



Health Innovation Subcommittee

Wednesday, January 11, 2017
3:30 PM – 5:30 PM
Mashburn Hall

Richard Corcoran
Speaker

MaryLynn Magar
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Health Innovation Subcommittee

Start Date and Time: Wednesday, January 11, 2017 03:30 pm
End Date and Time: Wednesday, January 11, 2017 05:30 pm
Location: Mashburn Hall (306 HOB)
Duration: 2.00 hrs

Overview of the Certificate of Need Program by the Agency for Health Care Administration

Panel Discussion on Certificate of Need:

Professor James Bailey, Creighton University
Dr. Daniel Yip, Mayo Clinic Jacksonville
Professor Matthew Mitchell, The Mercatus Center at George Mason University
Marshall Kapp, Director, Center for Innovative Collaboration in Medicine & Law, FSU
John Couris, CEO, Jupiter Medical Center
Richard Thomas, American Health Planning Association

NOTICE FINALIZED on 01/04/2017 4:02PM by Ellerkamp.Donna

Agency for Health Care Administration Certificate of Need (CON) Program

Presented by Deputy Secretary Molly McKinstry

Health Innovation Subcommittee
January 11, 2017



CON Program – In General

- Regulates entry into the marketplace for licensed hospitals, nursing homes, hospices, intermediate care facilities
 - Decisions for *applicable hospital programs* are made in **June and December**
 - Decisions for *applicable other beds and programs* are made in **February and August**
- Expedited reviews must meet statutory criteria and can be reviewed at any time



CON Program – In General

- Allows beds to be added to health services by exemption for certain programs:
 - Added to hospitals:
 - Comprehensive medical rehabilitation (CMR)
 - Neonatal intensive care unit (NICU)
 - Mental health services
 - Community nursing home beds
- Hospitals can add acute care beds by notification
- Publishes utilization of the services monitored



CON Program – Fixed Need Pool

- Have Fixed Need Pools -Hospice, Nursing Homes, NICU II and NICU III, Psychiatric, Substance Abuse, CMR, Pediatric Catheterization and Pediatric Open Heart Surgery
- Need Calculation
 - Population for the identified service area (depending on the service this can be regional, district, county or ZIP code based)
 - Considers the utilization of existing services (occupancy or penetration rates) to determine whether additional services are needed for the identified service areas
 - For NICU services, the calculation includes birth data supplied by the Department of Health (DOH). For hospices, the calculation includes death data, also supplied by DOH.
- No Fixed Need Pool
 - Intermediate Care Facilities for the Developmentally Disabled, inpatient hospice, acute care hospitals, long-term care hospital, and transplant programs



CON Regulatory Authority

- CON regulates program entry and sets standards for program establishment, including many tertiary services such as NICU, CMR, transplants and pediatric cardiac services.
- A CON does not impose standards once implemented and cannot be revoked unless a program has ended or fails to renew.
- During the application process, a program can self-impose a condition for approval which will be monitored on an annual basis once a CON has been implemented.

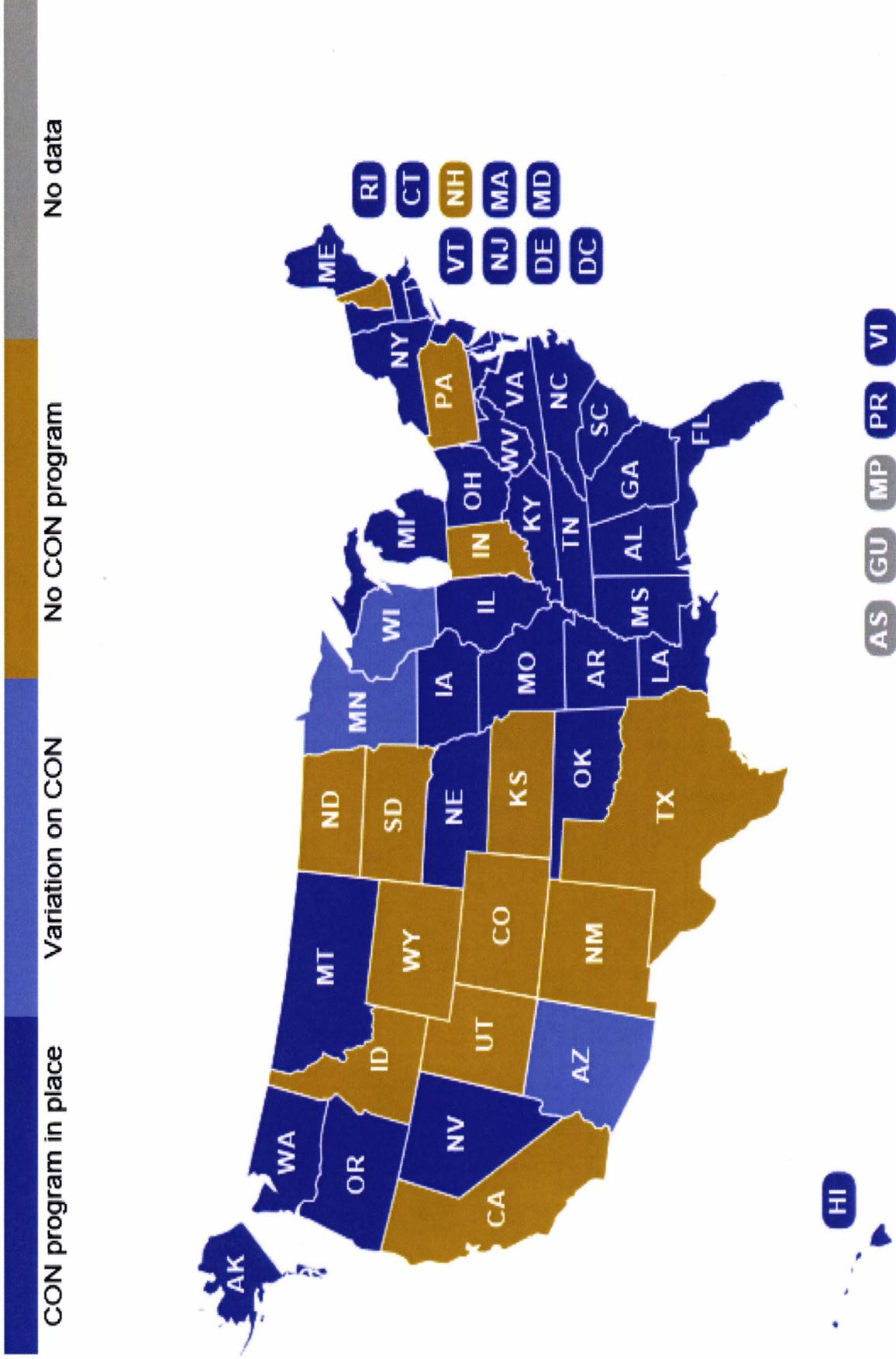


CON Regulatory Authority - Conditions

- Conditions are voluntary commitments/obligations that exceed the minimal requirements and that applicants believe give them a competitive advantage in the Agency's review process.
- Most conditions are tied to a provision of Medicaid/indigent patient days and/or provisions of specific services.
- Conditions can be modified or removed when good cause is shown by request of the applicant.



CERTIFICATE OF NEED STATE LAWS



Source: NCSL, August 2016

How Florida Compares

- Nationally 31 services subject to CON in various states.
- Florida requires CON for 10 of 31 services.
- Regulated services that require CON are specialty hospital beds and services, ICF-DDs, nursing homes and hospices.
- Equipment costs, medical buildings, regular procedures (i.e. lithotripsy, adult cardiac catheterization), outpatient services, assisted living facilities, and home health agencies are not regulated by the CON program as they are in other states.



CON Programs in Other States

CON “Light” States

- Arizona
 - No CON program, but they have a planning approval process in place for ambulances and ambulance services
- Louisiana
 - Approval process before becoming a licensed assisted living facility

CON “Heavy” States

- Vermont and District of Columbia
 - Majority of all facilities and services including major medical equipment, hospital beds, home health, obstetrics and ultrasound
- Alabama
 - Major medical equipment, obstetrics, nursing homes, open heart surgery, outpatient services, dialysis



CON Timeline in Florida

1973	Certificate of Need created
1982	Elimination of local Health System Agencies--eliminated local CON review
1987	<u>CON eliminated:</u> Obstetric services Capital expenditure of inpatient projects under \$1 million Major medical equipment reclassified as equipment which costs more than \$1 million and which has been approved by the FDA for less than three years Outpatient services <u>CON expanded:</u> Specified tertiary services Statutory authority to levy fines for non-compliance of conditions
1988	Rules promulgated specify a list of tertiary services
1997	<u>CON eliminated:</u> Acquisition of medical equipment, regardless of cost



CON Timeline in Florida

2000	Exemption authorized for increase of up to 10 beds or 10 percent of a hospital's or nursing home's licensed capacity <u>CON eliminated:</u> Cost overruns of approved projects Home health agencies
2001	CON moratorium established for new community nursing home beds
2003	<u>CON eliminated:</u> Rural hospitals when specific criteria is met
2007	<u>CON eliminated:</u> Hospital burn units - moved regulation to licensure Adult cardiac catheterization and adult open heart surgery services - moved regulation to licensure



CON Timeline in Florida

2008	Streamlined the approval process for new acute care hospitals
2011	Eliminated authority to fine community nursing home beds for failure to meet Medicaid conditions
2013	Modified requirements to allow deed restricted communities to apply for nursing homes through expedited review
2014	CON moratorium for new community nursing home beds lifted with limit on new community nursing home beds as of cycle approving statewide total of 3,750 beds Published need for new community nursing home beds for the first time since 1999 Modified requirements to allow maternity beds in children's hospitals under certain conditions
2016	Reached limit of new community nursing home beds – effective moratorium on community nursing home beds
2017	Restriction on new nursing home beds will be repealed June 30, 2017



CON Activities

	2013	2014	2015	2016 (partial)
CON Applications Received	32	116	96	53
CON Applications Reviewed	24	25	149	38
CON Condition Compliance Reports	617	696	673	669
CON Exemptions	17	31	49	24



AHPA Perspective Certificate of Need Regulation

Richard K. Thomas, Ph.D.

January 11, 2016

Background: AHPA

- **Voluntary national organization focused on community health services planning**
- **Supports community oriented health services planning in all health sectors**
- **Supported by experienced health services and facility planners (many with CON experience)**
- **Tracks state planning and CON activity**
- **Comments on CON and other health planning issues**



Background: Richard K. Thomas

- **Experienced in health services research, planning, and evaluation (40+ years)**
- **Author of a widely used health services planning text**
- **Consultant to healthcare organizations**
- **Extensive involvement in the CON process and in state health plan development**
- **AHPA board member**

AHPA Perspective: Opening Statement

- **AHPA is not an indiscriminant proponent or opponent of CON regulation**
- **AHPA's main interest is the promotion of the orderly development of the health care services and of the health care system**
- **Our focus and emphasis is on the promotion of public and private community-oriented health services planning and operations**
- **AHPA supports CON regulation where, and to the extent, it serves this purpose**

Questionable Assertions Concerning CON

- **Primary purpose of CON is to:**
 - **“Control” healthcare costs**
 - **Limit entry into the market**
 - **Protect existing providers**
 - **Limit the expansion of services**

Original Purpose of the National Health Planning Act (PL 93-641)

- **To manage, through regional planning and related regulation, the supply and distribution (location) of health services**
- **To promote and facilitate access to health and medical care; other functions are subsidiary to this**
- **CON regulation is a tool to this end**
- **In implementing CON other functions may have been added**

Potential Benefits of CON Regulation

- **Improves access to care (especially for the underserved)**
- **Supports safety net hospitals**
- **Supports rural hospitals**
- **Helps assure availability of services to the community**
- **Helps ensure the provision of charity care**



Potential Benefits of CON Regulation (cont.)

- **Establishes standards for the provision of services**
- **Prevents unqualified entities from providing certain services**
- **Limits excess bed capacity**
- **Assesses quality by monitoring outcomes**



Portential Benefits of CON Regulation (cont.)

- **Discourages unnecessary growth/expansion**
- **Standardizes processes for service and facility development**
- **Encourages alignment of supply and demand**
- **Identifies and stops some really bad ideas**
- **Creates a forum for public involvement and discussion**

Comment on Attempts to Evaluate the Impact of CON

- Numerous attempts over the years to evaluate the impact of CON
- Some designed *a priori* to discredit CON
- Many conducted by researchers with limited knowledge of healthcare
- Most flawed in some major way
- Most come to tentative rather than definitive conclusions



Challenges in Conducting Evaluation of CON

- **Circumstances are different in every state (and among CON programs)**
- **Difficult to measure the relevant variables (e.g., quality, access, costs) or to even track the utilization of services**
- **Many difficult to measure factors affect the operation of the system and its attributes**
- **Very difficult to isolate, much less assess, the effect of planning and CON regulation**



The Impact of CON on Competition

- **Detractors often argue that CON regulation stifles competition**
- **We (U. S.) have operated as a competitive market for decades, but there is little evidence of positive benefits**
- **Arguably the U. S. is the most competitive and profit oriented health care system in the world**
- **Many assume that health/medical care operates like a traditional “free market,” but does it?**

No Market = No Competition

Many economists acknowledge that healthcare does not have the characteristics of a competitive market

- **No efficient, rational way of setting prices and ensuring adequate access to care**
- **Little relationship between costs, prices and payments**
- **Consumers do not make most of the purchase decisions**
- **Consumers (and professional decision makers) often do not know prices or take them into account**
- **Normal laws of supply and demand do not operate**



The Impact of CON on Supply

- **Some argue that CON artificially limits supply by preventing entry of new providers**
- **Admittedly there is some localized shortage of certain personnel and services**
- **Main problem often is maldistribution, not limited supply**
- **U.S. overall has higher ratios of facilities, personnel and equipment to population than most countries**



The Impact of CON on Supply

Counter argument:

- **To the extent that CON operates to assure appropriate allocation of resources, it reduces the likelihood of maldistribution and localized shortages**

Response to FTC Testimony

Questionable value –includes information that is:

- **Outdated**
- **Misleading**
- **Irrelevant**
- **Unsubstantiated**
- **Doctrinaire, Ideological**

Response to FTC Testimony

Based on published results of 2003 FTC hearings

- **Much of the testimony based on outdated information and data**
- **Reflects very different circumstances than exist today**

Response to FTC Testimony

Very little based on defensible research:

- **Opinions accepted as fact**
- **Stated facts are cherry-picked to reflect often unique situations**
- **Situations described without full context**
- **Persistent use of “may”, “could”, “potentially”, “may possibly” indicating little or no solid evidence**

Response to FTC Testimony

Presentation of irrelevant arguments:

- Comparison to anti-competitive situations that are not related
- Reference to cases in other industries quite different from healthcare
- Cites and lends credibility to “studies” that are not credible (e.g., Mercatus Center [GMU])

Response to FTC Testimony

Unsubstantiated statements:

- Little supporting documentation (even in original hearings)
- Claims that could not possibly be verified
- Presentation of statistics without citation, documentation or context



Have changes in the healthcare system eliminated the need for CON?

- **Argument has been made that changes in the system make CON no longer necessary**
- **This argument is grounded in the assumption that the primary purpose is to “control” costs**
- **It is argued that elimination of cost-based reimbursement makes CON no longer necessary or relevant**



Have changes in the healthcare system eliminated the need for CON?

- Main purpose of CON is not cost control
- Nevertheless, the cost of healthcare continues to be an issue
- Other issues, e.g., access, that indicate a need for targeted regulation remain
- Increases in health disparities indicate that problems have not been eliminated



Have changes in the healthcare system eliminated the need for CON?

Counter argument

- **Shortages/maldistribution of facilities, services and personnel persist**
- **Millions of newly insured patients making demands on the system**
- **Emergence of “population health” approach with emphasis on system-wide population-based planning and responses**
- **New evidence of potential reduction in the overall healthcare costs**



AHPA Perspective: Closing Statement

- **Unlike the FTC and other critics, AHPA is not a doctrinaire proponent or an opponent of CON regulation**
- **AHPA's main interest is the promotion of the orderly development of the health care system and assuring reasonable access to services**
- **So . . . our emphasis for more than 50 years has been on the promotion of community oriented health services planning**
- **We support CON regulation to the extent it serves this purpose**

AHPA Perspective: Closing Statement

- **As suggested above, it is virtually impossible to evaluate accurately and reliably the impact of CON regulation**
- **Relatively few opponents of CON regulation are objective observers; many are philosophically opposed to regulation and appear to have an ideological opposition to CON controls**
- **There are ways to improve the CON process; grounding it in a transparent community oriented health services planning program is critical**
- **To the extent that CON regulation contributes to the orderly development of the healthcare system, AHPA will continue to be supportive**

AHPA Perspective: Additional Information

**American Health Planning Association
3040 Williams Drive, Suite 200
Fairfax, Virginia 22031
703-573-3101
info@ahpanet.org**

THE ECONOMICS OF

CON LAWS IN HEALTHCARE

Matthew Mitchell
Senior Research Fellow

WHAT IS A CON LAW?



A permission slip to compete

Not a quality gate

Designed to assess “need”

Unusual in a market economy

A barrier to entry that restricts supply

A SHORT HISTORY OF CON LAWS



1974
National Health
Planning and
Resources
Development
Act

Ensure an adequate supply of HC

Ensure rural access to HC

Promote high quality HC

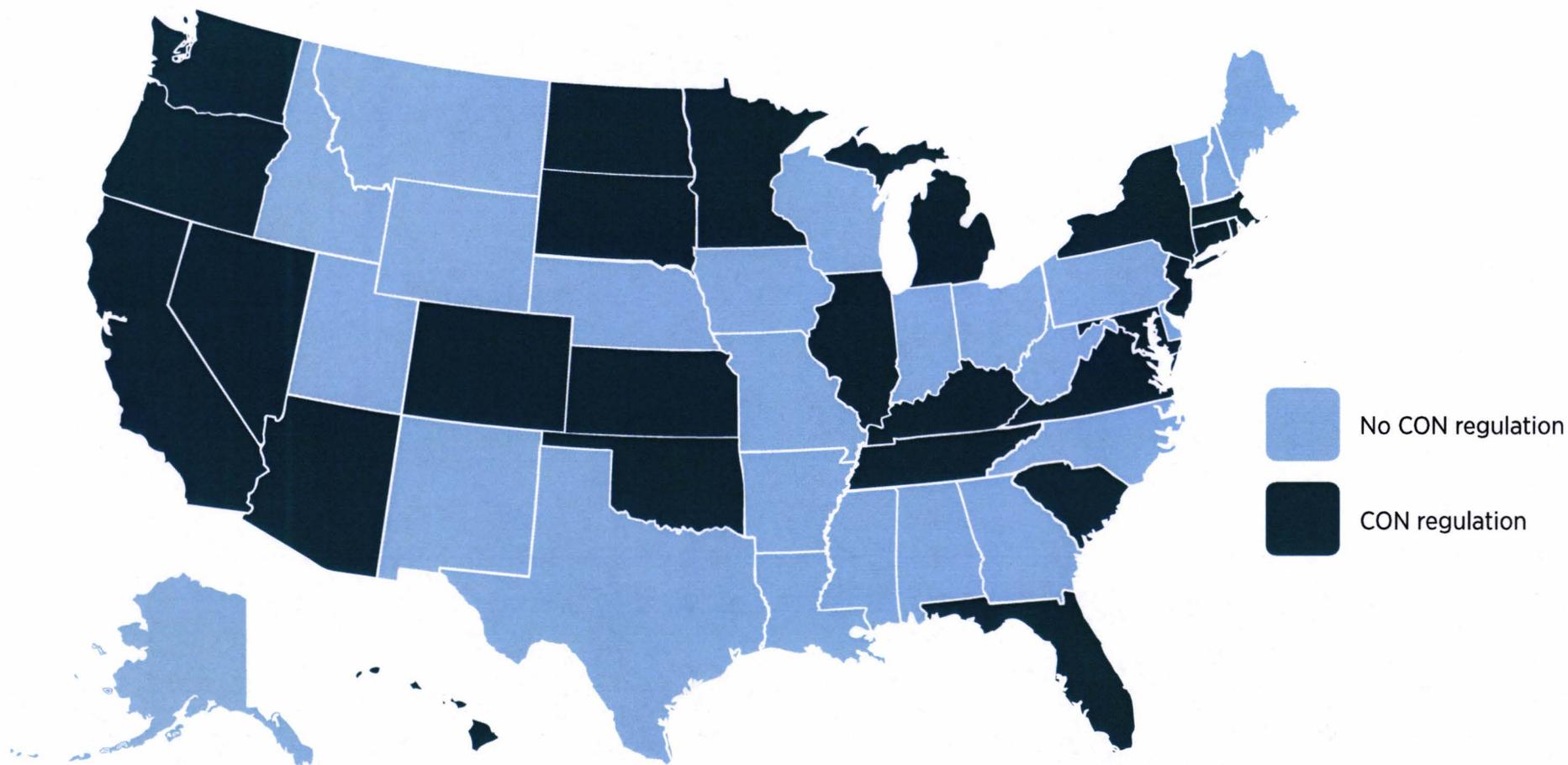
Promote charity care

Encourage hospital substitutes

Restrain the cost of care

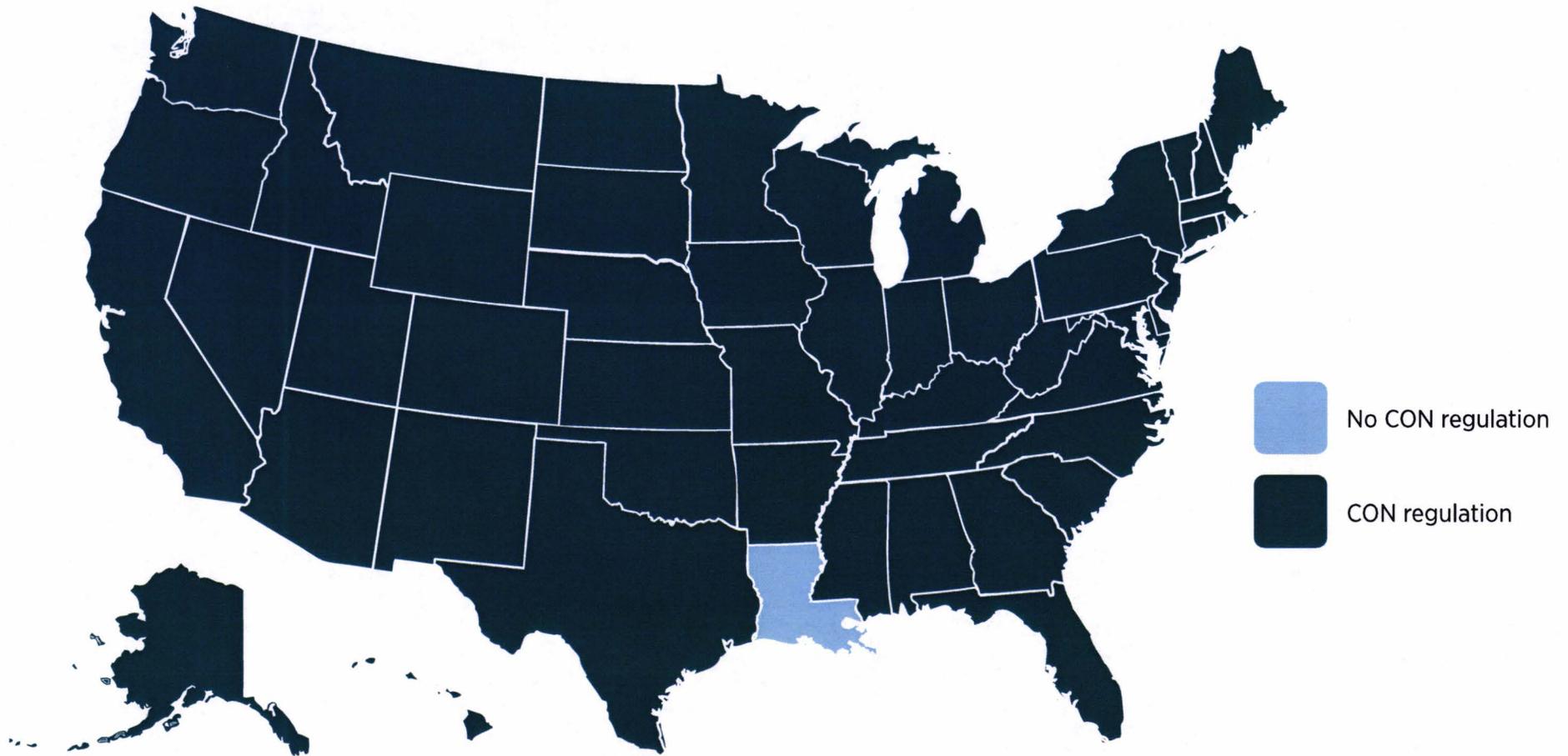
A SHORT HISTORY OF CON LAWS

1974



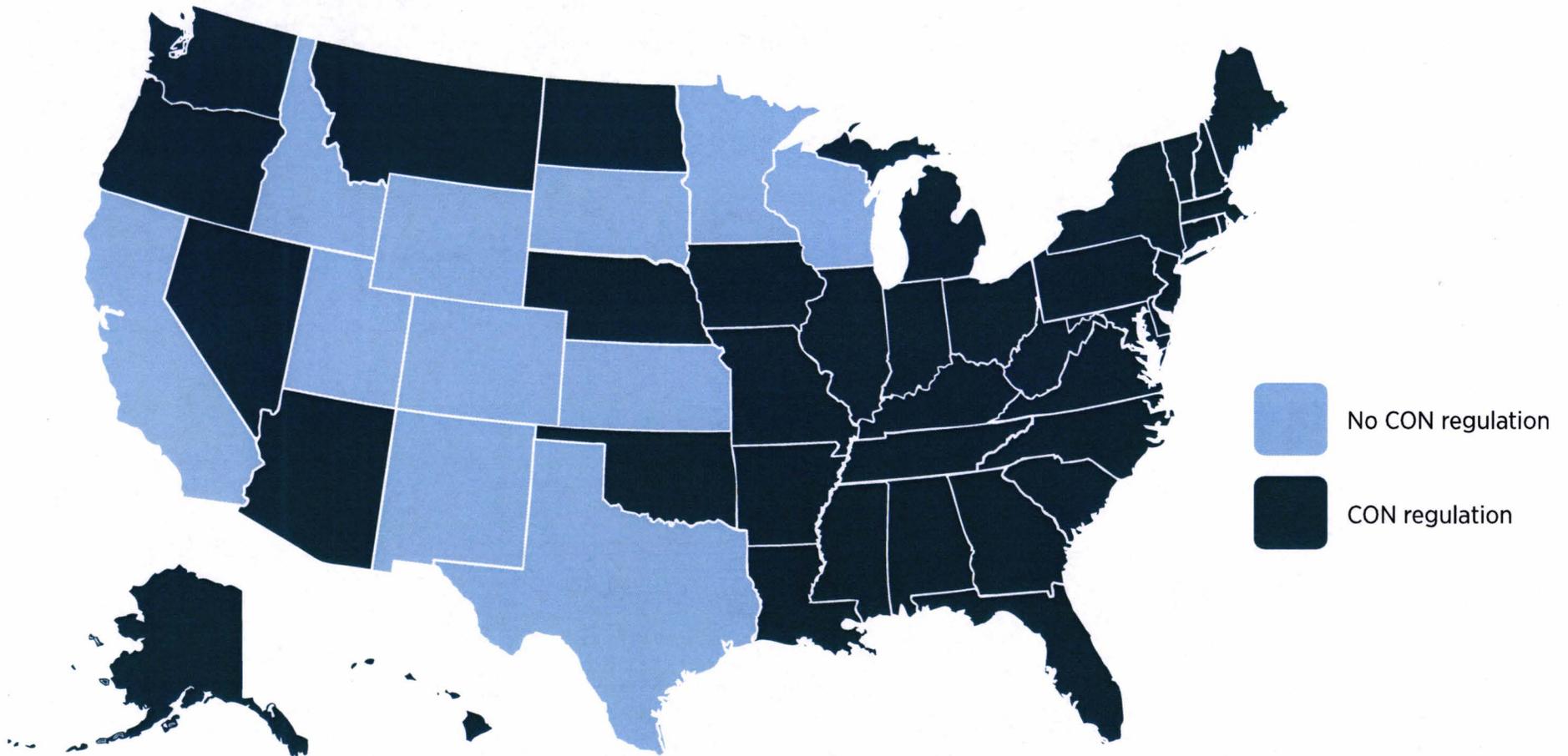
A SHORT HISTORY OF CON LAWS

1980



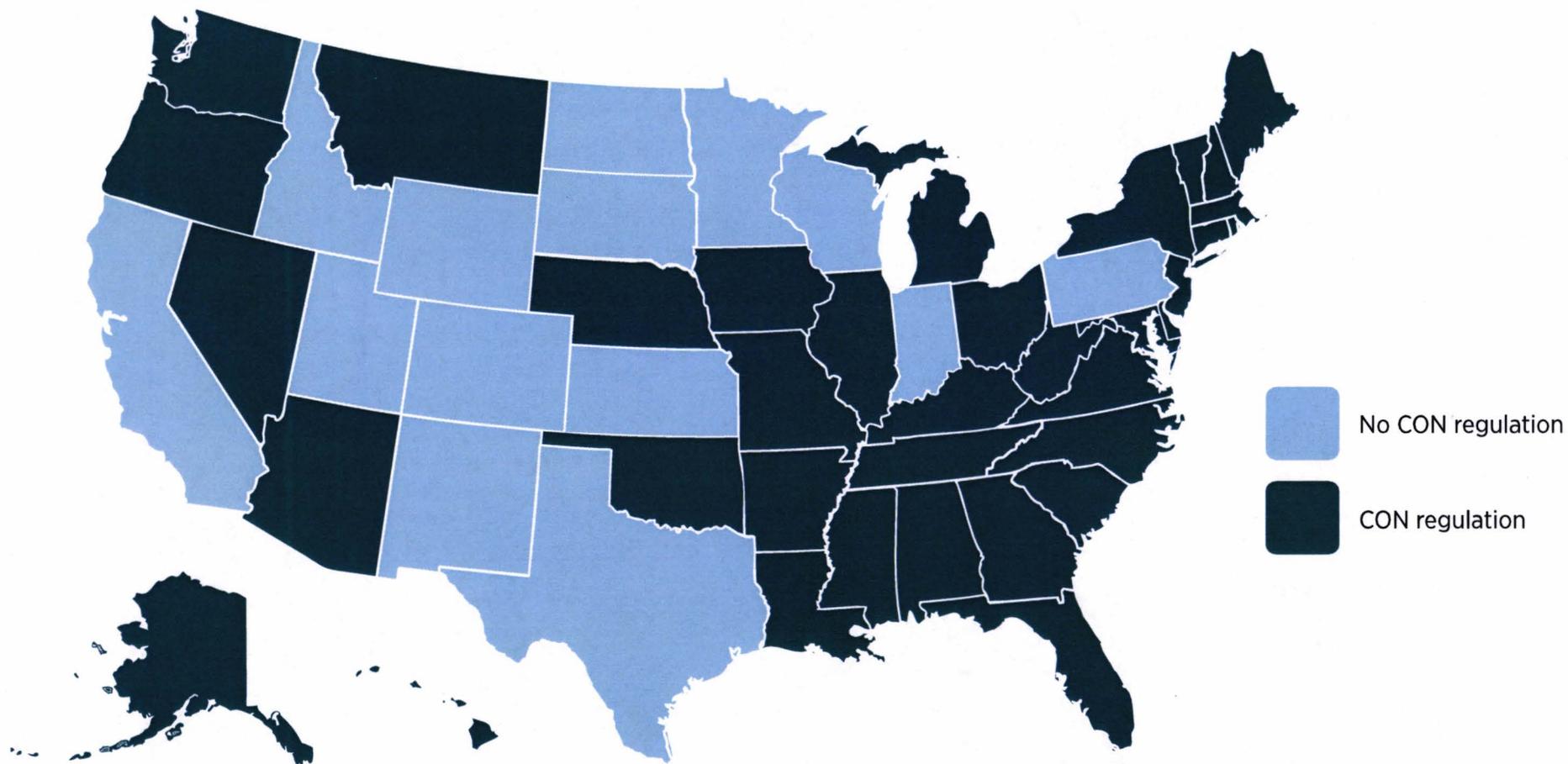
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1990



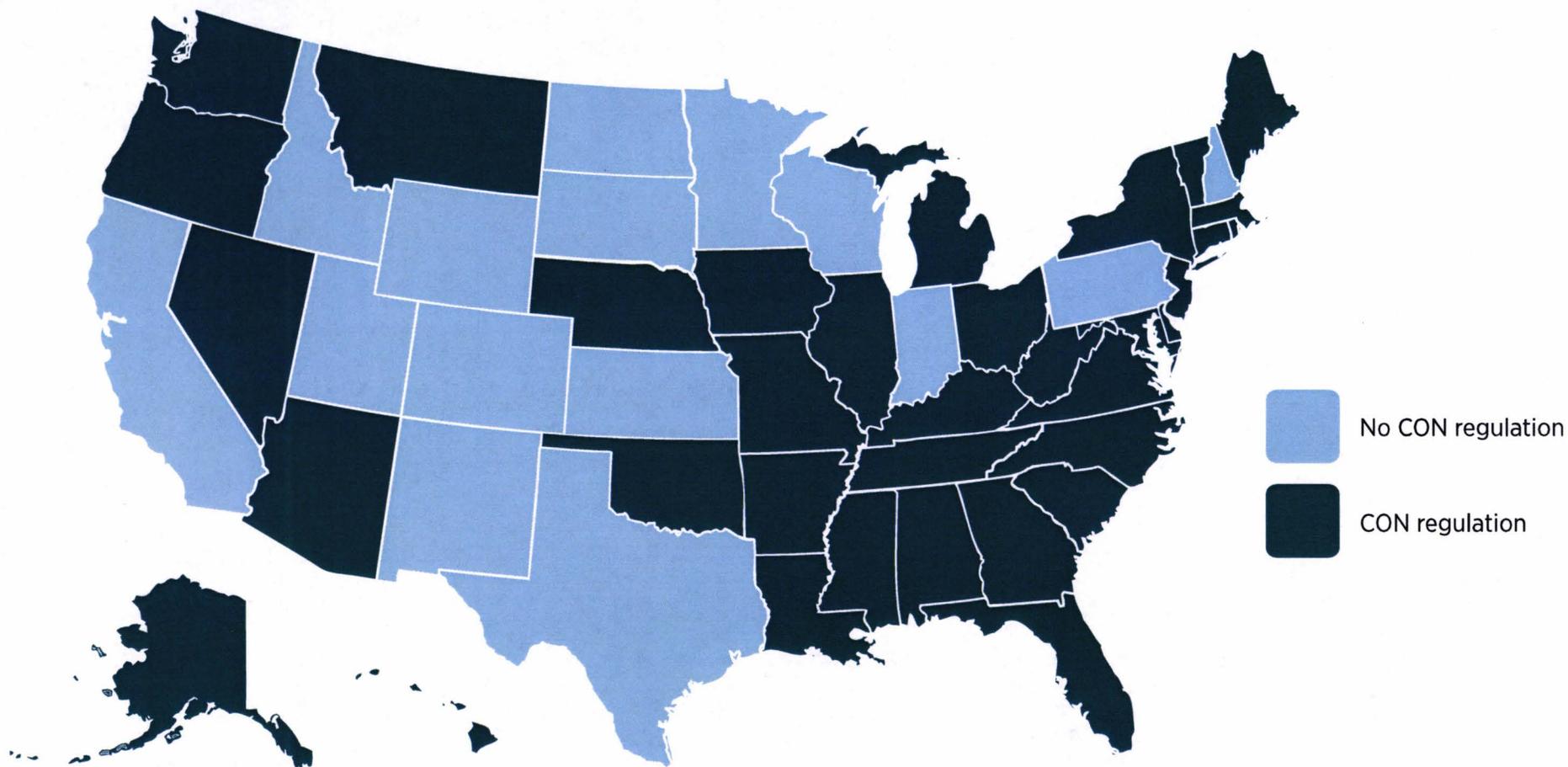
A SHORT HISTORY OF CON LAWS

2015



A SHORT HISTORY OF CON LAWS

2017



A SHORT HISTORY OF CON LAWS



1974
National Health
Planning and
Resources
Development
Act

Ensure an adequate supply of HC

Ensure rural access to HC

Promote high quality HC

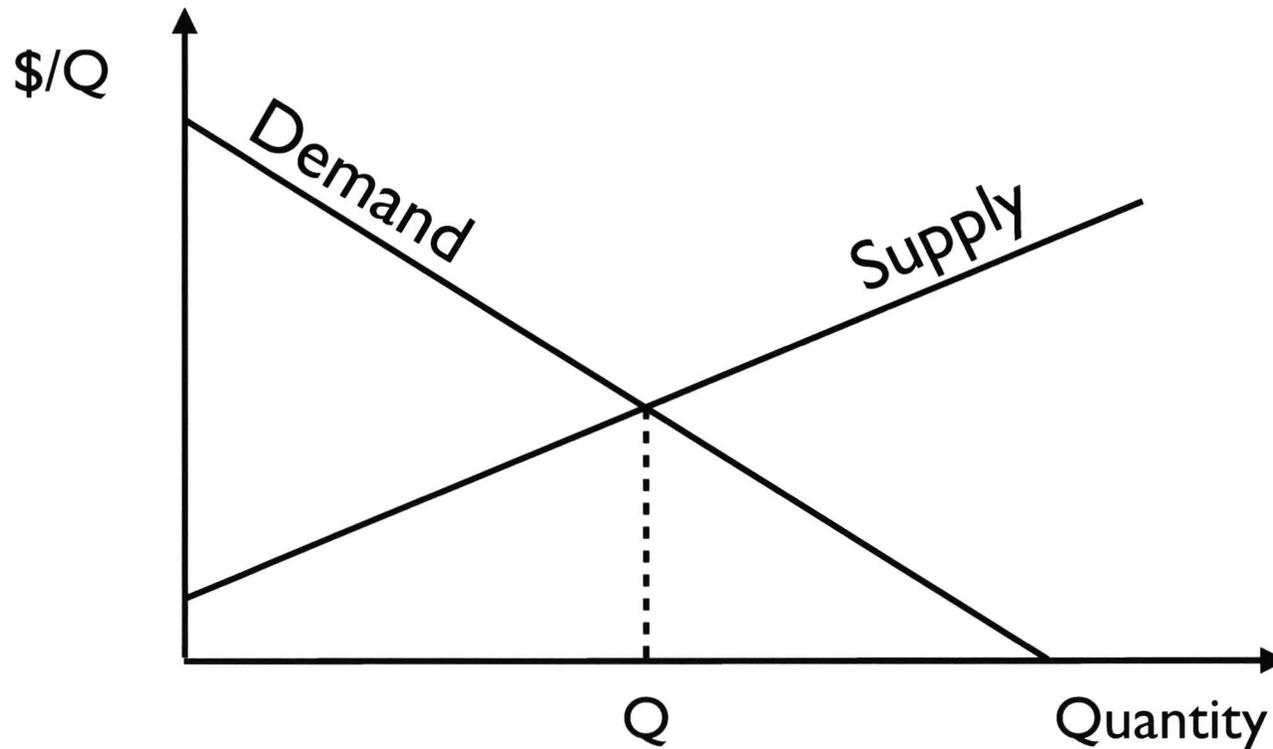
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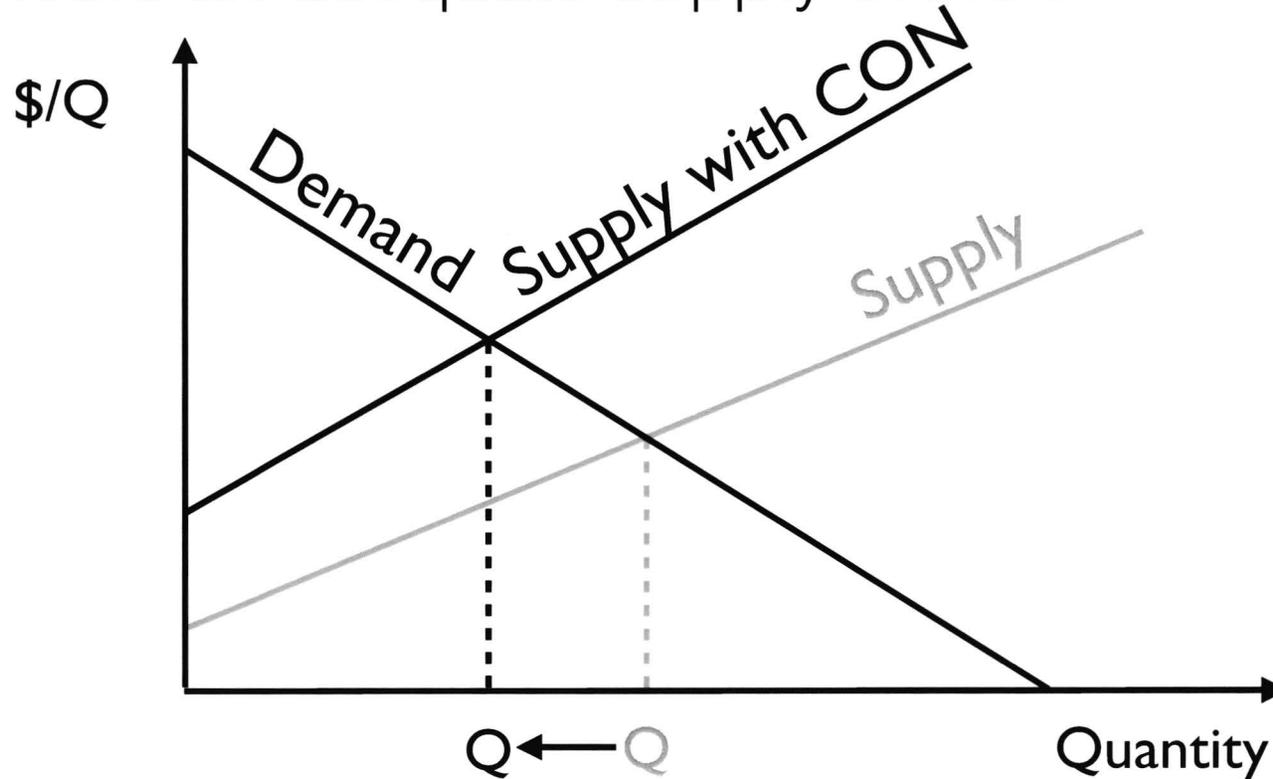
THE REALITY OF CON LAWS

Ensure an adequate supply of HC?



THE REALITY OF CON LAWS

Ensure an adequate supply of HC?



THE REALITY OF CON LAWS

Ensure an adequate supply of HC?

Limited supply of dialysis clinics (Ford and Kaserman, 1993)

Limited supply of hospice care (Carlson et al., 2010)

Fewer hospitals per capita (Stratmann and Russ, 2014)

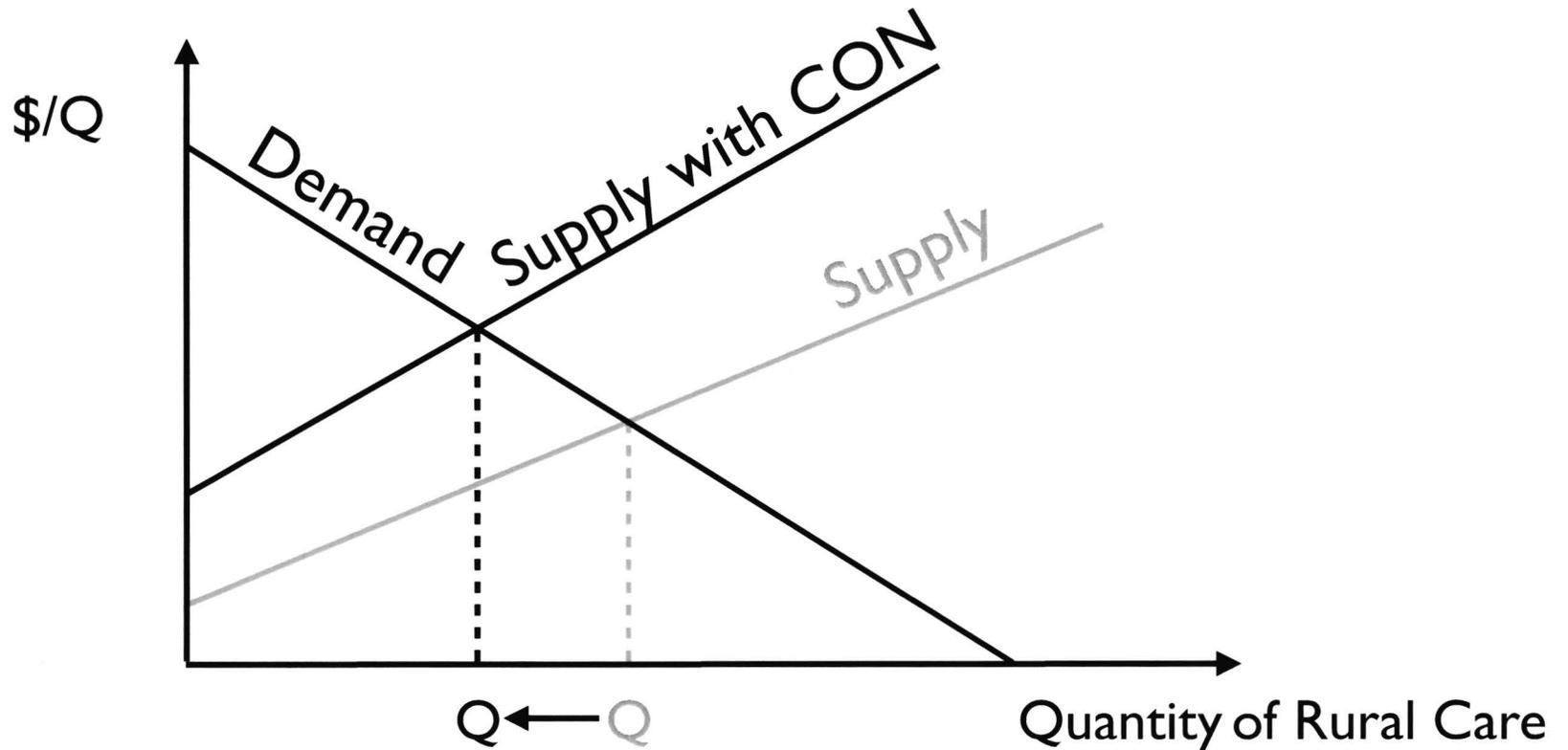
Fewer hospital beds per capita (Stratmann and Russ, 2014)

Fewer hospitals with MRIs (Stratmann and Russ, 2014)

More out-of-state CT, MRI, PET scans (Stratmann and Baker, 2016)

THE REALITY OF CON LAWS

Ensure rural access to HC ?



THE REALITY OF CON LAWS

Ensure rural access to HC ?

30% fewer rural hospitals (Stratmann and Koopman, 2016)

Less access to rural hospice (Carlson et al., 2010)

Longer travel distance to care (Cutler et al., 2010)

THE REALITY OF CON LAWS

Promote high quality HC ?

Scale competence

Less competition: lower quality

X-inefficiencies

Unproductive entrepreneurship

THE REALITY OF CON LAWS

Promote high quality HC ?

Mixed evidence on individual conditions (Vaughan-Sarrazin, 2002; Cutler et al, 2010; Ho et al., 2009)

No effect on all-cause mortality (Bailey, 2016)

Higher death rates from treatable complications following surgery (Stratmann and Wille, 2016)

Higher mortality rates following heart failure, pneumonia, heart attacks (Stratmann and Wille, 2016)

THE REALITY OF CON LAWS

Promote charity care?

No evidence of higher rates of charity care
(Stratmann and Wille, 2016)

Greater racial disparity in the provision of
services (DeLia et al., 2009)

THE REALITY OF CON LAWS

Encourage hospital substitutes?

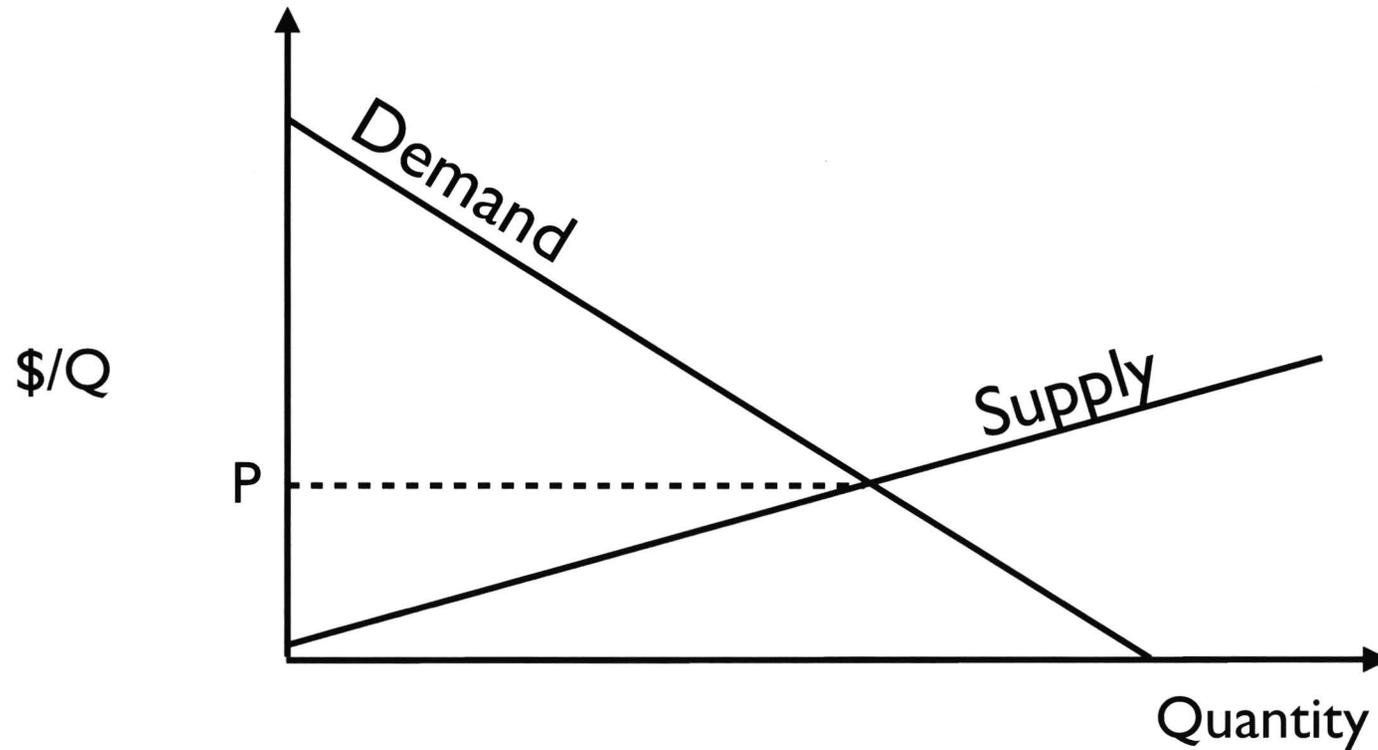
ASC-specific CON states have 14% fewer ASCs per capita (Stratmann and Koopman, 2016)

ASC-specific CON states have 13% fewer rural ASCs per capita (Stratmann and Koopman, 2016)

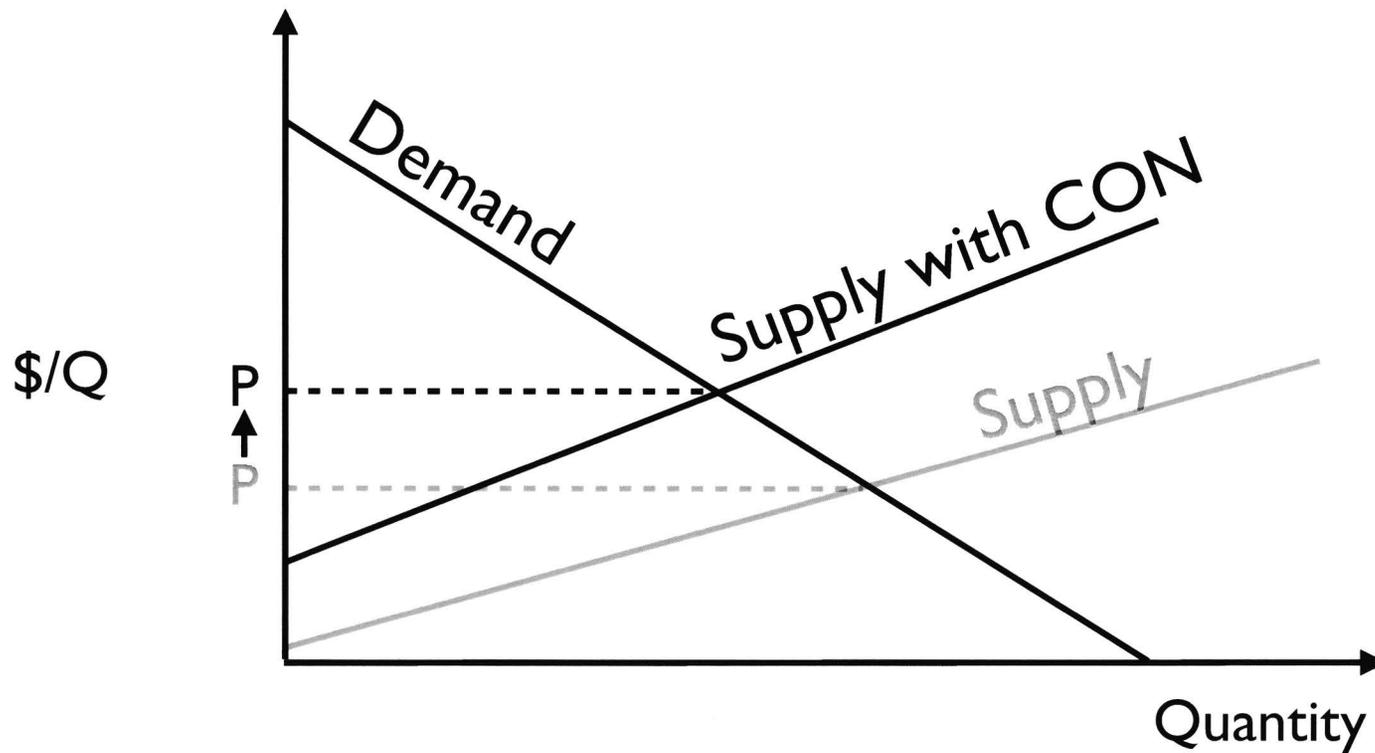
CON states have fewer non hospital providers of medical imaging services (Stratmann and Baker, 2016)

Do CON LAWS Restrain the cost of care?

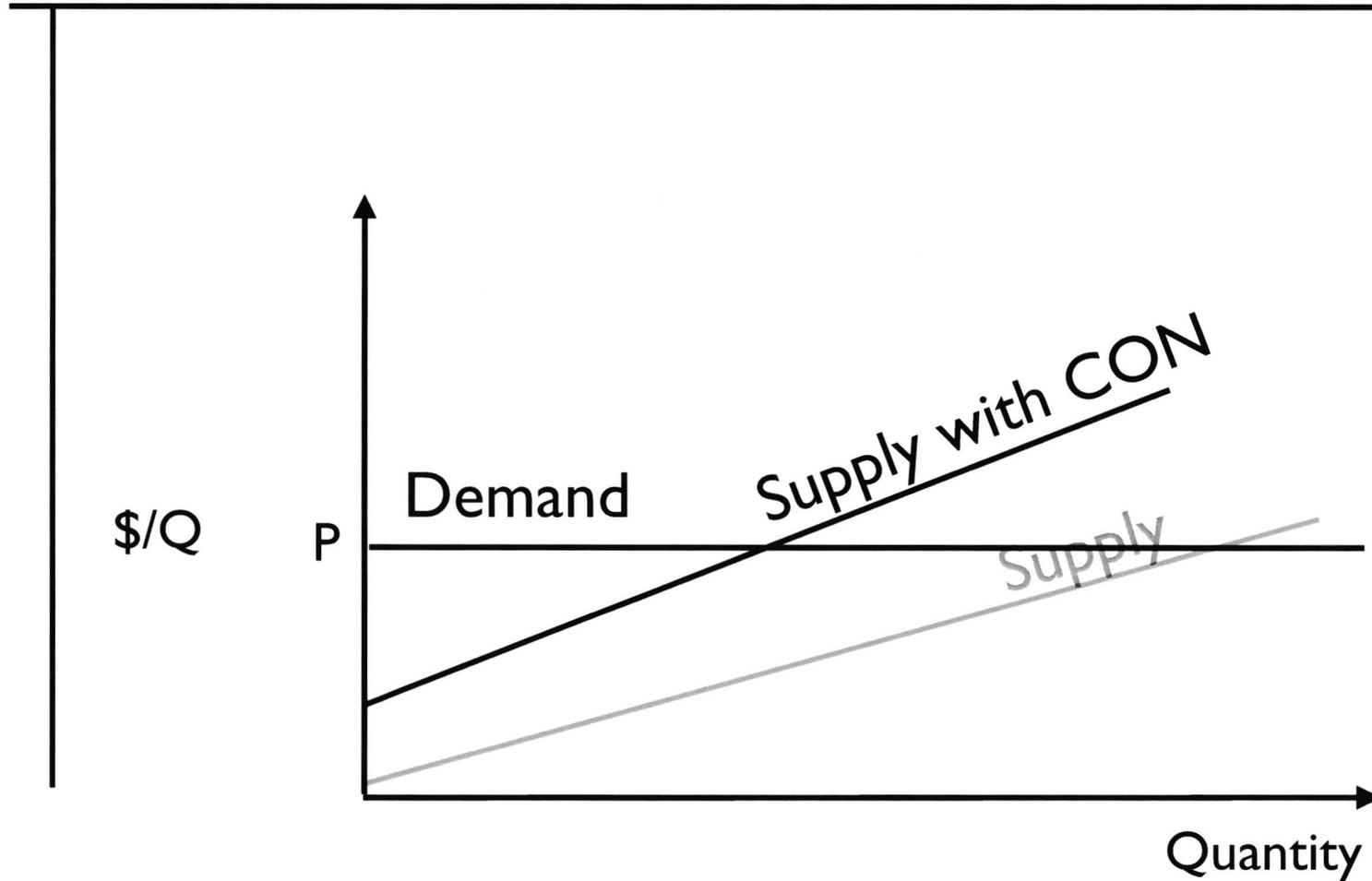
Do CON LAWS Restrain the cost of care?

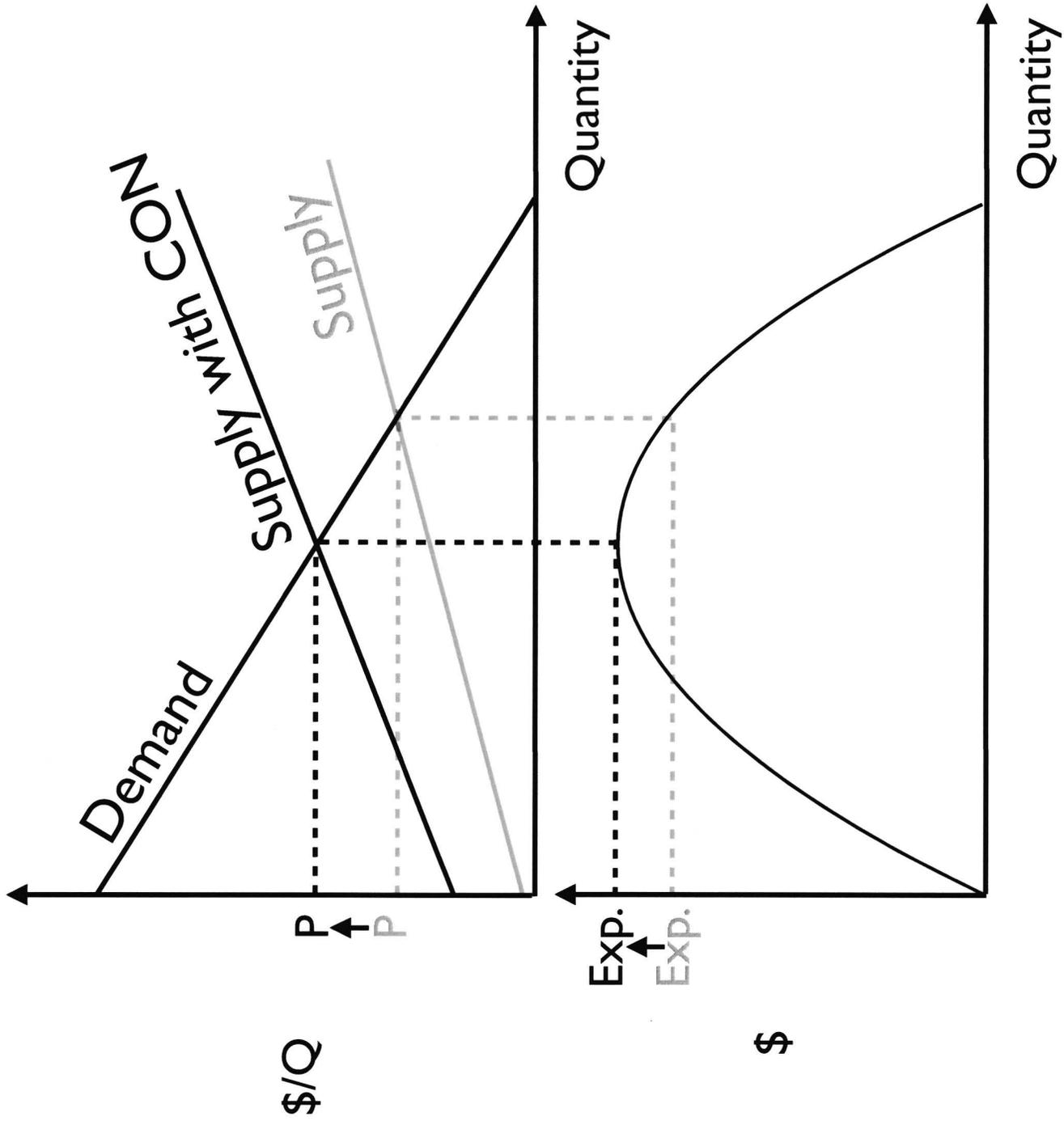


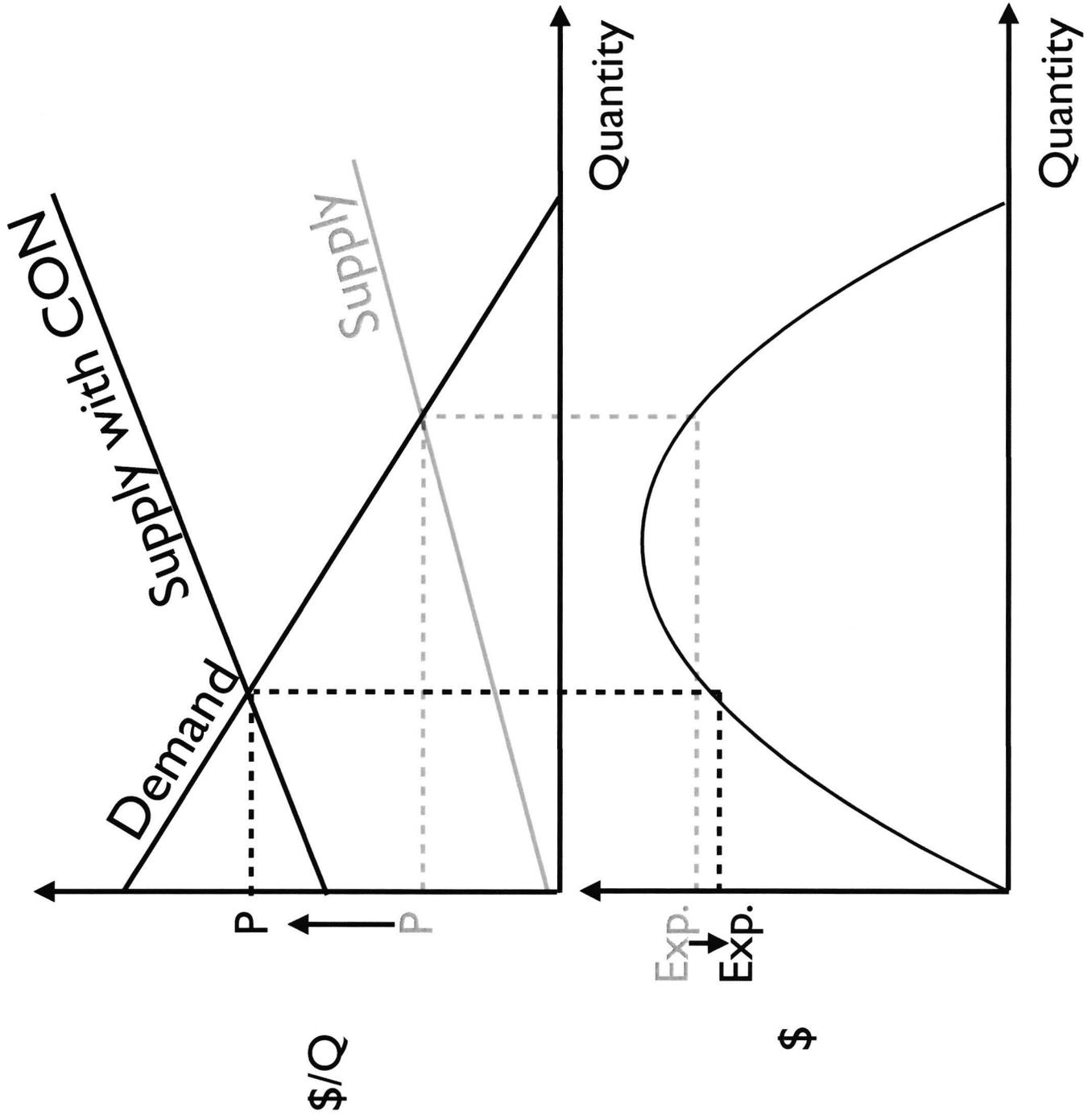
Do CON LAWS Restrain the cost of care?



Do CON LAWS Restrain the cost of care?







Do CON LAWS Restrain the cost of care?

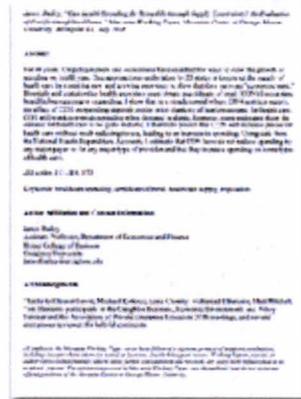
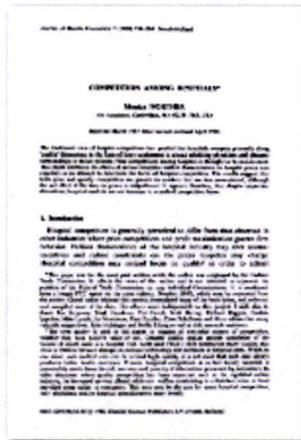
4 decades of research

20 studies

only peer reviewed

Do CON LAWS Restrain the cost of care?

Per Unit Cost or Price

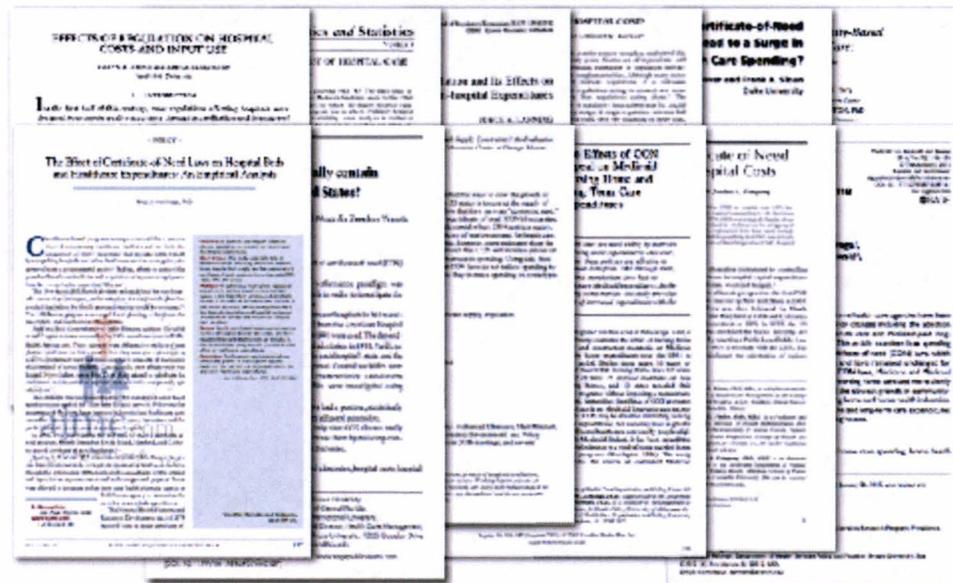


3 studies: CON associated with higher cost

1 study: No detected effect on Medicaid costs

Do CON LAWS Restrain the cost of care?

Total Expenditures



- 7 studies: CON increases expenditures
- 2 studies: No statistically significant effect
- 2 studies: Increases some expenditures and reduces others
- 1 study: Reduces the number of beds

Do CON LAWS Restrain the cost of care?

Hospital Efficiency



- 2 studies: CON increases some measures of efficiency
- 1 study: CON has no effect on efficiency
- 1 study: CON reduces efficiency

Do CON LAWS Restrain the cost of care?

Investment



1 study: CON fails to reduce investment but changes its composition

1 study: CON backfires, increasing investment

THE ECONOMICS OF

CON LAWS IN HEALTHCARE

Matthew Mitchell
Senior Research Fellow
mmitchell@mercatus.gmu.edu
mercatus.org

COLLEGE OF MEDICINE

FLORIDA STATE UNIVERSITY



Florida Certificate of Need Program House of Representatives, Health Innovation Subcommittee

January 11, 2017

Marshall B. Kapp, J.D., M.P.H.

Florida State University
Center for Innovative Collaboration in Medicine
and Law

State Authority to Regulate Health Resources



- Inherent state police power (reserved to the states by the 10th Amendment) to protect and promote the general health, safety, welfare, and morals of the population

Policy Rationales for CON



- Generally, competition is a good thing for consumers, **but** *health care* has some distinctive characteristics compared to other kinds of consumer goods and services, namely:



- 1. Supply creates its own demand
 - Consumers cannot judge their needs (lack knowledge)
 - Health care has a special priority
 - Consumers are largely insulated from costs by insurance/Moral hazard
 - “A bed **built** is a bed **filled** is a bed **billed**.” Roemer’s law



- 2. Many health care dollars are ***public*** dollars (e.g., Medicaid), unnecessary or inappropriate spending is bad.



- 3. Unbridled marketplace entry or expansion allows for market segmentation by financial/health insurance status, i.e., Cherry-picking or Skimming.



- When the poor are left behind, there is no opportunity for cost spreading. Providers servicing them must either:
 - Raise prices for everyone else (including the publicly insured) (but there are limits) or
 - Skimp on quality or
 - Go out of business (totally or partially), impairing consumer access to services



- One way or the other, we must pay for the poor. Society will not let uninsured people die in the street. Providers cannot pick and choose their patients.
 - EMTALA
 - Restrictions on transfers and discharges
 - Provider missions



- The best and most economical way to pay for their care is to integrate everyone within the same providers and spread/subsidize the costs.



➤ 4. Unbridled competition for human talent and patients may impede quality of care

- Providers may have to skimp to remain \$\$ viable.
- Providers may have reduced volume (which correlates to quality) because patients are too spread out.
- Human resources (including volunteers) are insufficient to properly staff all the providers.



- 5. Health care policy picture is very uncertain and unsettled now. This is ***not*** the time to introduce further chaos by radical change that may or may not be consistent with future health policy direction.

Resource



- Marshall B. Kapp & Leslie M. Beitsch, *Florida's Health Care Certificate of Need*, Miami, FL: Health Foundation of South Florida (Jan. 2014), available at http://hfsf.org/certificate_of_need.pdf.

The Effect of Certificate of Need Laws on Healthcare Quality and Spending

James Bailey
Assistant Professor
Department of Economics and Finance
Creighton University

CON and All-Cause Mortality

- Main finding: CON does not affect mortality
- Specifically, states adding or repealing CON restrictions does not affect overall mortality in a statistically significant way
- Source: ["The Effect of Certificate of Need Laws on Mortality"](#)
 - (James Bailey, *Health Services Research* 2016)

Specific CON Restrictions

Certificate of Need Coverage Summary
By State, 2010

State	Services/Equipment	Acute Hospital Beds	Air Ambulance	Ambulatory Surgery Ctrs.	Burn Care	Cardiac Catheterization	CT Scanners	Gamma Knives	Home Health	Hospice	ICF/MR	LTAC	Lihotpay	Nursing Home Beds/LTC Beds	Medical Office Buildings	Mobile HI Tech	MRI Scanners	MCU	Obstetric Services	Open Heart Surgery	Organ Transplant	PET Scanners	Psychiatric Services	Radiation Therapy	Rehab	Renal Dialysis	Res Care/Assisted Living	Subacute Services	Substance Abuse	Swing Beds	Ultra-sound	Number of Services/Equip
Alabama	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	20
Alaska	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	19
Arkansas	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	6
Connecticut	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	17
Delaware	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	8
Dist. of Columbia	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	28
Florida	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	11
Georgia	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	17
Hawaii	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	27
Illinois	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	15
Iowa	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	9
Kentucky	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	18
Louisiana	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	3
Maine	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	24

Source: American Health Planning Association website

Other Literature on CON and Mortality

Table 1: Literature on CON and Mortality

Paper	Effect of CON of Mortality	Years Studied	States Studied	Dataset	Mortality Measured Among
Vaughan-Sarrazin et al. 2002	-22%	94-99	50	Medpar	CABG patients
Popescu et al. (2005)	-6%	98-00	50	Medpar	AMI patients
Ho (2006)	-2.50%	88-00	49	HCUP	CABG patients
Robinson et al. (2001)	0	94-99	PA	PHC4	CABG patients
DiSesa et al. (2006)	0	00-03	50	STS	CABG patients
Popescu et al. (2006)	0	00-03	50	Medpar	AMI patients
Cutler et al (2010)	3.50%	94-03	PA	PHC4	CABG and PTCA patients
Stratmann & Wille (2016)	2.5-5%	11-15	34	CMS	Pneumonia, Heart Attack, Heart Failure patients
Shortell & Hughes (1988)	5%	83-84	45	Medpar	Patients w/ 1 of 16 conditions
Ho et al (2009)	10%	89-02	50	Medpar	CABG and PCI patients

Notes: PHC4 data is from the Pennsylvania Health Care Cost Containment Council. STS data is from the Society of Thoracic Surgeons' National Cardiac Surgery Database. HCUP is the Healthcare Cost and Utilization Project. Medpar is Medicare claims data.

CON and Spending

- Main finding: CON increases health care spending by 3.1%
- CON restricts the supply of health care. This leads to higher prices paid and lower quantities used.
- Source: [“Can Health Spending Be Reined In Through Supply Constraints? An Evaluation of Certificate of Need Laws”](#)
 - (James Bailey, Mercatus Center Working Paper 2016)

Other Literature on CON and Spending

Table 1. Summary of Literature on CON and Spending

Study	Empirical Strategy	Findings: Effect of CON
Rivers et al. (2010)	State FE, Hospital controls	0% effect on hospital spending; strict CON increases hospital spending 4.9%
Conover and Sloan (1998)	State FE	Decreases hospital spending 5%, overall spending 0%
Lanning et al. (1991)	2SLS	Increases hospital spending 20.6%, overall spending 13.6%
Hellinger (2009)	GEE	Decreases hospital beds by 10%, which in turn decreases spending by 1.8%
Grabowski et al. (2003)	State FE	Changes Medicaid nursing home expenditures 0%

Source: Bailey 2016



Implications of Certificate of Need Deregulation in the State of Florida



John Couris, President & CEO
jcouris@jupitermed.com · 561.263.2020

 inventinghealth.blogspot.com

 /jcouris

 @jcouris



- 1. Deregulation As We Understand It**
- 2. Research Review Summary**
- 3. Case Study – State of Texas After Healthcare Deregulation**
- 4. For vs. Against Certificate of Need**
- 5. Independent Not-For-Profit Operator’s Perspective**
- 6. Proposed Recommendation**
- 7. Final Thought**

Deregulation As We Understand It



Government Perspective

Deregulation is believed by some in government to improve quality, cost and access, while others in government feel it will have the opposite effect.

Healthcare Perspective

Deregulation will alter quality of care, change reimbursement ratios, open the market to an endless number of competitors, impact where services are placed, and shift the demographic of the patient population.

Independent Community Hospital Perspective

Deregulation will lower quality and clinical outcomes, increase cost to the consumer, affect future growth of services, and alter access for the community.

Research: For/Against Certificate of Need



Reviewed 16 studies, with 9 in support and 7 against Certificate of Need Laws.

FOR – Certificate of Need
Cost
2006 – HealthLeaders-InterStudy
2012 – Michigan’s Manufacturers Association
2009 – American Journal of Managed Care
2007 – Medical Care Research and Review
2007 – American Heart Journal
2002 – Chrysler Corporation
Quality
2007 – American Heart Journal
2002 – JAMA
Access
2004 – Foresight/Kentucky Policy

AGAINST – Certificate of Need
Cost
2016 – Mercatus Center
2013 – Michigan State University
2007 – The Lewin Group
Quality
2016 – Mercatus Center
Access
2016 – Mercatus Center
2015 – American Bar Association
2008 – Annals of Surgical Oncology

Case Study: State of Texas Healthcare Deregulation



- In the non-CON regulated state of Texas, specifically the Dallas-Fort Worth market, deregulation has driven up costs and encouraged redundancy of medical facilities and services.*
- In 2013, the Dallas-Fort Worth market was in the midst of an explosion in physician-owned health care businesses, and health care costs in the area tended to be significantly higher than elsewhere.*
- Proliferation of free-standing Emergency Rooms has resulted in staffing issues and strain on finite resources; costs have not been reduced as expected, instead patient costs have increased.

*Source: 2006, HealthLeaders-InterStudy

 JUPITER MEDICAL CENTER

Certificate of Need Proponents vs. Opponents



FOR CERTIFICATE OF NEED

AGAINST CERTIFICATE OF NEED

Cost

- Lowers the cost of care by applying the *economies of scale* principle

- Costs decrease as hospitals will compete on price
- Rules of supply & demand would prevent oversupply of beds & services

Quality

- Better medical outcomes – concentrated services and volumes at fewer facilities.
- Channels more procedures through fewer hospitals, allowing those hospitals to gain expertise.

- Quality increases due to more competition

Access

- Ensures the effective supply of resources for community need
- Provides public input and accountability to the health care consumer
- Encourages the use of lower-cost hospital substitutes
- Provides for charity care

- CON stifles competition
- CON propagates monopolies
- Non-CON provides more community choice

Independent Not-For-Profit Operator's Perspective



Independent Community Hospitals in Florida:

- 39 independent acute care hospitals (about 20% of all hospitals in Florida)
- 6,000 patient beds
- Employing over 49,000 full-time employees, and hundreds of thousands of part-time employees

Certificate of Need Deregulation Will Cause:

- **Higher Cost:** For-profit hospitals/systems are higher cost options
 - In our market, for-profit systems are the highest cost providers
 - St. Mary's (Tenet): \$18,850 vs. Jupiter Medical Center: \$9,038 (average managed care reimbursement per admission)
- **Lower Quality:** Diluting fixed volume of services spread over a greater number of programs puts quality of programs at risk
- **Less Access:** Not all hospitals provide same level of uncompensated care
- **Currently excess capacity in our sub-district:**
 - Good Samaritan Medical Center: 38% Occupancy
 - JFK North: 46% Occupancy
 - St. Mary's Medical Center: 64% Occupancy
 - Jupiter Medical Center: 66% Occupancy
 - Palm Beach Gardens Medical Center: 69% Occupancy

Recommendation



It is our recommendation to continue Certificate of Need regulation for acute care hospitals in the state of Florida.

Deregulation of service lines is a viable option for other types of services such as recovery care centers attached to surgery centers, so long as the volume thresholds and quality requirements for these programs continue to be regulated and highly monitored.

Final Thought



- **We recognize there is no pending legislation for deregulating Certificate of Need, but as our leaders you are contemplating the pros and cons.**
- **In your review, ask yourselves what is broken in the current healthcare system that would be repaired by deregulating Certificate of Need. Would changing Florida’s healthcare planning process through Certificate of Need improve healthcare for your community & constituents?**

“CON regulation is here to stay, if for no other reason than it provides an established public forum at the local level, where healthcare is personally meaningful, for stakeholders to discuss, debate and decide what kind of healthcare access and services they need and want for themselves.”

-2006 HealthLeaders-InterStudy

Richard K. Thomas, Ph.D.

Richard K. (Rick) Thomas, Ph.D., has spent four decades in health services research and planning. A native Memphian, he began his professional career with the Memphis Regional Medical Program and helped establish the research department at Baptist Memorial Hospital before embarking on a consulting career. He has had a long career in health planning in both the public and private sectors and was partly responsible for the development of the field of health demography. He has taught courses in health planning, healthcare marketing and health services research. He is an expert on health data and has led numerous workshops on the application of health data in health planning and serves on the board of the American Health Planning Association. He currently provides consultation services to hospitals, physician practices, health plans, and other healthcare organizations. Dr. Thomas holds a Ph.D. in medical sociology from Vanderbilt University and has authored dozens of articles and over twenty books on healthcare (including *Health Services Planning*). He holds faculty appointments at the University of Tennessee Health Science Center and the University of Mississippi.



Matthew D. Mitchell

Matthew D. Mitchell is a Senior Research Fellow and Director of the Project for the Study of American Capitalism at the Mercatus Center at George Mason University. He is also an adjunct professor of economics at Mason. In his writing and research, he specializes in public choice economics and the economics of government favoritism toward particular businesses, industries, and occupations. Mitchell has testified before the US Congress and has advised several state and local government policymakers on both fiscal and regulatory policy. His research has been featured in numerous national media outlets, including the *New York Times*, the *Wall Street Journal*, the *Washington Post*, *US News and World Report*, National Public Radio, and C-SPAN. He blogs about economics and economic policy at Neighborhood Effects and at Concentrated Benefits. Mitchell received his PhD and MA in economics from George Mason University and his BA in political science and BS in economics from Arizona State University.



Marshall B. Kapp

Marshall B. Kapp was educated at Johns Hopkins University (B.A.), George Washington University Law School (J.D. with Honors), and Harvard University School of Public Health (M.P.H.). He is the Director of the Florida State University Center for Innovative Collaboration in Medicine and Law, with faculty appointments as Professor, Department of Geriatrics, FSU College of Medicine, and Professor of Medicine and Law in the FSU College of Law. He also is a Faculty Affiliate of the FSU Pepper Institute on Aging and Public Policy and the FSU Institute for Successful Longevity. He is an Adjunct Professor, Stetson University College of Law (teaching in the Elder Law LLM program).



Previously, Kapp served as the Garwin Distinguished Professor of Law & Medicine at Southern Illinois University School of Law and School of Medicine and as Co-Director of the School of Law's Center for Health Law and Policy (2003-2009). He is Professor Emeritus from the School of Medicine at Wright State University, where, from 1980 through 2003, he was a faculty member in the Departments of Community Health and Psychiatry and taught courses on the legal and ethical aspects of health care. He also was Director of WSU's Office of Geriatric Medicine and Gerontology and held an adjunct faculty appointment at the University of Dayton School of Law.

From 1998-2001, he was designated Wright State University's Frederick A. White Distinguished Professor of Service. He is the author or co-author of a substantial number of published articles, book chapters, and reviews. Mr. Kapp was the founding editor (2000-2005) of the *ETHICS, LAW, AND AGING REVIEW* (formerly the *Journal of Ethics, Law, and Aging*, 1994-1999) formerly published by Springer Publishing Company and founding editor (1994-2006) of Springer's Book Series on Ethics, Law and Aging. Additionally, he served from 2004-2010 as the Editor of the *Journal of Legal Medicine*, the official scholarly publication of the American College of Legal Medicine, and was named as an Editor Emeritus of JLM in 2010. He currently serves as the Editor of the Social Science Research Network (SSRN) e-Journal *Medical-Legal Studies* and as the Associate Editor of the "Liability" section of the *International Journal of Risk and Safety in Medicine*. He is a Fellow of the Gerontological Society of America and of the American College of Legal Medicine and served as Secretary of the American Society on Aging from 2003 to 2006. He spent the 1987-88 academic year on Professional Development Leave as a Robert Wood Johnson Foundation Faculty Fellow in Health Care Finance. In 1997, he received the *Journal of Healthcare Risk Management* Award for Writing Excellence as Author of the Year from the American Society for Healthcare Risk Management. In 1998, he was named Ohio Researcher of the Year by the Ohio Research Council in Aging. In 2003, he received the Donald Kent Award of the Gerontological Society of America for exemplifying "the highest standards for professional leadership in gerontology through teaching, service, and interpretation of gerontology to the larger society." In 2009, he received the American College of Legal Medicine Gold Medal, the highest award given by ACLM for service, professionalism, and dedication to the field of legal medicine.

James Bailey

James Bailey is an assistant professor of economics at the Heider College of Business at Creighton University. He was previously a visiting instructor at the University of West Florida. He received his PhD in economics from Temple University in 2014, and received his B.S. in economics from the University of Tulsa in 2009. His research has focused on the effects of government regulations, including Certificate of Need laws, on health care, health insurance and entrepreneurship. His work has been published in *Health Services Research*, *Applied Economics*, and the *Journal of Health Economics*.



John D. Couris

John D. Couris serves as President and Chief Executive Officer of Jupiter Medical Center, the region's leading medical center. Under Mr. Couris' leadership, Jupiter Medical Center has continued to expand its services and forge innovative partnerships with some of the leading providers in the nation—from Mount Sinai, New York to Nicklaus Children's Hospital (formerly Miami Children's) and NuVista Living—with the primary goal of providing world-class care to its patients at every stage of their health care journey. In the process, Jupiter Medical Center has received numerous accolades for hospital quality, safety and patient satisfaction, including an A rating for hospital safety from the Leapfrog Group and a 4-star rating for quality of care from the Centers for Medicare and Medicaid Services, the highest ranking a hospital received in either Martin or Palm Beach Counties. This 4-star rating places the organization in the top 10% within the state of Florida and the top 20% in the nation. With Mr. Couris at the helm, Jupiter Medical Center has been able to become an innovative and entrepreneurial organization in one of the most highly regulated industries in the country.



Mr. Couris' time at Jupiter Medical Center has been marked as a period of expansion and innovation coupled with high level financial performance. Under his leadership, Jupiter Medical Center has established a clinically-integrated network with over three hundred physicians in order to provide high quality low cost care to the organization's team members, community and regional businesses. At the same time, he led his team to reduce the organization's overall expense by \$15 million while increasing revenue over the last five years. Jupiter Medical Center has also seen an increase in market share in all major service and product lines under Mr. Couris.

During his tenure, Jupiter Medical Center completed a \$50 million expansion plan, installed \$30 million in medical technology and established the hospitals' new pediatric wing as well as the oncology campus. Finally, and under Couris' leadership, the organization is in the midst of raising 300 million dollars to meet the region's growing demand for critical health services, such as advanced cardiac care, expanded pediatric services and comprehensive stroke care. In addition, funds raised through the campaign will also support the construction of new high-tech treatment and research facilities, including a Comprehensive Cancer Institute at Jupiter Medical Center.

Mr. Couris is active in numerous community and philanthropic activities and serves on the board of the Maltz Jupiter Theatre, where he serves as Chairman, MyClinic (a free clinic for the uninsured), the Loggerhead Marinelife Center and The Honda Classic. In addition, he is Chairman of the Board of the Palm Beach North Chamber of Commerce and active in many national professional health associations. Mr. Couris is the recipient of multiple awards, including being named one of the top 10 "Ultimate CEOs" in Palm Beach County as well as "Power Leader in Health Care" for 2014, 2015 and 2016 by the *South Florida Business Journal*. In 2014, he was awarded the "Healthcare Professional of the Year" by the Chamber of the Palm Beaches and was named the "Healthcare Business Leader of the Year" by the Palm Beach Medical Society. John is also an active member of the Young Presidents Organization (YPO).

Prior to coming to Jupiter Medical Center, Mr. Couris served as Chief Operating Officer/Administrator for Morton Plant North Bay Hospital, part of the BayCare Health System in Tampa Bay, Florida. He began his career at Massachusetts General Hospital (MGH) in Boston, Massachusetts. Mr. Couris is a graduate of Boston University and holds a Master of Science in Management from Lesley University in Cambridge, Massachusetts.

Daniel S. Yip, M.D.

Daniel S. Yip, M.D. is a Consultant in the Department of Transplant, Mayo Clinic, Jacksonville, FL. He joined Mayo Clinic in 2001 to start the heart transplant program in Mayo Clinic in Florida. He currently serves as medical director for Advanced Heart Failure, Mechanical Circulatory Support, and Transplantation.

Dr. Yip's other roles include medical director for Patient Experience Surveying at Mayo Clinic, medical director for Patient Experience at Mayo Clinic in Florida, and medical director for Pharmacy at Mayo Clinic in Florida. Dr. Yip is a member of the Communication in Health Care faculty.

A native of California, Dr. Yip completed his undergraduate degree at University of California, Los Angeles. He obtained his medical degree at American University of the Caribbean. He completed his Internal Medicine Residency, Cardiovascular Diseases Fellowship, and Advanced Heart Failure and Transplantation Fellowship at St. Louis University School of Medicine.



