

**TESTIMONY ON BEHALF OF THE  
MEDICAL SOCIETY OF THE STATE OF NEW YORK  
PRESENTED BY RICK ABRAMS, JD  
BEFORE THE PLANNING COMMITTEE OF THE  
STATE HOSPITAL REVIEW AND PLANNING COUNCIL (SHRPC)  
July 23, 2008  
Albany, New York**

My name is Rick Abrams, JD. I am the Executive Vice-President of the Medical Society of the State of New York. On behalf of the Medical Society and its twenty-five thousand physician members, I want to thank you for inviting MSSNY here today to discuss proposed reforms to the certificate of need (CON) process. First, let me state for the record that the Medical Society unequivocally supports the goal of the Committee which is to assure the appropriate alignment of health care resources with community needs. This objective is very important, particularly now that the members of the baby boomer generation age into retirement and their health needs become more intensive at a time when the economic realities of our state and our health care delivery system are becoming more fragile. The Medical Society is committed to work with all interested parties to assure that the iron triangle of cost, access and quality remains robust, responsive to community need and efficient.

As you know, in 1964 New York became the first state in the nation to enact a statute that required a governmental determination of need before any hospital or nursing home was constructed. Thereafter, the American Hospital Association embraced CON laws and began a national campaign for states to

generate their own CON laws. By 1975, 20 states had enacted CON laws; and by 1978, prompted in part by the enactment of the 1974 National Health Act, 38 states had enacted a CON law. The National Health Act provided substantial federal funding for state and local health planning activities. These funds, however, were conditioned upon the enactment of CON laws.

Understanding the underpinnings for the establishment of CON laws and, indeed, for Congressional support back in 1974 for state/local health planning activities and CON laws is essential to our discussion today. CON was intended to achieve three health care goals: restrain skyrocketing health care costs; prevent the unnecessary duplication of health service resources; and achieve broad access to quality health care at a reasonable cost. CON laws were premised on the theory that the structure and incentives inherent in the health care industry lead to overinvestment and that unneeded health care resources contribute significantly to inflation in health care costs. When a hospital cannot fill its beds, fixed costs must be met through higher charges for the beds that are used. When these laws were first enacted, prevailing theory held that the cost of excess supply was ultimately borne by third party purchasers and then passed on to the health care consumer in the form of higher premiums and costs for services. At that time, our reimbursement system was largely based on fee-for-service reimbursement. Those fee-for-service reimbursement rates typically included “overhead” including both operating costs and capital expenditures of health care providers. While overhead payments were initially made by the third

party payor, lawmakers believed that the costs were ultimately borne by the public through higher taxes for care provided to the Medicare and Medicaid population or through higher premiums charged by commercial carriers. It was this premise in addition to affordability and access concerns which served as an additional basis for government regulation of institutional establishment. Little in the payment structure of the 1950's, 1960's, or 1970's had operated to deter unnecessary construction because costs were passed on through higher fees. Consequently, a CON system was necessary to regulate the number of beds in hospitals and nursing homes and to prevent overbuying of expensive equipment. New or improved facilities or equipment would be approved only upon a showing of genuine need in a community.

As you know, the federal mandate of 1974 was repealed in 1987 along with its federal funding because it was felt that the CON laws had failed to effectuate a reduction of the nation's aggregate health care costs. Moreover, in certain areas of the country, CON laws were viewed as often producing detrimental effects in local communities. In the decade that followed, 14 states discontinued their CON programs.

Cost-based reimbursement which had provided a major rationale for the CON program is much less common today. This reality has sparked debate as to whether CON programs still have a role to play in the health care marketplace. Advocates of CON programs argue that market forces do not apply the same

rules for health care as they do for other products. "Supply generates demand". Patients don't shop for services, rather physicians "order" services such as lab tests and x-rays. The number of physicians affiliated with a hospital will affect the number of patients treated which will impact upon the number of tests ordered. Moreover, CON proponents support such programs as a means by which limited community resources can be allocated among priority services.

CON opponents, however, oppose CON programs because they believe that such programs may actually keep prices artificially high because they unfairly restrict entry into the market of competitive alternatives. Moreover, CON opponents contend that CON programs can serve to delay the entry into a market of more innovative and more effective treatment modalities. CON opponents also maintain that Certificates of Need many times are not granted based on objective analysis of community need but rather are often granted on the basis of political influence, institutional prestige or other factors apart from the interests of the community. The Federal Trade Commission, Department of Justice in its report entitled *Improving Health Care: A Dose of Competition (2004)* concluded that "CON programs are generally not successful in containing health care costs and that they can pose anticompetitive risks...CON programs risk entrenching oligopolists and eroding consumer welfare....for these reasons the Agencies urge states with CON programs to reconsider whether they are best serving their citizens' health care needs by allowing these programs to continue".

It is not my intention today to embrace either side of this debate except to say that all of these considerations should be fully analyzed as you deliberate the questions appended to your letter of invitation.

I would like to make the following observations and recommendations.

1) Respectfully, I am not unmindful of the fact that this is the Planning Committee of the State Hospital Review and Planning Council. While several of you are physicians and may also be members of the Board of Trustees from your respective institutions, I am here today to represent the interests of all practicing physicians in every practice configuration. As professionals committed to the improvement of our health care delivery system, we respect and embrace our symbiotic relationship with the hospitals and nursing homes within our community. Our institutions are the centerpiece of a health care delivery system which is revered by the entire world. However, there are many interests driven by community need and other legitimate consideration which can be viewed to be in competition with our institutions. Physician-driven ambulatory surgery centers, imaging services and even office-based surgery practices have often been perceived to be competitive alternatives to the services traditionally thought to be exclusively delivered through hospital or hospital owned facilities. This is as much an emerging technology driven phenomenon as it is a policy modification based on market force re-evaluation.

All interests within a community must be considered. Across the state there are communities which have a proven track record of collaboration on delivery system issues. It may be appropriate to borrow from their success and to consider the establishment of community based advisory committees which would operate on a regional level across the state and which would be comprised of all affected stakeholders including representatives from larger physician groups and county medical societies which could be used to help to identify existing community resources and to project community need. We note that the recently published RFP for HEAL NY 9 signals a move on the part of the State to shift health planning to the local level. This shift is premised upon the idea that local planning will discourage duplication of resources and more accurately identify healthy needs. We believe that such an initiative has a great deal of merit.

2) This body and the Public Health Council (PHC) have both labored over the years to explore the issues and concerns related to the provision of certain services including surgical procedures and imaging services at non-hospital or non-hospital owned facilities. In 2003, a report entitled *Out-Migration of Services from Hospitals* was issued by the Emerging Policy Issues Workgroup composed of several members of SHRPC and the PHC. The report describes the factors which are contributing to the increase in the development of ambulatory surgery centers, office based surgery practices and diagnostic imaging centers and their impact on quality, cost and access. Much of the focus of the report, however, is on how the development of these new service sites are impacting

upon the hospital community and the work of the SHRPC and PHC.

Consequently, in 2005, at the urging of the hospital community, the Public Health Council conducted a review of ambulatory surgery centers in New York State. Concern had been expressed that ASCs “were representative of the “niche” provider trend..selective [of] more lucrative services ..being removed from hospitals into the private sector, leaving hospitals with obligations for services that cannot be cross-subsidized by the provision of better compensated services”. The Council discussed and did not support the idea of putting restrictions on submission of applications for freestanding non-hospital sponsored ambulatory surgery centers, in part because it was anticipated that the Commission on Health Care Facilities in the 21<sup>st</sup> Century was about to begin its work and it was felt that it would be unwise to place any barriers on potential restructuring opportunities. Notably in a letter from the Chairman of the Public Health Council, it was determined that expansion of ASCs in New York State peaked between 1998 and 2001 and their number when compared to other states is not excessive. Importantly, it was also determined that “from a public policy perspective, the application process appears to have largely run its course and does not, at this time, warrant active intervention on the part of policy changes within the state”. The letter does note, however, that the surge in applications (which occurred between 1999 and ended in 2001), occurred prior to any review process based upon hospital consequences. The number of applications decreased significantly after a work group of PHC and SHRPC

members in 2000 developed supplemental information requirements related to hospital consequences.

Clearly, health system planning must necessarily involve a review of the impact of new service providers on existing health care providers and facilities, whether they are hospital sponsored or physician owned. A wide range of factors have fostered the development of ASCs, office-based surgical practices and imaging centers. They have proven to be high quality, cost efficient alternatives which allow for expeditious patient access to innovative, state-of-the-art services. Consumer demand for such service centers continues to grow and must be considered as planners continue to review further system development into the future.

3) Another facet to this discussion which must be examined is the recent approval by the Department of Justice of the concept of efficiency through clinical integration. The need for greater collaboration among health care providers has never been more compelling. Persistent fragmentation contributes to gaps in quality and efficiency that adversely impact providers and their patients. A number of commentators, including the IOM, advocate linking provider payment to provider performance on quality measures, because such an approach is “one of several mutually reinforcing strategies that collectively could move the health care system toward providing better-quality care and improved outcomes.” To be effective, clinical integration needs to foster collaboration by aligning hospital and

physician incentives, encouraging them to work toward the same goals of improving quality and patient safety, and providing effective and appropriate care to create better health outcomes. Such collaboration would be beneficial to both hospitals and physicians in large group practices as well as physicians who wish to remain in solo or small group practices. They can “clinically integrate” while remaining independent and can work together in ways that enable them to reap many of the benefits of practicing as part of a larger group or in a hospital system. Clinical integration benefits a community of physicians and hospitals in many ways through: improvement in quality of care through community collaboration; improvement in quality and efficiency of independent physician practices: enabling community physicians and hospitals to perform well in pay-for-performance initiatives; and enhanced coordination of care.

The Medical Society therefore, encourages that you work to establish a framework which will foster greater clinical integration in communities across New York State where each of the integrated provider elements is viewed as complementary to rather than simply competitive with the other elements.

## **Conclusion**

Your letter of invitation asks that presentations provide concrete recommendations and you ask that our focus be on one or more of a whole series of issues which you specifically articulate. We defer to the expertise of our institutional colleagues on most of these. We do believe however that the

answers to some of your questions are clear. The CON process in its current form is overly prescriptive and rigid and neither suitable to nor necessary for the modern healthcare delivery system. The historic cost control objectives which were an important reason for creating the CON process originally, can be better served through modern devices grounded in sophisticated linkages between payment incentives and appropriate clinical care protocol adherence and outcome measurement.

We would argue, therefore, against extension of the CON process. Further, to the extent that it might remain necessary and appropriate it must become a process more flexible than has historically been the case. Attempts to extend the system will not only fail to enhance the original goals of the establishment process but will, in all likelihood, serve to seriously impede the system advances which are now occurring and which are clearly contributing significantly to cost effective, quality enhancement. The health care system of forty years ago is not the system we have today and the continued application of a process- even a substantially modified process- designed for a system which disappeared long ago must be seriously questioned. All of us share the goal which is set forth in your letter of invitation which states that “Our goal is the development of a patient-centered, high performing health care delivery system – in other words, a system that offers accessible, affordable, high-quality and cost-effective care in settings that are appropriate to the needs and preferences of

health care consumers.” In our view the current CON process does not serve this goal.

I thank you for providing the Medical Society of the State of New York with this opportunity to present our thoughts and positions on the important issues you address today. We look forward to working with you in the future on these and other matters affecting the health care needs of all New Yorkers.