross Patient Revenue							
Inpatient Gross Revenue	$ 238,536	$ 254,306	$ 269,044	$ 283,807	$ 301,159	$ 328,486	$ 354,653
Outpatient Gross Revenue	101,579	109,508	129,039	141,935	156,147	179,789	207,083
Total Gross Patient Revenue	340,115	363,814	398,083	425,743	457,307	508,274	561,736
Contractual Allowances							
Medicare	39,036	51,463	6 ,299	-5,791	71,729	85,369	96,892
Medicaid	31,622	41,386	48,100	52,266	56,771	64,436	73,086
Commercial	26,118	30,035	37,347	43,092	49,456	55,749	64,672
Other Contractuals	8,105	8,191	10,802	12,125	13,578	15,544	17,787
Charity	11,910	11,267	14,061	15,093	16,207	18,007	19,958
Total Contractual Allowances	116,791	142,342	170,609	188,367	207,752	239,105	272,396
Net Patient Revenues	223,324	221,472	227,474	237,376	249,554	269,169	289,340
Other Operating Revenues	11,743	8,774	9,298	9,577	9,864	10,160	10,465
Net Revenues	$ 235,067	$ 230,246	$ 236,772	$ 246,953	$ 259,418	$ 279,329	$ 299,805
EXPENSES							
Expenses							
Salaries and Wages	$ 87,956	$ 89,938	$ 96,073	$ 100,255	$ 105,631	$ 112,881	$ 120,530
Benefits	17,914	19,518	21,270	22,195	23,386	24,991	26,684
Supplies	33,704	34,276	36,347	38,424	40,623	43,917	47,413
Professional Fees	12,030	5,042	4,035	4,075	4,116	4,240	4,367
Purchased Services	25,858	29,459	23,650	24,470	25,320	27,215	29,220
Purchased Healthcare	-	-	-	-	-	-	-
Interest	2,435	2,536	2,197	1,887	1,555	1,235	915
Depreciation/Amortization	14,316	16,367	16,422	18,232	19,639	21,875	24,039
Bad Debt	9,733	12,545	11,334	12,168	13,067	14,521	16,097
Other Expenses	8,895	7,534	8,091	8,334	8,584	9,871	10,168
Total Expenses	$ 212,841	$ 217,215	$ 219,418	$ 230,040	$ 241,921	$ 260,746	$ 279,433
Net Operating Income	$ 22,226	$ 13,031	$ 17,354	$ 16,913	$ 17,497	$ 18,583	$ 20,371
Non-Operating Rev/Exp.	10,097	5,891	11,149	10,925	7,672	8,064	9,348
Net Income Before Taxes	32,323	18,922	28,503	27,837	25,170	26,647	29,719
Taxes	-	-	-	-	-	-	-
Excess of Revenues Over Expenses	$ 32,323	$ 18,922	$ 28,503	$ 27,837	$ 25,170	$ 26,647	$ 29,719

From a CON application submitted by Providence

CERTIFICATES OF NEED:
A BAD IDEA WHOSE TIME HAS PASSED

BY PETER DOHERTY

Certificate of need laws and regulations restrict health care commerce and should be abolished.

Looking back to the 1960s and 70s, it is in some ways hard to believe how much faith policymakers had in the ability of government to manage the marketplace. This statement may be especially true for those of us who describe ourselves as conservative. Ask us today, 20 years after the dawn of the Reagan Revolution, and many of us will vigorously maintain that we opposed intrusions of government into the marketplace. We spoke out and we fought the good fight against them, but the lingering impact of the New Deal, as amplified through the Great Society, overwhelmed us until Reagan rose to national power. Yet, despite our protestations, the truth, as reflected by the record, is somewhat different than our memories. The facts, as revealed by votes in Congress as well as the speeches and writings of opinion leaders of the time, are that during this period, we were often not just complicit in government's efforts to control and manage the economy—we conservatives were active participants.

In the past 20 years, many of us have battled to moderate or eliminate the most egregious of these programs and the artificial controls they place on free markets, but despite our successes, vestiges of the past remain. Some are found at the federal level, but some, including a few that even the federal government has given up on as bad ideas,

linger in the states.

A case in point is the so-called Certificates of Need Program (CON), which, in those states that require them including Florida, apply to part or all of the health care industry. They directly affect the cost and availability of health care services. This article briefly recounts the philosophy and history of certificates of need. A subsequent article will focus on CONs in Florida.

Its History

In the late 1960s and early 70s, rising health care costs were becoming a serious concern. The market demand for services was increasing, as was the cost of providing those services. This was in part due to the advent of governmentally underwritten health care programs for the elderly and the poor, and in part due to the increasing availability of employer-provided health care benefits. Concepts such as managed care were all but unknown. In addition, there was in place an insurance (government and private) payment scheme known as retrospective cost reimbursement, which guaranteed providers would be paid on a cost-plus basis. That is to say, providers essentially were guaranteed to be paid for everything they did at the price they determined.[1] And following the iron law of economics that says, "People will do what you pay them to do and the more you pay them, the more they will do," providers nationwide responded by offering ever-increasing levels of care and by expanding their facilities.

Why would a state voluntarily keep a program that has been so much of a failure that its parent, the federal government, disowned it?

As the problem of increasing costs deepened and began to be labeled a crisis, policymakers in the state capitals and in Washington, D.C., scrambled to develop some solution that would control costs yet not appear to impact health care entitlement programs. Much debate and many studies were produced suggesting one course or another, but the plan that went the furthest was called certificates of need. It was a classic bureaucratic rationing and allocation scheme and after being endorsed by the American Hospital Association in 1968, this plan began to gain acceptance. In 1970, New York was the first to adopt it as law,[2] and once part of the law in that bellwether state, the concept spread. In 1974, the federal government embraced the idea and language was added to Section XV of the Public Health Services Act that provided "incentives" for the states to enact such a program.[3]

Needless to say, the federal government's incentives for states to adopt certificates of need legislation were in the nature of a godfather offer; the states couldn't refuse except at the risk of losing federal funds. So one by one, the states

complied, especially after 1979 when Congress amended the 1974 Act to tighten the compliance requirement.[4]

In short, certificates of need programs were intended to maintain and enhance the quality of care and to control health care costs in local communities. They were to do this by promoting a governmentally defined and overseen "rational distribution" of certain health care services. In practical terms, this meant limiting the number of health care providers offering identical services within a given market. To achieve this, procedures were put in place mandating that health care facilities seeking to initiate or expand services must get state approval. Generally speaking, approval was required before a facility or provider could initiate projects requiring capital expenditures above a certain dollar amount, and before they could introduce new services, expand existing services, or increase the number of beds.[5]

Its Objectives

Although the individual state programs varied, seven objectives applied within the general definition given above. The certificates of need application and review process would do the following:

- Ensure the presence of high-quality and appropriately distributed services; these would provide equal access for consumers and would allow health care providers access to sufficient manpower.
- Encourage health care facilities and providers to develop long-range operational and capacity plans based on local community health care needs.
- Require considerations of personnel and financial feasibility as well as need in the development of the long-range plans.
- Encourage the development of affordable and accessible health services to all areas of a state.
- Encourage the consideration of more cost-effective strategies through mandating a thorough review of alternative services.
- Promote the sharing of services between facilities and providers, especially in rural areas, where operational and administrative costs could threaten facility survival.
- Offer the public a forum for input regarding needs and desires prior to establishing or expanding health care facilities and services.[6]

Its Results

With the federal mandate in place and the states falling into line and adopting CONs, the promoters of the scheme sat back and waited for the expected positive results. But they never came. Despite all the good intentions and despite the federal government strengthening the role of state authorities in the late 1970s, it was clear by the early 1980s that the design was not working. Not only were costs failing to come down as a result of CON reviews by health care planning bureaucrats, but they were increas-

ing. In fact, it seemed that the only tangible products of the certificate mandate were:

- The creation and staffing of new taxpayer funded bureaucracies.
- Expensive and time consuming application processes (the costs of which were, of course, passed on to consumers).
- Local community dissatisfaction with health care planners who were often far away and perceived as insensitive to local needs and whose decisions had negative impacts on local health care availability.[7]

So profound and complete was the failure of the certificates of need plan that in 1983, Lawrence D. Brown, writing in the *Journal of Health Politics, Policy and Law,* said,

> In searching the scholarly journals, one cannot find a single article that asserts that CON laws succeed in lowering health care costs. CON has elicited a remarkable evaluative consensus—that it does not work."[8]

Brown's comment reflected more than just a simple failure of a bureaucratic solution. It also came at a time when radical changes were beginning to take place within the health care industry.

First change. The first change was that, gradually, both private insurers and government began to realize that the retrospective cost reimbursement plan was both inefficient and wasteful. They looked for a new model and what emerged was "prospective reimbursement," which, in part, we know today as diagnostic related groups (DRGs). These, in turn, helped launch the era of managed care. Under prospective reimbursement, a set sum is paid to a provider based on a given condition regardless of the number of tests or procedures. It is a plan that puts a premium on efficiency of treatment in its reward structure rather than the quantity of treatment.[9]

Second change. The second change was one of definition, and it owes its birth to the change in the payment paradigm and not to any CON process, however defined. Prior to the mid-1980s, measuring success in the health care industry was akin to the way Detroit measured success before the oil crisis of the 1970s—the bigger and flashier, the better. In health care, this meant the latest tools, the most tests, the more procedures performed. But in the 80s, as with automobile in the 70s, the criteria for measuring success changed. Auto makers had begun concentrating on efficiency and safety at the expense of fins, chrome, and raw gas-guzzling horsepower. In like manner, so health care providers began to focus on outcomes of their services as the amounts paid them became standardized. The focus that had been quantity became quality.[10]

Changes

Congress did not address whether to keep certificates of need until 1986, regardless of the fact that the verdict on CON requirements was in as early as 1983, and regardless that the economic structure of health care was undergoing profound change. But when it did, with the 1980s spirit

of market deregulation running at flood tide, the mandate was repealed. States were set free to do as they pleased. They could keep their certificates programs if they chose, but they did not have to.[11]

The CON scheme had been a federal mandate that by every measure failed to achieve its central goal. Given that, the reader might assume that, once freed from the requirement, the states would have rushed to eliminate the program, as they did when the federally mandated 55 mph speed limit was dropped.

However, in this case they did not. Though some states did drop the program in favor of a free market approach to health care, only 14 states had done so by 1999, and one that initially did (Texas) reenacted its law. Meanwhile, 36 enacted few or no reforms, thus opting to cling to some form of certificates of need.[12] This happened despite the fact that there has been ample opportunity for a full discussion of the program's worth. For example, in 1998 alone some 230 bills were filed in state legislatures nationally to severely limit or outright abolish the program.[13]

The question, then, is "why?" Why would any state given the opportunity to unleash the benefits of the free market in the important field of health care choose not to do so? And why would any state voluntarily keep a program that has universally been deemed a failure—so much of a failure that its parent, the federal government, disowned it?

In searching for this answer, it is useless to examine the reasons given by legislators who have opposed the changes. Their reasons run on a continuum from wrong to ridiculous. As compiled by Patrick J. McGinley for a study published in the *Florida State University Law Review*, among the justifications given have been, "curbing 'excessive competition,' solving a 'moral hazard,' rectifying 'inadequate information,' and eliminating 'inefficient incentives'."[14] If these have any meaning in the real world, it is difficult to ascertain what it may be, and if they are invalid, then what is behind them? What is, or are, the real reason(s) why this failed program has proved so durable and so difficult to eliminate?

The answers, of course, are money and the simple, monopolistic desire to restrain trade and increase profits by restricting one's competitors. Or as Clark Havighurst somewhat more delicately put it in an article on CONs in the *Wake Forest Law Review*, "avoidance of 'duplication' is of course consistent with a cartel's preference for minimizing competition."[15] Simply put, then, certificates of need survive because the large, well-heeled hospitals—including some run by state governments themselves such as wealthy university teaching hospitals—and hospital industry groups that are often dominated by these big players have seized upon the excuse provided by the "public interest" component of CON laws. These laws and the expensive, time-consuming regulations they prescribe allow them a

legal, pseudo-public interest way to restrict health care commerce and, in some cases, cripple or eliminate competition from what they see as "their" market.

If, for example, a rival provider desires to implement or expand services that might compete with an established operation, the "have" provider can argue in the name of the "consumer" that to allow the "have not" applicant to put in place such "duplication" would raise costs and harm the public. They can argue this despite any reasonable interpretation of market theory, which holds that competition invariably works to increase efficiency and to improve the quality of service to the consumer, and results in lower costs. And they typically argue this through paid professional lobbyists who pose as spokespersons for a concerned public. These same lobbyists, often assisted by campaign cash, influence legislators to keep certificates of need in place lest the consumer be damaged.

The lobbyists, the large well-established providers and provider groups have little of the public's interest in mind. They have their own interests in mind. Proof of this can be found in those states where the program has been dropped. A study by Christopher Conover and Frank Sloan of Duke University, which examined the experiences of states that had dropped CON requirements, found that no ill effects resulted. In fact, the opposite was true. When deregulation went into effect, per capita health care spending dropped and the quality and availability of service rose, thus providing a benefit to consumers. By contrast, they found that in those states that continued to require CONs, the effect of the regulations on per capita spending was not significant, nor did it work to increase availability or quality. Hence, there was little or no benefit to consumers. What was significant in those states retaining CONs, though, was the effective stifling of competition and the raising of existing providers' profits.[16]

Certificates of need continue to exist primarily for the benefit of wealthy and powerful providers and interest groups.

Taking into account the above, it clearly seems past time for certificates of need to be abolished. They have failed. They do not benefit the consumer of health care with lower costs, increased quality, or enhanced availability of services. They continue to exist primarily for the benefit of wealthy and powerful providers and interest groups who mask their true motives by claiming that they are acting in the name of the "public good."

Peter Doherty is a senior policy analyst at The James Madison Institute and may be contacted via e-mail at peterd@jamesmadison.org.

Endnotes

[1]Cook, David A. Testimony before State of Georgia Joint House and Senate Health Committee, September 2, 1997.

[2]Blaufeux, Peter. *The Certificate of Need Process*. New York: Peter Blaufeux AIA Architects, 1999.

[3]McGinley, Patrick John. "Beyond Health Care Reform: Reconsidering Certificates of Need Laws in a Managed Competition System." Tallahassee, Fla.: *Florida State University Law Review*, 1995.

[4]Ibid.

[5]Cauchi, Dick. *Certificate of Need Laws: A State Legislative Survey*. Denver, Colo.: National Council of State Legislatures, 1999.

[6]State of Montana. *Certificate of Need Program Overview*. Helena, Mont.: Health Policy and Services Division, Montana Department of Public Health and Human Services, 1999.

[7]Ibid.

[8]Brown, Lawrence D. "Common Sense Meets Implementation: Certificate of Need Regulation in the States." *Journal of Health Politics, Policy and Law*, No. 8, 1983.

[9]Ibid.

[10]Ibid.

[11]Ibid.

[12]Ibid.

[13]Ibid.

[14]Kaplan, Mark E. "An Economic Analysis of Florida's Hospital Certificate of Need Program and Recommendations for Change." Tallahassee, Fla.: *Florida State University Law Review*, 1991.

[15]Havighurst, Clark C. "Regulation of Health Facilities and Services by 'Certificate of Need.'" Charlottesville, Va.: *University of Virginia Law Review*, 1973.

January/February 1996: Health Care

Ending the CON Game

by Michael D Tanner

Last year's defeat of the Clinton health care plan was a major blow for the idea of central planning in health care. But the idea that government bureaucrats should manipulate the medical marketplace persists. Nowhere is that more apparent than in state Certificate-of-Need programs.

Certificate-of-Need (CON) is a program under which health care providers must obtain state regulatory approval before they can make capital expenditures or offer new services. CON was originally imposed on the states by Congress as part of the 1974 National Health Planning and Resources Development Act. That law required every state to adopt CON procedures or lose federal health funding. Eventually, every state except Louisiana complied. Congress realized the failure of CON and repealed the requirement in 1982. Since then, 12 states have repealed CON programs and 17 others have removed CON requirements for hospitals.

Certificate-of-Need is based on the dubious economic theory that increased supply and competition will increase prices. At one time, there might have been some justification for the idea. At the time CON was developed, federal Medicare and Medicaid reimbursement policies, traditionally a driving force behind health care price increases, were based on a "cost-plus" calculation, meaning that providers could recover their full costs--no matter how high. That virtually eliminated price-based competition from the medical marketplace. However, Medicare and Medicaid no longer reimburse on a "cost-plus" basis. Since 1983, the government has reimbursed on a fixed-price basis (the DRG system). In addition, other third-party payers have become increasingly sensitive to health care costs. As a result, price competition among providers has increased dramatically.

Today, there is no evidence that CON reduces medical costs. In fact, there is considerable evidence that CON increases the cost of health care. It does so in three ways:

1) Administrative costs

The CON program itself imposes substantial costs on both health care providers and the government. Since its inception, federal and state governments have spent more than $1 billion administering the program. For providers, preparing and defending a CON application can be a time-consuming and expensive process. Needless to say, the extra cost is later passed along to consumers.

2) Lack of competition

CON requirements erect barriers to market entry, thereby reducing competition among health care providers. In effect, existing providers are granted a monopoly. Providers frequently attempt to use the CON process to obstruct would-be competitors. The impact of entry barriers is made even worse because the new provider seeking to enter the market is often more innovative and cost-effective than are established providers. Some health care economists estimate that CON barriers to market entry increase hospital costs by as much as 5 percent.

3) Shortages

Where CON requirements have produced a shortage of a particular health care service, prices for those services that are available are certain to rise. At the same time, consumers may be forced to shift to alternative services that are often more expensive. For example, a shortage of nursing home beds may lead to longer stays in acute care hospital facilities.

The Federal Trade Commission estimates that CON regulations increase the cost of hospital care nationwide by more than $1.3 billion annually.

Certificate-of-Need programs also reduce access to health care for those who need it most. In particular, public hospitals serving the inner-city poor often lack the legal and political resources necessary to compete for technology in a CON environment. There is even evidence that CON restrictions may ultimately lead to higher patient mortality.

It is time to realize that Soviet-style central planning is as big a failure in health care as in all other aspects of the economy. States should repeal their CON requirements.

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Michael D Tanner is director of health and welare studies at the CATO Institute in Washington, DC.

JOINT HOUSE AND SENATE HEALTH COMMITTEES HEARINGS ON CERTIFICATE OF NEED LAWS (STATE OF GEORGIA)

TESTIMONY OF DAVID A. COOK DIRECTOR OF GOVERNMENT RELATIONS MEDICAL ASSOCIATION OF GEORGIA

September 2, 1997

Thank you Chairman Middleton and Chairman Childers for holding these hearings on this most important issue and for providing me with the opportunity to speak to you and the Committee members from the physicians' perspective. My name is David Cook and I represent the Medical Association of Georgia comprised of some 8,200 Georgia physicians.

The Medical Association of Georgia supports substantial reform of Georgia's Certificate of Need laws. Our position is based on a fundamental premise: that competition in a free and fair market is the best way to achieve quality health services at the lowest possible cost.

Certificate of Need laws were enacted in 1979 to restrain the cost of hospital and other health care services by regulating the number of facilities that may be built and the type of services that may be offered. In general, these government-sanctioned barriers have not been effective in restraining costs or even hospital investments. Because those with certificates are the only players in the market, they are not pressured to deliver high quality care at the lowest price. Basic economic principles indicate that artificial barriers on competition increase costs.

The fact that Certificate of Need laws have not worked is confirmed in the various studies already mentioned. Further evidence of the dissatisfaction with CON regulations is seen in the national trend to repeal such laws. Perhaps the strongest evidence that CON regulations are not working is found in the testimony you just heard: that Georgia's hospitals are operating at 55% excess capacity. It is rare that artificial restraints on competition benefit the consumers, our patients.

Even if you believe that Certificate of Need laws were appropriate two decades ago, the reasons underpinning enactment of the laws are no longer relevant in today's health care market. Let me give you three examples of how dramatically the health care market has changed in the past 20 years.

First, CON laws were enacted at a time when there was very little competition in the health care market. The same cannot be said of today's healthcare marketplace where competition is fierce.

Second, dramatic changes in reimbursement methodologies have turned provider incentives upside down. In 1979, hospitals were paid on a "cost plus" basis. This guaranteed that hospitals would be paid for every service provided and encouraged overutilization of services. The more the better. Today, hospitals are paid by "Diagnostic Related Groups" (DRG's) which is a set sum for the diagnosed condition regardless of the number of tests or procedures performed. The fewer the services the better.

Finally, we are in the midst of redefining "quality" as it relates to health care. Where hospitals

once measured quality by the number of procedures performed or the availability of the latest technology, quality is now being measured by outcomes achieved.

In sum, the health care market is not what it was in 1979.

The Medical Association of Georgia supports repeal of certificate of need laws except in a few narrow areas that deserve special consideration. The first is in the area of long term care facilities. Unlike many other areas of health care, Medicaid currently pays 80%+ of all nursing home services making this area very nearly a mini "single payor" system. As a result, nursing homes have not historically faced the same kind of competition that hospitals face. Thus, market forces will not work and a different strategy, including the possibility of retaining CON for nursing homes, should be considered.

We also appreciate the important role that caring for the indigent population has in this debate. I would like to take this opportunity to remind you that physicians, not hospitals, treat and care for patients. It is the physician that is called at 3:00 in the morning to come to the hospital to treat the patient. It is the physician who provides his services, often free of charge.

In a recent survey conducted by the Medical Association of Georgia, our members said that they incurred, on average, $50,000 in charity care (care for which there was no expectation of compensation) per year and some $91,000 in bad debt (services for which there is an expectation of compensation but an inability to collect) per year.

Recent reductions in Medicare and Medicaid reimbursement rates have exacerbated the problem. In FY 1996, the Governor proposed, and the General Assembly agreed, to cut Medicaid's physician reimbursement rates by some $21.5 million per year. Last year (FY 97), physicians suffered an additional $7 million in cuts. That is an annual reduction of $29 million in payments to Georgia physicians for the same level of services previously provided. **Physicians' services, which account for the smallest percentage (17%) of provider expenditures, took a whopping 36% of all cuts to Medicaid providers.**

In addition, the Balanced Budget Act of 1997 will squeeze some $5.8 billion from physician Medicare services over the next five years. The real kicker is that Medicaid reimbursement rates are tied to Medicare rates. (Currently Medicaid pays physicians 87% of the Medicare reimbursement rate known as RBRVS). Since Medicaid reimbursement rates for physician services are directly tied to Medicare rates, the new cuts in Medicare will result in even further reductions in Medicaid reimbursement rates.

Traditionally, physicians have shifted the costs of providing indigent care to the private sector. With the onslaught of managed care, physicians are becoming less able to shift these costs to private payors. Hospitals have an Indigent Care Trust Fund to help defray the costs of indigent patients, but physicians have no similar funding mechanism. The problem of providing physician services to indigents has now reached crisis proportions.

Thus, when looking at the question of indigent care, I would urge you to keep in mind who actually provides the care and treatment of indigent patients. I would also suggest that if the market continues to ratchet down physician reimbursements, some accomodation will be necessary to assure continued care for the indigent population.

On a final note, I want to underscore the points made by Dr. Tedesco and Dr. Skelton related

to Graduate Medical Education. Prior to this year, Graduate Medical Education was funded through Medicare. Recent federal legislation has changed this and new sources of funding are necessary to continue training doctors. The Senate is currently considering ways to continue funding medical education here in Georgia.

But the problem is not only with access to funds. Medical education, by definition, requires access to patients. It has been said that it is easier to obtain a certificate of need if you can demonstrate a contribution to medical education in Georgia. It has also been said that concentration of specific types of services makes it easier to train residents. Yet these CON solutions do not address a real problem: that is, managed care companies are driving patients from teaching institutions because they do not provide the cheapest care. A more realistic approach wouls be to require all managed care companies .o make some commitment to medical education, whether in the form of monetary contributions, a guaranteed supply of patients, or both.

I know I have used the time allotted and so I'll stop here and answer any questions you or the committee may have. Once again, I thank you for the opportunity to appear before you.

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HB407 Testimony

Carl Wales

2 April 2002

Statistics used

- The statistics used in this testimony are shown in accompanying material. The source of that information is shown in the material.

Certificate of Need (CON) Process

- While I have not found a written history which I can quote to support this, it is my understanding that the CON process evolved initially as a requirement of the federal government in hopes that it would control health care costs.

- Many states have realized that it does not serve that purpose so that now 30 % of the states have no CON.

CON Requirements

- Of the ten **least** densely populated states only two have a CON requirement. Of those two, one requires a CON only for counties with a population of over 100,000 and the other requires a CON only for long term care beds.
- Of the top 15 least densely populated states only four require the CON (the two above plus two more).

- Residents of states with high population densities have options/choices by virtue of having lots of facilities.

- This provides choice and drives efficiency in delivering health care.

- States with small populations need a "free market system" to foster choices and competition.

- Why is Alaska the only one in the top seven least densely populated states with a CON requirement?

Myth

- "Non-profit" and "Not-for-profit" do not necessarily mean efficient operation of the organization.
- Many "Non-profit" and "Not-for-profit" organizations that are funded through charities are driven to greater efficiency because the donors may donate to other causes (donors have choices).
- Health care organizations (and other types of organizations) that have a monopoly are not driven to be efficient and provide the highest quality– they can exist, and continue to exist, and be inefficient, by virtue of their being the *only* choice no matter how bad the choice is.

Carl Wales

- Resident of Fairbanks since 1993.
- I do not work for any part of the health care system.
- I do not own stock in or benefit in any way from the health care industry beyond being a patient.

Accompanying material

- Spreadsheet showing state sizes and populations plus the calculations to determine population density and ranking.
- Chart of states requiring the CON taken from the Community Catalyst web site.

Certifcate of Need shown compared to Population and Size

Rank by Population	State	Population (2000 est.*)	Rank by Size	State	Size (Sq. miles of land**)	Pop Density	Rank by Density	CON	
48	Alaska	626,932	1	Alaska	570,374	1.10	1	Y	
51	Wyoming	493,782	9	Wyoming	97,105	5.09	2	N	
47	North Dakota	642,200	17	North Dakota	68,994	9.31	3	N	
46	South Dakota	754,844	16	South Dakota	77,122	9.79	4	N	
36	New Mexico	1,819,046	5	New Mexico	121,365	14.99	5	N	
39	Idaho	1,293,953	11	Idaho	82,751	15.64	6	N	
35	Nevada	1,998,257	7	Nevada	109,806	18.20	7	Y	18
38	Nebraska	1,711,263	15	Nebraska	75,898	22.55	8	Y	17
34	Utah	2,233,169	12	Utah	82,168	27.18	9	N	
32	Kansas	2,688,418	13	Kansas	81,823	32.86	10	N	
28	Oregon	3,421,399	10	Oregon	96,003	35.64	11	Y	
40	Maine	1,274,923	39	Maine	30,865	41.31	12	Y	
24	Colorado	4,301,261	8	Colorado	103,729	41.47	13	N	
20	Arizona	5,130,632	6	Arizona	113,642	45.15	14	N	
27	Oklahoma	3,450,654	19	Oklahoma	68,679	50.24	15	N	
33	Arkansas	2,673,400	27	Arkansas	52,075	51.34	16	Y	
30	Iowa	2,926,324	23	Iowa	55,875	52.37	17	Y	
31	Mississippi	2,844,658	31	Mississippi	46,914	60.64	18	Y	
21	Minnesota	4,919,479	14	Minnesota	79,617	61.79	19	N	
49	Vermont	608,827	43	Vermont	9,249	65.83	20	Y	
37	West Virginia	1,808,344	41	West Virginia	24,087	75.08	21	Y	
2	Texas	20,851,820	2	Texas	261,914	79.61	22	N	
17	Missouri	5,595,211	18	Missouri	68,898	81.21	23	Y	
23	Alabama	4,447,100	28	Alabama	50,750	87.63	24	Y	
15	Washington	5,894,121	20	Washington	66,582	88.52	25	Y	
18	Wisconsin	5,363,675	25	Wisconsin	54,314	98.75	26	N	
25	Kentucky	4,041,769	36	Kentucky	39 732	101.73	27	Y	
22	Louisiana	4,468,976	33	Louisiana	43,566	102.58	28	Y	

Certifcate of Need shown compared to Population and Size

26	South Carolina	4,012,012	40	South Carolina	30,111	133.24	29	Y	
41	New Hampshire	1,235,786	44	New Hampshire	8,969	137.78	30	Y	
16	Tennessee	5,689,283	34	Tennessee	41,220	138.02	31	Y	
10	Georgia	8,186,453	21	Georgia	57,918	141.35	32	Y	
11	North Carolina	8,049,313	29	North Carolina	48,718	165.22	33	Y	
14	Indiana	6,080,485	38	Indiana	35,870	169.51	34	Y	
8	Michigan	9,938,444	22	Michigan	56,809	174.94	35	Y	
12	Virginia	7,078,515	37	Virginia	39,598	178.76	36	Y	
42	Hawaii	1,211,537	47	Hawaii	6,423	188.62	37	Y	
1	California	33,871,648	3	California	155,973	217.16	38	Y	
5	Illinois	12,419,293	24	Illinois	55,593	223.40	39	Y	
6	Pennsylvania	12,281,054	32	Pennsylvania	44,820	274.01	40	N	
7	Ohio	11,353,140	35	Ohio	40,953	277.22	41	N	
4	Florida	15,982,378	26	Florida	53,997	295.99	42	Y	
45	Delaware	783,600	49	Delaware	1,955	400.82	43	Y	
3	New York	18,976,457	30	New York	47,223	401.85	44	Y	
19	Maryland	5,296,486	42	Maryland	9,775	541.84	45	Y	
29	Connecticut	3,405,565	48	Connecticut	4,845	702.90	46	Y	
13	Massachusetts	6,349,097	45	Massachusetts	7,838	810.04	47	Y	
43	Rhode Island	1,048,319	50	Rhode Island	1,045	1003.18	48	Y	
9	New Jersey	8,414,350	46	New Jersey	7,418	1134.32	49	Y	19
44	Montana	902,195	4	Montana	145,556	6198.27	50	Y	
50	Washington, D. C.	572,059	51	Washington, D.C.	61.4	9316.92	51	Y	
		*Source; Department of Commerce, Bureau of Census			**Source: Almanac - U.S.; Department of Commerce, Bureau of the Census			Based on Community Catalyst 1999 chart	

http://www.ipl.org/youth/stateknow/popchart.html

Certifcate of Need shown compared to Population and Size

17	Only for long term beds
18	Only for counties over 100,000 population
19	Only for acute care hospitals

Certificate of Need Chart

18-Nov-99

State	CON (Y/N)?	Oversight Agency	Certificate is required for: Change in ownership	Constructing a new hospital	Closing a hospital	Decreasing services	Decreasing # of beds	Merger or consolidation	Limits # of acquisitions	Considers community benefits and/or level of indigent care before issuance	Public access to application	Public notice of application	Public hearing on application	Public able to appeal decision
Alabama	Y	State Health Planning and Development Agency		X			X[1]				X	X	X	
Alaska	Y	Department of Health and Social Services		X			X[1]							X
Arizona	N													
Arkansas	Y	State Board of Health (Division of Health Facilities Services)		X										
California	Y	Office of Statewide Planning and Development		X								X	X[2]	
Colorado	N													
Connecticut	Y	Office of Health Care Access	X			X	X					X	X	
District of Columbia	Y	State Health Planning and Development Agency	X		X	X	X[3]			X[4]	X		X[5]	X
Delaware	Y	Delaware Health Resources Board	X[6]	X							X	X	X[7]	X
Florida	Y	Agency for Health Care Administration	X[8]	X								X	X[9]	
Georgia	Y	Department of Community Health		X								X		
Hawaii	Y	State Health Planning and Development Agency		X[1]		X	X						X	X
Idaho	N													
Illinois	Y[1]	Health Facilities Planning Board	X	X	X	X	X				X	X	X	
Indiana	Y[8]	The State Department												
Iowa	Y	Department of Public Health and Facilities Council		X		X[9]	X[9]			X		X	X	X
Kansas	N													
Kentucky	Y	Cabinet for Human Resources	X[9]	X		X[9,1]	X[9,1]						X[1]	X[10]

18-Nov-99														
			Certificate is required for:											
State	CON (Y/N)?	Oversight Agency	Change in ownership	Constructing a new hospital	Closing a hospital	Decreasing services	Decreasing # of beds	Merger or consolidation	Limits # of acquisitions	Considers community benefits and/or level of indigent care before issuance	Public access to application	Public notice of application	Public hearing on application	Public able to appeal decision
Louisiana	Y	Department of Health and Hospitals		X										
Maine	Y	Department of Human Services and Certificate of Need Advisory Committee	X[11]							X	X	X	X	X
Maryland	Y	State Health Resources Planning Commission	X[3]	X	X[3]	X[9,1]	X[9,1]					X[12]	X[3]	X
Massachusetts	Y	Department of Public Health	X	X		X[1]	X[1]				X		X[13]	X
Michigan	Y	Department of Public Health and Certificate of Need Commission	X	X										
Minnesota	N													
Mississippi	Y	State Department of Health	X[3]	X								X	X[3]	
Missouri	Y	Missouri Health Facilities Review Committee				X[14]	X[14]					X	X[2]	
Montana	Y[15]	Department of Public Health and Human Services									X	X	X[16]	
Nebraska	Y[17]	Department of Health and Human Services Regulation and Licensure												
Nevada	Y[18]	Department of Human Resources		X[18]										
New Hampshire	Y	Health Services Planning and Review Board	X	X						X	X	X	X	X
New Jersey	Y	Department of Health and Senior Services	X[19]	X										
New Mexico	N													
New York[20]	Y	Department of Health		X									X[16]	
North Carolina	Y	Department of Health and Human Services	X[3]	X			X[1]			X				

18-Nov-99														
			Certificate is required for:											
State	CON (Y/N)?	Oversight Agency	Change in ownership	Constructing a new hospital	Closing a hospital	Decreasing services	Decreasing # of beds	Merger or consolidation	Limits # of acquisitions	Considers community benefits and/or level of indigent care before issuance	Public access to application	Public notice of application	Public hearing on application	Public able to appeal decision
North Dakota	N													
Ohio	N													
Oklahoma	N[21]													
Oregon	Y	Health Division of the Department of Human Resources		X										X
Pennsylvania	N													
Rhode Island	Y	Department of Health		X			X[1]				X		X	X
South Carolina	Y	Department of Health and Environmental Control	X	X								X	X[2]	X
South Dakota	N													
Tennessee	Y	Health Facilities Commission		X		X[22]						X	X	X
Texas	N													
Utah	N													
Vermont	Y	Health Policy Council	X	X			X[1]			X		X	X[2]	
Virginia	Y	Department of Health		X								X	X	
Washington	Y	Department of Health	X	X						X			X[2]	
West Virginia	Y	West Virginia Health Care Cost Review Authority	X	X	X	X	X			X	X	X	X[16]	X
Wisconsin	N													
Wyoming	N													
Total: 51	35		18	29	4	11	15	0	0	8	10	19	25	16
Percentage	69%		35%	57%	8%	22%	29%	0%	0%	16%	20%	37%	49%	31%

Notes are on the following page

Notes

1. For any change
2. Hearing not required, must be requested
3. CoN not needed if gave prior notice
4. All applicants must certify that they will provide uncompensate are (charity care and b d debt) for the next five years at a percentage equal to or greater than the previous two years
5. Hearing only for purchase or lease of hospital
6. Only for acquisition of a nonprofit health care facility
7. Referred to as "certificate of exemption"
8. CoN only needed for Comprehensive Care Beds
9. But may be exempt
10. Any affected person may appeal the decision
11. But, only in the case of lease arrangements
12. For change in bed capacity or services
13. DPH may hold a hearing, or applicant, state, or 10 taxpayers may request a hearing
14. CoN not required, but must give notice
15. CoN not required for hospitals
16. Hearing not required, must be requested, or Authority may schedule on own initiative
17. As of June 12, 1997, a CoN in Nebraska is only required when creating, relocating, or converting long term care beds
18. CoN only required for counties with a population less than 100,000 and for projects costing more than $2 million
19. Only for acute care hospitals
20. New York does not have licenses or CoNs, it has "certificates" that encompass both licensing and CoN
21. CoN for long term care facilities such as nursing homes
22. Only for discontinuing obstetrical or maternity services