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**FINAL REPORT OF THE  
SENATE STUDY COMMITTEE ON  
INDEPENDENT PHYSICIANS IN GEORGIA**

**COMMITTEE MEMBERS:**

**Senator Renee Unterman, Chair**  
**District 45**

**Senator Dean Burke**  
**District 11**

**Senator Gloria Butler**  
**District 55**

**Senator Chuck Hufstetler**  
**District 52**

**Prepared by the Senate Research Office**  
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## **I. INTRODUCTION**

The Senate Study Committee on Independent Physician Practices in Georgia ("Committee") was appointed by the Lieutenant Governor pursuant to Senate Resolution 340, which passed during the 2013 Legislative Session.

The Committee was composed of four members of the Senate: Senator Renee Unterman, serving as Chair; Senator Dean Burke; Senator Gloria Butler; and Senator Chuck Hufstetler.

Legislative staff assigned to the Committee included: Ms. Laurie Sparks, Legislative Assistant to Senator Renee Unterman; Ms. Shawna Mercer of the Senate Press Office; Ms. Emily Fisher of the Senate Research Office; and Ms. Elizabeth Holcomb of the Senate Research Office.

The Committee met on three occasions. The first meeting was held on September 11, 2013 at the State Capitol in Atlanta. The Senators in attendance at the first meeting were Senators Unterman, Burke, Butler, and Hufstetler. The second meeting was held on October 31, 2013 at the Medical Center of Central Georgia in Macon. The Senators in attendance at the second meeting were Senators Unterman, Burke, Butler, and Hufstetler. The third meeting was held on December 17, 2013 at the Harbin Clinic's Main Campus in Rome. The Senators in attendance at the third meeting were Senators Unterman, Butler, Hufstetler, and Burke.<sup>1</sup>

## **II. BACKGROUND**

The Committee was created to study the current health care system in Georgia and its relationship to independent physician practices. Issues to be studied included whether state policies may be contributing to the decline in the number of independent physicians in Georgia and what impact this decline may have on the state's health care quality and costs.

Certificate of Need ("CON") programs have been created in over 30 states in an effort to manage health care facility costs and facilitate coordinated planning of new services. In theory, a CON program allows a state to reduce health care price inflation by regulating the building of health care facilities and the amount of money spent on expensive equipment. Generally, new or updated facilities and equipment must be approved by the state, where approval is granted depending on the actual need of the community.<sup>2</sup>

Georgia's CON program was established by General Assembly in 1979.<sup>3</sup> In Georgia, the CON program is administered by the Healthcare Facility Regulation Division ("HFR") of the Georgia Department of Community Health ("DCH"), and aims to achieve three goals: 1) to measure and define need; 2) to control costs; and 3) to guarantee access to health care services.<sup>4</sup> A CON is the official determination that a new or expanded health care service or facility is needed in Georgia. All multi-specialty and certain single-specialty Ambulatory Surgery Centers ("ASCs") must apply for and acquire a CON. A health care facility wanting to offer a health care service that was not provided on a regular basis during the previous twelve-month period must first obtain a CON. In an effort to improve upon Georgia's CON program, the Commission on the

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<sup>1</sup> Senator Burke attended the third meeting through teleconference.

<sup>2</sup> <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

<sup>3</sup> O.C.G.A. Title 31, Chapter 6.

<sup>4</sup> Georgia Department of Community Health <http://dch.georgia.gov/certificate-need-con>

Efficacy of the CON Program in Georgia was established in 2005 and the final report to the Georgia General Assembly and Governor Sonny Perdue was published on December 29, 2006.<sup>5</sup> During the 2008 Georgia Legislative Session, major reforms to the statute were enacted with the passage of Senate Bill 433.

### **III. TESTIMONY**

#### **A. Wednesday, September 11, 2013**

The first meeting was held at the State Capitol in Atlanta, Georgia, where testimony was given on behalf of the Independent Doctors of Georgia ("IndDoc"). Victor Moldovan, a health care attorney from McGuireWoods, LLP, provided testimony on behalf of IndDoc along with Dr. Jeff Reinhardt, President of The Longstreet Clinic, P.C. and current Board Member of IndDoc.

A document from IndDoc was distributed to the Committee, titled "Who is IndDoc?" This document outlined critical policy points identified by IndDoc, which included Georgia's CON requirements for ASCs, the State Health Benefit Plan (SHBP), and ideas on how the credentialing and self referral laws could be amended.<sup>6</sup>

#### **Who is IndDoc?**

Independent Doctors of Georgia, Inc. ("IndDoc") is a not-for-profit trade association that represents over 500 providers and includes four major independent groups in Georgia. These independent groups include the Harbin Clinic in Rome, Southcoast Medical in Savannah, The Longstreet Clinic in Gainesville, and Hughson Clinic in Columbus. IndDoc's stated mission is to advocate for independent physician groups and educate state and federal officials about the impact of proposed government action. "Independent physicians" are defined by IndDoc as those "not employed by Hospital systems."

#### **Increase in Hospital Acquisitions**

Mr. Moldovan provided the Committee with a history of our health care system and the issues currently faced by providers in the marketplace. He stated that there has been a dramatic increase in acquisitions of physician practices and other ancillary services by hospitals over the past five years. He further explained that this increase in acquisitions by hospitals is a result of various factors including federal referral laws ("Stark"), the Affordable Care Act (ACA), and the recent trend of physicians leaving independent practice to work for hospitals. Dr. Reinhardt acknowledged that physicians, especially younger generations, are spurring the increase in hospital-employed physicians. Additionally, testimony from IndDoc suggested that many hospitals have decided to acquire physician practices or employ as many physicians as possible to capture the market for all health services in its area.

It was stated that the effects of hospital acquisitions include many physician and ancillary services becoming hospital-based services, thereby increasing the costs of services for payers. IndDoc forecasts that the effects of an increase in costs of services will be seen in increased costs to insurers, higher co-pays and premiums for patients, and an increase in the amount the

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<sup>5</sup> The Commission's recommendations specifically addressed free-standing single specialty and multi-specialty Ambulatory Surgery Centers, recommending that both types of centers be required to obtain a CON from DCH.

<sup>6</sup> "Who is IndDoc?" is attached in Appendix A.

State pays for Medicaid and SHBPs. IndDoc acknowledges the need for an improved health care system as all providers, including hospitals, are challenged with lower reimbursement rates and payments. As independent physicians, they have played a traditional role in providing care to patients as well as giving patients a choice of providers, which helps to maintain lower costs for patients by creating competition in the market. IndDoc believes that the traditional referral pattern in many communities has been significantly disrupted by hospital acquisitions and the replacement of independent physicians with hospital-employed physicians. The following example of this disruption was shared by IndDoc to the Committee. Once a physician is employed or acquired by a hospital, that physician must refer patients to other hospital-employed physicians and for other hospital services, even if that means referring a patient outside the community. Mr. Moldovan stated that the reason for this hospital referral system is "to allow the Hospitals to capture the revenue and capture a higher price."

#### Relationship Between Independent Physicians and Hospitals

Dr. Reinhardt stressed the importance of collaborative relationships between hospitals and physicians. He explained how independent physicians generate their revenue from professional service fees, ancillary services, and revenue from hospitals where they provide services such as being on call or managing a department. IndDoc provided the Committee with a brief overview of the traditional roles of physicians and hospitals. Summarizing this testimony, a hospital wants a variety of services to be available at its facility and independent physicians have a long history of providing those services under the roof of the hospital, while remaining separate entities. The hospital provides the facility and hospital services, including nursing staff, and physicians then provide the professional services to patients. As hospitals are acquiring physician practices and employing more physicians, this model has evolved to one in which professional services may be provided either by an independent physician or a hospital-employed physician.

It was stated by IndDoc that independent physicians face threats of losing their privileges at a hospital if they do not want to be employed by the hospital and/or they are not a member of the Physician Hospital Organization ("PHO"), an entity through which the hospital contracts with insurance companies. IndDoc explained that depending on the circumstances, a physician may opt out of participating in the PHO or be excluded from the PHO by the hospital. In either case, the physician is not part of the insurance contracts and cannot see patients covered by those insurance policies. IndDoc indicated this exclusion process is termed "economic credentialing," a process that they described as a penalty to a physician "because he or she is not working for or with a hospital." IndDoc believes there should be State policies that prohibit such exclusionary activity, noting that physicians cannot practice without privileges at a local hospital and "if they are barred for economic reasons their patients will lose their provider and probably pay more because they will need to use a hospital employed physician."

Additional testimony was given on behalf of IndDoc, suggesting that hospitals are "predatory" in how they recruit physicians to be employed by the hospital. In an effort to keep patients within the hospital system, hospitals seek to "employ their own physicians who refer within the hospital system rather than contract with independent physicians with hospital privileges." Compared to independent physician practices, hospitals are able to offer better recruitment packages to physicians. For example, a new hospital-employed physician does not have to worry about establishing a patient base because he or she will get referrals from within the hospital system. Therefore, independent physicians with contracts to provide services within a hospital can easily be replaced by physicians who are willing to be employed by the hospital. Testimony was given that independent physicians have been forced into selling to a hospital before they are replaced by hospital-employed physicians who can provide the same service. Dr. Reinhardt also noted

that younger physicians have led the trend toward more physicians being employed by hospitals.

#### Need for Change

IndDoc spoke on how the CON program in Georgia regulates and affects multi-specialty groups like The Longstreet Clinic, urging that the CON requirements be loosened for independent physician groups. This is also outlined in the "Who is IndDoc?" referred to above and attached in Appendix A. Multi-specialty groups are prohibited from acquiring a single-specialty ASC regardless of whether the center is to remain a single specialty ASC. IndDoc explained that as a result of this constraint, many physicians that would like to join a multi-specialty group cannot do so and often times end up selling their practice to a hospital because they cannot afford to remain a single-specialty ASC. IndDoc further added that as more independent physician practices are being acquired by hospitals, the number of independent physician providers in a community decreases, lowering patient-choice and competition.

IndDoc indicated that regulatory and legislative policy should enhance cost effective quality health care by supporting choices for patients and fair competition for providers. The payer system is not currently uniform, but should be for all providers. This would permit patients to select a provider willing to see them for the payment and under the terms and conditions offered by Medicaid directly, through a Care Management Organization ("CMO"), or a commercial carrier. IndDoc asked the Committee to "level the playing field" by making changes to the CON program that would sustain healthy competition among providers in local markets.<sup>7</sup>

"Bitter Pill: Why Medical Bills Are Killing Us," an article published in TIME Magazine and "The Doctor Won't See You Now. He's Clocked Out" from the Wall Street Journal were cited by IndDoc during testimony and shared with the Committee. These articles are attached in Appendices B and C, respectively.

#### **B. Thursday, October 31, 2013**

The second meeting, held in Macon at the Medical Center of Central Georgia, allowed the Committee to hear testimony primarily from the hospitals and also a rebuttal from the independent physicians at the end of the meeting.

The Georgia Hospital Association ("GHA") presented its testimony regarding the efficacy of the state's health planning process. Speaking for GHA was Keri Conley, Associate General Counsel at GHA, and Jason Bring, a partner in Arnall Golden Gregory's Healthcare and Litigation Practices group. For a number of reasons, GHA's testimony focused on the belief that changes to health care laws in the midst of health care reform would be "too much, too soon."

As stated by GHA, hospitals provide a full continuum of care for patients who enter their facilities, regardless of the size of the hospital. They are unable to focus on just one type of health care service because they have a broader mission of providing a full spectrum of health care services, such as emergency care, trauma care, and intensive care for the most vulnerable populations.

GHA explained that the standby role of hospitals is one that requires a large investment of time, capital, and resources to allow them to respond when a challenge, such as a large-scale

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<sup>7</sup> These policy points are included in "Who Is IndDoc?" This document was referred to previously and attached in Appendix A.

accident or disaster, occurs. However, until patients arrive with these emergency needs, there is no payment for the hospital and its staff to be at the ready; instead, the standby role is funded by cross-subsidization of revenue created from providing services that still maintain a positive profit margin, such as outpatient surgery and imaging. GHA posited that the hospitals' ability to be ready in a standby role is only possible with the revenue from these profitable services, unlike independent physicians, who are able to drop an unprofitable service line, such as endocrinology or pediatric neurology, if it is not producing revenue. As an example, GHA illustrated the Longstreet Clinic, which eliminated its endocrinology practice because it was not profitable. However, this service was then provided by Northeast Georgia Medical Center. Were hospitals unable to cost-shift from profitable practices, such as outpatient surgery, to the practices that are not profitable, they would be unable to subsidize the essential services provided only by hospitals. Adding to its previous point, GHA stated that cross-subsidization also allows hospitals to provide services to underinsured and uninsured patients, as well as Medicaid patients. It also allows 24 hours a day, seven days a week emergency safety net access.

#### Relationship between Hospitals and Doctors

GHA stressed the importance of the relationship between doctors and hospitals: in this symbiotic relationship, hospitals need physicians in order to carry out their mission, and physicians depend on hospitals to serve as the foundation for the local health care delivery system. The ACA encourages collaboration and integration between hospitals and physicians and allows younger physicians coming out of school with a desire to more closely collaborate with hospitals that want more physicians on staff to accomplish that goal. One example of such collaboration includes the assignment of Medicare patients to accountable care organizations ("ACOs") in which the hospital and physicians manage care for the patient by working to improve quality and patient satisfaction while also lowering costs in order to receive a part of the savings to Medicare. Another example of collaboration is the use of bundled payments for a patient's services to be shared among the providers and facilities. The integration and collaboration goal is encouraged under the ACA to improve patient quality and lower costs.

During the prior meeting, Dr. Reinhardt suggested that hospitals are predatory in their recruiting of physicians. GHA countered this position, citing physicians' desires for stable hours, stable paychecks, a better work/life balance, a lack of interest in dealing with increasingly complex regulatory and payment schemes, and a desire to focus care on patients while allowing hospital administrators to deal with the business side of delivering care. In turn, GHA explained that hospitals need these physicians to ensure emergency room coverage, the availability of specialists, and the ability to accept Medicaid patients. Hospitals continue to support independent physicians through participation in the provider payment program under Medicaid. This participation prevented an across-the-board payment cut to all Medicaid providers in 2013, including both hospitals and independent physicians. These funds are used to draw down federal funds and generate hundreds of millions of dollars per year for payments to physicians and other providers who treat Medicaid patients. GHA indicated that while the hospitals' participation in the provider payment program preserved these funds for all providers, it caused "85 Georgia hospitals to lose \$70 million in 2013."

#### The Health Care Climate for Hospitals

GHA reported that hospitals are already experiencing the consequences of changes made by the ACA and pointed to the following indicators. The increased costs and decreased reimbursements are hitting hospitals hard: the two-percent cut made under sequestration equated to a \$90 million per-year loss in Medicare payments to Georgia hospitals. Additionally, reductions in hospital disproportionate share payments are on the horizon; GHA estimated that

Georgia hospitals will likely lose over 40 percent of these DSH funds by 2019, which equates to approximately \$124 million in 2019 alone. GHA also stated that Georgia's decision to select Blue Cross Blue Shield as the sole vendor for the state health benefit plan will cut rates for providers, anywhere from \$50 million to \$200 million dollars a year, as stated. The cost-sharing component, which requires patients to pay a larger percentage of the cost of care in exchange for lower premiums, is an additional anticipated loss.

Even without these future cuts, GHA told the Committee that Georgia hospitals are suffering in the present. GHA reported that according to the DCH, 38 percent of the hospitals in Georgia have a negative operating margin. More than half (55 percent) of Georgia's rural hospitals are losing money. Three hospitals closed this year: Calhoun Memorial Hospital, Charlton Memorial Hospital, and Stewart Memorial Hospital.<sup>8</sup> Even with significant layoffs at hospitals across the state, GHA reported that hospital CEOs have indicated a need to cut an additional 20 to 30 percent from their operating costs.

#### Georgia Alliance of Community Hospitals

Following GHA's presentation, the Georgia Alliance of Community Health (GACH) presented on the climate for hospitals on a more micro level. Presenting was Monty Viesy, President of GACH, and John Parker, who presented the findings of a summer 2013 study on the financial health of community hospitals across the state and how the impact of changing CON laws would impact community hospitals. This study was completed by Bill Cleverley of Cleverley & Associates.

GACH's presentation addressed three questions: what is the current financial position of GACH; what is the potential risk that GACH hospitals would experience if they lost outpatient surgery volume; and, has the presence or absence of CON in three sunbelt states (Georgia, Arizona, and Texas) made a difference?<sup>9</sup>

#### Current Financial Position of GACH

Mr. Parker presented the current financial position of GACH by explaining the adequacy of cash reserves, the reasonableness of profits, and reinvestment in local community facilities.<sup>10</sup> He explained that the importance of adequate cash reserves is four-fold: cash is needed for working capital needs, capital replacement, contingencies, and supplementation of operating earnings. Additionally, the number of days of cash on hand ("DCOH") is an indicator of a hospital's ability to satisfy its working capital needs; this figure is determined by dividing the hospitals' cash and reserves by the average daily cash expenditures. The average daily cash expenditures of GACH hospitals is \$28.93 million, equating to \$868 million for 30 DCOH. GACH stated that along with cash reserves, debt is the only source of funding for voluntary not-for-profit hospitals. With regard to capital replacement, cash reserves less than the required replacement needs will force greater reliance on debt, which raises the cost of service delivery. As they presented to the Committee, GACH hospitals conservatively have an aggregate deficiency of at least \$1.8 billion in cash and reserves to meet their established

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<sup>8</sup> The top 10 diagnoses for patients served in each of the three closed hospitals and a payor mix for the three closed hospitals are included in Appendix D.

<sup>9</sup> A copy of GACH's Power Point presentation is included in Appendix E.

<sup>10</sup> This data came from recent audits of participating Georgia Alliance Systems, comprised of 26 health care systems with 50 hospitals; a Medicare Cost Report, which was used for five GACH systems with five hospitals; and public-use file data for Alliance not-for-profit hospitals and all United States acute-care hospitals, including Medicare Cost Reports, Medpar, and HOPPS.



needs, which include allowance for depreciation and adjustments for inflation and technological improvements.

#### Reasonableness of Profits

According to Mr. Parker, the reasonableness of GACH hospitals' profits tends to be lower than other health care sectors. When looking at the percentage of return on equity over a five-year average, GACH hospitals were at no more than half of other sectors' returns. This data is summarized below in Table 1.

**Table 1**

<b>Sector</b>	<b>Return on Equity Percentage (5 yr. avg.)</b>
GACH Hospitals (4 yr. avg.)	7.8
Drug Manufacturers - Major	18.9
Medical Care	31.2
Health care Plans	16.1

According to Mr. Parker, the Alliance of Not-for-Profit Hospitals' growth is not sustainable, as more profit and equity growth is required to keeping pace with the liabilities. This low level of profitability implies that Alliance hospitals are transferring value to their communities.

#### Potential Impact of Losing Outpatient Surgery

By looking at twelve months of outpatient (OP) surgery claims between July 1, 2012 and June 30, 2013 in 30 GACH hospitals, Mr. Parker posited that the loss of commercial OP surgery business could have a devastating impact on GACH's financial position. The following data was made available to the Committee through GACH's presentation, which is attached in Appendix E. OP surgery is an area of higher margins than other hospital services due largely to the payer mix, as 70% are commercial patients (as opposed to Medicaid or Medicare payers). These commercial OP surgery patients produce a 30.8% profit margin, which counterbalances the profit losses sustained from Medicaid and Medicare OP surgery patients, thus producing a 21.2% total profit margin. A reduction in OP surgery volume of 50% could reduce profits by \$209 million.

#### Comparing Georgia to Arizona and Texas

Mr. Parker gave a short overview of how Georgia compares to Arizona and Texas with regard to CON laws. Adjusting for case mix and cost of living differences, Georgia hospitals have lower prices than Arizona or Texas. The costs in Georgia are somewhere between Arizona and Texas, the differences of which appear related to clinical decision-making. However, as stated by Mr. Parker, actual costs per unit of production are lower in Georgia. Finally, he indicated that Georgia hospitals have lower levels of profit compared to Arizona and Texas.

#### Audience Comments

A number of members of the audience spoke to the committee following the testimony from GHA. First was Joe Stubbs, an internist/geriatrician with Albany Internal Medicines, an independent physician group created in 1954. For him, the key issue for the committee is value, which is the highest quality health care at the lowest price. Because health care no longer operates in a free market environment in Georgia, Dr. Stubbs argues that health care outcomes are far below the optimal level in the state. The anti-competitive, monopolistic trends across the state result in higher cost, less choice, and less security for patients. In conclusion, Dr. Stubbs asked for a level playing field to allow independent physicians to better compete in the marketplace.

John Marrero, the group administrator for SouthCoast Medical Group, spoke next. SouthCoast Medical Group is a 70 physician practice providing primary care and which is seeking to become a patient-centered medical home. Mr. Marrero argued that the current business environment leaves physicians with no other option than to consolidate or join with a hospital. For example, Mr. Marrero spoke of a number of physicians in the community who desire to consolidate with SouthCoast, but are unable to do so because of CON laws. Mr. Marrero argued that an already inefficient system is not improved by CON laws; instead, such laws are increasing the cost of healthcare, as office visits performed in a hospital by the same physician who can provide the service outside the hospital setting cost 70 percent more than if the physician provided the service in his private practice.

Finally, Victor Moldovan of McGuireWoods, LLP spoke for IndDoc, arguing that competition and choice is good in the health care market. If everyone agrees that the mission of health care is lowering costs and increasing quality of care, IndDoc believes the best way to achieve those ends is to facilitate choice of providers. Mr. Moldovan stated hospitals are acting like free markets and divert patients from local communities; this free market should apply across the board. Even though the hospitals argued that the health care climate is changing dramatically and rapidly, Mr. Moldovan argued that everyone feels this pressure; the state should not be in the business of picking winners and losers in business.

### **C. Tuesday, December 17, 2013**

The third meeting was held at Harbin Clinic in Rome, Georgia. Dr. Ken Davis, President of the Harbin Clinic and member of IndDoc, welcomed the Committee and gave opening comments. Harbin Clinic has served the Rome community for 150 years and is the largest privately-owned, multi-specialty group in Georgia with over 200 providers in 34 subspecialty locations. Harbin Clinic existed as a hospital until the 1940s, when it closed due to its physicians not wanting to compete with a public hospital owned by the community. Harbin Clinic is concerned about its survival due to critical issues facing independent physicians in Georgia.

Victor Moldovan, a health care attorney from McGuireWoods, LLP who presented testimony at the first two meetings, also gave opening comments on behalf of IndDoc. He stated that IndDoc supports a system with strong hospitals and strong clinics that is conducive to supporting a healthy, competitive environment. To support this point, he cited to the Rome community, where physicians and hospitals work well together because the physicians are strong enough to partner with hospitals. He explained that when there is little competition, the costs for all payers will increase. These costs referred to by Mr. Moldovan include copays, deductibles, insurance premiums, as well as those paid by the state under Medicaid and SHBPs. It was also explained that independent physicians have expressed a growing frustration regarding their relationship with hospital staff and administration. This includes concerns that they are losing their autonomy and voice in hospitals, where hospital-employed physicians are beginning to control hospital boards through majority votes.

Ms. Carrie Conley and Mr. Jason Bring presented for GHA on hospitals' standby role. GHA noted that since the previous meeting, the ACA rollout has gone from "bad to worse, which further underscores the need for temperance at the state level" and "now is not the time for the State of Georgia to challenge hospitals even further."

### Importance of Hospitals from a Patient Perspective

GHA stressed the unique importance of hospitals to their patients in local communities, as these patients are the reason that the state and local communities have invested so many resources in local hospitals for the last fifty years. To illustrate the “real life” consequences that occur when hospitals are forced to close, GHA gave an example following the closure of Charlton Memorial hospital in Folkston, Georgia. A patient who was horribly burned could not be taken to Charlton Memorial and there were no ambulances in Folkston to transport her to a hospital because those ambulances were all in use transporting patients to other area hospitals. According to GHA, this patient was forced to wait for an available ambulance to return to Folkston and upon seeing the severity of the burns, EMS called for an airlift, and treated her pain in the meantime; it had been an hour and a half since the patient’s accident and she had yet to see a medical professional. GHA reported that local citizens who need routine hospital access were also affected by the hospital closure and are contemplating moving from Folkston to other communities that have hospitals.

GHA spoke on the broader mission of hospitals, where one type of health care service cannot be the focus, and what GHA believes is expected of hospitals. Georgians rely on hospitals to be equipped with resources and skills, standing by and ready to provide around-the-clock access to care and be a safety net provider. Patients expect and need hospitals to be available to respond to disasters. GHA reminded the Committee of the sugar refinery plant explosion in Savannah that took place in February of 2008. Memorial Medical Center was ready to respond and immediately went into response mode, implementing a disaster plan that was regularly rehearsed by hospital administration and staff. GHA played a brief video to illustrate the important role Memorial Medical Center played, supporting GHA’s argument that this sort of orchestrated response and care could only have come from a hospital.

### The Standby Role of Hospitals

The “standby role” is defined as “the need to stand at the ready to handle large-scale accidents, respond to natural and other disasters, and provide care for epidemics,” as stated by GHA. While the hospital is standing at the ready, there is no payment for the hospital facility and staff. GHA explained that since the standby role is not explicitly funded, it is built into the hospital’s overall cost structure, supported by revenues from profitable services such as outpatient surgeries and imaging. While GHA agrees with IndDoc that the state’s health care mission should include higher quality and lower costs, GHA believes the mission must also include access to care. GHA pointed out that hospitals remain the primary location where all patients can access quality health care 24 hours a day, seven days a week, regardless of payment source.

GHA responded to the argument that hospitals cost more, saying that hospitals are highly efficient and do not cost more. GHA explained that reimbursement is higher for hospitals because of the standby role, doing “so much with so little.” Additionally, pulling high margin cases from hospitals is not a cost saving measure and is instead a net loss to their health care system. GHA stated to the Committee that Hospitals have been working to lower the cost curve so everyone has access to care, regardless of their payor source.

GHA next presented figures for physician-owned ASCs, arguing a lack of access to care. These figures are summarized below in Table 2. In each year figures were given, the physician-owned ASCs provided less than half the Medicaid, about one-fifth the indigent, and only about one-fifth the charity care. GHA offered that the disparity is even greater than the numbers indicate since the physicians were included in the number for all ASCs.

**Table 2**

<b>2012</b>	<b>Medicaid</b>	<b>Indigent</b>	<b>Charity</b>
All ASCs	5.13%	1.58%	3.15%
Physician Owned	2.67%	0.38%	0.43%
<b>2011</b>			
All ASCs	6.15%	2.05%	2.75%
Physician Owned	2.48%	0.42%	0.56%
<b>2010</b>			
All ASCs	6.62%	1.99%	2.86%
Physician Owned	2.40%	0.37%	0.31%

As stated to the Committee, the indigent and charity patients who are not accommodated by physician-owned ASCs are sent to hospitals. GHA believes "it's not so much who the physician's aren't treating; it's who they are treating that's the problem." GHA stated that for various reasons, physician-owned ASCs get high paying insurance cases, while other facilities like hospitals pick up a "highly disproportionate share" of the Medicaid, indigent, and charity care patients. One reason GHA pointed to was that "more elective surgeries are performed in ASCs and those getting elective surgery usually have private insurance." GHA stated there is a shifting of lucrative, high margin cases away from hospitals and the state should not make changes to its CON program that would pull more cases away from hospitals. GHA also noted that the indigent and charity obligations for hospitals are tremendous.

GHA argued that what IndDoc and its supporters are proposing is not a leveling of the playing field because it would leave struggling hospitals without the resources to meet standby role obligations. Hospitals play vital roles in communities, often times serving as the largest employer, in addition to providing around-the-clock emergency services and access to necessary specialties. GHA pointed to the obligations of hospitals and the services they must provide to meet federal regulations such as the screening and stabilization of every patient that comes to the emergency room.

GHA disagrees with IndDoc's belief that consolidation trends between hospitals and physicians will ultimately reduce market competition for physicians, pointing to the lack of evidence offered in support of IndDoc's argument. GHA believes that the focus should be on patient quality, not on physician bargaining ability in the local market. Furthermore, it reports that the most prestigious health systems in the country are highly integrated models and the ACA encourages integration to improve patient quality. GHA pointed out to the Committee that competition is no longer on just a local scale and is present on a national level; large employers are entering into national contracts with high quality health systems to provide services to employees.

GHA reminded the Committee that in 2005, the Georgia General Assembly and Governor Perdue appointed a commission of the efficacy of CON. The 2007 report revealed that not one member of the commission voted for the exemption of multi-specialty groups. GHA stated that again in 2008, CON arguments were heard again and while the CON program underwent major reform, no special exemption for multi-specialty groups was passed. GHA believes that in this current "tidal wave of change," a change to the CON program would be "too much too soon." The federal health care reform has reduced payments for hospitals and physicians and hospitals help to fund the ACA. GHA warned the Committee that "we're about to see huge cuts to hospitals in order to make up for these increased expenses," making it ever more important

for hospitals to sustain their remaining profit centers. Finally, GHA asked that "we all step back and take the time to digest the flood of change that is currently upon us," and asked that the Committee recommend no CON action be taken at this time.

Advocating for CON change, Mr. Frank Barron, a Rome community business leader, gave testimony on the importance of the Harbin Clinic to the Rome community. As a business man, he also recognizes and suggests that new times require new ways of doing business.

Next, Ms. Stephanie Zaremba of Athena Health Care ("AHC") presented testimony, advocating for independent physicians and new referral policies. A Power Point presentation titled, "Consolidation in Healthcare: Unintended Consequences for Independent Providers" was shared with the Committee and is attached in Appendix F. The presentation explained how market consolidation and anti-trust laws will result in higher insurance premiums for patients. It also explains the ACO model, where risk is shared by the members of the ACO. AHC believes that accountability will decrease while costs increase in these ACO "biospheres that lock in patients, doctors, and data." AHC also stated that there may be lower cost providers outside the ACO structure and empowering independent physicians to take on risk will eliminate these "biospheres." Urging that "we must enable third parties to help independent physicians share risk," AHC suggested that Independent Risk Managers ("IRMs") acting as these third parties could 1) enable risk pooling; 2) allow providers to contract with payers to offer a risk-based reimbursement model; and 3) provide a technical infrastructure and administrative expertise. These IRMs would enable providers to transition from fee-for-service to value-based models, focus on providing high quality, low cost care, coordinate care based on clinical objectives, and allow physicians to remain independent. AHC also suggested that referral patterns be changed to reduce costs and allow for interoperability and high quality care to be delivered to patients in the health care system.

Next, Dr. Donald J. Palmisano, Jr., Executive Director and CEO of Medical Association of Georgia ("MAG"), provided testimony on behalf of MAG. A Power Point presentation titled, "What is Happening to Independent Physicians in Georgia?" summarized state and national trends among independent physicians. This presentation is attached in Appendix G and includes the sources relied upon by MAG in presenting the following data and statistics. Independent physicians directly create 100,000 jobs in Georgia, generating more than \$15 billion in wages and benefits and more than \$1 billion in state and local tax revenue. MAG also indicated that over the past ten years, the number of private practices has decreased nationally due to administrative burdens, student debt, patient protection and the ACA, Medicaid and Medicare payments, and hospital and large practice group environments. MAG reported that prior authorizations are costing the national health care system between \$23 billion and \$31 billion per year and every full-time physician \$82,975 to \$85,276 per year. The cost of implementing the ICD-10 coding system has also been significant to all providers, including independent, small practices. MAG's presentation reported that the Centers for Medicare and Medicaid Services ("CMS") Medicare fee schedule regulation shows that the 2014 relative values will only cover 54 percent of the direct practice costs for each service. MAG also noted that for hospital and large practice group environments, legal costs are cheaper, there are in-house coders, and younger physicians are attracted to these systems because they want stability in their practice.

Finally, closing comments were given first by Dr. Davis and then Mr. Moldovan. Dr. Davis responded to the hospitals' testimony, rebutting that the closure of three small hospitals is not a reliable or appropriate indicator of how the large hospitals are doing. He further argued that large hospitals are rapidly expanding through acquisitions and the building of new structures

and should be distinguished from small hospitals that cannot survive regardless of physician choice and employment. Mr. Moldovan agreed with this point, emphasizing that the independent physicians have not impacted in any material way the closing of small hospitals. Instead, he argued that the smaller hospitals are being negatively impacted by the larger hospital systems by taking the traditional pool of patients in a community and sending them to the larger hospitals in neighboring counties.

Mr. Moldovan briefly provided closing comments before the Committee adjourned. On behalf of IndDoc, he shared the feelings felt by many independent physicians who believe they are treated differently than employed physicians by hospitals. The Committee was reminded of the purpose of IndDoc, which is to raise the voice of frustrated independent physicians who are not being heard. He noted that these physicians are the sole source of competition for hospitals and they need to be able to compete and remain a "less costly alternative to hospital-controlled physician services." A Power Point presentation was submitted to the Committee, addressing WellStar and summarizing major points of IndDoc's testimony over the past three meetings.<sup>11</sup>

#### **IV. RECOMMENDATIONS**

It is the recommendation of the Committee that no action regarding Georgia's CON Program be taken at this time. With the ACA taking effect January 1, 2014, the significance of the effects the ACA will have on the State's health care system and patients is yet unknown. Therefore, no changes should be made at this time that could negatively interfere with the ability to independently evaluate the effects of the ACA and the issues brought before the Committee. While the Committee recommends no change at this time, it recognizes there may be some issues for the Senate's attention in the future.

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<sup>11</sup> The Power Point presentation is attached in Appendix H.

## **V. CONCURRING REPORT BY SENATOR HUFSTETLER OF THE 52<sup>nd</sup>**

While the CON laws in Georgia were set up to define need, control cost, and guarantee access to health care they appear to result in different results in different markets in Georgia.

One of the biggest changes in recent years has been when a doctor works for a hospital it often means more money for the exact procedure, quite often in the same location if the physician is hospital owned. This has resulted in hospitals acquiring physicians at a rapid pace since they can use the extra payment to pay for the acquisition. The end result is often more centralization of control in the marketplace and is one of several reasons contributing to less independent physicians. This is because of an arbitrage between Medicare's inpatient (part A) and outpatient (part B) billing schemes. Hospitals have gone on a buying spree with the aim of bringing the physician services and procedures under Part A. The Federal Government has set up this system and it is not a result of State of Georgia policies.

Additionally it was stated that the State of Georgia's change to Blue Cross will cost millions to hospitals and/or surgeons due to lower negotiated rates. But it is not the state's responsibility to negotiate rates between health care and insurance companies. It is the state's responsibility to get the best plan at the best price for both the taxpayers and the employees of the state of Georgia.

Hospitals counter that many hospitals are in the red, particularly in rural areas and need the help to survive. While many hospitals are in financial distress I don't believe this is caused in any way by physicians but is the result of increasing specialization and patients migrating to larger facilities that can handle more complex cases. Nevertheless it is a problem and the rural hospitals and we as a state need to study different business models in these rural areas.

While this is an arbitrary rule I am also concerned that the marketplace would be disrupted by this change alone, particularly with the higher percentage of Medicare, Medicaid and Indigent care now furnished by hospitals in relation in ASC's and I believe further work needs to be done to address this inequity before any changes are made.

The one area that I believe should be looked at now is the issue of "economic credentialing". This is most often a problem in areas with only one hospital who will use their monopoly to keep out competition. This law should be changed in my opinion as it reduces competition and I believe decreases quality of care.

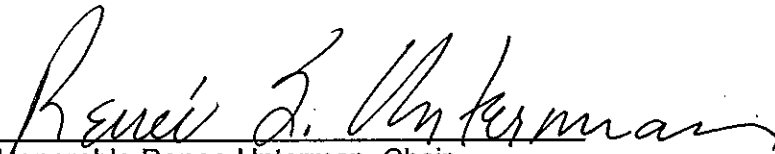
In summary, while the playing field is not level and is somewhat exacerbated by the Federal Government, I don't believe we are ready to recommend a change at this point but I do believe we need to address the issue of "economic credentialing" in this session.


## **VI. APPENDICES\***

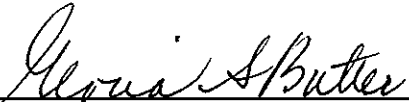
\* Due to the number of attachments and file size constraints, all Appendices not attached with this report are available and on file in the Senate Research Office.

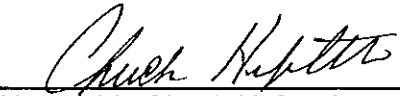


Respectfully Submitted,  
Members of the Senate Study Committee on Independent Physicians in Georgia

  
Honorable Renee Unterman, Chair  
Senator, District 45

  
Honorable Dean Burke  
Senator, District 11

  
Honorable Gloria Butler  
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