# Public Hearing

before

## ASSEMBLY HEALTH AND HUMAN SERVICES COMMITTEE

"An Evaluation of the Certificate of Need Process
and Related Procedural and Policy Issues"

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**LOCATION:** Committee Room 8
Legislative Office Building
Trenton, New Jersey

**DATE:** May 6, 1993
10:00 a.m.

## MEMBERS OF COMMITTEE PRESENT:

Assemblyman Harold L. Colburn, Jr., Chairman
Assemblyman Nicholas R. Felice, Vice-Chairman
Assemblyman Stephen A. Mikulak
Assemblyman Thomas S. Smith
Assemblywoman Barbara W. Wright
Assemblywoman Loretta Weinberg
Assemblyman Louis A. Romano

## ALSO PRESENT:

David Price
Office of Legislative Services
Aide, Assembly Health and
Human Services Committee



***Hearing Recorded and Transcribed by***
The Office of Legislative Services, Public Information Office,
Hearing Unit, 162 W. State St., CN 068, Trenton, New Jersey 08625-0068

**New Jersey State Legislature**

ASSEMBLY HEALTH AND HUMAN SERVICES COMMITTEE
LEGISLATIVE OFFICE BUILDING, CN-068
TRENTON, NEW JERSEY 08625-0068
(609) 292-1646

# NOTICE OF PUBLIC HEARING

The Assembly Health and Human Services Committee will hold a public hearing on the following:

**An Evaluation of the Certificate of Need Process and Related Procedural and Policy Issues**

The hearing will be held on **Thursday, May 6, 1993, at 10:00 A.M. in Committee Room 8, Legislative Office Building, Trenton, New Jersey.**

*The public may address comments and questions to David Price, Committee Aide and persons wishing to testify should contact Helen Rouze, secretary, at (609) 292-1646. Those persons presenting written testimony should provide 12 copies to the committee on the day of the hearing.*

**PLEASE NOTE: The public hearing is in lieu of the committee meeting scheduled for the above date and time.**

Issued 4/21/93

New Jersey State Legislature

ASSEMBLY HEALTH AND HUMAN SERVICES COMMITTEE
LEGISLATIVE OFFICE BUILDING, CN-068
TRENTON, NEW JERSEY 08625-0068
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# COMMITTEE NOTICE

TO: MEMBERS OF THE ASSEMBLY HEALTH AND HUMAN SERVICES COMMITTEE

FROM: ASSEMBLYMAN HAROLD L. COLBURN, JR., CHAIRMAN

SUBJECT: **COMMITTEE MEETING - May 6, 1993**

*The public may address comments and questions to David Price, Committee Aide, or make bill status and scheduling inquiries to Pamela Chisolm, secretary, at (609) 292-1646.*

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The Assembly Health and Human Services Committee will meet on **Thursday, May 6, 1993 at 10:00 AM in Committee Room 8, Legislative Office Building, Trenton, New Jersey.**

The following bills will be considered:

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|---|---|
| AR-119<br>Farragher/Moran | Designates May 1993 as "Lyme Disease Awareness Month." |

At the conclusion of the meeting, the committee will hold a public hearing, as previously announced, on the **Certificate of Need Process.** The hearing will be continued on **Monday, May 10, 1993 at 2:00 PM in Committee Room 8, Legislative Office Building, Trenton, New Jersey,** in order to allow everyone who wishes to testify to do so.

Issued 04/30/93

New Jersey State Legislature

ASSEMBLY HEALTH AND HUMAN SERVICES COMMITTEE
LEGISLATIVE OFFICE BUILDING, CN-068
TRENTON, NEW JERSEY 08625-0068
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# COMMITTEE NOTICE

TO: MEMBERS OF THE ASSEMBLY HEALTH AND HUMAN SERVICES COMMITTEE

FROM: ASSEMBLYMAN HAROLD L. COLBURN, JR., CHAIRMAN

SUBJECT: **COMMITTEE MEETING - May 24, 1993**

*The public may address comments and questions to Robbie Miller, Committee Aide, or make bill status and scheduling inquiries to Pamela Chisolm, secretary, at (609) 292-1646.*

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The Assembly Health and Human Services Committee will meet on **Monday, May 24, 1993 at 10:00 AM in Committee Room 8, Legislative Office Building, Trenton, New Jersey.**

The following bill will be considered:

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| A-1792<br>Kelly/DiGaetano | Designated the "Health Wellness Promotion Act." |

**The committee will take testimony on this bill for one hour only, from 10:00 AM to 11:00 AM. The remainder of the meeting will be devoted to the conclusion of testimony on the Certificate of Need Process.**

Issued 05/14/93

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**ASSEMBLYMAN HAROLD L. COLBURN, JR. (Chairman):** I guess most of you are here because of our call to discuss the Certificate of Need process. As I said before, we're really not here to have you advocate your bills. I know there will be interest in bills to remediate the so-called Health Care Reform Bill -- and no doubt, other things -- and we're interested in hearing from you by mail, then in person, but not so much at this hearing.

I'd like to welcome you here today, and thank you for being here. I want to tell you about the purpose of this hearing. Given the changes wrought by our Reform Act, concerns about the CON program's susceptibility to political manipulation -- which appeared in the press -- and a recent Superior Court decision which affirmed the advisory status of the State Health Plan and invalidated certain regulations, we feel it's appropriate for our Committee to return to the CON issue, and not only go into the current status of it, but also go into the history of it so that our Committee members can better understand the process by which this is all taking place, evaluate the value of CONs, and decide what might be done in the future with respect to CONs.

We had thought in the Health Care Reform Act that we were creating a more competitive atmosphere in health care. I think that concept is controversial to some extent, even in my own mind, so I wouldn't say that our opinions are fixed. That's why we want to hear from you. If there are alternatives to the CON process to help control health care facilities, we'd like to hear about those. We know that the people in this room have a strong personal, and, perhaps, even financial interest in one side of the issue or another.

Speaking personally, I don't have a fixed position on CONs in general. I was a little leery of eliminating them altogether when our Reform Act was being written, and that runs a little bit counter to some of the philosophy, even in my own

group. So, I'm not sure that we should be eliminating CONs altogether. I think maybe some are different than others, and we ought to try to recognize that.

The first witness I'd like to call is Dr. Bruce Siegel, who is from the State Department of Health, as Commissioner.

Would you come on up here, Bruce, with anybody that you wish to bring with you? As long as they're from the Health Department. (laughter)

**C O M M I S S I O N E R B R U C E S I E G E L:** I think they're from the Health Department. I've seen them before. (laughter)

ASSEMBLYMAN COLBURN: That's good. You might want to introduce them. Bruce, before you start-- I failed to do one thing.

Currently, as far as I know, we have at least 24 people who want to speak on this subject. We have a limited time today, because we have to vote on some bills about 12:30. So my guess would be that we're only going to get to a maximum of 10 today. I'm going to tell you who the first 10 are, because we'll be coming back on Monday, and then maybe again even on May 24, if we have to. I hope we don't have to, but as you've seen, we have Dr. Siegel. We have Ralph Dean, Vincent Maressa, Sister Brady, Patrick Roche, Maurice Coffee, Jean Earle, Leonard Fishman, Judith Burgis, and Rick Abrams. They're on the list for today. So, unfortunately, we're going to have to ask the other people to return.

Dr. Siegel.

COMMISSIONER SIEGEL: All right. Thank you, Doctor/Chairman. Thank you, members of the Committee. With me from the Department of Health, are Ms. Pamela Dixon and Mr. Paul Langevin.

The Health Care Facilities Planning Act of 1971 created the Certificate of Need program to ensure that New

Jerseyans could have access to the highest quality of health care at an affordable price. In the 1990s, I believe it is more important than ever to maintain the CN program to meet its original goals.

Several states have turned away from Certificate of Need -- from health planning -- and interesting things have happened in those places. After Arizona eliminated CN regulation of nursing homes, the number of beds per 1000 persons over age 65 increased from 20.9 to 33.5, an increase of over 50 percent. Occupancy rates dropped and many homes went bankrupt, causing serious displacement problems for patients -- for the institutionalized elderly, especially.

If Arizona's nursing home experience were duplicated in New Jersey, the result would be over $600 million in new construction costs which would eventually be picked up either by our elderly citizens, or through Medicaid expenditures in our own State budget.

Arizona also deregulated cardiac procedures. Since deregulation, 10 hospitals have initiated open-heart surgery programs. Medicare patients receiving bypass surgery at these new low-volume programs have died at twice the rate of patients at the high-volume hospitals.

Overall death rates for Medicare patients who underwent bypass surgery in Arizona jumped 35 percent in the two years after deregulation. Arizona's mortality rate went to twice the national average for these procedures. Also, I should note--

**ASSEMBLYWOMAN WRIGHT:** Excuse me.

Mr. Chairman, are there copies of Dr. Siegel's testimony available for the Committee?

**ASSEMBLYMAN COLBURN:** Do you have any copies of your testimony?

**COMMISSIONER SIEGEL:** Sure, we do. I thought you had them already.

ASSEMBLYWOMAN WRIGHT: I mean, you're giving us many facts. It would help us.

COMMISSIONER SIEGEL: We will get them to you as soon as possible. I apologize for not having them.

ASSEMBLYWOMAN WRIGHT: They're not available now?

COMMISSIONER SIEGEL: We're looking for the person who should have them.

ASSEMBLYWOMAN WRIGHT: Okay, because what you're giving us-- It's very hard for us to be able to follow at the detail level you're giving us. (testimony is handed out to members)

I apologize.

COMMISSIONER SIEGEL: No, no. My apologies.

ASSEMBLYWOMAN WRIGHT: Thank you, Mr. Chairman.

ASSEMBLYMAN COLBURN: Please go ahead.

COMMISSIONER SIEGEL: Okay. I should also note that in this experience in Arizona, hospital charges for bypass surgery rose by about 50 percent.

Another state, Virginia, liberalized CN in 1989. They ended CN review for equipment such as linear accelerators, MRIs, and lithotripters, as well as for regionalized services such as organ transplants and neonatal intensive care. In 1992, the Virginia Legislature reinstituted CN for these services because the medical arms race had led to much higher costs, and there was serious concern over high death rates for transplant recipients and low birth weight babies.

I believe that the CN program protects New Jerseyans from the specter of fly-by-night operators springing into the health care business overnight, and disappearing just as quickly; from the mushrooming of health care services without any basic standards of quality upon which New Jerseyans can rely. I believe that New Jersey citizens rely upon the government to assure that this type of institutional malpractice is not permitted here.

The CN approval process is a remarkably open and public one which takes carefully into account the health care needs of all New Jerseyans. It is clear-cut; it is formal; and it is governed by regulation and statute. It is a model for the competitive process at its best. The announcement of a call for applications is made publicly. All parties have a chance to apply, and then are compared through a public process using regulatory standards.

Applications are reviewed at six staff levels of the Department of Health; for 45 days by the local advisory board -- or LABS -- which are required to solicit input from the public; and then for another 45 days by the State Health Planning Board, whose recommendation is announced at an open public meeting. The recommendations of these two bodies are then submitted to the Commissioner of Health for a final decision.

I have received some inquiries as to CN time frames, and I know it's been an issue of concern for you. Under the old statute, CNs were valid for one year after approval. The long experience taught us that due to factors such as financing, zoning, and local approvals, it took considerably longer -- five years on average -- to move a long-term care facility from CN approval to licensure and operation. The Health Care Cost Reduction Act of 1991 allowed for a more realistic time frame to be put into regulation, and the current regulations allow for five years. The benefit of this new time frame is termination of the onerous process of regularly reviewing the one-year extensions that were required previously.

As you know, C.160 recently deregulated a number of services from the C of N process. I support that action since I think it streamlined the process and addressed only those services such as community-based primary care, which do not represent the high cost, highly technical services that are most appropriately reviewed through the Certificate of Need process.

As an example, C.160 deregulated chronic dialysis services. Assemblyman Colburn, you have appropriately raised the issue of whether deregulation of this particular service is wise. I have considered both sides of the issue carefully, and very frankly, have agonized over this. I have concluded that while there are valid quality of care concerns here, the answer is not to require Certificate of Need review for dialysis services. CN, I believe, should be used where, and only where, it makes real sense.

In thinking about what services should receive CN review, I think about access, cost, and quality. Since many New Jerseyans need to utilize chronic dialysis services on a regular basis, providing ready geographic access can be important. Moving on to the next criterion can be important. Cost for chronic dialysis services is not an issue, since this service is covered exclusively and completely by the End Stage Renal Disease Program of Medicare. However, the quality of the dialysis services provided is an important issue. Given the access and cost considerations, I believe we can assure quality through an effective set of licensure standards requiring prospective providers to meet strict quality of care guidelines before they can go into business.

However, the public would not be well served by a similar deregulation of other services. For example, I believe we can all agree that not every hospital in New Jersey should be in the organ transplant business. The demand for these services and the expertise involved in delivering them are such that the public interest is best served by their concentration in a limited number of hospitals. But who will determine which hospitals these will be? Should the market decide? Should insurance companies decide? Or, rather, isn't the public better served through an impartial decision-making process such as that represented by the CN program?

We also know that there continues to be discrimination in admissions by nursing home operators on the basis of HIV status, race, and socioeconomic class. This is intolerable, pure and simple. But what is the process by which this legitimate public concern -- ensuring access to long-term care -- is translated into policy?

We know that when certain kinds of facilities and/or high-tech equipment are operated by individual physicians or small groups of physicians, there is increased use of the services they provide. This increases the cost of health care in the State. Here, the question is not which specific physician or group should be permitted to obtain an MRI, but, again, that there should be a rational, public process to make that determination.

Finally, we know that there are certain hospitals in New Jersey that are essential to their communities and whose economic viability should be assured. Historically, this has been accomplished in large measure through the CN system's ability to make sure those hospitals can deliver high-quality, high-volume specialty services. If we remove this safeguard, we risk serious damage to these hospitals and to the public interest.

I know that the impact of regulating health care planning is very much on your mind today. I would suggest that there is no other area of health care more important. I would hope that we can enter into an open dialogue -- and I thank you for providing this forum today -- an open dialogue to determine where our health care system's public and private interests intersect. I have initiated this process by convening a number of advisory groups around the CN process in my own Department, reflecting consumers, payers, and providers. I am dedicated and committed to this process, and hope it will become a hallmark of my tenure as Commissioner.

Thank you for your time, and we look forward to answering any questions you may have.

ASSEMBLYMAN COLBURN: Thank you.

Ms. Wright, do you have anything to ask?

ASSEMBLYWOMAN WRIGHT: Well, since I have the statement, I guess one of my first questions would be that on page three, I believe it's the top of the-- You have said that you believe that, "The CN program protects New Jerseyans from the specter of fly-by-night operators springing into the health care business overnight, and disappearing just as quickly." Are you suggesting the licensing standards would not address this concern?

COMMISSIONER SIEGEL: Yes. I'm going to ask Mr. Langevin to speak to that in more detail. I think licensure does help, but it's absolutely essential. I don't think that's enough by itself. I think there needs to be a process which not only makes sure you meet certain licensure standards, but needs to be a process to make sure that something is feasible in all senses of the word, and as part of that process, that it really is needed in a given county or in a given community. I think when you start to break through that barrier, and the CN program provides that barrier, you set up a situation which is very dangerous where you can't have these sort of situations take place, and licensure is not enough.

I'll ask Mr. Langevin to add to that, if you'd like.

**P A U L R. L A N G E V I N, JR.:** I think one of the key things is that licensing, in and of itself, is not a guarantee as to who will be providing the service, because any individual can apply for the license. They could also, with some notification, especially under the less stringent regulatory reform that we've had in the last year or two, exit the provision of that service in the State by simply notifying the Department of Health within 60 or 90 days, depending on the service. Certificate of Need does not allow that easy entry

and easy exit of the system without a lot of scrutiny at both ends of the process, and that's something that licensing by itself does not offer.

If somebody makes an application, we look at their financial feasibility, and we look at their suitability as far as other operations that they have performed either in New Jersey, or elsewhere. But based on need and access, and some of the other criteria which are not inherent in the licensing program, you could not keep an individual from obtaining a license and beginning to provide services. Those are some of the safeguards that only a Certificate of Need or similar process could offer.

ASSEMBLYWOMAN WRIGHT: I guess a follow-up question through you, Mr. Chairman, would be: Might the licensing standards have a level of modification that might be able to include some of the issues that you're addressing?

MR. LANGEVIN: Certainly they could, and we have, in fact, in those instances where we have discontinued applying the Certificate of Need process to things like chronic renal programs, and a lot of the ambulatory care services. We have incorporated some of the key protective elements that we could incorporate as Certificate of Need into licensing. I think the key element that you can't incorporate is the competition piece; getting 20 people to apply so that you can get not only the minimum standard inherent in the license, but even better services to the community. That's a key element of Certificate of Need.

COMMISSIONER SIEGEL: I would add something to that. I think there's a certain bit of value in the public review that takes place on a C of N that does not take place on a license, and they're very different processes; I mean processes absolutely critical here. A C of N has to go through these multiple layers of review, not so much in the Department, that's not the critical point, but really out in the public

arena, in the local advisory boards, in the planning boards, in those sorts of settings. And there are clear time frames set up for that to happen, so something can't be raced through or shot through. So there's due deliberation, and everybody in the community knows what's happening. They know at the local advisory board, you know, who has come forward to apply to provide a needed service, what their records are, and they have, you know, some input in a forum -- in a publicly organized forum and a locally based forum -- as to who should be doing that. I think that's a critical issue for communities in New Jersey, and that's really the central value of CN and local health planning.

ASSEMBLYWOMAN WRIGHT: Through you, Mr. Chairman.

ASSEMBLYMAN COLBURN: Assemblywoman Wright.

ASSEMBLYWOMAN WRIGHT: I guess, basically, in your testimony, Dr. Siegel, you have kind of touched lightly on C of N in both acute care as it relates to -- I think it's diagnostic as well as therapeutic. In addition, you have touched on long-term care. You did not address it in home health care, and I wondered-- I see some of these issues, or areas of delivery of service, as a very different kind of need, and I just wonder if you have a comment about these in a different way. Or are you testifying that Certificate of Need in acute care, both therapeutic and diagnostic, as well as long-term care and home health care-- You're saying all of those are needed? Nothing needs to be changed, or-- How would you break out some of those areas, because I see them as quite different, like--

COMMISSIONER SIEGEL: Right. I think things needed to be changed, and I think you did that in C.160, and that was appropriate. There's recently been a major change in the scope of regulation in New Jersey under C.160, and if you go through that -- The Health Care Reform Act -- you will see a number of things that have been removed from regulation, including--

We're talking about one today: dialysis services.

ASSEMBLYWOMAN WRIGHT: But that would be therapeutic.

COMMISSIONER SIEGEL: There are others, like community-based primary care services, and the like. I would suggest, respectfully, that at this point we reassess what happens with those items before going ahead into making other changes. I don't think those changes have played out yet. And clearly, for instance, there's one of issue to you right now on the agenda, and I think we need to see how these things play out first before going ahead and, you know, again, changing the regulatory field.

So I would also, out of fairness to providers and physicians in New Jersey-- I think there's a value to having, you know, some stability in the system, and seeing where it goes for awhile before going through another period of dramatic change.

ASSEMBLYWOMAN WRIGHT: It is clear that you did not address home health care in your presentation today.

COMMISSIONER SIEGEL: Right. That is true.

ASSEMBLYMAN COLBURN: Assemblywoman Weinberg, would you like to ask anything?

ASSEMBLYWOMAN WEINBERG: Not right at this moment.

ASSEMBLYMAN COLBURN: Not right now. Okay.

I wanted to ask you, could you give me an example of something of a category of service that might lend itself to fly-by-night attack on-- It's not clear to me what you're talking about.

COMMISSIONER SIEGEL: I am talking about, I think, a wide variety of services that can be done either by scrupulous people or unscrupulous people.

ASSEMBLYMAN COLBURN: You're talking about labs? Are you talking about IV teams, or--

COMMISSIONER SIEGEL: I'm talking about all those things. I mean, I'm talking about things that could be

regulated. We don't necessarily regulate IV teams, and the like. First, we are always very concerned in the areas of long-term care, for instance, that the people who operate long-term care institutions be people who have good track records at other institutions. I have Paul Langevin here, who I think is probably one of the most, you know, completely scrupulous people in New Jersey, if not the world -- he holds my feet to the fire on a daily basis -- who sees to it that we don't have people operating those sorts of facilities who have, you know, lousy records in New Jersey of other facilities or of other states.

Another thing we're concerned about -- this has been an issue in other states -- is mobile cardiac catheterization vans. I mean, you have that sort of stuff that can come in if you remove the CN process. Do you want a truck that would go from doctor's office to doctor's office, or hospital to hospital, doing cardiac catheterizations in the truck? I have a little bit of a concern about that, and I wouldn't want my cath done there. Those are the sorts of things that can spring up or come into being, and they're the sort of issues we try to protect against.

ASSEMBLYMAN COLBURN: My other question is: I think the CON process has been functioning since '71 or '72, and during that time we became overbedded in the State. Were we overbedded when it began? It just seems to me that the planning process didn't work too well, and we wound up with so many extra beds.

COMMISSIONER SIEGEL: We were overbedded. Our number of beds actually dropped through that time, and compared to other states that did not have CN, especially some in the mountains west, and some in the south and southeast, we were not nearly as overbedded to the extent that they were. So is there room for improvement? Clearly. But we were, I would say, well served by the CN program. Other states had

outrageous overbedding cases which I think was a problem financially, as well as a problem in terms of quality of care delivered at those institutions in other states.

ASSEMBLYMAN COLBURN: But you would say that in '71 we had more beds, more acute care beds than we do now?

COMMISSIONER SIEGEL: Yes. Absolutely, yes. And we can provide those numbers to you. We have seen-- Well, we'll get the numbers to you. It's a very dramatic decrease and I don't know the exact numbers, but we'll provide them.

ASSEMBLYMAN COLBURN: Okay.

Mr. Mikulak, do you have any questions?

ASSEMBLYMAN MIKULAK: Thank you, Mr. Chairman. Thank you for having this hearing.

Let's see. Dr. Siegel, who wrote the long-term care chapter in the State Health Plan?

DR.SIEGEL: The key person involved on the staff to writing the long-term care chapter in the State Health Plan, which was also reviewed by the planning board, and she worked as staff to the planning board, is a woman called Dr. Nancy Moyer -- M- O- Y- E- R, who is a Ph.D. in health planning. She actually holds a faculty appointment at the University of Pennsylvania, and is really one of the best experts we have in New Jersey on long-term care.

ASSEMBLYMAN MIKULAK: And the original plan, did that call for a moratorium -- about approximately a 10-year moratorium -- on nursing home beds?

COMMISSIONER SIEGEL: I wouldn't characterize it as that. The thrust of the plan is, I think, very clear. What it says is that if you look across America right now, you will see by looking at other states -- which is something I think we should do, but we shouldn't mimic them -- you will see states which have developed alternatives to nursing homes; alternatives like assisted living, for instance. These have been embraced nationally, and I think the greatest success

story here is the State of Oregon, which has been able, really, to keep their nursing home numbers -- or nursing home bed numbers -- static, while increasing these alternatives. That's the direction we should be moving in.

ASSEMBLYMAN MIKULAK: But there was a call for a moratorium in the State Health Plan under long-term care, because I have it here. I could quote you the--

COMMISSIONER SIEGEL: Okay. There was a general moratorium on the CN process while the planning board was creating a State Health Plan. I don't think you'll see a call for a moratorium permanently on long-term care. It just calls for changing the mix and approving more alternatives, rather to more nursing home beds. Clearly, this year, actually, in the current nursing home batch, we are going to be approving additional nursing home beds.

ASSEMBLYMAN MIKULAK: Right, but it called-- I saw in here a date of 1998, that there was supposed to be a moratorium on those beds, and then you were going to develop the alternatives.

COMMISSIONER SIEGEL: Right.

ASSEMBLYMAN MIKULAK: And then I think that changed when the HCAB approved it. I think they backed off.

COMMISSIONER SIEGEL: Well, I don't think they backed off. I think the issue was, if you don't have the alternatives, then you can't restrict the number of nursing home beds. You need to make sure there's enough places for people to be taken care of in New Jersey. The alternatives haven't come on-line, or haven't been developed as quickly as we'd like. We're still working on them in conjunction with the Department of Human Services, and because of that, we've issued a call for more nursing home beds in New Jersey, in counties where it seems to be needed.

ASSEMBLYMAN MIKULAK: Right. I don't think any discussion today would be complete without addressing an

argument that's frequently made by opponents of the C of N process, and they say that government politics often gets into this process.

So with that in mind, I'd like to ask you a few questions based on the series that I read in The Trentonian at the end of January, beginning of February of '92. These articles, to me as a layman just reading the newspaper, appeared most disquieting. Now, are you aware of any verbal approvals given for C of N?

COMMISSIONER SIEGEL: No, I am not.

ASSEMBLYMAN MIKULAK: You're not aware of them?

COMMISSIONER SIEGEL: No, I am not.

ASSEMBLYMAN MIKULAK: Then you would say that you would never, as Health Commissioner, give any kind of verbal approvals?

COMMISSIONER SIEGEL: We don't give verbal CN approvals.

ASSEMBLYMAN MIKULAK: And--

COMMISSIONER SIEGEL: Period.

ASSEMBLYMAN MIKULAK: Period? Okay, that's good to know.

Were you personally involved in any of the decisions that were contained in those articles for the nursing homes -- Meadowview or Whiting?

COMMISSIONER SIEGEL: No, I was not.

ASSEMBLYMAN MIKULAK: Do you know the people who were, at the time?

COMMISSIONER SIEGEL: Well, there's a number of Department of Health staff. I think I've got some flanking me right now. I think the then Commissioner, I assume, would have been involved if there was a final Commissioner's decision.

ASSEMBLYMAN MIKULAK: Okay, because in light of the recent Federal investigation into the bond -- bonding -- and the administration people that are involved in that, I think

this is a very important fact. Have you done your own complete and thorough investigation since you've taken Office as Health Commissioner?

COMMISSIONER SIEGEL: Yes, I have.

ASSEMBLYMAN MIKULAK: You have?

COMMISSIONER SIEGEL: I have.

ASSEMBLYMAN MIKULAK: Have you presented that to the Senate, and could you present a copy of that to--

COMMISSIONER SIEGEL: Yes, we discussed this at length with the Senate, as you may know, during the confirmation process that I went through, and provided testimony there that embodied my findings. The one thing that I found disturbing was that we didn't have an automated system in the Department for tracking CN applications, making sure that everything got done at the time it was supposed to get done. We now have that, and we'd be happy also to provide this to you.

ASSEMBLYMAN MIKULAK: A tracking system. That's technical. Yes.

COMMISSIONER SIEGEL: Both things are very important.

ASSEMBLYMAN MIKULAK: That's important. That's good. That's why--

COMMISSIONER SIEGEL: The point about this, now, is that we have one single volume where any individual in the State can find out where any CN is, you know, in terms of the approval process.

ASSEMBLYMAN MIKULAK: Okay. So then, therefore, you investigated the article, the five articles, and you found no improprieties whatsoever?

COMMISSIONER SIEGEL: Absolutely none.

ASSEMBLYMAN MIKULAK: You found no appearance of an impropriety?

COMMISSIONER SIEGEL: No. No appearance of impropriety either.

ASSEMBLYMAN MIKULAK: You looked into blind trusts and things like that, and you think that that's a good mechanism for government to function in the executive level?

COMMISSIONER SIEGEL: That is something that would have to be discussed, I think, by you and the staff of this Committee, and others. I'm not an expert on corporate structures or blind trusts.

ASSEMBLYMAN MIKULAK: Yes, I'm not an expert on C of N, and I don't want to get into details on this because this didn't happen under your watch.

So, I would ask the Chairman at this time to refer this to the SCI. There were specific allegations made of people that potentially profited from setting policy, on the appearance, to me-- It's the appearance of a conflict. So I would like the SCI to get involved, and I would also like, therefore, that Dr. Siegel make all his findings known to the SCI. They could do some investigation. They could get some documentation -- the Legislature -- then they could come back to us with recommendations regarding things like blind trust and C of N process, how we could maybe streamline it, make it less political, less subject to potential political manipulation.

ASSEMBLYMAN COLBURN: I think it's appropriate that this Committee not get into details of that kind. We're not a judicial body. One other time -- I think when Governor Kean was Governor -- I turned something over to the SCI because a man came before the Committee and made some drastic accusations. I think it was about the Health Department, as I recall, and we did turn it over to them and got a satisfactory report. I really think they're a body that's capable of doing this, far more than we are. So, all we have to do to accomplish that is for me to write a letter to the SCI and ask them if it would be appropriate for them to look into these things. That's what I'll do. I think that can end that part of this hearing.

Anybody else with further questions for Dr. Siegel?

Yes, Ms. Weinberg.

ASSEMBLYWOMAN WEINBERG: I would like to go back to following up on some of Assemblywoman Wright's questions about the home health care industry.

How does, or would, the C of N process affect things like the home health care and the infusion -- home IV?

COMMISSIONER SIEGEL: Home IV? Okay.

ASSEMBLYWOMAN WEINBERG: Yes.

COMMISSIONER SIEGEL: Okay. If I could just ask Mr. Langevin to provide some more detail. Home infusion services, to my knowledge, are not now under the CN process, and are not really regulated or licensed. You know, that is a matter of some concern to me, I have to say. There's been, you know, discussion -- anecdotal things talked about in New Jersey about home infusion operations, whether or not they provide appropriate care for the appropriate time, and those sorts of things. It's something I'm frankly concerned about.

I'll ask Paul to speak a little more to that..

MR. LANGEVIN: With regard to home health care, generally, the Department only directly regulates about 60 home health care providers in the State which are known as comprehensive home health services, and they qualify as health care facilities under the 1971 law.

There's a whole array of providers out there, some of whom -- in fact, most of whom -- are licensed by the Division of Consumer Affairs in the Department of Law and Public Safety. They're licensed as employment agencies and other types of businesses that go in and provide a real microcosm of what a comprehensive home health agency would supply. And those folks aren't regulated so much as health care providers, as they are businesses. Right now, they're beyond the purview of the State Health Department to regulate in any way, shape, or form, although as Dr. Siegel said, we've gotten anecdotal

complaints about the quality and costs of those services. Until there's a statutory change, the Department cannot regulate those individuals directly.

ASSEMBLYWOMAN WEINBERG: If I may, Mr. Chairman, through you, and I know that Assemblyman Mikulak, since he has concern with investigating certain abuses further will join me in this, but I did write to the Committee Chairperson of this Committee to ask for an investigation into this industry, because we have gotten reports that seem to be more than anecdotal and they affect a large portion of our population, people who are not being treated well by what should be a health care provider, rather than an employment agency; where it is questionable the kind of fees that are being charged, and whether or not the medical profession is in some way involved. So, I would hope since this affects so many people in the State of New Jersey, that this Committee will look into this whole area. As I said, I did write quite some time ago, and I know that certainly Assemblyman Mikulak will join in asking for a further investigation by this Committee, as well as finding out what legislative changes we should be making to protect the sometimes frail consumers of this service.

COMMISSIONER SIEGEL: I should, if I might, through the Chair--

ASSEMBLYMAN COLBURN: Excuse me.

It was my impression at the time that you could have written directly to the SCI yourself.

ASSEMBLYWOMAN WEINBERG: I did-- I'm sorry, Dr. Colburn--

ASSEMBLYMAN COLBURN: Was it the SCI you were asking for?

ASSEMBLYWOMAN WEINBERG: I did write to the SCI as well as writing to you, to ask that two independent ideas -- that this Committee investigate this, as well.

ASSEMBLYMAN COLBURN: The SCI and Health Committee are really different things.

ASSEMBLYWOMAN WEINBERG: Correct, and I wanted two different investigations. I believe--

ASSEMBLYMAN COLBURN: I kind of like the SCI better than the Health Committee for that.

ASSEMBLYWOMAN WEINBERG: Well, the-- In fact, I have heard from the SCI just very recently that they feel that there are legislative changes that are required first. I just received the letter a couple of days ago, in fact.

ASSEMBLYMAN COLBURN: Okay, well why don't we look those over and see what they have to say.

ASSEMBLYWOMAN WEINBERG: Right, which is why I think it is in this Committee's bailiwick to be looking into this.

ASSEMBLYMAN COLBURN: We can get the bills written and we can go over them.

Excuse me, we don't want to get too far off the subject.

ASSEMBLYMAN MIKULAK: Mr. Chairman?

ASSEMBLYMAN COLBURN: Mr. Mikulak?

ASSEMBLYMAN MIKULAK: I appreciate what Assemblywoman Weinberg has just said. I think she's talking about a larger area. We used to have an Ombudsman for the Institutionalized Elderly. I haven't really heard a lot about it since I've been in office, but I assume that position still functions and that would be the purview of the Ombudsman for the Institutionalized Elderly. The first one, Senator John Faye, was a personal friend of mine, and I helped him when that was being set up back in the late '70s, but they're supposed to look into specific abuses, and there's always additional, you know, need for protecting the frail elderly like that.

ASSEMBLYWOMAN WEINBERG: Mr. Chairman?

ASSEMBLYMAN COLBURN: Yes?

ASSEMBLYWOMAN WEINBERG: If I may? We're not talking about institutionalized people; we're talking about people who are being treated in their homes.

ASSEMBLYMAN MIKULAK: That, too. They could do that, too. That's--

ASSEMBLYWOMAN WEINBERG: They're not always elderly, but very often are, Assemblyman.

ASSEMBLYMAN COLBURN: I guess I'd better ask us to get to that some other time. I guess that's--

Oh, Nick, I'm sorry. Vice-Chairman of the Committee.

ASSEMBLYMAN FELICE: Thank you, Mr. Chairman. Through you, I'd like to ask Dr. Siegel a question.

Dr. Siegel, in your statement you say that the CN approval process is clear-cut, formal, and governed by regulation and statute. However, on February 10 of this year, the Appellate Division unanimously, and in no uncertain terms, upheld the validity of P.L.1992, c.31 rendering the State Health Plan advisory only. It invalidated all Department of Health regulations seeking to give the Plan or its goals, objectives, or health planning recommendations the force of law. Would you kindly advise this Committee on how you are handling the CON applications in light of this development and, in particular, what role does the State Health Plan play in evaluating these applications?

For instance, prior to this Appellate Division's ruling on February 10, were there any CN applications that were processed to any degree in reliance on the regulations that the court has now said are invalidated, and, if so, what is the status of those applications? I think those are the questions there.

COMMISSIONER SIEGEL: It's a good question. First of all, there have been no-- No applications were processed under those regulations that were invalidated by the court decision. You need to be very clear about that.

Secondly, the court decision -- and I'm not a lawyer -- clearly seems to indicate that those parts of the regulations which were based -- those planning regulations that are based in the Plan -- are no longer regulations and are no longer valid as such, and we respect that. It does not invalid every regulation dealing with planning ever created; it does invalidate those things directly based, or part of the State Health Plan. I think the decision was fairly eloquent in defining that scope. Again, I'm not an attorney, and I don't want to go too far afield here. But we can talk more about that.

This has raised a problem in that many providers do want to have regulations out there, because they do want some sort of criteria arrived at to -- you know, which are arrived at and publicly debated and promulgated, for their application to be considered. I think they see regulation not so much, necessarily, as being onerous, but as protecting them from an arbitrary or capricious decision on the part of the Commissioner of Health -- certainly not this Commissioner of Health, but perhaps another Commissioner of Health. So, they see some protection in that.

This has been a problem, because we're trying to now pick through and figure out which regulations are valid, which are not valid, and what do we do? Have we lost certain regulations that may be important to the provider community in New Jersey? We've had meetings with a variety of provider groups, including the Hospital Association, trying to pick through this and figure out what we can consider as still regulation, and what not. It's very difficult. It is a problem for us. And I made-- In the hearings on the budget process where this came up, you know, we spoke to this also. Assemblyman Lance was very interested in this issue, and we spoke to him and made it clear that we could use some help, maybe, from the Legislature, in allowing us to continue to do

rule making in certain areas -- not to reflexively base them on the State Health Plan, but to continue to do rule making in certain areas that are important, so there's a level playing field for everybody.

Other process regulations which were not based on the State Health Plan, but just give, you know-- Issues about time frames and others were valid and we have not been invalidated by a court's decision. We consider-- I consider the State Health Plan now to be an advisory document.

ASSEMBLYMAN FELICE: Thank you very much, Dr. Siegel.

ASSEMBLYMAN COLBURN: Thank you. Thanks very much, Dr. Siegel. We will be looking forward to consulting with you in the future, maybe the near future. We don't quite know. Thank you.

COMMISSIONER SIEGEL: Thank you.

ASSEMBLYMAN COLBURN: Ralph? Ralph Dean, New Jersey Hospital Association. Please tell us who's with you.

**M U R R A Y B E V A N:** Mr. Chairman, let me extend my apology on Mr. Dean's behalf. He has a State Health Planning Board meeting this morning, and I know he--

ASSEMBLYMAN COLBURN: I thought you changed your name.

MR. BEVAN: --wanted to attend.

For the record, my name is Murray Bevan, Vice President of Government Relations. With me today is Diana Stager, who is our Vice President for Planning. Diana has the prepared text of Mr. Dean's statement, and we would be glad to answer any questions you might have.

**D I A N A S T A G E R:** Good morning. Thank you for the opportunity to speak to you today on the Certificate of Need program.

The New Jersey Hospital Association has long been an advocate of the CN regulation for regionalized health care services. CN is an important governmental program for controlling health care costs by regulating the proliferation of technology and expansion of health services.

Certificate of Need has worked in New Jersey. Hospitals in this State have one of the highest occupancy levels in the country, and that's a measure of hospital efficiency. Specialized and expensive health care services, such as trauma centers, organ transplantation, and cardiac surgery, have been distributed in regional centers around the State as a result of the CN process. Over the years, the CN process has been modified and improved. For example, in 1991, the State Legislature leveled the playing field, that is, included all providers under Certificate of Need, thereby making everybody play by the same set of rules. And, the 1992 Health Care Reform Act raised the CN threshold for hospitals to a more reasonable level. These kinds of changes are important refinements to the system.

Interestingly, a number of states that deregulated Certificate of Need in the 1980s are now moving back to CN regulation because of the medical arms race caused by a free market in health care. Specifically, Minnesota and Wisconsin both brought back CN programs in 1992.

The CN process has served New Jersey well for over 20 years. And, while NJHA continues to support CN for the reasons just listed, we do recognize that major reforms in health care are on the horizon. In particular, NJHA expects that over the next decade, hospitals will become part of community care networks -- cooperative relationships among hospitals, physicians, and community organizations that give providers financial incentives and organizational linkages to work together to meet community needs. In community care networks the delivery system is more rational and providers are given the incentives to improve primary and preventive care, not to increase hospital beds or purchase expensive technology. As this kind of delivery system reform occurs, it will be necessary to reexamine the CN program to ensure that it's not an impediment to this new system of health care. In fact, even

under a new system, CN is likely to continue to play a role, albeit somewhat diminished.

I urge you to maintain the CN program in New Jersey, and I encourage you to look at the program as a comprehensive regulatory mechanism. It would be wrong to dismantle the CN process piece by piece, deregulating a certain service here and a particular service there. While meaningful health care delivery system reform takes shape in New Jersey and the nation, Certificate of Need should be maintained as it can continue to play a role in holding down health care costs.

Thank you.

ASSEMBLYMAN COLBURN: Thanks very much.

Ms. Wright, did you have something?

ASSEMBLYWOMAN WRIGHT: Thank you, Mr. Chairman. I'll ask this speaker the same question I asked Dr. Siegel.

Although I recognize that you represent the Hospital Association, you really didn't specify-- You're talking about community care networks. Are you talking about C of N as it relates to only hospitals, both diagnostic and therapeutic, or are you talking about also how it relates to long-term care and home health care?

MS. STAGER: Well, I think it would be presumptuous of us as a Hospital Association to address long-term care policy, and I think I'd let, maybe, the Nursing Home Associations do that.

But we do support Certificates of Need as a regulatory mechanism for hospital services, and we understand that some hospitals do have nursing homes and home health agencies. So for all those services, yes, we do support CN. And we do support a level playing field whereby all providers have to play by the same rules.

ASSEMBLYWOMAN WRIGHT: Since you have the largest group of hospitals delivering services in terms of your expertise, do you differentiate between diagnostic and therapeutic services under the C of N?

MS. STAGER: No, we do not.

ASSEMBLYWOMAN WRIGHT: Okay.

Thank you, Mr. Chairman.

ASSEMBLYMAN COLBURN: I wanted to ask, when you speak of community care networks, I guess those are the ones we expect from the Federal legislation?

MS. STAGER: Actually from the Federal legislation it's HFICS. Is it--

MR. BEVAN: Health Alliance.

MS. STAGER: HFICS.

ASSEMBLYMAN COLBURN: Are they similar?

MS. STAGER: HFICS would be the purchasing cooperatives, and that would be the insurers' cooperatives, and--

ASSEMBLYMAN COLBURN: Okay. Well how about on the care side?

MS. STAGER: Providers side? Community care networks, and we'll be sharing shortly with the Legislature some material on this, are something that we're starting to look at -- cooperative relationships among providers in a community -- and they would be held responsible for the health care in that community. Health indicators, for example, would be their measure of quality.

ASSEMBLYMAN COLBURN: Well, the reason I'm asking you this question is, it seemed to me that if the Federal legislation spoke of providers getting together and bidding with the recipient, so to speak, or the patients, that the providers would probably be providing a specified group of services, that they would tell you what was needed within the group of services, wouldn't they? And then you wouldn't need a Certificate of Need because they'd tell you what you need.

MS. STAGER: You're probably right, but there are some services which are so high-tech that you'd probably continue to need the CN program for that.

ASSEMBLYMAN COLBURN: Because it would cover more than one group of providers. Okay. Yes, that's the question I had.

I had, I guess, an unfortunate personal experience with the early Certificate of Need, with the Zurbrugg Hospital trying to get together with Burlington County. We came up here and met with Commissioner -- I think it was Goldstein, then -- asking if those two hospitals could join to have a CAT scanner. He told us they were experimental, and there were only to be, I think, five in New Jersey, so we were turned down. And the physicians were in favor of it. It was one of those things where the doctors were in favor of it, and the hospitals were in favor of it. We were stopped. Then I went home and read an article in the "New England Journal" that very day, which spoke of the great expectations for Cat scanning, and it was the government here who turned us down.

So I think this shows you how these things can misfire, and actually make these services inaccessible to patients in need of them. I recognize I shouldn't overturn the whole system, but a little anecdote, you know, sticks in one's mind.

MR. BEVAN: Mr. Chairman, you raise another problem, though, in that there are Federal antitrust laws that prohibit or inhibit the ability of people to get together -- that were in a number of states, including Minnesota and Wisconsin -- that still maintain or went back to the CN process but, in doing that, also modified their state antitrust laws to overcome this state action immunity doctrine. I think that's something-- I know I spoke to Mr. Hook about it, that that's something we need to seriously look at in this State for the next few months.

ASSEMBLYMAN COLBURN: That's certainly true. Thank you.

Any other questions? Ms. Wright?

ASSEMBLYWOMAN WRIGHT: I want to go back to some specifics, since your testimony was very general. I think, if not today, it would be helpful if you could provide the Committee with some clear-- I mean, the data out there are not consistent. There's some data that indicate that -- and we'll stay with hospitals, right now -- the repeal of Certificate of Need in some states has not increased the expansion of beds, and you must have these data readily available. You didn't put any of that in your testimony, and that's what I'm looking for. I'm looking for a very concrete evaluation of the Certificate of Need program; how it works in New Jersey; what has happened since '71. I notice that Dr. Siegel didn't put that in, and we will probably have to ask him for more of that. Is it possible to have, you know, something that really is substantive regarding these issues since 1971? You probably have monographs and things over the years that perhaps somebody could synthesize for us so that we could see a lot more clearly, than anything you've given us today. Is that a fair question, Dr. Colburn?

ASSEMBLYMAN COLBURN: I'm sorry, I didn't hear that.

MS. STAGER: Sure, Assemblywoman Wright, I'd be happy to provide you the material.

ASSEMBLYWOMAN WRIGHT: I just wondered if that's an appropriate request of the Hospital Association?

ASSEMBLYMAN COLBURN: Oh, sure. Oh, absolutely. More information, yes. Absolutely.

MS. STAGER: I'd be happy to share that with you, although I would concur with Dr. Siegel's numbers that the number of beds in New Jersey has remained relatively stable, if not decreased since the '70s.

ASSEMBLYWOMAN WRIGHT: But I'm asking you for more than that.

MS. STAGER: More than that. Sure.

ASSEMBLYWOMAN WRIGHT: I have articles that show me that in some states during the repeal, the number of beds has gone down. So, nobody here said anything to me this morning that is more than a relative platitude in terms of this issue. There's been no really substantive data presented here, yet, this morning. It's mostly, "I like Certificate of Need," or, "I don't," or what have you. We've got to get into a lot more of, really, the nuts and bolts of this issue to make policy decisions.

ASSEMBLYMAN COLBURN: Okay. Thank you very much.

MS. STAGER: Thank you.

ASSEMBLYMAN COLBURN: Vincent Maressa, from the Medical Society.

**V I N C E N T A. M A R E S S A:** Thank you, Mr. Chairman. With me, is Neil Weisfeld from the Medical Society.

Let me, perhaps, give the Committee a different perspective on the issue. The Certificate of Need program is basically an effort at cost containment that employs a rationing concept of supply and demand. It has failed. It is replete with questions of conflict and impropriety. You've touched on a few of them, but you haven't really scraped the surface.

What the program essentially does is, it superimposes the judgment of the folks at the Health Department over the judgment of the trustees and the management of our hospitals, in terms of strategic planning and processes that go forward to their supply of services and facilities to our people. Now, if the basic assumption is correct, that the State agency ought to be deciding the strategic future for health care services and facilities--

ASSEMBLYMAN COLBURN: Excuse me, do you have copies of your testimony?

MR. MARESSA: No, I don't.

ASSEMBLYMAN COLBURN: Okay, well, you'll maybe get some and send them to the Committee?

MR. MARESSA: We will send you something down in writing.

ASSEMBLYMAN COLBURN: I'd appreciate it.

MR. MARESSA: If the concept is that the State agency ought to be making these strategic decisions, how then can they trust the managers and the trustees to operate the facilities? So, the premise has a basic flaw in it. It is replete with conflict because-- The Commissioner testified earlier, and said that one of the designs of the program was to attempt to keep inner-city hospitals afloat by moving technology to those hospitals through the Certificate of Need process. That is an indication that the decisions are not based upon normal demographics and feasibility -- whether it's financial or otherwise -- but that there has been a process in New Jersey which continues to attempt to salvage, or to buttress, or to support inner-city hospitals by the placement of needed essential services of a tertiary nature. It is replete with conflict, because many times the people on the various boards and advisory committees happen to be either the Chief Executive Officer, or a Trustee of a hospital that is either favorably or adversely impacted. The fact that they are there and may not vote on a particular issue does not mean that the conflicts have not pervaded the system.

A number of years ago, the Health Commissioner used to be ex officio on the Board of the University -- UMDNJ -- which operates four very large hospitals in New Jersey, and in addition, has affiliations with 12 others. It is stretching credulity to believe that a Commissioner serving on a board ex officio can then sit in the office and make decisions objectively and dispassionately, one way or the other, affecting that entire system, when the Commissioner sits on the University Board.

However, that isn't the real issue. The real issue is that Certificate of Need cannot, and will not work, has not worked, and is, frankly, out of time and place.

Washington is talking about managed care -- managed competition. Certificate of Need is an exercise in futility in the face of that movement. We had a great illustration of that in New Jersey last week. New Jersey Blue Cross said it was moving to 56 managed hospitals in its network. The end result was, all planning issues aside, they don't care. They're deciding where they're going to place patients insured by them -- in which hospitals -- and which patients they will send out of State for what services. Likewise, U. S. Health Care -- the largest managed care plan in the State at this time, covering 400,000 New Jersey residents -- decides which hospitals and which doctors it wants to use, and it really doesn't care where their Certificates of Need have landed. And if it doesn't like the price at a given hospital, it will divert patients to Philadelphia, to New York, and as far away as Texas. So managed care and managed competition will simply frustrate any logic in the planning process.

My final comment will relate to an issue raised by a number of speakers, and that is: quality. We have a very stringent, very well-designed regulatory format in New Jersey. The New Jersey Administrative Code related to hospital licensing standards is about this thick. (demonstrates) Likewise, Medical Board regulations related to physicians run to hundreds of pages. And when we finish up with all of the policy decisions, we have very extensive manuals. These are not, for the most part, fly-by-night operators. I can't remember the last time somebody picked up a New Jersey health care facility and walked away with it to another state. So the issue of quality is very well-addressed through licensing standards, licensing regulations, and licensing inspections.

Dr. Siegel pointed out that there was supposedly a phenomena in Arizona, where after they lifted CON they had a high rate of morbidity and mortality. Well, if the Health Department is licensing these facilities, and it conducts its

annual inspections and does quality assurance and peer review as it ought to, the reasons for the increased morbidity and mortality ought to be demonstrable to the licensing agency, and they as a licensing agency obviously can impose a plan of corrective action. So, I think the issue of quality is, as a matter of fact, a nonissue. Because whether there is a Certificate of Need or not, you need a license to practice medicine, you need a license to operate a health care facility, and you must comply with very stringent rules and regulations in the process.

Mr. Chairman, that's all I have as part of my comments.

ASSEMBLYMAN COLBURN: Thank you.

I, also, picked up on that business about mortality with the cardiac facilities, because I felt that was a reflection. Also, the agencies that would have to do with those procedures-- I didn't go further into it, but I, you know, really felt that way when he said that.

MR. MARESSA: Well, as a matter of fact, an institution or a service in this State can receive a Certificate of Need, and it may, indeed, two or three years subsequent to being operational, have adverse morbidity and mortality statistics. So I don't understand why one anticipates that the CON program is a corrective measure. It has absolutely nothing to do with the assurance of quality. As a matter of fact, the decision is made, as Dr. Siegel indicated, before they even know if they can get zoning board approval to go into the building they want to go into.

ASSEMBLYMAN COLBURN: Ms. Wright.

ASSEMBLYWOMAN WRIGHT: Thank you, Mr. Chairman. I'll just ask the same question of Mr. Maressa that I asked--

In regard to acute care services specifically, the question of diagnostics seems to be different than the question of therapeutic services, and I wondered if you would address that? Does that have any impact, as you view it?

MR. MARESSA: No, I think-- Well, your question, as I understand it, is, do we see that therapeutic services should be separated out and remain under a Certificate or-- I'm not sure I understand.

ASSEMBLYWOMAN WRIGHT: My question is: Is there any heavier wait for a need for a Certificate of Need or not, under-- Well, like the MRIs, for example.

MR. MARESSA: Oh, I follow you. There is an assumption among those that advocate the Certificate of Need that, when it comes to diagnostic services, the private sector will have a proclivity to overexpand to provide diagnostic services, but somehow this same inclination is stifled when it comes to therapeutic services. I think that simply defies logic, because if people are properly motivated, they will use the same prudence, the same judgment, the same methodology in using feasibility analysis when they decide to go into a diagnostic service, as they will when they decide to provide a therapeutic service.

I would also suggest that on occasion, the State government has bailed out a few folks who have imprudently decided to proceed, and got a Certificate of Need by leveraging certain carriers, and even preventing other people from going into the market on the theory that these things would then become feasible or maintain themselves, and they have not.

So, no, I think the brief answer to you, Assemblywoman, is, I see no valid distinction between the two. I think you approach -- and you should approach -- as a physician, a hospital, or a provider of any type, the same type of analysis. You should only give services that are indicated and necessary, and the price ought to be reasonable and competitive.

ASSEMBLYMAN COLBURN: Vince, something that bothers me is, periodically we see articles, especially in the "New England Journal," which I feel is certainly one of the biggest

watchdogs in medicine, and people listen to them and they have their press conferences and get their material publicized-- How can we prove in New Jersey that our physicians actually do exercise the very thing you're talking about, because the "New England Journal" articles would suggest that there are physicians nationwide that overdo things and order too many of things? I don't know whether it's bad judgment or just the need to make more money, but we really can't have people doing that.

MR. MARESSA: Well, I understand that, and that's why we believe the licensing standards, coupled with quality assurance reviews and peer reviews, are the answer, as opposed to telling people they can or cannot not go into a particular--

ASSEMBLYMAN COLBURN: You're suggesting we can apply those to MRIs and other major expenditures?

MR. MARESSA: Absolutely. There is no reason why you cannot. The owners of the MRIs that are physicians, are licensed by the Board of Medical Examiners. They have all sorts of rules and regulations on providing medically necessary services at reasonable prices.

ASSEMBLYMAN COLBURN: I think it's incumbent on the Medical Society to come up with some suggestions about how that can be assured, and I'm not certain that-- Legislative things are really pretty tough, as you know. I'd like to see the Medical Society maybe over prove their case to us because, you know, we're under the gun. We all are. All of us practicing physicians are.

MR. MARESSA: I understand that, Assemblyman, but let me give you the reverse. Why is it necessarily assumed that because a facility has received a Certificate of Need, that utilization is appropriate?

ASSEMBLYMAN COLBURN: Well, they could all be subjected to the same review.

MR. MARESSA: I would suggest that that's what ought to happen.

ASSEMBLYMAN COLBURN: Okay, well, tell us what should be done -- at another time. (laughter)

MR. MARESSA: Well, we will certainly work on that. I don't know if the Health Department employees who will have something else to do will appreciate it, but--

ASSEMBLYMAN COLBURN: Well, you tell us about it. We'd like to hear about that. Okay. Thanks a lot.

Sister Brady? Sister Brady, are you-- It's still morning. Good morning.

**S I S T E R J A N E F R A N C E S B R A D Y:** Good morning. Before you ask me, I will confess that I do not have copies with me.

ASSEMBLYMAN COLBURN: Okay. Maybe sometime you can make some available.

SISTER BRADY: I will mail them today when I go home. I had a family -- hospital emergency -- this morning and left without the copies, and my suit jacket. (laughter)

Thank you very much for allowing me the opportunity today, and I'll try to be succinct in my comments.

My name is Sister Jane Frances Brady, but I'm here today as the President of the newly incorporated Hospital Alliance of New Jersey, a group of approximately 20 hospitals which have joined together to focus on issues that we think are of paramount importance to our membership, most of which is teaching hospitals.

I have been in hospital administration in New Jersey for 26 years now, and have been a very close observer of the CN process. I have been an observer of the processes that existed before CN, and certainly those that followed CN adoption in 1971. I served on the review committees in my local HSA and the Board of Trustees for many years, and so I bring firsthand information, I think, to the topic.

Access to care, assurance of quality of that care, and cost control are the major concerns of the American public

today when we talk about health care. The focus of the major health care reform efforts presently underway in Washington is on those very topics. It is my belief that deregulation is the antithesis of cost control. Deregulation will allow proliferation of costly facilities, equipment, and programs with totally unnecessary -- and, today, outrageously expensive -- duplication. Perhaps more importantly, deregulation of CN programs in New Jersey would begin to destroy the efforts expended over years at regionalization, collaboration, where expertise has been concentrated and carefully honed, with large volumes of patients and procedures in the areas like invasive cardiac procedures, cardiac surgery, perinatal and neonatal care, and, with all due respect to the Commissioner of Health, renal dialysis.

CoChairman Felice, who isn't here, is the cosponsor, as you know, of a bill to reregulate dialysis. It is very clear from the literature -- and there is profuse documentation -- that concentration of expertise in patients greatly increases quality and good outcomes. That is indisputable today. In fact, I have an article here which talks about the Arizona experience of deregulating cardiac surgery, deregulating CN. Following deregulation, death rates were 60 in 1000 patients at the busy hospitals, and 117 at the lower volume hospitals. It's clear where you and I would go, I think, for our surgery. In the "Journal of The American Medical Association," in deference to Mr. Maressa, the statement appears in this article: "The greatest improvement in average outcomes for coronary artery bypass surgery would result from closing low volume surgery units," exactly what would be encouraged with no CN.

We know nationally, and we certainly know in New Jersey from our own experience of 22 years now, that deregulation does not work to improve quality; it does work beautifully to increase costs. Every hospital cannot, and

should not, do everything. There must be systems in place to assure the best quality possible at the lowest cost possible. It's something we are searching for.

CN regulation is an important item, I believe, to determine right from the outset whether, in fact, the valid need exists for the service or equipment, or whatever is being discussed, and what the financial feasibility is of providing that service. Is it going to be cost-effective? Is it needed in the first place? Other than documenting those two things, why would anyone want to let any project proceed? If these two questions are answered in the positive, then a Certificate of Need should be granted, and I would venture to say that in most cases in New Jersey it has been granted. This is very important protection for the consumers, for the providers, and for the payers. Without CN regulations and rules, without public discussion, and without any oversight, the possibility of the rule for mischief in politicking through things is increased at least a thousandfold.

I would offer that Certificate of Need in New Jersey has worked, and it has worked very well since 1971. Has it worked perfectly? No. Has it been politicized? Sure. But I have been as close to the process as anyone else, and in my role as President of a large teaching hospital, I have been personally through the CN process literally dozens of times.

There isn't any question that the CN process in New Jersey has avoided the expenditure of tens of millions of dollars, and, more importantly, it has built a referral network and created centers of excellence with care being delivered at an appropriate level of expertise, as well as cost. These centers of excellence exist in many of the urban and teaching hospitals that the Hospital Alliance now represents. They perform at a very high level. They receive referrals on a regular basis from hospitals in their regional area. Some may dismiss Certificate of Need as franchising; I choose to support

it as an important component of the whole concept of regionalization.

If Certificate of Need were to be abolished, and deregulation ensue where anyone could set up business in whatever service they chose, these centers of excellence -- many, as I say, in urban hospitals -- would be eroded entirely as to their referral base, to the point where they would literally be unable to remain in existence. They have been extremely important not only to the suburban hospitals which do not have the same expertise or equipment, in some cases, but because of their existence in the inner cities of this State, they have permitted the local city populations to have immediate availability of high-tech tertiary services which clearly would have been unavailable to them because of geography, or lack of insurance coverage.

And, additionally, there are tens of millions of dollars which have already been spent in equipment and staffing the present centers of excellence. That would now go for naught if the CN were to fold. All of the services that are available in the inner-city major teaching hospitals at the tertiary level will be cherry picked instantly if CN is to fold. Those expenditures were made with the full concurrence of local boards made up of a majority of consumers, by the way, and with the full concurrence of the Department of Health, which ultimately grants any CN.

Further, these centers of excellence in our teaching hospitals have provided the setting for a great education of the physicians who, in the future of New Jersey, will be able to keep us at the cutting edge in these important specialties, and never again let us see what we saw for so many years, with everybody rushing over the bridge to try to get these specialty services in New York City. In a flash, these specialty services can be an all-consuming need in our own families; I have a present emergency of that very kind.

And so, I would urge you not to deregulate by abolishing Certificate of Need. Other states have done so; they are trying very hard to reestablish the very processes we have in place and the very ones that have worked so effectively. The type of regulation that CN provides is totally consistent with the goals that we all share of quality care and cost containment. I believe that nothing else will satisfy either our responsibilities -- yours as legislators, mine as a provider -- and nothing less will satisfy the clear and compelling demands that we hear from the citizens, both of our State and of our country.

I thank you for the opportunity to make these remarks today, and I would be very happy to answer any questions.

ASSEMBLYMAN COLBURN: Thank you.

Mr. Mikulak?

ASSEMBLYMAN MIKULAK: Yes, through the Chair.

Are you suggesting that every state that's deregulated wants to reregulate?

SISTER BRADY: I didn't make that statement, Mr. Mikulak. What I said was that there are some states which have deregulated which are now trying hard to reregulate, because the experience has proven that costs accelerated and quality went down. I'd be happy to provide you with that documentation. It's replete in the literature.

ASSEMBLYMAN MIKULAK: Okay. We've had C of N in New Jersey since -- what was it, 1971?

SISTER BRADY: Right, '71.

ASSEMBLYMAN MIKULAK: You say that this is such a great cost containment, and yet our health care costs have exploded. So, I mean, I don't see the correlation, myself. Maybe, perhaps, you could enlighten me as to how this has kept health care costs down.

SISTER BRADY: Sure, I'll be glad to. I think my statement was that it has avoided tens of millions of dollars that would otherwise have been spent.

There are many reasons for the explosions in health care. Since 1971, which is a span now of 22 years, there have been many things introduced which didn't even exist in 1971 -- CAT scans, MRIs, many procedures. Invasive cardiology also exploded in that time period. All of those things have led to the increase in costs.

Mentioned before was the problem of overbedding. The main reason that overbedding has accelerated so fast in this last time period has been that the length of stay has decreased. Overnight, the length of stay for some procedures, like knee surgery, went from 10 days in my hospital to same day. That's going to provide you with overbedding.

So you cannot hang, nor can we claim, that cost containment nor cost explosion revolves only on the Certificate of Need issue, but I really do believe it has kept costs-- I've watched it keep costs down. I, myself, have been part of voting against CNs, that it would have created totally unnecessary facilities for services at great costs.

ASSEMBLYMAN MIKULAK: With all due respect, I find that the people who are testifying in favor of the C of N have an interest in the C of N process, and the people who are against it have no interest. So that's what I'm seeing.

SISTER BRADY: Well, I see something a little bit different, Assemblyman. I think it's quite interesting to watch people like me come up here and ask you to keep regulation in place. One would think that I would be here today trying to get out from under regulation. I think as you see people proceed after me -- my counterparts in the State -- asking to keep regulation in place, that that should create some real thought in your mind.

ASSEMBLYMAN MIKULAK: Thank you.

ASSEMBLYMAN COLBURN: Anything, Ms. Wright?

ASSEMBLYWOMAN WRIGHT: Just for the record, I believe that Sister Jane Brady has had a public policy role in

Certificate of Need at a different level. That, the record might want to show.

Can you discuss that with us, Sister?

SISTER BRADY: Are you talking about health care administration work?

ASSEMBLYWOMAN WRIGHT: Yes, now that--

ASSEMBLYMAN COLBURN: Membership on some--

SISTER BRADY: I was a member of the Health Care Administration Board of this State for four or five years. My term ended a year ago. Is that what you mean?

ASSEMBLYWOMAN WRIGHT: Yes, but that is not the Board that approves Certificate of Need, but handles the appeals, so that I would think she's seeing it at a broad level -- at the State level -- and I just thought the record might show that.

SISTER BRADY: Thank you.

ASSEMBLYMAN COLBURN: From my point of view, to defend all of us, I think we all have an interest on one side or another. I'm a physician, you know, and these other guys are different kinds of things, and they all have an interest. They're kind of protective, but we're learning from everybody. I find I learn something every day.

Thanks a lot, Sister.

SISTER BRADY: You're welcome.

ASSEMBLYMAN COLBURN: (laughter) A little confession on my part, there.

Mr. Roche? Patrick Roche?

**P A T R I C K F. R O C H E:** Good morning. My name is Patrick Roche. I'm the President of St. Francis Medical Center. We are an urban teaching hospital in the heart of Trenton.

I would like to begin my remarks with a little background on the reform legislation. This legislation which promoted the philosophy and principles of competition, I believe was necessary, and I do also believe it's beginning to show some positive results.

I also believe that major reform in health care is essential; it's not an option. Aggregate costs are excessive and unacceptable. There is great duplication of services, equipment, and facilities in the State, and access is a serious problem to many of our population. I believe that pro-competitive concepts such as formation of large purchasing groups, insurance reform, universal access, and formation of comprehensive provider networks must be implemented. I believe that quality, access, and reasonable costs can be compatible if we undertake reforms properly. I think there's enough money in the health care system. I don't think we're using it particularly well.

The regulatory and voluntary cooperation approaches to access and costs, I believe, have been obvious failures. Micro management of health care by governmental bodies is unworkable and costly.

Reform can be painful to some providers when we're going through a change, but I do believe that the benefit will accrue to the public as a result of many of these changes.

There are unique needs and circumstances of selected populations -- the poor, people who suffer from HIV -- and there are certain locations in the State that might not fully benefit by competitive principles, and I do think that they have to be otherwise addressed.

I think the Health Department should address these unmet needs as their principal focus, rather than trying to micro manage those services which I think can respond to marketplace forces. I think there are many providers who will work collaboratively with the Health Department to those ends.

Competition is the predominant emerging force throughout the country in regulating costs of health care, but in New Jersey we are not accustomed to this form of approach. We've been accustomed to a regulatory model, and we're only beginning to understand such principles and implement them since the legislation went into effect as of January 1.

I think that the CN legislation needs to be modified to reflect these new dynamics. I do not believe, however, that CN should be entirely eliminated until New Jersey providers truly understand and adjust to the competitive environment. Otherwise, we could witness a significant increase in capital costs and an additional proliferation and duplication of services.

I believe we should retain CN only for major services and major capital expenditures. Introduction to new services, such as neonatal intensive care, organ transplants, cardiac surgery, traditional services like OB, PEDS, mental health, should be retained, as well as MRI, surgicenters, nursing homes, and other major tertiary services.

I also think that the capital expenditure threshold should be raised from the current 5 percent of revenue, perhaps up to 10 percent to 15 percent. I think that that will largely be controlled by the competitive forces.

I think it would also be beneficial if the Health Department expended much more of its time and resources to evaluating new technologies prospectively, rather than retrospectively reacting when someone wishes to acquire them.

I also think CNs should be granted to those who have demonstrated responsibility, those who have the ability to document consistently high quality outcomes -- these are measurable outcomes -- to have reasonable competitive costs, who have a track record of providing services to a cross section of the population in a given region, including the poor, minorities, and those at-risk; not just to be able to cherry pick a narrower population, who also have a demonstrated track record of a community focus emphasizing prevention and early detection, and also who can clearly document sufficient volume to meet minimum standards.

We've seen instances where people have been granted CNs and have not followed through on their responsibilities, so

I would suggest the consideration of conditional CNs being issued, perhaps for a maximum of two to three years -- varying by the type of CN -- and then to be judged ultimately whether they have met the performance standards to which they had agreed.

I also believe that when CN is required, it should apply to all providers, not just to hospitals. It's essential that we streamline the process, that we have a maximum allowable time, and I do not believe that CN submission should be dependent solely upon some State agency or public agency declaring the need, and we simply have an opportunity to respond at that point in time.

I think that we should give particular emphasis to opportunities in ambulatory care, and when institutions are going to transfer license capacity to community-based centers, such as surgicenters, I think they should be given priority consideration.

As an overview on my last comment, I would hope that the CN would be guided by a prevailing attitude towards macro, rather than micro management, reform through a competitive philosophy, and recognition of special and unique needs of populations, rather than by evaluation by rigid formula.

I'd be happy to answer any questions you might have.

**ASSEMBLYMAN COLBURN:** Thank you. When you spoke of improving -- looks like improving the process -- do you have any examples of major trouble in the process, or delay, or cost? I'm interested in how much it costs the hospital to get the information together to give to the Health Department and consultants, and all that kind of thing.

**MR. ROCHE:** As a matter of fact, we do have one that I think is a good reflection of the injustice of the current system. Approximately five years ago, we began to assess and evaluate the need for cardiac surgery in this locality -- in the greater Trenton area. We submitted a CN three years ago,

and we are still in the process. We went through the whole HSA evaluation. We were approved by five county subcommittees. We were approved by the SHCC. The Commissioner at the time rejected it. The SHCC reaffirmed it, and our only recourse was to then go to an administrative hearing. The law judge, in January, remanded it back to the Health Department and, finally, Commissioner Siegel assures us to a fair review.

One of the things I would like to point out where I think the process went awry, is that the standard was a million population without consideration of unique population. In the City of Trenton when you look at some of the health and disease, the quality of care -- the availability of care -- is truly appalling. For cardiovascular diseases, we are 77 percent higher incidence than the national average. For heart attacks for people under the age of 65, we are 259 percent of the national average. We have twice the incidence of cardiovascular disease, and we have half the level of services available locally as the rest of the State. These were unique circumstances that were not considered -- but hopefully will be considered promptly -- but we must do something to improve this. We cannot have that kind of delay.

Now, the cost to St. Francis Medical Center has probably been in the vicinity of $150,000; far greater than necessary. The cost to the public who have had cardiac surgery has probably been in the $10 million to $12 million -- over and above the cost if it had been done locally. Most people go to Philadelphia; the cost is dramatically higher. Those are costs that employers have paid. The cost to the population who do not have access might be a serious continued illness and maybe even death, because there are many people who simply cannot leave this town to get care, and I think they are deserving of such care.

**ASSEMBLYMAN COLBURN:** Thank you. It sounds like the Health Department ought to consider targeting health problems

for attention, you know -- where they crop up -- and zero in on the darned things.

MR. ROCHE: I would hope so. Commissioner Siegel said he would give it such consideration this time around.

ASSEMBLYMAN COLBURN: Anybody else? Ms. Wright?

ASSEMBLYWOMAN WRIGHT: Mr. Roche, in your testimony you talked about retaining C of N for major services, and you identified OB, pediatrics, mental health, MRIs, etc. There are a number of hospitals in this State that find it difficult to compete under the competitive system, since the insurance companies are focusing on institutions with full services, primary care, particularly. Doesn't that serve as a disservice to the-- You were just talking about delivery of more local-- I don't think everything has to be local in the sense of, in your neighborhood, but it just seems that that flies in the face of what you just said about cardiac services.

MR. ROCHE: Well, first of all, I can speak best about this in Mercer County. We are grossly overbedded, running in the low 60 percent occupancies. We already have a high length of stay, which will go down. We do have access beds in every category in the area, and I don't think that should be compounded in any way.

I'm very familiar with hospitals around the country, some within our own health care system -- the Franciscan health system. We have 12 hospitals, and there are hospitals in the State which do not have a full range of service, which do compete very effectively. So I don't think it's absolutely necessary for every hospital to have every service. We simply can't afford it. We have to find a way to contain costs.

ASSEMBLYWOMAN WRIGHT: I'm not talking about every service. I was speaking about primary health care services, and I'm not sure how many of the insurers are contracting with institutions that do not have the basic primary services.

ASSEMBLYMAN COLBURN: Thanks a lot. Oh, I'm sorry, Steve. Did you have a question?

ASSEMBLYMAN MIKULAK: No, I just wanted to say that your testimony was good in that you give us some alternatives and you make some recommendations. It wasn't just a carte blanche status quo -- a defense of the status quo. I think it was very thoughtful.

MR. ROCHE: I think we can simplify it. There are a lot of abuses there. There are things we just shouldn't have to send through for obvious reasons, but there are some things that must, in the interest of the public, in the interest of costs, still be controlled.

ASSEMBLYMAN MIKULAK: Thank you.

ASSEMBLYMAN COLBURN: Mr. Coffey? Maurice Coffey, are you present? (no response) Not here, I guess. Mr. Fishman.

Jean Earle has agreed to appear on Monday, so you're moving up one.

**L E O N A R D F I S H M A N:** Thank you, Mr. Chairman, Committee members. My name is Len Fishman, and I'm General Counsel to the New Jersey Association of Nonprofit Homes for the Aging. I have my son with me today, so I know you won't ask me any questions I can't answer. Right? (laughter)

ASSEMBLYWOMAN WEINBERG: Well, if you can't, I'm sure he can. (laughter)

MR. FISHMAN: Okay, stick by there, Linc.

NJANPHA is comprised of 130 health care and housing facilities for the elderly, which serves more than 25,000 seniors in New Jersey every year. Protestant, Catholic, and Jewish organizations sponsor two-thirds of our members. The balance are sponsored by county governments, private charities, and fraternal organizations. Our members include the full spectrum of long-term care and housing facilities, including subsidized housing. Our nursing home and RHCF members are subject to the Health Care Facilities Planning Act.

We at NJANPHA have spent a lot of time recently contemplating today's topic. We've attempted to organize our analysis by posing the questions: What are the avowed purposes of the CN program? Are they meritorious? If so, are they being achieved? And, finally, are they being achieved in the most efficient and least intrusive manner?

These questions provide the framework for my testimony. Before I go further, I want to anticipate Assemblywoman Wright's question. My comments are directed only at the CN program as it applies to long-term care. I also want to note that this is just a discussion of some important issues; it's not an exhaustive analysis of the subject.

Let me begin with an examination of the purposes. Over the years, proponents have claimed many benefits for the CON program:

1) It encourages and promotes planning and a wise allocation of resources.

2) It provides local input in the planning process.

3) It allows screening so you get high quality providers.

4) It controls the supply of beds.

5) That controlling the supply keeps occupancy rates high.

6) Keeping occupancy high improves efficiency and economy.

7) Keeping occupancy high helps to assure an adequate revenue stream so facilities have the money they need to provide quality care.

And, finally, the prospect of high occupancy makes financial institutions more willing to finance construction.

Those are the arguments. I included every one I could think of that have been made to defend the CN program.

In fact, the chief benefit boils down to the claim that the CON program assures high occupancy which, in turn, is

said to promote efficiency, adequate reimbursement, quality of care, and access to financing. If you measure these characteristics in New Jersey, you'll find that nursing homes scored pretty well. Occupancy is reasonably high. It could be higher -- it was about 93 percent in 1992. In general, quality of care is also high. In the most recent survey of the U. S. Health Care Financing Administration, New Jersey's nursing homes scored equal to, or better than, facilities nationwide in 19 out of 32 criteria -- that's 59 percent -- despite tougher surveying procedures.

Now whether these favorable characteristics are attributable to the CON program, however, is an open question, at least in our view. For this reason, we think this Committee is right in examining the CON program. Our Association recently began an inquiry of its own which we've undertaken with an open mind. We thought it was time to step back and consider how well the program has fared in New Jersey, and also to look at how states are doing that have abolished their CON programs. We have not reached final conclusions, but we have some information that may assist the Committee in its work.

I want to start with occupancy, since it figures so prominently in the arguments in support of a CON program. In fact, Commissioner Siegel led off with that issue. I've provided you with an exhibit -- that I hope you have now -- in addition to my testimony, that shows nursing home occupancy rates around the country for 1990, which is the most recent year for which information is available. There are 12 states that have abolished the CON program, and I'm not going to list them for you; they're listed on page 4 of my testimony -- from highest occupancy to lowest -- that is, Minnesota to Utah. You can see that some of these states have high occupancy rates, and some have low occupancy rates. By the way, on the data that we supplied you, the states that have abolished CN are highlighted so you can easily see which they are.

We don't see a significant trend either way in terms of occupancy. The median occupancy rate among states without the CN program is 93.45. New Jersey, which as you know has a CN program, has a median rate of 93.91. That's less than half a percentage point of difference. It's just a little below the median occupancy rate of 94.82 among all states in the U. S. So to summarize, for all states the occupancy rate is 94.8; in New Jersey, it's 93.9; among non-CON states it's 93.45. Not a very great difference.

We have spoken with representatives, at length, from 11 of the 12 states that abolished their CON programs. A couple -- California and Kansas -- reported that occupancy rates did drop when the CON program was terminated, but then climbed back up again. In those states where CON was abolished some years ago -- where you really can begin to see some trends over a longer period of time -- all reported that occupancy rates have stabilized since then.

Now, these figures are a little misleading, because three of the states -- Louisiana, Minnesota, and South Dakota -- have some sort of moratorium on new nursing home beds. Two states have some limitation in the certification of new Medicaid beds, and since Medicaid is such a large payer, this has discouraged new construction in those states. On the other hand, elimination of the CN program in some states, especially in California, coincided with the introduction of more community-based, long-term care alternatives, and that would have reduced nursing home occupancy in any case.

Our counterparts in other states, without exception, report that termination of the CN program had no negative effect on quality of care. In fact, in two states, representatives said eliminating the CN program had actually increased quality of care because of increased competition. Another state reported the competition had spurred providers to offer a greater array of services, and in no state did people claim either way that access to financing had been affected.

So, in summary, it appears that in states where CON has been abolished there's not been a material negative effect on occupancy, quality of care, or access to financing. But, our survey also convinces us that there is a limit to how much you could extrapolate from the experience of other states, because there are so many other factors that affect utilization and quality of care; for example, Medicaid reimbursement levels -- that would certainly be the most important one -- moratoriums, licensure requirements, and so on.

For the record, it should be noted that sometimes the CON program has an adverse affect on utilization. During the 1980s, for example, here in New Jersey, there was an unwritten rule that when an applicant applied to build a nursing home, the applicant also had to agree to build a residential health care unit. There was no demonstrated need for these units and, in most cases, the applicants didn't want to build them. Interestingly, the Department of Health had not undertaken any market or feasibility studies to determine whether consumers wanted these units, as the Department, of course, would have expected providers to do. Nevertheless, the Department made clear it would not approve a CON for a nursing home unless the RHC component was included.

Not surprisingly, when these RHC units were constructed, they had high vacancy rates that continue to this day. This ought to serve as a warning of what happens when facility construction is driven by commands of the Department without regard for the demands of the market, and the RHC is the most glaring example of that. No one will contest that their vacancy rates are high and that there would be far fewer RHC beds in this State, but for the Department of Health requiring that they be built.

Another example of induced underutilization is in the area of continuing care retirement communities. Some of you have these communities. I know, Mr. Chairman, you have

Medford-Lees in your district; other members may have them as well. These are facilities that offer continuum of care from independent living to nursing care, with supportive services in-between.

Until recently, we were the only State in the country that had minimum-sized requirements for the nursing home component of a CCRC. Under the CON rules, the nursing home had to be at least 60 beds, and that meant for arcane reasons that I won't explain, that the CCRC itself had to have at least 240 independent living units.

This requirement was arbitrary and indefensible, and after years of pleading, we finally got the Department to eliminate it. But, in the meantime, some CCRCs were built bigger than they should have been, and now they have vacant units that are financially stressing the community. Some CCRCs that would have been built, weren't built at all, because they couldn't face the financial nut of a facility that large -- you're talking about $30 million or $40 million -- or because they just couldn't find a parcel that was big enough to house a facility of that size. So these are a couple of examples where the CN program can actually cause underutilization, contrary to what one might think.

As for screening applications with a view to quality of care, the CON program has been disappointing on this count, as well. Recently, when the Department of Health promulgated its CON Policy Manual for Long-term Care Services, a section set out 13 criteria for ranking Certificate of Need applications. The first three criteria were worth two points each and the remaining 10 were worth one point. Twelfth out of 13 criteria, and worth only one point, was an applicant's track record for high quality patient care. Certainly, if you were trying to screen applicants for quality providers, you'd make that your number one, or at least our Association believed that that ought to be the number one criterion. When we appealed to

the Health Care Administration Board, they pressured the Department of Health to award that criterion two points. But it certainly speaks to, at least in our minds, a lack of adequate attention to the quality of care issue which, as I have said, I think is the most important.

One of the arguments in favor of the CON program is, it allows for local review of projects but, historically, the health system agency reviews were tainted by parochialism, turf-protection, and conflicts of interest.

Now, I want to make a distinction here between a couple of things. I'm talking about the old HSA reviews which no longer exist, because the Health Care Cost Reduction of 1991 replaced the HSAs with local advisory boards which, I think, are likely to produce less conflict of interest than has been the case in the past. I also want to make clear I'm not talking about Department of Health CON staff. In my dealings with them I found them to be professional and quite fair. But the local review process, at least in the past, has-- I think the perception is universal that applications are sometimes reviewed by members of those agencies with an eye to protecting turf -- rewarding your friends and hurting your enemies. That may be less true now with the local advisory boards, because their role has been recast from being the final arbiter at the local level, you know, voting applications up or down, to really having more of a screening function; screening out the bad actors.

Whether the positive attributes of the CON program outweigh the negative ones is a matter that our Association is continuing to examine. In addition to the problems I've mentioned above, the CON process does sap time, money, and energy. Timing is everything in the CN process. An applicant has got to be ready to go when the call comes for applications. Those of you who have had experience with volunteer community-based boards of trustees know that they

tend to move cautiously and slowly, and so this kind of timing issue often works against nonprofit providers. Besides the application fees, there are professional fees and the value of time spent complying with the local review process.

In the last part of my testimony, I want to talk about planning, because whatever happens to the CON program, the State need not -- and we would argue, should not -- surrender its planning role. In fact, potentially the greatest innovation that has been proposed in long-term care in New Jersey in many, many years, came in the form of the final State Health Plan that proposed less reliance on nursing facilities to provide care, and more attention to residentially based alternatives that would be less expensive, and that people would prefer. This is an example where the Department has helped to lead, not through a CON program, but through some progressive thinking and appropriate licensure regulations.

I'll give you some examples of other cases. In California, when the CON program was eliminated, it was replaced with a law that requires developers to file a notice of intent with the state's health planning agency if they contemplate building a health care facility. They've got to actually report, then, when local permits have been granted, and they have to report a third time when ground is broken. What this creates, really, is an information clearing house. So if I want to build a nursing home in California, I can call a number at the Department of Health and find out every project that is contemplated within the region that I'm planning to build. This is one way of making the market smarter and helping to diminish the prospect of overbuilding.

Concerns about quality of care can be addressed through a Certificate of Authority approach which is used now by the Department of Community Affairs to license CCRCs. You've got to meet very rigorous requirements to get a Certificate of Authority, and you have to include very detailed

information on prior experience, legal history, professional background, records of infractions, and financial interests of the owners and the operators, and you have to satisfy DCA that you're capable of running a CCRC well.

You can also reduce the risk of overbuilding by building in strategies that put the potential provider at financial risk if the facility is underutilized. I'll give you a couple of examples: In New Jersey, the State's Medicaid reimbursement methodology for nursing homes assumes a minimum occupancy rate of 95 percent when it reimburses a facility's fixed costs. That means if you're operating at less than 95 percent occupancy, you're not getting your full cost. That's the Medicaid program's way of saying, "If you're underutilized, we're not going to pick up the slack. You're going to have to eat that." We think that's appropriate. It's an appropriate way of controlling or inducing providers to be well utilized.

You could also increase equity requirements so that there's more money at risk. You could tie the approval to build to a designated maximum occupancy level within the LAB, or the county in which the facility is to be located.

The point of the examples I've given you is this: The choice is not really between a full-blown CON program, as we now have in New Jersey, or no planning process at all. If anything, planning is likely to become even more important as health care reform advances.

You know, if you were to do away with the CON program -- and I want to underscore that we're not advocating it -- but if you were to do that it wouldn't put planners out of work. It would make planners' jobs a little tougher because they would really have to analyze a more fluid market and help facilities that they work for figure out what services are demanded, whether reimbursement is available, all the stuff that they now do in the context of the Certificate of Need program. Again, this is an open issue for us that we continue

to examine, and my remarks are confined to the long-term care industry. The issues may be different in other areas.

The last thing that I'll mention, briefly, that was raised, I think, by Assemblyman Felice, has to do with the Appellate Division decision that invalidated the Department of Health regulation adopting the State Health Plan. That decision, and particularly the way the Department of Health is now interpreting that decision, has caused tremendous uncertainty in the Certificate of Need program. We have a CON manual that is supposed to guide Certificate of Need applications and reviews. The Department of Health is taking the position that it can't follow that manual because some elements of it come from the State Health Plan. We've argued that the Department is not prohibited from using anything that appears in the State Health Plan. After all, the State Health Plan calls for quality long-term care, and surely the Department can adopt regulations to implement that goal. It also, as clearly, cannot reflexively adopt the whole State Health Plan as a regulation.

Nevertheless, the Department is taking a very broad view of that Appellate decision, and that's causing problems. I think everybody agrees that there should be a uniform public set of rules that guides applications and reviews, so that everybody knows what the rules are in advance, and we may come to this Committee to ask for its assistance in collaborating with the Department of Health and working out the problems that that decision has engendered.

I thank you for your time and this opportunity to testify. I'd be happy to answer any questions that you might have.

**ASSEMBLYMAN COLBURN:** Thank you.

Members?

**ASSEMBLYWOMAN WRIGHT:** I just want to say, for the record, that I would hope that the summary of the CON status,

state-by-state, which has been carefully documented by Mr. Fishman, would become part of the record of this hearing, because it's exactly the kind of data I'm looking for.

I want to thank you very much for your, really, very instructive comments.

MR. FISHMAN: Thank you.

ASSEMBLYMAN COLBURN: Thank you very much.

ASSEMBLYWOMAN WRIGHT: We'll give him and "A."

ASSEMBLYMAN COLBURN: I presume we'll have your availability some time in the future for more information?

MR. FISHMAN: I'd be pleased to be. Thank you.

ASSEMBLYWOMAN WEINBERG: Mr. Chairman, if I may? Just one quick question.

Mr. Fishman, most of the problems that you talked about in the earlier part of your testimony were actually things that have been rectified by the Department of Health under the present C of N process. Correct?

MR. FISHMAN: I think many of them have.

ASSEMBLYWOMAN WEINBERG: Okay. I just wanted to make sure I understood that.

MR. FISHMAN: Some of them were eliminated as a result of the Health Care Reform Act of 1992, as well.

ASSEMBLYMAN COLBURN: Thank you.

Judith Burgis, are you still here? You are.

**J U D I T H E. B U R G I S:** I do have copies.

ASSEMBLYMAN COLBURN: I think after we hear you-- Thank you. Would you give them to Kelly (Minority Staff Aide) over here? He'll pass them around.

We'll hear from Mr. Bornstein after you, and Rick Abrams has agreed to appear on Monday. So that will be it for this morning.

MS. BURGIS: Good afternoon. I'm Judy Burgis, and I'm the Senior Vice President for Corporate Services at Robert Wood Johnson University Hospital. My remarks will focus on the

common good citizens expect of the hospital care system in New Jersey.

In New Jersey and throughout the United States, the public wants the health care system to deliver high quality care that is accessible to all the people at reasonable cost, and in a cost-effective manner. The experience of other states that have deregulated health care and the Certificate of Need process during the 1980s, shows that rational health care planning and Certificate of Need regulations are required for the attainment of this common good.

In Arizona, after deregulation, the number of cardiac surgery facilities increased significantly, and resulted in increased cost and poor quality outcomes -- you heard detail of Arizona's experience in earlier testimony. The proliferation of beds and services after Certificate of Need deregulation also occurred in Texas and Utah. These, and other examples, highlight the fact that supply, demand, quality, and price relationships in health care do not adhere to traditional economic models. Deregulation increases the number of providers and high-tech services, and does not create a competitive environment that lowers cost and improves quality. In fact, experience demonstrates that just the opposite occurs.

Is it any wonder, then, that the pendulum has been swinging away from deregulation over the past couple of years? According to the Intergovernmental Health Policy Project at George Washington University in Washington, D.C., a renewed interest in health planning and regulation has emerged as states have enacted health care reform.

For example, in 1990, the Governor's Task Force on Access in Georgia recommended strengthening Certificate of Need regulation, and legislation to this effect was passed in 1991. Also in 1991, West Virginia lowered Certificate of Need review thresholds for the first time in years. Delaware brought all medical equipment under the purview of Certificate of Need.

Virginia halted its plans for further deregulation in 1991, and in 1992, significantly broadened its Certificate of Need program. In 1992, Minnesota's Health Reform Law reinstated capital expenditure review in that state. Vermont incorporated health planning and CON review into a legislative global budgeting process for health care. Wisconsin enacted a cost-containment law establishing capital expenditure review for hospitals in 1992. Also in 1992, Kentucky and Indiana both expanded their Certificate of Need program for specialized services. Maryland, Pennsylvania, and South Carolina also expanded regulatory provisions governing the dissemination of medical technology. Already in 1993, Florida's universal Health Access legislation has Certificate of Need review as its centerpiece.

There is an additional key issue that faces New Jersey: We share two of our prime borders with New York and Pennsylvania, both of which have Certificate of Need regulation in place. Without Certificate of Need regulation in New Jersey, we become an attractive fertile target for the highly capitalized health care providers of New York and Pennsylvania, including not-for-profit and proprietary companies from around the country. We see that this has happened in other states that deregulated. These providers stand at New Jersey's borders like predatory giants ready to cannibalize our best health care markets. The cut-throat competition they will unleash will bring about:

* destabilization of existing providers,

* needless duplication of services and technology and a concomitant increase in cost -- we saw increases in cost across the country,

*decreased quality of care resulting from the unnecessary proliferation of services and providers which prevents providers from reaching the critical number of procedures required to achieve and maintain skill proficiency,

*health care dollars flowing out of New Jersey into New York, Pennsylvania, and elsewhere.

The health care of New Jersey's citizens is too important an issue to be left to the unworkable economic theory of deregulation and the vagaries of the marketplace. We should learn from the experiences of states across the nation that a rational, cost-effective system of health care emphasizing health planning and CON review works best to attain the common good we all seek.

Thank you.

ASSEMBLYMAN COLBURN: Thank you. Now, you were saying that these predators are on our borders ready to pounce on us, and if they pounce on us the cost will go up for the services that they would-- Is that what you were saying?

MS. BURGIS: Because we have had mainly a workable system through CN.

ASSEMBLYMAN COLBURN: But, I mean, if we changed it they would come in?

MS. BURGIS: Yes.

ASSEMBLYMAN COLBURN: Well, then, the people that were getting these services and paying more, would they then go back to New York and Pennsylvania where they have the CONs, because it gets more expensive here? I'm trying to figure this out.

MS. BURGIS: We believe that, because the experience of other states is something we should learn from once you deregulate. New Jersey's going through a lot of change; this is a transition year for all of us. We are all watching bottom lines very carefully, to be cost-effective. There are large, as we know, institutions on both sides of the New Jersey corridor, highly capitalized with lots of dollars to invest in New Jersey, because they, too, need additional patients and the paying patients that are so attractive to their own programs.

ASSEMBLYMAN COLBURN: No, but I'm trying to figure out this one thing you were saying. It seems to me that the payers

for the services -- which are mostly not individuals -- if we let this thing open up and all these predators came in here and provided all these services and the costs went up, wouldn't our payers then send the people to New York and Pennsylvania where the price was lower?

MS. BURGIS: Not necessarily.

ASSEMBLYMAN COLBURN: No?

MS. BURGIS: No, and the price isn't necessarily lower in Philadelphia, either.

ASSEMBLYMAN COLBURN: But they have CONs, and their prices will be more stable than ours if we deregulate.

MS. BURGIS: Yes, what we have seen, just to be more specific, is that there's a lot of interest, for example, in investment groups coming into New Jersey -- if we do regulate -- to develop freestanding MRIs, that's basically outpatient; freestanding CATH labs, basically outpatient; additional lithotripcy programs, again, basically outpatient, so that the way we have regionalized access to these specialty services would no longer work in a deregulated system -- that these additional programs would emerge. For example, Chicago, which originally had a strong CON review process, had regulated regional services the same way we had in New Jersey. Once deregulated, the number of MRIs simply doubled; doubled by for-profit groups coming in chains that really had capital that we haven't seen in New Jersey.

ASSEMBLYMAN COLBURN: One aspect which we don't have time now to get into that concerns me, is advertising by such groups and encouraging business, and advertising by hospitals and physicians. I don't like it much, myself. I think it creates demand that might be artificial.

Do you have any questions, folks? We have access to all the statistics that the Robert Wood Johnson Foundation can make available, don't we -- especially on this subject?

MS. BURGIS: Well, I am speaking for Robert Wood Johnson University Hospital, but I'm sure that--

ASSEMBLYMAN COLBURN: Oh, okay. You're not the Foundation. I'm sorry.

MS. BURGIS: I'm sure that we would be able to provide those examples, and particularly the GW report, yes.

ASSEMBLYMAN COLBURN: Okay. Yes, because, you know, we would like to see things like that. Thanks a lot. I appreciate it.

Mr. Bornstein, you're going to make it today. The Speaker may be waiting for us, you know, but we don't care. (laughter)

ASSEMBLYWOMAN WEINBERG: Maybe you don't care, but I do. (laughter)

ASSEMBLYMAN COLBURN: If we get a few demerits, we will.

**L E S T E R M. B O R N S T E I N:** I won't be long. Good afternoon, Mr. Chairman, Committee members, ladies and gentlemen. My name is Lester Bornstein, President of Newark Beth Israel Medical Center. I'm here to present my views on how Certificate of Need has benefited people in the State of New Jersey.

You, our representatives, can take great pride in the progressive way health care has been delivered to citizens of this State. Not only has access been assured, but has enabled all of our people to receive the best quality health care at a cost far below those in the 10 highest industrial states.

One of the ways that record of quality has been sustained is through the Certificate of Need program. You are now examining the CON program. As you go forward with your deliberations, I would like to offer these comments.

Certificate of Need is not a perfect process. Critics raise three key issues when discussing the program. Those are:

1) Institutions that receive a CON enjoy a unique franchise for particular health care service which cannot be

duplicated in other area hospitals unless specific criteria are met.

2) The unique franchise decreases competition, and consequently increases cost.

3) Concentrating health resources in specific institutions decreases access for some citizens who do not have a particular health service in their community.

While those negative aspects of Certificate of Need are worth considering, I believe the positive results of the program far outweigh any negative, and contribute to the overall public good.

More specifically, I want to address those concerns with the facts:

1) The creation of an exclusive franchise is not necessarily bad. In health care, quality is directly related to volume. That's been said here before. It has been demonstrated repeatedly and conclusively that a minimum quantity of procedures must be performed to maintain the techniques necessary to ensure quality. Concentration of a health service at particular institutions serves to ensure that volume is sufficient to maintain quality.

This principal is demonstrated by the California experience, where elimination of the Certificate of Need laws resulted in the proliferation of unnecessary programs, rising cost, and increased patient mortality.

2) Health care costs do not necessarily decrease with increased competition. The nature of health care is such that the expected cost savings anticipated from free market competition are not readily achieved.

Eliminating Certificate of Need is expected to reduce red tape and allow for competition between hospitals to control health care costs, but it just doesn't happen that way.

We only have to look at those states that have weakened CON laws and now seek to return to an organized health

planning system. California, again, is the classic example of the shambles health care systems suffer with the reduction of Certificate of Need authority. All I ask is that before embarking on the road to dismissing Certificate of Need, you check on other states' experience. There are numerous articles available for your review which describe how many states, including Minnesota, Colorado, Wisconsin, Montana, Kentucky, Missouri, Virginia, California, and Georgia, are moving to reinstate CON laws in order to control health care costs.

I ask the Committee, just to digress-- When you get to the end of this, and later on when you have a chance, I attached a news release from The New York Times dated May 11, 1992, which outlines the problems of the states that had Certificate of Need deregulation and are now moving to reregulate. It's a very specific thing that you're looking for in terms of data. So, I've attached it; I'm not going to read it.

3) Access is far from diminished under a Certificate of Need process. In fact, I would argue that access is hampered with Certificate of Need as entrepreneurs cherry pick successful programs out of the hospitals, leaving institutions with only high cost, high risk cases.

Mr. Chairman, I heard you talk about what would happen when these entrepreneurs crowd in from these states and cherry pick. I was thinking about how I would have answered you. I would think these payers-- "Yes," they'll say, "you have to go to New York," but some of these people can't move and they don't have the free access and transportation. I think that would be one of the answers you were looking for.

**ASSEMBLYMAN COLBURN:** You know, you raise something which has been in my mind for a long time, about how to transport sick patients to distant sites, and I felt the CON process might even aggravate that. So, I guess-- You know, whenever we do any of these things, we have to be able to

modify and fine-tune them, as they say, to take into account those things. Because I, certainly, hate to see a sick patient moved much of a distance, and the transportation costs are pretty high, too, just from a nursing home to a hospital to get an MRI. So, you know, still those things--

MR. BORNSTEIN: All right. I think in terms-- I don't want to digress too much, but I think in terms of what you're talking about, going to another state when you're talking about crossing the river--

ASSEMBLYMAN COLBURN: Sure.

MR. BORNSTEIN: Let me continue with my last--

ASSEMBLYMAN COLBURN: Oh, I'm sorry.

MR. BORNSTEIN: No, I'm glad you brought that in. I was the one that digressed.

With Certificate of Need, New Jersey can avoid the dim prospect of a two-tiered health care system. Many of our State's most sophisticated services are located in urban/inner-city teaching hospitals such as Newark Beth Israel. People from the suburbs are able to access not only urban programs, but any programs for their medical needs. However, the same is not true of inner-city residents who lack the transportation -- this is what I was talking about before -- and resources necessary to leave their local communities if programs are lost to the suburbs.

I want to bring this down to my own personal hospital, here, just for a moment. We're not talking about pre-generic; we're now talking about what it has meant to us. I'd like to take this discussion of Certificate of Need back to the effect on my own institution. Newark Beth Israel's survival is dependent upon our ability to maintain our balance of tertiary and primary services. Anything that disturbs this delicate balance will undermine the Medical Center's viability. Our tertiary capability, which is now sanctioned by Certificate of Need laws, brings a large number of physicians from their

suburban homes and offices to the inner city. In exchange for their medical staff privileges, they help to staff our clinics, treat service cases, and educate medical students. When other hospitals were fleeing Newark, the Beth made a commitment to stay. That commitment has fostered primary care and outreach programs crucial to the well-being of Newark's South Ward population. In an area devoid of private practitioners, this Medical Center is the sole provider of a total range of primary health services from pediatric through geriatric care. If our tertiary services erode, our ability to provide quality care to the inner-city population will be severely compromised.

The Beth also provides employment to 3000 people, approximately a third of whom are Newark residents. The inner-city community is dependent upon the Beth for jobs as well as health care. If we are forced to reduce services, layoffs will follow quickly.

I know that you, as elected officials, share the Beth Israel's commitment to excellent, accessible health care provided with cost efficiency.

I thank you for giving me the last slot here of the day, this morning.

ASSEMBLYMAN COLBURN: Thank you very much.

Members? (no response)

Thanks a lot.

That's the end of the hearing now. We'll reconvene at 2:00 on Monday, May 10.

**(HEARING ADJOURNED UNTIL MAY 10)**

**(HEARING OF MAY 6 RECONVENED)**

ASSEMBLYMAN COLBURN: I would like to call the hearing to order, and remind you that we are here to discuss CONs. If you would like to mention the bill here and there, that's okay, but we are not testifying specifically on bills.

I expect this will extend over one more time to May 24, which is not good news for any of us, and I apologize for those who have had to wait.

The projected order now for the rest of the speakers is: Mr. Hatala will be first this afternoon; Mr. Abrams; Jean Earle; Carol Kientz; Ken Jeffries; Joseph Sherber; Michael Bernstein; Dr. Sachs; Dr. Meltzer, and Mr. Fanburg with him; Richard Oths and Carol Paul -- they will be together; Suzanne Sblendorio; Lisa Verniero; Thomas McNamara; Maurice Coffee; Larry Garinello; Gwenn Levine; Sharon Pavelich; Steven Schneider; and Fred Title. That will be the order, and that may wind up on another day.

I am going to ask Assemblywoman Wright to come to my seat here and preside over the first few witnesses of this hearing. The first witness will be Mr. Hatala.

ASSEMBLYWOMAN WRIGHT: Thank you very much, Mr. Chairman.

Mr. Hatala, will you please proceed?

**A L E X A N D E R J. H A T A L A:** Sure.

Assemblywoman Wright and members of the Committee: I thank you for the opportunity to address the Committee today on the Certificate of Need issue. With me is Dr. John Capelli, Vice President for Medical Affairs. My name is Alexander Hatala. I am Chief Executive Officer of Our Lady of Lourdes Medical Center in Camden, and also, Chairman of LAB V for the five counties in southern New Jersey.

The Certificate of Need process was instituted as a mechanism to "assure that New Jersey's hospital and related health care services are of the highest quality of demonstrated need, efficiently provided, and properly utilized at a reasonable cost." This was defined in the 1971 Health Care Facilities Planning Act that established the CN process. To me, that translates into three basic health care values: access, quality, and cost containment. These three values or goals are utmost in the minds of individuals of the local, State, and national level seeking to reform the U.S. health care system. Let me address each one of them:

In terms of access, the removal of Certificate of Need requirements would exacerbate the problem of access for the medically indigent resideing in urban areas. Abolishing CN regulations would result in the overzealous expansion of services perceived to be financially lucrative, rather than meeting a health need in a community. A hospital like Our Lady of Lourdes would be compromised in its ability to provide critical services like high risk maternity, dialysis, cardiac services, and rehabilitation to the medically indigent, specifically to Camden residents, if it were unable to draw patients from a broad geographic and payer base; a strategy that the Medical Center has pursued over the last 20 years.

Many urban hospitals depend on a delicate balance of primary and tertiary services to fulfull their mission to the urban patient population. With deregulation of services, not only would specialty care be denied to the most vulnerable segments of society, but the entire survival of inner-city hospitals would be in jeopardy. However, the need for heatlh services would still remain. As access is diminished treatment would be delayed, only to be manifested in emergency rooms and critical care wards where the dollar cost is high and the human cost substantial.

As a hospital administrator working in Chicago in the late 1970s and early 1980s, I experienced the devastating effects of a new competitive market on the urban hospitals. Deregulation, which included a relaxation of CN rules, led to the closing of 10 urban medical centers. First, hospitals in the inner city with high uncompensated care, Medicare, and Medicaid loads closed quickly. Secondarily, the hospitals in the suburbs and affluent areas of the city embarked upon a medical arms race, building and duplicating facilities, buying physician practices, and expanding technologies, all operating at extremely profitable levels even at low utilization rates.

Millions of dollars were wasted for marketing, advertising, and the pursuit of market share, all in the name of competition. From a price and rate point of view, costs continued to go up. Meanwhile, the needs of people in the inner city did not go away. It is not like doing without in order to get by. Initially, that doing without occurred as access became more difficult and as people were required to travel greater distances to get to Cook County Hospital. These people made decisions to put off care until they were really sick, and then the cost for treating their illnesses was not a matter of a simple visit to an ambulatory care clinic. It required expensive hospitalization. This system caused a maldistribution of resources, increased costs, and reduced quality of life.

In terms of quality, some health care policymakers promote market competition as a means of improving quality in the health services industry. In a competitive market, services tend to expand and are managed at lower utilization rates. This is especially true with the proliferation of sophisticated services such as open-heart, dialysis, radiation therapy, and others. However, many studies have found higher mortality rates associated with underutilized services. Considering, for example, that the State Health Plan study

found cardiac cath labs in the State operating at only 58.8 percent of capacity, underutilization has to be of great concern.

Additionally, quality of care is jeopardized due to the provision of medically questionable care motivated by the economic concerns of a competitive market. As payers and reformers look to reducing unnecessary procedures and channeling subscribers into regional centers of excellence, removal of CN requirements is contradictory to these efforts. Certificate of Need regulations are essential to ensure that facilities meet minimum quality and volume standards.

In terms of cost containment, one of the myths of competitive reform is that removal of CN requirements allows market forces to squeeze out inefficient providers, and thus, reduce costs. But instead, abolishment of the Certificate of Need process results in the unnecessary duplication of costly facilities and equipment. The "medical arms race" is a major factor behind the rising cost of health care, and removal of CN requirements would only compound that problem. In most hospital markets, competing to attract well-insured patients yields greater financial rewards than efforts to increase efficiency, improve access, or improve the health status of the community. Deregulation will increase costs rather than decrease costs, because it will evolve into nonprice rivalry based on expensive services, technology, marketing, and advertising. Intervention is needed to prevent the proliferation of costly, unnecessary services.

Closer to home, we can see the example of a proliferation of services in Pennsylvania. In February 1990, the State relaxed its rules regarding the initiation of cardiac catheterization services. The new rules allowed hospitals that did not have catheterization services a chance to apply for them for the first time in more than a decade. It also did away with the requirement of open-heart surgery on-site to have

catheterization approval. The result: approval for 45 new catheterization sites in the last two-and-a-half years, with more than 20 of those in the Delware Valley alone.

The Department of Health in Pennsylvania is now concerned about the appropriateness of all the cardiac caths done in these new sites, and is requiring standardized data to be submitted about each case. In this way, they will be able to track utilization and its appropriateness because they realize that the proliferation of sites can lead to inappropriate use or underutilization. No firm conclusions have been reached yet as data is just coming in. However, this influx of 20-plus cath sites in the Delaware Valley can have a significant competitive impact on South Jersey. If New Jesey is a deregulated State and these Pennsylvania hospitals with new cath labs are seeking volume to maximize profits on their labs, South Jersey becomes the obvious choice. This, of course, can severely hurt South Jersey hospitals and the financial investments you have made into those hospitals in the past.

I advocate continued Certificate of Need regulation, and believe it has been an effective tool to allocate health care resources to maximize effectiveness and health status outcomes. It ensures the provision of comprehensive and appropriate services. It helps remove availability, geography, and economic considerations as artificial barriers to care. It controls the cost of provision of health care services. Moreover, it involves the community in the development and provision of health care services.

Finally, I would like to address comments made by Dr. Segal at the last hearing; comments related to dialysis as an example of services to be deregulated -- his testimony being that dialysis is an example of services that should be deregulated. The data related to the growth in ESRD facilities in Maryland and in Tennessee -- two states that deregulated

ESRD programs in the early 1980s -- as highlighted in the State Health Plan section on deregulation of ESRD, is of particular interest. There has been a 104 percent and a 134 percent increase, respectively, in the number of dialysis facilities in those states since deregulation. The State health Plan speaks to the issue of quality as it relates to volume of services provided. It cites as the "major concern" related to ESRD proliferation the fact that larger facilities have been associated with lower morbidity and mortality. Proliferation can lead to lower volumes per facility and possibly decrease the quality of treatment provided.

The comments and opinions expressed by the Commisssioner of Health last Thursday favoring the deregulation of ESRD services clearly conflicts with the language contained in the ESRD chapter of the State Health Plan. Through his statements, the Commissioner appears to have minimized the concerns his Department originally raised when they wrote the ESRD chapter of the State Health plan just a short time ago.

I thank you for the opportunity to address the issue of CN deregulation, and certainly would advocate and encourage you to support continued regulation in this area.

**ASSEMBLYWOMAN WRIGHT:** Thank you very much, Mr. Hatala. Are there questions from the Committee? (no response)

Dr. Capelli, do you have anything further that you would like to add at this point?

**J O H N C A P E L L I, M.D.:** Well, maybe I could just make a comment. I think--

**ASSEMBLYWOMAN WRIGHT:** Would you please introduce yourself for the record?

**DR. CAPELLI:** I am Dr. Capelli. I am with Mr. Hatala. I am the Vice President for Medical Affairs at Our Lady of Lourdes.

I think we have all been hearing and focusing on what is happening in health care today with managed care, managed

competition, in an effort to contain the costs that define those strategies for insuring the uninsured patient. We are very concerned, and government is very concerned, about the ability to provide access to care for patients, and provide high quality at reasonable costs. I feel the Certificate of Need is a strategy for providing that kind of a framework of high quality and reasonable cost. By controlling the number of providers who offer sophisticated services, the State can continue to ensure citizens, I think, of quality health care at a reasonable cost.

It has been alluded to a number of times -- I am sure you have heard it in previous testimony, and it was alluded to by Mr. Hatala -- about the problem of volume and quality. Here is a graph that came out of one of the quality review journals. It shows the relationship between the mortality rate with coronary bypass surgery. Would anyone here want to have their coronary bypass surgery in a facility that does 50 coronary bypasses in a year and has a 50 percent mortality, as opposed to a facility that does 200 bypasses a year and has a 2 percent mortality rate?

Recently, in The Philadelphia Inquirer, there was published some data on the mortality rates by surgeons who do open-heart surgery. It was really surprising that the number of surgeons -- that the number of cases per surgeon in Philadelphia is very, very low, less than 200, on the average. One of the most prestigious institutions in the city had the highest mortality rate because the number of cases in that institution were relatively low.

The Urban Institute, which is contracted by HCFA to do ESRD mortality and all sorts of outcome studies, has shown the relationship between the size of facilities and the outcome in mortality. There was an inverse relationship between the size of facilities in ESRD care and the mortality rate. So the smaller the facilities, the higher the mortality rate. This is

what we think will happen, not only in end stage renal disease, but in all the sophisticated tertiary services in this State. If they are deregulated, we will have a proliferation of multiple small units.

I don't like to disagree with the Commissioner, but having been in ESRD for 25 years-- He made the point that you can strictly control quality by setting strong standards prior to the initiation of the program. I can assure you, absolutely, that is not the case. We are the most industrialized, most advanced country in the world, and we have, in the United States, the highest mortality rate in ESRD in the world right now, because of the problems of maintaining the quality that goes into the ESRD facility on an ongoing operational basis, not on a licensing basis, where that relates primarily to facility life and safety codes and standards.

I appreciate the opportunity to have made some of these comments. Certainly you can see from my comments that I support the need for continued health planning under some sort of control design.

ASSEMBLYWOMAN WRIGHT: We thank you for your comments. Could you make your graph available to the Committee, please?

DR. CAPELLI: I'll give it to you. I only have one copy, but I will be happy to give it to you.

ASSEMBLYWOMAN WRIGHT: Good. Are there any questions or comments from the Committee regarding this testimony? (no response) Hearing none, I want to thank you very much, Mr. Hatala and Dr. Capelli.

MR. HATALA: Thank you.

DR. CAPELLI: Thank you.

ASSEMBLYWOMAN WRIGHT: Our next speaker will be Rick Abrams.

R I C K A B R A M S: Thank you very much, Madam Chair.

ASSEMBLYWOMAN WRIGHT: Please proceed.

MR. ABRAMS: First, for the record, my name is Rick Abrams. I am Vice President of the New Jersey Association of Health Care Facilities. We are a statewide trade organization that represents over 225 nursing homes, residential health care facilities, and adult day health care centers in the State.

While some of my remarks certainly will span the array along the health care continuum, really my constituency, if you will, is long-term health care, and really I confine my remarks to this group.

First, before I begin my prepared remarks, I would just like to address two questions that were raised on Thursday, if I might. The first was from Assemblyman Mikulak regarding the provision of the 10-year moratorium on nursing home beds in the initial draft of the long-term care chapter of the State Health Plan. I would agree that initially that was in there, but it was taken out. The reason it was taken out-- Certainly we were very strongly against it, and the reason we were strongly against it was that we saw what happened with the moratorium in the State in the late '70s and early '80s. The result of the moratorium was a shortage of nursing home beds. I represent nursing home providers, but it is in nobody's interest to have a shortage of beds around the State.

The second question that was raised -- and I can speak to this question from experience -- was regarding the jurisdiction of the Ombudsman for the Institutionalized Elderly with regard to durable medical equipment in the community. The Ombudsman's jurisdiction is restrained to folks who are aged 60 or older who reside in facilities where health or health-related service is provided. So, it is facility based. I would suggest, though, that a possibility is Adult Protective Services, if, indeed, there is a problem with the services someone is receiving in the community. In most -- I won't say in all counties, but in most counties the Adult Protective Services Program is administered through your county board of social services.

With that, I will begin my remarks.

Madam Chair, my remarks are rather lengthy. I would be happy to hit the high points, as they say, rather than read verbatim, but what is easiest for the Committee?

ASSEMBLYWOMAN WRIGHT: Let me consult with the Chair, because we want them to show in the record? (consults with Assemblyman Colburn) We will submit the document for the record. If you would hit the high points, we would appreciate it.

MR. ABRAMS: Great. I appreciate that.

The first point I would like to make, folks, is that certainly the New Jersey Association of Health Care Facilities is very supportive of health planning and the vehicle by which that is accomplished in New Jersey, which is the Certificate of Need. The first reason why we are very supportive of this is that we believe that through Certificate of Need and health planning, three goals, which I think we are all after, especially in this era of health care reform, are achieved. In New Jersey, we think we have done a very good job at that. Those three goals are: cost containment, access to care, and the high quality of care.

The first point, cost containment: Without health planning and Certificate of Need in the long-term care -- in long-term health care -- facilities would be built without regard, we believe, to cost or to need. This becomes particularly important to State and Federal government, in that right now in the State of New Jersey, Federal government through the Medicare program and State government through the Medicaid program shoulder approximately 50 percent of the costs of just nursing home care. Our concern is that, if, indeed, there were no control, or no health planning in the long-term care field, facilities would continue to be built until some future saturation point is reached. It is our position that the taxpayers, through the Medicare program and the Medicaid program, would pay dearly.

The second point on cost containment is that the Certificate of Need process assures that a health care project is going to receive favorable financing terms. Without Certificate of Need-- We feel, and we believe, that the normal result of no Certificate of Need would be a rise in the cost of financing, or even difficulty in obtaining financing. Again, if financing becomes more expensive, this again exerts pressure on the Medicare and Medicaid budgets, and, in a sense, it is the taxpayer who pays for the funding of those programs.

Regarding the access issue, if you look-- I took a look at the Department of Health's most recent -- to my knowledge, the most recent data regarding the vacancy factor, or occupancy levels in nursing homes in the State of New Jersey. The data that I was looking at was dated April 1992. This data showed that the occupancy level in nursing homes in the State of New Jersey was at 89.6 percent, or stated another way, you had a vacancy factor of 10.4 percent. This certainly does not show me that there is a shortage of nursing home beds in the State, but on the contrary, shows precisely the opposite; that you've got an efficient industry with enough flexibility to ensure that anybody who needs a bed in this State is able to get one, regardless of the payment source.

If you look at the Medicaid waiting list data, you will find that the waiting list-- I am not aware of the number. What I am aware of is that that waiting list has continued to drop in recent years after we had gotten past the moratorium on nursing home beds in the early '80s.

In conjunction with the whole issue of access, is this whole issue that whirls around regarding paper beds. Now, I will say that when you look at the Department of Health April '92 data that shows the 10.4 percent vacancy rate, paper beds are not included. So it is our position that the 10.4 percent vacancy rate is a solid figure. But on paper beds, it is our position that paper beds come about for one or two reasons.

The first reason is that the project owner, or the project developer, is experiencing some kind of difficulty at the municipal level, such as a sewer moratorium. Now, when you have problems at the municipal level getting zoning approval or with a sewer moratorium, that is not the project developer's fault, but rather, it is a problem that is engendered, or is part of the system, no matter who has the project.

However, the second reason why you may have paper beds, is simply because that project owner has been stalling. Last September, the Department of Health attempted to address the problem pursuant to a recent amendment in the regulations. Specifically for the record, that regulation is 8:33-3.10. What this regulation did was change the term -- okay? -- or the length of a Certificate of Need from one year to five years. It is our feeling that the five-year period is a very reasonable and appropriate time period. The reason we feel like that is through experience. It has been our experience that a nursing home project, in order for it to be on-line, takes certainly a minimum of three years, but in most cases five years to be completed. For that reason, we see it, again, as being very reasonable.

Sure, the regulations do contain exceptions, but it is our position that these exceptions are very few and very narrowly drafted. This amendment, this five-year term on the Certificate of Need, is designed to give that project developer, or project owner, one bite of the apple. If they can't do it in five years, they are out of the box. We feel that that is appropriate. Certainly with the one-year-- The problem with the one-year term on the Certificate of Need is, you kept on having multiple extensions and multiple costs. This five-year term, again, by being a one-shot item, does away with that problem, which, quite frankly, the industry had a problem with beforehand.

Regarding the issue of quality, it is indeed true that health planning and Certificate of Need do control the supply of beds. However, as I said before, the trick, if you will, or the call, is to ensure that supply meets, but does not exceed, demand. Again, we think we have done a good job in New Jersey, with an occupancy level currently at around 90 percent.

We feel that if you did away with Certificate of Need and health planning, and as I will get to in a couple of minutes, as you look at other states across the nation, occupancy levels have dropped, and the health care literature that is taking a look at these situations in other states is unanimous that when occupancy drops, quality drops, and no one really wants to see that happen.

In addition, on the quality issue, in thinking about it -- and again, I have had the luxury of hearing the testimony on Thursday-- In really thinking about the Certificate of Need process, in our opinion, it is really quality assurance at its finest, because when you look at the particular Certificate of Need process, the competition is not closed or isolated, but rather, it is very, very fierce competition. So it is our position that when those Certificates of Need to build those projects are finally awarded, it is the cream of the crop, not the fly-by-nights who are going to win these projects.

Now, it was suggested on Thursday that maybe licensing regulations will be able to solve the entire problem. I would respectfully disagree, and I would respectfully disagree for two reasons: First, licensing regulations only recognize a minimum level of care that a provider is required to meet. But I think secondly, and most importantly, the problem that I personally have, and my organization has, with licensure regulations and controlling the whole health care planning scenario, is that quite often, and unfortunately, you find out that you have a subpar performance after you have determined that the care is poor. And when you have determined that the

care is poor, that care has been given to residents who, in turn, have suffered.

Now, I am not saying that the Certificate of Need process is perfect and that mistakes aren't made in projects that are given. What I am saying, is that by the kind of batching that is done, by the multilayered procedure both within the Department and in the community, you are assured, to the utmost extent possible, that the provider who gets that project is a quality player, not a fly-by-night.

The next issue: It has certainly been argued, especially recently, that the Certificate of Need process and health planning is a closed process. I would respectfully and strongly disagree with that. We feel that the project is open; that it is fair; and, most importantly, it is community based. Okay? To justify those arguments, I will just raise two more points:

First, when you talk about the long-term care chapter in the State Health Plan and long-term health planning, the determination of need -- okay? -- as to the various long-term care alternatives that were available-- I would point out, too, that when we talk about long-term care now in the State of New Jersey, we are not just talking about nursing homes. Okay? But in the future we are going to be talking about nursing homes. We are going to be talking about assisted living facilities. We are going to be talking about comprehensive personal care homes, alternative living settings, kind of a foster care setting, and an increase in the Community Care Program for the elderly and disabled.

The long-term care committees -- okay? -- as part of the health planning process-- These are committees that are made up of consumers, providers, and government people who live in each one of the 21 counties. It is these committees which are going to make the determination of how the long-term care needs of the county residents are going to be satisfied.

Therefore, at the community level, the needs are going to be -- the issue of how the needs are going to be satisfied is going to be addressed. It is not going to be at the regional local advisory level. It is not going to be at the State Health Planning Board level, and the Commissioner of Health is not going to make that determination.

So, the county long-term care committees assure that it is a bottom up, not a top down process in long-term care -- health planning.

Secondly, and I alluded to this a little bit before, when you talk about competition for Certificates of Need, that competition, in our minds, is very fierce, and again you are talking about a bottom up, not a top down review of Certificate of Need applications. Really, the procedure is followed.

First, the local advisory board for the region will receive all of the Certificate of Need applications that have been disseminated for a particular call for projects. Those local advisory boards will review those applications. All applications that receive at least a 25 percent affirmative vote are required by both law and regulation to move to the next step, which is the State Health Planning Board step. The local advisory board must review a Certificate of Need application within 45 days of having it deemed complete by the Department of Health. So that assures, to the extent possible, that this is going to be an efficient process.

The process at the State Health Planning Board level is very, very similar. The State Health Planning Board is going to review all of those Certificates of Need that got at least a 25 percent affirmative vote at the LAB level. Any application that gets a 25 percent affirmative vote at the SHPB level, as it said, will continue ahead to the Commissioner of Health. The State Health Planning Board has to render a decision on a Certificate of Need application within 90 days of that application having been deemed complete. So again, the efficiency of the process moves forward.

Finally, with the Commissioner of Health -- okay? -- he or she -- in this case, he -- will render his decision on the Certificate of Need application. An applicant who is denied the Certificate of Need certainly has a right to appeal before the Health Care Administration Board. In addition, if the Commissioner's decision was contrary to the recommendation of the State Health Planning Board or the appropriate regional LAB, then the State Health Planning Board will also have that right of appeal. So again, there is fierce competition, and we feel that the process is open.

The next issue I would like to address is the experience in some other states. What I have appended, or attached, to my testimony are some charts that try to outline the experience that Colorado had after it did away with Certificate of Need in 1986. Given Colorado's experience, in a two-year period 2200 additional nursing home beds came on-line. Their occupancy level dropped from 92 percent, which is a very, very good and solid occupancy level which assures flexibility -- dropped 7 percent to 85 percent in just a two-year period. In addition, what Colorado found was that the Medicaid budget skyrocketed. What it did was prompt the Colorado Department of Social Services to lay down a moratorium on new Medicaid providers for nursing home beds. That, in our opinion, is tantamount to a moratorium on nursing home building, given the fact that if you look in New Jersey, 315 of 360 nursing home providers are Medicaid providers. That moratorium on Medicaid construction exists until today. If you review -- and I know it was submitted for the record on Thursday by Mr. Bornstein of Beth Israel-- If you look at that New York Times article dated May 12 (sic), you will see that Governor Romer, in his State of the State, I believe, for 1992, called for a reimplementation of Certificate of Need in Colorado.

In the experience in Texas, what we found was that in some counties Texas nursing home occupancies dropped to 60 percent, which is a dangerously low level. Quite frankly, a nursing home with a 60 percent occupancy level in New Jersey probably would not be in business anymore, or worse yet, if they are, they are probably cutting corners in the quality of care.

What you will also find in Texas -- or what we found in Texas since they have done away with Certificate of Need, are 22,000 vacant nursing home beds. To put that into perspective, there are approximately 120,000 licensed nursing home beds in the State of Texas, so that is a vacancy rate of about 18 percent.

Finally, the Texas Legislative Health and Human Services Board, in a report dated December 1992, recommended that there be a comprehensive long-term plan, and one of the points to be made, or to be addressed in the plan, is to try to address the surplus of nursing home beds in the state.

Another state that we took a look at was Florida and its assisted living facility industry. Florida public policymakers made the decision to allow assisted living facilities to exist and to grow and to develop outside the Certificate of Need process. What they found very quickly was that there is an overabundance of assisted living facilities in the State of Florida. Now, rather than bring them within Certificate of Need -- I don't know why they didn't -- what they did was develop stringent licensing standards to try to place a hold, or put a cap on the number of assisted living beds or slots that were developing.

Certainly we are very, very supportive of health planning and Certificate of Need in the area of long-term care. But, as I note in my statement, on page 7, we would make two recommendations on how the process should be amended.

The first would be to amend section 19 of the Health Care Reform Act of 1992 to repeal the CN exemptions that were given to adult day health care centers, changes in residential health care facility services, and continuing care retirement communities.

I will try to be very quick. I go into great detail in my written testimony. Why should you repeal the exemption for adult day health care centers? It is simply that adult day health care is one of those long-term care alternatives that I spoke about earlier. Our position is that if you let one of those alternatives exist outside the process, and you let five others exist inside the process, we feel that long-term care health planning is going to be turned on its ear. Within time, you are going to have an overabundance of adult day health care centers in the State of New Jersey. We feel this is bad for a couple of reasons:

The first is, by taking the adult day health care centers out of the process, you are not letting the county long-term care committees do their job. They are really not making a decision as to how long-term care in the county is going to be addressed for the residents, because one of those options is out of the process.

Secondly, we feel -- and only time will tell -- that there will be, in time, an overabundance of these adult day health care centers, and as with nursing homes, many of these folks are going to be Medicare and Medicaid providers, especially Medicaid, so the State is going to pay a part of the tab.

Thirdly, we feel that if, indeed, there is an overdevelopment of adult day health care, this could hurt the long-term health care consumer, because as, quite frankly, is happening at times now when folks are placed in a nursing home, because this is where the public funding is, with an overabundance of adult day health care centers, and possibly an

undersupply of other alternatives, people will be put where the funding is and where there are vacancies, when maybe in reality that might not be the appropriate place to place them. So we feel that adult day health care should be placed within the Certificate of Need process.

Regarding the second exemption within section 19 for residential health care facility services, I guess, to say it nicely, we feel that this term is vague. Frankly, we don't know what it means. The reason is that the types of services that a residential health care facility can provide are not driven by the health planning or the Certificate of Need process, but by the licensing process. A residential health care provider, if indeed they receive a Certificate of Need and also the license to build that residential health care facility as a condition to build and to operate, has to provide a variety of services for folks, such as room and board, laundry service, assistance with activities of daily living, in return for that license and that Certificate of Need.

Now, a residential health care facility does not care for nursing home level clients. They will deal-- I call them the "way stations" of the health care continuum, because they care for folks who can no longer live independently, but yet do not need nursing home level care. So I don't understand-- The reason we think -- or the reason why we see no reason or rationale for the exemption, is that exempting them from Certificates of Need will not prompt that change in residential health care facility services.

What we are concerned about, is that folks may interpret that that language changing residential health care facilities surfaces as a way of bringing long-term care services into the residential health care facilities. We think this is bad, and it is bad primarily because a lot of these facilities are not equipped, both from a life safety perspective and a construction code perspective, to provide the

long-term care services. Our concern is that long-term care services will be brought into these facilities with people who really don't know what is required in the construction and life safety areas.

ASSEMBLYWOMAN WRIGHT: Will you please sum up with your last point?

MR. ABRAMS: Regarding continuing care retirement communities, before the exemption in section 19 was provided there were -- certain CCRCs were allowed to proceed through expedited review, or a quicker review with a Certificate of Need through the Department of Health. Long-term care beds in CCRCs, I would submit, were fairly easy to come by, along with the community. What exempting them from the Certificate of Need process has done -- which is stated in more detail in my written testimony -- is that it has done away with some of the restrictions that were in the regulations regarding CCRC development. Those are on a ratio of four independent living units to one long-term care bed, with the requirement that they be built either consistent with or subsequent to the construction of the independent living units.

Finally, and most importantly, there is a requirement that after seven years of construction for the noncommunity members who resided in these long-term care beds, at least 45 percent of those nonmember beds have to be occupied by Medicaid recipients. By exempting them entirely from the CN process, you have exempted them from the requirement of caring for indigent residents.

ASSEMBLYWOMAN WRIGHT: Your last point is regarding fees, which you have laid out for us?

MR. ABRAMS: Yes, that is laid out in my testimony. We feel that in certain instances Certificate of Need application fees should be lowered. Specifically where you have an expedited, not a substantive review, we are recommending that the fee be one-quarter of the current minimum fee. That would be $12.50.

The second point is that we feel that on projects of $10 million or more, to have a Certificate of Need fee that, in all instances, is $100,000-- We just feel it is excessive and really unfair, because when you have a Certificate of Need fee that is that extensive, then you are pouring people out of the process. Some cannot afford to gamble that $100,000 on the possibility of obtaining the Certificate of Need.

I was still rather lengthy. I'm sorry.

ASSEMBLYWOMAN WRIGHT: You have a lengthy testimony and it is very important, so we do appreciate the kind of input you have given us.

I just want to see if there are any questions from the Committee?

ASSEMBLYMAN FELICE: Madam Chairperson, if I may?

ASSEMBLYWOMAN WRIGHT: Yes. Please go ahead, Mr. Felice.

ASSEMBLYMAN FELICE: Thank you.

Rick, you stated that without the Certificate of Need the long-term care facilities would be built without regard to cost or need, and there would be an overproliferation of homes. You have also said that without a Certificate of Need financing would become that much more difficult to obtain.

In a sense, aren't these statements inconsistent with each other, because doesn't increased difficulty in obtaining that financing that you would need under a deregulated system suggest that the market would place a natural hold, or brake on the overproliferation of homes?

MR. ABRAMS: No, I don't think they are inconsistent, Assemblyman. Let me take your second point first regarding the financing.

The fact that you would, in a sense -- and I hate this word -- have a franchise to build that nursing home, for instance, assures that lender that that home will be built and that there will be people there to occupy those beds. Okay?

If you don't have the assurance -- okay? -- that you will have that franchise and the assurance that a facility, thinking that the market is ripe, will not come and open a facility across the street-- Our sense is that the financier -- okay? -- will not be as likely, or as forceful to give you that funding.

ASSEMBLYMAN FELICE: Well, you know, my real bottom question is this: As you well know, throughout the United States, including New Jersey, we have been meeting with other states, not just Florida -- Vermont, the State of Washington. The consensus out there throughout the United States for long-term care is to have more community-based facilities.

My question is: That seems to be the direction that these states have successfully undertaken; some of them have, without Certificate of Need, to encourage more individual groups, or states, to get involved in long-term care with assisted living and so forth. If we have everything under Certificate of Need, aren't we then saying, "You are going to make a choice, whoever is in control, that it is going to be more people in nursing homes, or less people in community-based facilities"? Isn't there a danger then that one would control-- Naturally, those who have nursing homes are going to look to utilize them to the fullest, while other groups are saying, "This new concept of community-assisted living is the direction to go," not just for nursing homes, but even for health care.

So, isn't there a danger if it is all under one roof of CON?

MR. ABRAMS: Well, not really, because-- In fact, New Jersey, as you well know, is moving in this direction, too. My organization is very supportive of it. In fact, that determination and the reason why you need either everything or nothing under the Certificate of Need process, is so that, in the case of New Jersey, the county long-term care committee can make sophisticated assessments as to how that need in their community is going to be reached.

The point I tried to make with exempting adult day health care centers, is that when you take one alternative -- one of the six alternatives out of the control, and you leave the other five in, that long-term care committee for that county -- okay? -- can plan until it is blue in the face, but if developers wish to come into the county and place an adult day health care center on every corner, there is no control over that.

So I would think, again -- just in closing -- that New Jersey is doing what Vermont and Oregon especially are doing. We support it, and I think Certificate of Need will make it a better process, not a worse process.

ASSEMBLYMAN FELICE: You don't think there would be a turf battle then between the two?

MR. ABRAMS: Well, I think the reality is that there will be, but that is not my decision; that is the decision of each county's long-term care committee, which, I emphasize, has equal representation from consumers, providers, and government people. We think it is a good process. We think it is unique as you look across the health care continuum in New Jersey.

ASSEMBLYMAN FELICE: Thank you.

ASSEMBLYWOMAN WRIGHT: Are there any other questions from the Committee?

ASSEMBLYWOMAN WEINBERG: Yes.

ASSEMBLYWOMAN WRIGHT: Assemblywoman Weinberg?

ASSEMBLYWOMAN WEINBERG: Mr. Abrams, if I may, what did you say the occupancy rate was in 1991 for long-term care beds here?

MR. ABRAMS: In April 1992, which was the date of the data, the occupancy rate was 89.6 percent. The vacancy rate was 10.4 percent.

ASSEMBLYWOMAN WEINBERG: In 1990, according to testimony we received from Mr. Fishman -- the New Jersey Association of Nonprofit Homes for the Aging -- the 1990 occupancy rate in New Jersey was almost 94 percent.

MR. ABRAMS: That is a possibility. I am not familiar with that.

ASSEMBLYWOMAN WEINBERG: How was yours compiled?

MR. ABRAMS: It is Department of Health data dated April 1992. It came right from the Department's computer. They may have come out with their 1993 data, but-- Yes. In fact, it is here.

ASSEMBLYWOMAN WRIGHT: I think the Assemblywoman is just raising, perhaps, the point that if we were under Certificate of Need, how did it turn out that the rate was lower in '92 than it was in '91? I think we can get that information. Mr. Abrams will probably be sure that we have the correct data.

MR. ABRAMS: Yes. I would be happy to ask the Department of Health to--

ASSEMBLYWOMAN WEINBERG: I would be interested, particularly with the contrasting-- Mr. Fishman uses some of the very same states that you used to prove that you should have done the Certificate of Need process. It is going to be interesting to compare the statistics raised by each of you.

MR. ABRAMS: Certainly, you know, we would like to-- Clearly, I agree with you. My comments differ a little bit from Mr. Fishman's, but certainly on this continuing dialogue and discussion, we would really like to continue to be part of it, and we appreciate the opportunity.

ASSEMBLYWOMAN WRIGHT: I think that is one of the reasons that we spent so much time with your testimony, because this is a very critical issue and we have had very in-depth testimony from different perspectives.

Assemblyman Mikulak?

ASSEMBLYMAN MIKULAK: Mr. Abrams, who appoints the county long-term care committees?

MR. ABRAMS: The county long-term care committees, I believe, in the law, are appointed-- The makeup of each one of those boards is submitted to the Commissioner of Health.

ASSEMBLYMAN MIKULAK: Do they come from the LAB?

MR. ABRAMS: Oh, sure.

ASSEMBLYMAN MIKULAK: Does the LAB pick the makeup?

MR. ABRAMS: The LAB picks, and then, as I understand it, under the Health Care Planning Act, then the final decision would rest with the Department of Health.

ASSEMBLYMAN MIKULAK: So that is about a year in progress now?

MR. ABRAMS: Yes, yes.

ASSEMBLYMAN MIKULAK: Do you think that possibly a less top-down, centralized approach, like getting some real local input at the county level, might have some benefits, rather than everything-- Under this system, the Governor appoints the LAB, and the LAB appoints the county long-term care committees. I don't care who the Governor is. I am just saying, a less centralized approach.

MR. ABRAMS: Well, you know, I would agree with you, Assemblyman, from the standpoint of having the LAB submit the names to the Commissioner. Maybe there is a problem with that, but, you know, we are the first year out of the box and, you know, the concept on paper, from our position, or from our perspective, is a bottom-up and not a top-down process.

Quite frankly -- and I hope that Mr. Fishman would say the same thing -- we have been part of the process. I think elder advocates, as I call them, have been part of the process, too. Now again, I only speak on long-term care. I don't know how things are in the other parts of the continuum.

ASSEMBLYMAN MIKULAK: Fair enough. On page 4, I would like you to elaborate-- Let me read it: "In addition, the CN process is quality assurance at its best. The process ensures, to the utmost extent possible, that the people operating health care facilities in New Jersey are the 'cream of the crop.' Licensure regulations alone are not sufficient to ensure high quality care. Worst yet, licensure requirements often uncover

poor quality care 'after the fact,' after patients or residents have suffered."

Could you explain that?

**MR. ABRAMS:** Yes, sure. The licensure regulations will apply to people who have already built their facilities -- okay? -- and seek to care for residents. The point about the Certificate of Need process is that up-front you are, to the extent possible, determining who is the best person to build that project and care for those residents in the facility. Okay? You don't have that if you just have the licensure process.

With licensure you are, as they say, closing the proverbial barn door once the horse is out. The Department of Health surveyor has gone into that facility and has seen that that facility has certain serious licensure deficiencies. By that time, it is indeed possible that not only has the quality of care gone down, but the quality of care given to those residents may be bad.

**ASSEMBLYMAN MIKULAK:** We use a combination right now, so--

**MR. ABRAMS:** Yes, yes, and we like the combination. We think it does well.

**ASSEMBLYMAN MIKULAK:** Thank you.

**ASSEMBLYWOMAN WRIGHT:** I just have one very brief question: I would like you to comment on the chart you provided showing the increase in the number of long-term care beds in Colorado after the elimination of CN. Do you have any data that indicate there was any impact on the daily cost of care for those people?

**MR. ABRAMS:** Yes. If you turn to, I believe it is the next chart, you will see that--

**ASSEMBLYWOMAN WRIGHT:** Okay, I see it. That is helpful. Thank you.

MR. ABRAMS: Again, you know, I freely admit that my statistics are these, and again, they are for the record to provide-- In fact, again, I had the luxury of listening on Thursday. I called back to Colorado because, as you see at the top of this, this was provided by our colleagues in Colorado, but the source is their Department of Social Services. I called just to see if, indeed, my understanding continued to be correct. They said, "Well, this data is accurate, from our perspective."

ASSEMBLYWOMAN WRIGHT: We certainly want to thank you for your extensive testimony. Are there no other questions from the Committee? (no response) Thank you. We do appreciate it.

MR. ABRAMS: Thank you very much. Sorry I was so long.

ASSEMBLYWOMAN WRIGHT: Our next witness will be Jean Earle.

Mr. Abrams represents 225 institutions. We understand that some of you, particularly if representing one-- We will ask you to move along as quickly as you can, since you have colleagues who are waiting to testify. Thank you.

Would you please proceed, Ms. Earle?

J E A N B. E A R L E: Thank you. Good afternoon. My name is Jean Earle. I serve as Vice President of Strategic Planning for Overlook Hospital. Prior to working at Overlook, I was at Memorial Hospital, Burlington County, so I have been in New Jersey health care for more years than I care to talk about.

First, commendations and appreciation to all of you for providing this opportunity for open discussion of planning regulation in this new age of health care reform. I commend you for asking questions and becoming more knowledgeable about these processes. Only with questions, knowledge, facts, and bold experimentation can we really expect to improve processes and improve health care delivery systems for all citizens of New Jersey.

New Jersey was recognized several years ago as a leader in experimentation with hospital reimbursement systems. From those courageous steps a great deal has been learned that will help to craft health care delivery models of the future. The parts of the system that have not worked are just as important as those that have proved beneficial. We admire the states engaged in bold, widespread health reform attempts currently: Wisconsin, where Governor Thompson just announced formation of regional health care purchasing cooperatives; the 12 states with innovations funded through the Robert Wood Johnson Foundation. One fact regarding health care cost and access inroads has become very clear: The issues are "dauntingly complex" -- as mentioned in The New York Times last week -- and reasonable solutions are not readily apparent despite major time, resources, and attention. Thus, the desperate need for innovation and carefully evaluated new models and new systems.

Pursuant to these realities, many of us are changing our vision of health care delivery systems of the not-very-distant future. Our vision of the system of the future is that of local and regional community-based cooperative care networks. There is a single point of entry for each person in this health care system. Each of us has a quarterback in charge of our care -- a patient ombudsman. Care delivery is definitively focused on prevention. In the event of tertiary, acute service needs, collaborative decisions are made taking each individual's unique needs into account. We are learning through sound health services research, that individual social and psychological factors are critically important to health and healing. We believe we must incorporate these factors when we discuss health care delivery systems. We will soon consider measures of quality as well, because we will discover definitively that high quality care is lowest cost in the long run. And while early efforts to

measure outcomes, especially those that are long-term, have been far less than perfect, we are learning to use information technology to effectively measure these factors.

The incentives in this new delivery system are very different from what we now know. All providers -- hospital, home care, support services alike -- add value by taking steps to keep all citizens as healthy and fully functioning as possible. Individuals may have additional personal, tangible, and positive incentives to do the same.

How does Certificate of Need fit into this scenario? Certificate of Need is a relatively long-standing regulatory and public planning method. We have heard in prior testimony about the objectives and the history of Certificate of Need. The system was primarily established to stem the rising tide of health care cost growth, reduce duplication of expensive technologies, and assure equity of access to care. The questions that yoE ask today are the right ones. Has this system met one or all of these objectives? Can it meet these objectives in the future? What systems really might help us achieve these objectives in a better way?

The issue of Certificate of Need is fraught with paradoxes, as suggested by many speakers. It has probably saved some dollars, but it has also cost both the Department of Health and providers, and therefore, New Jersey citizens, a lot of money. It has assured access for some people, but not for all. We now know, again through sound health services research, that access is a much more complicated issue than originally thought. Some of the worst health status profiles are in communities with the nation's finest community-based and acute care providers.

What is the problem? Some folks have hypothesized that the problem is money and insurance coverage. While that may be a factor, researchers have started to ask people, people hospitalized for conditions which, had they had adequate

primary care, they probably would not have been hospitalized: "Why are you here?" The most frequent answer: "I didn't know I should go to my doctor for this." Education, the next major reform when we realize that fixing health care is not possible without addressing educational, social, and psychological needs. The World Health Organization has pointed this out clearly, and we will evolve this way, as suggested by my scenario, where all providers, schools, churches, all sorts of community groups ban together to reach out to help and improve life and improve health for all citizens.

Access has also not been adequately assured by the Certificate of Need process as we know it, because not all providers have historically been subject to regulation. Therefore, we have situations such as the eight approved MRIs for which we have wonderful data about utilization, and 91 "unapproved" MRIs for which we have no information, and major inconveniences for some of our sickest citizens because many of these untis had to be located outside of hospitals to avoid regulation. There were also undoubedly access problems because many, if not most, of the unregulated services operated with profitability motives. Here, in all honesty, we cannot say the Certificate of Need process worked.

Why has Certificate of Need been reinstituted in some states? Simply because our health care cost growth is out of control; our incentives are still pointing in the wrong direction. Certificate of Need is one method of trying to cap expenditures. In the absence of meaningful and substantial reform, it probably is at least a temporary answer. Removing Cerfiticate of Need, especially in the absence of adequate data upon which to base need calculations -- which incidentally are always subject to great debate by planners -- may result in supply which exceeds demand. With current financial incentives, some important health care providers are driven to provide tertiary services and preserve volume in order to

survive. This is real today -- we have heard it in both of these sessions already -- despite our knowledge that the scenario should be different, and this is what underlies what we have been hearing.

Certificate of Need has received some, albeit not a lot, of health services research attention. Keeping my prior comments foremost, I wish to provide you today with some current major findings:

1) From the "Journal of Regulatory Economics," from the faculty of the Lister Institute for Health Policy of the University of Alabama:

"Our results regarding CON regulation suggest that these programs not only have not contained costs, but have led to higher costs. The health care industry is characterized by extensive insurance and service competition. One explanation for our finding is that the CON process is very costly in and of itself. Capacity expansions occur as they would in the absence of regulation, but simply cost more. A second explanation is strategic. It may be that the CON process raises uncertainty about the ability of a hospital to expand in the futue. If so, providers may get their construction and service expansions 'while the getting is good.' Such a strategy would lower profits relative to an unregulated market, but would nonetheless be an optimal second-best solution for the firm, given the presence of CON. In any event, there seems to be little economic justification for continuing CON regulation."

2) From the American Legislative Exchange Council, again I quote:

"There is substantial evidence that CON may actually increase health care costs. It does this in three ways:

One, direct administrative/process costs of many types.

Two, where need exceeds demand of services, shifts may be more expensive.

Three, competition among providers is reduced by creating barriers to entry."

3) On the subject of quality, from the "New England Journal of Medicine," from faculty of the Kellogg School of Northwestern:

"The influence of the stringency of CON programs is of particular interest because it can be argued that stricter CON legislation should be associated with lower mortality rates, since many reviewing agencies explicitly evaluate whether patient volume is sufficient to produce positive outcomes when they consider CON applications. The contrary argument is that the requirement for a Certificate of Need serves as a barrier to the development of innovative programs and the possible upgrading of hospitals' physical plants and equipment. Our findings indicate that regulation of capital expenditures appears to have particularly adverse effects on outcomes for patients with the conditions most directly affected by the regulation."

I think it is important to note here, pursuant to Dr. Seigel's comments and others, that research findings indicate that there are threshold levels of service volume required to achieve optimal results and outcomes. More than the threshold volume of cases or procedures has not been found to yield even better results.

4) From "An Effect of State Certificate of Need Laws on Hospital Costs: An Economic Policy Analysis," from the Staff Report of the Bureau of Economics, again I quote:

"The primary rationale for CON regulation is the belief that competition among hospitals takes place primarily, and excessively, in terms of the quality of facilities and services offered to patients and physicians, rather than on the price of hospital services, and that this quality competition inefficiently raises the cost of health care to the consumer.

"The empirical results provide no evidence that subjecting more of a hospital's projects to regulatory review serves to decrease hospital costs. The results indicate that states that provide less regulation of hospitals by setting higher review thresholds across-the-board, appear to have lower costs than those states which review more of a hospital's expenditures. This suggests that the recent general lifting of CON thresholds in many states may lower hospital costs and therefore benefit consumers."

Many of us in the health services field view deregulation, both financial and planning in nature, with fear and trepidation. We hold onto our heritage and our dreams of truly serving all people, studying and understanding their needs -- meeting their needs. We like to think of meeting these needs regardless of the financial picture. Today, we know that the cost problem is so great that there is a collective, overriding need to bring cost growth back under control. We know we need to be open to change. We know we need to be open to evaluating and questioning old, expensive systems. We know we need to experiment thoughtfully with streamlining processes.

In closing, I wish to offer four specific recommendations to you regarding New Jersey's Certificate of Need and planning processes:

1) Maintain the exceptional work of data collection and information provision started by Dr. Seigel in the renewed and talented Office of Health Policy and Reserach. Improving health requires facts and data, and we need much more information than a Certificate of Need process can provide in order to do that.

There are four specific areas I would like to respectfully suggest for future extensive study by this Office:

One, the Development of informational data bases for all types of nonacute care.

Two, impact analysis for the future of medical education programs in New Jersey, including setting recommendations for primary and subspecialty program mix goals, so that New Jersey can be a leader in the provision of much needed primary care services for whatever public or private delivery systems exist.

Three, establish sound research-based volume thresholds and outcome factors that may be incorporated into licensure -- even prospectively, that doesn't have to be retrospective -- so that services may be effectively unbundled from the Certificate of Need processes without the problems experienced by states that just abandon all controls.

Four, conduct impact analyses for increasing Certificate of Need thresholds and removing services so we have clearer ideas of the potential scenarios. This way, we might focus on the realities of detrimental effects for citizens and providers that are important to their communities, which could aid in propelling us toward truly effective reform.

2) Do not, at this time, eliminate Certificate of Need completely. Experiment, as we seem to be doing, with certain services. Measure and evaluate the results.

3) Incorporate informational and outcome reporting requirements into licensure regulation and whatever Certificate of Need processes are maintained. Conditional Certificates of Need were suggested previously. It seems licensure really could play a large role as well: minimum volumes within specified time frames, community focus, improved health outcomes, and health status.

As well-known health policy expert Alain Enthoven says regarding managed competition: "It is not deregulation. It is new rules, not no rules." We need rules; we need data; we need information, particularly, about how healthy New Jersey citizens are. We need to focus our efforts collectively on improving this degree of "healthiness" and improving the

methods by which we learn about this and evaluate our experiments and models for change. We can do this through new and improved roles for licensure rules. We can do this through significant improvements upon the Certificate of Need processes.

Thank you for this opportunity.

ASSEMBLYWOMAN WRIGHT: Thank you for your very comprehensive testimony. As you are Vice President of Strategic Planning, I think it does bring us a different perspective.

Are there any questions from the Committee? Assemblyman Smith?

ASSEMBLYMAN SMITH: Yes. Ms. Earle, we have heard a lot of testimony last Thursday and today which seems to suggest that the idea of Certificate of Need cannot be separated from the concept of health planning in general. Could you comment on this, please? Does elimination of the CON necessarily mean the elimination of the health planning?

MS. EARLE: No, sir, I do not believe it does in any way. In fact, I think health planning is encumbered by the Certificate of Need process, because a lot of time and effort is spent gathering information and data which really isn't health planning, from my viewpoint. It is a lot of paperwork that is really not directly health planning as I like to think of it.

ASSEMBLYWOMAN WRIGHT: Thank you. That is very helpful.

Are there any other questions from the Committee? (no response) Hearing none, thank you again, Ms. Earle, for your testimony.

Our next witness will be Carol Kientz. After Carol will be Ken Jeffries and Joseph Sherber.

C A R O L J. K I E N T Z, R.N., M.S.: Thank you, Madam Chairman. It is a pleasure to speak before this Committee. I thank all of the Assembly people here.

My name is Carol Kientz. I am the Executive Director of the Home Health Assembly of New Jersey, which is a trade association which represents all types of home care providers across the State. We have over 160 member agencies and companies.

I will try to highlight some of my testimony, but I think it is fairly brief so I will not belabor you with too much repetition. Certainly some of what I will say will support what you have heard from facilities that are traditionally looked at as larger and more substantial. Home care is just coming of age and being recognized for the substance it provides to communities.

You will find that the last page of the handout you received is a Fact Sheet that we put together to give you a bit of a sense of the volume, the size, the services of home care in New Jersey, which may be of help to you in your considerations.

Since the adoption of the original 1971 Health Care Facilities Planning Act, home health agencies have been included in the Certificate of Need process of planned and appropriate service growth in New Jersey. Every citizen has access to well-coordinated home care, provided 24 hours a day, seven days a week. Planned growth has enabled agencies to move into a high-tech environment, delivering a wide variety of specialized care to their communities, from pediatric intensive care, to intravenous therapy, to hospice care and rehabilitation for the disabled. At the same time, the stable fiscal environment facilitated by Certificate of Need has allowed agencies to continue meeting indigent and lower income needs to a significant extent.

There are, we think, some clear reasons for the orderly progress fostered by Certificate of Need stability, and they all boil down to economies of scale and volume-related quality. These are certainly issues which you have heard from many of the other speakers today and last week.

In other states without Certificate of Need for home health services-- I say specifically "for home health services" because certainly there are a variety of methods of implementing Certificate of Need across the country. In some cases, the inpatient types of facilities may be covered by Certificate of Need, whereas other types of outpatient or community providers may not be, so I am specifically addressing those states which do or do not have Certificate of Need relative to home care.

ASSEMBLYWOMAN WRIGHT: Thank you. I think you are the first speaker to address something like this.

MS. KIENTZ: In those states without Certificate of Need for home health services, chaotic proliferation of relatively small agencies is the common pattern. Literally hundreds of home health agencies spring up on street corners. That may sound somewhat overreactive, but that is, in fact, the case, and I have seen it in many states. In Tennessee, for example, when the CON for home health was abolished back in 1981, the number of agencies in that state mushroomed within two years by 385 percent.

On the other hand, the number of consumers receiving home care grew by only 20 percent. So obviously more agencies did not result in more care for the public. That 20 percent growth is probably the same growth, approximately, that occurred throughout home care across the country. What did happen was chaos for patients, for physicians, for social workers, for discharge planners, the whole array of individuals in the industry, in health care, trying to coordinate care for patients.

Small agencies, as are the norm in non-CON states such as Tennessee and Texas, at this point, tended to want just the cream from the crop of patient referrals; that is, in many cases, the Medicare clientele, because that, while it may not be an affluent level of pay for each Medicare patient, is a

fairly stable, fairly guaranteed level of payment. The check does come in from Medicare. Therefore, those clients were accepted by these small home health agencies. However, if there was not any guaranteed source of insurance or payment, those clients were persona non grata. The low income and the indigent are out of luck in most of those small agencies.

In Tennessee, having realized that this proliferation wasn't solving any problems at all and was creating more problems, the consumer had no idea where to turn or which agency was god or bad, and neither did discharge planners, despite the fact that they have licensure in Tennessee. That state reinacted Certificate of Need for home care back in 1984.

Not only does coordination chaos result, but costs tend to increase as well, and I am reiterating what you have heard from others. The average cost per visit for Florida and Texas home health agencies back in 1981 was about the same. At that point in time, the Texas Legislature abolished Certificate of Need. So we have Texas and Florida at about the same cost level for home care. During the next three years, the number of home care providers in Texas grew by over 500 percent. What happened in terms of cost, though, was the opposite. Cost of care did not go down in Texas. It increased by 15 percent, whereas in Florida, where Certificate of Need remained in place, the cost factor grew by only 10 percent. So there certainly was not, during that three-year span of time at least, any indication that Certificate of Need saved anybody any money.

Increasing the number of agencies also increases personnel costs for the industry. We have a limited number of human beings who are capable professionals and paraprofessionals to serve the public. We are not going to increase those bodies, despite the fact that we try really hard to attract people from across both rivers -- New York, Pennsylvania -- into New Jersey to provide health care. We

have a limited number of human beings. Increasing the number of agencies does not increase services, because you still have the same number of human beings delivering the service. Instead, it breaks the service up into smaller packages. It also costs agencies more because then they are trying by any way they can to attract those limited numbers of professionals, offering higher salaries and various kinds of perks in order to attract them. That has to be passed along ultimately to consumers, whether it is Medicare, whether it is Medicaid and the State is paying for that, or whether it is the private consumer.

Planned growth can actually save dollars by eliminating the duplication of overhead and administrative costs, and this you have heard before, too. There are very fixed, definite costs that every Medicare certified and, in this State, licensed home health agency must incur to meet all of the State and Federal -- and the Federal regulations are significant-- You must have all of those quality assurances and procedures in place whether you provide 5000 visits a year or 500,000 visits a year. Therefore, there is a significant piece of overhead simply attached to being a home health agency. That cost, again, winds up getting passed on to taxpayers.

In New Jersey, the Certificate of Need process has enabled gradual increases in agency numbers. We have not been static and there have been increases. It has enabled the existing agencies, however, as the numbers gradually increased, to also increase in size and scope of services that they are offering their communities. Our strong, stable, innovative home health agencies in this State truly are the envy of much of the country.

Our Visiting Nurse Associations, for instance, which 20 or 30 years ago were thought of as providing mother and infant care and bed baths for the elderly, are now providing a

full array of 24-hour-a-day, seven-day-a-week services of high-tech home care, hospice care, pediatric intensive care, acute care for adults, long-term care -- the full range. As hospitals have lengthened (sic) their stay in order to cut inpatient costs, home care providers have been growing and taking on those patients who are acutely ill and providing all the necessary care.

In New Jersey, we also have an innovative home care program for AIDS patients; people who are HIV positive. Extensive care in the community is provided to those individuals all the way from basic minimum maintenance care to high-tech I.V. therapy in the home for those individuals. We are keeping significant numbers of those individuals out of hospitals, again, decreasing the in-hospital costs to the community.

Now, I also ask you to keep in mind that all of these innovations and the growth in programs are being created by agencies without any uncompensated care system having existed for home care over the years. When home care provides indigent care, home care provides indigent care, and finds the money where they can, whether it is donations from local United Way, community outreach, literally cake sales and flea markets at home care agencies, to try to raise the money needed to cover the costs for the indigent and for new special programs. Nevertheless, they are growing, and the stability of that growth has enabled New Jersey to be well served. Though we have lacked tabulated statistics from the State Health Department -- and this is a concern I will speak to again -- over the last few years, we can postulate that at least two million home health visits are currently being made across New Jersey -- and that is a very conservative estimate -- to over 50,000 patients and families. So that is a significant volume of care that is being delivered.

Our hospital-based agencies in this State are also unique. We have over 20 hospital-based home care agencies in New Jersey. They are providing a broad range of community services as well. They have really taken their impetus from the community-based Visiting Nurse Associations that were their precursors, whereas in other states without Certificate of Need, you tend to see that just about every hospital has a little home health agency of some sort, but meeting just the needs of its own patient population, and not really expanding into broader community outreach with that program, whereas in New Jersey our hospitals have really opened their doors to some very innovative programs, again, many of them being in the forefront of home care for HIV positive individuals and the like.

These economies of size are passed on to consumers also in the form of new and better services. Again, the issue of does volume produce higher quality? Yes, that certainly may be, but there is a benchmark level at which if you do 5000 or 500,000 of a procedure, you are not going to get a lot better. But certainly if you do 50 of something versus 500, you do know what you're doing and economies are passed along as well. It may be the case that you will find with someone who is less experienced, they will feel it necessary and would require extensive care or, in our case, we are taught that visits-- We might be visiting an individual over six or eight weeks. A large stable agency with good, solid, well-trained professionals may find that two or three weeks will resolve the problem and put that person back on his or her feet again.

So the principle is simple and true: The more you do, the better you should get.

Now, if I can find my place here -- and I apologize to you-- To summarize: New Jersey's home health agencies are among the finest in the country. Our home health agencies have expanded to keep pace with new technologies and growing

consumer needs. New specialty programs have been developed, which I have described to you already. At the same time, they have controlled costs as well. Most of our home health agencies are below the Federal Medicare cost caps, and that is a useful mark, I think, because those cost caps apply across the country, although there are differences of cap based on different regions of the country. In most parts of the country where there are no CONs in a particular state, agencies are vying to get to that cost cap, and are then complaining to the Federal government that the cap needs to be raised higher and higher.

In New Jersey we have prided ourselves on staying below that cap, proving that we can meet the communities' needs and do it cost-effectively, without going all the way to the top of the cost chart.

Removal of Certificate of Need, we feel, will serve the public no good, in terms of home care at least. It fragments care horrendously for the public. There is no coordination between numerous little providers. It raises costs. It will leave the indigent without care, because you will find that your voluntary, or Visiting Nurse Associations and existing home health agencies who are providing that indigent care, if they no longer have a good, stable base of Medicare and insurance and private paying clients to balance out the indigent, they will be cutting back on their indigent care. There is just no other choice. The cost has to be covered somehow.

Is there anything we can do? Well, we certainly agree that the process isn't perfect yet. This is probably an ideal year for home care to be in this discussion with you, because this is the year in which the revision of the home care portion of the Certificate of Need regulations is due for revision, and the industry is very eager to work with the State Health Department to make it a better process.

The needs methodology for home care is not an easy one. We do not deal with beds. We deal with a very flexible and constantly growing number of individuals in the community looking for home care of various sorts. So it is a complex type of methodology to be worked out, but we believe we can make it better. We believe it can be as fair as possible. We also believe that if there were better, more constant statistical monitoring and tabulation by the State Health Department, that the State, that the LABs, that the Legislature would have better figures with which to judge: Is there sufficient home care? Is it meeting the needs?

I have to say that the State Health Department has been collecting data from the Medicare certified and licensed agencies each year, but since 1988 none of that data has been tabulated. It has been sitting in the State Health Department for lack of people and computer programs. We are pushing as hard as we can to try to get that changed.

We also believe that there could be more public education as to the entire CON process. While LABs are working very hard, I think, right now, and through their county committees as well, to open the process to the public, I think the average citizen really has very little idea of what it is we are discussing right now. Perhaps we can all work together on educating the public, so that in truth, as there are hearings and as issues arise with potential new Certificate of Need applications, the average people in the community can be involved as much as possible in the process.

So, we think there is work to be done, but we do not think the solution is throwing the baby and the bath water out.

Thank you.

ASSEMBLYWOMAN WRIGHT: Thank you very much, Ms. Kientz. Are there any questions from the Committee? Assemblyman Mikulak?

ASSEMBLYMAN MIKULAK: Yes. One point that I do not think you have addressed is access. Wouldn't eliminating a Certificate of Need, or in the states where they did eliminate the Certificate of Need-- You said there would be more smaller units evolving from that. Wouldn't there be better access to all different kinds of areas?

MS. KIENTZ: You would think so in the ideal, but what we have seen happening, which I tried to describe, is that you have numerous little home care agencies that do, in fact, open up, but they only want a selected clientele. They want the good paying customers. They want them for only a short duration of guaranteed payment, and they do not want any that potentially could not be covered by their insurance.

It may seem like good business sense, and it certainly is. One does not want to go out of business once you have opened up. But the tradition of home care in New Jersey has been one of being open to all individuals to the greatest extent possible, including over 5 percent of indigent care, which is also part of the CON requirement, and to taking referrals as broadly as possible and then trying to figure out, as you work with that client, how to help that client to find adequate reimbursement; helping them to contact their insurance coverage; helping to track down whatever can be done to get paid; looking at community resources, such as their local service organizations. There may be churches and other groups that would be willing to assist that individual in paying for some of their care, as well as using families, friends, neighbors, a whole variety of volunteer efforts to keep the costs low and see that that individual gets some kind of help that they need.

That isn't generally the pattern with the smaller, basically Medicare-oriented companies. They are strictly there to do a small amount of care, get it done, do it as well as they can, but then move on. But in home care, because we are

talking about people in the community-- They have moved out of the hospital; they don't need that acute intensive level anymore -- they often need very acute care, but not at that intensity -- and they often have ongoing needs. Well, what happens when you have gone past that two weeks of Medicare, but you really still need someone watching you or helping you to figure out how to get Meals on Wheels down the road, or something else? Those smaller agencies do not tend to meet that full gamut of care, social service, and community resource case management that our larger agencies are able to do because they have the staff and the ability to take the time to do all of that.

ASSEMBLYWOMAN WRIGHT: Are there any other questions from the Committee? (no response)

I just want to make a comment about access: Remember that in this kind of care, the nurses and the physical therapists and the workers are going to the home, so it is a different situation.

I want to thank you very much, Ms. Kientz, for testifying.

MS. KIENTZ: Thank you.

ASSEMBLYWOMAN WRIGHT: We will now move on to our next witness, Dr. Bernstein.

UNIDENTIFIED SPEAKER FROM AUDIENCE: Madam Chairman, he had to leave.

ASSEMBLYWOMAN WRIGHT: Okay.

UNIDENTIFIED SPEAKER FROM AUDIENCE: May Dr. Sachs take his place? He is here.

ASSEMBLYMAN COLBURN: Does Dr. Sachs have office hours?

UNIDENTIFIED SPEAKER FROM AUDIENCE: Yes.

ASSEMBLYMAN COLBURN: That's why we called Dr. Bernstein. Do you have office hours, Dr. Sachs, or do you have to get somewhere?

**R. G R E G O R Y S A C H S, M.D.:** (speaking from audience) I do later today. (remainder of Dr. Sachs' comment indiscernible; no microphone)

ASSEMBLYMAN COLBURN: We'll take you in a couple of minutes here. I'm sorry.

ASSEMBLYWOMAN WRIGHT: Ken Jeffries.

**K E N N E T H G. J E F F R I E S:** Thank you. My name is Ken Jeffries. I am the Vice President of Finance for Hamilton Hospital. For your information, I have condensed my statement down from the handout.

ASSEMBLYWOMAN WRIGHT: The record will have your complete testimony. Thank you for condensing it so we can move along.

MR. JEFFRIES: Okay, thank you.

The opening paragraph of the Health Care Reform Act of 1992 indicates the desire to promote a truly competitive market environment. However, in order to promote equitable and fair competition, hospitals must not only compete on price, but they must be able to compete from a basic level of service.

As it exists today, not all hospitals are at the same starting point from which to compete. Hamilton Hospital, for example, does not have obstetrics and pediatric services. Without this basic primary level of services we are at a competitive disadvantage, which we do not believe was the intent of the legislation.

Hamilton Hospital recommends that basic primary care services be exempt from the Certificate of Need requirement. Basic primary care services include: medical/surgical services; operating room; ICU/CCU; pediatrics; obstetrics; and emergency services.

Our recommendation does not propose eliminating the entire CN process. It is our position that highly specialized tertiary services should be restricted, such as cardiac surgery and trauma centers. These services serve a very small portion

of the population and require tremendous resources. However, it is the Legislature's intent to promote competition, and that competition should occur at a primary care level. It is at the primary care level where the vast majority of health care services are rendered.

Questions may arise about the proliferation of unnecessary beds. The key control in this regard is one on which the Health Care Reform Act is based. Let the market determine who will get these beds and where the services should be rendered. In order to add beds, financial feasibility must support the addition of these services, or the financial community will not provide the funds. This is your strongest controlling fact. Other options would be to limit the number of beds for each service to 10. There are 14 hospitals in the State that do not have either pediatrics or obstetrics. If all 14 added both of these services, a total of 280 beds would be added to the system, which is an increase of less than 1 percent. Keep in mind that all 14 may not have the need nor the ability to finance these additions.

A third option you may wish to consider is that if an institution adds beds for these services, it must reduce medical/surgical beds in equal numbers so that the total number of licensed beds is not changed.

Now I would like to address some specific concerns with regard to Hamilton Hospital's market. Hamilton Hospital is located in Hamilton Township, New Jersey, in Mercer County. We are the seventh largest municipality in the State, and the only hospital in this municipality. We are the only hospital in the 14th District which has a population of approximately 200,000 people. Of the largest 15 municipalities in the State, only Hamilton Township does not have pediatric and obstetric services in its community.

In 1991, there were 120,000 births in this State, the highest volume DRG. This is precisely the type of service

where competition may prove to lower costs. Of the 120,000 births, 4860 were in Hamilton Hospital's primary service area. Our community residents, because of current CN regulations, did not have the opportunity to give birth at their community hospital. We are a community hospital that is asking for the opportunity to meet the needs of its community.

With the passage of the Health Care Reform Act, managed care will continue to intensify in our county, which already has one of the highest penetrations of managed care in the State. To date, managed care companies have preferred to do business with full service hospitals, those with primary care services mentioned previously. Recently, Blue Cross excluded Hamilton Hospital from its network. One of the reasons cited was that we were not a full service hospital. In addition, I have included a letter from the Aetna Health Plan, indicating that Hamilton was never considered for their network because we are not full service.

We believe the intent of the Legislature was to create a truly competitive market environment. However, in order to promote equitable and fair competition, hospitals must not only compete on price, but they must be able to compete from the same basic level of services. The current CN regulations are outdated and no longer apply to the current health care environment, or to the demographics of the community we serve.

We are asking you to amend the current CN regulations with one of the options outlined above, to allow all hospitals the opportunity to compete. We do not believe that you want us to fight in the marketplace at a competitive disadvantage imposed by outdated regulation.

Thank you for the opportunity to speak before you.

I would like to apologize on behalf of Michael Bryant, the CEO of Hamilton Hospital. He was not able to attend because of a family emergency.

If you have any questions, I would be happy to answer them.

ASSEMBLYWOMAN WRIGHT: Thank you, Mr. Jeffries. You have been very succinct and to the point.

Does the Committee have any questions it would like to ask of Mr. Jeffries? (no response) Hearing none, I thank you very much.

MR. JEFFRIES: Thank you.

ASSEMBLYWOMAN WRIGHT: Joseph Sherber, Tim Harrington, and then the spokesperson for Dr. Bernstein.

**J O S E P H S H E R B E R:** My name is Joseph Sherber, and I am the President and Chief Executive Officer for the Kimball Medical Center, in Lakewood, New Jersey. I would like to thank you for the opportunity to make this presentation.

I am not urging that the process of CN be abolished entirely. It has a limited place even in this new era of managed care, managed competition, or whatever system under which we are now operating. But the Certificate of Need process is in desperate need of another updating to make it relevant. As you know, the Certificate of Need system was put in place to assure the orderly growth of the health care industry -- to prevent construction of unnecessary beds and facilities or acquisition of unneeded equipment. The object was to keep the costs down.

Sadly, in most instances, it has had an opposite effect and actually raised costs in many instances. This was, in part, because there was not enough flexibility in the process to recognize the difference between a medical "luxury" and a "necessity." Nor could it adapt to the fact that today's medical "luxury" could become tomorrow's "necessity."

The classic case that I want to bring to your attention involved regulation of CAT scanners. I bring it to your attention because 12 years later, to me, the same situation happened with MRIs in much the same sequence. While I know the CN is no longer required for CAT scans, this is a classic case of the CN process gone wrong.

The State Department of Health limited acquisition of CAT scanners to eight hospitals at the outset. No other hospital was allowed to purchase one. As a result, many hospitals had to transport their patients to other hospitals, often at some distance. This meant higher costs because of transportation and the need to staff ambulances with nurses and even physicians to assist the patient. It also meant long delays in diagnostic testing. This, in turn, drove up the length of stays at hospitals. And, considerably more exploratory neurosurgery took place before elimination of these State-approved monopolies than afterwards. So a process that was meant to save money, in fact wound up wasting it.

The supreme irony, of course, was this: When we eliminated the cost of transportation, personnel, and the other mentioned factors, we found that the payback on a CAT scanner was only three years or less; that is, the cost of providing the CAT scan in the first place. This does not include, of course, the increase in quality of care.

The CN process simply did not recognize soon enough that CAT scanners were becoming fundamentally critical to the practice of medicine. Presently, all hospitals have come to acquire a CAT scanner, and the health care in our State is better for it. But there was a period of substantial and costly legal and political confrontation, and I speak from experience on that point.

Let me point out to you that it took 14 years after the original administrative law judge decision to remove CAT scanners from the CN process. Reform of the CN process, then, should not repeat the problems of the past.

Moreover, changes should reflect the changing nature of health care. We are in an era of competition -- managed or otherwise. Therefore, the State should let many health care institutions function in a free market atmosphere, applying all the sound principles of business to its operations. In that light, I urge you to consider the following points:

First -- and I must tell you this reluctantly -- I recommend that you limit the construction of new hospital beds in our State, and they should require a Certificate of Need. Such plans demand close scrutiny. There are no doubt too many beds in the State presently. At the same time, I would not require CNs for nursing home beds. I would suggest to you that market forces drive this phase of the industry.

In Ocean County, where we have been under CN and where we have a significant number of nursing homes, we have 500 to 600 paper beds which clog up the system. The paper beds-- The Certificate of Need itself probably has more value right now than the final construction project in its ability to transfer ownership from one to another.

Those who propose to open such facilities should be allowed to do so as any other business. They should be allowed to plan, develop, build, and market as businesses do, and to succeed or fail as businesses also do. This includes the financing of these additional beds. If the money dries up for these additional beds, that is a better brake on the control of building than government regulation.

Esoteric programs such as those to create open heart surgery centers or to install technology still in a research or investigatory state should still require Certificates of Need. I should note that even here the system has not functioned properly. There are something like 20 heart surgery installations in the State, when, I am told, there is a need for seven. Of course, all other programs and technology should not require CNs.

If you approve this limited use of the CN proces, I would urge you to also consider a "sunset" provision for those projects which come under the regulation. Under this, requirements that specific programs and technology require CNs could be reviewed after a period of time. If it is determined that these programs and equipment should have broader

distribution than a few teaching hospitals, the CN requirements should be eliminated. This would cut down on the time it takes to recognize the difference between "luxury" and "necessity."

On routine technological advances, why not let the market forces prevail? Again, a hospital should be free to do its research, financial studies, and projections, and to make the decision to buy the equipment on a business basis. Let the market and the hospital's own business judgment determine success or failure. If you follow this line of reasoning, I would also suggest this:

That the State take a hard look at the current local advisory board system which replaced the previous HSA process. Is it really necessary now to maintain two different levels of approvals for projects? Or, should the remaining CNs go directly to the State Health Department, eliminating unnecessary steps and levels of administration? In this era of enormous financial pressure on government, I believe the State Department of Health could save substantial amounts of money by this step.

Speaking of financial presssure, the fees charged to hospitals for submitting Certificates of Need have become excessive. A hospital must pay $5000 for projects of $1 million or less. For those over $1 million, the price is $5000 plus 5 percent of the total cost, and $100,000 for a $10 million project. This, in effect, penalizes hospitals for daring to submit CNs.

In summary, a modified Certificate of Need process may indeed have a place in our State's health care system. But you now have the opportunity to modernize it to reflect the changes that we now see taking place, changes that are irreversible. If we are truly in an age of competition in health care, then let it happen; let the free market system prevail. There is no longer a reason, or a need, to micromanage the health care system.

Health care institutions, like businesses, will succeed or fail depending on their own smarts and their own skills.

I have heard much about access here today. I would suggest to you that access really means the funds to provide care for those who themselves do not have funds.

I would also suggest to you that if, in fact, we do get a universal health insurance package in this country, that that will take care of itself. I am not willing to write off the inner-city hospitals and their future ability to compete. So I would suggest very strongly to you that there are other things in the works that would have a very significant effect on our whole process of providing health care, and that if we do make any changes to the Certificate of Need process, they will be to limit the amount of items to go under it, not to expand it.

ASSEMBLYWOMAN WRIGHT: Thank you, Mr. Sherber. Are there questions from the Committee? Assemblyman Mikulak"?

ASSEMBLYMAN MIKULAK: Mr. Sherber, you said that there were over 500 paper beds -- nursing home beds -- clogging the system in Ocean County. Is that correct?

MR. SHERBER: That is correct.

ASSEMBLYMAN MIKULAK: Could you give us some idea as to how that situation came about?

MR. SHERBER: I have no idea. I will tell you that all of these are Certificate of Need-approved beds that have been hanging around there for years, much longer in some cases than the five-year period that was mentioned before.

ASSEMBLYMAN MIKULAK: Well, I can see that the population of Ocean County-- There are a lot of retirees, and retirees eventually would be in need of nursing homes. Could you explain how these paper beds are more valuable than existing nursing home beds?

MR. SHERBER: Because they are salable. The Certificates of Need are salable.

ASSEMBLYMAN MIKULAK: Like a commodity?

MR. SHERBER: Exactly so.

ASSEMBLYMAN MIKULAK: Thank you.

ASSEMBLYWOMAN WRIGHT: Thank you very much, Mr. Sherber. We know you bring to us from many, many years in New Jersey, in different parts of the State, your expertise in health care administration, and we really value that.

Just one moment. Assemblywoman Weinberg has a question.

ASSEMBLYWOMAN WEINBERG: Mr. Sherber, in your written testimony you say: "Health care institutions, like businesses, will succeed or fail depending on their own smarts and their own skills." Why does that differ in the nursing home field?

MR. SHERBER: It doesn't.

ASSEMBLYWOMAN WEINBERG: But you are recommending that nursing homes be deregulated, but acute care hospitals still need CNs for expansions.

MR. SHERBER: Only in very limited areas. I would only reluctantly recommend that we limit the number of beds we allow -- additional beds we allow in acute hospitals. Quite honestly, if somebody said to me, "We are going to open the system up," I would not care too much about it, because I think the competitive environment would control, one, access to finances to build additional beds; and two, the willingness of hospitals to undertake the building of beds if they already have empty beds -- the building of beds if they already have empty beds.

ASSEMBLYWOMAN WRIGHT: Thank you very much again.

Our next person to testify will be Tim Harrington. After Mr. Harrington will be Dr. Sachs.

T I M O T H Y H A R R I N G T O N: Good afternoon, Madam Chairman and members of the Assembly Health and Human Services

Committee. It is a pleasure and honor for me to speak before you today. My name is Timothy Harrington. I am representing the Mid-Atlantic Health Group and its principal member, the Monmouth Medical Center, a 564-bed, acute care, tertiary teaching hospital in Long Branch, Monmouth County.

Mid-Atlantic Health Group believes that the Certificate of Need program, as it is currently structured, is no longer consistent with the evolution of the health care system in New Jersey. We are not supporting a total elimination of the program; rather, we support a restructuring which would limit the scope of the program to large construction/renovation projects and bed additions.

Acute care hospitals are operating in a different environment. Revenues are no longer guaranteed. Annual expense increases are no longer automatic. Insurers have recognized that they have a new opportunity to control their costs through negotiated rates. Managed care is rapidly increasing its presence.

Competition, by its nature, requires a rapid response to opportunities, changing demographic trends, and shifting community needs. The structured, lengthy process of the Certificate of Need program creates an impediment to the new competitive model of health care.

The three fundamental underlying principles of the Health Care Reform Act are access, quality, and cost. The current Certificate of Need program can, and does at times, impede access by virtue of its principles of regionalization. Quality is tangentially linked to the program under the same principle. In theory, global costs are meant to be constrained by the goal of prohibiting "unnecessary duplication of services and programs," but in practice, are aggravated by specific providers being delayed or deterred in providing cost-effective delivery alternatives. Frequently, patient treatment is interrupted and unnecessary costs are incurred by transferring

patients back and forth between institutions under the guise of regionalization.

Mid-Atlantic Health Group asserts that these principles -- access, quality, and cost containment -- can be upheld without the current program by virtue of the following:

1) Improved access to health care services can be achieved through creative program development, sponsored by the individual health care institution or through collaborative efforts of multiple providers.

2) Quality care will soon be a significant measure of a health care organization's ability to service and attract patients. The State of New Jersey has the fiduciary responsibility to assure its citizens that all health care providers meet acceptable standards of quality care. The mechanism for this is called licensure.

3) Controlling costs has now become everyone's responsibility. Health care providers are at risk for their financial condition. Insurers, HMOs, and other third-party payers are using their purchasing power to secure price discounts which, in turn, will be passed on to the consumer.

Discounted prices will force cost control which now includes capital costs as well as operating expenses. The financial ramifications of technology acquisition and building expansion will be thoroughly scrutinized by the institution prior to action being taken. It is no longer appropriate to rely upon historical utilization patterns as predictors of future bed and equipment needs, but rather, progressive institutions should be encouraged to implement innovative models of health care delivery.

For example: Subacute care beds to decrease length of stay; off-site ambulatory surgery programs; and less costly and user-friendly diagnostic treatment centers, all of which are impeded or precluded by current Certificate of Need regulations. Micromanagement via Certificates of Need results

in untimely or ineffective solutions to rapidly changing health care delivery.

In closing, we believe that the Certificate of Need program is no longer a central component in the health planning process. The program should be substantially modified to reflect the realities of the health care industry today.

Thank you for your time today. If you have any questions, I will answer them to the best of my ability.

ASSEMBLYWOMAN WRIGHT: Thank you, Mr. Harrington. Are there any questions from the Committee? (no response) It looks like you were very clear.

MR. HARRINGTON: Thank you.

ASSEMBLYWOMAN WRIGHT: We appreciate your coming.

Dr. Sachs? Next will be Dr. Meltzer and Mr. John Fanburg; then Richard Oths, and Suzanne Sblendorio.

DR. SACHS: Thank you for the opportunity to speak to you here today. My name is Dr. Greg Sachs. I am a cardiologist in private practice, with offices in Summit and Morristown, New Jersey. I am speaking not on behalf of myself, but as a representative of the Medical Society of New Jersey. I have been on the Board of Trustees at the Medical Society of New Jersey for seven years, and have been asked to speak on their behalf today. For those of you who are not aware, the Medical Society of New Jersey is the oldest Medical Society in this country, about 210 years old. It represents over 10,000 physicians in the State, and approximately 70 percent of the practicing physicians in the State.

The timing of this discussion is very appropriate because last week we had the annual meeting of the House of Delegates of the Medical Society of New Jersey. The House of Delegates is composed of physicians who are elected from their hospital staffs. De@ending upon the size of the hospital, there may be anywhere from one to three representatives who sit

on the Executive Committee of their component county medical society for regular meetings, and then once a year gather for an annual meeting. Therefore, since we have about 110 hospitals in the State, that represents about 350 members of the House of Delegates.

At our meeting last week, there were approximately 40 resolutions discussed. One of the resolutions discussed concerned itself with this very subject and was stated as, "Resolution: Certificate of Need in New Jersey is no longer necessary and desirable, and should be abolished." That was the resolution proposed. It was discussed at length by the House of Delegates, and the final vote was 353 in favor of that, and three opposing.

Now, realize that these physicians came from small hospitals, large hospitals, urban hospitals, rural hospitals, suburban hospitals, teaching hospitals, nonteaching hospitals; hospitals that saw themselves benefited in the past by Certificates of Need, and hospitals that saw themselves in the past harmed by Certificates of Need. The strong, strong, strong conviction of these physicians was that Certificate of Need is no longer necessary and desirable.

Of course, your question, most naturally, is why? I would say it is a combination of four things: perceived quality, cost, availability, and -- I hate to use this word -- politics. One, in terms of quality, physicians welcome competition. They accept that as a fact of life. If an orthopedic surgeon, a pediatrician, or, in my case, a cardiologist moves into the community and is qualified, we immediately grant them privileges on the staff of the hospital to go into competition with us.

Why do we do that? Because we perceive it is in the best interest of the patient to have the maximum number of choices in terms of quality, new techniques, availability, etc. Even though it may be economically and professionally

undesirable for us as individuals, we perceive it to be in the best interest of the patient. Well, if it is in the best interest of the patient for physicians, why isn't it in the best interest of the patient for hospitals to be playing by the same rules?

The second corollary of that is, unfortunately -- and I was a member of the HSA for many years in this State -- objective standards of quality were never taken into account in granting, extending, much less ever closing down programs in the State that required Certificates of Need. There are objective standards available. If you take a subject like cardiovascular surgery, Medicare posts statistics every year, not just on gross mortality, but what they call "acuity adjusted mortality," adjusting for the state of illness of the person before surgery. There are national firms that provide this data for non-Medicare patients to managed care programs. People like Iameter present these statistics on a regular basis. Not only that, the State of New Jersey, itself, has calculated these statistics, but keeps them well hidden within committee wrappings, and they never get presented to the public.

So, as a result, when a hospital has particularly high or particularly low numbers, as judged by these outcome standards, it never comes into consideration for whether a program ought to be expanded or shut down.

Second, cost: Cost was a major consideration when we had a regulated process, for all the reasons the gentleman explained to you here before. I have sat on finance and budget committees of hospitals for probably 12 years in this State. I think I am one of the few people, probably other than chief financial officers, who understand how hospitals were reimbursed in the old days, much less in the new days.

But it was a very simple matter, and it led to many absurdities. For example: In the City of New Brunswick, there were two hospitals of relatively comparable size -- St. Peter's

and Robert Wood Johnson -- both basically served by the same physicians, medical students, or residents from the UMDNJ taking care of the patients of both of them. For many, many years, Robert Wood Johnson would be reimbursed between two and two-and-a-half times for every unit of service -- whether it was a gall bladder removal, a pacemaker implantation, a birth -- because of some perceived, you know, "unusual costs" of this institution.

In the new system, these rates are not going to be established by the State. They are going to have to go into the marketplace to establish rates. They are going to have to bargain with managed care providers. If those managed care providers are not happy with those rates, they are going to send their patients to other places, as they do, both within the State and, unfortunately, outside the State of New Jersey, when they perceive that the costs are too high.

We had at our House of Delegates meeting doctors from one of the "children's centers" in the State, arguing that they should be guaranteed existence. Why? Because managed care payers were pushing their patients out of the State. You tell me why. I assume it was on the basis of perceived cost and quality. Remember, too, that when these hospitals start to embark on a new service, it takes money, either digging into their own equity or borrowing money. And if you borrow money, you have to go to the bond market. If you go to the bond market and they are not convinced that you can pay for it, they ain't going to lend you the money. Therefore, what better limit might you have on hospitals getting involved in projects that they do not need.

The third reason the MSNJ opposes it is availability, as has been said. We see this again and again. I see it, even though as a cardiologist I have a number of patients who are on chronic dialysis. Because the facilities are limited by State regulation at my own hospital, I have patients who get every

other service at my hospital who have to drive 35 miles to other centers three times a week, and 35 miles back, because that is the nearest place that they can get their dialysis, even though all their other care is provided at, you know, one hospital.

We also see it in terms of outpatient services, how it affects physicians too. There is a law in the State of New Jersey that says a doctor, or a doctor and his partners, can have an outpatient operating room. That makes a lot of sense because plastic surgeons, ENT surgeons, ophthalmologists do a number of minor surgical procedures in their office. Therefore, it makes sense for the patient, for convenience and cost, to be able to provide that service.

But, if you are a doctor in a large organization, if you are a member doctor of HIP which has over 100 doctors in one setting, or the University Health Program in Newark, which has over 80 doctors, or the Summit Medical Group, which has over 70 doctors in one place, you can still only have one operating room; this at a time when we are talking about trying to get physicians to function together as units. And you say, "Oh, they can apply for a Certificate of Need," but you don't say what their chances are of getting a Certificate of Need if some hospital nearby perceives it as a potential loss to them in terms of revenue.

Fourth, politics. This is the saddest point. I joined the HSA many, many years ago, trusting that some form of platonic ideal would determine how Certificates of Need were granted. What I saw after a period of time was, there were Certificates of Need which were turned down at every level of the local HSA. The regional HSA would check, and then the Commissioner of Health suddenly would grant the Certificate of Need. Or conversely, turned down by all three levels -- or I should say, granted by all three levels and turned down by the Commissioner of Health.

Why does that happen? Well, because, unfortunately, even the finest Commissioner of Health is a political appointment. He is appointed by the Governor, and he is under tremendous pressure from the Governor and the Governor's aides to further certain political purposes, whether they are necessarily in the best interest of public health or not. I guess it would be nice if the people who made these decisions had the independence of a Supreme Court, but we all know that even Supreme Court appointees get politicized by whomever happens to be President or Governor at the time. Unfortunately, the only nonpoliticized force that can make these decisions -- we were told about 200 years ago by Adam Smith -- is the marketplace. Only the marketplace removes itself from the political decision.

Finally, one of the gentlemen talked about sunset laws. There are sunset laws on the books, but they never get applied. In my part of the State, there are, at present, six operating rooms at three hospitals in the City of Newark doing 1400 open-heart cases a year, and one hospital in Morristown doing over 1000 a year. Now, State law says that if you are doing more than 350 cases a year, you should automatically be given a second operating room. But the program in Morristown has been repeatedly turned down by the Commissioner of Health. Conversely, the law says -- the regulations, I should say, say -- that if you are doing fewer than 250 cases a year, you ought to lose your operating room. Well, you don't have to be a wizard to divide six into 1400, to know that they ain't all doing 250 cases a year. It doesn't happen. It is too politicized, and it won't happen as long as you leave it in effect.

I would like to quote one last thing, the American Hospital Association. I'm reading from their State Issues Form. David Hellman, the Associate Director for Financial Policy and Capital Finance, states: "Certificate of Need has

not been seen as an effective mechanism nationally, and has become so politicized in many areas that people discount it immediately in terms of health care reform." That is the opinion of the AMA; that is certainly the opinion of the physicians of the Medical Society of New Jersey. I certainly hope it is your opinion as well.

Thank you.

ASSEMBLYWOMAN WRIGHT: Thank you very much, Dr. Sachs. Are there any questions of Dr. Sachs from the Committee?

ASSEMBLYMAN COLBURN: I'm sorry to hold you up here, Dr. Sachs. As you can see, you have a lot of fellow sufferers out there in the audience waiting to testify. One thing I just wanted to say -- it is probably an aside, but I said it to Mr. Maressa -- is, I think it is incumbent upon we physicians to somehow demonstrate to people that we are not doing unnecessary procedures as we ask for these privileges which, you know, by and large, we have had. I know you are sincere about that, as am I.

DR. SACHS: Well, I think there are major cultural differences in this country, too. I was in the military in Florida. People tried to get me to go into practice there. It was obvious to me that it was a much too entrepreneurial environment for me to want to function in it for life. Most of the examples where removal or reduction of Certificate of Need led to abuses happened in places which culturally are very different from New Jersey. You only have to look at zoning in Florida or Southern California to realize how different it is from New Jersey. In New Jersey, we don't have private investor-owned hospitals. We don't have doctor-owned hospitals. Hospitals, virtually all of them, are community based; run by boards of trustees who come from the community. These people are not entrepreneurs. They may be entrepreneurs in their own business, but they aren't running the hospitals. So you are not going to see the sort of excesses in a State

like New Jersey that you might see in other areas of the country. It is just culturally different.

**ASSEMBLYMAN COLBURN:** Thank you.

**ASSEMBLYWOMAN WRIGHT:** Thank you very much. For the record, Dr. Sachs, did you tell us where you practice?

DR. SACHS: In Summit and Morristown, New Jersey.

**ASSEMBLYWOMAN WRIGHT:** Okay. I thought that was what you had said. Thank you very much.

Dr. A. Donald Meltzer and Mr. John Fanburg. They will be followed by Richard P. Oths, Suzanne Sblendorio, and Lisa Verniero.

**A. D O N A L D M E L T Z E R, M.D.:** Thank you for allowing me to speak. My name is Donald Meltzer. I am a radiologist practicing at Memorial Hospital of Burlington County, Southern Ocean County Hospital, and I also have a private practice in Mount Laurel, New Jersey. I am also President of the Radiological Society of New Jersey.

The Society welcomes this opportunity to speak before you to discuss the Certificate of Need program and its impact upon the practice of radiology and upon the availability of radiological services to the citizens of New Jersey.

There can be no question that the State of New Jersey has a compelling need to control the rapidly rising cost of medical care. The cost of high technology services, such as MRI, makes a substantial contribution to the total heatlh care bill.

However, such services have revolutionized medicine. Diseases formerly discovered only at surgery or autopsy are now diagnosed routinely. Critical trauma patients are now treated for life-threatening injuries that were formerly unsuspected until the patients were moribund.

An attempt to contain these costs has been the requirement to obtain a Certificate of Need to purchase high technology equipment and also for radiation therapy equipment.

Former Commissioner of Health, Joanne Finley, explained its principle to the medical community quite succinctly: If the number of pieces of equipment necessary to perform a service is limited, then the number of services that can be performed will be limited. The total cost for those services will be controlled.

While this may limit cost, it also limits access to the service. But it does not account for the need for those services. We believe that the Department of Health is not able to assess the needs adequately.

In the past, two different commissioners dealing with two different high technologies have seriously underestimated need. In the mid-1970s -- and this has already been stated -- the Department of Health approved certification of two CT scan units in New Jersey, and then proposed a three-year moratorium before considering any more. In less than three years, there were more than 30 in operation in the State, all fully utilized. Countless patients would not have benefited from this technique, which has revolutionized medicine, had not private physicians taken it upon themselves to make substantial personal investments to bring CT scanning to New Jersey.

To cite my own experience, our small hospital in Ocean County was unable to obtain a CON for a CT in its 100-bed facility. We installed a unit in our office in 1983, and now, 10 years later, the hospital finally is getting an in-house CT following the removal of CT scanning from the CON process. What would have happened to medical care in these last 10 years? In the diagnosis of head injuries alone, countless lives have been saved. As a result, the Society is pleased to see that the State has deregulated CT services.

Many of us thought we were having deja vu when the Department of Health provided approval for only eight MRI scanners. Again, private practice brought this entirely new modality to its present level.

Had the private practice of medicine been included in the requirement for Certificate of Need in the late 1970s, we would be seriously behind in the delivery of appropriate health care in New Jersey today.

The Health Care Reform Act of 1992 was intended to develop a marketplace health care economy. If physicians are to compete, they must be able to have appropriate technology and be allowed to replace outmoded equipment without governmental interference.

We believe that the Health Care Cost Reduction Act has produced unintended and paradoxical effects. While the Legislature intended in the Act to permit existing uncertificated equipment to operate, an upgrade or replacement requires a Certificate of Need. The technologies of MRI and other diagnostic modalities are not static. There is continuing progress in image quality as well as development of important new applications. For most new developments, many scanners can be upgraded. Some may require replacement to offer the best available technology. If an upgrade or replacement is denied by the Department, what will the effect be?

It is not likely that a unit will be removed from operation. While a radiologist is motivated to upgrade his equipment because he wishes to offer the best possible examinations to his patients, if he cannot do so, he will do the best he possible can with what he's got. We must understand that the fee or insurance reimbursement for an examination is based only on the type of examination. It does not depend upon the age of the equipment. In preventing the upgrade, there is no cost saving to the State. The only savings might be to the radiologist who had been willing to invest in the upgrade but was denied approval. However, at no reduction in cost, the patient may be denied a state-of-the-art examination.

The potential for increased utilization of radiologic procedures by self-referring physicians has been demonstrated in a study reported in the "New England Journal of Medicine" in December 1990. Self-referring physicians utilized diagnostic x-ray procedures between four and four-and-a-half times more often than physicians who referred their patients to radiologists. This, by the way, is what Dr. Sachs mentioned about in Florida. In addition, for three common examinations which were studied by the author, the self-referring physicians charged significantly more than did the radiologists. There was no evidence that the group that had more x-ray examinations had better care.

A study commissioned by the State of Florida produced similar findings. Recently, the American Medical Association Council on Ethical and Judicial Affairs drafted guidelines indicating that ownership of medical facilities to which physicians can refer their own patients, but it is not part of their practice, may not be an ethical practice.

While the Health Care Cost Reduction Act of 1991 does contain a ban on self-referral, it permits the practice to continue if it existed prior to August 1991. The Society contends that cost containment would be well served by completely prohibiting self-referral. We urge that there be no "grandfathering."

Not coincidentally, prohibition of self-referral would improve the quality of care available to the citizens of New Jersey. The physicians who are in a position to control patient flow to high technology imaging that they own are expert in specialties other than imaging. Most are not well trained in imaging, nor as highly motivated to maintain imaging skills as they are the skills of their own specialties. This is supported by a study performed in conjunction with Pennsylvania Blue Shield, which basically showed that radiologists and orthopedists provided outpatient x-ray images

which were acceptable, but a strikingly high incidence of unacceptable images were obtained among virtually all of the other nonradiologist providers.

If self-referral to high technology imaging were prohibited, imaging physicians could only compete with health care facilities and other private offices on the basis of the quality of service that they offer, a strong financial incentive, therefore, to maintain excellence as the only means of attracting referrals.

We believe that free market competition would work better than the present CON requirement for private practice if it were accompanied by a total prohibition of self-referral. A physician who can refer his own patients takes little financial risk in establishing an imaging center. A radiologist, since he cannot refer patients, must be a prudent investor. He will not install expensive equipment for which there is no need. He alone bears the entire financial loss for an unnecessary installation. Few examinations will be performed by an unneeded office, and such a failed radiology office does not add to the total heatlh care expenses of the State. If his judgment of need for the installation is sound, such a system permits physicians to introduce necessary equipment in a timely fashion, as we have in the past.

The recent promulgation of safe harbor regulations for Medicare providers will require that projects be restructured when its physician investors have the potential to refer patients. Such restructuring is tantamount to the sale of ownership interests and, therefore, will require a Certificate of Need or a waiver. Either of these may be denied in accordance with standards set by the Department of Health. The intent of the Act was to permit a practice with existing uncertified equipment to continue. The intent of the Legislature was clearly also to discourage self-referral. Restructuring to permit physician investors to divest

themselves of their interests advances this goal and should not be thwarted. The requirement for a CON in order to restructure inhibits this action.

In summary, the Radiological Society of New Jersey proposes that the requirement for Certificate of Need for private practice of medicine be withdrawn. Had it been in place for the past 15 years, New Jersey would have had a serious shortage of high technology imaging today. We propose, instead, that the Legislature consider a complete prohibition of the practice of self-referral. Such a prohibition would limit purchases of costly high-tech equipment to units for which there is a legitimate need, reduce the overutilization of such equipment, and would improve the quality of care.

If the requirement for CON for the private practice of medicine is not withdrawn, then we propose that the requirement for Certificate of Need for upgrade or replacement of existing equipment be withdrawn. And finally, we propose that the requirement for Certificate of Need be waived when an existing practice is restructured for the purpose of permitting physician investors to divest themselves of practices to which they refer patients.

ASSEMBLYWOMAN WRIGHT: Thank you very much, Dr. Meltzer. Are there any questions from the Committee?

ASSEMBLYMAN COLBURN: I assume when you are speaking about the effect of self-referrals on radiology that you might-- Would you be talking about orthopedists owning their own equipment?

DR. MELTZER: No. What I am talking about is what they found, particularly in Florida. Florida has a very strong self-referral law now where family practitioners, or internists, or surgeons bought into -- basically these were mostly MRI units and imaging centers. In return for buying in, they received the profits. The more they sent, the profits were there. Where a practice may have been marginal, I assume that more patients ended up going for studies.

ASSEMBLYMAN COLBURN: Okay.

**J O H N F A N B U R G, ESQ.:** If I may, I would like to make an additional comment on--

ASSEMBLYWOMAN WRIGHT: Would you please introduce yourself for the record?

MR. FANBURG: Oh, I'm sorry. I am John Fanburg, counsel for the Radiological Society.

Last week when Commissioner Siegel spoke about the lifting of the CN requirements in the State of Virginia, the number of purchases for linear accelerators, MRIs, etc. increased. Virginia does not have a prohibition of self-referral law on its books. I would say that that has a lot to do with the fact of the increase and acquisition of this high-tech equipment.

There has been much said in New Jersey in terms of the numbers of MRI units, I think primarily due to self-referral. The motivations are high. In addition, this self-referring and the laws on the Federal level affect access to care. When the Medicare rules began to change in terms of the safe harbor criteria, you saw many of the investments in MRI and other imaging which were held by referring physicians close their doors to Medicare and Medicaid patients. So a lot of these projects that do have self-referring going on-- That access has been eliminated to these Medicare and Medicaid patients.

ASSEMBLYWOMAN WRIGHT: Let me just clarify: Did you say that in Virginia they do have a self-referral restriction?

MR. FANBURG: They permit self-referral.

ASSEMBLYWOMAN WRIGHT: They do permit self-referral. Okay.

If there are no other questions, I want to thank you, gentlemen. Just one moment, please. Assemblywoman Weinberg?

ASSEMBLYWOMAN WEINBERG: On the issue of self-referral, would you hold-- I know you were talking about self-referral to radiological services that have capital

intensive equipment. What about other types of services, such as the home infusion industry or physical therapists that physicians might have an interest in?

MR. FANBURG: Basically, my experience has been in the imaging field. However, the self-referral laws that I am aware of hold laboratories, physical therapy, and everything else in the same regard.

ASSEMBLYWOMAN WEINBERG: Okay. Thank you.

ASSEMBLYWOMAN WRIGHT: Thank you, Assemblywoman.

Richard Oths will be our next witness.

**C A R O L P A U L:** Obviously, I am not Mr. Oths. I am Carol Paul. I am the Senior Vice President for External Affairs and Outcome Management at Morristown Memorial Hospital, speaking on behalf of Mr. Oths. He was here last week, but was not able to come this afternoon and asked me to present his remarks.

Just by way of my background, I have been at Morristown Memorial for 15 years in the position of Director of Planning, and have had planning responsibilities for the full 15 years I have been there. My comments will be brief.

The health planning and Certificate of Need process began in New Jersey in 1971. The system, now more than 20 years old, has successfully controlled the construction of unnecessary and costly hospital beds, the proliferation of high technology programs in both hospital and nonhospital settings, and concomitantly, has resulted in control of capital and operating costs. Without the Certificate of Need process, many hospitals would have completed costly capital construction projects in the early 1980s resulting in beds that would be empty today. Only hospitals which can demonstrate the ability to develop, finance, and maintain costly regionalized services based on documented community need have been allowed to develop such programs. Programs that did not meet minimum utilization criteria or quality standards, as defined by the State regulations, have been encouraged through the regulatory process to improve, or ultimately close, their programs.

States which have moved to free competition are experiencing massive capital expenditures and reduction in access to, and quality of, care. They have seen a medical arms race that has resulted in a plethora of mediocre facilities and programs, rather than a select number of high quality services. For example, Greater Los Angeles, which serves a population comparable to New Jersey, has at last count 47 open-heart surgery programs; New Jersey has 12. These programs and services never would have been established in a regulated setting. Ultimately, it is the patient who pays, both in terms of the capital and the operating costs, and in terms of the compromised quality of care they receive in these environments.

Ironically, program competition can actually drive up costs and tends to do just that in our open/competitive hospital and health care markets. Two examples for your consideration: The aforementioned case of cardiac surgery in Los Angeles creates a potential for significant underutilization and concern about the quality of these "free market" programs. California, which deregulated their Certificate of Need regulations in 1985, tends to have some of the highest helath care costs in the United States. Last August, a trustee at a large multihospital system in greater Cincinnati stated that he felt that Cincinnati hospital trustees in general had failed in their fiduciary responsibilities to the community by allowing a "medical arms" race to occur during the previous decade.

Any move to a freely competitive environment in terms of planning will be costly and detrimental to the health care system in New Jersey and to its residents. While there is no question the Certificate of Need regulations should be less restrictive and should focus primarily on costly projects, the process is an integral part of cost and quality control, and must continue to exist.

To document these concerns, the Morristown Memorial Hospital Board of Trustees voted unanimously at its October 28, 1992 meeting to approve a resolution supporting the State health planning process and the Certificate of Need process. To do otherwise would result in increasing hospital costs and decreasing clinical quality. Certificate of Need deregulation would indeed have a major and detrimental impact on the cost of health care in New Jersey, something which none of us in this room today and, particularly, the citizens of New Jersey, want to see happen.

We thank you for the opportunity to share our concerns with you, and I would be happy to entertain any questions you may have.

ASSEMBLYWOMAN WRIGHT: Thank you. Assemblyman Mikulak, please, and then we will proceed.

ASSEMBLYMAN MIKULAK: Hi. You said that states that eliminated the Certificate of Need process are being caught up in a medical arms race. Is that right?

MS. PAUL: The data would indicate that that is what is happening, yes.

ASSEMBLYMAN MIKULAK: Okay. There is something I can't quite fathom here, and that is: Where are these people who are involved in the medical arms race getting all this money to pump into these technologies and these facilities? Are the banks just giving it to them? I mean, is that--

MS. PAUL: In some states, the hospitals have very, very deep pockets. They have the moneys available and have been able to shelter that money. We have also found, from talking to my financial officer, because this question has come up on several occasions, that the money has been out there to borrow. That has been our understanding. Simply, it has been there when it has been needed.

ASSEMBLYMAN MIKULAK: Do you think New Jersey would find itself in this situation if we further--

MS. PAUL: I think we would find ourselves at a level of that situation, yes. Perhaps not as radically, because I don't think New Jersey hospitals have the deep pockets that other hospitals do. But I think we would find ourselves at a level that we would not want to see.

ASSEMBLYMAN MIKULAK: I don't think any of us have deep pockets in this economy.

MS. PAUL: I think you're right.

ASSEMBLYMAN MIKULAK: Thank you.

ASSEMBLYWOMAN WRIGHT: My question is with regard to the comment you made toward the end of your testimony, at the bottom of page 2, where you thought that the Certificate of Need regulations should be less restrictive, and you describe how they should focus. However, you are reporting to us that the Morristown Board supports the Certificate of Need process without-- I mean, are those mutually exclusive statements?

MS. PAUL: Let me comment on that: We believe many of the things you have heard; that is, it is still probably too restrictive. I think my philosophy -- and, I think, the philosophy shared by my Board -- is that those areas that are highly technical, highly costly, your regionalized services, are the ones that should be regulated.

One of the Board member's comments, which I think sort of synopsizes their feelings, is, "We always felt it was too restrictive. We never felt it should go away." I think that the legislation has taken some of the areas that could be deregulated; I think there are more that could be. We are looking at one coming up, which is the issue of dialysis.

ASSEMBLYWOMAN WRIGHT: Some people have suggested that diagnostic versus therapeutic might be another way to look at it, but the people I have asked who have testified have not verified that. But some of the things you are talking about fall into that high cost category of technology.

MS. PAUL: And I think both diagnostic and therapeutic do. That is why I think it becomes a difficult line.

ASSEMBLYWOMAN WRIGHT: Certain aspects.

MS. PAUL: Yes.

ASSEMBLYWOMAN WRIGHT: Okay. Are there any other questions from the Committee?

ASSEMBLYMAN ROMANO: Through you, Madam Chair, to my good colleague, Assemblyman Mikulak, you mentioned about being able to fathom -- okay? -- what that was all about. I, too, sometimes feel I am in the bends right here, because it doesn't hold true to-- Remember our past in terms of the Certificate of Need and the State Health Plan and the planning process, and yet here today it is like I am in a new world. Before, it was eliminate the Certificate of Need; eliminate the State Health Plan. I hear more and more from people today where there should be some sort of controls on Certificate of Need. That is what I find, having the bends.

ASSEMBLYWOMAN WRIGHT: Thank you, Assemblyman Romano. Well, we'll try to oxygenate you (laughter) and help you with your illness. The physician to cure a person is here.

UNIDENTIFIED MEMBER OF COMMITTEE: It's better than "Alice in Wonderland."

ASSEMBLYWOMAN WRIGHT: Yes. Are there any other questions for Ms. Paul? (no response) Thank you very much for representing Mr. Oths.

The Chair has advised me that we are going to try to hear everyone who is here today.

ASSEMBLYMAN COLBURN: By 5:30.

ASSEMBLYWOMAN WRIGHT: Oh, yes, by 5:30. If we go fast, it might be sooner.

Suzanne Sblendorio? (no response) Suzanne is not here. Lisa Verniero? (no response) Thomas McNamara? (affirmative response from audience)

**T H O M A S  C.  M c N A M A R A,  M.D.:** Thank you, Madam Chairperson. Members of the Assembly Health and Human Services Committee: I apologize for not having a copy of my brief remarks, but I shall certainly make sure that you have those in the future.

I appreciate the opportunity to be able to comment on the legislation under consideration pertaining to the CN process as it relates to extra corporeal shock wave lithotripsy. I am a physician/urologist in private practice in Camden County who is a member of the Medical Society of New Jersey and a Medical Director of the Mid-Atlantic Stone Center, a free-standing, licensed and certified facility, and I might add, the first in the State.

While I am generally a supporter of medical designed policy, I am here today to testify that in this particular instance, Dr. Sachs and the Medical Society do not represent my interests, nor, do I believe, the best interests of those members involved in lithotripsy. While the free market system may be best for some aspects of health care delivery, I submit that there is no need nor advantage in abrogating the CN process for lithotripsy.

The CN process is consistent with the philosophy of regionalized services, and has proven effective with lithotripsy. The number and location of approved machines in the State -- three -- is appropriate for the incidence and prevalence of stone disease in the State relative to population. All three continue to provide cost-effective quality care to all of New Jersey's citizens.

One only has to look -- as one of the other speakers did -- at the Los Angeles area, where the population is not too dissimilar, where driven by market competition 20 lithotripter machines, at one time, were in place, of which nine have since become defunct. The several remaining are operating on marginal grounds. Is there any more clear example of the

failure of the free market system than this inappropriate proliferation?

One could argue that the CN process is drudgingly slow and, as used to be the case, delays appropriate new technology, as we heard earlier. But with the new rules that provide for expedited reviews and physician labors, current flexibility does allow for the future, while continuing to present some sense of appropriate conservatism when dealing with such high cost technology, where one false assumption can cause the tax system millions of dollars of inappropriate expenditure.

We are reminded specifically of the gall bladder lithotripsy situation where, if the free market had been allowed to go on, there may have been many more gall tripters which now would be somewhere else or sitting idly by but because of the advent of laparoscopic cholecystectomy. Therefore, in the area of lithotripsy, the three essential aspects of service, again that we have heard today -- access, quality, and cost-effectiveness -- have, in fact, been fulfilled by the CN process. Every urologist and every patient in the State currently has access to a lithotripsy machine and treatment, regardless of ability to pay. The CN process ensures access by the indigent. That might not otherwise be true. This service is provided by current facilities where quality assessment activities are an integral part of treatment. The service is also provided at the most cost-effective rate because these sites have that sufficient threshold volume, again which you heard earlier, and can develop the expertise that is important in the management of stone disease.

I urge, therefore, that the CN process which has proven to be effective in the area of extra corporeal shock wave lithotripsy, and for which no cogent argument can be made against it, be continued, regardless of the fate of the CN process for other areas.

Thank you for the opportunity to appear before you today.

ASSEMBLYWOMAN WRIGHT: Thank you, Dr. McNamara, particularly for holding on with us. We do appreciate your coming today.

Assemblyman Romano?

ASSEMBLYMAN ROMANO: I wonder if you might help me, Doctor. You used a few terms here, and I am only too anxious to learn new terms. I don't even want to attempt to pronounce litho--

ASSEMBLYWOMAN WRIGHT: Lithotripsy.

DR. McNAMARA: Lithotripsy.

ASSEMBLYMAN ROMANO: What is lithotripsy?

DR. McNAMARA: Lithotripsy is the process by which kidney stones, urinary tract calculi, can be treated in a noninvasive, nonoperating, nonincisional manner.

ASSEMBLYMAN ROMANO: So, we are not talking about diagnosis now, we're talking about therapy?

DR. McNAMARA: Yes, we're talking about therapy -- absolutely.

ASSEMBLYMAN ROMANO: Now, you made a statement before that the indigent are assured service by having the CN process, or words to that effect.

DR. McNAMARA: Yes, sir.

ASSEMBLYMAN ROMANO: How does that work?

DR. McNAMARA: Because when we applied for CN, in our particular instances, one of the criteria was that, in fact, we would ensure access to the indigent, and we have continued to do that.

ASSEMBLYMAN ROMANO: I see.

DR. McNAMARA: And I believe that is true for the other centers also. That is one of the criteria in the application.

ASSEMBLYMAN ROMANO: You used another high-tech term at the beginning.

ASSEMBLYWOMAN WRIGHT: About the gall bladder, I think.

ASSEMBLYMAN ROMANO: In the beginning when you first started off.

DR. McNAMARA: Extra corporeal?

ASSEMBLYMAN ROMANO: Yes.

DR. McNAMARA: That means treatment that is extra, outside the body. So basically, in 20 words or less, again it is treatment where high pressure energy from an external source is focused upon kidney stones, causing them to shatter. Then they can pass through the system as fine pieces of sand and gravel, and therefore avoid invasive procedures -- operations and those kinds of things.

ASSEMBLYMAN ROMANO: If we could use construction terms, it would be a stone crusher.

DR. McNAMARA: That's exactly right.

ASSEMBLYWOMAN WRIGHT: Thank you very much, Assemblyman Romano. Dr. Colburn?

ASSEMBLYMAN COLBURN: I just want to say a word to you, because it seems to me that your facility represents cooperation among the physicians in the interest of the patients. That is pretty refreshing. You know, we didn't know you had this project in mind, and some of us signed some sort of an endorsement based on the idea that you would provide indigent care and that you would also give access to other qualified urologists to this facility. I have not heard any complaints about it; I have only heard compliments. I think, really, it might be sort of a model for what else we ought to be doing, because you appear to have done a really good job.

DR. McNAMARA: I appreciate that. Thank you very much.

I might add that at one time we did have 110 urologists throughout the State and, in fact, outside of the State on our staff. Many of them continue to come and treat patients every day.

ASSEMBLYWOMAN WRIGHT: Thank you, Dr. Colburn. Assemblyman Mikulak?

ASSEMBLYMAN MIKULAK: Where are the three sites located?

DR. McNAMARA: The Mid-Atlantic Stone Center is in Marlton, which is in the southern part of the State; there is one in New Brunswick, and there is one at the medical school in Newark. So they are strategically located in geographic parts of the State.

ASSEMBLYMAN MIKULAK: Do your opinions on C of N go beyond this particular, specific item -- this particular site?

DR. McNAMARA: Well, I am not sure that I am qualified to talk about C of N regarding other areas. I am specifically here today to talk about lithotripsy. Again, I would encourage that what has worked well in the past be continued for this particular area.

ASSEMBLYMAN MIKULAK: Thank you.

ASSEMBLYWOMAN WRIGHT: Thank you very much, Dr. McNamara. Just one moment, we have one more question.

ASSEMBLYMAN ROMANO: Just one final question: Are these stand-alone installations, or are these freestanding facilities?

DR. McNAMARA: Ours is a freestanding facility. It is licensed and certificated, as mentioned. The other facilities are in conjunction with Robert Wood Johnson Hospital and the hospital at Newark.

ASSEMBLYMAN ROMANO: Are they located within the hospital there?

DR. McNAMARA: I believe in Newark it is a building adjacent to it; in New Brunswick, it is in the hospital, yes.

ASSEMBLYMAN ROMANO: Thank you, Doctor.

ASSEMBLYWOMAN WRIGHT: Thank you, Doctor. We appreciate your testimony.

DR. McNAMARA: Thank you very much.

ASSEMBLYWOMAN WRIGHT: Maurice Coffee. Please proceed.

**M A U R I C E C O F F E E, JR.:** Good afternoon, Madam Chairman. Members of the Committee: My name is Maury Coffee. I am the Chairman of the Health Issues Committee and a member of the Board of the Chamber of Commerce of Southern New Jersey. I am employed by the West Jersey Health System as Assistant to the President and Vice President for Planning. We appreciate very much this opportunity to share with you our thoughts, and to help inform the New Jersey Assembly on Health and Human Services Committee this afternoon regarding the question of continuing the need for a Certificate of Need process in this State.

The Chamber of Commerce of Southern New Jersey has had health care reform as one of its most important priorities since 1991. The availability of affordable quality health care to the employees of its members is an issue of continuing and paramount concern. The Chamber supported the coalition that led to the passage of the Health Care Reform Act of 1992. In this effort we developed a statement of "Goals for Health Care Reimbursement Policy," which I have passed to you. You have a copy there. We are gratified, I should say, that many of the components of that goal statement were incorporated in the Health Care Reform Act of 1992.

The Chamber of Commerce of Southern New Jersey shares the growing recognition that access, quality, and affordability of health care services is the nation's most important objective next, perhaps, to the overall health of our economy. Our membership in the Chamber has seen the increasing problems of achieving affordable health care coverage firsthand.

We see a very limited necessity for Certificate of Need review in the State of New Jersey. This subject was a critical part of item number 1 on the Chamber's "Goals for Health Care Reimbursement Policy," which you have before you.

I would like to quote from that goal number 1, because it is important to the message we have to convey:

"Efficient hospital and provider service should be delivered with greatly reduced governmental regulation and involvement. The present Chapter 83 reimbursement system should be repealed. A market system should replace mandated rate setting. "Certificate of Need regulation should be limited" -- and I repeat this -- "Certificate of Need regulation should be limited to those areas having a significant impact on the quality of care. That would include, but not necessarily be limited to: regional trauma centers; intensive perinatal services; burn centers; organ transplant centers; and cardiac surgery centers."

The Health Care Reform Act of 1992, of course, has repealed the Chapter 83 reimbursement system. A market system, however, cannot properly take effect without the providers having the ability to easily increase needed services or decrease services no longer needed. The Health Care Reform Act, as you will recall, provided only limited CN deregulation of a few health care services. Certificate of Need imposes a delay of up to one-and-a-half years on some needed services, and may even totally prevent needed adjustments from taking place to make the total health care system more efficient.

The above specialty services that I just mentioned are the only areas -- there might be one or two other areas that could be included, I would certainly agree -- but they are the only areas, pretty much, where a certain minimum number of patients is required to maintain the quality of the teams providing specialized tertiary care. These services really should remain under Certificate of Need regulation, but it should be very limited.

With the advent of health care reform -- and this is key to our position -- it is essential that provider networks not be subjected to the risks of a competitive marketplace

without having the ability to respond to it rapidly and effectively. It is not rational to think that providers will continue to expend scarce capital resources on facilities or on services that will not be fully utilized. There will be no great proliferation of hospital or other construction. Those of us who have studied -- and I think many of you have -- the impact of managed care throughout the nation, although there is a lot to be learned, would probably agree -- as a shake-out would show -- that the additional construction and new services would be slow to be imparted because of the risk that would be taken. The health care system, we think therefore, cannot be micromanaged while it adapts to this change. It has been widely recognized in the literature since the early 1980s that Certificate of Need is not an effective cost control mechanism.

Speaking from our experience in the West Jersey Health System, the existing Certificate of Need process is unresponsive to the need for rapid change. In this new era it has reacted by not allowing any change at all. The following are some of the most recent trends: imposing of moratorium; fewer annual review cycles; use of old data to forecast future in a reform environment, which is just not acceptable.

This has had the following serious impact on the health care system:

* Additional development cost is forced on the hospitals in the form of superfluous Certificate of Need regulatory burden, monitoring of project completion, monitoring of conditions, etc.

* Projects focused on the State Plan, rather than actual need. Everyone looks at the State Plan; they focus on the State Plan; and the actual need is not fully taken into consideration.

* Inability to develop lower cost alternatives, e.g. freestanding versus hospital based ambulatory surgery.

All of these are negatives that the Certificate of Need has impacted on in the health care system over the past several years.

We believe that modification of the Certificate of Need process is clearly essential. Limiting its application to the specialty tertiary services will retain its proven strength. At the same time, it will eliminate its proven inefficiencies. Continuation of the Certificate of Need process in its most recent form will surely inhibit successful health care reform.

In summary, we need to deregulate most hospital services from Certificate of Need review. Positive change in our health care reform system depends on removing significant barriers to achieving change through competitive managed care. Managed care cannot be proven successful in the State of New Jersey unless all of the health services and the providers are given the opportunity to reduce the costs through managing the services and the facilities they have available.

I can give you an example of the frustration I presently have with our own system; that is, where the system has four hospitals. We have operating rooms, of course, in each of the hospitals. We have a freestanding surgery center which has been very successful. Our ability to move operating rooms and shift in a way that would be much more cost-effective is not really available to us without a long, costly process. We are going to do those things. We have to do them if we are going to keep competitive. If we are not able to do those things properly -- and thank goodness the West Jersey Health System is one of the lowest cost hospital systems in the State-- If we are not able to do those things properly and make those shifts on a timely basis, we are not going to be in business, and that is the same way with all of the other hospitals in the State. There are going to be a lot of hospitals, unfortunately, that are not going to make it. Every

decision we make from this day forward will be based on good decision making, but being able to make those decisions not having to wait for a year or two or three to do it.

I can tell you, I have been in the health care system for a long time, and I have consulted for at least 18 counties -- for hospitals in 18 counties in the State, and I know of some of the frustrations and so forth that have gone on, and I know some of the good things that have taken place in the Certificate of Need process. But at this particular point in time, we really need to give the institutions the opportunity to competitively take the position and do the things that are necessary so that we can keep costs under control. Otherwise, in a competitive, caring environment -- in a competitive managed care environment, which is most likely going to come from the President, as well as through the Health Reform Act of 1992, we are not going to be able to do the things you will want us to do, we won't be able to reduce costs, and there will be a lot of fatalities that should not take place.

Thank you very much for the opportunity of expressing our thoughts.

**ASSEMBLYWOMAN WRIGHT:** Thank you. We really appreciate your endurance in holding out for this testimony. Are there any questions from the Committee?

**ASSEMBLYMAN COLBURN:** I only want to say that I have known this man for about 36, 37, 38 years, starting at Jefferson Medical School, and he does know the subject, as have a number of our other speakers. People like you are going to help us a great deal with what we are trying to do. Thank you, Mr. Coffee.

**MR. COFFEE:** Thank you very much, Dr. Colburn.

**ASSEMBLYWOMAN WRIGHT:** Are there any other questions from the Committee? (no response) I want to thank you very much. We do appreciate your testimony.

MR. COFFEE: Thank you again. Good luck on your decision.

ASSEMBLYWOMAN WRIGHT: Thank you.

The next speaker will be Larry Garinello. (no response) Okay. Gwenn Levine. Please be seated.

**G W E N N K A R E L L E V I N E, Ph.D.:** Thank you for extending the hearing so we would all get a chance today -- or, as many of us as possible. I appreciate it.

My name is Gwenn Levine. I am Vice President of Planning and Marketing at St. Joseph's Hospital and Medical Center. I am here today to speak in favor of Certificate of Need regulation in New Jersey.

The first point I wish to make is that it is premature to entertain any discussion on the deregulation of the Certificate of Need process. One reason is that the Clinton Health Care Plan has not yet been released. It is likely to supersede any action taken by New Jersey legislators at this time. In fact, there is some indication that it may be even more regulatory than first believed.

The other reason is that we are still evaluating the impact of the Health Care Reform Act which became law last November. To deregulate Certificate of Need at this time would seriously complicate an already difficult transition year for New Jersey's hospitals.

My second point is that deregulation of Certificate of Need will drive up the overall cost of the health care system, which is the complete antithesis of what was intended by the Health Care Reform Act. I would like to give you just a few examples of what would happen in the aftermath of CN deregulation:

1) Health industry manufacturers will respond to the increased demand for high-tech equipment and supplies by boosting their prices.

2) The proliferation of services will create competition for scarce, specialized staff. This will result in a salary war, which will further drive up costs.

3) In addition, the proliferation of services among providers will mean that economies of scale cannot be achieved.

4) In health services, higher volumes of patients are correlated with higher levels of quality because the proficiency and expertise of the staff is assured. Deregulation will decrease patient volume, thereby decreasing the quality of care.

5) Entrepreneurs will skim off the "healthiest" patients from the existing system, thus turning a profit for themselves while leaving the sicker and more resource-intensive patients to be cared for by hospitals. Patients who are uninsured will be left behind in our hospitals, as well. This will make hospital-based programs so vulnerable that they may have to close, thus leaving the sickest and least well-insured patients with nowhere to go.

6) The severe discounting hospitals are now experiencing based on the demands of third-party payers makes it imperative that patient volume remain high in order for hospitals to remain financially viable. This is a critical issue. Certificate of Need deregulation would allow competing programs to proliferate, thus undermining patient volume at hospitals throughout New Jersey which currrently operate Certificate of Need approved services.

The regionalized services for which such hospitals have been legitimately approved over the past 20 years reflect a tremendous investment in equipment, facilities, and staff. If we were creating a health system in New Jersey from scratch, it might be okay to expect market forces to define the industry. But we are not starting from scratch; the system of regionalizing certain specialty services in the past should be honored, not abandoned, because hospitals which sought and won

"franchises" to provide such services as cardiac surgery, perinatal care, and renal dialysis acted in good faith. The State must not break faith with these hospitals now.

As legislators, you have a special obligation not to allow these things to nappen. You must ensure quality of care for all members of society and keep health care costs under control, in part through Certificate of Need regulation.

I would like to conclude with some personal observations. Before becoming a Vice President at St. Joseph's, I was the Director of Planning. As such, I prepared all of our Certificates of Need. I navigated them through the regulatory system, and I prepared formal comments -- both pro and con -- on the Certificates of Need of other hospitals. As an "insider," I can tell you that CN regulation accomplished a number of things:

1) It facilitated hospital planning by linking the planning function with clinical services during the preparation of CN applications.

2) It helped chief executive officers to say, "No," to the demands of physicians and trustees for new technology, expanded services, and more beds which were unneeded or too costly by invoking the fact that the State would not allow this under the CN rules. In this way, the Certificate of Need process has played an important gate-keeping function.

3) It slowed down the dissemination of new technologies, like CT scanners, until the technology had evolved beyond first generation equipment. First generation equipment soon became obsolete and if all hospitals had purchased it, they would all have been out of a lot of money when they wanted the new CT technology.

4) It provided a rich opportunity for open discussion, negotiation, and accommodation on issues of importance. If you can imagine the legislative process without a committee system, you will have some inkling what it would be

like to initiate new health services without the Certificate of Need process.

5) Finally, it forced local boards to choose among competing CN applicants. Both the need to make this choice and the resulting competition served the public good by raising questions about the financial feasibility and the technical capability of hospitals and nursing homes.

As legislators, it is your role to serve the public good, as well. I urge you to support the continuation of Certificate of Need regulation in this regard.

ASSEMBLYWOMAN WRIGHT: Thank you very much, Dr. Levine. Is there anyone who would like to question this witness?

ASSEMBLYMAN ROMANO: I am not questioning; just kindly give my regards to Sister Jane. I'm sorry that I wasn't here the day she testified.

DR. LEVINE: I will. She spoke on Thursday for the Hospital Alliance of New Jersey.

ASSEMBLYWOMAN WRIGHT: I was interested, Dr. Levine, that you pointed out the link between planning as you view it and how it related to your involvement with the C of N.

DR. LEVINE: I can really tell you from the inside that that linked us up very closely. It forced a planning process where sometimes in the rush of things and the crises that are going on, that connection can be lost.

I would direct your attention to an attachment to my written testimony that I didn't go into, "Why Competition Cannot Work in Health Care," which I thought was very well done by Boston University.

Thank you very much.

ASSEMBLYWOMAN WRIGHT: Since there are no other questions, thank you very much. We appreciate your staying.

Sharon Pavelich. Steven Schneider and Fred Title will follow Sharon, and then we will be finished.

Is there anyone else in the room who didn't sign up or who expected to testify today? (no response) Please proceed, Sharon.

**S H A R O N P A V E L I C H:** Good afternoon. My name is Sharon Pavelich. I am a Planning and Certificate of Need Coordinator for the Local Advisory Board for Bergen and Hudson Counties. The Local Advisory Board is actually a project of the Public Administration Institute located at Fairleigh Dickinson University. The views I am going to present today are those of the staff, not necessarily those of the Board members.

We are responding to your notice for testimony on the Certificate of Need process. My comments will address the question: Is Certificate of Need review a useful activity? We believe it is, and we would like to take a few minutes to tell you some of the points of why we believe it is.

First, the march to competition in health care is a sensible one provided that resources are not squandered on unneeded duplication of services. A basic tenant of the Certificate of Need process is to balance what we need in light of what we have. The process has had imperfections, but essentially, Certificate of Need review requires providers to justify their requests for new services, upgrades, renovations, etc. The State has made the process more flexible over the past few years by raising the dollar threshold and including certain exemptions. But, it remains difficult for providers to evade questions about their investment decisions so long as CN reviewers have the power to make recommendations to the Commissioner of Health on the validity of these expenditures.

A second value in the Certificate of Need process relates to its usefulness in overseeing the statewide allocation and distribution of resources. Certificate of Need enables a provider to initiate, expand, or renovate a service or building with information about the other services that

providers are giving to the community, and provides information they can use in determining whether their project is financially feasible. Once granted, the Certificate of Need gives the provider "franchise power." We believe this power is actually useful. The power provided by defining the local service providers is often an important consideration in helping those providers to obtain capital. If the Certificate of Need disappears, it is likely that many providers will find their access to capital restricted, since providers will be more limited in their ability to project the financial feasibility of their projects. This is particularly important in the current financial environment.

Also, limiting CN may encourage the health care market to offer services only to those individuals who can afford to pay for them. The CN review process has ensured that providers take into account the needs of low-income or uninsured individuals by requiring that applicants address the needs of these individuals in the application and by monitoring what services are actually provided. Without Certificate of Need, there is no protection for these individuals.

A third value of the Certificate of Need process is public participation. Like this meeting here, we recently made recommendations to the State Health Planning Board regarding the proposed closure of Saddle Brook Hospital, and convened a meeting where over 500 people attended and had a chance to testify, also, on their views about the closure of Saddle Brook Hospital. In doing so, we gathered much information. It should be noted that in that testimony there were a number of legislators who also provided information about that review.

If there is no Certificate of Need process, opportunities for public comment will be severely limited and curtailed. The fact that so many people came to participate in our process of review of that application is only part of that equation. The second part is that the Certificate of Need

process requires a decision. The information we gathered in that process goes on from our level to the Commissioner of Health, who is held accountable for the fairness of his or her actions.

Had there been no Certificate of Need process, hospitals and other providers would make decisions on what services to provide, whom they will or will not serve, without any review. This oversight function is very important; an inherent element in the Certificate of Need process.

There are, obviously, other points, but these are just a few of the key reasons why we believe it is important to continue the Certificate of Need process. As others come before you and suggest that the health care system is overregulated and that Certificate of Need no longer applies, we can only suggest that the absence of a straightforward regulatory review process will lead to predatory competition among the haves, reduced protection of the have-nots, and a very destabilized environment for institutions and providers seeking scarce capital for needed projects.

Certificate of Need does not protect every institution or provider in every instance, but it does allow an opportunity to take a stand on a position when public policy dictates. As a conclusion, let me just share our hope that we will not develop a system in which State government finds itself always picking up the pieces of the system.

Thank you.

**ASSEMBLYWOMAN WRIGHT:** Thank you very much, Ms. Pavelich. Is there anyone on the Committee who would like to ask a question or make a comment? (no response) We want to thank you for your endurance in staying with us, and we appreciate your testimony.

**MS. PAVELICH:** Certainly. Thank you.

**ASSEMBLYWOMAN WRIGHT:** Our next speaker will be Steven Schneider. Is Fred Title here? (no response)

**S T E V E N  S C H N E I D E R:** I would like to thank the Committee for staying to let us speak today.

**ASSEMBLYWOMAN WRIGHT:** Thank you, Steve.

**MR. SCHNEIDER:** My name is Steve Schneider. This is Terry Beck. We are from MCOSS, which is a certified home health agency, a nonprofit organization. We have delivered a comprehensive package of community-based clinic and in-home services for 80 years. The perspectives I will share on Certificate of Need revolve around four basic issues: access to care; provision of care in the least restrictive and least costly settings; cost control; and home care reimbursement.

As you know, the Certificate of Need process guarantees a number of things:

* It allows for the planned, orderly growth of home health services where need and cost-effectiveness have been demonstrated.

* It includes a requirement to serve the uninsured and medically underserved populations in an industry which has never received rate relief for uncompensated care.

* It requires that new providers offer seven-day-a-week, 24-hour-a-day service.

Access to care is an issue upon which the entire nation is focused. The Certificate of Need process promotes access by requiring that new providers render a specified level of service to the indigent. If Certificate of Need were eliminated, the burden of uncompensated care would remain solely with existing agencies. However, as established agencies lose referrals for fully compensated visits to new agencies, the established agencies will be unable to provide the level of uncompensated care to which they are currently committed. The end result will be that patients will either access more costly institutional care, or go without needed service.

To give you an example of patients who would be impacted, I will share with you the following anecdote. Currently, MCOSS is providing care to Mrs. M., a 45-year-old retired teacher who has a diagnosis of cancer of the colon. Repeated illness resulted in her exhausting her lifetime health benefit. Yet, she is receiving in-home nursing and intravenous therapy at no cost through the MCOSS uncompensated care fund. This is made possible through the donations of private citizens, United Way, the County Freeholders, and other funders.

Many patients like Mrs. M. are able to receive high-tech services at home such as intravenous therapy, chemotherapy, and hyperalimentation. The provision of high-tech services at home affords patients access to services in the least restrictive and least costly setting. As an example, we are currently providing care to an eight-month-old child awaiting a heart transplant. Too weak to suck, the child is fed through a tube in her stomach. An 11-year-old boy received six weeks of intravenous antibiotic therapy at home for a wound which extended to the bone, sustained while he was riding a bicycle. Although these visits cost more due to the length of the visit and the training of the staff, agencies such as MCOSS are able to offset these costs through their regular visit volume.

If Certificate of Need were eliminated, new agencies entering the home care system would initially pursue less costly, traditional types of cases. As existing agencies lose patient referrals for traditional care, they would be forced to cut the more costly, high-tech services in order to remain cost-effective. The result would be that increasing numbers of patients would access acute care institutions for care that would be more appropriately provided in the home.

Certificate of Need facilitates cost control, a critical element of health care reform. The experience of other states attests to the fact that the elimination of

Certificate of Need for home health would result in the proliferation of smaller agencies throughout the State, increasing the total cost to the system. As Carol mentioned before -- Carol Kientz -- in Texas, the Certificate of Need for home health agencies was repealed in 1981. Over the next three years, the number of home health agencies increased by 500 percent. From 1981 to 1984, Medicare costs in Texas rose by 36.2 percent, as compared to 27.2 percent in the United States, and only 21.7 percent in New Jersey. Tennessee also repealed Certificate of Need for home health agencies in 1981. Medicare costs in Tennessee rose by 34 percent for that three-year period. As a result, Certificate of Need for home health care agencies was reinstated in 1984. The proliferation of agencies in New Jersey that would result from the elimination of Certificate of Need would cause an increased cost to the health care system and consumers due to several variables: start-up financing of the individual agencies; competition for home health care personnel; duplication of administrative overhead; and increases in State budgets due to the necessary expansion of staff for agency licensure reviews.

There are many who assert that elimination of Certificate of Need will spark competition, thereby reducing consumer prices. That argument is not applicable to certified home health care, which is a cost-reimbursed industry. Certified home health agencies receive the majority of funding through Medicare and Medicaid from patient billing on a per-visit basis. Patient fees are based upon actual costs with no markup allowed. There is no supplemental billing over and above the Medicare and Medicaid reimbursement, and even in the event of a denial of service, the patient cannot be billed for the care rendered. As a result, no surplus can be derived from providing these services.

In a cost-reimbursed industry, consumer price equals provider cost. The only way to reduce costs in a service

organization is for the provider to reduce overhead. Overhead results from regulations promulgated by the Federal government, standards of licensure dictated by the State government, and quality controls imposed by accrediting bodies and the agencies themselves. Since the governmental requirements are not within the agency's control, the only cost-cutting alternative available involves a reduction of internal quality assurance measures.

In summary, the elimination of Certificate of Need is not consistent with the State and national agenda for health care reform which emphasize that access to care is an issue of paramount importance. It is counterproductive to eliminate a system which has protected the needs of community-based residents throughout the State. Elimination of Certificate of Need will leave in its wake significant numbers of uninsured community-based residents going without needed care. Certificate of Need must be maintained.

**ASSEMBLYWOMAN WRIGHT:** Thank you very much, Steve. Terry, do you have anything you would like to add at this point?

**T E R R Y B E C K:** No, but we are open to questions from the Committee.

**ASSEMBLYWOMAN WRIGHT:** Okay. Does the Committee have any comments or questions?

**ASSEMBLYMAN ROMANO:** If I may? I know we all want to leave, but--

**ASSEMBLYWOMAN WRIGHT:** Assemblyman Romano.

**ASSEMBLYMAN ROMANO:** In your next to the last paragraph, "Since the governmental requirements are not within the agency's control--" You're talking about the Department's?

**MR. SCHNEIDER:** Yes.

**ASSEMBLYMAN ROMANO:** No, no, "the only cost-cutting alternative available involves a reduction of internal quality assurance measures." What do you mean by internal?

MR. SCHNEIDER: Each organization is responsible for meeting Federal regulations, State licensing standards, the quality assurance standards of accrediting bodies, and their own self-imposed quality assurance standards. The only overhead that an organization would legally be able to cut would be what they self-imposed and they felt was necessary to achieve a quality output.

ASSEMBLYMAN ROMANO: Thank you.

ASSEMBLYWOMAN WRIGHT: Any other questions or comments? (no response)

I just want to thank the home health care people because I am a great advocate of home health care. I think it is an important dimension of the delivery system. It is something we are focused on, both at the State level and the Federal level. I think this is an alternative to high cost care. So we are very grateful for the partibipation and the contributions that I think all of you are making to health care delivery.

Yes, just a moment. I'm sorry. Assemblyman Colburn?

ASSEMBLYMAN COLBURN: Just as a matter of information, it is my understanding that hospitals and physicians have their rates set by Medicare. Do you have your rates set by Medicare, or how does that work?

MR. SCHNEIDER: There is a cost limit that you cannot exceed.

ASSEMBLYMAN COLBURN: A max?

MR. SCHNEIDER: Right. If you are under that limit, you receive your costs.

ASSEMBLYMAN COLBURN: Yes.

MR. SCHNEIDER: At the end of the year, you prepare a cost report and reconcile, and all reimbursement is adjusted -- the costs for both Medicare and Medicaid.

ASSEMBLYMAN COLBURN: Do you receive a listing from Medicare of what they will reimburse for various services at the beginning of the year?

MR. SCHNEIDER: The cost limits are set-- Well, they are supposed to be set by the beginning of the year. Most of the time they are delayed, but they are set.

ASSEMBLYMAN COLBURN: Okay. That is really all I wanted to ask. What is your agency's name? What do those letters stand for?

MR. SCHNEIDER: MCOSS stands for quality. (laughter) It used to stand for the Monmouth County Organization for Social Services, but it was always confused with a governmental organization. So we took the acronym and it's MCOSS Nursing Services. It is a certified home health agency servicing Middlesex and Monmouth.

ASSEMBLYMAN COLBURN: So the letters do not mean a lot.

MR. SCHNEIDER: The letters do not mean anything. It is just MCOSS.

ASSEMBLYMAN COLBURN: I was just trying to figure that out.

MR. SCHNEIDER: We service Central New Jersey.

ASSEMBLYWOMAN WRIGHT: I think the thing you might not have mentioned is the magnitude of the services you provide in relation to the rest of the country. I think you are one of the largest--

MR. SCHNEIDER: We are the largest agency in New Jersey, and of the 6000 nationwide, we are the fifth largest.

ASSEMBLYWOMAN WRIGHT: The fifth largest in the country.

MR. SCHNEIDER: Providing over 500,000 home visits a year.

ASSEMBLYWOMAN WRIGHT: We really appreciate your contribution in New Jersey. Really, thank you for coming today.

One other quickie: What does it cost per visit? Can you answer that question?

MR. SCHNEIDER: The average cost per visit of all disciplines is somewhere-- On the average, it is around $60 for a home visit.

ASSEMBLYWOMAN WRIGHT: For home visits.

MR. SCHNEIDER: That is the aggregate cost per home health aide, nursing--

ASSEMBLYWOMAN WRIGHT: I understand, you are putting it all together.

MR. SCHNEIDER: --a variety of services.

ASSEMBLYWOMAN WRIGHT: Okay, fine. Thank you very much. We really appreciate it.

We think everyone has been heard. We did not hear that Fred Title was here.

ASSEMBLYMAN COLBURN: He has previous testimony on file.

ASSEMBLYWOMAN WRIGHT: Okay. He has submitted written testimony.

I am going to turn this back to the Chair for where we go from here.

ASSEMBLYMAN ROMANO: Before you do, Madam Chair, just let me say that you have performed with aplomb and distinction.

ASSEMBLYMAN COLBURN: That's the truth. Very well.

ASSEMBLYWOMAN WRIGHT: Thank you, Assemblyman Romano.

ASSEMBLYMAN COLBURN: I really got a rest today. Thanks a lot.

We are going to hear Fred Title on May 24, at the beginning of our Committee meeting, because he had to leave to pick up his children at school.

We will adjourn this session today until May 24.

adjourned

**(HEARING CONVENED UNTIL MAY 24)**

**(HEARING OF MAY 10 RECONVENED )**

ASSEMBLYMAN FELICE: The first speaker in this portion of the hearing will be Edward Tetelman. Ed, would you come forward, please?

**E D W A R D T E T E L M A N, ESQ.:** Thank you, Assemblyman Felice, and good morning. I see that our ranks have dwindled a little.

I represent the--

ASSEMBLYMAN FELICE: Just hold on a minute while everybody is moving in and out. If you want to have conversations, please take them outside. Go ahead. I'm sorry.

MR. TETELMAN: I represent the Department of Human Services. I am the Director of the Office of Legal and Regulatory Affairs.

I sat through most of the testimony on Certificate of Need, and I just want to preface my remarks with a couple of things. One, the discussion is primarily focused on cost, but not on access and quality, for the most part. I think that is important to recognize when we are talking about Certificate of Need.

In addition, I think we have really heard a mix from hospitals ranging from, "Don't tamper with the system," to some saying, "Change it" -- especially if they lack any kind of money-generating service, they have a very big interest in changing things -- to the Medical Society that says that it doesn't want any regulation of what they consider to be private ventures, to the radiologist saying, "We want more regulation of high-tech so you will only use us." When you get this kind of disagreement on both sides, what always occurs to me is, we must be doing something right with Certificate of Need.

Additionally, as I listened to the testimony, it reinforced my belief that our system of health care institutions really need to cooperate more. There really needs

to be more networks of care in our regions flowing up from the communities with our nurse practitioners, physicians' assistants, and primary care doctors, right into the hospitals, especially as we are beginning to move into what we might call "the brave new world of no rates," where everybody is going to be competing with everybody else. This, in turn, does not assure that we are going to get quality or access. It is very unclear and more than a bit scary, as we move into this world if there is no strong patient base in these communities, in one way or another, to support these institutions.

Now, with that preface, I would like to say that the Department of Human Services strongly supports the Certificate of Need process, and we support the program for a number of reasons:

First, the Certificate of Need does add structure to the health care delivery system. It doesn't allow it just to grow without any kind of rhyme or reason.

Secondly, and very importantly, it offers the public an important forum within which to have input and it talks about the growth of the health care delivery system.

Third, it does defer, and it contains cost.

Fourth, and most importantly I would say, is that it assures that low-income people and persons who might be considered undesirable patients, such as persons with AIDS or mental disabilities, have access to health care services, and it helps to guarantee quality.

Overall, the Certificate of Need process provides a public mechanism to compensate for the defects within our health care delivery system. New Jersey has long supported strong health planning and Certificate of Need, and these processes have done a couple of things: They have helped to hold costs in check, for the most part, and they have assured access and quality.

I served, since 1976, as a consumer member on the State Health Coordinating Council, and only once during that

entire time was there ever any overt political manipulation in the system. That time we took the State to court. I can tell you very intimately about taking the State to court, because I am the lawyer who had to represent the SHCC because we couldn't get the AG to come to represent us in court over that. Ultimately, the Department of Health changed its position. That was in the late 1970s, early on. Since that time, I think the process, while there may be some criticism of it, has been very public and overwhelmingly fair. It really represents, in my mind, how government with citizen input can work.

Some interests within the State have recommended that CON be eliminated in New Jersey, but ironically, the overwhelming movement in most of the states has been to restore and strengthen the Certificate of Need process, and with good reason.

Let me say that only 11 states eliminated CON when the Federal government allowed them to do away with it. Then, simply put, unnecessary beds and services were built and established, and costs increased in those states.

Now, you have heard some of this testimony before from other people, so I will just point out that in Texas there were nine new hospitals, including five psychiatric facilities opened in Houston alone, when they did away with their CON. Their psychiatric beds grew from 4700 to 8300. If you recall the television coverage in this area, what happened was, many of these institutions were actually kidnapping, literally, patients to put them into these psychiatric institutions. There was a big scandal in Texas over the empty beds. You have to keep these beds filled.

In Utah there were also cost increases. In fact, benefit plans changed when that happened.

In Virginia, the number of magnetic imaging facilities nearly doubled -- from 38 to 72. Remember, the cost of these machines is over a million bucks apiece, and the screens run

between $700 to $1000 a screen. That probably doesn't include the physician fee, as well.

In Arizona, 11 new open-heart surgery programs, mostly suburban, were created. You heard already about how the death rate went up in that state. Again, remember that the cost of each of these open-heart procedures is about $25,000, without the fees and therapy that follow afterwards.

As a result, we have seen other states really strengthen their CON programs.

Virginia has reinstated its CON law and, in fact, moved away from just doing institutions to services as well. David Brickley, one of the members of the Virginia House of Delegates, stated: "Our premise in 1989" -- when they opened up the law -- "was that health care was based on supply and demand. If there were more MRI and CAT scanners available, the price would go down. What happened was just the opposite. More machines are available. They're not being fully used and costs are higher than ever." So they reinstated their CON law -- expanded it.

Wisconsin is a state that has a very substantial portion of people in HMOs. If that is where the country is going, this is an important thing to look at. Governor Tommie Thompson, who can hardly be characterized as a liberal in any way, reinstated the CON law in 1992, after growth in services continued to skyrocket after deregulation. The managed care forces in the State of Wisconsin were not able to contain the growth. As a result, Wisconsin set its criteria for review of hospital construction at $1 million and purchases of individual equipment at $500,000, which is quite low.

Other states -- Colorado and Florida -- are also moving to reestablishing their CON programs. Georgia, which never gave up its CON program, also moved to cover physician services and increase standing clinics. The Atlanta Health Care Alliance, which is a business organization, was in strong support of this restoration. Adele Cohen, Vice President of

the AHCA, stated: "We have supported the Certificate of Need law and health planning regulations as a way to assist in the appropriate allocation of services and capital expenditures. Duplicative, unnecessary health care services have been very costly to our members." I have attached the article -- actually their lobbying document on that.

Obviously, states are realizing that some kind of public scrutiny -- public scrutiny in the health care delivery system in so-called competitive situations is really necessary. Indeed, a major study by Robinson and Luft found that costs were substantially higher in hospitals operating in more competitive local environments than in less competitive environments. After controlling for wage rates, patient case mix, state regulatory programs, and hospital teaching roles, their study found the average cost of admission to be 26 percent higher in hospitals in the most competitive markets than in hospitals in less competitive markets.

Now let's turn to New Jersey: Our CON program has been, overall, a very successful program. First, New Jersey's CON program creates positive competition based on local needs. Indeed, by setting out needs, local hospitals and facilities have cooperated in establishing joint services. This is especially true in the perinatal area and in the MRI area. We never thought we would see them cooperate, but what we did was create competition where they actually joined together to establish these services. They have also avoided established services in one another's backyards where there was marginal utilization, especially in the pediatric and obstetrical units of the State. If you take a close look at them, you will find many of them in the 30 percent range. So we haven't seen hospitals start these up because we have capacity within the State.

It has also kept the hospitals from raiding one another's backyard because it is subject to public scrutiny.

You can't do it behind someone's back. You have to come out into the public and explain why you are doing it.

Additionally, it allowed hospital administrators -- and I think this is important, especially as public officials-- Oftentimes, public officials don't want to be pressured into doing something that they may not think is right, and the ability to say, "No," is enhanced by having a public process. The same is true with the hospital CEOs.

It has also helped to facilitate some hospital mergers in this State and transformations -- not closures, but mergers. Examples of this are: Alexian Brothers/Elizabeth General, hospitals which merged together, and St. Clare's and Riverside also merged.

Second, it did help to control cost. Essentially, it prevented the establishment of unnecessary services where quality services already existed. This is regionalization. I know people have talked about it, but most are against regionalization. This is mostly true for people who do not have the regionalized service coming in and talking about this. This has been especially true in our cardiac area. Our open-heart surgery programs have good utilization and higher quality care. Indeed, the process stimulated the establishment of a blue-ribbon physician panel, and they actually closed some services because they weren't doing a good job in this State.

Moreover, the process presented and reinforced other alternatives to surgery. It got us to really press the system about medical management using TPA with drugs, doing things like streptokinesis, whereas that wasn't being particularly talked about. It was just, "Let us do surgery, and leave us alone." Whenever possible, of course, these types of interventions are much less costly and much safer.

Third, and very importantly, it assured access to care. Utilizing regionalization, major services were established at urban teaching centers and at centrally located

centers around the State. This assured that both low-income and wealthier New Jerseyans would have access to centers of excellence. Indeed, open-heart surgery again is a good example of a service that works under regionalization. Without a mixed paying base that is brought in by regionalized services, these facilities would be ghettorized and would have difficulty surviving. This is even more the case as we do away with the regulatory rate system.

Also, nursing homes did not take Medicaid patients. I can speak to you on this from very direct hands-on experience. We used the Certificate of Need program to make sure that nursing homes, when they came into the process, took Medicaid. In fact, what ultimately ended up happening was that they actually competed for Medicaid patients, and we got even higher numbers than even the law involved. The Medicaid waiting list was way reduced. In addition, we were able to get ex-psychiatric geriatric patients out of our public institutions, public institutions that do not have one dollar of Medicaid money -- 100 percent State money -- and move them over into nursing homes which allowed us then to match it with Federal funds.

Additionally, HIV positive and low-income persons were assured access to facilities that were reluctant to serve these patients. CON conditions were used to make services available to all citizens, not just those who could pay or who were desirable.

Additionally, freestanding facilities that would drain away paying patients from our existing hospital services were required to serve the indigent patients, and this helped us to level the playing field. You just couldn't go into the business and not take people who were indigent.

The Certificate of Need process also assisted this Department in expanding psychiatric services. While hospitals were more than willing to do open services in acute settings

for psychiatric patients, they were not willing to do closed. We didn't let them have the open units unless they did closed, through CON. So this helped us to establish these kinds of facilities and also short-term care in children's crisis units.

The existence of New Jersey's CON program has resulted in better bond ratings as well. Analysts state that the CON process helps to ensure that the facility will be financially viable, making our New Jersey facility bond interest rates lower. Eliminating CON will obviously have a negative effect on these bond ratings and will cost us more money in that market.

It is also important to remember that the Federal government still has not eliminated the 1122 review, which is a Social Security Act review. Under this section, if the Federal government finds that we aren't acting in a controlling way, they can withhold Medicare and Medicaid funds for facilities or services that are determined to be unnecessary. I understand that the Federal administration is looking at this again -- at CON -- to see how the new health care plan is ultimately going to work.

Also, unregulated services open the State's pocketbook through Medicaid, especially in the long-term care area. In the past, the planning of these services allowed us to have reasonable growth, and at the same time allowed us to offer alternative services, such as CCPED, which, as you know, is a very, very good service.

I did put in a call, also, to Dr. Coye, who is now the head of Medicaid out in California, to ask her about the testimony that was given about whether or not the Medicaid rates and growth increased in California. She has not gotten back to me, but I expect she will, and I will be happy to share that when she does get back to me.

In addition, I just wanted to talk about the CCRCs, which was another issue that was raised. The continuing care

retirement communities, while they have been deregulated, were required under the Certificate of Need to preserve a person's income in the CCRC, because as you know, CCRCs take a lot of money to get into. God forbid somebody runs into financial problems and can't make the maintenance payment, they get thrown out. That is still the case today. The Department of Community Affairs does not have that kind of protection built in right now.

Also, you can't sell a CN in this State. The place has to be built. To my knowledge, there has never been a CN sold while it is still not built.

In conclusion, New Jersey's CON system, I think, has served the State well. It has assured controlled growth, promoted competition between facilities, and cooperation, and even mergers, to eliminate unnecessary services and costs. It has helped to pull down costs by reducing unnecessary growth and construction, and has been a major tool in opening our services to low-income families and individuals, the elderly, and the so-called undesirable populations. Through CON, all New Jerseyans in need of a particular service have been able to obtain access where a new service or expansion of a facility has occurred.

Finally, and most importantly, the Certificate of Need process is a public process. Citizens can actually see how the health care delivery system is moving and have a say in what is going on locally or regionally, and can voice their opinions about problems. CON is one of the few areas where public scrutiny does play an important role. We think it has served New Jersey well. We hope it will continue. We hope to see the process expanded so that the playing field becomes level for all health care providers, and even as we move into the payer-driver delivery system. We must remember that the payers' focus may be inconsistent with the concerns of New Jersey. I mean, all they care about is the bottom line

particularly, and our focus has to be on both quality and access to care as well. So, our public CON process helps to assure that in this new system as well, that we are going to maintain some balance again.

Thank you very much.

ASSEMBLYMAN FELICE: Mr. Tetelman, while the CON process has been a good check and balance for our health care system, the cry out there has been that there should be some reform because of the time period in obtaining a Certificate of Need for what people feel are vital services. Do you feel there has to be some reform as far as the time periods of people who are applying for a Certificate of Need? I think that is one of the reasons why we are having these hearings.

MR. TETELMAN: Well, I think you are not incorrect in that. I think sometimes the time period takes longer than we would like. I think in the past it was because the plan-- There weren't plans developed, and people were waiting for the plans to be developed before they did batches and other things, and I think that did delay some things.

On the other hand, there have been times when it was good to go slow because the technology changed so darned quickly. CAT scanners is a perfect example. I know Joe Sherber came here and said, "Oh, if we had only had an open market on CAT scanners, everybody could have had them in the first generation." Well, the first generation-- If any of you had ever seen the pictures coming out of the first generation CAT scanners, they were very, very poor. By delaying for about a year and the market opening up, the CAT scanner-- They jumped to the fifth generation of CAT scanner, and the pictures were clear. So rather than everybody getting first generation, spending $45 million approximately in the initial stage, they waited a little bit, spent the money, and got a better product, where you don't have to respend the money. So I don't disagree with you that the process could be made quicker.

ASSEMBLYMAN ROMANO: Just one quick question--

ASSEMBLYMAN FELICE: Yes, Assemblyman Romano.

ASSEMBLYMAN ROMANO: --related or not related. Dialysis: How do you feel about dialysis in this whole picture of Certificate of Need?

MR. TETELMAN: Well, you know something, I think you have to remember how dialysis is paid for in this State. The Federal government pays for dialysis. So I think you want to assure that there is quality of care at these units and that there is enough economy in each of these services. The size of the unit does make sense. On the other hand, you want to make sure that they are spread around the State enough to allow people access to them.

So I have less of a problem with dialysis being deregulated, so long as it is connected to a hospital and there is some strong backup on it. I know people disagree on this particular one, but dialysis-- Remember, the payer source is the Federal government, so--

ASSEMBLYMAN FELICE: Assemblywoman Wright?

ASSEMBLYWOMAN WRIGHT: Thank you, Mr. Chairman. I want to ask you, Mr. Tetelman, the same question I have asked when it hasn't been clearly identified. You went back and forth in your testimony over CN for acute care, long-term care, and you didn't, I don't think, mention home care. But, can you delineate the settings at all as they relate to your perspective?

MR. TETELMAN: Well clearly, any major institutional care has to have a CON, I think, any facility.

ASSEMBLYWOMAN WRIGHT: Acute tertiary.

MR. TETELMAN: Acute, no, in primary and preventable. We have these surgery centers opening up and undercutting the hospital. There is no reason why they have to see indigent patients or low-income patients, and that is what has happened. When they have come into CN, they have had to do

it. It also fleshes out who is really supporting a hospital. Remember, the very doctors who go and open these surgery centers to make some bucks, are the same people who are on the staff of the hospital, and we continue to pay the bill at the hospital. I mean, it makes people come to the surface that they are doing this.

I know you are very interested in home health care as well. I think that what we have seen in home health care, again, is economies of scale. That is why I think it is important that it still remain in the process. I don't think there has been any complaint in this State that we do not have enough home health care in the State. In fact, the growth-- When there have been needs, it has grown. Again, you know, we are very supportive of increasing -- moving away from institutional care, especially in the long-term care area, into the alternatives; into assisted living, into foster care. I think our CCPED program in Medicaid is quite good. We would love to see it continue to expand.

ASSEMBLYWOMAN WRIGHT: Mr. Chairman, may he tell us again what the community care -- what the CCPED--

MR. TETELMAN: It is the Community Care Program for the Elderly and the Disabled.

ASSEMBLYWOMAN WRIGHT: Okay.

ASSEMBLYMAN FELICE: Assemblywoman Weinberg? I'm sorry, Assemblywoman Wright, do you have another question?

ASSEMBLYWOMAN WRIGHT: No. I can ask it after she is finished.

ASSEMBLYWOMAN WEINBERG: I just wanted to follow-up a bit on Assemblyman Romano's question about the renal dialysis units. You said they should be hospital based?

MR. TETELMAN: No, they should be connected to hospitals. They need to have backups. If something serious happens in one of these units, there has to be a backup system for people to be able to go to. We have freestanding centers

all around the State. Many of them are done by for-profit providers. BMA comes to mind. There have been issues in a former life that actually represented the renal patients at one point. There have been issues with these for-profits about reusing the filters, to make sure that they just aren't dunked in formaldehyde, especially with AIDS coming on. People were concerned about that. You can understand why. So there has to be some connection, I think, with the hospital backup to make sure they have those kinds of connections.

ASSEMBLYMAN ROMANO: Do you have any literature on that?

ASSEMBLYWOMAN WEINBERG: Couldn't that be-- (both Assemblypeople speaking at once; indiscernible)

ASSEMBLYMAN FELICE: Hold on.

ASSEMBLYMAN ROMANO: Oh, I'm sorry.

ASSEMBLYWOMAN WEINBERG: Couldn't--

**L I N D A W O O D:** Excuse me for speaking from the audience, but that is already in place. I am not a BMA facility representative, but that exists right now in the Certificate of Need process. There is a requirement that they must have a backup, as well as the Federal government requirement, for emergency situations.

MR. TETELMAN: That is why I feel less uncomfortable. Again, you have to look at the economy of scale though. You know, one or two units. There is actually a push, Assemblywoman Weinberg, to try to get people to do more peritoneal dialysis and those kinds of programs so it would be out-of-hospital, because the hospital-based ones do tend to be more expensive. Now rememeber, there are some patients who have very acute problems that also have to be monitored at the same time they have the dialysis. That is why you still have to have a mix in the State of both inpatient and some freestanding ones for the healthier patients.

ASSEMBLYMAN FELICE: Thank you. Assemblywoman Wright, did you have another question before?

ASSEMBLYWOMAN WRIGHT: My other question was in regard to diagnostic versus therapeutic treatments or procedures or care. It sounds like you are saying you've got to evaluate these things; you can't break them down--

MR. TETELMAN: I agree.

ASSEMBLYWOMAN WRIGHT: --as simply as the high-cost diagnostic -- which you mentioned when the CAT scan came out and now the MRI.

MR. TETELMAN: Sure. Well, look at linear accelerators. That is a treatment modality, and they are a couple of million bucks apiece, too. Again, that refers to economies of scale. It is better to regionalize that service and develop a center of excellence. Make sure that it is in a region where everybody has access to it, rather than have a proliferation of them.

ASSEMBLYWOMAN WRIGHT: Mr. Chairman, I am not sure that the dialogue on the renal dialysis issue is clear in terms of what Mr. Tetelman said, because under CN we have independently standing renal dialysis centers, and they have worked within the framework of the quality of care, as I understand it.

ASSEMBLYMAN FELICE: But they must be tied to Federal statute. If I am not mistaken, they must be tied into hospital-based units because of the complications that might occur.

MR. TETELMAN: They have to have an agreement with them.

ASSEMBLYMAN FELICE: Yes.

MR. TETELMAN: They have to have an agreement for that.

ASSEMBLYMAN FELICE: An affiliation.

ASSEMBLYWOMAN WRIGHT: Okay. I don't want to--

ASSEMBLYMAN FELICE: Okay. I think that is another issue that is going to come up very strongly again.

Yes, Assemblyman Mikulak?

ASSEMBLYMAN MIKULAK: Coincidentally, talking about renal dialysis, I just left to call my office, and I had a message from a person in Port Reading, New Jersey, a senior citizen -- that is part of Woodbridge Township -- a person who needs dialysis. Raritan Bay and Perth Amboy are filled, and this person has to go to Bay Shore, which is over 20 miles. The person is a senior citizen. His wife does not drive; he does not drive, so he is looking for transportation.

So, I mean, I would hope that with the deregulation there would be greater access, because this is quite a frequent occurrence.

MR. TETELMAN: The other question is: Why aren't they going north, instead of south? Were they filled also?

ASSEMBLYMAN MIKULAK: That is where they were referred by Raritan Bay.

MR. TETELMAN: That is where they were referred to. The State does have quite a few renal units around. Also, the other question we always have to ask is, what are their hours? Are they providing three shifts of service? So, it is not--

ASSEMBLYMAN FELICE: I think that is a big question, because a lot of people do it after working hours, or when staff -- family members -- are available to take them to the different centers. I think that is a major question.

MR. TETELMAN: Sure, that is an issue.

ASSEMBLYMAN FELICE: Are there any other questions for Mr. Tetelman? Go ahead.

ASSEMBLYWOMAN WEINBERG: Just to follow up -- and I guess we are getting hung up on this subject, and probably shouldn't -- why can't you guarantee access with the CN process?

MR. TETELMAN: We do. That is exactly what it does.

ASSEMBLYWOMAN WRIGHT: He is saying that is the reason he supports it.

MR. TETELMAN: That is the reason why.

ASSEMBLYWOMAN WEINBERG: Yeah, but you said-- I am talking about renal dialysis units now. You said you were comfortable with them being deregulated.

MR. TETELMAN: More comfortable than with other services. I think we have pretty good access overall in the State with renal dialysis. I know that in Hunterdon and in Morris Counties there was a need and people opened up freestanding centers with backup. It probably, again, deserves a closer look to see how many units there are, what there shifts are -- a fuller discussion.

ASSEMBLYWOMAN WEINBERG: But the CN process does not mitigate against that.

MR. TETELMAN: No, it doesn't.

ASSEMBLYWOMAN WEINBERG: It helps that.

ASSEMBLYMAN FELICE: I think that is a process we are going to have to look into separately when these bills get overturned.

Thank you very much for your report.

MR. TETELMAN: Thank you very much, Assemblyman.

ASSEMBLYMAN ROMANO: Isn't there a bill pending on that, though?

ASSEMBLYMAN FELICE: Yes, there is. We will probably have a lot more discussion on that issue alone. I think that is the bill we have from our Bergen and Passaic legislators.

At this time, Debra Levinsen, Health Care Planning and Marketing Society. Debra, thank you for your patience.

**D E B R A L E V I N S E N:** Thank you for having me here.

I'm Deb Levinsen. I am here on behalf of the Health Care Planning and Marketing Society of New Jersey. I thank you for having me here and giving me the opportunity to speak. The Planning Society has a membership of approximately 150

professionals throughout the State of New Jersey. As a professional organization, we are concerned about the total deregulation of the industry, and we do support the Certificate of Need process.

There is strong evidence that there is a need for CN regulation. You have heard it all by this time, just about. There is the inability of the free market to allocate health care resources due to the absence of essential market conditions and the uniqueness of the health care market. There are adverse effects that are caused by the repeal of CN in the other states, and the national trend of deregulated states reimplementing Certificate of Need legislation.

Health care market conditions are unique, and they affect the rational allocation of service. This includes the nonpriced competition and the ability of providers to artificially push demand. There are uninformed consumers, large providers, and consumers who can force prices below or above cost. There is a need to provide accessible care to all, regardless of their ability to pay. There is a need to support the teaching and research, and there is the presence of third-party payers.

Given these market conditions, health care cannot be appropriately allocated by a free market. The Certificate of Need process is required to assure that the proper number, location, and types of services are provided. Without CN, the market will duplicate services, neglecting their cities, and expose existing local community providers. These outcomes were observed in Arizona, as you have heard, with the open-heart surgery programs.

In addition to that, some research I did back in '87, when I was going to college doing a master's thesis-- I had an undergraduate in marketing, so my premise was-- I started out by saying that we have to have deregulation of Certificate of Need. Afterwards -- after investigating it -- in Arizona, they

found out that many of the major hospitals that had been located in the inner cities had been moving out of the cities. They were left with only public hospitals. We don't have public hospitals in our inner cities which would be able to take care of the indigent people.

It has also been found that health care costs are higher in a more competitive market. One study showed that hospital costs in two-hospital towns are 30 percent higher than in one-hospital towns. Another study in the "Journal of the American Medical Association" has shown cost per admission to be 26 percent higher in hospitals in more competitive markets.

As stated by James O'Donnell, the American Health Planning Association, when Texas ceased their CN process, Houston hospitals entered a construction frenzy; only 60 percent occupancy, nine new hospitals, including five psychiatric hospitals, as you have heard. Nursing home beds in Arizona increased. After deregulation in Utah, psychiatric beds doubled, as well.

The frustration with the free market's ability to allocate accessible quality health care is evidenced by the national trend toward reinstating or strengthening CN legislation. Wisconsin and Minnesota have both reinstituted a full-fledged CN program. Virginia, as you heard today also, has CNs for higher cost medical equipment, and recently expanded it for new technology. Ten other states have expanded the CN process. Colorado's Governor Romer, in his '92 State of the State Address, called for the abolishment of the CN program in the state. That has led to an explosion of costly and duplicative services.

We urge you to please maintain the Certificate of Need process. It is a rational way of allocating health care resources. It is a system that allows us to have regionalization and collaboration amongst providers, and it

ensures that we can still provide primary, preventive care, while restraining technological growth.

As far as delays, I think with the State Health Plan we have experienced delays, but also some planners have indicated that delays are being experienced because of-- Previously, there used to be two batches for certain items per year, and nowadays you only find one.

The other thing I wanted to point out is, as a health care planner, if you do away with the Certificate of Need process, I will still have a job. There are so many things to keep planning. So it is not because of want of a job that I am saying this.

ASSEMBLYMAN FELICE: That was my question, Debra. (laughter) The Health Care Planning and Marketing Society-- Is that the main professional purpose, to help people with the CN process and other things? What is the main purpose?

MS. LEVINSON: We work together to promote our profession, of course, which is more than just Certificate of Need. For instance, at my particular hospital, community health assessment-- We are working with our local advisory board and we are working with the Ocean County Health Department. There is only one Health Department, basically, in Ocean County, and we are working together to achieve that. We share this information with other planners throughout the State to help them to develop programs throughout the State, as well.

ASSEMBLYMAN FELICE: So if we eliminate the CN, then you only get half of your salary. Is that right?

MS. LEVINSON: No. We fill it up with other planning issues.

ASSEMBLYMAN FELICE: Let me ask you, Debra, Larry Garanello (phonetic spelling)-- Is he here? He is from the same company, isn't he? You're covering both of them? Then you should get his bonus today, too.

Are there any questions from the panel? Yes, Assemblywoman Wright?

ASSEMBLYWOMAN WRIGHT: Tell me the speaker's name again, Mr. Chairman -- the speaker's name.

ASSEMBLYMAN FELICE: Oh, I'm sorry. Debra Lovinson. Did I pronounce that correctly -- Lovinson?

MS. LEVINSON: It's Levinson.

ASSEMBLYMAN FELICE: Oh, I'm sorry. There is an "o" here on the list. Thank you.

ASSEMBLYWOMAN WRIGHT: Mr. Chairman, as I understand it, this is the professional society for health care planners. This is not a business, other than an association.

ASSEMBLYMAN FELICE: I saw the "Marketing," and I thought maybe--

ASSEMBLYWOMAN WRIGHT: Well, but, apparently there are planners and marketers, so I think it is a professional society. It is probably a not-for-profit agency. It says, "150 professionals."

You raised something in your testimony that interested me. I couldn't help but think, as you read about the Houston occupancy rate-- I'm sure no one has ever looked at CON as it relates to the economy, in the sense that I would predict that when the Houston hospitals had their 60 percent occupancy, it was at an all-time low in the economy in Texas. I think it is important when we are looking at CON. You know, it seems to have a different function in a growing economy, than in one that is in recessionary periods. I just found that interesting in your testimony.

ASSEMBLYMAN FELICE: Is there anyone else who has a question? (no response) Thank you very much, Debra. We appreciate your testimony.

MS. LEVINSON: Thank you.

ASSEMBLYMAN FELICE: I think last, but not least, we have Dawn Perotta, from the New Jersey Business & Industry Association. Are you in favor, or are you against?

**D A W N  P E R O T T A:** Neither.

ASSEMBLYMAN FELICE: Neither? Okay.

MS. PEROTTA: I am taking a real definitive commitment at this point -- only at this point. I will try to be brief. You want to go to lunch, I'm sure.

ASSEMBLYMAN ROMANO: Take as long as you want.

MS. PEROTTA: Thank you. You're so good.

As you know, BIA's members have indicated health care costs as their number one concern for three years, but I would like to correct something that Mr. Tetelman said. I was just talking to him about this. While health care costs are an overriding concern in many ways, that is a fact--

Let me start again: Companies are having to drop insurance coverage. Some are close to going out of business if they continue insurance coverage because costs are so extreme. However, BIA has long supported reforms to the system that would also ensure access and quality, and I think that most of you are aware of what those are. I just wanted to go on record as saying that. We are not concerned with just the bottom line; it is the whole package.

We supported funding for uncompensated care, and we would not have done so if we were not concerned about ensuring access and quality also. Having said that, we really believe that one of the primary ways to rein in costs while also meeting the other goals, is to support the managed care/managed competition system that has been put into place as a result of the Health Care Reform Law. We think that is a key factor in containing costs.

Certificate of Need, we believe -- and this is very tentative at this point, because there is so much conflicting data -- but at this point we believe that the elimination of most aspects of Certificate of Need really is the way to go in a deregulated environment. However, we have no strong recommendation to change the system, at this point. We believe

it should stay in place for at least another year, possibly two years, to give the hospitals, buyers, consumers, everyone, time to adjust to the new deregulated system. Networks are just now being developed. We think there needs to be time allowed to get used to the system and not shock it with something major at this point.

We also see this as a protection in terms of costs right now. We won't have to worry about hospitals possibly overspending at some level, and those costs ultimately getting passed on to the payers in some form.

We also have some concerns -- I think you understand, Mr. Chairman -- about the preservation of managed care. While we have just gotten going on it, we are concerned about some of the legislation that would, as we see it, begin to chip away. I think one of the bills that we are most concerned about-- You have been wonderful, and we have been working together to try to reach a compromise.

ASSEMBLYMAN FELICE: Wait; just wait.

MS. PEROTTA: I won't go into that. But we really want to make sure that managed care is in place before we tamper with the system in any other way.

Ideally, we think -- we think, I will emphasize that -- that the Certificate of Need process should be modified so that it is reserved only for the most specialized of services, such as trauma and burn centers, organ transplant and cardiac surgery centers, and intensive peritoneal services and centers. We could accomplish this, possibly, through raising the $1 million cap to $10 million. Everything over that goes through a CN; everything under is subject to what the hospitals feel they can bear.

So, we are not definitive one way or the other at this point, but believe it should be preserved for awhile to see how the system--

ASSEMBLYMAN FELICE: So, in a sense, you are really saying that you support the existing Certificate of Need, with possibly a time period to look into it again in a year or two.

MS. PEROTTA: Exactly.

ASSEMBLYMAN FELICE: Okay. Are there any questions from the members of the panel? Yes, Assemblywoman Wright?

ASSEMBLYWOMAN WRIGHT: Thank you, Mr. Chairman.

Ms. Perotta, you gave us trauma, organ transplants, burn centers, and something else.

MS. PEROTTA: Cardiac surgery centers and intensive peritoneal services.

ASSEMBLYWOMAN WRIGHT: Okay.

ASSEMBLYMAN FELICE: No one else? (no response) Thank you very much, Dawn. That was one of your shortest presentations.

ASSEMBLYMAN ROMANO: Thank you for coming, Dawn. I was waiting to hear your testimony.

ASSEMBLYMAN FELICE: Thank you.

Is there anyone else? There is no one else on the list here. (no response) If there is no one else here to testify, then I will adjourn the meeting.

Thank you all very much for your testimony.

**(HEARING CONCLUDED)**

# APPENDIX

# OPENING REMARKS

LADIES AND GENTLEMEN I WANT TO WELCOME YOU TO THE COMMITTEE AND THANK YOU ALL FOR BEING HERE TODAY. BEFORE WE BEGIN LET ME TAKE A BRIEF OPPORTUNITY TO EXPLAIN TO YOU THE GENERAL PURPOSE OF OUR HEARING TODAY AND CONTINUING ON MONDAY.

GIVEN THE CHANGES WROUGHT BY THE REFORM ACT, CONCERNS ABOUT THE CON PROGRAM'S SUSCEPTIBILITY TO POLITICAL MANIPULATION BROUGHT TO LIGHT MOST RECENTLY IN THE "TRENTONIAN" SERIES ON NURSING HOMES

EARLIER THIS YEAR, AND A RECENT SUPERIOR COURT DECISION WHICH AFFIRMED THE ADVISORY STATUS OF THE STATE HEALTH PLAN AND INVALIDATED ALL DOH REGULATIONS SEEKING TO GIVE ITS PROVISIONS THE FORCE OF LAW, IT IS AN APPROPRIATE TIME FOR THE COMMITTEE TO RETURN TO THIS ISSUE AND BEGIN AN INQUIRY INTO THE VALIDITY OF THE CON POLICY AND PROCESS IN GENERAL. IT IS OUR HOPE THAT THE PRIMARY FOCUS OF THIS INQUIRY WILL BE ON THE FOLLOWING POINTS:

1) IDENTIFICATION OF THE GOALS WHICH CON WAS INTENDED TO ACCOMPLISH AND AN ASSESSMENT AS TO WHETHER IT HAS PROVEN TO BE

SUCCESSFUL, IN NEW JERSEY OR ELSEWHERE, IN ACCOMPLISHING THOSE GOALS;

2) WHETHER, NOTWITHSTANDING ITS ORIGINAL PURPOSE, CON IS CONCEPTUALLY CONSISTENT WITH THE LIMITED GOVERNMENT, MARKET CONCEPT POLICIES EMBODIED IN THE HEALTH CARE REFORM ACT OF 1992;

3) WHETHER THERE MIGHT NOT BE SOME ALTERNATIVE APPROACHES TO ACCOMPLISHING THE FUNDAMENTAL PURPOSE OF CON THAT ARE MORE CONSISTENT WITH THE POLICIES OF THE HEALTH CARE REFORM ACT AND THAT ARE LESS SUSCEPTIBLE TO THE DISTURBING CHARGES OF

POLITICAL MANIPULATION THAT CAST A CLOUD ON THE OBJECTIVITY AND RELIABILITY OF THE PROCESS.

WE ARE AWARE THAT THERE ARE STRONG PERSONAL AND FINANCIAL INTERESTS ON BOTH SIDES OF THE ISSUE. IT IS NOT OUR INTENT TO ARBITRATE A DISPUTE BETWEEN THOSE WHO SEEK TO PROTECT FRANCHISES AND THOSE WHO SEEK TO OBTAIN THEM. NEITHER IS IT OUR INTENT TO DEBATE IN THESE HEARINGS THE MERITS OF ANY PARTICULAR BILL. LAST, IT IS CERTAINLY NOT WITHIN THE INTENT NOR FOR THAT MATTER THE CAPABILITY OF THIS COMMITTEE TO SIT IN FINAL JUDGEMENT ON ANY OF THE ALLEGATIONS OF

IMPROPRIETY THAT HAVE SURFACED REGARDING THE CON PROCESS. RATHER, IT IS OUR INTENT TODAY AND MONDAY TO BEGIN AN INQUIRY INTO EXACTLY WHAT ROLE, IF ANY, THE CERTIFICATE OF NEED PROCESS SHOULD PLAY IN HELPING GOVERNMENT TO STRIKE THE DELICATE BALANCE BETWEEN COST, ACCESS, AND QUALITY OF CARE THAT IS FUNDAMENTAL TO MEANINGFUL HEALTH CARE REFORM.

WITH THAT, I WOULD LIKE TO INVITE THE COMMISSIONER OF HEALTH, DOCTOR SIEGEL, TO START THINGS OFF WITH AN OVERVIEW OF WHERE THE CERTIFICATE OF NEED PROCESS CURRENTLY STANDS IN NEW JERSEY, HOW WE GOT HERE, AND WHERE HIS DEPARTMENT THINKS WE SHOULD BE HEADED.

CN PROCESS - PUBLIC HEARING

MAY 6, 1993

BRUCE SIEGEL, M.D., M.P.H.

COMMISSIONER OF HEALTH

TALKING POINTS

THE HEALTH CARE FACILITIES PLANNING ACT OF 1971 CREATED THE CERTIFICATE OF NEED PROGRAM TO ASSURE THAT NEW JERSEYANS CAN HAVE ACCESS TO THE HIGHEST QUALITY OF HEALTH CARE AT AN AFFORDABLE PRICE.

IN THE 1990'S, I BELIEVE IT IS MORE IMPORTANT THAN EVER TO MAINTAIN THE CN PROGRAM TO MEET ITS ORIGINAL GOALS.

SEVERAL STATES HAVE TURNED AWAY FROM CN. AND INTERESTING THINGS HAPPENED IN THOSE PLACES.

- AFTER ARIZONA ELIMINATED CN REGULATION OF NURSING HOMES, THE NUMBER OF BEDS PER 1,000 PERSONS OVER AGE 65 INCREASED FROM 20.9 TO 33.5. OCCUPANCY RATES DROPPED AND MANY HOMES WENT BANKRUPT, CAUSING SERIOUS DISPLACEMENT PROBLEMS FOR PATIENTS.

  IF ARIZONA'S NURSING HOME EXPERIENCE WERE DUPLICATED IN NEW JERSEY, THE RESULT WOULD BE OVER $600 MILLION IN NEW CONSTRUCTION COSTS WHICH WOULD EVENTUALLY BE PICKED UP

EITHER BY OUR ELDERLY CITIZENS OR THROUGH MEDICAID EXPENDITURES IN OUR OWN STATE BUDGET.

- ARIZONA ALSO DEREGULATED CARDIAC PROCEDURES

  . SINCE DEREGULATION, 10 HOSPITALS HAVE INITIATED OPEN HEART SURGERY PROGRAMS.

  . MEDICARE PATIENTS RECEIVING BYPASS SURGERY AT THESE NEW LOW-VOLUME PROGRAMS HAVE DIED AT TWICE THE RATE OF PATIENTS AT THE HIGH-VOLUME HOSPITALS.

  . OVERALL DEATH RATES FOR MEDICARE PATIENTS WHO UNDERWENT BYPASS SURGERY IN ARIZONA JUMPED 35% IN THE TWO YEARS AFTER DEREGULATION. ARIZONA'S MORTALITY RATE WAS TWICE THE NATIONAL AVERAGE.

  . HOSPITAL CHARGES FOR BYPASS SURGERY ROSE BY 50% IN TWO YEARS.

- VIRGINIA LIBERALIZED CN IN 1989. THEY ENDED CN REVIEW FOR EQUIPMENT SUCH AS LINEAR ACCELERATORS (FOR RADIATION THERAPY), MRI, AND LITHOTRIPTERS AS WELL AS FOR REGIONALIZED SERVICES SUCH AS ORGAN TRANSPLANTS AND NEONATAL INTENSIVE CARE. IN 1992, THE LEGISLATURE

REINSTITUTED ON FOR THESE SERVICES BECAUSE THE "MEDICAL ARMS RACE" HAD LED TO MUCH HIGHER COSTS, AND THERE WAS SERIOUS CONCERN OVER HIGH DEATH RATES FOR TRANSPLANT RECIPIENTS AND LOW BIRTH WEIGHT BABIES.

I BELIEVE THAT THE CN PROGRAM PROTECTS NEW JERSEYANS FROM THE SPECTRE OF FLY BY NIGHT OPERATORS SPRINGING INTO THE HEALTH CARE BUSINESS OVERNIGHT AND DISAPPEARING JUST AS QUICKLY; FROM THE MUSHROOMING OF HEALTH CARE SERVICES WITHOUT ANY "BASIC STANDARDS OF QUALITY" UPON WHICH NEW JERSEYANS CAN RELY.

I BELIEVE THAT NEW JERSEY CITIZENS RELY UPON THE GOVERNMENT TO ASSURE THAT THIS TYPE OF INSTITUTIONAL MALPRACTICE IS NOT PERMITTED HERE.

THE CN APPROVAL PROCESS IS A REMARKABLY OPEN AND PUBLIC ONE WHICH TAKES CAREFULLY INTO ACCOUNT THE HEALTH CARE NEEDS OF ALL NEW JERSEYANS. IT IS CLEAR-CUT, FORMAL, AND GOVERNED BY REGULATION AND STATUTE. IT IS A MODEL FOR THE COMPETITIVE PROCESS AT ITS BEST. THE ANNOUNCEMENT OF A CALL FOR APPLICATIONS IS MADE PUBLICLY - ALL PARTIES HAVE A CHANCE TO APPLY AND THEN ARE COMPARED THROUGH A PUBLIC PROCESS USING REGULATORY STANDARDS.

APPLICATIONS ARE REVIEWED AT SIX STAFF LEVELS OF THE DEPARTMENT OF HEALTH; FOR 45 DAYS BY THE LABS, WHO ARE REQUIRED TO SOLICIT INPUT FROM THE PUBLIC; AND THEN FOR ANOTHER 45 DAYS BY THE STATE HEALTH PLANNING BOARD, WHOSE RECOMMENDATION IS ANNOUNCED AT AN OPEN PUBLIC MEETING. THE RECOMMENDATIONS OF

THESE TWO BODIES ARE THEN SUBMITTED TO THE COMMISSIONER OF HEALTH FOR A FINAL DECISION.

I HAVE RECEIVED SOME INQUIRIES AS TO CN TIME FRAMES. UNDER THE OLD STATUTE, CNS WERE VALID FOR ONE YEAR AFTER APPROVAL. BUT LONG EXPERIENCE TAUGHT US THAT DUE TO FACTORS SUCH AS FINANCING, ZONING, AND LOCAL APPROVALS, IT TOOK CONSIDERABLY LONGER--FIVE YEARS ON AVERAGE--TO MOVE A LONG-TERM CARE FACILITY FROM CN APPROVAL TO LICENSURE AND OPERATION. THE HEALTH CARE COST REDUCTION ACT OF 1991 ALLOWED FOR A MORE REALISTIC TIME FRAME TO BE PUT INTO REGULATION, AND THE CURRENT REGULATIONS ALLOW FOR FIVE YEARS. THE BENEFIT OF THIS NEW TIMEFRAME IS TERMINATION OF THE ONEROUS PROCESS OF REGULARLY REVIEWING THE ONE-YEAR EXTENSIONS THAT WERE REQUIRED PREVIOUSLY.

AS YOU KNOW, C. 160 RECENTLY DEREGULATED A NUMBER OF SERVICES FROM THE CERTIFICATE OF NEED PROCESS. I SUPPORT THAT ACTION SINCE I THINK IT STREAMLINED THE PROCESS AND ADDRESSED ONLY THOSE SERVICES, SUCH AS COMMUNITY-BASED PRIMARY CARE, WHICH DO NOT REPRESENT THE HIGH COST, HIGHLY TECHNICAL SERVICES THAT ARE MOST APPROPRIATELY REVIEWED THROUGH THE CERTIFICATE OF NEED PROCESS.

AS AN EXAMPLE, C.160 DEREGULATED CHRONIC DIALYSIS SERVICES. ASSEMBLYMAN COLBURN HAS APPROPRIATELY RAISED THE ISSUE OF WHETHER DEREGULATION OF THIS PARTICULAR SERVICE IS WISE. I HAVE CONSIDERED BOTH SIDES OF THE ISSUE CAREFULLY AND CONCLUDED THAT, WHILE THERE ARE VALID QUALITY OF CARE CONCERNS HERE, THE ANSWER

IS NOT TO REQUIRE CERTIFICATE OF NEED REVIEW. CN SHOULD BE USED WHERE, AND ONLY WHERE IT MAKES REAL SENSE.

IN THINKING ABOUT WHAT SERVICES SHOULD RECEIVE CN REVIEW, I THINK ABOUT ACCESS, COST AND QUALITY. SINCE MANY NEW JERSEYANS NEED TO UTILIZE CHRONIC DIALYSIS SERVICES ON A REGULAR BASIS, PROVIDING READY GEOGRAPHIC ACCESS CAN BE IMPORTANT. MOVING ON TO THE NEXT CRITERIA, COST FOR CHRONIC DIALYSIS SERVICES IS NOT AN ISSUE SINCE THIS SERVICE IS COVERED EXCLUSIVELY AND COMPLETELY BY MEDICARE. HOWEVER, THE QUALITY OF THE DIALYSIS SERVICES PROVIDED IS AN IMPORTANT ISSUE. GIVEN THE ACCESS AND COST CONSIDERATIONS, I BELIEVE WE CAN ASSURE QUALITY THROUGH AN EFFECTIVE SET OF LICENSURE STANDARDS REQUIRING PROSPECTIVE PROVIDERS TO MEET STRICT QUALITY OF CARE GUIDELINES BEFORE THEY CAN GO INTO BUSINESS.

HOWEVER, THE PUBLIC WOULD NOT BE WELL SERVED BY A SIMILAR DEREGULATION OF OTHER SERVICES. FOR EXAMPLE, I BELIEVE WE CAN ALL AGREE THAT NOT EVERY HOSPITAL IN NEW JERSEY SHOULD BE IN THE ORGAN TRANSPLANT BUSINESS. THE DEMAND FOR THESE SERVICES, AND THE EXPERTISE INVOLVED IN DELIVERING THEM, ARE SUCH THAT THE PUBLIC INTEREST IS BEST SERVED BY THEIR CONCENTRATION IN A LIMITED NUMBER OF HOSPITALS. BUT WHO WILL DETERMINE WHICH HOSPITALS THESE WILL BE? SHOULD THE "MARKET" DECIDE? SHOULD INSURANCE COMPANIES DECIDE? OR, RATHER, ISN'T THE PUBLIC BETTER SERVED THROUGH AN IMPARTIAL DECISION-MAKING PROCESS SUCH AS THAT REPRESENTED BY THE CN PROCESS?

WE ALSO KNOW THAT THERE CONTINUES TO BE DISCRIMINATION IN ADMISSIONS BY MANY NURSING HOME OPERATORS ON THE BASIS OF HIV STATUS, RACE, AND SOCIOECONOMIC CLASS. THIS IS INTOLERABLE. BUT WHAT IS THE PROCESS BY WHICH THE LEGITIMATE PUBLIC CONCERN--ENSURING ACCESS TO LONG-TERM CARE--IS TRANSLATED INTO POLICY?

WE KNOW THAT WHEN CERTAIN KINDS OF FACILITIES AND/OR HIGH-TECH EQUIPMENT ARE OPERATED BY INDIVIDUAL PHYSICIANS OR SMALL GROUPS OF PHYSICIANS, THERE IS INCREASED USE OF THE SERVICES THEY PROVIDE. THIS INCREASES THE COST OF HEALTH CARE IN THE STATE. HERE, THE QUESTION IS NOT WHICH SPECIFIC PHYSICIAN OR GROUP SHOULD BE PERMITTED TO OBTAIN AN MRI, BUT--AGAIN--THAT THERE BE A RATIONAL, PUBLIC PROCESS TO MAKE THAT DETERMINATION.

FINALLY, WE KNOW THAT THERE ARE CERTAIN HOSPITALS IN NEW JERSEY THAT ARE ESSENTIAL TO THEIR COMMUNITIES AND WHOSE ECONOMIC VIABILITY SHOULD BE ASSURED. HISTORICALLY, THIS HAS BEEN ACCOMPLISHED IN LARGE MEASURE THROUGH THE CN SYSTEM'S ABILITY TO MAKE SURE THOSE HOSPITALS CAN DELIVER HIGH-QUALITY, HIGH-VOLUME SPECIALTY SERVICES. IF WE REMOVE THIS SAFEGUARD, WE RISK SERIOUS DAMAGE TO THESE HOSPITALS-AND TO THE PUBLIC INTEREST.

I KNOW THAT THE IMPACT OF REGULATING HEALTH CARE PLANNING IS VERY MUCH ON YOUR MIND TODAY. I WOULD SUGGEST THAT THERE IS NO OTHER AREA OF HEALTH CARE REFORM MORE IMPORTANT. I WOULD HOPE THAT WE CAN ENTER INTO AN OPEN DIALOGUE TO DETERMINE WHERE IN OUR HEALTH CARE SYSTEM PUBLIC AND PRIVATE INTERESTS INTERSECT. I HAVE INITIATED THIS PROCESS BY CONVENING A NUMBER OF ADVISORY

GROUPS AROUND THE CN PROCESS REFLECTING CONSUMERS, PAYERS AND PROVIDERS. I AM DEDICATED AND COMMITTED TO THIS PROCESS AND HOPE IT WILL BECOME A HALLMARK OF MY TENURE AS COMMISSIONER.

THANK YOU FOR YOUR TIME. I WOULD BE HAPPY TO ANSWER ANY QUESTIONS YOU HAVE.

Testimony on Certificate of Need Regulation - May 6, 1993

My name is Sister Jane Frances Brady, and I am here today as President of the newly incorporated Hospital Alliance of New Jersey, a group of approximately 20 hospitals who have joined together to focus on issues of paramount importance to the membership, most of which is urban and teaching hospitals.

I have been in hospital administration in New Jersey for 26 years now and have been a close observer of the Certificate of Need process since its inception in 1971. I have served on Review Committees and on the Board of Trustees of the local H.S.A. for years--so I bring firsthand information on this topic.

Access to care, assurance of quality of care and cost control are the major concerns of the American public today when it comes to health care. The focus of the major health care reform efforts presently underway in Washington, D.C. speak to these very topics.

It is my belief that de-regulation is the antithesis of cost control. Deregulation would allow proliferation of costly facilities, equipment and programs with totally unnecessary

and today--outrageously expensive duplication.

Perhaps more importantly deregulation of our Certificate of Need program in New Jersey would begin to destroy the efforts over years at regionalization--collaboration--where expertise was concentrated and carefully honed with large volumes of patients and procedures in areas like invasive cardiac procedures, cardiac surgery, perinatal/neonatal care, renal dialysis. This concentration greatly increases quality and good outcomes--the documentation is very clear and profuse in the literature.

We know nationally and we certainly know in New Jersey from our own experience of some 22 years now that deregulation does NOT work to improve quality but it does work to increase costs. Every hospital cannot and should not do everything. There must be systems in place to assure the best quality possible at the lowest cost possible.

Certificate of Need regulation is important to determine from the first application whether, in fact, a NEED exists for the service or equipment, and what the financial feasibility is of this service or equipment being cost-effective. Other

than documenting these two things why else would any project or idea be allowed to proceed? If these two questions are answered in the positive, then a Certificate of Need should be granted. This is important protection for the consumer of care, for the provider of care, and for the payor of that care. Without Certificate of Need rules, without any public discussions or any oversight, the possibility for politicization is increased a thousand fold.

Certificate of Need in New Jersey HAS worked and worked well since 1971. I have been as close to the process as anyone. In my role as President of a large teaching hospital, I have been through the Certificate of Need process literally dozens of times. The Certificate of Need process in New Jersey has avoided tens of millions of dollars of expenditures over the years and more importantly has built a referral network and created centers of excellence with care being delivered at the appropriate level both of expertise and cost.

These centers of excellence exist in many of the urban and teaching hospitals the Hospital Alliance counts in its membership. They perform at a high level, and receive referrals on a regular basis from hospitals in their regional

area. Some may dismiss Certificate of Need as "franchising." I choose to support it as an important component of the concept of regionalization. If Certificate of Need were to be abolished and deregulation ensued wherein anyone could set up business in whatever service they chose, these centers of excellence, many as I say in urban hospitals, would be eroded as to their referral base to the point where they would literally be unable to remain in existence. They have been extremely important not only to the suburban hospitals which do not have the same expertise or equipment, but because of their existence in the inner cities of our state, they have permitted the local city populations to have immediate availability of high-tech, tertiary services which otherwise most probably would have been unavailable to them because of geography or lack of insurance coverage. Additionally, the tens of millions of dollars which have already been spent in equipping and staffing these centers of excellence would go for naught were they now to fold--all those expenditures were made with the full concurrence of local boards made up of a majority of consumers, by the way, and with the full concurrence of the Department of Health which ultimately grants any Certificate of Need. Further, these centers of excellence in teaching hospitals have provided the setting

for a great deal of education for our future physicians who will be able to keep us at the cutting edge in these important specialties that can, in a flash, become an all-consuming need in our own families.

And so, I would urge you not to deregulate by abolishing Certificate of Need. Other states that have done so are now trying to re-establish the very process we have in place and the very one that has worked so effectively in New Jersey. The type of regulation which Certificate of Need provides is totally consistent with the goals we all share of quality care and cost containment. Nothing else will satisfy either our responsibility as legislators and providers, and nothing less will satisfy the clear and compelling demands of the citizens of our State and indeed, our country.

Thank you for this opportunity to speak today.

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# POSITION ON CERTIFICATE OF NEED REFORM

- The Health Care Reform legislation of 1992, which promoted the philosophy and principles of competition, was necessary in New Jersey and it is beginning to show positive results.

- Major reform of healthcare is essential, not an option. Aggregate costs are excessive and unacceptable, there is duplication of services, equipment and facilities, and access is a serious problem to many people. Pro-competitive concepts such as formation of large purchasing groups, insurance reform (community rating and uniform policies), universal access, and formation of comprehensive provider networks must be implemented. I believe quality, access and reasonable costs can be compatible goals if we undertake these reforms properly.

- Regulatory and voluntary cooperation approaches to access and costs have been obvious failures. Micro management of healthcare by governmental bodies is unworkable and costly.

- Reform can be painful to some providers but I believe that the public will benefit from these changes.

- Unique needs and circumstances of certain populations (the poor, HIV, etc.) may not fully be met by competition and will have to be otherwise addressed.

- The Department of Health should address these unmet needs as their principal focus, rather than trying to micro manage those services which will respond to marketplace forces. I believe there are providers who are willing to work collaboratively with the Department of Health to fill these voids.

- While competition is the predominant emerging force to contain health costs throughout the country, New Jersey providers, accustomed to a regulatory model, are only beginning to understand and implement competitive principles since the legislation became effective on January 1, 1993.

- C.N. legislation needs to be modified to reflect these new dynamics. I do not believe, however, that C.N. should be entirely eliminated until New Jersey providers truly understand and adjust to the competitive environment; otherwise we could witness a significant increase in capital costs and additional proliferation and duplication of services.

- I believe we should retain C.N. only for major services and major capital expenditures. Introduction of new services such as O.B., Pediatrics, Mental Health, MRI, Surgi-Centers, Cardiac Surgery, and other expensive tertiary services should require C.N.'s for a period of time. Approval for capital expenditures should be retained, but the threshold should be raised substantially.

- Department of Health staff should prospectively conduct cost benefit analysis of new technology and educate and advise providers, rather than retrospectively react when providers wish to purchase them.

- C.N.'s should only be granted to providers who meet the eligibility test of:
  - ability to document consistently high quality outcomes
  - reasonable, competitive costs
  - provision of services to the full cross-section of the population in the region/county, including the poor, minorities, and those at risk.
  - have demonstrated track record of community focus on prevention and early detection.
  - can reasonably document anticipated volume which meets minimum standards.

- C.N.'s should be issued conditionally (2-3 year max) until provider has fulfilled commitment to agreed-upon standards of performance.

- When C.N. is required, it should apply to all providers, not just hospitals.

- The process should be streamlined, including maximum allowable time for processing. Eligibility to submit a CN should not be dependent upon a State or public agency declaration of need.

- There should be expedited administrative review for services moving from acute hospital settings to lower cost ambulatory sites, with special recognition to providers who are willing to transfer licensed capacity to community-based centers; i.e., surgi-centers.

- C.N.'s should be guided by a prevailing orientation towards macro rather than micro management, reform through a competitive philosophy, and recognition of special and unique needs of populations, rather than evaluation by rigid formula.

NJANPHA
Founded 1931

*New Jersey Association of Non-Profit Homes for the Aging*
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**Testimony of Len Fishman, General Counsel**
**New Jersey Association of Non-Profit Homes for the Aging**
**Before the Assembly Health and Human Services Committee**
**on May 6, 1993**

Good morning. My name is Len Fishman and I am General Counsel to the New Jersey Association of Non-Profit Homes for the Aging (NJANPHA). NJANPHA is comprised of 130 health care and housing facilities for the elderly who serve more than 25,000 seniors in New Jersey every year.

Protestant, Catholic and Jewish organizations sponsor two thirds of our members; the balance are sponsored by county governments, private charities and fraternal organizations. Our members include nursing homes, residential health care facilities (RHCFs), continuing care retirement communities (CCRCs) and subsidized housing facilities for the elderly.

Our nursing home and RHCF members are subject to the certificate of need (CON) requirements of the "Health Care Facilities Planning Act" (N.J.S.A. 26:2H-1), as amended by the "Health Care Cost Reduction Act of 1991" (P.L. 1991, c.187) and the "Health Care Reform Act of 1992" (P.L. 1992, c.160).

We at NJANPHA have spent a fair amount of time contemplating today's topic. We've attempted to organize our analysis by posing the following questions:

First: What are the avowed purposes of the CON program?

Second: Are they meritorious?

Third: If so, are they being achieved?

Fourth: Are they being achieved in the most efficient and least intrusive manner?

These questions provide the framework for my testimony. Before I go further, I want to note, first, that my remarks are directed to the CON program only as it applies to long-term care facilities and services. Second, this is merely a discussion of some important issues and is by no means intended as an exhaustive analysis of the subject.

I'll begin with an examination of the purposes. Over the years, proponents have claimed many benefits for the CON program:

1. It encourages and promotes planning and a wise allocation of resources.
2. It provides local input in the planning process.
3. It allows screening of applicants to assure quality providers.
4. It controls the supply of beds and thereby assures that we do not build more facilities and beds than are needed.
5. Controlling supply keeps occupancy rates high.
6. Keeping occupancy high improves efficiency and economy.

7. Keeping occupancy high helps to assure an adequate revenue stream so facilities have the money to provide quality care.

8. The prospect of high occupancy makes financial institutions more willing to finance construction.

The chief benefit claimed for the CON program is high occupancy which, in turn, is said to promote efficiency, adequate reimbursement, quality of care and access to financing. If you measure these characteristics in New Jersey, you'll find that nursing homes score well. Occupancy is reasonably high, about 93%, in 1992. In general, quality of care is also high. In the most recent survey by the U. S. Health Care Financing Administration, New Jersey's nursing homes scored equal to or better than facilities nationwide in 19 out of 32 criteria (59%), despite tougher surveying procedures. Access to financing, at least for non-profits, has been adequate. And efficiency, in our opinion, is high.

Whether these favorable characteristics are attributable to the CON program, however, is an open question in our view. For this reason, we think this Committee is right to examine the CON program. Recently, our Association launched an inquiry of its own. Our review was undertaken with an open mind. We thought it was time to step back and consider how well the program has fared in New Jersey and how states are doing that have abolished their CON programs. We have not reached final conclusions, but we have information that may assist this Committee in its work.



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Let's start with occupancy, since it figures so prominently in the arguments in support of a CON program. I have provided you with an exhibit that shows nursing home occupancy rates around the country for 1990, the most recent year available. The 12 states that have abolished CON, listed from highest to lowest occupancy, are:

| | State | Median Occupancy (1990) |
|---|---|---|
| 1. | Minnesota | 96.18% |
| 2. | South Dakota | 95.10% |
| 3. | Wyoming | 94.72% |
| 4. | California | 94.46% |
| 5. | New Mexico | 94.46% |
| 6. | Kansas | 93.79% |
| 7. | Louisiana | 93.11% |
| 8. | Idaho | 92.17% |
| 9. | Arizona | 90.21% |
| 10. | Colorado | 85.84% |
| 11. | Texas | 82.98% |
| 12. | Utah | 78.87% |

You can see that some of these states have high occupancy rates and some have low occupancy rates, but we do not detect a significant trend either way. The median occupancy rate among states without a CON program is 93.45%. That value is just a little below New



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Jersey's, which had an occupancy rate of 93.91% in 1990, and just a little below the median occupancy rate of 94.82% among all states in the United States:

| | |
|---|---|
| Median occupancy rate--all states | 94.82% |
| Median occupancy rate--New Jersey | 93.91% |
| Median occupancy rate--non-CON states | 93.45% |

We have spoken with representatives from 11 of the 12 states that abolished their CON programs. A couple (California and Kansas) reported that occupancy rates dropped when the CON program was terminated but then climbed back up again. And in those states where CON was abolished some time ago, all reported that rates have stabilized since.

Now, these figures are a little misleading because three of the states (Louisiana, Minnesota and South Dakota) have some sort of moratorium on new nursing home beds. Two states (New Mexico and Utah) have some limitation on the certification of new Medicaid beds and, since Medicaid is such a large payer, this has discouraged new construction. On the other hand, elimination of the CON program in some states, especially California, coincided with the introduction of more community-based long-term care alternatives which would have reduced nursing home occupancy rates in any event.

Our counterparts in other states, without exception, report that termination of the CON program had no negative affect on the quality of care. In fact, in two states



24 X

(California and Kansas), representatives report that the quality of care has improved because of increased competition. Another state (South Dakota) reported that competition has spurred providers to offer a greater array of services. No state reported an impact, either way, on access to financing.

In summary, then, it appears that in states where CON has been abolished there has been no material negative affect on occupancy, quality of care, or access to financing. But, our survey also convinces us that there is a limit to how much you can extrapolate from the experience of other states because so many other factors affect utilization and quality of care--for example, Medicaid reimbursement levels, moratoriums, licensure requirements, and so on.

For the record, it should be noted that in some cases the CON program actually has had an adverse impact on utilization. During much of the 1980s, there was an unwritten rule in New Jersey that an applicant for a nursing home CON had to promise to construct a residential health care (RHC) unit. There was no demonstrated need for these units and, in most cases, applicants did not want to build them. (Interestingly, the Department had not undertaken any market or feasibility studies to determine whether consumers wanted the service--as it would have expected providers to do.) Nevertheless, the Department made clear that it would not approve a CON application for a nursing home unless an RHCF component was included.



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Not surprisingly, when these "command" RHC units were built they had high vacancy rates that continue until this day. This ought to serve as a warning of what happens when facility construction is driven by the commands of the Department without regard for the demands of the market.

Another example is in the area of continuing care retirement communities (CCRCs). CCRCs offer a continuum of care, from independent living to nursing care, with supportive services in between, all on the same campus, usually upon the payment of an entrance fee which guarantees the resident care for life. CCRCs help residents stay in their independent living units longer than if they resided in a traditional apartment or single family home by providing services such as housekeeping, dining, and assisted living. CCRCs provide a high quality of life and make it possible for older people to pay for their own care by using their assets in a planned and conservative way. Along with long-term care insurance, CCRCs represent one of the few programs in this country that encourage people to plan ahead and pay for their own long-term care.

Until recently, New Jersey was the only state in the country that had minimum size requirements for the nursing home component of a CCRC. Under the CON rules, the nursing home component had to have 60 beds and this, taken together with another requirement--that there be a minimum ratio of four independent living units to each nursing home bed--meant that a CCRC had to have at least 240 independent living units.



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This requirement was arbitrary and indefensible, and after years of pleading we finally got the Department to eliminate it. But, in the meantime, some CCRCs were built bigger than they should have been, and now have empty units which financially stress the community. Some CCRCs may not have been built at all because the cost of a large project was prohibitive or because a large enough parcel could not be found.

As for screening applications with a view to quality care, the CON program has fallen short of its potential. Several months ago, the Department proposed a *Certificate of Need Policy Manual for Long-term Care Services*--a set of regulations to guide CON applications and reviews for long-term care. One section contained 13 criteria for ranking CON applications. The first three criteria were worth two points each. The remaining 10 were worth one point each. Twelfth out of 13 criteria, and worth only one point, was an applicant's "track record for high quality patient care"! We argued that quality of care should rank first and count for two points or more. Under pressure from the Health Care Administration Board the Department accepted the recommendation.

One of the arguments in favor of the CON program is that it allows for local review of projects but, historically, the health systems agency (HSA) reviews were tainted by parochialism, turf-protection and conflicts of interest. The situation may improve with the advent of the local advisory boards (LABs). The "Health Care Cost Reduction Act" replaced the HSAs with LABs, and reframed their role from that of final arbiter at the local level to the more modest task of screening out unworthy CON applications. Some of the



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LABs are showing themselves to be independent, resourceful and creative, but there is still widespread skepticism about their ability to rise above the conflicts of interest that have characterized local review in the past.

Whether the positive attributes of the CON program outweigh the negatives is a matter we continue to examine. In addition to the problems mentioned above, the CON process saps time, money and energy. Timing is everything in the CON process. An applicant has to be ready to go when the call comes for applications. This is tough on most non-profits whose volunteer boards of trustees tend to move cautiously and slowly. The finanacial costs are also considerable. Besides the application fee, there are are professional fees and the value of time spent complying with the local review process.

Whatever comes of the CON program, the State need not--and should not--surrender its planning role. Potentially the greatest innovation in long-term planning in New Jersey is the recent commitment to reduce our historic reliance on nursing homes by encouraging the development of residentially-based alternatives (assisted living residences, comprehensive personal care homes, adult foster care). The Department deserves praise for launching this initiative. If this concept works it will be because of progressive thinking and appropriate licensure standards--not CON requirements.

In California, when the CON program was eliminated, it was replaced with a law that requires developers to file a notice of intent with the State's Health Planning Agency if they

contemplate building a health care facility. They must also report when local permits have been granted and again when ground is broken. A provider who is thinking of building a facility can easily determine what facilities are planned in the surrounding area by calling the state agency. This is one way of making the market "smarter" so overbuilding is less likely to occur.

Concerns about quality of care could be addressed through a "Certificate of Authority" (COA) approach, which the Department of Community Affairs now uses to license CCRCs. Applicants have to meet rigorous requirements to get a COA to operate a CCRC but this program is not intended to restrain trade--that is, if you meet all the requirements you get the certificate of authority. The prior experience, legal history, professional background, record of infractions and financial interest of the owners and operators all are required to be reported as part of the COA application process.

The risk of overbuilding can be diminished through strategies that put the potential provider at financial risk if the facility is underutilized. The State's Medicaid reimbursement methodology for nursing homes already does this. A minimum occupancy rate of 95% is applied to a facility's fixed costs, so a facility receives less than full reimbursement if occupancy falls below that level.

Other controls, such as increasing equity requirements or tying the approval to build to a designated minimum occupancy level within the LAB region or county should also be

explored.

As the above examples demonstrate, the choice need not be between having a full-blown CON program, as we have in New Jersey, or no planning process at all. If anything, planning is likely to become even more important as health care reform advances.

This concludes my remarks. NJANPHA appreciates this opportunity to testify. I would be happy to answer any questions you might have.

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TESTIMONY OF

MRS. JUDITH E. BURGIS
SENIOR VICE PRESIDENT FOR CORPORATE SERVICES
ROBERT WOOD JOHNSON UNIVERSITY HOSPITAL
NEW BRUNSWICK, NEW JERSEY 08901

ASSEMBLY HEALTH AND HUMAN SERVICES COMMITTEE
PUBLIC HEARING
AN EVALUATION OF THE CERTIFICATE OF NEED PROCESS
AND RELATED PROCEDURAL AND POLICY ISSUES

MAY 6, 1993

MY NAME IS JUDITH BURGIS, AND I SERVE AS SENIOR VICE PRESIDENT FOR CORPORATE SERVICES AT ROBERT WOOD JOHNSON UNIVERSITY HOSPITAL IN NEW BRUNSWICK, NEW JERSEY. MY REMARKS WILL FOCUS ON THE COMMON GOOD CITIZENS EXPECT THE HEALTH CARE SYSTEM TO DELIVER.

IN NEW JERSEY AND THROUGHOUT THE UNITED STATES, THE PUBLIC WANTS THE HEALTH CARE SYSTEM TO DELIVER HIGH QUALITY CARE THAT IS ACCESSIBLE TO ALL THE PEOPLE AT A REASONABLE COST AND IN A COST-EFFECTIVE MANNER. THE EXPERIENCE OF OTHER STATES THAT HAVE DEREGULATED HEALTH CARE AND THE CERTIFICATE OF NEED PROCESS DURING THE 1980'S SHOWS THAT RATIONAL HEALTH PLANNING AND CERTIFICATE OF NEED REGULATIONS ARE REQUIRED FOR THE ATTAINMENT OF THIS COMMON GOOD.

IN ARIZONA, AFTER DEREGULATION, THE NUMBER OF CARDIAC SURGERY FACILITIES INCREASED SIGNIFICANTLY AND RESULTED IN INCREASED COST AND POOR QUALITY OUTCOMES. THE PROLIFERATION OF BEDS AND SERVICES AFTER CERTIFICATE OF NEED DEREGULATION ALSO OCCURRED IN TEXAS AND UTAH. THESE AND OTHER EXAMPLES HIGHLIGHT THE FACT THAT SUPPLY, DEMAND, QUALITY AND PRICE RELATIONSHIPS IN HEALTH CARE DO NOT ADHERE TO THE TRADITIONAL ECONOMIC MODELS. DEREGULATION INCREASES THE NUMBER OF PROVIDERS AND HIGH TECHNOLOGY SERVICES AND DOES NOT CREATE A COMPETITIVE ENVIRONMENT THAT LOWERS COSTS AND IMPROVES QUALITY. IN FACT, EXPERIENCE DEMONSTRATES THAT JUST THE OPPOSITE OCCURS.



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IS IT ANY WONDER, THEN, THAT THE PENDULUM IS SWINGING AWAY FROM DEREGULATION OVER THE PAST COUPLE OF YEARS? ACCORDING TO THE INTERGOVERNMENTAL HEALTH POLICY PROJECT AT GEORGE WASHINGTON UNIVERSITY IN WASHINGTON, D.C., A RENEWED INTEREST IN HEALTH PLANNING AND REGULATION HAS EMERGED AS STATES HAVE ENACTED HEALTH CARE REFORM. FOR EXAMPLE IN 1990 THE GOVERNOR'S TASK FORCE ON ACCESS IN GEORGIA RECOMMENDED STRENGTHENING CON REGULATION, AND LEGISLATION TO THIS EFFECT WAS PASSED IN 1991. ALSO IN 1991, WEST VIRGINIA LOWERED CON REVIEW THRESHOLDS FOR THE FIRST TIME IN YEARS. DELAWARE BROUGHT ALL MEDICAL EQUIPMENT UNDER THE PURVIEW OF CON. VIRGINIA HALTED ITS PLANS FOR FURTHER DEREGULATION IN 1991, AND IN 1992 SIGNIFICANTLY BROADENED ITS CON PROGRAM. IN 1992, MINNESOTA'S HEALTH REFORM LAW REINSTATED CAPITAL EXPENDITURE REVIEW IN THAT STATE. VERMONT INCORPORATED HEALTH PLANNING AND CON REVIEW INTO A LEGISLATIVE GLOBAL BUDGETING PROCESS FOR HEALTH CARE. WISCONSIN ENACTED A COST-CONTAINMENT LAW ESTABLISHING CAPITAL EXPENDITURE REVIEW FOR HOSPITALS IN 1992. IN 1992, KENTUCKY AND INDIANA BOTH EXPANDED THEIR CON PROGRAM FOR SPECIALIZED SERVICES. MARYLAND, PENNSYLVANIA AND SOUTH CAROLINA EXPANDED REGULATORY PROVISIONS GOVERNING THE DISSEMINATION OF MEDICAL TECHNOLOGY. ALREADY IN 1993, FLORIDA'S UNIVERSAL HEALTH ACCESS LEGISLATION HAS CON REVIEW AS ITS CENTERPIECE.



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THERE IS AN ADDITIONAL KEY ISSUE THAT FACES NEW JERSEY: WE SHARE TWO OF OUR PRIME BORDERS WITH NEW YORK AND PENNSYLVANIA--BOTH OF WHICH HAVE CERTIFICATE OF NEED REGULATION IN PLACE. WITHOUT CERTIFICATE OF NEED REGULATION IN NEW JERSEY, WE BECOME AN ATTRACTIVE, FERTILE TARGET FOR THE HIGHLY CAPITALIZED HEALTH CARE PROVIDERS OF NEW YORK AND PENNSYLVANIA, INCLUDING NOT-FOR-PROFIT AND PROPRIETARY COMPANIES FROM AROUND THE COUNTRY. THEY STAND AT NEW JERSEY'S BORDERS LIKE PREDATORY GIANTS READY TO CANNIBALIZE OUR BEST HEALTH CARE MARKETS. THE CUT-THROAT COMPETITION THEY WILL UNLEASH WILL BRING ABOUT:

* DESTABILIZATION OF EXISTING PROVIDERS,
* NEEDLESS DUPLICATION OF SERVICES AND TECHNOLOGY AND A CONCOMITANT INCREASE IN COST,
* DECREASED QUALITY OF CARE RESULTING FROM THE UNNECESSARY PROLIFERATION OF SERVICES AND PROVIDERS WHICH PREVENTS PROVIDERS FROM REACHING THE CRITICAL NUMBER OF PROCEDURES REQUIRED TO ACHIEVE AND MAINTAIN SKILL PROFICIENCY, AND
* HEALTH CARE DOLLARS FLOWING OUT OF NEW JERSEY INTO NEW YORK, PENNSYLVANIA AND ELSEWHERE.

THE HEALTH CARE OF NEW JERSEY'S CITIZENS IS TOO IMPORTANT AN ISSUE TO BE LEFT TO THE UNWORKABLE ECONOMIC THEORY OF DEREGULATION AND THE VAGARIES OF THE MARKETPLACE. WE SHOULD LEARN FROM THE EXPERIENCES OF STATES ACROSS THE NATION THAT A RATIONAL, COST-EFFECTIVE SYSTEM OF HEALTH CARE EMPHASIZING HEALTH PLANNING AND CERTIFICATE OF NEED REVIEW WORKS BEST TO ATTAIN THE COMMON GOOD WE ALL SEEK.



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**LESTER M. BORNSTEIN**
**PRESENTATION**
**TO**
**ASSEMBLY HEALTH AND HUMAN SERVICES COMMITTEE**
**THURSDAY, MAY 6, 1993**
**10:00 A.M.**

Good morning Mr. Chairman, Committee Members, Ladies and Gentlemen.

My name is Lester Bornstein, President of Newark Beth Israel Medical Center. I am here to present my views on how Certificate of Need has benefitted people in the State of New Jersey.

You - our representatives - can take great pride in the progressive way health care has been delivered to citizens in this state. Not only has access to care been assured, but it has enabled all of our people to receive the best quality health care at a cost far below those in the ten highest industrial states.

One of the ways that record of quality has been sustained is through the Certificate of Need program. You are now examining the CON program. As you go forward with your deliberations, I would like to offer these comments.

Certificate of Need is not a perfect process. Critics raise three key issues when discussing the program. Those are:

**First,** institutions that receive a CON enjoy a unique franchise for a particular health care service which cannot be duplicated in other area hospitals unless specific criteria are met.

**Second,** the unique franchise decreases competition and consequently increases cost; and

**Third,** concentrating health resources in specific institutions decreases access for some citizens who do not have a particular health service in their community.

While those negative aspects of Certificate of Need are worth considering, I believe the positive results of the program far outweigh any negative, and contribute to the overall public good.

More specifically, I want to address these concerns with the facts:

**First**, the creation of an exclusive franchise is not necessarily bad. In health care **quality** is directly related to volume. It has been demonstrated repeatedly and conclusively that a minimum **quantity** of procedures must be performed to maintain the techniques necessary to insure **quality**. Concentration of a health service at particular institutions serves to insure that **volume** is sufficient to maintain **quality.**

This principal is demonstrated by the California experience where elimination of the Certificate of Need laws resulted in the proliferation of unnecessary programs, rising cost, and increasing patient mortality.

**Second**, health care costs do not necessarily decrease with increased competition. The nature of health care is such that the expected cost savings anticipated from free market competition are not readily achieved.

Eliminating Certificate of Need is expected to reduce red tape and allow for competition between hospitals to control health care costs, but it just does not happen that way.

We only have to look at those states that have weakened CON laws and now seek to return to an organized health planning system. California, again, is a classic example of the shambles health care systems suffer with the reduction of Certificate of Need authority. All I ask is that before embarking on the road to dismissing Certificate of Need, you check on other states' experience. There are numerous articles available for your review which describe how many states including Minnesota, Colorado, Wisconsin, Montana, Kentucky, Missouri, Virginia, California, and Georgia are moving to reinstate CON laws in order to control health care costs.

**Third**, access is far from diminished under a Certificate of Need process. In fact, I would argue that access is hampered without Certificate of Need as entrepreneurs "cherry pick" successful programs out of the hospitals, leaving institutions with only high cost, high risk cases.

With Certificate of Need, New Jersey can avoid the dim prospect of a two-tiered health care system. Many of our state's most sophisticated services are located in urban/inner-city teaching hospitals such as Newark Beth Israel. People from the suburbs are able to access not only urban programs but any programs for their medical needs. However, the same is not true of inner-city residents who lack the transportation and resources necessary to leave their local communities if programs are lost to the suburbs.

I would like to take this discussion of Certificate of Need back to its effect on my own "institution". Newark Beth Israel's survival is dependent upon our ability to maintain our balance of tertiary and primary services. Anything that disturbs this delicate balance will undermine the Medical Center's viability. Our tertiary capability, which is now sanctioned by Certificate of Need laws, brings a large number of physicians from their suburban homes and offices to the inner city. In exchange for their medical staff privileges, they help to staff our clinics, treat service cases, and educate medical students. When other hospitals were fleeing Newark, the Beth made a commitment to stay. That commitment has fostered primary care and outreach programs crucial to the well being of Newark's South Ward population. In an area void of private practitioners, this Medical Center is the sole provider of a total range of primary health services from pediatric through geriatric care. If our tertiary services erode, our ability to provide quality care to the inner-city population will be severely compromised.

The Beth also provides employment to 3,000 people, approximately a third of whom are Newark residents. The inner-city community is dependent upon The Beth for jobs as well as health care. If we are forced to reduce services, layoffs will follow quickly.

I know that you, as elected officials, share Beth Israel's commitment to excellent, accessible health care provided with cost efficiency.

I urge you to consider these factors in your deliberations.

Thank you.

50X

New Jersey Association of Health Care Facilities

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# TESTIMONY OF RICK ABRAMS, VICE-PRESIDENT, NEW JERSEY ASSOCIATION OF HEALTH CARE FACILITIES, BEFORE THE ASSEMBLY HEALTH AND HUMAN SERVICES COMMITTEE CONCERNING THE CERTIFICATE OF NEED PROCESS

MAY 10, 1993

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My name is Rick Abrams, and I am the Vice-President of the New Jersey Association of Health Care Facilities (NJAHCF). NJAHCF is a trade association representing over 225 nursing homes, residential health care facilities and adult day health care centers in New Jersey.

The Association supports the concept of health planning, and the primary manner by which health planning is accomplished: the Certificate of Need (CN) process. Today, when we try to come to grips with the health care issue, we focus on three things: cost containment, access to care and quality of care. Health planning and CN are the vehicles to accomplish these goals. In long term health care, without health planning and CN, the goals of cost containment, access to care and quality of care cannot be realized.

Long term care health planning and CN contain costs by insuring that the supply of long term care beds in New Jersey meets, rather than exceeds, demand.

The federal and State government, through the Medicare and Medicaid programs, pay for approximately 50% of the cost of long term care in New Jersey. Given government's substantial responsibility in this area, we owe it to the taxpayers to insure that the long term health care system in New Jersey is efficient and cost effective.

The CN process insures efficiency. Without this process, long term care beds would be built all over the State with no attention being paid to cost or to need, until the market becomes overly saturated. There is a saying around the country, "a bed built is a bed occupied". The taxpayers would pay dearly until the future saturation point is

reached because the Medicare and Medicaid programs reimburse facilities for their costs of construction, maintenance and upkeep, in proportion to the beds occupied by Medicare or Medicaid recipients.

Additionally, CN ensures that health care projects receive favorable financing terms. Without CN, the cost of financing will rise and/or become more difficult, if not dry up entirely. If health care facility financing becomes more expensive, again this directly impacts upon the taxpayers through the Medicare and Medicaid programs.

Long term care health planning and the CN process insure access to care by providing a system where supply will safely meet, but not exceed, demand.

A review of April 1992 Department of Health nursing home occupancy data reveals that the Statewide nursing home occupancy rate is 89.6%, which means that there currently exists a 10.4% vacancy factor in the State. This hardly shows that long term care health planning and CN have created a long term care bed shortage in the State, as has been alleged. On the contrary, the long term care health planning system and CN has created an efficient long term care delivery system in New Jersey where anyone who needs a bed can get one, regardless of payment source.

It has been argued that the 10.4% vacancy factor is "soft" because it includes "paper" beds, or beds that have been approved, but not yet built. The 10.4% vacancy factor is not "soft" in that it does not include "paper beds". It is a solid figure. Nevertheless, I would

like to briefly address the paper bed issue.

In many of these instances, projects have been stalled not through the inaction of the project owner, but because of problems that the owner has encountered with obtaining necessary municipal approvals, or by impediments at the municipal level (i.e.: sewer moratoriums). This problem is particularly acute in urban areas.

Where an owner has been stalling, the Department of Health has attempted to address this problem through recent amendments to the CN regulations, specifically at N.J.A.C. 8:33-3.10. This regulation provides that in almost all instances, the duration of a CN shall be five years. Five years represents a reasonable period of time. It is a known statistical fact in New Jersey that it takes a minimum of three years, and in most instances, five years for a new nursing home to be on line. The regulation does contain exceptions to the five year rule, but they are few and very narrow.

N.J.A.C. 8:33-3.10 is designed to give a project owner a single, reasonable opportunity to complete a project. If the owner cannot do so, he/she is out of luck. The regulation is further designed to dispense with the necessity for multiple CN extensions at multiple cost because under the old system, CN's were good for only one year, an impossible period in which to complete a long term care facility project.

Long term care health planning and CN insure that the high quality of care currently existing in New Jersey is maintained.

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It is indeed true that health planning and CN control the supply of long term care beds in the State. The goal is to have efficient delivery of care. This is accomplished by having high utilization, but not so high that people are frozen out of the system.

New Jersey has accomplished this balance by having a Statewide occupancy level of approximately 90%. At 90% occupancy, efficiency and high quality are maintained, but there exists enough flexibility to ensure that anyone who needs a long term care bed can get one, regardless of payment source. If health planning and CN is terminated, the number of long term care beds in the State will grow uncontrollably and will outstrip need. When this occurs, occupancy levels will drop. The health care literature on experience in other states is unanimous in its finding that low occupancy levels breed sub-standard care and added Medicaid costs. Please do not let this occur in New Jersey.

In addition, the CN process is quality assurance at its best. The process insures, to the utmost extent possible, that the people operating health care facilities in New Jersey are the "cream of the crop". Licensure regulations alone are not sufficient to ensure high quality care. Worst yet, licensure requirements often uncover poor quality care "after the fact", after patients or residents have suffered.

It has been argued that the health planning and CN process is a "closed" process. In the area of long term care, I would respectfully disagree. <u>The long term care health planning and CN process is open, fair and community-based</u>. The focal point of the long term care health

planning process is the county long term care committees. There is a committee for each county, each made up of equal representation of consumers, providers and government employees. It is these committees that decide how the long term care needs of county residents will be met; not the regional local advisory boards (LAB's), the State health planning board (SHPB), the Commissioner of Health or the Health Care Administration Board (HCAB).

Additionally, while a CN could be described as a "franchise", competition for available projects is fierce. The review of each application is an efficient, public, "bottom up" process.

A LAB will review each CN application submitted for a project in its region. Any application receiving at least 25% affirmative vote of LAB members in attendance when the vote is taken must be forwarded to the SHPB for its recommendation. A LAB must complete its review of a CN application within 45 days of the application having been deemed complete for processing. N.J.A.C. 8:33-4.12 and 4.14.

The SHPB will then review all of the CN applications that received at least 25% affirmative vote at the LAB level. Any CN application that receives at least 25% affirmative vote from SHPB members in attendance at the meeting in which the vote is taken must be submitted to the Commissioner of Health. The SHPB must complete its review of a CN application within 90 days of the application having been deemed complete for processing. N.J.A.C. 8:33-4.13 and 4.14.

Finally, the Commissioner of Health will decide whether to grant or

deny the CN application. If the Commissioner denies an application, the applicant has the opportunity for a fair hearing before the HCAB. Additionally, the SHPB shall have the opportunity for a hearing before the HCAB, if the Commissioner's decision is contrary to the SHPB's or the appropriate LAB's recommendation. N.J.A.C. 8:33-4.15.

If what I have said does not convince you to retain health planning and CN for long term care in New Jersey, I invite you to look at other States that have dispensed with health planning and CN in the long term care area. In Colorado, after CN was dispensed with on July 1, 1986, in just two years, 2200 nursing home beds were built and occupancy dropped from 92% to 85%. This prompted the Colorado Department of Social Services to institute a moratorium on new long term care Medicaid providers, becaause their Medicaid budget exploded. This moratorium, which has caused nursing home bed construction to cease, is still in effect in Colorado. I have attached for your review information on the Colorado experience.

In Texas, nursing home occupancy levels in some counties have dropped to 60%. There currently exists 22,000 vacant nursing home beds in the State. In a report of the Texas legislative Health and Human Services Board dated December 1992, the Board recommended that a comprehensive plan for long term care be developed that should, in part, address the oversupply of nursing home beds. Finally, in Florida, it was decided to allow the assisted living facility industry to develop outside the CN process. The result again was an exploding Medicaid budget and an oversupply of assisted living facilities. Florida is now attempting to control the proliferation of assisted

living facilities through its stringent licensure regulations.

While the NJAHCF strongly endorses the concepts of long term care health planning and CN, the process is not perfect. Accordingly, we respectfully recommend the following changes to the process:

1. Amend section 19 of P.L. 1992, c. 160, the Health Care Reform Act of 1992, to repeal the CN exemptions for adult day health care centers, changes in residential health care facility services and continuing care retirement communities.

If you would agree that long term care health planning and CN represents good public policy, then exempting adult day health care centers, changes in residential health care facility (RHCF) services and continuing care retirement communities (CCRC) entirely from the CN process makes no sense.

Adult day health care is one of the long term care alternatives that is available in the State, along with nursing homes, and the soon to be available assisted living facilities, comprehensive personal care homes, alternate family care and an expansion of the continuing care program for the elderly and disabled (CCPED). All of these other long term care alternatives either are subject or will be subject to long term care health planning and CN. Therefore, by exempting adult day health care centers from long term care health planning and the CN process, the process has been turned "on its ear".

This action hinders the county long term care committees in their

attempt to comprehensively plan for the long term care needs of county residents. It will have an impact on the Medicare and Medicaid budgets, and hence the taxpayers, because these programs will pay part of the cost for the uncontrolled building of adult day health care centers that will probably ensue. Finally, exempting adult day health care centers from the CN process may hurt the residents of the State. With an overabundance of adult day health care centers will come lower occupancy levels and a lower quality of care. If there is an overabundance of adult day health care centers and a shortage of other long term care options, the elderly and the disabled may be pushed to this long term care option when such a placement is inappropriate.

The CN exemption for "changes in RHCF services" should also be repealed. First, the term is vague. The array of services that may be offered in a RHCF is not controlled by the health planning or CN process, but by the RHCF licensure manual, N.J.A.C. 8:43-1.1 et seq.. The "quid pro quo" for receiving a CN to build and a license to operate an RHCF is the agreement to provide certain services to the clients that you serve. These services include room, board, laundry, assistance with activities of daily living, medication supervision and limited nursing services. A person who needs nursing home level care cannot reside in an RHCF. Given the current regulatory scheme, frankly we are puzzled as to what the term "changes in RHCF services" even means!

We are concerned that by exempting "changes in RHCF services" from CN, the phrase could be interpreted to allow RHCF's to indiscriminately bring long term care services into facilities with physical plants that are not equipped to properly serve people with long term care needs.

Allowing long term care services to be rendered in facilities that do not meet the construction and life safety specifications required in long term care facilities could place unsuspecting long term care consumers at risk.

Finally, we respectfully ask that the CN exemption for CCRC's be repealed to insure that the number of long term care beds built is proportionate to the number of independent living units on a CCRC campus.

Before the enactment of the Health Care Reform Act of 1992, the Department of Health's review of a CCRC's CN application was an expedited review. A CCRC's long term care beds were also never included when the long term care bed need was calculated for a county. However, Department regulations, N.J.A.C. 8:33H-1.10, insured that a CCRC's long term care bed contingent would properly serve its members, that a CCRC could not flood the market with long term care beds and that a CCRC took its fair share of Medicaid recipients from among the non-CCRC community members occupying the CCRC's long term care beds. Specifically, the Department's regulations required that:

a. A CCRC contain four independent living units for every one long term care bed;

b. The CCRC's long term care beds be constructed concurrently with or subsequent to the number of independent living units set forth in its CN application; and

c. After seven years of occupancy of the first independent unit,

no more than 10% of the occupants of the long term care beds could be drawn from outside the CCRC community and of this group, at least 45% must be Medicaid eligible persons.

With the passage of the Health Care Reform Act of 1992, these safeguards no longer apply. A CCRC may now build as many long term care beds as it wishes without paying any attention to its members' needs or to the needs of the surrounding community. In addition, a CCRC now has no obligation to care for its fair share of Medicaid recipients.

The CN exemption for CCRC's was well-intentioned. However, the exemption has created a loophole that again turns long term care health planning "on its ear". Now, a CCRC developer has no obligation to build a required number of independent living units to go with his/her long term care beds. Therefore, a developer could now obtain a Certificate of Authority from the Department of Community Affairs, build 10 independent units and a 180 bed nursing home, and there is nothing anyone can do to stop it. Worse yet, the developer would have no responsibility to open up some of those beds to the indigent and needy. This is a bad result and one that needs to be rectified!

Accordingly, we respectfully request that the CN exemption for CCRC's set forth in section 19 of P.L. 1992, c. 160 be repealed sothat the reasonable safeguards set forth in Department of Health regulations (N.J.A.C. 8:33H-1.10) will, once again, apply.

Allowing CN exemptions for adult day health care centers, changes

in RHCF services and CCRC's to stand as enacted in section 19 of P.L. 1992, c. 160 impedes all efforts to contain costs, and maintain access to and ensure a high quality of care in the long term care arena. Accordingly, we strongly urge you to make these amendments as part of your continuing health care reform initiative.

2. CN application fees for certain projects and services should be lowered. The current CN application fee structure consists of a $5,000 minimum fee plus an add-on of .05% if the project is worth more than $1 million but less than $10 million or an add-on of 1.0% if the project is worth $10 million or more. N.J.S.A. 26:2H-10.

There are two problems with the current fee structure. First, it does not recognize the difference between expedited review and substantive review CN applications. Secondly, the 1.0% add-on for projects of $10 million or more, because it results in a CN application fee of $100,000, knocks some viable applicants out of the process because they cannot afford to "gamble" such a substantial amount of money. We propose the following amendments to N.J.S.A. 26:2H-10 to address both problems:

a. The expedited review CN application fee should be $1250 or 25% of any higher minimum CN application fee that is established in the future. Expedited review CN applications take minimal work by Department of Health (DOH) staff because staff only examines the operational track record and financial resources of the applicant. In addition, these applications are not referred to the appropriate Local Advisory Board or to the State Health Planning Board. Thus, a lower

fee is justified.

b. The add-on for a project worth $10 million or more should be .05% which is the same add-on as for a project worth more than $1 million but less than $10 million. A fee of $5,000 plus an add-on of .05% is reasonable and affordable. A fee that makes the application cost of a $10 million project, $100,000 is unreasonable and must be lowered so that all applicants have the opportunity to be considered. Thus, a lower add-on of .05% for projects worth $10 million or more is justified.

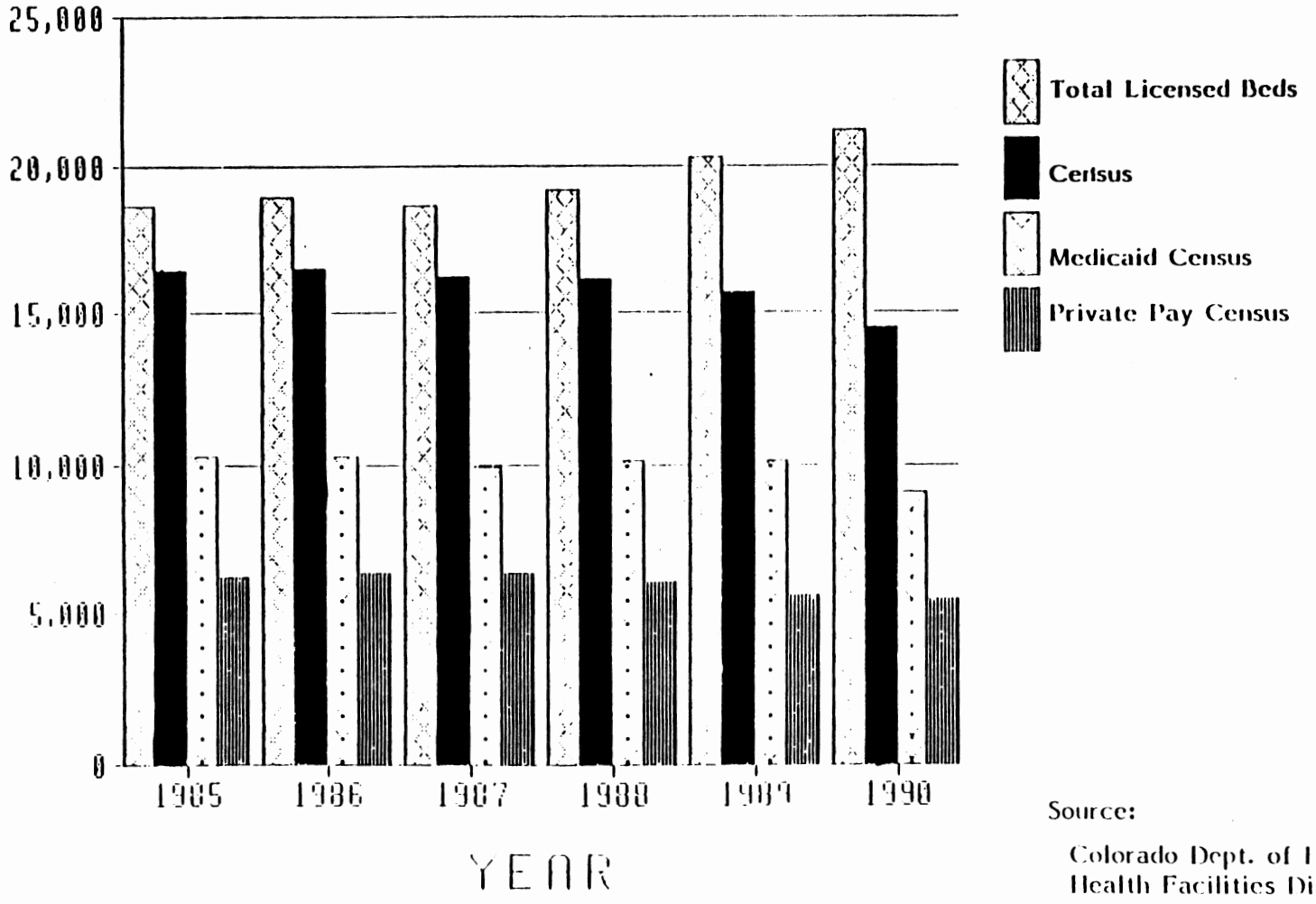
I have attached a draft bill containing these two CN application fee amendments for your consideration.

Once again, thank you for the opportunity to present the NJAHCF's position on long term care health planning and Certificate of Need. I would be pleased to answer any questions that you may have.

COLORADO HEALTH CARE ASSOCIATION

CENSUS FOR LICENSED NURSING HOME DATA

WITHOUT CERTIFICATE OF NEED




Source:

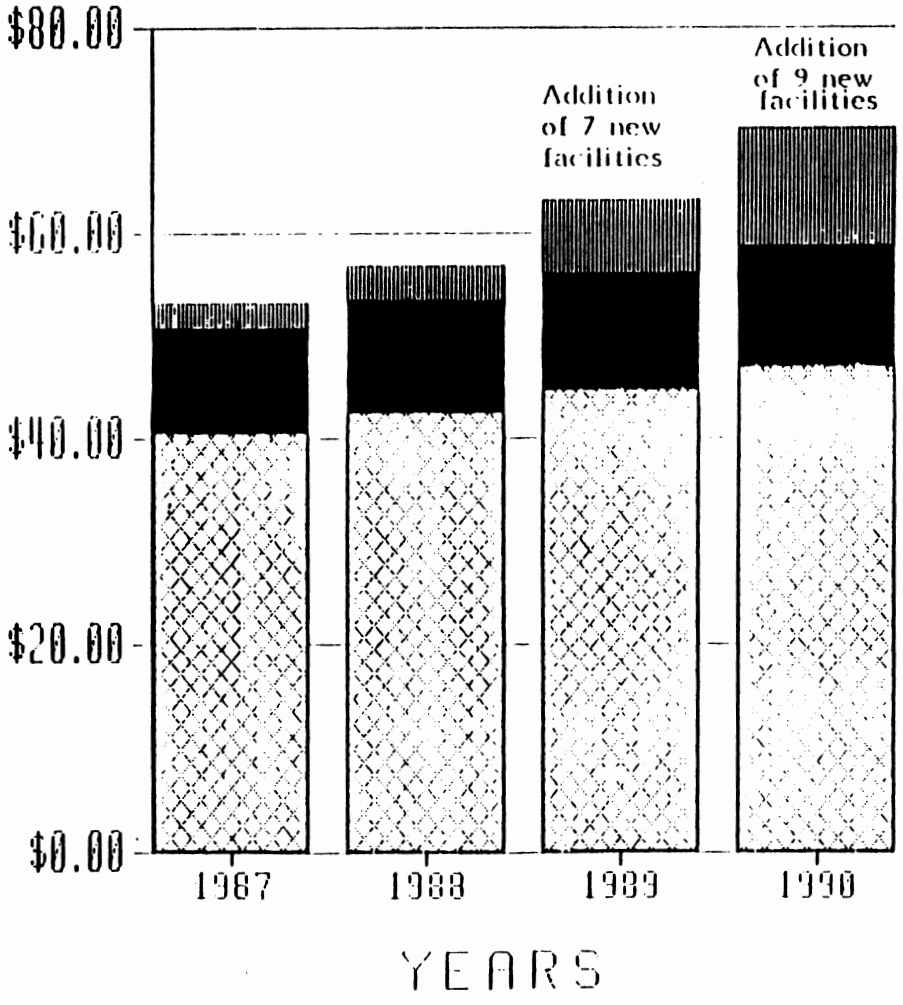
Colorado Dept. of Health
Health Facilities Division

X79

COLORADO HEALTH CARE ASSOCIATION

NURSING HOME COST DATA

WITHOUT CERTIFICATE OF NEED




Source:

Colorado Dept. of Health
Licensure & Cert./Construction

Colorado Dept. of Social Services
Long-term Care Division

# Occupancy Rates In Colorado

| County | 1988 Total Occupancy | 1989 Beds Added | *1989 Total Occupancy | 1990+ Beds Added | **1990 Total Occupancy |
|---|---|---|---|---|---|
| Adams | 90.58% | 60 | 87.53% | 0 | 87.53% |
| Arapahoe | 85.31% | 60 | 82.70% | 122 | 76.01% |
| Boulder | 75.62% | 120 | 77.58% | 120 | 68.73% |
| Denver | 83.10% | 80 | 76.26% | 120 | 73.57% |
| Douglas | 97.50% | 14 | 82.98% | 0 | 82.98% |
| El Paso | 86.69% | 137 | 78.12% | 0 | 78.12% |
| Fremont | 88.49% | 0 | 86.63% | 0 | 86.63% |
| Jefferson | 94.37% | 0 | 88.17% | 210 | 81.99% |
| Larimer | 83.21% | 0 | 84.90% | 120 | 76.31% |
| Mesa | 90.96% | 0 | 91.68% | 0 | 91.68% |
| Pueblo | 96.07% | 180 | 75.98% | 27 | 74.15% |
| Weld | 87.20% | 0 | 87.90% | 0 | 87.90% |
| All Other | 85.40% | 60 | 85.97% | 0 | 85.97% |
| **Total** | **87.19%** | **651** | **83.03%** | **734** | **80.07%** |

X69

*Projected occupancy based on 1st Quarter 1989 information plus addition of new beds coming on line throughout 1989.

**Projected occupancy assuming census remains constant from 1989.

*AN ACT* concerning certificate of need application fees and amending P.L.1971. c.136.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. Section 10 of P.L.1971. c.136 (C.26:2H-10) is amended to read as follows:

10. a. Application for a certificate of need shall be made to the department. and shall be in such form and contain such information as the department may prescribe. The department shall charge a nonreturnable fee for the filing of an application for a certificate of need. The minimum fee for the filing of an application shall be $5.000, except as provided in subsection b. of this section. For a project whose total cost is greater than $1 million [but less than $10 million] the fee shall be $5.000 plus .05% of the total project cost [, and for a project whose total cost is $10 million or more, the fee shall be $5.000 plus 1.0% of the total project cost] except that, the maximum fee for the filing of an application shall be $100.000. Upon receipt of an application. copies thereof shall be referred by the department to the appropriate local advisory board and the State Health Planning Board for review.

These appropriate boards shall provide adequate mechanisms for full consideration of each application submitted to them and for developing recommendations thereon. Such recommendations, whether favorable or unfavorable, shall be forwarded to the commissioner within 90 days of the date of referral of the application. A copy of the recommendations made shall be forwarded to the applicant.

Recommendations concerning certificates of need shall be governed and based upon the principles and considerations set forth in section 8 of P.L.1971. c.136 (C.26:2H-8).

No member, officer or employee of any planning body shall be subject to civil action in any court as the result of any act done or failure to act, or of any statement made or opinion given, while discharging his duties under this act as such member, officer, or employee, provided he acted in good faith with reasonable care and upon proper cause.

b. Notwithstanding the provisions of subsection a. of this section to the contrary, in the case of a Certificate of Need application that is subject to the expedited review process pursuant to N.J.A.C. 8:33-5.1 et seq. or successor regulations, the fee shall be $1250 or 25% of any higher minimum Certificate of Need application fee established after the effective date of this act.

Home Health Assembly

Home Health Assembly of New Jersey, Inc., 760 Alexander Road, CN-1, Princeton, NJ 08543-0001 609-452-8855

TESTIMONY
MAY 6, 1993
CERTIFICATE OF NEED PROCESS: SUPPORTS COST CONTROL AND QUALITY GROWTH IN HOME HEALTH SERVICES

Since the adoption of the original 1971 Health Care Facilities Planning Act, home health agencies have been included in the Certificate of Need process of planned and appropriate service growth in New Jersey. Every citizen has access to well-coordinated home care, provided 24 hours a day, 7 days a week. Planned growth has enabled agencies to move into a high-tech environment, delivering a wide variety of specialized care to their communities, from pediatric intensive care to intravenous therapy to hospice care and rehabilitation for the disabled. At the same time, the stable industry fiscal environment facilitated by CON has allowed agencies to continue meeting indigent and lower income needs to a significant extent.

There are clear reasons for the orderly progress fostered by certificate of need stability, and they all boil down to economies of scale and volume-related quality.

In other states without Certificate of Need for home health services, chaotic proliferation of relatively small agencies is the common pattern. Literally hundreds of home health agencies spring up on street corners. In Tennessee, for example, when the CON for home health was abolished in 1981, the number of agencies mushroomed within 2 years by 385%. On the other hand, the number of consumers receiving home care grew by only 20%. So obviously more agencies did not result in more care for the public. That 20% growth would have occurred naturally as happened in all states during those years. What DID happen was chaos for patients, doctors, and social service workers trying to sort through which agency was which, who had what competency and quality, and the like. Coordination of care was a disaster. Small agencies, as are the norm in non-CON states, tend to want just the "cream from the top" of patient referrals - namely Medicare, which provides very limited acute home care reimbursement but pays adequately and promptly, and the more well-



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heeled private patients. As soon as Medicare coverage comes to an end, home care quickly stops and patients are left to fend for themselves. The low income and indigent are "persona non grata" at such agencies.

Tennessee quickly realized that it had created more problems than it solved by eliminating CON, and thus in 1984 the CON process for home care was reinstated.

Not only does coordination chaos result, costs tends to increase as well when the CON process is eliminated. The average cost per visit for Florida and Texas home health agencies was nearly the same in 1981, when the Texas legislature abolished CON. During the next 3 years, the number of agencies in Texas increased by over 500%, while the number of Florida agencies increased by just 15%. During the same time, the average home health cost per visit in Texas grew by over 19%, while Florida grew by only 10%.

Increasing the number of agencies inflates personnel costs as well. There are a limited number of trained home health professionals and para-professionals. Unemployment is virtually non-existent in the New Jersey home care industry. With a proliferation of agencies drawing from the same employee pool, salaries go up, the shortage of well-qualified staff becomes more severe, and costs of care are driven up. That cost is passed on to taxpayers and consumers, whether Medicare, Medicaid, or clients themselves are being billed.

Planned growth fostered by CON can actually save dollars by eliminating duplication of overhead and administrative costs. These are costs necessitated by Federal and State regulation and must be incurred by every agency whether that agency makes 5,000 visits a year or 50,000. Thus as numbers of agencies multiply, the taxpayer, once again, gets socked with a higher bill.

In New Jersey, the CON process has enabled gradual increases in agency numbers, which has also enabled existing agencies to increase in size and scope of services offered to their communities. Our strong, stable, innovative home health agencies in this state are the envy of the rest of the country. VNA's have grown from just periodic mother/infant visits and chronic care for the elderly to "full service" agencies providing a variety of programs such as 24 hrs/day, 7 days/week acute care, high-tech services, hospice care, adult and pediatric day care, psychiatric outreach, boarding home outreach, case management, care for acute and long-term AIDS patients and much more. Often these innovative programs are the result of special grants, community donations, and nursing research initiatives. And keep in mind that this has all been without an "Uncompensated Care" system. Home health agencies are on their own when it comes to indigent care, and they're doing it anyway - in excess of 5% of services annually. And in New Jersey, the volume of services is growing steadily. Though we have lacked tabulated statistics from the State Health Department over the last few years, we can postulate that at least 2 million visits a year are now made, by our certified agencies, to over 50,000 patients and families (based on 1988 tabulated data plus a growth factor).

Our hospital-based agencies also tend to be more innovative and open to the full community than non-CON states. In those states, hospitals open small agencies catering just to their own patients, and providing just the care they are sure will be fully reimbursed. In New Jersey, the stability of the planned growth environment has encouraged our twenty-plus hospital-based or related agencies to follow the same community service model of their VNA predecessors.

These economies of size are passed on to consumers in the form of new and better services. At the same time, the public benefits from the quality inherent in volume. It is no secret why people want to go to a hospital like New Jersey's Deborah when they need heart surgery. The principle is simple and true: the more you practice the better you get. And generally, you become more efficient as well. Larger agencies get more experience with more types of home health services, from simple chronic care to complex I.V. therapy, etc. Thus, the ability of staff and quality of care is better, and the consumer is better served. One has to speculate on that quality level if the number

of agencies suddenly grew by 500% here as it did in Texas when the home care CON was removed. I believe the public will quickly see the difference and be worse off for it.

## To Summarize

New Jersey's home health agencies are among the finest in the country. Our home health agencies have expanded to keep pace with new technologies and growing consumer needs. New specialty programs have been developed including geriatric assessment programs, pediatric high-tech care, hospice care, boarding home outreach, A.I.D.S. home care and case management programs, pediatric day care, and on and on. The norm is now 24 hrs/day, 7 days/week availability all over the state, and in most areas there are at least two or three agencies from which patients can choose - in some counties there are six or seven certified, licensed agencies.

At the same time, these agencies have controlled costs as well. Most are below the federal home care cost caps, whereas in other non-CON states, agencies seem to compete to hit the caps and push for still higher caps.

Removal of Certificate of Need for home care will serve no public good. Instead it will fragment care, raise costs, and leave many indigent without care, as the existing agencies "pull in the carpet", suffer loss of clients, and are forced to reduce or eliminate many community services.

The confusion of uncontrolled growth, the lack of service coordination for the public, and the failure of the new system to control costs all caused Florida to re-enact certification of need legislation for home care. New Jersey's high percentage of senior citizens mirrors that of Florida, and we believe removal of home care from the CON process would serve our citizens no better than it did the people of Florida.

Acting in haste to alter a well-functioning service in New Jersey may have disastrous long-term effects which could be difficult to repair.


## SHOULD ANYTHING BE DONE?

Yes. The existing CON process is certainly not yet perfect - but, then, what is? We need to review and improve it through industry/government collaborative efforts. Standards to determine when and where public need exists can be tightened and clarified. Better statistical monitoring can help the state, as well as local advisory boards, keep a better-informed eye on services and existing gaps. Better public education about the process can enable more citizen comment and input to help guide decisions as to when and where certificates should be granted.

Yes, we have work to do. But we <u>can</u> do it, without giving up in frustration and destroying the whole process. New Jersey has bright, capable leaders throughout government and industry, and their talents need to be tapped to work for a <u>better</u> system, rather then a non-system. Let's not throw in the towel.

Carol J. Kientz, R.N., M.S.
Executive Director
Home Health Assembly of New Jersey, Inc.

May, 1993

Home Health Assembly

# NEW JERSEY HOME CARE FACT SHEET

## What is Home Care?

A broad spectrum of professional, technical, and support services delivering health care to an alternative site, the client's home, guided by the prescribing physician's plan of treatment.

Home Care Services include:

- Nursing
- Rehabilitation Therapies
- Paraprofessional Home Health Aides
- Infusion Therapy
- Medical Social Work
- Nutritional Counseling
- Individual & Group Case Management

Levels of Care available through Home Care:

- Acute Care - both pre/post-hospital, and in lieu of hospitalization
- Short and Long-Term Rehabilitation
- Specialized and High-Tech Services:
  - Intravenous Therapy
  - High-Tech Maternity & Pediatric Care
  - Preventive Health Services
  - Long-Term Care
  - Respiratory Therapy
  - Care for HIV+ Adults and Children
  - Hospice Care

## Home Care Access and Volume:

Home Care agencies are available to serve clients in every New Jersey municipality. In most areas, clients can choose from more than one service provider. Home care is available 24 hours a day, 7 days a week.

Currently, over 100,000 clients in New Jersey receive home care, and total annual home care visits in this state number more than 2 million. Approximately 73% of these clients are referred to home care agencies by hospitals for acute care services.

## Home Care Reimbursement:

Home care funded through Medicare reimbursement continues to function within Federally-mandated cost caps. New Jersey home health agencies have maintained a cost-effective status below those caps. Similarly, this state's Medicaid home health agency reimbursement is based on those same cost limits. Growing numbers of contracts between home care providers and managed care systems exist in New Jersey as well, and are individually negotiated to meet the needs of both the benefit plan and the provider agency.

## Quality Assurance:

New Jersey's home care system is one of the most extensively regulated in the United States. Medicare-certified agencies are licensed by the Department of Health. Non-Medicare agencies are licensed by the Division of Consumer Affairs. Many New Jersey agencies also hold accreditation such as JCAHO, CHAP, or the N.J. Commission on Accreditation for Home Care. Home health aides must be state-certified, and regularly supervised by a registered nurse.

**HAMILTON HOSPITAL** A CPC SUBSIDIARY

Hamilton Hospital is committed to [illegible]

May 10, 1993

Assemblyman Harold L. Colburn, Jr.
Chairman of the Assembly Health Committee
c/o David Price, Assembly Health Committee Aide
Legislative Office Building
CN 068
Trenton, NJ 08628

Dear Dr. Colburn:

Thank you for the opportunity for Hamilton Hospital to discuss the Certificate of Need, or CN issue before your Committee.

The intent of the Legislature with the Health Care Reform Act '92, or HCRA '92 was to create a truly competitive market environment. However, in order to promote equitable and fair competition, hospitals must not only compete on price, they must be able to compete from a basic level of service.

The goal of this Committee should be to ensure that the intent of this Legislation is carried out. That means an environment for an equitable and fair competitive system from which all hospitals can compete needs to be in place. As it exists today, not all hospitals are at the same starting point from which to compete.

There are two aspects to this competitive issue. One is, rate or price. The second is, a starting point from which to compete. The first issue was addressed under HCRA '92 when prices were completely deregulated, subject to certain conditions for 1993. The second issue about an equal starting point was never addressed. This is where the CON regulations fit in today. Clearly, it is Hamilton Hospital's opinion that all hospitals should be at least at the same starting point so that true competition can occur.

The CN issue is one that is extremely important to Hamilton Hospital. The CN program was originally intended to limit the growth of medical services and equipment so that dollars would not be inefficiently spent. The CN program in New Jersey led to unanticipated and undesired outcomes, many states abolished CN regulations for these reasons. By tying reimbursement to CN regulations, hospitals have become bigger, and have more debt, which has increased the cost of health care. As you probably know, the average size hospital in New Jersey is approximately 350 beds and is more tertiary in nature, versus the average size hospital in the rest of the country, which is 150 beds, and primary care and

community oriented in nature. With the passage of Public Law 160, the Health Care Reform Act of 92, or HCRA '92, only the reimbursement to hospitals was materially altered. The CN regulations were left intact with the exception of minor changes.

There are two general areas in terms of service. One is primary care; the other is tertiary care. Primary care services, in general, are those services of which the vast majority can be rendered in a community hospital. Tertiary services, such as cardiac surgery, or trauma centers, are the highly sophisticated types of services, requiring tremendous resources, and serve a very small portion of the population. If competition is going to occur, and true cost savings are going to be realized, competition should occur at the primary care level, while the CON regulations should remain in force for the tertiary services.

Hamilton Hospital recommends that Section 19 of HCRA '92 be amended as follows: Basic primary care services provided by an acute care hospital including

- Medical/surgical services
- Intensive Care/Coronary Care services
- Emergency Room services
- Operating Room services
- Pediatric/Obstetric services

Our recommendation does not propose eliminating the entire CN process. It is our position that highly specialized tertiary services should be restricted, such as cardiac surgery and trauma centers. These programs serve a very small portion of the population and require tremendous resources. However, it is the Legislature's intent to promote competition and that competition must occur at a primary care level. It is the primary care level where the vast majority of health care services are rendered.

Questions may arise that this will cause the proliferation of unnecessary beds. First, your key control and one that HCRA '92 is based on is that the market will determine who will get these beds, and where these services should be rendered. If an institution cannot demonstrate financial feasibility which will support adding these services, the financial community will not provide funds. This is, in fact, your strongest control to ensure proliferation of beds will not occur.

Second, there are approximately 32,000 acute care beds in total in this State. There are only 14 hospitals who do not have either pediatric and obstetric services. You may wish to consider limiting the number of new beds to 10 for each service, or a total of 20 new beds per hospital. This will restrict the increase to a maximum of 280 beds or .08% of total beds available.

Finally, you may wish to consider if these beds are added, an institution's medical/surgical beds must be reduced in equal number, so that the total complement of licensed beds are not changed.

A common misperception exists about obstetrics. Current obstetrical CN regulations list 4 levels - basic, intermediate, intensive and regional. We are talking about healthy births, i.e., basic obstetrics. Again, in the rest of the country, most births occur in a community hospital. In addition, there were 120,000 births in 1991, the highest volume DRG in New Jersey. It is precisely this type of DRG that competition may provide lower costs.

I would like to address, more specifically, the concerns in the marketplace for Hamilton Hospital. Hamilton Hospital is located in Hamilton Township, New Jersey, in Mercer County. We are the 7th largest municipality in the State, and the only hospital in this municipality. We are the only hospital in the 14th District which has a population of approximately 200,000 people. It is one of the areas in central New Jersey that is believed to have growth potential over the next decade. Of the largest 15 municipalities in the State of New Jersey, only Hamilton Township does not have pediatric and obstetric services in its community.

In 1991, according to Department of Health statistics, there were 4,860 births in our primary service area. Our community residents, because of current CN regualations, did not have the opportunity to give birth at their community hospital. We are not a hospital in a small service area asking to break into a new service area. We are a community hospital who is asking for the opportunity to meet the needs of its community.

The managed care environment has come to Mercer County much earlier than the rest of the State. HMO's began doing business in Mercer County in 1983, and today, Mercer County has the highest penetration of HMO's and managed care companies. Obviously, with

the passage of HCRA '92, this will only intensify. To date, managed care companies have preferred to do business with full service hospitals, i.e., those hospitals that have basic primary care services as defined above. For example, Blue Cross announced that being a full service hospital was one of the criteria for inclusion in their network. We were not included in the Blue Cross network.

In addition, we have a letter indicating that Hamilton was never considered for the Aetna Health Plans of New Jersey network, because we are not a full service hospital. We pursued legal action and proved in court for the period 1985 - 1990, Hamilton Hospital had the lowest DRG rates of any hospital in Mercer County. However, even as the lowest cost provider, without full service capabilities, our ability to effectively compete in the managed care environment will not be an easy one. It is our belief that this Legislature wants us to compete on an equitable basis and not be restricted because of outdated regulations developed some 20 years ago that no longer apply to the current health care environment, or to the demographics of the community that we serve.

We are not asking for financial assistance, special assistance or protection. We are asking you to give all hospitals the opportunity to compete. If we are successful, we should enjoy the rewards of such. We do not believe that you want us to fight in this marketplace with one hand tied behind our backs. We ask you to modify Section 19 so that hospitals such as ours have the opportunity to compete in order to meet the needs of the communities that we serve.

Regards,

Michael Bryant

W. Michael Bryant
President and CEO

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*IMPORTANT FAX: DELIVER TO HOSPITAL CEOS IMMEDIATELY*
*Route Copy to Public Relations Department*
*April 26, 1993*
*New Jersey Hospital Association*
***Blue Cross / Blue Shield Announces Preferred Network;***
***56 Hospitals Named as Participants***
***(List of Participating Hospitals Attached)***

*Blue Cross and Blue Shield of New Jersey has chosen 56 of the state's 85 acute care hospitals to participate in a new select hospital insurance plan. The plan, announced today at three locations statewide, essentially directs the Blues 2.2 million subscribers to hospitals they should use if they want full coverage.*

*The network will be marketed to employers who buy group health insurance for their employees. Discounts negotiated with participating hospitals will be passed on to groups buying the new coverage plan, according to BC/BS officials. Members of the employer groups that select the network will be reimbursed more money if they are hospitalized at the participating hospitals than if they are hospitalized outside the network.*

***"This is a fact of life in an emerging managed care environment," said Ralph Dean, NJHA executive vice president, "but we're very concerned that a patient's freedom of choice won't be compromised here. The public needs assurances that they can access quality care, close to home and not have to shop for the right hospital."***

*According to BC/BS President John Petillo, the move represents a "fundamental change in the way we do business," as the Blues will no longer be content to simply "sell insurance and process claims." He added: "the network was formed to control rapidly rising medical costs and slow down premium increases for Blue Cross customers as we move toward a total managed care environment."*

*Participation criteria included seven points: access, range of services, participating physicians, occupancy, BC/BS volume, teaching status, price and cost efficiency.*

***(See Attached List)***

81X

**Aetna Health Plans**
**of New Jersey, Inc.**℠
700 East Gate Drive, Suite 210
Mount Laurel, NJ 08054-3899

April 27, 1993



Mr. W. Michael Bryant
President and CEO
Hamilton Hospital
1881 Whitehorse - Hamilton Square Road
Hamilton Square, New Jersey 08690-3599

Dear Mr. Bryant:

Thank you for your continued interest in becoming a provider hospital in the Aetna Health Plans of New Jersey, Inc. (Health Plan) Network.

As I understand from Ms. Mazer, she and her staff have indicated in all prior discussions Health Plan's commitment to strengthening its position in the marketplace. Toward that end, we wish to contract with a relatively small network of preferred hospital providers and which, where possible, are full service. This enables us to monitor the quality of health care rendered to our members more efficiently, and also enhances our ability to manage rising medical costs.

At this time, Health Plan's goals are best met in your area by limiting the preferred provider network to two full-service hospitals. It is our understanding that Hamilton Hospital is not a full-service hospital. In addition, Health Plan has long-standing, satisfactory relationships with two full-service hospitals and intends, if feasible, to continue those relationships. Therefore, at the present time, we do not think it would be mutually beneficial for Hamilton Hospital to become a part of the Health Plan network, and must decline your invitation to discuss that proposal.

Sincerely,

Kaye S. Morrow

Kaye S. Morrow
Associate Executive Director

cc: Christine L. Kulina, Manager, Network Development

HAMILTON
HOSPITAL A Cinn Affiliate

Hamilton Hospital is committed to excellence through service. We exist to promote, preserve and restore the health of our community.

May 10, 1993

Assemblyman Harold L. Colburn, Jr.
Chairman of the Assembly Health Committee
c/o David Price, Assembly Health Committee Aide
Legislative Office Building
CN 068
Trenton, NJ 08628

Dear Dr. Colburn:

As a follow up with additional information since I spoke to the State Assembly Health Committee regarding the Certificate of Need issue, I am enclosing our Bond rating review by Moody's Investors Services and Standard and Poors.

Standard and Poors maintained our current Bond rating, but listed out outlook as negative. As the enclosed letter indicates, it was downgraded because of the lack of full services in a very competitive environment. In addition, Moody's maintained our rating, but in their outlook also indicated "difficulties of operating a small hospital without a full service array in a competitive service area, and in an increasingly managed care environment pose longer term concerns." Again, in our case the lack of obstetrics and pediatrics makes the financial community nervous, even though we are a very solid organization. Please include this with your information about Hamilton Hospital.

We hope that you will continue to react favorably to our position about modification of CON laws to allow every hospital the opportunity to have basic primary care services from which to serve their community, and to compete in the managed care environment promoted under the Health Care Reform Act of 1992.

Regards,

Michael Bryant

W. Michael Bryant
President and CEO

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cc: Senator Inverso
Assemblyman Kramer
Assemblywoman Wright



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KIMBALL
MEDICAL CENTER
600 River Avenue • Lakewood, N.J. 08701-5281 (908) 363-1900

Office of the President

STATEMENT BY
Joseph Sherber, President
Kimball Medical Center
Lakewood, New Jersey
May 10, 1993

I appreciate the opportunity to speak to you today on reform of the Certificate of Need process in our state.

Let me say that I think that you, as members of the Legislature, have an important opportunity to once again restructure the CN Process to make it more in keeping with today's health care world.

I am not urging that the process be abolished entirely. It has a place even in this new era of managed care, managed competition or whatever system under which we are now operating.

But the CN process is in desperate need of another updating to make it relevant. As you know, the Certificate of Need system was put in place to assure orderly growth in the hospital industry——to prevent construction of unnecessary beds and facilities or acquisition of unneeded equipment.

The object, of course, was to keep health costs down.

Sadly, it had the opposite effect and actually raised costs in many instances. This was because there was not enough flexibility in the process to recognize the difference between a medical "luxury" and necessity. Nor could it adapt to the fact that today's medical "luxury" could become tomorrow's necessity.

The classic case involved regulation of CAT Scanners—Computerized Axial Tomography Scanning that was at one time state of the art diagnostic technology.

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While I know that a CN is no longer required, its history from regulation to deregulation is a classic case of the CN process gone wrong.

The State Department of Health limited acquisition of CAT Scanners to eight hospitals at the outset. No other hospital was allowed to purchase one.

As a result, many hospitals had to transport their patients to other hospitals, often at some distance.

This meant higher costs because of transportation and the need to staff ambulances with nurses and even physicians to assist the patient. It also meant long delays in diagnostic testing. This, in turn, drove up the length of stays at hospitals. And, considerably more exploratory neuro-surgery took place before elimination of these state-approved monopolies than afterwards. So a process that was meant to save money in fact wound up wasting it.

The supreme irony, of course, was this: When we eliminated the cost of transportation, personnel and the other mentioned factors we found that the payback on a CAT scanner was only three years or less! This does not include, of course, the increase in quality of care.

The CN system simply did not recognize soon enough that CAT scanners were becoming fundamentally critical to the practice of medicine.

Nearly all hospitals came to acquire CAT Scanners. And health care in our state was better for it. But there was a period of substantial and costly legal and political confrontation and I speak from experience on that point.

And, let me point out that it took 14 years after the original administrative law judge decision to remove CAT scanners from the CN process.

Reform of the CN process, then, should not repeat the problems of the past.

Moreover, changes should reflect the changing nature of health care. We are in an era of competition——managed or otherwise. Therefore, the state should let many

health care institutions function in a free market atmosphere applying all the sound principles of business to its operations.

In that light, I urge you to consider the following points:

First, proposals to construct new hospital beds in our state should continue to require certificates of need. Such plans demand close scrutiny. There are no doubt too many beds in the state now.

At the same time, I would not require CNs for nursing home beds. Let market forces drive this phase of the industry.

Those who propose to open such facilities should be allowed to do so as any other business. They should be allowed to plan, develop, build and market as businesses do——and to succeed or fail as businesses also do.

Esoteric programs such as those to create open heart surgery centers or to install technology still in a research or investigatory state should still require certificates of need. I should note that even here, the system has not functioned properly. There are something like 20 heart surgery installations in the state when, I am told, there is a need for seven.

Of course, all other programs and technology should not require CNs.

If you approve this limited use of the CN process, I would urge you to also consider a "sunset" provision for those projects which come under the regulation.

Under this, requirements that specific programs and technology require CNs could be reviewed after a period of time. If it is determined that these programs and equipment should have broader distribution than a few teaching hospitals, the CN requirements should be eliminated.

This would cut down the time it takes to recognize the difference between luxury and necessity

On routine technological advances, why not let the market forces prevail?

Again, a hospital should be free to do its research, financial studies and projections and to make the decision to buy the equipment on a business basis.

Let the market and the hospitals' own business judgment determine success or failure.

If you follow this line of reasoning, I would also suggest this:

That the state take a hard look at the current Local Advisory Board system which replaced the previous HSA process. Is it really necessary now to maintain two different levels of approvals for projects? Or should the remaining CNs go directly to the State Health Department, eliminating unnecessary steps and levels of administration.

In this era of enormous financial pressure on government, I believe the State Department of Health could save substantial amounts of money by this step.

An speaking of financial pressure, the fees charged to hospitals for submitting Certificates of Need have become excessive. A hospital must pay $5,000 for projects of one million dollars or less. For those over one million, the price is $5,000 plus 5 percent of the total cost——and $100,000 for a 10 million dollar project. This, in effect, penalizes hospitals for daring to submit CNs.

In summary, a modified Certificate of Need process may indeed have a place in our state's health care system. But you now have the opportunity to modernize it to reflect the changes that we now see taking place—changes that are irreversible.

If we are truly in an age of competition in health care, then let it happen——let the free market system prevail. There is no longer a reason—or a need——to micromanage the health care system.

Health care institutions——like businesses——--will succeed or fail depending on their own smarts and their own skills.

CHAMBER OF COMMERCE OF SOUTHERN NEW JERSEY

## Goals for Health Care Reimbursement Policy

1. Efficient hospital and provider service should be delivered with greatly reduced governmental regulation and involvement. The present Chapter 83 Reimbursement System should be repealed. A market system should replace mandated rate setting. Certificate of Need regulation should be limited to those areas having a significant impact on the quality of care:

   - regional trauma centers
   - intensive perinatal services
   - burn centers
   - organ transplant centers
   - cardiac surgery centers

2. The number of uninsured or underinsured families and individuals should be reduced through encouraging the availability of affordable, price sensitive health insurance. Basic coverage should consist of a defined package of fundamental health care. Managed care should be encouraged as a gatekeeper to the health care system.

3. The effectiveness of the medical care system should be monitored by an independent Health Care Commission. It should be responsible for collecting comparative health data, including managed care reports. The commission should study and make recommendations on the major issues contributing to the cost of health care:

   - preventive care in health insurance packages
   - medical malpractice
   - inappropriate care
   - excessive regulation and paperwork for business, providers and consumers
   - cost benefit studies

4. Public funding for a portion of uncompensated care should be provided through taxing employers and employees on a wage base similar to the New Jersey Unemployment Insurance and Disability model. Preventive health, safety and wellness programs should be publicly and privately supported.

5. Current health programs or requirements should be evaluated, those with doubtful benefit should be targeted for elimination. Innovative or controversial programs which could produce substantial cost saving should be subjected to neutral evaluation.

Kevon Office Center • Suite 210 • 2500 McClellan Avenue • Pennsauken, NJ 08109-4698
609/665-7900 • Fax 609/665-3975

# Why Competition Cannot Work in Health Care

**Access and Affordability Monitoring Project**
B.U. School of Public Health, 80 East Concord St., Boston, MA 02118
(617) 638-5042

October 9, 1991

Market competition cannot contain costs in health care (nor can it do a good job of allocating resources), fo

**First, the four fu... ...ents for a functioning free market are absent in health care and are impossible to attain:**

a) Each buyer or seller must be small, unable to influence price. But in health care, some payors cover so many patients that they can require price concessions from hospitals; and hospitals can set firm prices in areas with high occupancy rates or few hospitals.

b) Supply, demand, and price must face no artificial restraints. But in health care, hospitals, doctors, drug companies, and others shape demand to a great extent. And fee-for-service caregivers face financial incentives to increase care -- and HMOs, to provide less.

c) Sellers must be able to enter and exit the market freely. But in health care, there are many entry barriers (capital costs, licensing, etc.); where high occupancy lets hospitals raise prices, building new hospitals would be an extremely costly way to drive prices down.

d) Buyers and sellers need good information on price and value. But in health care, few patients have comparative information on price or, especially, quality. Few are willing to balance price and quality. Many people believe that costlier care is likely to be better care. Most must trust their doctors to choose their hospitals.

**Second, without a free market, "competition" merely grants benefits to those with market power** -- payors controlling many patients or hospitals with high occupancy rates or geographic monopoly, for example. In the absence of a free market, hospitals seldom compete primarily by price. Instead, scope of services, physician loyalty, financial reserves, and other factors tend to influence hospital growth and survival. Between 1988 and 1989, for example, our analyses show that the more costly, less efficient Massachusetts hospitals were most likely to gain patients.

**Third, focusing only on prices ignores the effect of volume on total costs.** Even if competition initially reduces some prices, hospitals will strive to make up revenue losses by providing more services. Higher volumes will offset any short run savings from price reductions. Competition will force some hospital and bed closings. But the hospitals that close unfortunately will not tend to be the least efficient, in part because hospitals seldom compete by price, as just noted. And hospitals that close tend to be among the more needed institutions, because they are often located in areas where many uninsured and lower income citizens reside. Higher volumes of patients plus fewer hospital beds equals higher occupancy rates, giving hospitals even greater market power, so any prices that had been cut will go right back up.

Particularly great problems exist for market competition in Massachusetts: we have high occupancy rates, geographic monopolies, and prevalent non-price competition, so many hospitals will feel little pressure to cut prices.

If excess beds had actually caused our high costs, competition might be a solution. But our bed-to-population ratio, just above the US average since 1975, fell to just below the US average in 1989. Our occupancy rate is 10 percentage points higher than the nation's. Our state has already tried competition to cut costs, and it has failed. Discounting became legal in 1983 for Massachusetts HMOs, which have the nation's second highest rate of enrollment. To stimulate competition, since 1988 we have rewarded hospitals that gain patients, and penalized those that lose patients. Volume has soared, and so have hospital costs -- from 34.5 percent above the national per capita average in 1987 to 39.7 percent above in 1989 (the most recent data available). Nationally, more competition was associated with significantly higher increases in health care costs during the eighties.

The pro-competition bills filed by the governor and approved by the Health Care Committee will raise our costs for several other reasons:

-- All hospitals will have powerful financial incentives to boost admissions and outpatient visits because serving more patients raises a hospital's revenues much faster than it increases costs. Competition advocates assume there is a fixed amount of care to be divided among hospitals. This is just not true.
-- Competition means still higher spending on medically useless advertising and marketing.
-- Competition will also increase spending on duplicative services and costly equipment.

And competition creates other problems as well:

-- Discounting means *cost-shifting*. Rather than containing costs, H. 6100 means workers in large companies may benefit from short-lived price concessions, but others will be increasingly priced out of care.
-- Deregulation and price competition advocates rarely mention that they rely heavily on *private regulations* like utilization review in hopes of limiting volume. But financial incentives generally prove stronger than such rules.
-- Competition in health care disrupts long-established relationships between patients and physicians.
-- Forcing payors and caregivers to focus on price means a risk that quality will suffer. Price is easy to measure, but quality is hard to measure. Hospitals may lower standards in order to lower their prices, either to maintain volume or simply to make money.
-- Competition means many hospitals will be forced to close needed but unprofitable services. And more hospitals will be lost, even many badly needed by their communities.

To contain costs, the Health Care Committee bill, House 6100, relies almost entirely on encouraging hospitals to offer discounts and bargain competitively over prices with payors. The governor's bill, House 5900, depends primarily on these methods, but as a back-up, it provides for loose charge control regulations.

The bottom line is that neither bill has a bottom line: they do not legislate a clear and certain limit on spending for hospital care.

In the governor's bill, the back-up method to limit hospital charges contains intelligent elements, but the controls are very loose. They fail to assure that actual hospital *revenues* will be capped statewide (or for each hospital) at any specified level. If charges must be high enough to permit competitive discounting, the charge caps would not constrain hospitals' abilities to generate revenues.

And finally, the competitive elements of both bills will, for the many reasons described earlier, tend not to control hospital costs, but to increase them.

FDU
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# CERTIFICATE OF NEED TESTIMONY

## Sharon Pavelich, Local Advisory Board-Region II

Public Administration
Institute

Local Health
Advisory Board

Rutherford
New Jersey 07070
(201) 460-5385

Good Morning. My name is Sharon Pavelich. I am a Planning and Certificate of Need Review Coordinator for Local Advisory Board-Region II, which serves Bergen and Hudson Counties under a grant from the New Jersey Department of Health. The Local Advisory Board (LAB) is a project at Fairleigh Dickinson University in the Public Administration Institute. The views presented here are those of the LAB staff.

We are responding to your notice for testimony on the Certificate of Need (CN) process. My comments will address the question: is Certificate of Need review a useful activity? We believe it is and we would like to take a few minutes to tell you why.

First, the march to competition in health care is a sensible one provided that resources are not squandered on unneeded duplication of services. A basic tenant of CN is to balance what we need in light of what we have. The process has had imperfections but essentially CN review requires providers to justify their requests for new services, upgrades or renovations of health care facilities. The State has made the process more flexible over the years



Florham-Madison, N.J.
Rutherford, N.J.
Teaneck-Hackensack, N.J.

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by raising the dollar threshold. But, it remains difficult for providers to evade questions about their investment decisions so long as CN reviewers, such as LABs and the State Health Planning Board (SHPB), have the power to make recommendations to the Commissioner of Health on the validity of these expenditures.

A second value in the CN process relates to its usefulness in overseeing the statewide allocation and distribution of resources. CN enables a provider to initiate, expand or renovate a service or building with information about the other service providers and a sense that the proposed service or facility is both needed and financially feasible. Once granted, Certificate of Need gives the provider "franchise power." The power provided by defining the local service providers is often an important consideration in obtaining the necessary capital for many projects. If CN disappears, it is likely that many providers will find their access to capital will be severely restricted, since providers will be more limited in their ability to project financial feasibility. This is particularly important in the current lending environment. Also, limiting CN may encourage the health care market to offer services only to those individuals who can afford to pay for them. The CN review process has ensured that providers take into account the needs of low income or insurance poor individuals by requiring that applicants address the needs of these individuals in the application and by monitoring what services are actually provided. No Certificate of Need, no protection.



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A third value of the Certificate of Need process is public participation. Recently, LAB II made recommendations to the SHPB regarding the proposed closure of Saddle Brook Hospital. Over 500 people attended the LAB meeting and much information was gathered. It should be noted that some of the important issues raised at the public meeting on Saddle Brook Hospital were raised by area legislators. If there is no CN process, opportunities for public comment will be eliminated or severely curtailed. The fact that so many people came to participate in this process is only part of the equation. The second part is the fact that the CN process requires a decision. Thus, information gathered in the process goes to an individual (in this case the Commissioner of Health) who can be held accountable for the fairness of his actions. Had there been no CN process, hospitals and other providers will make decisions on what services to provide, whom they will or will not serve, without any review. This oversight function is an important inherent element in the CN process.

There are other points, but these are just a few key reasons why it is important to have a Certificate of Need process. Others may come before you today and suggest that the health care system is over-regulated and that the CN process no longer applies in a "business environment." We can only suggest that the absence of a straight forward regulatory and review process will lead to predatory competition among the "haves," reduced protection for the "have-nots," and a very de-stabilized environment for institutions and



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providers seeking scarce capital for needed projects. Certificate of Need does not protect every institution or provider in every instance. But, it does allow a window through which to view the health care system and to take a stand when public policy dictates. Let us hope that we will not develop a system in which state government finds itself always picking up the pieces.



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# TESTIMONY OF THE DEPARTMENT OF HUMAN SERVICES CONCERNING THE CERTIFICATE OF NEED PROCESS

BY: EDWARD TETELMAN
DIRECTOR--OFFICE OF LEGAL AND REGULATORY AFFAIRS

The Department of Human Services strongly supports the Certificate of Need process (CON). We support the program for a number of reasons.

First, the CON program helps to add structure to the health care delivery system.

Second, it allows the public an important forum in which to have input concerning the growth of our health care delivery system.

Third, it helps contain and defer cost.

Fourth, it assures that low income and perceived undesirable patients, such as persons with AIDS or mental disability, have access to health care services, and it helps to guarantee quality.

Overall, the CON process provides a public mechanism to compensate for defects in our health care delivery system. New Jersey has a long supported health planning and CON. These processes have helped to hold costs in check and assure access and quality.



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I served on the former SHCC and its review committee as a consumer representative appointed by both Governors Byrne and Kean. Only once during that entire period (and that was in the mid-1970s) was outside influence used in the process, and, at that time, the SHCC took the Department of Health to court and the department corrected the situation. The process has been very public and overwhelmingly fair. It truly represents how open government with citizen input should work.

Some interests have proposed that CON be eliminated in New Jersey. Ironically, the overwhelming movement of most states is to restore and strengthen CON and with good reason.

Let me review with you what occurred in states that eliminated CON after federal government support was reduced. First, only 11 states eliminated CON. Then, simply put, unnecessary beds and services were built and established and costs increased in those states.

TEXAS: Nine new hospitals including five psychiatric facilities opened in Houston. At the time there was an average occupancy rate of 60%. Statewide, the psychiatric beds grew from 4,712 to 8,371. Many of these beds were owned by proprietary institutions. You will recall the recent scandals by these same hospitals in Texas--overbilling and false admissions to facilities there.

UTAH: Psychiatric bed capacity doubled, costs increased and resulted in severe benefit cuts by major employers.



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VIRGINIA: The number of magnetic resonance imaging facilities nearly doubled--from 38 in 1989 to 72 in 1991. These machines cost over $1 million and cost between $700-$1,000 per screen.

ARIZONA: Eleven new open heart surgery programs, mostly suburban, were created. The result was underutilization at many facilities, resulting in Medicare patients dying at twice the rate of the high volume centers. It was 60 per 1,000 at high volume facilities and 117 per 1,000 at lower volume centers.

Remember also--the cost of these surgeries is approximately $25,000 excluding tests, physician fees, and therapy.

As a result of this costly, uncontrolled growth that had no public scrutiny, states are now moving to strengthen their CON programs.

VIRGINIA has reinstated its CON law and strengthened it to cover not just institutions but services as well. This would include free-standing facilities and physician offices. David G. Brickley, a member of the Virginia House of Delegates who sponsored the new law, said: "Our premise in 1989 was that health care was based on supply and demand. If there were more MRI and CAT scanners available, the price would go down. What happened was just the opposite. More machines are available, they're not being fully used and costs are higher than ever."



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Very importantly in **WISCONSIN**, a state with a substantial portion of the population in health maintenance organizations, Governor Tommie Thompson reestablished its CON law in 1992 after costs and growth of services continued to skyrocket after deregulation in 1987. Managed care market forces did not control growth. As a result, Wisconsin has set its criteria for review of hospital construction at $1 million and purchases of individual equipment at $500,000.

Other states, including Florida and Colorado, are moving toward reestablishing their CON programs.

In GEORGIA, which never gave up its CON program, they expanded their CON program to cover medical equipment valued at more than $500,000. So they now cover physician offices and free-standing clinics. This move was spurred on by the Atlanta Health Care Alliance (AHCA) which represents employers such as Coca-Cola, Bell South, and Delta Airlines. Adele Cohen, Vice President of the AHCA, stated: "We have supported the certificate-of-need law and health-planning regulations as a way to assist in the appropriate allocation of services and capital expenditures. Duplicative, unnecessary health-care services have been very costly to our members."

Obviously, states are realizing that without some kind of public scrutiny, the health care delivery system in so-called competitive situations becomes uncontrolled and results in increased cost.



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Indeed, a major national study of hospital costs by Robinson and Luft found that costs were substantially higher in hospitals operating in more competitive local environments than in less competitive environments. After controlling for wage rates, patient case mix, state regulatory programs, and hospital teaching roles, their study found the average cost of admission to be 26% higher in hospitals in the most competitive markets than in hospitals in less competitive markets.

Let us now turn to New Jersey. Our CON process has been a successful program in a number of aspects.

First, New Jersey's CON program creates positive competition based on local needs. Indeed, by setting out needs, local hospitals and physicians and other facilities have cooperated in establishing joint services (perinatal, MRIs). They have also avoided establishing services where another facility already had such a service, especially if that service had marginal utilization (e.g., pediatric and obstetrical units). It also kept hospitals from raiding one another's service areas because the establishment of such services was subject to public scrutiny. Additionally, it allowed hospital administrators to slow staff down in acquiring services and equipment that might have marginal utilization.

It also helped to facilitate some hospital mergers and transformations where facilities were underutilized and costly (e.g., Alexian Brothers/Elizabeth General; St. Clare's/Riverside).



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Second, it helped to control cost. Essentially, it prevented the establishment of unnecessary services where quality services already existed. We have a strong, positive history of regionalizing expensive services. This is especially true in the cardiac area. Our open heart surgery programs have good utilization resulting in higher quality care. Indeed, the process stimulated the establishment of a physician panel to review quality of care in this area and resulted in the closure of some underutilized services.

Moreover, the process presented and reinforced other alternatives to surgery. (E.g., medical management through drugs.) When possible, it is safer and less costly.

Third, and very importantly, it assured access to care. Utilizing regionalization, major services were established at many urban teaching and centrally located centers. This assured that both low income and wealthier New Jerseyans have access to centers of excellence. Indeed, open heart surgery is a good example of a service that works under regionalization. Without a mixed paying base that is brought in by regionalized services, these facilities would be ghettorized and have difficulty surviving. Also, nursing homes that did not take Medicaid patients in the past competed to get them in the CON process. The Medicaid waiting list was very substantially reduced as a result of this process. The same is true for ex-psychiatric geriatric patients who had previously remained

unnecessarily in state psychiatric facilities. Under CON, facilities accepted them in order to receive an approved application.

Additionally, HIV positive and low income persons were assured access to facilities that were reluctant to serve these patients. CON conditions were used to make service available to all citizens, not just those who could pay or who were desirable.

Additionally, free-standing facilities that drain paying patients away from hospital services were required to serve the indigent which provided access but also leveled the playing field.

The Certificate of Need process also assisted this department in expanding psychiatric services. While many hospitals were willing to serve less difficult patients in open acute psychiatric units, they did not want to serve difficult patients in closed units. Using CON assured those patients of being served through the establishment of full-service closed and open units. It also helped us establish short-term care and children's crisis units in an orderly and public manner.

The existence of New Jersey's CON program also resulted in better bond ratings. Analysts state that having a CON process helps to ensure that the facility will be financially viable making our New Jersey facility bond interest rates lower. Eliminating CON will obviously have a negative effect and concomitant cost increases.

It is also important to remember that the federal government has not eliminated the requirement for states to conduct an 1122 review. Under this section, the federal government may withhold Medicare and Medicaid funds for facilities or services that are determined to be unnecessary. I understand that the federal administration is revisiting the CON process as a tool to reduce cost in the national health care reform discussion.

Also, unregulated services open the state's pocketbook through Medicaid, especially in the long-term care area. In the past, the planning of services allowed us to have reasonable growth and at the same time develop alternative services such as CCPED.

In conclusion, New Jersey's CON system has served our state well. It has assured controlled growth, promoted cooperation between facilities and even mergers to eliminate unnecessary services and costs. It has helped to hold down cost by reducing unnecessary growth and construction. CON has been a major tool in opening services to low income families and individuals, the elderly, and to so-called undesirable populations. Through CON, all New Jerseyans in need of a particular service have been able to obtain access when a new service or expansion of services to a facility has occurred.

Finally, this is a public process. Citizens can see how the health care delivery system is moving, have a say in what is needed in a local or regional area, and voice their opinion about problems with

local providers and the system. CON is one of the few arenas where publie scrutiny plays an important role.

CON has served New Jersey well and we hope you will continue and expand the process to assure a level playing field for all health care providers even as we move into a more payer-driven delivery system. We must remember that the payers' focus may be inconsistent with the concerns of New Jerseyans--particularly that all citizens have access to quality services. Our public CON process clearly helps to assure this important goal.

5/24/93



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*Atlanta Healthcare Alliance*

# STATE LEGISLATIVE ALERT

Alert No. 1
February 1991

## CON guidelines needed for privately owned equipment

The State Legislature is considering HB 508 which would require privately owned free-standing expensive diagnostic and treatment services to have prior review for need in the same manner as hospitals. Under the current system, hospitals must undergo stringent review requirements to add services such as Magnetic Resonance Imaging (MRI), lithotripsy, radiation therapy and cardiac catheterization. On the other hand, non-hospital entities can develop these services without review, place them at any location, and establish their own charge structure.

The Alliance Public Policy Committee has taken a strong position in favor of this legislation. The Committee's analysis indicates the unnecessary duplication of services adds too great a burden of additional costs to the already costly system of health care. This proposed legislation also endorses a recommendation made in the recent report of the State Access to Health Care Commission.

In summary, employers, insurers and hospitals are unified in supporting HB 508. As some physicians are currently in ownership positions with respect to free-standing health services, opposition consists of organized medicine, in addition to many entrepreneurial health service ventures.

A brief summary of the issues involved follows:

### Issues in Support of HB 508

- The laws of supply and demand, which normally drive price and quality do not work in health care - the consumer does not make the decision to select specific services.
- The ability of non-hospital entities to add service capacity without review duplicates services, resulting in under utilized capacity, with higher costs and charges.
- There is a negative impact on hospital-based services, in that utilization of hospital services is reduced, forcing hospitals to recover their capital costs through higher charges and cost shifting.
- Patients are able to self-refer to non-hospital based diagnostic and treatment services, resulting in some inappropriate, unnecessary and avoidable consumption of health care resources and benefit dollars. Studies have shown significantly higher utilization rates for some free-standing services.
- Inappropriate utilization threatens the ability of the services to achieve optimum outcome for the patient.
- Charges for privately owned free-standing services can be substantially more than similar hospital based services. In some cases, the charges have been double and triple compared with hospital charges for similar services.

### Issues in Opposition to HB 508
### (For your information)

- Entrepreneurs would not be able to develop new services, at ostensibly reasonable charges, without being pre-approved through CON review.
- The newest technologies may not be able to be available immediately if hospitals or other non-hospital similar services have already been recently approved in the service area.

**Status of HB 508**

The House passed HB 508 on Monday, February 11. The Senate Health and Human Services Committee will probably consider the bill on **Thursday, February 14 at 3:00 p.m.**

**Action Steps to Support HB 508**

*Support is needed from the employer community*

Have a representative **present testimony** at the Committee hearing.
**Inform** your company lobbyist about the importance of containing health care costs through this legislation.
**Contact** members of the Senate Committee on Health and Human Services (see list).
**Contact** other members of the Senate for the full Senate vote.

## *ACT NOW!*

Support HB 508 - Strengthen CON

Support SB 292 - Loosen Constraints on PPOs

HPMSNJ
HEALTHCARE PLANNING AND MARKETING SOCIETY OF NEW JERSEY
SEVEN HUNDRED SIXTY ALEXANDER ROAD • CN 1 • PRINCETON, N.J. 08540 (609) 275-4000

Testimony on the Evaluation of Certificate of Need

The Assembly Health and Human Services Committee

May 6, 1993

On behalf of the Healthcare Planning and Marketing Society of New Jersey (HPMSNJ) I would like to thank you for the opportunity to speak to you today. The HPMSNJ has a membership of approximately 150 professionals involved in health care planning throughout the state. As a professional organization, we are concerned about the total deregulation of the industry and support the certificate of need (C/N) process.

There is strong evidence supporting the need for C/N regulation. This includes:

I) The inability of the free market to allocate health care resources due to the absence of essential market conditions and the uniqueness of the health care market.

II) The adverse effects caused by the repeal of C/N regulations in other states.

III) The national trend of deregulated states re-implementing C/N legislation.

Unique health care market conditions affecting the rational allocation of services include:

1) Non-price competition and the ability of providers to artificially push demand.

2) Uninformed consumers and large providers and consumers who can force prices below or above costs.

3) Need to provide accessible care to all, regardless of ability to pay.

4) Need to support teaching and research.

5) Presence of third party payors.

Given the above market conditions, health care can not be appropriately allocated by the market. A C/N process is required to ensure that the proper number, location and types of services are provided. Without C/N's, the market will duplicate services, neglect the inner cities, expose existing local community providers to the predatory practices of for-profit and out of area providers and compromise quality. The above outcomes were observed when Arizona repealed its C/N regulations. In that state, according to an investigative report by the Phoenix Gazette, deregulation resulted in:

- Ten new open-heart programs.
- Low volume programs with twice the death rate of higher volume programs.
- A fifty percent increase in charges for by-pass surgery.

It has also been found that health care costs are higher in a more competitive market. One study indicated that hospital costs in two-hospital towns are thirty percent higher than in one-hospital towns. Another study in the Journal of the American Medical Association has shown costs per admission to be twenty-six percent higher in hospitals in the more competitive market. As stated by James O'Donnell of the American Health Planning Association, when Texas ceased their C/N process, Houston hospitals entered a construction frenzy. With only a 60.7 percent occupancy rate, nine new hospitals, including five psychiatric hospitals, were opened. The number of nursing home beds in Arizona increased seventy-six percent from 8,313 to 14,643 after the C/N process was eliminated. After deregulation in Utah, the number of psychiatric beds doubled.

The frustration with the free market's ability to allocate accessible quality care is evidenced by the national trend toward reinstating or strengthening C/N legislation. Wisconsin and Minnesota have reinstated a full-fledged C/N program. Virginia which abolished C/N's for higher cost medical equipment, recently expanded C/N review for new technology. Additionally, ten other states have expanded the C/N process. Colorado's Governor Roemer, in his 1992 State of the State Address called the abolishment of the C/N program, "A mistake leading to an explosion of costly and duplicative services."

We urge you to maintain a C/N process and rational system of allocating health care resources for the common good. We believe if left purely to market forces, costs will increase, the inner cities will be neglected and valuable health care resources and dollars will be wasted.

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Louis P. Scibetta, FACHE
President and
Chief Executive Officer

New Jersey Assembly Committee on Health and Human Services

Hearing on Certificate of Need

May 6, 1993

Testimony of the

**New Jersey Hospital Association**

1094.

New Jersey Assembly Committee on Health and Human Services

Hearing on Certificate of Need

May 6, 1993

Testimony of the New Jersey Hospital Association

Good morning. I am Ralph Dean, Executive Vice President of the New Jersey Hospital Association. Thank you for the opportunity to speak to you today on the Certificate of Need program.

The New Jersey Hospital Association has long been an advocate of Certificate of Need regulation for regionalized health care services. Certificate of Need is an important governmental program for controlling health care costs by regulating the proliferation of technology and expansion of health services.

Certificate of Need has worked in New Jersey. Hospitals in this state have one of the highest occupancy levels in the country -- a measure of efficiency. Specialized -- and expensive -- health care services, such as trauma centers, organ transplantation, and cardiac surgery, have been distributed in regional centers around the state as a result of the CN process. Over the years, the CN process has been modified and improved. For example, in 1991, the state legislature "levelled the playing field" -- that is, included **all** providers under Certificate of Need -- thereby making everybody play by the same set of rules. And, the 1992 Health Care Reform Act raised the CN threshold for hospitals to a more reasonable level. These kinds of changes are important refinements to the system.

Interestingly, a number of states that de-regulated certificate of need in the 1980s are now moving back to CN regulation because of the "medical arms races" caused by a free market in health care. Specifically, Minnesota and Wisconsin both brought back Certificate of Need programs in 1992.

The Certificate of Need process has served New Jersey well for over twenty years. And, while NJHA continues to support CN for the reasons just listed, we do recognize that major reforms in health care are on the horizon. In particular, NJHA expects that, over the next decade, hospitals will become part of Community Care Networks -- cooperative relationships among hospitals, physicians, and community organizations that give providers financial incentives and organizational linkages to work together to meet community needs. In Community Care Networks the delivery system is more rational and providers are given the incentives to improve primary and preventive care, not to increase hospital beds or purchase expensive technology. As this kind of delivery system reform occurs, it will be necessary to re-examine the Certificate of Need program to ensure that it is not an impediment to this new system of health care. In fact, even under a new system, Certificate of Need is likely to continue to play a role, albeit somewhat diminished.

I urge you to maintain the Certificate of Need program in New Jersey and I encourage you to look at the program as a comprehensive regulatory mechanism. It would be wrong to dismantle the CN process piece-by-piece -- de-regulating a certain service here



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and a particular service there. While meaningful health care delivery system reform takes shape in New Jersey and the nation, Certificate of Need should be maintained as it can continue to play a role in holding down health care costs.

Thank you.



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UMD
NEW JERSEY

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May 6, 1993

Assemblymen Harold L. Colburn, Jr.,
Chairman of the Assembly Health Committee
c/o David Price, Assembly Health Committee Aide
Legislative Office Building
CN 068
Trenton, New Jersey 08625

**Re: Testimony on Certificate-of-Need law**

Honorable Assemblyman Colburn:

Thank you for the opportunity to present my testimony on an issue critical to health care reform. University Hospital strongly advocates the continuation of the certificate-of-need (C/N) law in the State of New Jersey.

The concept of the C/N process evolved with the recognition to conduct regional planning. The driving forces behind regional planning were (1) cost containment; and (2) access to health care. A historical review of the impact of the C/N process will demonstrate that it effectively curtailed duplication of services, appropriately minimized capital spending, and increased access to care by ensuring that the geographic distribution of programs and services was reflective of the degree of need in the respective areas. Yet for a variety of <u>other</u> reasons, health care costs and access continue to plague the system. Should then the C/N process be eliminated when it has served as one of the few mechanisms to combat two of the most critical issues facing health care?

The C/N process is essential to ensure access of services to the entire population of New Jersey. Eliminating the C/N process will result in the most affluent hospitals doing the most, which will result in the syphoning off of paying patients from inner city hospitals thus compromising those hospitals that serve the underserved. Clearly, inner city hospitals will be adversely affected by this change.

Quality of care is another issue particularly in relation to high technology programs like



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trauma, organ transplant, neonatal, and cardiac surgery. Such services ought to remain regionalized because these are low volume services, involve critical care, and rely on a scarce pool of highly specialized staff. It is not cost-effective to have ten liver transplant services in the State of New Jersey doing 20 procedures per hospital. In addition, there is a direct relationship between volume and quality of care. In spreading the volume of cases across hospitals and diluting volume, we run the risk of compromising quality of care for the critically ill.

Finally, in circumstances where major construction is involved, the monetary risks are significant. Eliminating the C/N process is likely to result in heightened construction activity accompanied by competition for market share. There are bound to be losers! Who then will bear the social responsibility when hospitals default on their loans? The State has a responsibility towards its citizens to ensure the financial integrity of the health care system.

In light of the justification provided above, I reiterate that the C/N law in the State of New Jersey remain unchanged and intact.

Thank you again for the opportunity to present testimony on this issue.

Sincerely,

Marc H. Lory
Vice-President and CEO

Tstmny.cn

A New Jersey Non-Profit Corporation

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# TESTIMONY BEFORE THE ASSEMBLY HEALTH AND HUMAN SERVICES COMMITTEE REGARDING THE CERTIFICATE OF NEED PROCESS

PRESENTED BY THOMAS E. TERRILL, Ph.D.

EXECUTIVE VICE PRESIDENT

UNIVERSITY HEALTH SYSTEM OF NEW JERSEY

MAY 6, 1993

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**TESTIMONY BEFORE THE ASSEMBLY HEALTH AND HUMAN SERVICES COMMITTEE REGARDING THE CERTIFICATE OF NEED PROCESS**

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**&**
**EXECUTIVE VICE PRESIDENT**
**UNIVERSITY HEALTH SYSTEM OF NEW JERSEY**

**MAY 6, 1993**

GOOD MORNING, I'M TOM TERRILL, EXECUTIVE VICE PRESIDENT OF THE UNIVERSITY HEALTH SYSTEM OF NEW JERSEY. ON BEHALF OF OUR ORGANIZATION, WHICH REPRESENTS THE UNIVERSITY OF MEDICINE & DENTISTRY OF NEW JERSEY AND EIGHT OF THE STATE'S MAJOR TEACHING HOSPITALS, I WANT TO EXPRESS OUR SUPPORT OF THE CERTIFICATE OF NEED PROCESS.

FOR THE PAST TWO DECADES, THE STATE HAS INVESTED SIGNIFICANT RESOURCES IN THE UNIVERSITY OF MEDICINE & DENTISTRY, NEW JERSEY'S UNIVERSITY OF THE HEALTH SCIENCES. WITH THESE RESOURCES, UMDNJ HAS DEVELOPED THREE MEDICAL SCHOOLS, A DENTAL SCHOOL, A SCHOOL OF HEALTH RELATED PROFESSIONS, A GRADUATE SCHOOL OF BIOMEDICAL SCIENCES, TWO COMMUNITY MENTAL HEALTH CENTERS, AND A STATEWIDE NETWORK OF TEACHING HOSPITALS.

SOME OF THE LEADING HEALTH CARE AUTHORITIES IN THE NATION, AND THE WORLD, TRAIN TOMORROW'S HEALTH CARE PROFESSIONALS AND TREAT TODAY'S PATIENTS AT THESE HOSPITALS. IN ADDITION, THESE INDIVIDUALS ALSO CONDUCT STATE-OF-THE-ART RESEARCH PROJECTS AT THESE INSTITUTIONS.

BECAUSE OF THESE RESOURCES, THE UNIVERSITY HEALTH SYSTEM OF NEW JERSEY RECOMMENDS THAT CERTIFICATES OF NEED FOR NEW TECHNOLOGY BE EVALUATED BY THE UNIVERSITY OF MEDICINE & DENTISTRY OF NEW JERSEY AND ITS TEACHING AFFILIATES. WE BELIEVE THAT NEW TECHNOLOGY MUST MEET TWO CRITICAL FACTORS: IT MUST DEMONSTRATE CLINICAL EFFICACY AND IT MUST BE COST-EFFECTIVE. UMDNJ, ITS FACULTIES AND AFFILIATED INSTITUTIONS ARE CAPABLE OF MEASURING BOTH FACTORS.

OUR GOAL IS NOT TO RESTRICT ACCESS TO NEW TECHNOLOGY, BUT TO GUARANTEE THAT IT IS HIGH-QUALITY AND COST-EFFECTIVE. AFTER THE NEW TECHNOLOGY HAS BEEN EVALUATED, WE SUGGEST THAT IT BE MADE AVAILABLE TO OTHER PROVIDERS IN THE STATE. THE CRITERIA FOR DISTRIBUTION OF NEW TECHNOLOGY SHOULD BE DETERMINED BY A CORE CLINICAL ADVISORY GROUP, AS PROPOSED IN THE STATE HEALTH PLAN.

I WOULD ALSO LIKE TO RECOMMEND THAT THE OBJECTIVES OF THE STATE HEALTH PLAN--TO CONTROL COSTS, ENSURE ACCESS AND MAINTAIN AND IMPROVE QUALITY--BE BROADENED TO INCLUDE THE DEVELOPMENT OF A COMPLETE RANGE OF SERVICES WITHIN THE STATE. IN THE PAST, ONE CHARACTERISTIC OF NEW JERSEY HAS BEEN THE WILLINGNESS TO ENDURE AN INFERIORITY COMPLEX ABOUT OUR HEALTH CARE SYSTEM--TO BELIEVE THAT BETTER HEALTH CARE IS AVAILABLE

ACROSS THE RIVER.

I ARGUE THAT BETTER CARE DOES NOT EXIST ACROSS THE RIVER, BUT MORE SERVICES DO. WE NEED TO EXPAND THE SCOPE OF HEALTH CARE SERVICES OFFERED IN NEW JERSEY, ESPECIALLY IN THE AREA OF TRANSPLANTATION. THE INSURED AND SOPHISTICATED HEALTH CARE CONSUMER CAN EASILY TRAVEL TO OUT-OF-STATE FACILITIES FOR THE SERVICES, BUT WHAT ABOUT THE POOR AND UNINSURED? OFTEN, THEY CANNOT TAKE ADVANTAGE OF SUCH OPTIONS AND, AS A RESULT, MAY BE DENIED STATE-OF-THE-ART HEALTH CARE SERVICES.

THROUGH THE CREATION OF REGIONALIZED NETWORKS OF SERVICES UNDER THE GUIDANCE OF A STATEWIDE CERTIFICATE OF NEED PROCESS, WE CAN GUARANTEE THAT ALL NEW JERSEYANS WILL HAVE ACCESS TO THE BROAD RANGE OF HIGH-QUALITY, COST-EFFECTIVE SERVICES THAT THEY DESERVE.

FINALLY, THE CERTIFICATE OF NEED PROCESS SHOULD PROVIDE INCENTIVES FOR COOPERATION AMONG HEALTH CARE INSTITUTIONS AND PROVIDERS AS OPPOSED TO COMPETITION. COMPETITION HAS ONLY SERVED TO CREATE UNNECESSARY DUPLICATION, AND TO INCREASE COSTS WITH NO RESULTANT IMPROVEMENT IN HEALTH STATUS.

THE STATE HEALTH PLANNING BOARD, IN EVALUATING ITS CRITERIA FOR CERTIFICATE OF NEED, SHOULD TAKE INTO ACCOUNT SEVERAL QUESTIONS:

- DOES THE CERTIFICATE OF NEED APPLICATION CONSIDER THE COORDINATION OF THE CONTINUUM OF HEALTH CARE SERVICES FROM PREVENTION THROUGH PRIMARY CARE, ACUTE CARE, REHABILITATION AND LONG-TERM CARE?
- DOES IT ENCOURAGE THE DEVELOPMENT OF NETWORKS ALONG THIS

CONTINUUM WHERE INSTITUTIONS WILL BE GIVEN INCENTIVES TO COOPERATE RATHER THAN COMPETE?

- DOES THE CERTIFICATE OF NEED PROCESS CONSIDER THE IMPACT ON THE EDUCATION OF HEALTH PROFESSIONALS AND THE DEVELOPMENT OF APPROPRIATE RELATIONSHIPS IN HEALTH PERSONNEL PLANNING?
- AND LAST, DOES THE PROCESS ALLOW FOR APPROPRIATE CAPITALIZATION OF THE PROJECTS ENVISIONED?

ONLY WITH A COORDINATED CERTIFICATE OF NEED PROCESS CAN NEW JERSEY CONTINUE TO MEET THE HEALTH CARE NEEDS OF ITS CITIZENS. THANK YOU FOR THE OPPORTUNITY TO ADDRESS YOU TODAY.

My name is Fred Title and I am representing HIP/Rutgers Health Plan headquartered in Somerset, New Jersey, where I serve as General Counsel. HIP/Rutgers is a not-for-profit, federally qualified and state certified health maintenance organization with approximately 180,000 members in New Jersey. Approximately 3,000 employers offer our Plan as a health care option for their employees. In addition to employed groups, our goal is to serve all segments of our service area, including Medicare eligibles, Medicaid recipients and individuals by providing quality health services at a reasonable cost.

In December of 1992, you and your colleagues in the Legislature redefined the Certificate of Need process as part of the adoption of Chapter 160... which took effect this past January 1. The result was a liberalization of some areas of Certificate of Need oversight and a tightening of others. In the Health Care Reform Act, you also took other steps in improving the healthcare delivery and financing system in New Jersey.

HIP/Rutgers Health Plan believes that it is too early to eliminate the revised CON process. Elimination of the revised CON process so soon after it was streamlined will not contribute to the rational health planning process in New Jersey. It's important to evaluate the revised CON process and make adjustments where they are required. Do not shake the revised healthcare infrastructure until the foundation has had a chance to settle. In conclusion, we support continuation of the revised CON requirements with a look at strengthening what works and changing what does not.

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