

Remarks of Kurt Stuenkel
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And
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as prepared for delivery to
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Certificate-of-Need System
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Mr. Chairman, members of the Commission, good afternoon. I am Kurt Stuenkel. I am president of Floyd Medical Center, a 304-bed community not-for-profit hospital serving Rome and northwest Georgia. Floyd Medical Center is a trauma care center, serves about 60,000 patients a year in the emergency room alone, and has the only neonatal intensive care unit in the area.

I am here today in my capacity as the current chairman of the Georgia Alliance of Community Hospitals.

The Alliance is an association of not-for-profit and public community hospitals throughout the state. It was established two decades ago to represent the discrete interests of community not-for-profit hospitals on a range of health policy issues, including Certificate-of-Need.

The Alliance believes CON has served Georgia well as a rational regulatory system. It has, we submit, helped ensure broad financial access to health care for all Georgians, regardless of economic status. It has helped hold down costs, ensure high quality care, and preserve the excellence of this State's academic medical centers and community teaching hospitals.

Make no mistake: Certificate of Need serves the public interest.

That fact is clear and is supported overwhelmingly by an ever-expanding number of empirical studies and findings by researchers, the business community, and health care providers, including many physicians.

In support of my testimony, the Alliance and our fellow hospital organizations have submitted a binder containing a number of empirical studies, reports, and recent articles on issues pertaining to health care costs and overutilization ... safety and quality concerns related to office-based ambulatory surgery and freestanding diagnostic imaging ... "cherry picking" of profitable services and patients by freestanding self-referral surgical centers, limited

service hospitals, and freestanding imaging centers ... and the growing crisis in emergency room care due to lack of coverage by certain surgical specialists who have abandoned hospitals for their own surgical facilities which have no emergency rooms.

All of these studies lend overwhelming support for a strong CON program. Time won't permit me to cover the studies in detail here today, but I would like to quickly cite a few pertinent facts.

First, the Cleverley Study. Three years ago, one of the nation's leading healthcare finance experts looked at the price differential for inpatient and outpatient care in Georgia, a CON state, versus two other rapidly growing Sun Belt states, Arizona and Texas, which eliminated their CON programs in the 1980's.

As this slide illustrates, Georgia, under CON, has substantially lower prices, at both the procedure and aggregate levels, across all charge measures, as shown by the national database studied by Dr. William Cleverley, an Ohio State professor. Whether you look at Medicare charges, room rates, the price of chest X-rays, or basic mark-up rates, the picture is the same, and it is compelling.

We see similar conclusions in very interesting studies from the Big Three automakers. As everyone knows, healthcare costs are one of the biggest problems for U.S. businesses. As this graph shows, DaimlerChrysler found that the lowest healthcare costs, without exception, were at its plants in states with CON programs. The highest-cost plants were in non-CON states – and this wasn't just a factor of regional cost differentials. For example, Chrysler's healthcare costs per worker in Kenosha, Wisconsin, were nearly three times what they were in Syracuse, New York.

Ford Motor Company found the same thing. Its costs in Indiana and Ohio, both non-CON states, were 21 percent higher than in Michigan, a CON state; costs in Kentucky and Missouri, both CON states, were very close to the Michigan costs.

The most in-depth study on the subject of health care costs and the impact of an unregulated supply of health care facilities and services comes from one of

the most authoritative, ongoing studies of the nation's healthcare system, the Dartmouth Atlas on Health Care.

The Dartmouth Atlas, first published in 1996, shows that in health care, supply often dictates demand, rather than the other way around. Consistent with the theory behind Certificate-of-Need, the Dartmouth Atlas reveals that increased capacity in the number of health care facilities and 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 overutilized, resulting in higher costs for the whole health care system and the consumer.

This phenomenon is influenced by a variety of factors unique to health care, including heavy funding of health care by government and the impact of self-referral incentives on overutilization where physicians own their own surgical centers or MRI units.

Those factors, unique to health care, are present today more than ever, and they can be contained by a strong Certificate-of-Need program. Thus, we respectfully disagree with Dr. Deese's suggestion at the first Commission meeting that there is no longer any reason for CON from a cost standpoint. Similarly, we disagree with those who suggest that a 2004 report by the Federal Trade Commission and Department of Justice on health care competition offers any empirical support whatsoever for the argument that more competition would reduce health care costs. The binder we've submitted includes the remarks of an FTC official who authored that 2004 report, stating unequivocally that it is "not an empirical study" at all. She acknowledged as well that its recommendations regarding the potential effects of Certificate of Need on competition were made in a vacuum and do not account for important considerations such as the provision of indigent care, medical education, emergency rooms, intensive care units, and perverse financial incentives from disparately high government funding of freestanding health care facilities.

As shown by many of the studies and articles in our binder, much of the recent explosion in health care costs is attributable to the proliferation of freestanding surgical facilities and diagnostic imaging centers, particularly where ownership by physicians has created self-referral financial incentives leading to overutilization and "cherry-picking" of profitable services, a resulting explosion in health care cost increases, and critical shortages in surgical coverage of hospital emergency rooms.

A recent look at these issues comes in a new study from Georgetown University. This study examines the effects of the recent trend toward physician-owned, limited-service hospitals and ambulatory surgical facilities. These "niche" facilities are spreading rapidly in non-CON states, and single specialty, physician-owned ambulatory surgical centers are also proliferating in Georgia due to an unintended statutory loophole that has evolved from loose agency interpretation of the 1991 amendments to our CON statute.

Georgetown's Public Policy Institute looked at physician owned limited-service hospitals and ambulatory surgery centers in Oklahoma and Arizona, two non-CON states, and found, in both instances, "substantial increases" in volume for the niche procedures in question.

To quote from the study: "These findings suggest that the financial incentives linked to ownership caused physician owners to change their practice patterns. Physician self-referral arrangements resulted in increased utilization of medical procedures, and increased costs to third-party insurers."

Let me build on this last point in regard to the cost of health care.

The physician-owned ambulatory surgery community will argue that the cost of surgical procedures performed in their freestanding am-surg centers often is lower than in hospitals. As an aside, it should be lower because studies consistently show that the freestanding centers generally perform simpler, profitable procedures, while leaving the more costly and complex procedures to hospital-based outpatient surgery centers. But it's not the case that even the simpler cases cost less in freestanding ambulatory surgery centers.

As this slide illustrates, the Medicare Payment Advisory Commission, or MEDPAC, found that for eight of the ten most common outpatient surgical

procedures, Medicare actually paid higher reimbursement rates to free-standing am-surg centers than to hospital outpatient facilities.

We already see these same economic forces at work here in Georgia. In Columbus, for example, orthopedic surgery coverage is no longer available from local private orthopedists for the largest hospital's emergency room, because orthopedic surgeons now have their own surgical facility.

And it is not just physician-owned surgical centers that lead to overutilization and cherry-picking of profitable health care procedures. A recent nationwide study by Stanford University researchers for the Blue Cross Association shows that health care costs per capita increase in a community each time a new freestanding imaging center is added. The Blue Cross study also found that the increase in costs is the highest whenever those imaging centers are owned by physicians with self-referral financial incentives. The Wall Street Journal focused on this issue in a story just last week about a federal investigation of freestanding imaging centers in Florida. I quote:

"The investigation .comes amid a continuing boom in scanning and rising concern that financial incentives for doctors who order scans may be prompting overcharges and overuse.. . Scanning costs are Medicare's fastest-growing item. They rose at three times the rate of other medical services from 1999 to 2002, increased a further 16% in 2003, the latest year of federal data, and have continued to grow since"

But in addition to increased costs, as I have noted, there are other important reasons not to dismantle or weaken CON. One of those is quality of care.

In a nutshell, practice makes perfect. When a given community has an excess of medical facilities, physicians and nurses do not get the optimal volume of practice that they need working together as a team in the same facility to maintain skills.

Here again, we make this judgment not on personal opinion, but on scientific research, which has consistently found a correlation between volume

and quality of health care services performed in hospitals.

For example, a study published in the Journal of the American Medical Association in 2002 looked at this issue in cardiac care. Researchers at the University of Iowa found, based on a nationwide database, that hospitals in non-CON states performed far fewer heart-bypass surgeries, on average, than those in CON-regulated states ... with a 22 percent higher risk of fatalities at the hospitals in the non-CON states.

And just last month Cancer magazine published the results of a study on cancer surgery, which mirrored the University of Iowa study on open-heart surgery. Across the board, as this slide shows, it found better survival rates at high-volume hospitals for cancer patients.

These concerns are not limited to hospitals and complex surgery, however. As CON programs have been rolled back in some areas of the country, they have seen an explosion in freestanding imaging centers. That has also been the experience in Georgia, which has more than 200 MRI units in a five-county area of metro-Atlanta alone, because physicians and imaging companies have exploited an unintended loophole in the 1991 CON amendments.

A report in The New York Times looked at 462 imaging facilities, and found that more than a third of those run by non-radiologists could not pass state inspection. Georgia, to the best of my knowledge, does not regulate free-standing imaging centers at all from a licensing and safety aspect, and very few of the facilities are owned by radiologists. Many are owned by surgeons with no particular training in diagnostic imaging.

And beyond the studies of outcomes and success rates, is one more simple fact: Our state, and our country, have a serious shortage of skilled health-care nurses and technicians. Every new medical facility you add, duplicating services already available in the area, still requires a full complement of nurses, technicians, and other staff. These skilled personnel must be recruited, for the most part, from existing facilities that are already short of staff themselves, in such vital patient care areas as the ER, OR suites, and intensive care units. The bidding for these employees just drives up the most expensive component of

health care - skilled personnel.

This panel is considering recommendations that might lead to the removal or weakening of an established regulatory system that we know puts a brake on healthcare costs, improves the quality of care, protects financial access for all Georgians to needed health care services, and preserves the financial viability of essential community institutions, our safety net hospitals and medical training centers.

Let me be clear that this is not a fight between physicians on one side, and hospitals on the other. The opposition to CON has been led by a relatively small group of doctors who want to own surgery and imaging centers, with the support of the Medical Association of Georgia and a related group, the Georgia Society of Ambulatory Surgical Centers. But physicians are very divided on this issue. Indeed, most have no quarrel with the CON program. A majority of Georgia doctors aren't even members of MAG and many disagree with MAG's advocacy of CON deregulation. Physicians of many specialties such as emergency room doctors, radiologists, neonatologists, and primary care physicians strongly support CON.

Our hospitals are fighting for an established program that works. And we have always supported common-sense measures to streamline and improve the effectiveness of the administrative process.

As I wrap up these remarks, I would ask you to be mindful of both the CON program, and the CON process. We will acknowledge that the process can be somewhat cumbersome. But, the CON process in itself performs an important public service by giving all parties a forum to debate the necessity and appropriateness of a proposed new health care facility or service. The state has never allocated sufficient budget or staff resources to fully and adequately review each CON application and audit approved facilities. It has therefore fallen to the interested parties - applicants and existing providers, for the most part - to assume much of that responsibility. That requires both sides to present their case, and more often than not, a reasonable judgment winds up being made. Again, that process takes time, but it does serve the public interest.

That said, we are always looking for ways to strengthen, streamline, and make the process more efficient, and we will be prepared at an appropriate point in this Commission's deliberations to make specific recommendations regarding the scope of CON review of non-clinical facilities and modifications to the present multi-tiered appeals process in order to reduce the costs of the process for the state and providers alike.

At the same time, we strongly believe that two glaring loopholes have evolved in agency interpretation of the scope of the CON law, which call for tightening through statutory amendments.

First, the capital threshold for review of major diagnostic imaging equipment needs to be lowered back to its original 1991 statutory amount of \$500,000. In 1991, no one could acquire an MRI unit or develop a multi-modality freestanding imaging center for \$500,000, and the legislature did not intend for an annual cost inflation index that has been applied to that threshold to open the floodgates for the recent explosion we have seen in freestanding imaging centers.

Second, and equally important, the excessive proliferation of freestanding, physician-owned single specialty ambulatory surgery centers needs to be addressed. That can be done through tightening of the CON statutory language to prevent the excesses that have flowed from loose agency interpretations. Every licensed ambulatory surgery center in this state should have to undergo CON review and make an indigent care commitment, just as all new hospital-based surgery centers and all other licensed healthcare institutions in this State do now. There is no logic or fairness in exempting licensed physician-owned surgical centers from CON review and the indigent care commitments that attach to CON-approved facilities. There are more than 230 licensed ambulatory-surgery centers in Georgia, a majority of which in recent years, contrary to legislative intent, have obtained complete exemptions from CON review from the Department of Community Health with the claim that they are located in single specialty physician offices. We certainly don't need more of these specialty surgical centers, and the self-referral financial incentives behind them are bad for overutilization and health

care costs; bad for patient safety; bad for safety net providers and their patients; bad for hospital emergency room coverage; and bad for the continued financial viability of our teaching hospitals. In conclusion, let me stress that CON holds down overutilization and health care costs. CON promotes quality health care. CON protects safety net hospitals which provide essential access for all Georgians, regardless of ability to pay, and it protects our teaching hospitals which provide costly medical education. CON protects the availability of full-service emergency rooms, trauma programs, and intensive care units in general hospitals. And independent studies prove it. We urge you to heed the conclusions of those studies. Mr. Chairman, members of the Commission, the issues here are not regulation and bureaucracy. The issues here are the affordability, quality, and accessibility of health care in this State and the effectiveness of our health care delivery and financing system. Please do no harm. Instead, please help us strengthen Georgia's Certificate-of-Need program. Thank you so much for your consideration.