

To: members of the Joint Legislative Oversight and Sunset Committee

From: Joann O. Hasse

Comments re Health Resources Board

I would have preferred to offer these comments in person but I no longer drive after dark if I can avoid such it. I served as a public member on the HRB for 15 years and felt, and feel, that I was serving a useful service for my fellow Delawareans. I was a nurse many years ago (but never worked in Delaware) and have followed health care public policy issues as a volunteer for the past 30+ years.

I read the op-ed submission by Drs. Cassells and Beck, both associates with the Caesar Rodney Institute, in the Sunday, March 8 News Journal with some dismay. I strongly disagree that accessing health care is equivalent to deciding where one buys groceries. I really object to their statement that the Health Resources Board “has been populated by competitors”. As one of several public members, I believed that I represented the interest of the public at large. In my mind that included protecting access to care as well as quality of care. Basically, I do not believe that society’s interests are best served by having a gas station/MRI/hospital/whatever on every block if the purpose is just to promote free enterprise and “competition”. Having a health care facility close because of too little business is NOT the same for society as having a restaurant fail because of too little business.

Having said that, I also believe that most agencies, boards and commissions need to be reviewed and perhaps re-organized periodically and I support the “Sunset process”. In this case and assuming the decision is to retain the HRB in some configuration, I offer some comments based on my tenure:

* It takes some time to “learn the ropes” of being on a Review Committee which is the way the Board handles its duties. After the original presentation of a project before the full Board, a small group of members is assigned to do an in-depth review of the submission (for many projects this can be voluminous), meet with the applicant, and sometimes visit the facility. After the committee discusses and makes a decision to recommend approval or denial, the entire Board makes the final decision. The applicant’s project is frequently presented by people (attorneys, lobbyists, managers) well versed in representing their client’s point of view and in enlisting support of others. (In one case, this included evening calls to my home.) **The review committee needs to have members with sufficient experience in being on a committee to ask, and keep asking, sometimes difficult questions. I think this needs to be a major consideration in your recommendations for length or number of terms allowed.**

* If this program is to continue and function properly, it is very important that adequate staff be available to do the job.

*Though some members of the Board represent specific groups and Board service is part of their jobs, public members receive no monetary compensation, including for mileage. We have done it because we think it important and a service to our State. It certainly involves more time than attending a 2 hour monthly meeting.

* If the Certificate of Public Review process is to work as intended, politics must be kept out of it. If proper procedures were used, Board decisions cannot be overridden or reversed to serve political needs nor should the appointment process of public members be used to influence decisions. An action such as this in my last term caused mass resignations, including mine, the Chair and several others.

Anecdotal-type Comments:

*When visiting during a meeting break of another state health care committee, one of the out of town participants (governmental) asked me what the breakdown was in Delaware between nonprofit and for profit hospitals. When I answered that, except for the VA hospital and a couple of small mental health facilities, all of our hospitals were nonprofit. Her answer, "Oh, you're so lucky!"

*We were told several times that prospective applicants who were considering Delaware locations for their projects decided against proceeding when they learned we have a Certificate of Public Review Process.

From: Larry Bennett
Sent: Friday, March 6, 2020 11:12 PM
To: Walsh, John (LegHall)
Subject: Sunset Outdated Certificate-of-Need (CON) Laws

Dear Senator Walsh,

I am reaching out as a constituent asking that you vote to sunset The Delaware Health Resources Board on March 11, 2020. Delaware's certificate-of-need laws are outdated, and need to be repealed.

Research finds that CON laws are associated with higher health care and physician spending per capita; in Delaware, CON laws create a barrier to entry into the market, inhibit expansion, and fail to provide adequate health care services in some areas.

A report by the Mercatus Center estimates a savings of \$270 on total healthcare per person without CON laws, and an increase in access to hospitals and ambulatory surgical centers. They also estimate an increase in local services without these restrictions, helping residents access healthcare and keeping spending local.

Delawareans' health should not be at the whim of a health care monopoly blocking competition that is needed in many areas.

Delaware has utilized the CON process since 1978. It is time for a change.

Sincerely,

Larry Bennett



Delaware Hospitals' **Recommendations to Improve the Health Resources Board**



According to Title 16, Chapter 93 of the Delaware Code, the purpose of Delaware's Health Resources Board (HRB) Certificate of Public Review (CPR) process is to "assure that there is continuing public scrutiny of certain health-care developments which could negatively affect the quality of health care or threaten the ability of health-care facilities to provide services to the medically indigent. This public scrutiny is to be focused on balancing concerns for cost, access and quality." The Delaware HRB was established to "foster the cost-effective and efficient use of health-care resources and the availability of and access to high quality and appropriate health-care services."

The HRB is scheduled to come under Sunset Committee review in February 2020. The Delaware Healthcare Association **recommends several procedural changes to improve the process and function of the Health Resources Board and improve consistency in the review of CPR applications. DHA recommends the following changes:**

1. **Provide funding for independent staff or consultants with expertise in health policy and planning** to review CPR applications, support the HRB with analysis and interpretation, and to help guide HRB business, debate and determinations.
2. **Allow dialogue between applicants, impacted parties, and the HRB during the CPR review process** to facilitate real-time discussion and answers to questions to aid the HRB in their deliberations.
3. **Allow technological capabilities** for HRB members to participate remotely to improve meeting attendance, deliberation and function.
4. **Convene a working group** that includes representatives with appropriate health planning background from industries subject to CPR review and other stakeholders for the purpose of updating the review criteria and application process. Specifically, the working group should:
 - a) ensure information requested in CPR application is relevant for assessing the service being proposed;
 - b) foster better and more consistent alignment with the criteria that the Health Care Commission has established by ensuring that the information being requested in the application aligns with the criteria for evaluation and supports the HRB's deliberations on these criteria;
 - c) restrict any new criteria from evaluations unless the new criteria is communicated to the applicant prior to the application being submitted;



Delaware Hospitals' **Recommendations to Improve the Health Resources Board**

- d) create a schedule for regular review, and training for HRB members on the review criteria and to allow for consistent assessment of applications; and,
 - e) consider eliminating the Health Resources Management Plan and, instead, detail criteria for CPR review in the Statute to simplify process.
5. With the input of providers, **update the list of health care expenditures**, including medical equipment and activities that require a CPR.
 6. Ensure that CPR criteria requires facilities to care for the underserved in Delaware by requiring all facilities subject to a CPR review to **take all public insurance** (e.g. Medicare, Medicaid and TRICARE), with a clear enforcement mechanism for violations.
 7. **Revise the composition of the HRB to improve quorum** by the following means: accept more at-large members to prevent the consistent issue of multiple recusals; allow those that recuse themselves to still be counted toward quorum; and quorum should be based on the number of sitting members, not the number of seats, or at least five members.
 8. **HRB should explore models from other states to develop a model for evaluating capacity and demand for any facility or service** included in HRB's authority. Such models exist for inpatient beds of all types (acute care, Obstetric Care, Skilled Nursing Facilities, etc.), but there is no model for free standing Emergency Departments (EDs) or cardiac catheterization labs, for example.
 9. **Optimize administrative support processes** to assure transparent and effective communications regarding the HRB activities, applications, meetings and agendas. For example, allow reports to be "considered read" into the public record without having to verbally read through the entire report during HRB meetings.

Contact:

Wayne A. Smith
President and Chief Executive Officer
Delaware Healthcare Association
wayne@deha.org
office: 302-674-2853

Christina Bryan
Director, Communications and Policy
Delaware Healthcare Association
christina@deha.org
office: 302-674-2853



**Delaware Healthcare Association Statement on the Health Resources Board
Before the Joint Legislative Oversight & Sunset Committee
March 11, 2020**

Thank you Chairman Bentz, Co-Chair Lockman and members of the Sunset Committee. My name is Christina Bryan, Director of Communications & Policy for the Delaware Healthcare Association -- the association for hospitals and health care delivery systems in Delaware.

I appreciate the opportunity to comment on the Health Resources Board, which administers Delaware's Certificate of Need System, making determinations on whether or not facilities, projects and services meet approval criteria.

We understand the focus of this hearing is not on the future of Certificate of Need in Delaware. However, we would like to communicate that Delaware's certificate of need system, known as Certificate of Public Review, provides important value for our community and should remain.

This system ensures that the public has a say in health care investments in our state — helping our health care system grow in ways that improve — and don't harm — quality, cost and access to care. It also shields the most vulnerable Delawareans from being left without care.

The Health Resources Board that administers this system faces several challenges that need to be addressed.

These challenges include: consistent lack of quorum, canceled meetings that delay projects, non-transparent (and often inconsistent) analysis and decisions and lack of adequate staff support.

Simple changes would improve the effectiveness of the board and the Certificate of Public Review Process. Our recommendations are as follows:

1. Provide funding for independent staff or consultants with expertise in health policy and planning to review applications and help guide Board analysis and determinations.
2. Allow dialogue between applicants, impacted parties, and the Board during the review process to facilitate real-time discussion and answers to questions to aid deliberations.
 - Without this dialogue, questions must be fielded in writing after the meeting, further delaying the process.
3. Allow technological capabilities for Board members to participate remotely to improve meeting attendance and function.
4. Convene a working group with the purpose of updating the review criteria and application process.
 - There is now inconsistency between what is asked of applicants and what is ultimately discussed and considered by the Board in making decisions.
5. Update the list of health care expenditures, including medical equipment and activities that require review.

6. Ensure care for the underserved in Delaware by requiring facilities subject to review to take all public insurance.
7. Revise the composition of the Board to improve quorum.
 - Meeting quorum is a significant challenge that leads to last minute meeting cancellations. Six meetings were cancelled in the last year, four of which were due to the lack of quorum. This happened as recently as February 27th and, like the other cancellations, lead to project delays that carry real costs and can delay patient care.
8. Explore models from other states to develop a model for evaluating capacity and demand for any facility or service included in the Board's authority.
 - Currently, there is no model in DE for free standing Emergency Departments (EDs) or cardiac catheterization labs, for example.
9. Assure transparent and effective communications of Board activities.

Thank you for your consideration.

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March 11, 2020

Joint Legislative Oversight and Sunset Committee
JFC Hearing Room
Legislative Hall
Dover, DE

RE: Delaware Health Resources Board

Committee Members:

The Caesar Rodney Institute (CRI) is a non-partisan 501(c)(3) non-profit think-tank focused on public policy issues and their impact on Delawareans.

Over the past two years we have conducted research into the Certificate of Need (CON) laws nationally and in Delaware and reviewed the Health Resources Board policy decisions and litigation history.

Attached for your review and consideration are the following:

- Since the Federal Government repealed its CON law in 1987 and recommended that states do the same, a number of non-partisan studies from the federal government, state governments and non-partisan think-tanks appeared over the ensuing 30 years. The list of studies and links to each is attached. Of note the conclusions of all studies are the same, namely the CON laws have not achieved the desired outcome of lower healthcare costs, better quality, and better health access.
- A short list of Delaware health cost data is attached.
- The major recent CON study by the Mercatus Center of George Mason University also estimated by state what health outcomes could be achieved without the CON laws. Attached is their three-page analysis for Delaware.
- We have also attached a letter to the committee from Dr. Christopher Casscells, a well-known Delawarean physician who is also CRI's Director of Center for Health Policy.

Thank you,

John R. Toedtman, Executive Director
Caesar Rodney Institute

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Non-Partisan Studies Regarding CON Laws

David, C. Grabowski, Robert L. Ohsfeldt, & Michael A. Morrissey, *The effects of CON repeal on Medicaid nursing home and long-term care expenditures*, National Institutes of Health, 2003, <https://www.ncbi.nlm.nih.gov/pubmed/13677562>

Dr. Roy Cordato, *Certificate-of-Need Laws: It's Time for Repeal*, John Locke Foundation, November 27, 2005, <https://www.johnlocke.org/research/certificate-of-need-laws-its-time-for-repeal/>

Jon M. Ford, David L. Kaserman, *Certificate-of-Need Regulation and Entry: Evidence from the Dialysis Industry*, Southern Economic Journal, April 1993, http://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/CON_modernization_workgroup/Articles/Article%201.pdf

Mark J. Botti, *Competition in Healthcare and Certificates of Need*, The United States Department of Justice, February 23, 2007, <https://www.justice.gov/atr/competition-healthcare-and-certificates-need>

Mercatus Center, *Certificate-Of-Need Laws Delaware State Profile*, George Mason University, September 27, 2016, https://www.mercatus.org/system/files/delaware_state_profile.pdf

Momotazur Rahman, et al., *The impact of Certificate-of-Need Laws on Nursing Home and Home Health Care Expenditures*, National Institutes of Health, June 22, 2016, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4916841/>

National Conference of State Legislatures, *Certificate of Need State Laws*, February 2019, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

Roger Stark, *Why Washington's restrictive Certificate of Need medical services law should be repealed*, Washington Policy Center, February 17, 2016, <https://www.washingtonpolicy.org/publications/detail/why-washingtons-restrictive-certificate-of-need-medical-services-law-should-be-repealed>

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Tracey Yee, et al., *Health Care Certificate-of-Need (CON) Laws: Policy or Politics?*, National Institute for Health Care Reform, May 2011, <https://www.nihcr.org/analysis/improving-care-delivery/prevention-improving-health/con-laws/>

U.S. Department of Health and Human Services, U.S. Department of the Treasury, & U.S. Department of Labor, *Reforming America's Healthcare System Through Choice and Competition*, U.S. Department of Health and Human Services, December 3, 2018, <https://www.hhs.gov/about/news/2018/12/03/reforming-americas-healthcare-system-through-choice-and-competition.html>

University of Washington's School of Public Health and Community Medicine, *Effects of Certificate of Needs and Its Possible Repeal Report 99-1*, State of Washington Joint Legislative Audit and Review Committee, January 8, 1999, <http://leg.wa.gov/jlarc/AuditAndStudyReports/Documents/99-1.pdf>

Vivian Ho, Meei-Hsiang Ku-Goto, & James G. Jollis, *Certificate of Need (CON) for Cardiac Care: Controversy over the Contributions of CON*, Health Services Research, April 2009, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2677050/>

Caesar Rodney Institute, *Delaware Certificate of Need*, June 19, 2019, <https://www.caesarrodney.org/cri-focus-area/Delaware-Certificate-of-Need-.htm>

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According to the Kaiser Family Foundation, Delaware ranks:

- 3rd among the states in health care expenditures per capita.
- 4th in hospital adjusted expenses per day.
- 2nd in mail order prescription drugs per capita.
- 3rd in Medicaid physician fees relative to the nation's average.
- 3rd in Medicaid spending per aged enrollee (i.e., \$21,255 per enrollee).
- 11th in Medicare spending per enrollee.

Over the last 10 years (2006-16) as private sector earnings in Delaware increased 8.4%, Delaware's health care industry's earnings rose 64.2% (U.S. Department of Commerce). Earnings in nursing care increased 98%, as hospital earnings soared 85%, and ambulatory care (e.g., offices of private physicians) went up 38%.

The most recent IRS Form 990 filed by Christiana Care for 2018 showed \$1.7 billion in revenue and \$167 million (10%) in operating income (same as pre-tax), but pays no taxes. Their balance sheet also shows \$1.8 billion in securities. The expected operating earnings for non-profit hospital systems is typically 4%.

CERTIFICATE-OF-NEED LAWS



DELAWARE STATE PROFILE

Certificate-of-need (CON) laws require healthcare providers to obtain permission before they open or expand their practices or purchase certain devices or new technologies. Applicants must prove that the community “needs” the new or expanded service, and existing providers are invited to challenge would-be competitors’ applications. CON laws have persisted in spite of mounting evidence from health economists, regulatory economists, and antitrust lawyers showing that these laws fail to achieve their intended goals. The following charts are based on studies comparing outcomes in states that have CON laws with outcomes in those that do not. *These comparisons account for socioeconomic differences and differences in the underlying health of the populations across states.* The studies give some insight into what is likely to happen in a Delaware without CON laws.



HEALTHCARE SERVICES THAT REQUIRE A CON IN DELAWARE

Acute Hospital Beds
Ambulatory Surgical
Centers (ASCs)

Cardiac Catheterization
Lithotripsy

Long-Term Acute Care
(LTAC)
Nursing Home Beds/
Long-Term Care Beds

Positron Emission Tomography
(PET) Scanners
Radiation Therapy

SPENDING

Research finds that CON laws are associated with higher healthcare spending per capita and higher physician spending per capita.

Estimated changes in annual per capita healthcare spending patterns in Delaware without CON

TOTAL HEALTHCARE SPENDING



PHYSICIAN SPENDING

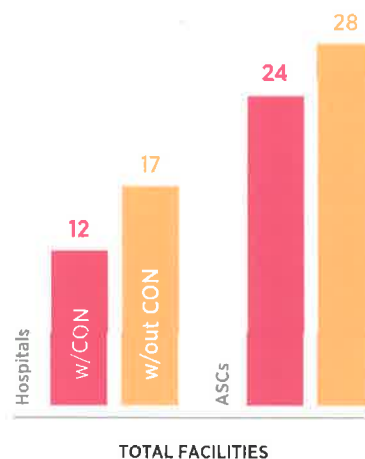


ACCESS

Comparing rural areas in CON states with rural areas in non-CON states, research finds that the presence of a CON program is associated with fewer rural hospitals. A subset of CON states specifically regulate the entry of ambulatory surgical centers (ASCs), which provide healthcare services and compete with traditional hospitals. These states have fewer rural ASCs.

Research also finds that states with CON programs have fewer hospitals in general (in rural and nonrural areas alike), and states with ASC-specific CON regulations have fewer ASCs in general.

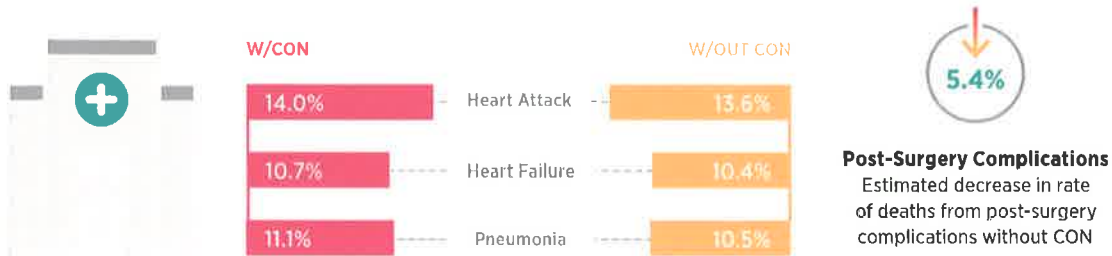
Estimated changes in access to healthcare facilities in Delaware without CON



QUALITY

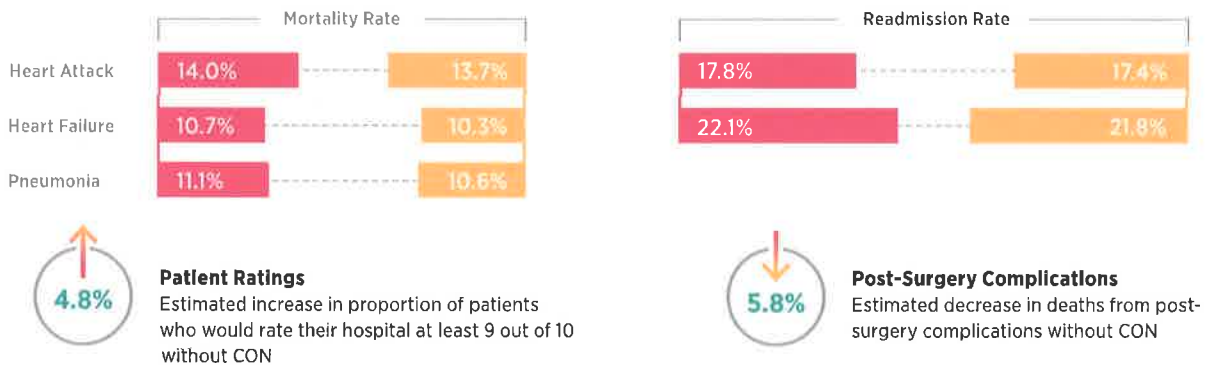
Supporters of CON suggest these regulations positively impact healthcare quality, but research finds the quality of hospital care in CON states is not systematically higher than hospital quality in non-CON states. In fact, mortality rates for pneumonia, heart failure, and heart attacks, as well as patient deaths from serious complications after surgery, are statistically significantly higher in hospitals in states with at least one CON regulation.

Estimated changes in Delaware healthcare quality indicators (full sample, at least one CON law)



Delaware is one of 32 states with four or more CON restrictions. The effects of CON regulations may be cumulative, meaning states with more entry restrictions may experience larger quality differences than states with fewer restrictions. Research finds that states with four or more CON laws have systematically lower-quality hospitals than non-CON states. The effect is evident across other quality indicators, including the share of patients surveyed giving their hospital the highest overall quality rating, heart failure readmission rate, and heart attack readmission rate.

Estimated changes in Delaware healthcare quality indicators (restricted sample, four or more CON laws)



Findings on heart failure readmission rates, heart attack readmission rates, and the percentage of patients giving their hospital a 9 out of 10 or 10 out of 10 overall rating were statistically significant only in the restricted sample of states that regulate four or more services with certificate of need.

This study uses an identification strategy that exploits the fact that, on occasion, a local healthcare market is divided between two states, one with a CON law and the other without. Four is the median number of CON laws for CON states in this subsample.

The survey referred to is the Hospital Consumer Assessment of Healthcare Providers and Systems survey. It was developed by the Centers for Medicare and Medicaid Services in partnership with the Agency for Healthcare Research and Quality, and it is based on a standardized instrument and data collection methodology that allows for cross-hospital comparisons of patients' experiences related to different aspects of care. "Highest overall quality rating" is defined as a 9 out of 10 or 10 out of 10 rating on the survey.

Source: Thomas Stratmann and David Wille, "Certificate-of-Need Laws and Hospital Quality" (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, 2016).

MEDICAL IMAGING SERVICES

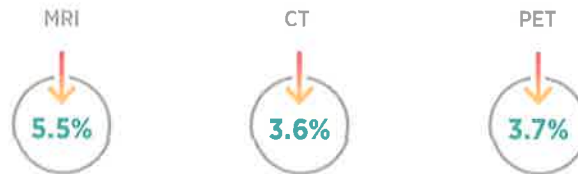
CON programs are associated with lower utilization rates for medical imaging technologies through nonhospital providers.

Estimated effect on medical imaging by nonhospital providers without CON



CON laws are also associated with more out-of-county travel for imaging services. Research finds that the presence of a CON program is associated with 5.5 percent more MRI scans, 3.6 percent more CT scans, and 3.7 percent more PET scans occurring out of county.

Estimated percentage point reduction in out-of-county scans without CON



Thomas Stratmann and Matthew C. Baker look at the relationship between CON and the imaging claims of Medicare beneficiaries, which constitute only a portion of the total market for medical imaging services. However, CON laws limit the supply of imaging technologies to all consumers, meaning the results here underestimate the total effect of CON regulation on the utilization of medical imaging services.

While CON programs are associated with reduced use of imaging services by nonhospital providers, they were found to have no statistically significant effect on the use of imaging services provided by hospitals. This suggests that CON laws protect hospitals from nonhospital competition. The net effect is to lower the overall use of imaging services.

The effect of CON on MRI and CT scans per 1,000 Medicare beneficiaries was statistically significant at the 15% level. The effect of CON on a patient's probability of travelling outside the patient's county of residence for PET services was also statistically significant at the 15% level. All other variables were statistically significant at levels ranging from 1% to 5%.

Some states have added CON requirements for particular services since these analyses were conducted; the states with such new requirements are not visualized. For the latest information on which states regulate which procedures through CON, see Christopher Koopman and Anne Philpot, "The State of Certificate-of-Need Laws in 2016," Mercatus Center at George Mason University, September 27, 2016.

Source: Thomas Stratmann and Matthew C. Baker, "Barriers to Entry in the Healthcare Markets: Winners and Losers from Certificate-of-Need Laws" (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, 2017).

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March 11, 2020

Joint Legislative Oversight and Sunset Committee
JLC Hearing Room
Legislative Hall
Dover, DE

Dear Committee Members,

Delaware's Certificate of Need (CON), aka The Certificate of Public Review, needs to end.

It is obviously anticompetitive and has resulted in lower quality metrics for health outcomes and less access to care in Delaware.

The *Mercatus study* which represents a "meta-analysis" of all the available good data clearly demonstrates this nationwide and forecasts significant improvements in Delaware for access to care, quality of outcome, improvement of diagnostic imaging, and lowering of cost.

There simply is no data or analysis anywhere to support the idea that care of the uninsured is improved by CON laws. They have been widely abandoned nationally. They are particularly irrelevant, anachronistic and obsolete after creation of The Affordable Care Act.

A reinstatement of this committee and process under any name is undoubtedly a victory of special interest lobbying over rationality.

Sincerely,

Christopher D. Casseells, MD
Director of Center for Health Policy
Caesar Rodney Institute

420 Corporate Blvd • Newark, Delaware 19702
(302) 273-0080 • www.caesarrodney.org

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