

Health Care in Kentucky Certificate of Need

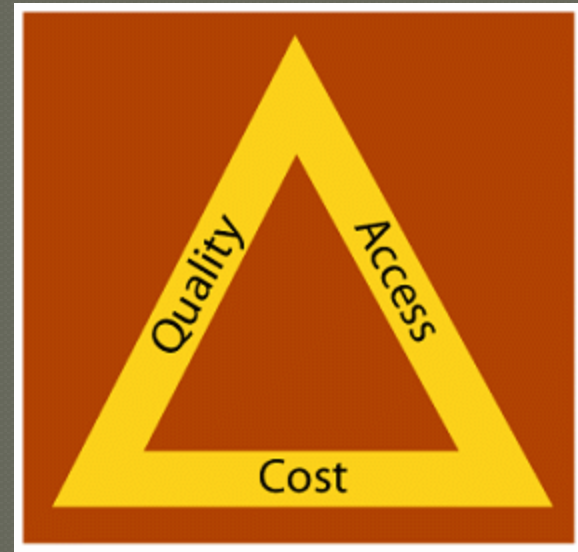
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All information in this slide presentation is the
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Iron Triangle Of Health Care

- Cost
- Quality
- Access



General wisdom is that to increase the performance of one of these factors will decrease the performance of the other two.

Transparency

Value = Price + Quality

Price is only part of the equation.

History of the Certificate of Need in the United States

Part II

Certificate of Need - History

- Designed to save healthcare costs by preventing duplication of costly services.

Certificate of Need - History

- In 1964 New York became the first state to enact a certificate of need law.
- In 1974(6) the federal "Health Planning Resources Development Act" mandated that States have a CON by tying it to Medicaid and Medicare healthcare dollars.
- At that time, the Federal Government was reimbursing on a cost - plus basis.

Certificate of Need - History

- 1975, 20 states had enacted CON laws
- 1978, 36 states had enacted CON laws.
- 1987, the federal "Health Planning Resources Development Act" and mandated CON was repealed, in part because it was ineffective in controlling costs – Morrissey, 2000
- In other words, the CON was promoted by Federal Government regulation which stifled free enterprise. It did not work, they abandoned it and the states were left with the mess to clean up.

Certificate of Need - History

- At its peak, all but one state had Certificate of Need Laws.
- Currently, 36 states have some form of a CON. Which include:
 - Ohio retains CON on long-term care facilities.
 - Nebraska retains on long-term care facilities and rehabilitation centers (currently a moratorium on construction.)
 - Louisiana which retains on assisted living, long- term care and intermediate-care facilities for the mentally handicapped.

Certificate of Need - History

- According to the National Conference of State Legislatures:

“States that have retained CON programs currently tend to concentrate activities on outpatient facilities and long-term care.”

History of the Certificate of Need in Kentucky

Part III

Kentucky CON - History

- Enacted in 1972, two years before the federal mandate.
- Healthcare costs are controlled by limiting competition with the certificate of need.
- The theory is that costly duplications in healthcare are prevented and the consumer benefits.

Certificate of Need - Kentucky

By Statue, the Purpose of the CON is as follows:

- Therefore, it is the purpose of this chapter to fully authorize and empower the Cabinet for Health and Family Services to perform any **certificate-of-need** function and other statutory functions necessary to **improve the quality** and **increase access** to health-care facilities, services, and providers, and to **create a cost efficient health-care** delivery system for the citizens of the Commonwealth. (KRS 216B.010)
- **It is mandated to improve all sides of the iron triangle.**

CON in Kentucky – Last Reviewd

Kentucky Subcommittee on Health Care Costs – June 1997
LRC Staff Notes of Meeting – Top of Page 1

Subcommittee on Health Care Costs
6/18/97
Senator Rose states that the
Subcommittee is not looking at long
John Kray, CON term care. Otherwise, plans
to look at costs and access.
CON does not control costs or increase
Access. Had a series of 5 public
hearings. Last hearing on price
competition. 2 experts testified –
Dr. Price - Ga & Dr. Morasse - Alabama
Both testified CON is not effective.

Access
w/ Rep
Kearney's
Comments

CON in Kentucky – Last Review

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Access - CON not effective for 2 reasons.

1. CON has no mechanism for uneven access. PRT example - Can't submit applications. Private market determines where services are needed;
2. In attempt to control costs, CO actually limits access. Example - Open Heart Surgery. Had app. for quality & was turned down on quality - not enough procedures.

Concludes that Kf CON doesn't control costs or increase access.

CON in Kentucky – Last Review -- Costs

Report on Certificate of Need in Kentucky – June 12, 1997 Subcommittee on Health Care Access and Cost Oversight

- When Kentucky looks at its increase in the volume of **outpatient services and costs**, particularly outpatient surgeries, it seems evident that the **CON process has fallen short** (of) its intended purpose.
- As **managed care** continues to develop in Kentucky and works to promote competition and **cost containment**, the usefulness of **CON** for certain services will be **limited at best**.

CON in Kentucky – Last Review - Quality

- The report on the Certificate of Need in Kentucky 1997, Subcommittee on Health Care Access and Cost Oversight.

“The CON has done very little to enforce the role of quality in reducing the rate of cost increases.”

CON in Kentucky – Revision Nov 2005

- “A historically and significantly higher **negotiated rate** for providing identical services at similar licensed hospitals.”
- “A documented history of uncorrected quality control problems which threaten the life, health and safety of the hospital’s patients. Examples may include higher than normal rates of preventable hospitalization, medication errors, or hospital acquired infections”.

CON in Kentucky – Final Reg. Jan 2006

- The adjusted revenue of each licensed acute care hospital located within the planning area exceeded one-hundred and fifty (150%) of the state mean **adjusted revenue**, for acute care hospitals, during each of the previous three (3) fiscal years.

CON in Kentucky – Final Reg Jan 2006

- All licensed acute care hospitals located within the planning area have experienced one or more of the following:
 - i. Final termination of their Medicare or Medicaid provider agreement;
 - ii. Final revocation of their hospital license issued by the Cabinet for Health and Family Services' Office of Inspector General; or
 - iii. Final revocation of their hospital accreditation by the Joint Commission on Accreditation of Healthcare Organizations.

CON in Kentucky – Analysis of Cost Criterion

- The Key is switching the terms of “**negotiated rate**” to “**revenues**”.
- Revenues are averaged out by Medicaid and Medicare Payments.
- If a hospital has 75% of their patients with Medicare and Medicaid, we estimate the private sector would have to pay 3 times above the state mean before this criterion is met.
- Even so, there is also the “Existing Hospital Protection Clause” where the CON is not granted unless all hospitals in all surrounding counties also meet the criterion.

How Well Is The CON Working in Kentucky Today ?

Part IV

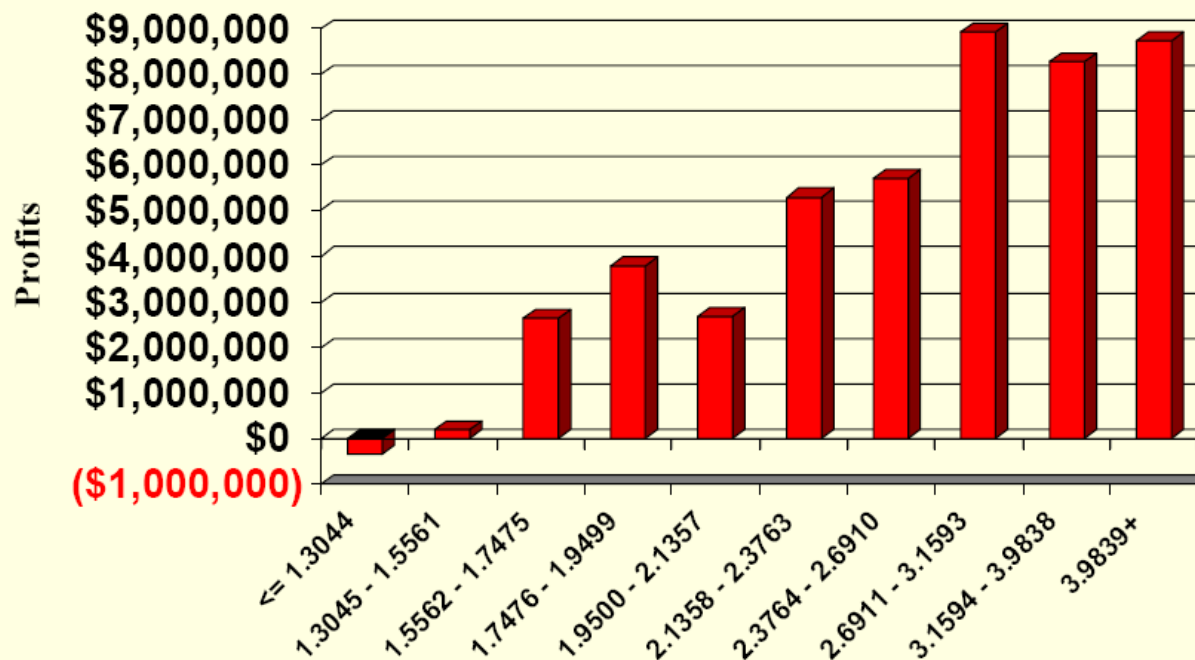
CON in Kentucky--Costs

- Kentucky's hospitals have the 17th highest total gross charge-to-cost ratio in the United States. 232.90% (IHSP: 2003-2004 Economic Data).

From Institute of Socio-Economic Policy, Third Annual IHSP 200, 2005

CON KY - List (Asking) Price Does Matter

Higher Hospital Charge to Cost Ratios and Higher Profits



From Institute of Socio-Economic Policy, Third Annual IHSP 200, 2005

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CON KY - List (Asking) Price Does Matter

- If you buy a car and one is priced at \$10,000 another at \$60,000 do you really think you will pay less for the \$60,000 asking price.
- This is the range we see in CTC Ratios in Kentucky.

CON in Kentucky--Access

- The CON is for protection (of) Medicaid so access is limited and it more likely causes those with CON to charge more in under-served areas. They have a monopoly on the provided services.

State Senator Tom Buford - Oct 2, 2006

Case Study - Jessamine County

- Nicholasville is the 13th largest city in Kentucky. There are approximately 100 acute care hospitals in Kentucky; and Jessamine County is the only densely populated county without a hospital.
- Jessamine County is growing and has an excellent economy. Nicholasville grew 40% from 1990 to 2000.
- It is surrounded by counties with major universities one of which even has a medical school.
- Jessamine County (Nicholasville) has not been approved for an acute care hospital.

Case Study - Jessamine County

- Since the planning area is all adjacent counties, the quality CON criteria will never be met.
- All hospitals except one could close in Lexington and this criterion would not be met. Actually, they all could close and the criterion still would not be met.
- I call this the “Existing Hospital Protection Clause.” A similar clause can be found with all criterion.

How Well Has The CON Worked in the United States.

Part IV

Case Against the CON

- At the time of CON adoption, publicly held for-profit hospitals were not commonplace. The CON was enacted under the assumption that a non-profit facility would return savings to the consumer.
- The healthcare industry has changed.
- "The principle difference between for-profit and nonprofit organizations is how the profits are spent. For-profit enterprises spend them on shareholders. Nonprofit entities are prevented by law from explicitly doing so. Morrissey, 2000

Economic Studies - Morrissey, 2000

CON Tends to Increase Costs

- Sherman (1988)
- Antel, Ohsfeldt, and Becker (1995)
- Lanning, Morrissey and Ohsfeldt (1991)
- Noether (1988)
- Zwanziger et al. (1993)
- Conover and Sloan (1998)

Economic Studies - Morrissey, 2000

CON-- Little or no effect on costs

- Sloan(1988)
- Steinwald and Sloan (1981, 1983)
- Salkever and Bice (1976, 1979)
- Melnick et al. (1981)
- Joskow (1981)
- Miske and Reynolds 1982)
- Ashby 1984)
- Morrissey, Sloan and Mitchell (1983)
- Sloan and Steinwald (1980a, 1980b)
- Coelen and Sullivan (1980)

CON Against - Competition Prevented

- In July 2004, a massive study by **the Federal Trade Commission and Department of Justice** compiled from 27 days of testimony from 250 panelists along with independent research concluded that:

“States should decrease barriers to entry into provider markets.”

"States with Certificate of Need programs should reconsider whether these programs best serve their citizens' health care needs," it said. "The Agencies believe that, **on balance, CON programs are not successful in containing health care costs**, and that they pose serious anti-competitive risks that usually outweigh their purported economic benefits."

Healthcare Systems

Part V

System of Regulations Lacking

- The near collapse of the banking industry has placed renewed interest in increasing government regulations
- In Kentucky, there are little regulations regarding hospital quality assurance. KRS 216B.185 prevents the State from making accreditation visits on most Acute Care Facilities.

System of Regulations Lacking

- The premise behind Kentucky's current health care system is that corporations will pass on their savings gained from state granted monopolies to the consumer and not to stockholders or officeholders.
- This is an honor system. Since in healthcare **there is no Public Service Commission.**
- **Without competition, a scenario of high prices and low quality can occur.** This can lead to net revenue in poor counties of up to 10's of millions of dollars.

Government Oversight

- **Utility Industry:** In the 2007 session, the Kentucky Legislature introduced a bill to “strip consumers of protections against unjustifiable rate increases” and that this removal will provide “benefits of monopoly pricing while effectively freeing (utilities) from regulatory oversight and enables the utilities to shift all their risk onto consumers”.

-- *Lexington Herald Leader Op-Ed Feb 22, 2006*

- **Healthcare Industry:** There is not a “Public Service Commission” for hospitals. Currently, the CON grants the benefits of monopoly pricing without effective public protections.

Competition

- **Consumer Driven Healthcare** – Competition, Transparency, and Choices in Providers.
- Dept. Health and Human Services' Secretary, Mike Leavitt, calls for support of the four "cornerstone" actions of the recent Presidential Executive Order calling for the interoperable health IT; transparency of quality; transparency of price; and incentives for high-value health care...
 - - February 5, 2007
- Endorsed by Major US Business: 3M, GE, Microsoft, Cisco, Caterpillar, Wal-Mart, Intel, McDonalds, and 450 other major industries.

Competition

- The airline industry could have argued in 1978 against deregulation by purporting that competition will cause fares to increase because the duplication of services with their over 200 million dollar a piece jumbo jets.



Imagine the airline executives who are paying for the high healthcare bills of their employee's and wondering why they too cannot have a protected monopoly.

Competition – Where it Works

- Plastic Surgery
- No better example than Lasik Surgery

Not covered by private insurance. Started with a few providers and a cost of several thousand dollars. Now there are many providers, increased technology and cost has dropped to several hundred dollars.

CON Concerns Regarding Elimination

Part VI

Concerns Regarding Elimination

- Fairness – Many individuals and industries have purchased CONs at a huge price. Elimination of the CON would make their CON investment worthless.
- Protection of small rural hospitals.

Surges – What is feared

Of the states where the CON was eliminated, five have experienced difficulties.

- Arizona had a doubling of nursing home beds in 5 years, also a surge in open heart surgery programs.
- Tennessee: Home Health Agencies (later reenacted CON for Home Health Agencies).
- Wisconsin: Hospitals and Psychiatric Hospitals.
- Texas: Nursing Homes and Psychiatric Hospitals.
- Ohio: Hospitals, Ambulatory Surgery Centers, Pediatric Services and dialysis.

Surges – If they occur they are temporary

- When they do occur they are temporary !
- 1998 (Conover and Sloan) who found that **mature CON programs** resulted “in a slight (2%) reduction in hospital bed supply but **higher costs per day and per admission**, along with higher hospital profits.” There was not a significant effect on total per capita spending and it was “doubtful” there was any effect on quality.

Regulatory Changes

Part VII

Suggested Regulatory Changes

- The statutory authority given to the Governor's office is very broad. There are no preconditions as to what the CON has to do other than promote the Iron Triangle.

“Therefore, it is the purpose of this chapter to fully authorize and empower the Cabinet for Health and Family Services to perform any certificate-of-need function and other statutory functions necessary to improve the quality and increase access to health-care facilities, services, and providers, and to create a cost-efficient health-care delivery system for the citizens of the Commonwealth.”

-- 216B.010 Legislative findings and purposes

Suggested Regulatory Changes

- If the CON is weakened, the licensure process can be used to promote quality and make sure facilities have the services and qualifications to meet State standards.

Suggested Regulatory Changes

- Hospitals which have an effective monopoly should be scrutinized. The CON was developed before publicly traded facilities were commonplace.

Rational: Market pressures need to be present in some markets. Some SEC Reports have stated that corporations “target” low-competitive environments.

Suggested Regulatory Changes

- For Profit Facilities who have an effective monopoly should have competition even in rural markets.
- In this case a CON for a non-profit competitor should be considered.

Suggested Regulatory Changes

- Kentucky has no CON Board. This process has a history of corruption in other states.
- Bid the CON similar to a Racetrack License.
- Set criteria of who can bid for CON.
(Prohibit outliers from bidding)
- Place proceeds in a fund to match Federal dollars for indigent care for all the facilities in the State.

Conclusion

- Why is Kentucky giving away CONs for free to for-profit and non-profit organizations, which are worth up to 5 to 10 million dollars when they could be sold and money matched for federal dollars and used for indigent care ?