

Written Testimony of the

Connecticut State Medical Society

Connecticut ENT Society

Connecticut Urology Society

Connecticut Society of Eye Physicians

Connecticut Dermatology and Dermatologic Surgery Society

Connecticut Chapter of the American College of Surgeons

On

SB5447 AN ACT CONCERNING THE CERTIFICATE OF NEED PROCESS

March 12, 2010

Good Morning, Senator Harris, Representative Ritter and other distinguished members of the Public Health Committee.

For the record my name is Dr. Steven Levine and I am a board certified otolaryngologist practicing in Trumbull, CT. I am also the President-Elect of the Connecticut Ear, Nose and Throat Society, Chair of the Connecticut State Medical Society's Ad Hoc Committee of Specialty Societies, and Member of the Connecticut State Medical Society's Legislative Committee.

Today, I am here to represent the more than 7000 physicians of the Connecticut State Medical Society (CSMS) including physicians in the various medical specialties listed at the top of this testimony. We support SB5447 with proposed amended changes.

On behalf of the aforementioned societies and specifically at the request of CSMS, I participated in the closed door meetings called by then Commissioner Christine Vogel and the Office of Health Care Access (OHCA). These meetings convened March 10, April 7, and May 1, 2009 at OHCA's office. Many of the changes recommended by those discussions are included in SB5447. For the sake of brevity, I will limit my comments only to those Sections that we believe should be amended.

Section 4 defines the purpose or essence of the Certificate of Need (CON) process. The original language is very detailed. The replacement language is short, leaves a lot of latitude, and has language that dictates that the process is intended to "**ensure access** for all state residents to **cost-effective services** and to **avoid duplication of health services**". Access and duplication are mutually exclusive and create inherent conflict since duplication of services ensures public access to those services. Tools of differing levels of sophistication and costs will increase access and more access further reduces the expense of services provided by those tools. More restricted access generally means more cost and higher cost of care. Therefore, in order to best serve the interests of our patients, we recommend that "duplication of health services" be deleted since "cost-effective" is the more important consideration.

Section 5 lists the events which will require a CON. I call your attention to sentence 9.

(9) The acquisition of imaging equipment, including CT scanners, MRI scanners, PET scanners, and CT/PET scanners by any person, physician or provider other than short-term acute care general hospital or children's hospital.

This bill has already clearly defined health care facilities in Section 1. Why is this section specific to "any person, physician or provider"? Furthermore, why are hospitals excluded from the CON process when it comes to acquiring such equipment? Please consider omitting this unique inclusionary and exclusionary language.

The sentence starts with the words "acquisition of imaging equipment." Where in the document is "imaging equipment" defined? What does that include and what does that exclude? Camera? Video camera? Endoscopic video camera? Imaging by light reflected means? Imaging by other parts of the electromagnetic spectrum including radio waves, ultrasound, thermal radiation, x-ray, gamma ray, laser refraction? How will this affect electronic health records and the myriad of new directions to image the body and share those images? Please consider omitting the use of the term "imaging equipment".

If, according to Section 4, the intent of the CON is to ensure access to cost-effective services, is any of that achieved by sentence 9?

New technologies are an important part of medicine, and there always will be growth in new technologies especially to image the human body and to do so with far greater detail and safety. So why is there such focus on these four types of scans or any particular technology? Is better patient care served by this?

On the other hand, we can appreciate the value of the CON process with regard to high expense items and we also recognize that with time all technologies become less expensive. We therefore support the re-establishment of a fixed dollar threshold, below which CON is unnecessary for imaging equipment, as was in place prior to 2005. Our recommended threshold is \$750,000. Furthermore, we contend that re-establishing a threshold solves other issues as well.

For example, why are acute care hospitals excluded from this requirement especially since such imaging is not typically an inpatient service? Most commonly, these are outpatient services. If a dollar threshold was re-established, then such exclusions become superfluous and unnecessary.

Sentence 12 of Section 5 has a similar concern and solution.

(12) The acquisition of equipment utilizing technology that has not previously been utilized in the state.

This is a catch-all phrase that is far too broad. New technologies are constantly being introduced in all aspects of the health professions. This sentence would obligate the Department of Public Health to review hundreds of CON applications per year with regard to every new nuance of modern medical practice. However, if a dollar threshold of \$750,000 was enacted, then a reasonable bar is established defining what technologies should require a Certificate of Need.

Next, I call your attention to sentence 17 of Section 5.

(17) Acquisition of cone-beam dental imaging equipment by a dentist.

Cone-beam imaging uses x-ray beam shaped like a cone rather than a fan as in conventional x-rays or conventional computed tomography (CT). After this beam passes through the patient the remnant beam is captured on an amorphous silicon flat panel or image intensifier/charge-coupled device (CCD) detector. The beam diameter ranges from 4 to 30 cm and exposes the head in one pass around the patient capturing from 160 to 599 basis images. This is the same technology used for office based CT scans of the head and neck including sinuses and mastoids. The only difference between dental and head & neck imaging is the software used to interpret the images derived from the cone-beam. If there was a dollar threshold, this too would be superfluous.

Finally, limiting Connecticut physicians from acquiring new technologies limits the interests of young physicians in joining practices in our state. If you can't have a hand held ultrasound to check a child's abdomen or to check if a bone is broken, and you are a pediatrician, why come to Connecticut? Go to New York, Massachusetts or Rhode Island where you can have not one but two of those machines without a Certificate of Need that exceeds the cost of the device. We don't just want these new technologies only in our crowded emergency rooms or hospitals; we want them in the hands of everyday practicing physicians so they can serve the public.

In closing, we ask that this committee consider an amendment, which would (1) remove the words "avoid duplication of health services" from Section 4, (2) remove sentences 9, 12 and 17 from Section 5, and (3) add new language to re-establish a reasonable dollar threshold which we contend is \$750,000. Such language is already available in Section 19 of this bill.

Thank-you for your consideration and I can answer any questions at this time.