



## *House of Representatives Rural Development Council*

### **2018 Highlights - Meeting Three**

**Co-chairman Terry England  
Representative, 116<sup>th</sup> District**

**Co-chairman Jay Powell  
Representative, 171<sup>st</sup> District**

Vice-chairman Sam Watson  
Representative, 172<sup>nd</sup> District

The Honorable Patty Bentley  
Representative, 139<sup>th</sup> District

The Honorable John Corbett  
Representative, 174<sup>th</sup> District

The Honorable Matt Hatchett  
Representative, 150<sup>th</sup> District

The Honorable Mack Jackson  
Representative, 128<sup>th</sup> District

The Honorable Dominic LaRiccia  
Representative, 169<sup>th</sup> District

The Honorable Eddie Lumsden  
Representative, 12<sup>th</sup> District

The Honorable Chad Nimmer  
Representative, 178<sup>th</sup> District

The Honorable Clay Pirkle  
Representative, 155<sup>th</sup> District

The Honorable Terry Rogers  
Representative, 10<sup>th</sup> District

The Honorable Ed Rynders  
Representative, 152<sup>nd</sup> District

The Honorable Darlene Taylor  
Representative, 173<sup>rd</sup> District

The Honorable Bill Werkheiser  
Representative, 157<sup>th</sup> District

**Ex-officio Members:**

The Honorable Brooks Coleman  
Representative, 97<sup>th</sup> District

The Honorable Sharon Cooper  
Representative, 43<sup>rd</sup> District

The Honorable Robert Dickey  
Representative, 140<sup>th</sup> District

The Honorable Penny Houston  
Representative, 170<sup>th</sup> District

The Honorable Rick Jasperse  
Representative, 11<sup>th</sup> District

The Honorable Tom McCall  
Representative, 33<sup>rd</sup> District

The Honorable Butch Parrish  
Representative, 158<sup>th</sup> District

The Honorable Don Parsons  
Representative, 44<sup>th</sup> District

The Honorable Jason Shaw  
Representative, 176<sup>th</sup> District

The Honorable Ron Stephens  
Representative, 164<sup>th</sup> District

The Honorable Kevin Tanner  
Representative, 9<sup>th</sup> District

**2018**

Prepared by the House Budget & Research Office

## Meeting Three Highlights – Statesboro

### *September 18, 2018 – Healthcare Access and Certificate of Need*

Chairman Jay Powell framed the third meeting of the House Rural Development Council (RDC) by noting that members are looking for a fresh perspective on some existing health care issues, specifically Certificate of Need.

Members of the community extended greetings to the members and shared some of their area perspective. Shelley Nickel, President of Georgia Southern University welcomed the council to the Eagle Nation, which is a newly consolidated institution that extends into the Savannah market with the former Armstrong and Liberty-Hinesville campuses and a footprint that reaches the Interstate 95 corridor from South Carolina and to Florida. Georgia Southern is now the fifth largest university in the state with 27,000 students, and like the council, has a mission to build the economy of southeast Georgia. Jonathan McCollar, Mayor of Statesboro, told the council to enjoy the community. As the city's representative, he believes their task is all about the economy. He encouraged everyone to come together to put people to work and create a great quality of life where Georgia is the number one state to live, play and work. Bulloch County Commission Chairman Roy Thompson also welcomed the RDC to rural Bulloch County and thanked them for their involvement.

Benjy Thompson, CEO Bulloch County Development Authority, offered that local leadership affects the success of the community. He thanked the local leaders and delegation, as well as the RDC members, because each of them plays a role in that success. Rural communities can be successful, and he shared some of the work being done in Statesboro with everyone working together as a team for local development. This is evidenced by the 50 citizens who got together in 1906 to start an Agricultural & Mechanical school in Statesboro that began the ongoing prosperity of this university town. Local entities have worked to leverage and enhance the school's growth with community efforts, such as "The Blue Mile" project to do a Main Street corridor facelift; the one mile stretch is now the site for numerous business start-ups, in-town residences, and beautification efforts. It was the centerpiece of Statesboro's submission in the America's Best Community contest, and won 3<sup>rd</sup> Place with a \$1 million prize for funding for future development. It is clear the role of private citizens can lead the charge and be champions for rural Georgia, and this type of participation can work in any rural community.

The community has joined with higher education partners, the local development authority, local governments, local manufacturers, local school board and the state to work together to provide programs, infrastructure, and space for projects that include professional soccer and recreation parks, an industrial maintenance lab, a retail center, and the Southern Gateway Industrial Park as regional hub with 2,000 plus employees. The passage of Tax Allocation Districts (TAD), Special Purpose Local Option Sales Tax (SPLOST) and Transportation Special Purpose Local Option Sales Tax (TSPLOST) show community support and leadership for funding economic development.

Challenges, which can be seen as opportunities, include: 1. *Broadband access*, which in a university setting provides a good market and more comprehensive coverage, can benefit by using the telephone cooperative as a progressive business model to bring service to users; 2. *Workforce*, the most critical

issue and the most difficult to address, has success through partnerships between education and industry that market opportunities and expose students beginning in the 8<sup>th</sup> grade to successful pathways to train, work and live in a rural setting; 3. *Infrastructure* for a regional hub can be stressed by non-contributing users of road and healthcare services, and leaders have helped to offset the need through various local option sales taxes; and 4. *Difficult demographics*, as with other rural areas that have high poverty rates, continue to be endemic to the community, and it is all of these combined efforts that can make rural Georgia successful in spite of these challenges.

Bryan Ginn, Chief Campus Officer of the Philadelphia College of Osteopathic Medicine (PCOM), began the day's discussion on health care, specifically medical education. PCOM is a private, non-profit medical institution established in 1899 with a mission to educate future practitioners. During the national call for more medical graduates, PCOM answered and established a presence in Suwanee, Georgia with an initial class of 80 students who went on to graduate in 2009 and joined the market in 2012. Today, the school is expanding into the Colquitt County region with a \$25 to \$30 million capital and faculty investment to bring medical providers to the area and build a healthier South Georgia. Despite the long-term investment, the school already boasts 801 alumni living in 84 counties, 625 matriculating native Georgian students from 79 different counties for an overall 107 county impact. The location of a campus has a huge impact on the health and economy of the region. Half of the current alumni have remained near the campus in Gwinnett, which bodes well for the southwestern quadrant of the state as the South Georgia PCOM campus grows, especially for primary care. Last year's PCOM osteopathic physician graduates, who can choose to practice any type of medicine, elected to go into core primary care specialty programs at a rate of 77.9%. In addition, the college's programming also includes degrees for pharmacy, physical therapy, biomedical sciences and physician assistant. Within four years, PCOM will be second largest medical school in the state.

Dr. Michael Sampson, Associate Dean of the new South Georgia PCOM campus, described their four-part mission: produce graduates who want to practice there; work with the five existing medical facilities to train in the area; develop pipeline programs in local communities; and ultimately expand the local economies with jobs, human capital and development. There are six goals for attaining this mission, beginning with the establishment of a state of the art facility with the latest in training technology and a curriculum designed to grow. Goal 2 is to partner with the state and philanthropic entities to invest in health professions through rural scholarships to reduce loan burden and encourage rural practice in primary care. Goal 3 is to bolster economic impact through new construction using Georgia companies and create high-paying jobs that foster spending in the region. For every physician locating in a community, there is a \$1.6 million economic impact associated with five additional, related jobs and \$1.4 million in health care savings.<sup>1</sup> Ben Robinson, Chief Program Development Officer, noted that Goals 4, 5 and 6 is partnering with education entities to create pipelines that attract students and provide them with opportunities. Data supports that 80% of students who go to medical school and do a residency in the state stay in the state. By locating in an underserved area, the goal is to build the workforce by integrating our own Georgia students. The clinical part of the pipeline in years three and four requires a residency in a medical practice, and because this is the strongest predictor of where a

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<sup>1</sup> Note: Quote attributed to Bert Brantley, Chief Operating Officer, Georgia Department of Economic Development.

graduate will establish a practice (85%), PCOM is partnering with hospital programs in the southern region to make the biggest impact and open more programs. Finally, mental health programming may be a viable future expansion into South Georgia from the Philadelphia base.

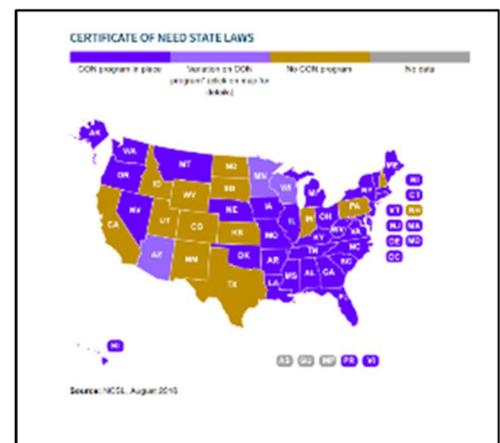
Mr. Jim Matney, CEO of the Colquitt Regional Medical Center, echoed the need for a program opportunity south of Macon to address the shortage of physicians and improve health care access. With a \$300,000 seed grant from the state, their facility started this medical school partnership to ensure that medical appointments are more timely and nearby. Jessica Rivenbark, Executive Director of the South Georgia Medical Education and Research Consortium, added that this five hospital collaborative is the best of regionalism as evidenced by the partnership and investments by these otherwise competing CEOs. It also engenders hope in the area because it is accessible, as well as a means for impacting poverty across the counties with pipeline education.

Mr. Ginn shared the group's recommendations:

- Build on the university system's GREAT Commission's efforts and focus on rural graduate medical education;
- Provide/partner undergraduate medical education and health profession scholarships;
- Incentivize expansion of clinical sites for education;
- Expand broadband investments and innovations for health care delivery and education;
- Leverage the tax Code
  - Expand the Preceptor Tax Incentive recognizing that there is a cost to the providers who participate, shift from a deduction to a credit.
  - Expand the Rural Hospital Tax credit
- Utilize the Center for Rural Prosperity to the expertise and resources of all providers.

Chairman Sharon Cooper noted that there has been a federal moratorium on residencies since the 1990s and that roughly 1,500 U.S. medical graduates could not find a residency slot, and when foreign students compete for slots, that number is even higher. Most graduates need at least one year in a residency before they can practice, but because the start-up costs are significant, there is reluctance to invest in creating new programs. Rep. Darlene Taylor noted the regionalism and partnerships needed to get the South Georgia campus started, and it was shared that the first class is anticipated to begin in August 2019 and there are already over 3,000 applicants for 55 slots.

The Executive Director of the Office of Health Planning in the Department of Community Health, Rachel L. King, was asked to give the council an education on the intent and current processes of Certificate of Need (CON) in Georgia. The 12-person office is charged with doing the CON reviews. The rationale for CON in a state health plan is to establish healthcare services which promote access, ensure quality, and contain costs. It began in 1946 with the 'Hill-Burton Act', and New York was the first state to pass CON into law. Since that time, the law was reconstituted and ultimately repealed by the federal government in 1987, after



which 12 states also repealed their laws. Thirty-eight states could be considered to have no CON law, but it is noteworthy that Louisiana never instituted it, Indiana reenacted it in 2018, and there are three states that regulate similar versions of CON. Arizona, Minnesota, and Wisconsin regulate specific services in addition to their licensure requirements, institute public notice and comment requirements, and require permission to operate from an authority of the state. The American Health Planning Association produces a chart that shows all of the states with CON and the services they provide.<sup>2</sup>

There are arguments for and against CON. The arguments against it, which are typically financial, include:

- Limits on competition that keep prices high;
- Payment systems (i.e., Diagnostic Related Groups) already sensitize to the market and make additional regulation unnecessary;
- Economics rather than politics should drive facility development;
- Lack of competition causes additional spending and construction;
- Potential undue political or institutional influence on awards;
- Defining the best interests of a community can be problematic; and
- There is no consistency across the state for administering CON.

Arguments for Certificate of Need tend to focus on health care delivery and the patient outcomes, and include:

- Health care is not a typical economic product;
- Services are ordered and therefore the patient does not have the consumer advantage of “shopping”;
- CON is a form of distributing care to areas that might be overlooked;
- The process allows for evaluation, public and stakeholder input; and
- Help ensure professional quality by not diluting the market with incompetent providers.

CON is a requirement based on the level of care being offered and provisions of Medicaid. It is the first step in determining if a service needs review or can be channeled straight to licensure. Georgia began reviewing projects in 1975 and promulgated its CON program in 1979. In 2008, the General Assembly passed SB 433, which was the state’s first revision of the statute. That bill identified general surgeons as a specialty that could open an ambulatory surgery center (ASC) through a letter of non-reviewability (LNR), waived CON for hospitals’ physical plant upgrades, and allowed the specialty hospital, Cancer Treatment Centers of America, to establish a presence in the state. Overall, Georgia regulates 14 services. Among states exercising CON, the highest number of services regulated is 30 and the lowest is four. There are 27 exemptions from statutory review,<sup>3</sup> such as self-pay personal care homes, continuing care retirement facilities, traumatic brain injury treatment facilities, some diagnostic/therapeutic equipment and certain ambulatory surgery centers. Moreover, the rules governing the process also recognize that there may be exceptions that extend beyond the numeric need calculated for evaluating an

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<sup>2</sup> [http://www.ahpanet.org/matrix\\_copn.html](http://www.ahpanet.org/matrix_copn.html)

<sup>3</sup> O.C.G.A. §31-6-47

application when the requestor can demonstrate that a service is not available to a certain population in an area and how providing it will remedy the problem. In addition, Georgia does not regulate some entities that other states do, including burn units, hospice, emergency department need, assisted living and renal dialysis. Finally, there expenditure thresholds for capital ranging from \$3 million to \$5.5 million, and an equipment cap at \$1.8 million before being subject to CON.



Reviews for CON typically use 12 service delivery regions, although for some services the map is adjusted with considerations for the number of available and proficient providers balanced to the needs of the population and utilization. Open heart surgery, for example, uses the entire state as a service delivery region. The regions are used to execute the State Health Plan and are developed by technical advisory committees (TACs) consisting of health providers, financiers and citizens who utilize or have a familiarity with the specific services. No TACs have been convened since at least 2008. Challenges to CON may cross these regional service lines, and violations of licensure requirements that result in a revocation of a license automatically revoke an entity's

Certificate of Need. The review process is regulatory and is not designed nor statutorily authorized to: a) ensure quality, which is a function of licensure; or b) negotiate or solicit to fill a gap in services. To that end, CON has to be requested by a provider and when awarded is attached to a facility. When a facility closes, there may be a gap in services, but if that facility is repurchased and operating within 12 months, the authorization for the CON remains valid and may transfer to the new owner. If the facility is inoperative for 12 months or more, the certificate lapses and is subject to a new review; this is the only way a CON expires. CON is specific to an entity, a location, and an expenditure and is not transferable from one facility to another, although there is a provision for moving within a three mile radius in urban areas or within the county in rural areas.

On the average, the department issues 72 CON requests annually, as well as 72 Letters of Non-reviewability, which are confirmations of criteria met (not subject to CON) primarily for equipment (46) and ambulatory surgery centers. Letters of Determination, the official confirmation that an entity is not subject to CON, exceed 200 a year.

The department has the legal authority to investigate, cease and desist, and repeal a CON, although it is rare. Fines for facilities operating outside of the parameters do occur, and can be \$100,000 per day after a certain point, although most facilities operate within the requirements and the department may negotiate a fine to incentivize performance and compliance. Non-compliance is generally an oversight issue. CON is the confirmation for the establishment of a necessary service, and while there is post-approval monitoring to ensure compliance, it is not reviewed for future need or modification.

Reviews are significantly data-based using information downloaded annually from 10 different surveys completed by 1,300 facilities through an online portal. Reviewers use the information to evaluate

Certificate of Need, and for the last three years, DCH has made significant efforts to ensure the accuracy of the data, especially since it is self-reported by the facilities.

CON also provides the mechanism for enforcing indigent and charity care compliance. Facilities are required by statute to provide 3% of their adjusted gross revenue, which is determined by the gross revenue minus Medicaid, Medicare, and some other third-party contracts. Psychiatric, state-run and critical access hospitals are exempt. The 'Provider Payment Act' requires 1.45% of a hospital's adjusted gross revenue to be paid into the state, and the department counts this contribution toward the indigent requirements as authorized by statute and board rule. Additional factors, such as county subsidies, participation in the hospital tax credit, and property ad valorem exemptions are values that are not considered as a part of the equation. Facilities are sent a letter of deficiency for failure to comply with the required indigent care, and the difference in the requirement and what was actually administered is "fined" and paid into the Indigent Care Trust Fund, an account separate from the state general fund. Most hospitals fulfill this provision of care, but ASCs and home health frequently pay to make the target.

The applications for CON are received every day, but the office completes most of them in batching cycles for certain services twice a year, which when evaluated in tandem gives the consumers the benefit of provider competition. September and March, for example, are open for ambulatory surgery centers, skilled nursing, home health, and free-standing birthing centers. The process begins with a facility submitting a letter of intent outlining the specific service, cost, and where the facility will be located. Thirty days later the application is due, and within 60 days, the reviewer assigned to the project will provide a status update. If there is opposition to the application, a meeting where the opposing party states their case will occur within 15 days, after which the applicant may provide a response. The reviewer takes all of the information and drafts a decision and a determination is made within 120 days. If the department has not taken action, it is automatically approved. Extensions to this timeline are extremely rare, and never for more than 150 days.

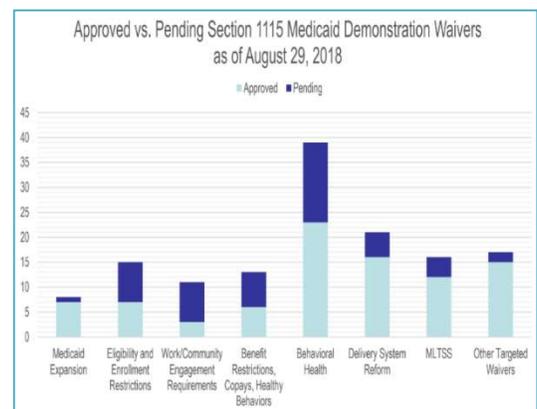
The process can last longer if a decision is appealed to the Certificate of Need Appeal Panel, an independent, statutory body appointed by the governor, to perform an administrative review and make a decision. If further action is needed, the commissioner of the Department of Community Health can be asked to re-review. Even that decision can then be taken to superior court, the Court of Appeals and ultimately the Supreme Court. There are fines for the "losers" in a dispute that continue to appeal as an obstruction alternative.

Also from DCH, Blake Fulenwider, Deputy Commissioner and Chief of Medical Assistance Plans, provided the council with a foundation of understanding about 1115 and 1332 waivers and the state's relationship with the federal Centers for Medicaid & Medicare Services (CMS). The state contract with CMS is called the Medicaid State Plan (the "Plan"), which is thousands of pages governing the financial and administrative agreement for delivering public health benefits in Georgia. The Plan evolves over time through routine changes, submitted as *State Plan Amendments* (SPAs), which are not typically time-limited and remain in place. A *waiver* to the Plan is not routine and is typically limited to five years, after which it must be extended or renewed. Waivers are established under the Title XIX of the 'Social Security Act,' which allows 1115 waivers to federal requirements for Medicaid and other social

services. The purpose of waivers is to try a substantial experimental, demonstration, or pilot project that deviates from the 50+ year-old design of the program for innovations. The most recent of these include PeachCare for Kids, health management organizations (HMOs), managed care, and in some states a program’s design or population benefits under the provisions of the ‘Patient Protection and Affordable Care Act’ (ACA). While it is often recognized that Medicaid is not a robust payer, it does cover an extremely large breadth of services that exceeds what is available in the average commercial market. The 1115 and 1137 waivers also allow a state to make emergency changes to the program, most commonly in the event of a natural disaster.

Per federal guidelines, an 1115 waiver should: improve access to care; be sustainable; coordinate across different needs, some of which may be social determinants that mitigate the future need for Medicaid services, such as Meals on Wheels; engage personal responsibility and community engagement options; align to similar benefits available in the commercial market; and innovate delivery and payment systems to support providers and increase value through methods like value-based purchasing.

There is a wide spectrum of 1115 waivers beyond ACA expansions, particularly in behavior health where opioids, for example are of national concern. Work requirements, cost-sharing, health behaviors, and tailored benefit packages are also trending. Currently, 44 waivers have been approved across 36 states with another 24 pending from 23 states.



Arizona was the first to expand Medicaid with a waiver in 2015 and instituted the work/community engagement requirement, which requires adults up to age 55 to complete 20 hours a week to remain enrolled. “Work” can be defined by the waiver in many ways: performing or seeking a job, training, or volunteering. Currently, three states have applied and eight are pending approval for this obligation, which opened on the federal level in 2017; however, Rep. Jan Jones noted that the Kentucky courts struck the provision in their state, which may now set a precedent that can only be rectified by Congressional action.

The 1332 waiver is an authorization through the ACA that is not actually a Medicaid, programmatic waiver, but rather an exception to the Internal Revenue Service Code to allow a state program to provide a plan that is at least as comprehensive, affordable, covers the same amount of people, and may not increase the federal deficit. These waivers apply to private sector plans (Marketplace and Exchange products) to capture the advance premium tax credits and cost-sharing reduction payments for the state to use on another program, such as high-risk pools or reinsurance mechanism. Georgia has a high-risk pool in statute, but it has never been enacted.<sup>4</sup> Thirty-five states have filed legislation related to certain provisions of the 1332 and eight have been approved, and 10 have statutorily authorized a program, which is a requirement for consideration within the federal Code.

<sup>4</sup> O.C.G.A. §33-24-21

These waivers redesign state programs to try and promote better care. Premium assistance is a tactic whereby a state uses the credits as subsidies within the Exchange as the benefit. Requiring nominal premiums or co-pays to inspire thoughtful utilization habits on the front end and rewarding good habits by providing wellness benefits are additional approaches. CMS has broadly approved 1115 waivers to non-emergency medical transportation and family planning. Finally, many states are requesting a waiver from the three-month retroactive eligibility that applies to new enrollees.

The waiver submission and approval process is intense. House Bill 990 (2014 Session) requires the legislature to approve any income threshold changes, as well as the submission of an 1115 waiver.<sup>5</sup> Following that approval, the DCH Board approves a waiver submission to CMS, which opens a public notice period that includes documented statewide meetings with DCH responses later sent to CMS for approval to continue proceedings and formally submit the waiver. Due to the complexity of these waivers, it can take months to review the proposal, and CMS may request additional information; an expedited response to CMS questions is critical to keeping the process moving. If the negotiation period is successful, the waiver moves to the implementation, operation, oversight and reporting stages. Significant reporting is required quarterly and annually on the performance of the waiver on operating and quality of care. If the state sees a need to amend a waiver, the process begins again. Within a year of reaching the end of the waiver, the department must indicate to CMS if the state wants to extend it (currently allowed for three years) or provide a transition plan to terminate it.

Georgia currently has one 1115 waiver for *Georgia Planning for Healthy Babies*, up for renewal before March 30, 2019, that provides a family planning and limited services package for women ages 18 to 44, at or below 200% of the Federal Poverty Level (FPL),<sup>6</sup> who have previously delivered a low-birth weight baby. This waiver currently serves about 2,500 to 3,000 women who are uninsured and not otherwise Medicaid eligible. In addition, the state has four 1915(c) waivers that are associated with skilled-nursing for long-term, home and community-based care services within Aged, Blind and Disabled (ABD) Medicaid; these are the: Community Care Services Program (CCSP); Service Options Using Resources in a Community Environment Program (SOURCE); New Options Waiver (NOW); Comprehensive Supports Waiver Program (COMP); and Independent Care Waiver Program (ICWP).

Dr. Mary Cahill-Roberts, owner and practitioner of Nuestrros Ninos Our Kids Practice, and Dr. M. Ann Kennedy, a nurse practitioner at the Veterans Affairs Administration, addressed the council regarding nurse practitioners as primary care providers and policy considerations with outcomes that could be implemented. It is known that there are 70+ counties, nearly half of the state, without access to care that result in poor infant and maternal mortality rates and outcomes overall. Georgia also has a significant veteran population of 660,000 with only three Veteran's Administration hospital across the large area of the state. In 2016, according to the [www.fightchronicdisease.org](http://www.fightchronicdisease.org) website, 60% of Georgians had one chronic illness and 42% had two or more. People with chronic conditions cost 14% more than those who do not, so chronic conditions are driving up costs. Barriers to seeking care are deductible and co-pays, and lost income from time away from work. By expanding the number of people who are able to provide routine care for these citizens, there will be savings in medical expenses and job earnings to the

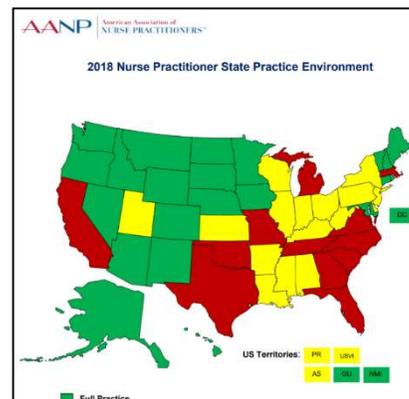
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<sup>5</sup> O.C.G.A. §49-4-142.1 and §49-4-142.2

<sup>6</sup> \$24,280 for an individual. [www.healthcare.gov/glossary/federal-poverty-level-fpl/](http://www.healthcare.gov/glossary/federal-poverty-level-fpl/), accessed November 15, 2018.

economy. In Dr. Cahill-Roberts' clinic, a group of nurse practitioners provide preventive and primary care for babies and children, but they are limited in how much they can do within the confines of existing state law despite the fact that this care results in significant cost-avoidance through education and averting costly emergency room visits. For her practice, a typical reimbursement from Medicaid is \$100 versus the same claim in the emergency department that bills \$715; when multiplied by the over 11,000 sick visits the clinic handled last year, that is an impactful cost aversion of over \$7 million. Drs. Cahill-Roberts and Kennedy offered four strategies to increase access.

- 1) Change the 'Nurse Practice Act' to give full authority for APRNs and remove the legal and regulatory barriers that prevent APRNs from practicing to the highest level of their training. A map presented during the presentation showed each states' authority level for nurse practitioners: green for full, yellow for reduced, and red for restricted.<sup>7</sup> Referrals, prescriptions and electronic medical records are more costly and lengthy because it requires a physician's collaboration, who may not even see the patient. The requirement to practice within 50 miles of a physician restricts access in some rural areas, despite the ability to provide quality care. The VA allows full scope of practice to ensure timely access to services.



- 2) Establish Nurse Practitioner Residency and Fellowship programs. The Atlanta Veteran's Administration Medical Center residency program with Emory University is a model to create supervised, experiential learning.
- 3) Strategically place clinics in the state with nurse practitioners, mental health nurse practitioners, midwives, health coaches, and connect them through an electronic medical record system.
- 4) Open the State Health Benefit Plan to small business to close the gap through access to affordable care. This could be done through a sliding scale. Not only could this help to stem the uninsured rate, but it would be an attractive benefit for businesses looking to relocate to the state.

In summary, they stated that health care is ethically and morally right, and there can be cost savings through the establishment of clinics with practitioners who exercise chronic disease controls and preventive care. With all Georgians taking ownership to close the healthcare gap, the state will become an attractive economic location for industries in the state.

The ensuing discussion registered a concern that the amount of training currently required of an APRN does not equip an APRN to practice to the level of a physician, and previous efforts to draw nurse practitioners to rural areas through programming were met with little interest; however, the state does have 200 or so federally-qualified health care centers that provide services in rural areas to patients on a sliding scale and have physicians and APRNs. Finally, it was commented that in an age of electronic information, the requirement for an APRN to practice within 50-miles of a physician does not guarantee better care or oversight.

<sup>7</sup> Map: "State Practice Environment." AANP - Membership, [www.aanp.org/advocacy/state/state-practice-environment](http://www.aanp.org/advocacy/state/state-practice-environment).

## *September 19, 2018 – Healthcare Access and Certificate of Need*

Patsy Whaley, Executive Director of the State Office of Rural Health, gave members an update on the new Rural Health System Innovation Center, a recommendation of the 2017 RDC that passed in the 2018 Session as a part of House Bill 769 sponsored by Rep. Rick Jasperse. Following the procurement policies of the state, DCH is establishing the criteria to be included in the Request for Proposal to be posted in October.

The office is also the administrator for the Rural Hospital Stabilization program. As of July 1, 2018, the 18 hospitals already engaged in the program were joined by four more for Phase 4: Burke, Clinch, Elbert and Evans. The program has addressed the reduction of non-emergent admissions to the emergency department, readmission rates, behavioral health, increased access to primary care, telemedicine, care coordination and other service lines that have improved local health care and the local economy.

The Rural Hospital Tax Credit program qualified and benefitted 58 hospitals, which can utilize the funds to replace outdated equipment, address long-term debt, renovate facilities, and recruit qualified staff. Chairman Terry England asked for a status report on the expenditures after they are submitted in January if there is a need to further clarify intent for permissible expenses and ongoing need. Ms. Whaley shared that last year's contribution amounts ranged from a low of \$5,000 to a high of \$850,000. Contributors can select the hospital of their choice to receive the donation; however it is not clear how funds are distributed if they are not designated nor if a hospital has reached its capped amount. This lack of transparency and allowing a third-party to dictate award amounts has never been the intent of the program and will require additional legislative or Department of Revenue regulation.

Jesse Weathington from Total Spectrum/Steve Gordon Associates began the day's conversation regarding Certificate of Need. Mr. Weathington told the RDC that he has interacted with CON as a policy analyst, regulator, budget analyst and advocate over the course of his career, and his presentation is based on his opinion and not on behalf of any client. He quoted Alex Azar, the U.S. Health and Human Services Secretary, who said that said Certificate of Need regulations can be a barrier to market competition and sometimes government rules stand in the way of necessary innovation. He touched on the timeline for CON that started as fallout from the 'Hill-Burton Act' and as cost control measure for the new Medicaid program, just as diagnosis-related group payments, value-based payments, and HMOs have been. Rather than get moored in the specific details of reforming the program, he offered the members some policy tools for evaluating CON since its last revision with SB 433 (2008 Session), since a great deal has changed in the past decade. The passage of ACA, which has passed and survived court challenges is the law of the land. It has reduced the number of uninsured, although Georgia still has one of the highest rates in the nation, as well as prompted market consolidation among provider groups.

As was discussed, Georgia is in the middle of the national average for the number of services it regulates. The CON Matrix provided by American Health Planning is an important guide for evaluating CON and making comparisons. In Georgia the debate is centered on hospital CON now, but ten years ago the context was about imaging and general surgery; this is important to remember if the statute is reopened. A policy tool for the committee is to consider how legislation would be written today if CON

was being introduced for the first time. In lieu of evaluating it on the back end after so many years in Code, this strategy may help define modern goals and remove ongoing, unintended consequences.

The most commonly accepted health policy format is the “iron triangle” or “trade-off triangle” with three cornerstones— cost, quality and access – which play off of each other in a dynamic manner. When quality, for example, is emphasized it creates a higher cost, or if cost is contained, there may be less access. There may be policies that positively affect all three, but for the most part, emphasis on one corner of the stool strains the other two. For rural communities, the consensus is to focus on access.

There are pros and cons for CON within the iron triangle. The premise of CON is to provide cost-containment by avoiding the duplication of services by demonstrating that there is an existing need. In conjunction with the Roemer Effect, which says that supply can drive utilization, an oversupply of services or capital expenditures may end up shifting increased costs to government, insurers and/or consumers. If cost containment is still being argued as the target of CON to control that corner of the iron triangle, evidence from the Department of Justice, Federal Trade Commission, state program evaluations, and numerous studies do not support that CON has made an impact. Healthcare costs have typically passed the rate of inflation on an annual basis.

For quality, the argument in favor of CON states that the specialization and experience of a limited number of teams inspires expertise, although research suggests it can be a trade-off if that team is located far away and not in a nearby community. For equipment, the spending thresholds have a distortionary effect by encouraging the purchase of a lower quality machine to get under the cap and avoid the whole CON process and other costs associated with it.

Finally, in terms of access, CON can actually delay access for extended periods, the longest which may have been a 14-year challenge in Greene County. As is evident from the work of this council, access is impaired even with CON in place because it has not provided access to rural Georgia.

Innovation, production, and capital investment are barriers to entry that are all impaired by the time and expense it takes to become a market participant in a CON state vs. a non-CON state. The FCC, which is charged with anti-trust enforcement, has come to the conclusion that it does not provide the claimed value and social benefits, especially for regional monopolies. Evidence of this is that Georgia had two of the top 10 most expensive exchange market areas in the nation, with number one being Vail, Colorado followed by southwest Georgia as number two. Market theory shows that the rent goes up to protect a privileged, non-competitive market position, which is evidenced by the expensive lobby and long, contentious legal work around this issue that has nothing to do with providing patient care. The ability of a third-party to interfere in a free market can also be a costly delay tactic that does nothing to control spending.

There are two Georgias, and the challenge is to create a policy that serves them both. There has been some discussion about bifurcating the system to assist a smaller population or rural service area differently. It is no surprise that counties with high poverty levels have high percentages of Medicaid, and then it becomes a moral question of whether or not there is a need to protect or prop up a hospital at the expense of competition. Competition will always be where people have the ability to pay, and

access will still be hard in rural areas because this basic economic tenet dictates that there is not likely to be a flood of investment into those struggling areas even with a repeal of Certificate of Need. The argument for CON is really one to protect the incumbents through regulation.

Options:

- 1) If you like what you have now, do nothing; however, this will not address access to rural healthcare and the slow drip of hospital closures is likely to continue.
- 2) Repeal the CON in its entirety. There may be hospital closures, but the benefits may outweigh the losses.
- 3) Tweak the statute. By going through the statute piece by piece, be prepared to have many “in the weeds” discussions as each service in the matrix is reviewed.
- 4) Increase transparency in the system and improve the rigor and enforcement of reporting for community standards by convening a group to outline what is needed and match those standards with accountability and meaningful monitoring.
- 5) Increase transparency in the system for finance by adopting the federal Schedule H (Form 990) to allowing for accurate reporting and comparisons of cost, as well as tax credits. The form is already required by the Internal Revenue Service and has the added benefit of accuracy ensured by penalties for false or inaccurate reporting. The one form can be used in lieu of duplicative reports required at this time.
- 6) Recalibrate the state’s discretionary payments by increasing the participation threshold of the state’s supplemental payments (DSH) to better target the rural areas and true safety net providers. Upper payment limits and hospital provider fee are additional, existing fiscal policy levers that can be revalued.

The committee engaged in discussion, and Rep. Ed Rynders noted that competition is already strained by minimizing access to the few remaining profitable revenue streams for a hospital, such as imaging. The payer mix shows the fiscal thresholds where the finances can work and how private insurers overpay to make up for the uninsured and shortfalls from Medicaid. One way to address this is subsidies to move the uninsured to the insured bucket, as well as directing the funding the state does control to fill the gaps to counter the CON supply-side barrier to entry on the supply side. The decision needs to be made to determine what critical stabilizing services have to be in place, what it costs to maintain them, and write a check.

David Tatum is the Chief Public Policy Officer for the Children’s Healthcare of Atlanta (CHOA), the only free-standing Medicaid center in the state with three hospitals, eight urgent care centers and 29 neighborhood locations. Last year, CHOA saw more than 390,000 individual children for over one million patient visits; that is more than the population of Statesboro, Valdosta and Savannah. Nearly two-thirds of these patients are covered by Medicaid, which makes them the largest Medicaid provider in the state. The hospital loses 13 cents on the dollar of cost for Medicaid patients, an amount which cannot be overcome given the volume of care. In addition, over half the children being born are Medicaid and that trend does not show signs of abating. CHOA had a legislative proposal to add their beds to existing hospitals, but Senate Bill 81 (2018 Session, sponsored in the House by Rep. Sharon Cooper) became a lightning rod for CON debate and CHOA asked that it be held rather than move

forward with unrelated CON changes to the bill being suggested by others in the hospital community. Mr. Tatum asked the council to review SB 81 as it came out of committee for consideration in the 2019 Session. SB 81 is not an exemption to CON, but simply adds a definition of another entity/category called “pediatric co-located hospital beds”. The model requires a children’s hospital to be invited to join an adult hospital to co-apply through CON for 10 to 14 beds to be located within that community, and if the partnership is ever terminated, the adult hospital retains the beds. The bill is designed to expand pediatric services around the state at a low cost. CMS rules already allow the hospital to operate beds located within 35 miles of the hospital, but outside of 35 miles, CHOA must create a subsidiary to open beds, but those beds are unrestricted and may locate across the state and provide access to rural Georgia.

Overall, Mr. Tatum offered that CON has value for protecting vulnerable hospitals and ensuring some level of indigent care is incorporated by new entrants to the market, but some changes should be made. Capital expenditures should be revisited, as most institutions are consciously looking for ways to avoid CON costs and regulatory processes to purchase equipment. Finally, he added that federal changes, potential waivers, and other decisions designed to increase the number of Medicaid clients must shift to the reasonable reimbursements to get a provider to cover that population.

The next speakers representing the Hospital Corporation of America (HCA) were Roy Robinson and Kimberly Anderson, an attorney with Robbins, Ross, Alloy, Belinfante, and Littlefield, LLC, discussed HCA’s experience in states with and without Certificate of Need. HCA is the largest hospital system in nation with a presence in 23 states that accounts for 5% of all in-patient care, as well as more Medicaid, Medicare and uncompensated care than any other provider in the United States. HCA has 10 hospitals in Georgia that are both rural and urban, include teaching, children’s specialties, and Level 1 through III trauma centers. It has invested over \$817 million in Georgia, to include over \$43 million in taxes and \$108.9 million in uncompensated care.

Ms. Anderson shared some statistics for patient access, outcomes, and affordability across five states with and without CON that have comparable populations to Georgia: Texas, Indiana, Florida, Tennessee, and South Carolina. Tennessee eliminated capital and equipment caps in 2016, and Florida reform exempts all ambulatory surgery centers. South Carolina regulates similar services and facilities as Georgia. Beginning with patient access, it is important to note that the available data is centered on primary and preventive care, which is not regulated by Certificate of Need, and therefore not impactful. In addition, the data for certain outcomes did not seem to correlate directly with CON reform because there are significant aspects that influence the data, such as culture, demographics, lifestyle, and location that are aside from how a hospital operates. For affordability and patient costs, data from employer-based premiums and average hospital expenses that are passed to the consumer show that Georgia premiums are in the average for the nation and hospital inpatient costs are in the bottom (42<sup>nd</sup>).

HCA recommendations include components from HB 299 (2018 Session):

- 1) Eliminate the threshold on capital and equipment expenditures for hospitals to allow updates and responsiveness to the community demands.
- 2) Deregulate hospital behavioral health services to meet unmet needs, especially following the closure of the state’s psychiatric hospitals. Deregulation of free-standing psychiatric hospitals to

allow them to accept government funded programs expand access, as well as offset pressures to other systems where these clients are presenting, such as law enforcement.

- 3) Lower the threshold for bed expansion requirements from 75% occupancy for two years to 60%, and increase the expansion capacity from 10% to 20%.
- 4) Exempt freestanding emergency departments that are tied to a hospital license and within 35 miles of the hospital to expand the reach of services.

John Hawkins, Senior Vice President for Advocacy and Public Policy for the Texas Hospital Association was invited to address the committee on Texas's experience after repealing Certificate of Need. He outlined the landscape of the 621 licensed hospitals in the state, nearly equally divided by government-owned, not-for-profit and investor-owned with 1/3<sup>rd</sup> located in rural areas. The Texas urban and rural dynamics mirror those of Georgia. The state's strong economy has benefitted the status of hospitals. Urban hospitals have an average 10% margin, although that strength is being challenged now by payment mechanisms and reductions that are building; rural hospitals margins are lower at 4.7% demonstrating greater challenges. It is noteworthy that 30% of all hospitals have a negative margin, which is being ameliorated within hospital systems. For rural individual hospitals, those operating in the negative is at 41%. Despite all the growth, with 1,000 people per day moving in and no income tax, Texas leads the nation with five million people uninsured, many service industry jobs and border state woes that reflect in a \$7 billion total in uncompensated care despite supplemental payments. This gap creates challenges along with payment shortfalls. Medicaid in Texas pays 58 cents on the dollar, which equates to \$2 billion shortfall being shifted to private pay. Rural hospitals are struggling, with only 66 of the 161 providing obstetric services (OB) and 19 being closed since 2013; three or four have come back online, but they only reopen the emergency rooms.

Texas repealed CON in early 1980s and has a fairly robust provider network. The free-market approach has allowed them to meet the needs of the growing state because the systems can move to areas around the state. The challenge for Texas is its 'corporate practice of medicine' that prohibits employing physicians by hospital systems which results in non-health care, out-of-state capital venture firms that pitch niche markets and create independent free-standing services. This is a challenge because it may improve access, but it is not always the solution from a quality or cost point perspective.

This is the new business model for the proliferating free-standing, non-hospital affiliated ERs, which started in the early 2000s to give more access and drive down costs. Now, there are 146 hospital ER affiliates versus 220 non-hospital, independent ERs in addition to urgent care centers. Hospital-affiliated facilities are able to off-load care to their associates to create better access and quality. The affiliate pays a facility fee to offset the hospital's expenses; however, some of them are building these as a defense to fend off competition, too, which demonstrates how competition can drive a misuse of capital. The quantifiable impact of these facilities can be found in several data points, starting with the state's retirement systems, which report a dramatic increase in utilization. The average cost paid by the system is \$2,260 for a hospital-affiliated ER visit vs. \$5,000 for the independent ER visit. Initially, rural hospitals did not engage in the debate for licensing these facilities because it was clear that they were not the profitable market; however, they have since actively engaged because it is affecting the availability of providers. Rural systems report that over 1,000 physicians have been drawn away, particularly from

hospital ERs, which has created a shortage. That shortage is shifting to nurses, as well. The state's three largest association health plans report that 21% to 56% of their in-network hospitals have no in-network ER physicians. Rural hospitals that now have to contract for an ER doctor report that results in an increase of \$200,000 to \$400,000 a year to the bottom line, which ultimately gets shifted to the taxpayer and private premium payer. The data also shows that independent ERs can be 10 times as expensive as an urgent care center with a 75% overlap in services. In Texas, one major national health plan reports its ER-related spending is 67% higher than other places; the average ER facility charge is 36% higher, and health care plans overall have seen an increase in over 12% for ER costs per year. The locations are carefully selected toward certain clients and more affluent zip codes of the state, a statement supported by federal The Medicare Payment Advisory Commission's (MedPAC) data.<sup>8</sup>

The Texas model does not require the independent ERs to participate in 'Emergency Medical Treatment and Labor Act' (EMTALA) mandates, the non-profit statutory standard for charity care,<sup>9</sup> or the safety net/community benefit, nor do emergency transporters typically take patients to these facilities. All of this supports the earlier commentary that the solution for rural hospitals is not through competition, but through comprehensive financial reforms or requiring a large system to locate in a rural area as a part of their community benefit. Those reforms, particularly in light of the independent ER experience, are critical to stabilizing rural hospitals in Texas. Finally, like most states, Texas has extensive licensing requirements that echo EMTALA to define community benefit; however, in practice, the state statute does not effectively regulate this market because it is a complaint-driven system with mediation. Georgia can learn from Texas's experience.

To share their organization's experience related to the Certificate of Need process in Georgia, Gina Lee, Founder and CEO of Legacy Sports Institute, described the institute's plan for a 30-acre campus run by its non-profit foundation that would operate on an annual \$5 to \$7 million budget from the personal donations of athletes and sports organizations to advance safety and care in the world through education, research, and innovation. One of the key components of the program is paid fellowship training for orthopedic and primary care physicians, which helps recruit and retain practitioners in the state. Innovation is created by bringing together academics, global brands and researchers to a focal point. Legacy Sports Institute is committed to provide 5% indigent care, as well as military programming, and already accepts all high school athletes for all treatment and supplies regardless of ability to pay; this was included in the over 1,000-page CON application submitted in May 2015 to establish an ambulatory surgery center to make Georgia the sports medicine capitol of the world. The application was approved in September 2015 by DCH, but one month later met opposition from one another hospital that vowed opposition until it is given ownership and a controlling interest in a partnership, even though that hospital does not perform any orthopedic surgeries. A lengthy, back and forth through the process ensued beginning with a March 2016 hearing which resulted in the reinstatement of the CON by the department six months later; however, the application ultimately ended up in court with a lawsuit filed by opposing hospitals to appeal that decision, and according to Ms. Lee, also designed to financially drain Legacy Sports Institutes' resources in the legal system until it becomes impossible to maintain the

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<sup>8</sup> Report to the Congress: Medicare and the Health Care Delivery System. <http://www.medpac.gov/>.

<sup>9</sup> The statute requires a 5% standard for charity care for not-for-profit facilities, which may be offset by the Medicaid shortfall, bad debt, and one percent of the community benefit.

process. Legislation was developed in 2018, but it did not make it through the process.<sup>10</sup> After four years and a cost of \$3 million, and despite global support and approval from the department two times, in August 2018, the superior court ended the process. Ironically, three days later the hospital leading opposition announced the creation of a sports medicine program.

Dr. Kenny Hancock, in charge of Healthcare Business Development for Legacy Sports Institute, shared his experience growing Resurgeons Orthopedics from an 11-doctor practice in the 1990s to over 70 practitioners in five surgery center locations today through the letter of non-reviewability (LNR) process. Legacy Sports Institute did not use this option initially because the goal was to create a non-competitive, world-class campus with comprehensive services provided through collaboration; surgery is only one portion of the overall vision. Despite losing the ability to include this, as well as the training and collaboration that would have accompanied it, the institute will proceed with the other components of the campus using the LNR option. He noted that if this center had been proposed in a non-CON state, it would have already been opened. Because the patient co-pays and the reimbursement cost for treatment in a free-standing ASC is 45% lower than in a hospital, the plan would have affordability; considering that there are 5,300 ASCs in the United States that perform seven million surgeries a year, resulting in an average savings of \$2.3 billion in Medicare.<sup>11</sup> An HHS study says there has been a \$7.5 billion savings created by free-standing ambulatory surgery centers from 2008 through 2011, as well as a projected savings of over \$60 billion over the next 10 years.

In the following discussion, Rep. Matt Hatchett went on the record to share that it is a sad day for the state and those seeking treatment when a non-profit hospital with over \$350 million in reserves uses those resources to block a CON request. One of the concerns often raised regarding ASCs is that most of these facilities do not serve non-paying patients, and Dr. Hancock shared that Legacy's application proposed a 5% indigent care minimum, which is higher than the CON standard of 3%. Rep. Sharon Cooper also shared that reputable providers have located in other states because it was simpler to establish across the state's borders. Providing and receiving reputable world-class services is beneficial to everyone.

Ray Williams, Cash Trivedi, and Dr. Alan Yohonda, representing the Cancer Center Treatment Centers of America (CTCA), have also experienced the same culture of negativity. The panel provided suggestions for better access to cancer care and how that could impact rural and urban Georgia. Dr. Yohonda, using data from the National Health Care Disparities Report<sup>12</sup> that broadly surveys 250 measures of state and national statistics on cancer treatment, shows that Georgia has fallen from the national average to worse than average in the delivery of cancer care. The American Cancer Society's data predicts 56,920 new cases and 17,730 deaths caused by cancer in the state this year. In addition, Georgia is below the national benchmark for surviving some of the most common cancers (colorectal, breast and lung) which ironically have the best prevention screenings.

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<sup>10</sup> House Bill 974, 2018 Session, House Second Readers.

<sup>11</sup> Economic Impact - Advancing Surgical Care, [www.ascassociation.org/home](http://www.ascassociation.org/home).

<sup>12</sup> American Cancer Society, 2018, [www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2018/cancer-facts-and-figures-2018.pdf](http://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2018/cancer-facts-and-figures-2018.pdf).

The speakers said that changes to CON will allow more access to cancer treatment in Georgia because CTCA, as the only destination cancer hospital in the country, could see more patients. In addition to CON requirements, CTCA is required to maintain a statutory 65:35 percent ratio of patients of in-state and out-of-state patients, respectively. This mandate has been met every year since CTCA began operating, and if it is not met, there is an annual fine of \$2 million that increases every year the threshold is not achieved, as well as possible revocation of the CON license for non-compliance. This ratio meant CTCA had to deny services to Georgians at the rate of 171 in 2016, 52 in 2017, and 90 to 100 in 2018. The panelists shared the video story of Georgian Pam Alford, who lamented that her access to the closest and most appropriate specialized care was challenged simply because she lives in Georgia. Moreover, the center's statutory 50-bed limit does not allow the hospital to expand services based on demand and need. In fact, CTCA cannot waive these limitations even in times of natural disaster. Finally, the center's requisite 3% indigent and charity care requirement has been met and exceeded with a five-year average of 4.5%, and also according to statute, CTCA is required to see Medicaid and Medicare patients, and year over year the hospital has assumed more of these recipients.

Incidences of cancer are lower in rural areas, but the death rates are higher than the national average and urban centers of the state,<sup>13</sup> which indicates that geography and not care dictates the opportunity for screening, diagnosis, prevention, and treatment.

The panelists recommend the adoption of the components of Senate Bill 31 (2017-2018 Session) to allow CTCA to offer solutions and effect treatment by creating personal choices, access, options for specialty care, competition, heightened innovation through clinical trials, and more collaboration:

- 1) Designate the center as a general hospital that specializes in cancer care as it is in four other states. The mission, vision and values are based in changing the nature of treating cancer, and CTCA seeks to fulfill that mission without restrictions in an equitable regulatory framework.
- 2) Eliminate the 65:35 in-state and out-of-state ratio and allow the facility to add beds to meet the demand for treatment.
- 3) Increase the indigent and charity care to 5% to meet that growing demand.

In response to the potential impact on rural Georgia, CTCA reviewed patients who came from Georgia counties with rural hospitals that participate in the Rural Hospital Tax Credit program and the Rural Hospital Stabilization program for cancer treatment in 2016 and found that they served one percent of that population, while the five large, urban Atlanta hospitals served the other 99%. This indicates that the migration for care to the metro area is the greater business threat to rural hospitals. Enlarging the footprint for CTCA will increase prevention and screenings, in conjunction with community partners and employers, to include firefighters and their organizations that endorse this proposal. The students at this facility from Mercer and Morehouse medical schools, who are being specifically trained to serve in rural areas, will be able to provide earlier detection, accurate diagnosis, treatment and survivorship to rural patients, as well as refer them back to a familiar setting for care. In addition, "CTCA Anywhere" is a telehealth program to help co-manage care with primary care providers and provide post-operative

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<sup>13</sup> "CDC Newsroom." *Centers for Disease Control and Prevention*, Centers for Disease Control and Prevention, 6 July 2017, [www.cdc.gov/media/releases/2017/p0706-rural-cancer-deaths.html](http://www.cdc.gov/media/releases/2017/p0706-rural-cancer-deaths.html).

follow-ups and other virtual appointments that save time and energy for the rural patient. Finally, as is evidenced by upgraded cancer centers in urban facilities, competition raises the bar for choice, access and innovation.

Thomas Stratmann, Senior Fellow of the Mercatus Center at George Mason University, conducted research on states with and without Certificate of Need laws by comparing the economic and health outcomes from four different academic, data-driven, and evidence-based studies. The research shows that CON has largely failed in meeting its stated objectives to increase access, particularly to the poor. In fact, CON harms patients by reducing the quality and availability of care and equipment that improve diagnoses that avoid premature death. The Federal Trade Commission, Department of Justice, and democratic and republican-controlled administrations argue that CON laws failed to meet their state goals, and the American Medical Association (AMA) favors the repeal of all CON laws.<sup>14</sup> While the purposes of Certificate of Need laws is well intentioned, their effectiveness should be measured by results. Instead, these law grant monopolies to incumbent providers and a government-protected monopoly has negative consequences, particularly for poor consumers. Moreover, CON has nothing to do with public health or safety, but is a permission slip to compete in a manner unknown to any other industry where competitors have unusual sway, akin to McDonald's asking permission from Burger King to open a restaurant. It limits the ability to offer less costly and less invasive procedures, such as virtual colonoscopies, because the procedure's equipment cannot be purchased without seeking permission.

The research shows that CON does not increase but actually diminishes access, diagnostics, indigent care, or quality of care. One measure of access to medical care is the number of hospitals in state per 100,000 population with more hospitals equating to shorter travel times and greater access; however, there are fewer hospitals in CON states. In 2017, Georgia had 175 hospitals vs. comparable states with 227, a 30% increase even when controlling factors for socioeconomic, age, health, Medicaid and Medicare. States without CON also have more hospital beds per patient, so a client has more choices and is less likely to be turned away. Georgia also has fewer ambulatory surgery centers than those states without CON, and its 350 ASCs in a non-CON environment would be numbered closer to 500. Another measure of access is medical inputs, such as diagnostics. Medical inputs are also lower in Certificate of Need states documented by 90,000 Georgia MRI scans vs. 120,000 in the non-CON state. CT scans also reflect a 30% difference. Lack of accessible equipment may increase wait times for diagnostics, reduce preventive care, and prevent more dramatic cost savings and cost avoidance for later care. Another goal of CON is to increase the quality of medical care, and because compensation is fixed in large part by the government, competition must occur through quality and not cost. CMS data does not support this claim, which shows higher hospital mortality and readmission rates in CON regulated states even though there is an intentional concentration of physicians. Finally, the claim that indigent care is lowered because of CON is not supported by the data because the amounts tend to be the same across both CON and non-CON states. The existence of 15 states without CON allows for comparisons, and those differences suggest Georgia does not need Certificate of Need laws.

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<sup>14</sup> "Certificate of Need: Evidence for Repeal." *AMA Advocacy Research Center*, 2015, [www.ama-assn.org](http://www.ama-assn.org).

Victor Moldovan, representing the Independent Doctors of Georgia, also summarized the components of CON, and clarified that Indiana only adjusted their CON program associated with skilled nursing facilities; no state is adding CON. There have been a lot of studies on the efficacy of CON, and the previously mentioned 2015 AMA study arrived at data-driven conclusions that it does not work<sup>15</sup>. Independent doctors run their own practices, large and are small, as business owners who are not a part of a hospital system, but who do pay taxes and are integral members of their communities. Independent doctors who want to include multi-specialties do not expand because of CON and the loss of their single specialty status.

The trend in health care has shifted from the long, hospital-centric inpatient care to a more desirable and cost-effective outpatient model; however, the regulatory framework of CON is frozen in place despite how the entire environment of health care delivery and payment has evolved over the past 40 years. The 1974 ‘National Health Planning and Resource Development Act’ to encourage hospital growth while holding down costs has only had two significant amendments in Georgia statute despite the fact that it was repealed on the federal level in 1987. In 1991, Georgia Certificate of Need law was amended to allow an exemption for physician-owned surgery centers, which began the LNR process that allowed an independent, single specialty service to be established under a certain spending cap. In 2008, that cap was lifted and CTCA was allowed to form, but there still has been nothing done to adjust for the payment system shifting to value-based as the means for expenditure control, antiquated definitions, and arbitrary funding caps.

CON became invasive at a certain point to hold off competition, and that is evidenced by the fact that there have been only two new hospitals since 1979 (CTCA and Lee County). There is obvious need, and in 2008 the statute was amended to allow ASCs to open through the LNR process, where through rule an indigent care requirement is established. The only statutory indigent requirement is for the Cancer Treatment Centers of America at 3%.<sup>16</sup> All others are set through rules and vary.

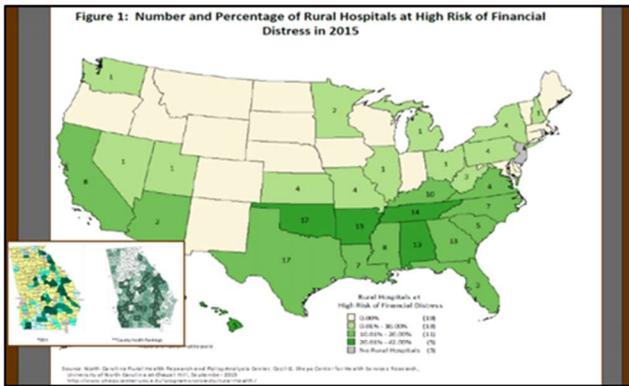
Some multi-specialty groups, just like single specialty, would like to expand and add ancillary services to support the patient and keep their care within the practice, but because these larger clinics offer multiple services, they are arbitrarily unable to expand under LNRs and the CON process makes this wrap-around approach too difficult. In addition, it prevents the lower cost savings available through ambulatory surgery centers; for calendar years 2012 to 2017, Medicare could have saved \$15 billion for services that could have been delivered at an ASC in lieu of the hospital rate. Without changes to CON, nothing else will change and there will be no innovation. Patients will continue going to city centers for care and leave the small communities to struggle with non-paying or government-paying clients. Naturally, doctors are going where people pay and they can make a living and will go where there is opportunity to innovate and/or partner.

Mary Eleanor Rawlings Wickersham, D.P.A. presented on rural Georgia’s challenges, including poor health outcomes and rural hospitals in distress, which are especially dominant in the southeastern U.S. Three things that were used to determine a hospital’s risk in a University of North Carolina study

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<sup>15</sup> “Certificate of Need: Evidence for Repeal.” *AMA Advocacy Research Center*, 2015, [www.ama-assn.org](http://www.ama-assn.org)

<sup>16</sup> O.C.G.A. §31-6-40.1(c)



included if a state has CON, did not expand Medicaid, and is socio-economically challenged. When comparing maps of Georgia's counties with hospitals at-risk (based on hospital authority financial data from DCH) and one reflecting poor health outcomes, the trend maps show poor socioeconomic status is tied to the poor outcomes. That is not to dismiss the positive community efforts to reverse these trends, such as the expansion of Federally-qualified Health Centers, workforce initiatives, and

hospital diversification; however, when tax dollars are going toward a high-risk endeavor, scrutiny needs to go deeper to ensure the investment is being made wisely. To that end, most rural hospitals are owned and governed by authorities, which are quasi-private entities with the power to issue bonds and borrow money, enter into multi-year contracts and work with local governments to levy taxes for operating to promote the public health goals of the state. In theory it allows for efficiencies, but with any quasi-private entity, there must be oversight to govern conflicts of interest and abuses. Over 1/3 of Georgia's governments are special districts with unreported or undisclosed expenses, and in a study of the 29 rural, registered hospital authorities available on the Department of Community Affairs' (DCA) website (which may or may not be all of the authorities that should be registered), none had a budget, audit, or any meeting minutes on the website. Digging deeper to the county websites revealed nothing more, so the research turned to what the state requires to be published and found that there are mandates for reporting on pensions, indebtedness, and a multitude of other items that could not be found and there is little attention is being paid to this. The state should mandate the use of web-based reporting portal for all special districts encouraged by incentives for transparency or sanctioned for a lack of it. Utah has check-level reporting, which might help avoid abuse and ensure money is well spent by authorities despite behaviors (administrator turnover, management companies, takeovers, and desertions) which encourage taking money off the top or poorly vetted business practices (borrowing, new lines of practice). Healthcare is changing, but rural hospitals have not necessarily recreated themselves for community needs; hospital authorities need to be realistic with cost expectations and the best interest of the public if they continue to be the governing entity. The case has been made for eliminating authorities in favor of a person who reports to the governing authority to ensure information is public.

As the council considers the repeal or revision of CON, it is noteworthy that Minnesota retained a public interest review process for hospitals locating near an at-risk hospital. New Hampshire's CON law sunset in 2016, but was replaced with a provision similar to Minnesota's for a review of new hospitals within a 15-mile proximity to a critical access hospital, which also mandates an indigent care requirement as well as an emergency room. In summary, considerations for action include:

- 1) Revisit hospital authority laws to mandate transparency.
- 2) Implement planning options for regions, as well as to identify areas of market failure.
- 3) Focus on sustainability for primary care and access to emergency services, as well as indigent care obligations.
- 4) Consider Medicaid options.

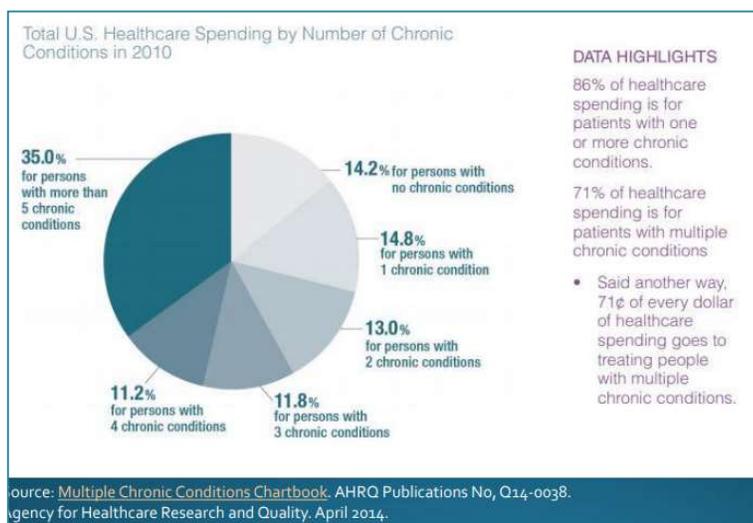
- 5) Support workforce development.
- 6) Put the public's best interest at the top of the CON debate.

Becky Ryles, Dev Watson, and R.B. Tucker, representing Community Health Centers, returned to the council this year to talk about their hospital partnerships to address community needs and vulnerable populations by establishing a medical home for the patient and a referral pattern for the hospital. Community health centers and Federally-qualified Health Centers (FQHCs) are terms used interchangeably as locally-governed, 501(c)(3)s. She introduced Dev Watson, who shared the organization's mission to reduce barriers to care by providing sliding fee access to an array of services at free-standing locations, school-based clinics, and mobile units in underserved areas of the state with poor health outcomes. There are 34 community health centers with 225 clinic sites covering 120 counties. Last year, they served almost a half million people, and over half of those were at or below 100 % of the FPL. Moreover, those patients were served at 75% of the cost on the national average. The centers are working toward certifications that enable greater reimbursement rates, telehealth, and school-based clinics. The centers have standardized health information technology and medical records. Chronic conditions present most frequently at the South Central Primary Care system (SCPCC) and include obesity, hypertension, tobacco use, and diabetes, respectively. In addition, behavioral care has been incorporated at SCPCC this year, which is the 6<sup>th</sup> highest point of contact in the clinics. The marked increase shows that they have touched on a silent but significant need for services. Community prevention, education, and health screenings are performed regularly. Partnerships with area hospitals are mutually beneficial, as seen by shared obstetrics/gynecology services because the provider can be covered under the federal 'Tort Claims Act' as a clinic provider, which offsets the hospital's medical malpractice premiums while bringing care to the clinic's clients. While these are some highlights for SCPCC, each center is different and reflects the community. Overarching challenges are: recruiting providers at every level; low or no reimbursement rates for certain services; and the availability of some infrastructure needs, such as broadband speed and bandwidth.

Chairman Powell introduced Speaker David Ralston, who knows rural Georgia and decided it was time to shine a spotlight on the issues facing rural communities to move the entire state forward over the past two years. Speaker Ralston thanked the council members and the Georgia Southern Eagles' interim President Shelley Nickel for the hospitality during this meeting. He noted how far the council has come over the last year and a half studying important public policy areas, from rural broadband, workforce development, tourism, and now health care. This week's topic on health care is of great interest and importance that touches the lives of every man, woman, and child in this state and nation. This is a turbulent time in health care. Federal mandates and rising costs have complicated the quickly changing marketplace and forces beyond our control are impacting the industry. Last year, the council took a significant first step to provide more access in health care by creating the regulatory framework for micro-hospitals. The agenda on health care can be overwhelming, especially regarding Certificate of Need, so he told the members of the RDC that he understands that comprehensive reforms will take time and involve all of our urban, suburban, and rural legislators to determine the appropriate next steps. Stakeholders should avoid the status quo and come forward with open minds and progressive proposals. Health care reform is for all of Georgia, and the council has given an ear to people's concerns that were perceived to never make it to the Gold Dome. The council has maintained its focus to attract and retain

jobs. People are excited about the passage of the council’s recommendation to create a Center for the Rural Innovation and Prosperity, which is already up and running in Tifton; however, rural communities in North Georgia should have the same access to the center’s services, so Speaker Ralston requests a satellite office to complement the work being done in Tifton for northern communities to use as a resource to help them grow and prosper. While the state has always worked for the needs of rural Georgia, it is astounding to see the heightened focus on rural development this council has engendered. Now the state has an entire division in the Department of Economic Development for rural development, the Georgia Chamber has opened a Tifton Office, and the University of Georgia has added a rural development manager position. We have succeeded in drawing attention to the issues that will move us forward as a state. Resources are being marshalled and momentum is on our side, so Speaker Ralston announced the two-year extension of the council to continue building our rural communities and infrastructure across the public and private sectors in Georgia. Most importantly, the message is to rural Georgians to know that the state will continue to fight for them and their children per Georgia’s first state motto: “It is not for self, but for others.”

Kyle Wingfield is the President and CEO of the Georgia Public Policy Foundation, a group supporting free market, limited government, and personal responsibility public policies. The foundation has advocated for the repeal Certificate of Need because the state does not have a functioning health care marketplace, in large part because of government intervention that distorts the framework for unintended results. Reform is based in the premise that competition can work in health care. This has already been recognized by the federal government, which in a rare move completely repealed the program within two decades of implementing it because it did not perform. It is true that consumers have limitations in the health care market, for example a consumer cannot shop for a doctor from the back of an ambulance; however, most of our health care dollars (86%, \$2.7 trillion, 2010) are spend on chronic care,<sup>17</sup> and the majority of that represents individuals with multiple and treatable chronic conditions. This is where health care consumers can affect spending and represents a large piece of what we could expect from reform.



Hospitals have a fair point about the unfunded mandate for EMTALA and uncompensated care. The public is already paying for this set of clients at a rate of 25% for the uninsured, 87% for Medicaid, and 96% for Medicare, which totaled \$1.74 billion in 2015. Payments should be more transparent and efficient, and once this is addressed, it will be easier to reform issues such as CON, which further distort the market.

<sup>17</sup> “Multiple Chronic Conditions Chartbook.” *Agency for Health Care Research and Quality*, U.S. Department of Health and Human Services, Apr. 2014, [www.ahrq.gov/sites/default/files/wysiwyg/professionals/prevention-chronic-care/decision/mcc/mccchartbook.pdf](http://www.ahrq.gov/sites/default/files/wysiwyg/professionals/prevention-chronic-care/decision/mcc/mccchartbook.pdf).

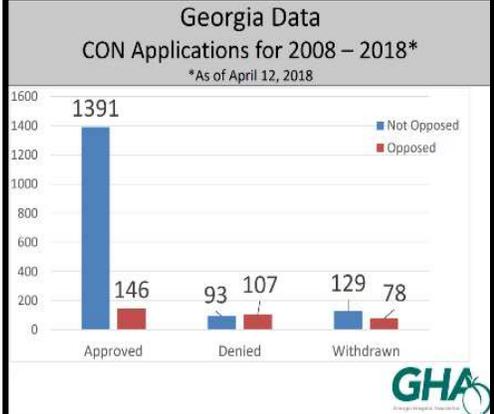
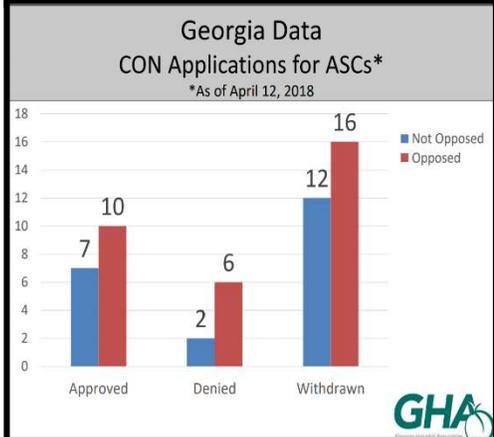
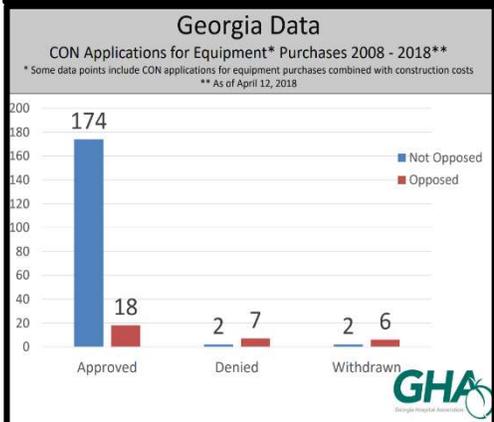
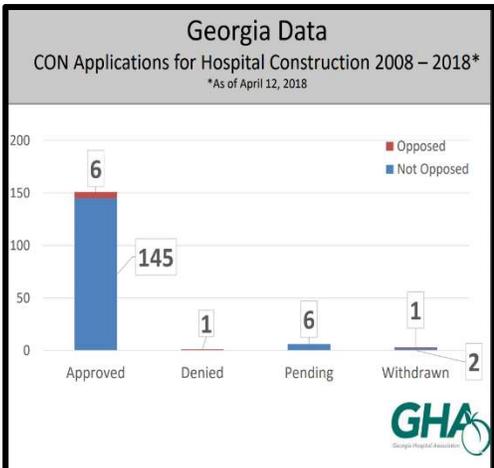
The 2017 federal reform bill (Graham-Cassidy) to repeal the ACA and create block grants would have produced \$1.43 billion for Georgia, an amount close to the state's need. Federal funding, coupled with innovative ways of delivering service to address the chronic cost drivers, will ease uncompensated care. In the absence of a federal reform proposal, one option for the state is Medicaid expansion, which as envisioned under the ACA by the Urban Institute would shift 253,000 people into Medicaid at an annual cost of \$246 million,<sup>18</sup> which still leaves a gap in funding with the 87% payment rate. The state needs to shift in the opposite direction from publically-funded coverage to private coverage that provides better access for consumers and higher reimbursement rates for providers. A Medicaid 1115 waiver would give the state and its communities more flexibility to design a state-specific plan to meet the needs of the population, cover more people, demonstrate cost savings and ultimately shrink uncompensated care. A well-designed waiver is created for demonstration projects to show that we can do more within certain fiscal constraints that work for the state budget with the potential to pool additional financial resources from those in the system. Finally, primary care, telehealth, scope of practice, and price transparency are other significant parts of needed reform. Direct primary care, which has been implemented in other states, requires legislation to allow a person to contract with a provider with a flat monthly fee for a schedule of routine appointments. This can be coupled with a catastrophic insurance plan.

The council closed the day with a panel discussion. Monty Veazey represented the Georgia Alliance of Community Hospitals, 90 urban and rural hospitals across the state which are owned by a county or are 501(c)(3)s. He noted that everyone agrees that access to quality health care is critical, and CON has been studied more than any other health issue since it was enacted. CON impacts all hospitals, but particularly the mid-level provider is where the impact on CON is seen on the local level through quality, access, and cost, regardless of a person's economic status. The General Assembly has concluded on three occasions that CON should be preserved statewide, the most recent of which came from the Rural Hospital Stabilization Committee. In a recent comparison commissioned by the alliance to compare audited financial statement and cost reports from Georgia to three non-CON states (Texas, Arizona and Colorado), it was determined that Georgia is the lowest cost provider. In response to a resolution passed this year, they also produced a report to review the financial health of Georgia's not-for-profit hospitals that revealed a deficit of \$4.1 billion in reserves for expansion and required activities. Reserves are vital for bond ratings, and the previously mentioned \$350 million in reserves only equates to 88 of the optimal 202 days in reserved operating funds for that 15,000 employee facility.

Ethan James, of the Georgia Hospital Association (GHA), thanked the council for their work last year that culminated in legislation for micro-hospitals as an option to closure, as well as the increase to the Rural Hospital Tax Credit to 100% with the hope the council will consider increasing the \$60 million state cap on the program in the future. GHA supports CON and has been doing work to look beyond the status quo for solutions, especially since there are components and methodologies of CON that have not been updated for decades. Seventy percent of the states do have some form of CON, although what is regulated is diverse. For all hospitals, the issues are statewide and intertwined, such as the provider shortage and financing shortfalls. CON recognizes that health care is not a free market; no other facility

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<sup>18</sup> Buettgens, Matthew. "The Implications of Medicaid Expansion in the Remaining States: 2018 Update." Urban Institute, The Urban Institute, 18 May 2018, [www.urban.org/research/publication/implications-medicaid-expansion-remaining-states-2018-update](http://www.urban.org/research/publication/implications-medicaid-expansion-remaining-states-2018-update).



is required to do what a hospital must and will continue to do 24-hours a day through EMTALA, emergency rooms, and neonatal units. CON is needed to prevent the proliferation of facilities without care requirements that draw doctors and nurses away from hospitals and the parts of the state in the most need. Ten years of CON statistics (2008-2018) actually show that the hospital community does not use the process to prevent competition and that most applications are approved; however, it is necessary to raise objections when there is a community impact. Regardless, the association is working on opportunities to modernize and compromise within the program and will report on their findings at a later date. In closing, he noted that no facility fights or is in competition for the uninsured, which falls to hospitals as their responsibility.

Jimmy Lewis represents Hometown Health, composed of 55 rural Georgia hospitals with a focus on operation improvements and education. While finance and payroll are at the forefront of concern from a rural standpoint, their members universally support CON in some form to control activity. Revisions should be logically planned. A primary concern for rural hospitals are ambulatory surgery centers, especially in markets where the 10-12 hospitals that perform surgeries as part of the hub and spoke sustainability model of the rural stabilization efforts exist. Loss of that market will have a quick, compounding effect that begins with the erosion of the hub hospital's patient volume and trickles down to the spoke hospital that depends on it to stay viable. The capital threshold equates to a tax for no reason. Beyond CON, rural hospitals, on fixed cost funding set by CMS and insurers, are concerned with workforce erosion due to the inability to increase wages in an environment of low unemployment. The only infusion of funds comes as a beneficiary of the Rural Hospital Tax Credit, which has breathed life into struggling hospitals and should be increased to a \$100 million cap after cleaning up and adding transparency to some of the processes. Another concern is the erosion of the patient base because insurers are directing patients through pre-authorization and the "within 30-mile rule" to their own insurance-owned ambulatory surgery and imaging facilities, which also needs to be addressed.

## *September 20, 2018 – Healthcare Access and Certificate of Need*

Wayne Chapman, Senior Vice-president of AllHealth Choice Solution, described their company's population health management app designed to reduce catastrophic events with intervention to address the red flags of chronic conditions, which are 80% of the cost for only 5% of the people. Only 2-3% of people with chronic conditions are getting proper care coordination, so unless that is addressed, chronic care will continue to consume the resources. Prescription controls, lifestyle management, remote health care, and data analytics are monitored and collected through the MyCharlie computer system. The company partners with providers, employers, and third-party administrators and has seen a reduction in readmissions, emergency room visits, as well as an increase in patient satisfaction and medication adherence. In particular, the program reduced total claims by 55% over 12 months with pool of 50 patients. Patients can access MyCharlie at home or on a mobile device, which is an important way to reach rural communities and provide a clinician.

Juliet Simpson, Chief Strategy Officer and Co-founder of AllHealth CHOICE, described the provider connection. AllHealth CHOICE provides 24/7 chronic condition control from a call center of nurses located in Macon. This allows for access hours outside of the work day for proactive and reactive management. The company contracts with Verizon to get broadband and gives Bluetooth-enabled devices to clients for the transfer of information to the MyCharlie or a nurse for immediate outreach. The contracts are paid by the entities with the at-risk clients, which is typically a monthly flat rate on the condition and not per person. The cost varies to the high end for significant interventions and on the low end for monitoring that requires intermittent interactions. There are about 1,000 patients in their chronic management now, and family members may also engage as necessary.

Karl Zimmer, CEO of Premium Peanut, returned this year to address the committee regarding work-based health care. While the company's core mission is to add value to rural peanut farmers in southern Georgia, that mission feeds into the discussion on health care and workforce because these also affect the company's returns. Premium Peanut draws its workforce from a seven-county area, and their employee's primary care physician is likely to be in their home county. The appointment and travel time for that employee or employee's family member becomes a lost day of production. In addition, year to date, the company has also experienced a 30% turnover caused in large part from failed drug tests, absenteeism, and performance issues. This also has a cost in time for recruitment, hiring, and training. To offset this, the company pays well and pays overtime (money is the easiest fix); provides skill enhancement and development courses that result in promotions (more money); and good benefits that include annual medical insurance at \$3,800 per employee.

Still, all of these things are not enough, as evidenced by the turnover rate, so the company partnered with the local hospital to provide an on-site mobile clinic as a further incentive to draw workers as an intangible benefit in lieu of slightly better pay. The mobile clinic costs \$4,200 month and is open two hours a day for employees, shareholders, or family members and is staffed by a nurse practitioner or physician's assistant. They believe it has reduced absenteeism, and when the \$10 co-pay was dropped, utilization increased by 30% to 40%.

The impact on medical costs is not yet clear. The company had a partially self-funded plan last year which did not save any claims or funding because one chronic case wiped out the savings. It is difficult to quantify the return investment at this time, although it is the right thing to do and there are likely reduced ER visits, reduced waiting times to see a doctor, and averted sick days; however, the company has no “direct” benefit. Business cooperatives are not eligible for tax credits to incentivize companies to make these investment, but an offset to payroll taxes has potential.

Russell Carlson, Vice-president from the Georgia Health Care Association (GHCA), introduced the discussion regarding telemedicine in skilled nursing facilities (SNFs). By 2030, Georgia will lead the southeast for the over 85 population, will be second only to Florida for the 65 and older group, and Atlanta is fastest aging city in the nation. In this industry, there is much preparation for workforce and innovation as the aging population comes this way. Tony Marshall, President of GHCA, shared their priorities for increasing access to medical care, which in conjunction with the U.S. HHS Region 4, includes telemedicine as a key component of the strategy. Telemedicine means a variety of things, from monitoring conditions to providing care over a live stream. Nationally, there are over 15,500 skilled-nursing facilities, of which 4,300 (30%) are rural. Physicians have sporadic daily hours in urban areas, which drops to sporadic weekly hours in rural areas that are supplemented with telecare.

For 2017 in Georgia, there were 345 operating skilled nursing facilities, of which 138 were rural with an 80% Medicaid occupancy rate. Telemedicine is not for every SNF because the system requires IT support, broadband, and provider buy-in to be effective. When properly in place, it can improve access to care, be a cost-effective way to deliver advanced and preventive care, and help address access to providers for rural areas. In addition, psychiatric services are the number one use for telemedicine in their most current survey, as well as primary, specialty and wound care that also have the added benefit of avoiding transport. The use of telemedicine also enhances staff training and adds to nurse satisfaction and retention because it increases skill sets and confidence. A Samuels Foundation Center study in New York of a 350-bed facility showed avoided readmissions, better care, and increased financial performance. An Agency for Health Care Administration grant in four centers found that telemedicine reduced readmissions, provided savings, and while it requires education and re-education, the outcomes are positive. The equipment must be easy to use and have a dedicated space that is functional with modern infrastructure. Two of the four centers showed financial success, and Medicare was successful in all four. Finally, the impact and access for patient care was dramatic.

Medicaid will only pay for services in a county outside a Metropolitan Statistical Area or a rural physician shortage area in a rural census tract. Medicare reimbursement for the clinician on the remote site is based on the Medicare Part B schedule, and the reimbursement for the center is an originating fee designed to cover the training and equipment of \$25.76 per visit. Medicaid reimbursement in Georgia for the clinicians is based on the 2018 Physician Fee Schedule and an originating fee for the center of \$20.52 per visit. GHCA is taking an active role in getting centers to review how this might work for residents, as well as using consultants and identifying grants as a template to improve care through telehealth services with a goal to increase the 15% to 20% percent of SNFs offering these services today.

Dr. Jean Sumner, Dean of the Mercer School of Medicine Care, spoke to the committee about health care in nursing homes, where there are opportunities to improve care. For the entire state, 73% of the beds are Medicaid, and 85% patients are over age 65 and at least 50% have dementia or depression. Looking into the future, two-thirds of those who are 65 and older will require long-term care, and 46% are likely to spending time in a nursing home, which is the most expensive place to house people. To offset the rapid growth in the aging population with long-term care needs, the state needs to bolster more cost-effective community care and telecare.

Telehealth can help by providing better physician services and decreased hospitalizations. The state can have the added offset for avoiding transportation costs and transports that are not good for the patient. Technology is a great way of practicing medicine and in Georgia it requires the same standard of practice for providers.<sup>19</sup> Telehealth requires state-of-the-art equipment, the cost of which has decreased immensely over time to \$10,000 or less or \$5,000 or less for behavioral health. A Certified Nurse Assistant can present the patient, as long as the person or physician on the other end is licensed and can take the orders or prescriptions if needed. Like all specialty visits, the presenter has to have the patient's records ready. The presentation site and the physician can bill, and while the fee is small, it is nearly always better for the patient to make a trip down the hall to the telehealth room in order to avoid a van trip and a waiting room.

To make all of this work, there must be an effort to address the physician shortage and direct them to work in our state's nursing homes and underserved areas. Nursing home physicians are unique in that they are not able to cover a large geographic area because time is so important to elderly care, but if there is telehealth, it can work. Telehealth also helps the medical director of a nursing home to stay engaged and manage physicians and coverage areas by phone. Attending physicians can immediately evaluate a nursing home client on admission; provide prompt post-hospital follow up; consult with families and therapists; provide wound care; and perform evaluations before any ER visit.

Telehealth as an alternative to transport for this frail population certainly saves money, but it also avoids the patient being driven for miles alone to arrive at a doctor's office with no one to "translate" what the doctor is saying. LogistiCare data says 38% of its non-emergency transportation trips are for behavioral health treatment,<sup>20</sup> and telehealth does this better than any other service while saving the transport costs. The state needs to reverse some of its incentives that encourage transport and discourage telehealth. CareNow is a behavioral telehealth service that already exists, works with families, and can do crisis management that thoughtfully provides for the patient 24/7 with certified care that avoids transport. Despite anecdotal hearsay that doctors do not like telehealth, residents gave high satisfaction ratings to their required telehealth experience. Telehealth equipment in nursing homes could also provide opportunities for ombudsman and family members.

To formalize telehealth in Georgia:

- Authorize a comprehensive study to compare the benefits and savings.

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<sup>19</sup> O.C.G.A. § 50-13-4(a)(3)(A), (B), (C) and (D).

<sup>20</sup> *Medicaid Gross Trips by Treatment Type*. LogistiCare Solutions, 2015.

- Reward nursing homes with an enhanced Case Mix Index for use of telehealth that results in lower ER visits, hospitalizations and transfers.
- Reward nursing homes and physicians that use telehealth resulting in lower re-hospitalization rates.
- Reinforce nursing homes that use telehealth for specialty consultations, as well as pre- and post-op.
- Restructuring Emergency Medical Service payment schedules to incentivize the appropriate use of transport.