GEORGIA ALLIANCE OF COMMUNITY HOSPITALS

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White Paper on CON
Georgia Alliance of Community Hospitals
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1. The Georgia Alliance of Community Hospitals ("Alliance") represents the interests of public and not-for-profit community hospitals located throughout Georgia -- institutions that are vital to the delivery of acute and emergency health care services to millions of patients annually in communities large and small, urban and rural, throughout our state -- and of thousands of aligned medical staff physicians, independent and employed, who support the continued soundness of their community hospitals.

2. The Alliance is an ardent defender of Georgia's certificate of need ("CON") program. The Alliance believes that CON not only helps contain health care costs, but has also contributed immensely to quality of care and to providing accessible health care for all Georgians, regardless of economic status. Considerable study and debate over the past decade, including extensive studies by the Commission on the Efficacy of the CON Program, appointed by the General Assembly and Governor Perdue, and by a Special Senate Study Committee on Independent Physicians in Georgia has led informed citizens and the General Assembly time and time again to conclude that the CON program should be preserved to ensure a sound health care delivery system statewide.

3. The Alliance's position in support of the CON program is based on sound evidence and numerous studies by leading national economists, health care providers, and health care finance experts.

Purposes of CON

4. First, the health care "market" -- for lack of a better term -- simply is different from other, traditional markets. That is the fundamental finding of the most comprehensive study of our nation's health care system, which was first published in 1996 as the Dartmouth Atlas on Health Care and has been supplemented periodically through the years. Citing that study, the Wall Street Journal pointed out: "in health care, supply often dictates demand, rather than the other way around." Of course, that is 180 degrees the reverse of what we learned in Econ. 101 with respect to traditional capital markets. It was found in the Dartmouth Atlas, as proponents of CON have consistently claimed, that higher capacity in health care facilities and proliferation of

services results in higher costs, with no evidence of improved quality. In other words, the more duplicative services and facilities you add, the more they are unnecessarily utilized, resulting in higher costs for the whole health care system and the consumer, and poorer quality of care.

5. Georgia's CON program has been shown to reduce costs and prices. A 2013 study by William Cleverley, Ph.D. compared hospital prices, costs, and profitability in Georgia, which is one of the large majority of states with a CON program, with two other comparable Sun Belt states that are growing and have diverse populations, Arizona and Texas, and which are non-CON states. Dr. Cleverley is a longtime nationally renowned Ohio State professor and consultant in health care finance, and he has previously testified before a joint session of the Georgia General Assembly's Senate and House health care committees. Dr. Cleverley's findings: Georgia, a CON state, has the lowest hospital prices. Georgia hospital routine costs per day are the lowest. And Georgia hospitals generate lower levels of profit than Arizona and Texas hospitals.

6. Second, numerous nationally prominent studies have consistently found that hospitals that have higher volumes of services (e.g., open heart surgery, angioplasty, orthopedic surgery, perinatal services) at their facilities typically provide higher quality services, with lower mortality levels, and at lower costs than hospitals with relatively low volumes. CON is designed for that reason to prevent a proliferation of duplicative services that would result in low volumes at existing providers' facilities. It is important that the team of physicians and skilled nurses and technicians at each facility work together on a high volume of cases to improve their skills through teamwork. "Practice makes perfect."

7. Third, there is a severe shortage of physicians and other health professionals in this state and around the nation. Every time you add or expand a new specialty hospital, a new ambulatory surgery facility, or a new service at an existing facility, you create a need for additional permanent staff of nurses and technicians for the facility or service that will be recruited from other facilities, which are already short on skilled personnel. That also forces the competing health care facilities to pay more to recruit and retain the nurses or other professionals they can find, which drives up health care costs and charges to the consumer.

8. Fourth, CON has been found in numerous studies to protect economic accessibility for all citizens by protecting "safety net" providers of substantial indigent care services. Reports by the federal Medicare Prospective Payment Assessment Commission and the National Institutes of Medicine have emphasized the growing pressures on our safety net hospitals and the importance to everyone of preserving these essential community providers. CON exemptions for certain profitable facilities and services would add additional pressures and would jeopardize the very existence of many safety net hospitals - - urban, suburban, and rural.

9. So what happens if you subject the health care market to unfettered free market forces? Several things. You guarantee "cream-skimming" strategies by the new entrants into the market. In the process, you unbundle the mix of profitable and unprofitable services now provided by Georgia's community hospitals and destabilize a central element of the state's health care system.

10. Sure, entrepreneurs will happily offer new health care services if they are profitable. But will they also commit to providing the broader array of critical, expensive, and ultimately unprofitable health care services Georgians need and expect? Would they provide neonatal intensive care for the hundreds if not thousands of infants born prematurely, at weights of barely a pound, each year in Georgia? Will they assume their share of the responsibility for the rapidly increasing burden of indigent care and substantially below-cost reimbursement for Medicaid services in Georgia? Will they provide substantial levels of uncompensated community outreach services and costly physician training programs as many hospitals do? Very little in the record of investor and physician owned imaging and ambulatory surgery facilities suggests they are willing to step up to the plate on these issues. And, will the physicians and entrepreneurs who build a freestanding ambulatory surgery center ("ASC") also provide a 24-hour emergency room and costly intensive care units that are provided by our community hospitals to serve tens of thousands of Georgians each year who are in need of essential health care service not available at freestanding ambulatory health care facilities (including some patients who experience complications in the ambulatory facilities and have to be rushed by ambulance to the nearest hospital emergency department)? -- Obviously, not.

11. Do hospitals generate surplus revenue on certain services such as outpatient surgery? Absolutely. But the surplus from those services is used to offset the losses on the host of other, unprofitable services hospitals provide to the community as part of the total package required to ensure adequate health care for our citizens. This "cross-subsidization" is vital.

Multispecialty ASCs

12. The importance of CON review of new multispecialty ASCs is an issue that highlights the concerns expressed here.

13. A proposed new multispecialty ASC to be utilized for more than one surgical specialty has always been subject to prior CON review and approval whether it is to be owned by a hospital, a multispecialty physician group, or multiple physician group practices of different specialties.

14. In December 2006, a special Commission on the Efficacy of the CON Program, appointed by the Georgia General Assembly and Governor Perdue and comprised of physician, hospital, and other provider representatives plus public health officials, issued its Report on a two-year comprehensive study of Georgia's CON program. Not a single Commission member (including surgeons) voted for exemption from CON of multispecialty ASCs. That Report influenced the legislative amendments to the CON law in 2008 that exempted certain single specialty physician-owned ASC's from CON review, but maintained full CON requirements for multispecialty ASCs.

15. The issue of CON review of multispecialty ASCs was revisited in 2013. Again, a Senate Study Committee on Independent Physicians in Georgia held numerous hearings statewide and

ultimately recommended in a January 2014 Final Report that there be no action to change Georgia's CON program as to multispecialty ASCs.

16. Recent studies and testimony supported by publicly reported data provided abundant support for the Senate Study Committee's recommendation to maintain CON review of all new multispecialty ASCs. A Study by Dr. Cleverley concludes in an October 2013 Report that the potential adverse impact on the financial soundness of Georgia hospitals statewide would be "devastating" if commercial outpatient (OP) surgical procedures performed by Georgia hospitals that could be performed in a freestanding ASC were lost at a substantial level through referrals to a freestanding multispecialty ASC owned by a multispecialty physician group whose physicians served on the hospital's medical staff. Key components and findings of the Cleverley Study included the following:

- The analysis of OP surgeries at risk of loss involved all billed claims by 30 hospitals during a 12-month period ending June 30, 2013. The 30 hospitals, which are members of the Alliance, are located throughout the state and range from small rural hospitals to large and mid-size urban and suburban hospitals.

- Approximately 72% of the billed OP surgery claims were determined to involve surgeries that could be performed not only in a hospital-based OP surgery setting but also in a freestanding multispecialty ASC, and it is the potential impact of a loss of a portion of those procedures that was analyzed by Dr. Cleverley.

- The Cleverley Study's findings support the generally accepted view that OP surgery is one of the very few areas of profitability remaining for hospitals. Those profits are necessary for hospitals to cross-subsidize the substantial losses from many unprofitable clinical services, substantial and growing levels of uncompensated care, costly emergency services, costly physician training programs, and other uncompensated community outreach programs that are essential for their communities but are not provided by freestanding multispecialty ASC's. And unlike hospitals, physician-owned ASC's are not required to participate in the legislated provider payment program, which at a cost of more than $70 million annually to certain hospitals, generates matching federal funds to prevent a substantial cutback in Medicaid payments to physicians as well as to some hospitals.

- As the Cleverley Study found, approximately 70% of the OP surgeries at risk of loss by the hospitals to freestanding multispecialty ASCs involve "commercial" pay patients. The same hospitals' Medicaid and Medicare OP surgeries at risk of loss to a freestanding multispecialty ASC accounted for only 25% of such surgical procedures combined, and the balance (5.0%) were self-pay patients.

- A freestanding multispecialty ASC, whose physician owners can elect which patients to refer to their own facility and which ones to admit to the hospital where they are members of the medical staff, would likely have a particularly high payer mix of

commercial patients since those surgeries are by far the most profitable. As demonstrated in the Cleverley Study, commercial OP surgeries generated a positive 30.8% operating margin for the 30 hospitals studied. In stark contrast, the Medicaid and Medicare cases that could be referred from those hospitals to freestanding ASCs generated a combined negative margin of 30.5%. Do not expect self-referrals by physician owners of multispecialty ASCs of a proportionate number of Medicaid and Medicare patients to their own freestanding ASCs.

- The profit (total change in equity) from OP commercial surgeries **of the 30 Alliance hospitals studied** accounted for **64% of the total profit of 55 Alliance hospitals in 2013 ($250 million)** for which audited financial statements were available.

- Loss of commercial OP surgery business to freestanding multispecialty ASCs could have a "devastating" impact on the financial position of hospitals, as observed by Dr. Cleverley. For instance, a hospital's loss of 50% of commercial OP surgeries that could be performed in a freestanding ASC is projected to reduce profits by $209 million for the 30 Alliance hospitals studied. That equates to 84% of the total profits of all 55 Alliance hospitals for which audited financial statements were available.

- Dr. Cleverley analyzed each of the 30 Alliance hospitals studied for the potential impact of a loss of OP surgery volume before aggregating the data for all. He found that a loss of 25% to 50% of OP surgery volume at each of four hospitals in counties where three large INDDOC member multispecialty clinics are located is projected to result in an annual reduction in profits at those four hospitals ranging from (i) $3.0 to $6.0 million; (ii) $1.8 to $3.5 million; (iii) $4.3 to $8.5 million; and (iv) $9.3 to $18.6 million, respectively. In several instances, the projected reduction in profits would leave the individual hospital studied with **an overall operating loss for all services combined**. For example, the first hospital noted above would be left with an annual operating loss hospitalwide of $1.0 to $4.0 million if it lost 25% to 50% of its OP surgical volume to a freestanding multispecialty ASC, and that is quite likely if a large portion of its medical staff are members of a dominant local multispecialty physician group that were to develop its own nearby multispecialty ASC.

- Based on available audited financial statements, Dr. Cleverley also concluded that Alliance hospitals (55) conservatively have an aggregate **deficiency** at this time of at least **$1.8 billion in cash and reserves** to meet their already established needs. Contrary to the claims of some, most hospitals do not have adequate reserves. The hospitals do not have excess reserves, and they obviously cannot afford a substantial reduction in profits which would only further reduce their reserves.

17. It is well known that community hospitals around the state are suffering severe financial pressures from major reductions in reimbursement associated with health care reform and the federal Affordable Care Act, federal sequestration cutbacks, and ballooning levels of uncompensated care from uninsured workers and Medicaid patients as well as increasing bad

debt from insured patients who are being forced to pay more for health care out of their pockets. Many community hospitals of all sizes are increasingly operating at a loss, and rural hospitals are being forced to close. And major reductions in federal disproportionate share payments, so vital to the financial viability of safety net hospitals, are on the horizon under federal health care reform. The hospital industry in Georgia and statewide is in crisis mode not seen in decades.

18. Your average hospital provides inpatient, emergency, and outpatient services to more than 100,000 patients annually. In stark contrast, the average freestanding ASC serves only a few thousand patients a year. A loss of profits from OP surgeries referred by hospital medical staff physicians to their own freestanding multispecialty ASC would likely force a nearby community hospital to downscale needed facility, medical equipment, and service replacements and expansions; to implement or increase significant workforce layoffs which are occurring ever more frequently at large hospitals statewide; and to eliminate or reduce important but unprofitable clinical services, physician training programs, and uncompensated community outreach services. Tens of thousands of community residents could be adversely impacted so that a freestanding multispecialty ASC could serve a few thousand profitable surgical patients who could have obtained the same OP surgical services from the same physicians at a community hospital facility.

19. The risks extend not only to the hospital itself, but also to those many members of the medical staff who would not be the owners of a multispecialty or multi-physician group ASC exempted from CON review.

20. The principal advocates for CON exemption legislation are a handful of large multispecialty physician groups in the state which formed the Independent Doctors Association of Georgia ("INDDOC"), primarily to support the lobbying effort under the guise of general concern for "independent" physicians. MAG lobbyists have joined with INDDOC's influential multispecialty groups in promoting such legislation. Although framed as an issue of importance for "independent" physicians in general, the principle advocates for a CON exemption for freestanding multispecialty ASCs are the small number of independent multispecialty physician clinics and certain independent single special physician groups acting in concert, which are located in a few areas of the state.

21. INDDOC's lawyers and the spokespersons for INDDOC's principal multispecialty group members have framed their arguments in a manner that leave the mistaken impression that many physicians statewide have voiced support for legislation exempting multispecialty ASCs from CON review, and that "independent" physicians statewide generally are supportive of their legislative initiative. -- And MAG lobbyists typically strive to leave the impression that they are speaking for all physicians statewide when they advocate a position on a piece of legislation. Of course, that is not the case. MAG membership constitutes a minority of physicians in the state, and MAG has not polled its members on this issue. Most MAG physician members oppose the effort to exempt multispecialty ASCs from CON review.

Conclusion

22. Make no mistake about it. Abolish CON, or deregulate a portion of Georgia's hospital market or its multispecialty ASC market, and you destabilize the state's health care delivery system. You threaten the system that makes it possible to ensure our citizens have access to a full array of critical health care services.

23. When it comes to health care, Georgia's community hospitals believe that it is the state's duty to create and sustain an environment that ensures its citizens access to a full spectrum of quality health care -- not to create a market environment that might be more profitable for a few entrepreneurial providers.

24. The CON system -- imperfect as it may be -- has helped sustain a stable health care delivery system; one that provides the vast majority of Georgians access to excellent health care and protects our safety net community hospitals. As a prior DCH Commissioner testified to a Senate Study Committee :

> "This [CON] issue is totally intertwined with the issue of the uninsured. Financial access, volume, revenues, and uninsured issues are all tied together. The CON program is absolutely needed for safety net hospitals . . . . Thus, issues of the uninsured, the lessons learned from managed care, and the dynamics of health care tell us that providers don't act in isolation, and the CON program is necessary."

25. To weaken the CON program would be a grave mistake. That would create a vacuum that would produce adverse changes that would cripple Georgia's overall system of health care delivery. The fundamental objectives of the CON program should be preserved as to all new institutional health services and facilities to contain health care costs and to improve quality and access for all Georgians.