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# Health Planning

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the newsletter of the  
American Health Planning Association

*President's Message  
Summer 2004*

## Health Planning TODAY ... and TOMORROW by Dean Montgomery

Surely, the disquieting anomalies of our health care system cannot go on forever. So, according to Herbert Stein, a former Chairman of the Council of Economic Advisors, they can be expected to stop. Stein had a long life and was right about many things (serving Richard Nixon may be the exception), so planners might keep his observation in mind as they confront current and looming difficulties. The underlying question is whether one can take comfort from the prospect that "things" will right themselves, someday.

Most planners either lack Stein's equanimity or, more likely, have the uneasy feeling that, as with many other arguments grounded in economic theory, the underlying principle has only limited applicability in health care. We are inclined to feel the need to act, to try to take control of the situation and guide change. Nevertheless, distinguishing between those things that may cure themselves, and those that must be cured, can be useful. Making use of Stein's admonition requires some basic information and tentative determinations:

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# Health Planning TODAY

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Dean Montgomery.... President  
Vacant..... President-Elect  
Sonya Albury.....Past President  
Robert Vogel..... Secretary  
Karen Cameron.....Treasurer  
Thomas Piper.....Information Coordinator

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**Dean Montgomery**  
7245 Arlington Blvd., Ste. 300  
Falls Church, VA 22042  
Phone: (703) 573-3103 Fax: (703) 573-1276  
Email: [AHPAnet@aol.com](mailto:AHPAnet@aol.com)

Information for the quarterly journal is due on March 1, June 1, **September 1**, and December 1. Articles should be short — no more than one page of text. The Editor reserves the right to edit any article or submission, as needed.

Information may be submitted via e-mail to:

"dschuess@mail.state.mo.us" or  
"tpiper@mail.state.mo.us" or  
faxed to (573) 751-7894.  
**Donna Schuessler, Editor**



## Health Planning TODAY . . . and TOMORROW Cont'd. from page 1:

- ❖ What are the principal or critical unsustainable aspects of the system?
- ❖ Is the unsustainable practice or trend largely positive or negative?
- ❖ What are the implications of the practice or trend stopping or reversing?
- ❖ Is the practice or trend at risk of ending, abruptly or otherwise, amenable to planning intervention?

Current patterns and trends that planners may profitably examine in this context include:

### The shift from inpatient to outpatient care:

The shift over the last two decades has been exceptional. Can it continue? If so, at what pace, and in what services and areas?

### Health care spending levels:

Can they continue to rise apace? If so, how long and at what consequence for the medically indigent?

### Health disparities:

Can disparities in health status, and in access to care, be permitted to widen? If so, at what social cost?

### Nursing home use levels:

Will they continue to fall? If so, how quickly and to what level(s)?

### Population growth and aging:

Recent demographic trends have been atypical. Are they sustainable, or likely to continue?

### Procedure rates:

Recent procedure growth rates (e.g., CT, MRI, surgery) have been extraordinary. Are they likely to continue?

### Shift to for-profit service delivery models:

Will it continue unabated? Are the long-term implications of the conversion of public and not-for-profit health care entities to for-profit status understood and acceptable?

### Current building boom:

Will it continue? Does it represent prudent investment or speculation? What is the more effective and constructive role of planning?

Answers are elusive. But, the questions are worth considering when one tries to decide whether intervention in a perceived health care problem is:

- First, necessary;
- Second, likely to be successful; and,
- Third, likely to be more useful than counterproductive.

It may also be worth keeping in mind another equally illuminating Stein maxim, namely "a thing that is unsustainable will not be sustained". We need to be alert for those unsustainable health care practices and trends that may come to an abrupt stop, lest we be ceremoniously unhorsed.

**"If a thing cannot go on forever, it will stop."**

Stein's Law, Herbert Stein, various dates 🍎




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<[ahpa@socket.net](mailto:ahpa@socket.net)>

# Policy Perspective

by John Steen, Consultant, Health Planning and Health Policy

## **Bioterrorism Preparedness and Community Hospitals**

At a time when protecting our communities is of paramount concern, many communities have yet to address preparedness for a major biological, chemical, nuclear, or radiological event. This is especially true in small towns with limited resources. It is our major metropolitan areas that are receiving attention, including national funding for preparedness, but terrorists bent on instilling fear in the population might well see the greater potential for having psychological impacts in small towns.

Community hospitals are key players in their communities, and small towns depend on them for most of their health needs. Noting that virtually all disasters, including intentional terrorist events, will be experienced at the local level, the Joint Commission on Accreditation of Health Care Organizations (JCAHO) issued a task force report last year offering guidance to hospitals in fulfilling their roles. The report, *Health Care at the Crossroads: Strategies for Creating and Sustaining Community-wide Emergency Preparedness Systems* can be accessed at <http://www.jcaho.org/accredited+organizations/ambulatory+care/advisor/2003issue1/emergency+preparedness.pdf>.

It emphasizes that many communities will be on their own for the first 24-to-72 hours after a disaster. The response that must be mobilized will, at a minimum, require the active involvement of emergency medical services, fire, police, hospitals, public health agencies, and municipal and county leaders. This is no task for a single hospital or agency, the report points out. "Many of our large metropolitan areas, such as New York City and Washington, D.C., are far better prepared to deal with terrorist attacks and other disasters than they were before September 11," says Dennis S. O'Leary, M.D., Joint Commission President. "However, most of America's communities are at the stage of waiting for someone to call the meeting. Knowing that terrorist strikes will focus on the objective of creating fear, small-town communities and cities of modest size can ill-afford complacency today," O'Leary says.

All told, the report offers 41 recommendations under the following three strategies:

- Enlist the community in preparing the local response;
- Focus on the key preparedness system priorities, such as definition of surge capacity, protection of caregivers, and provision of mental health support; and
- Establish accountability, oversight, leadership and funding.

## **Community Planning: Our Health Depends On It**

To address this compelling need, the report calls for key community leaders to play a convening role in those communities that lack emergency preparedness programs. If a community has an emergency management agency or a public health agency, they may play this role; otherwise it will,

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## Policy Perspective

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of necessity, be the responsibility of the local hospital to do so. The JCAHO report calls for the development of scalable model templates for this community planning. A great deal of funding is also needed to translate planning into potential action, but federal funding to date has not been directed toward community level public health. Despite their JCAHO accreditation mandate for emergency planning and preparedness activities, community hospitals have so far failed to receive federal terrorism preparedness funding for this specific purpose.

The challenge facing these communities is also one of conducting community-wide health education to gain the informed support of the general public as well as of emergency responders and health professionals. Public confidence in the plans and the players is the best defense against panic. And no plans will work without having earned the confidence of emergency personnel and caregivers who will be required to minister to public need rather than to their own families.

Our own vulnerability as a nation is in large part based on the under-investment in public health over the past thirty years, part of a short-sighted judgment to favor quick profits and low taxes at the expense of community resources. Among these resources are the hospital beds needed to accommodate the victims of terrorism along with the nurses to staff them, the lab technicians to do the testing, and the home care workers to allow the victims to be sent home. People are our greatest resource, and we all need to have a role in protecting our own communities. To rely on technology to protect us is as stupid as it is dehumanizing.

We have lived in the age of home rule for so long, we have forgotten how to do regional and national planning in the public interest. Our communities need an education in new realities, and renewed interest in public policy. We need our government agencies to work **with** our communities, not just **for** them.

### **Single-Payer Universal Health Care In California**

One year ago in this column, I wrote that California State Senator Sheila Kuehl had introduced State Senate Bill SB 921. On June 22nd, the bill was passed by the State Assembly Health Committee by a vote of 12 to 5. It had already passed the full Senate last year. The bill proposes a comprehensive health care reimbursement system to cover all of the state's residents that would include medical, dental, vision, mental health, and prescription drug coverage among its benefits. It would separate health insurance from employment status by making it an entitlement. It is the only state plan that uses the efficient single-payer approach in order to accomplish this. A key provision of the plan requires the State of California to use its purchasing power to negotiate directly with pharmaceutical companies to buy prescription drugs in bulk, thus drastically lowering their cost. It has been projected that the plan would save the state about \$14 billion in administrative healthcare costs alone.

Under California's legislative system, the bill will have to be reintroduced next year. In the meantime, economic studies will be initiated to develop the revenue package to fund the new health system. A tax system will replace what Californians currently spend in premiums, deductibles, co-pays and out-of-pocket expenses, with a net saving to the state's residents. Nevertheless, as a new tax increase, California law requires a two-thirds vote in both the Assembly and the Senate for passage. The Republicans vote as a solid block against all tax measures, and they constitute more than one-third of each chamber. To date, over 500 organizations have gone on record in support of the bill. 🍏

## Boutique Hospitals: Competition or Exploitation?

by John Steen, Consultant in Health Planning and Health Policy

These new medical centers are for-profit ventures that specialize in specific high-revenue procedures including cardiac, cancer, and orthopedic surgery. The federal government estimates that about 100 specialty hospitals are in operation nationwide.

Relative to general hospitals, specialty hospitals, as a group, are much less likely to have emergency departments, treat smaller percentages of Medicaid patients, and derive a smaller share of their revenues from inpatient services. For example, according to the General Accounting Office (GAO), 45% of specialty hospitals, but 92% of general hospitals, have emergency departments.

The GAO completed two studies of specialty hospitals for Congress last year. The first, released in May, found that specialty hospitals generally treat less-acute patients. It reported that the median percentage of severely ill patients treated in community hospitals is 29% higher than the median percentage of ill patients treated in cardiac boutique hospitals, 60% higher than at orthopedic boutique hospitals, and 100% higher than at surgical boutique hospitals.

The second study, released in October, found that growth in specialty hospitals tends to be in areas with large group practices and no certificate of need (CON) requirements for new construction. About two-thirds of the 100 specialty hospitals GAO identified were located in only seven states. Most of the specialty hospitals in development are also in those same states, each of which had 5-to-20 specialty hospitals. The states are Arizona, California, Kansas, Louisiana, Oklahoma, South Dakota, and Texas.

### **Medicare/Medicaid Moratorium**

As part of the Medicare reform legislation passed in November, Congress ordered a temporary ban on physician billing of Medicare or Medicaid for patients treated at any new specialty hospital in which the doctor has a financial interest. These two programs fund up to 70% of the revenues of specialty hospitals. The moratorium was aimed at giving federal officials time to study whether specialty hospitals are having a negative impact on community hospitals. The legislation directed the Medicare Payment Advisory Commission (MedPAC), the GAO, and the Department of Health and Human Services (DHHS) to study the issue and report to Congress before the ban expires. After 18 months, Congress will have to decide whether further action is warranted. Without additional legislation, the moratorium will expire in May 2005.

Two separate studies are to be completed within 15 months of the effective date. MedPAC is to determine differences in costs of services between physician-owned and full-service community hospitals; the extent to which both types treat certain patients; the financial impact of physician-owned specialty hospitals on full-service community hospitals; the proportions of payments by payer in both types of hospitals; and how the DRG system should be updated to better reflect the costs of hospital care. DHHS is to determine the percentage of patients admitted to physician-owned hospitals who are referred by physician owners; the referral patterns of physician owners to their own hospitals and to full-service community hospitals; the comparison of quality of care in both settings; and assessment of differences in compensated care in both settings, including the value of tax exemptions available.

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**commentary**

## Commentary

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The legislation effectively bans the development of new physician-owned specialty hospitals and limits the expansion of existing facilities for 18 months. That would allow congressionally-ordered studies to explore whether these hospitals are cherry-picking healthier patients and those who require surgery for which the government-run Medicare program provides generous reimbursement. Community and general hospitals argue that it is a conflict of interest for physicians to refer patients to facilities in which the doctors are investors. While federal law generally prohibits such self-referrals, there is an exception for hospitals.

### **Competition or Exploitation?**

Boutique hospitals like to claim that their success is a result of their ability to compete effectively for patients with community hospitals which they claim are no longer attractive to the physicians practicing in them nor to the patients served by them. The reality is that there is no true competition for patients between hospitals because the market is driven by physician referrals, and the driving force behind the success of boutique hospitals is the ability of their physician investors to self-refer patients. By referring their most desirable patients, those who are well-insured and healthier than the uninsured, and those requiring the best reimbursed services, they are able to assure the financial viability of their specialty hospitals. In this way, they are able to exploit the Medicare program because it pays a fixed sum for the treatment of a particular diagnosis, regardless of the cost of the services required by a particular patient. The first GAO study confirms that boutique hospitals tend to treat those patients that are less sick, and therefore more profitable.

Opening a boutique hospital in a rural community could cause the local community hospital to reduce charity care and community benefits, reduce services to the uninsured, and reduce quality-improving capital investments in medical technology and information systems. The entry of a specialty hospital in a rural area would require the community hospital to forfeit its sole community provider status under federal regulations. The entry of the specialty hospital would threaten the loss of millions dollars of sole-provider funds, half of which comes from the county and half from the federal government. To qualify for the federal funds, a hospital must be the only provider within a 30-mile radius.

Modeling the system, Medicare and Medicaid included, is nothing new in health care delivery. But this phenomenon is part of a much larger process of the polarization of service delivery, where financial considerations have replaced community values. If they can afford to do so, individual patients, physicians, and hospitals can serve themselves without concern for meeting community needs. Thus are communities divided economically. Those communities are left with harder-to-meet needs and less in the way of financial and other resources to meet them. It is left to legislators to decide whether they will legislate for regulation in order to seek greater equity in bearing the burdens of underserved populations and uncompensated services, thereby preserving the greater public interest.

### **Communities Divided**

Community hospital administrators are hard pressed to meet the growing demands of patients and medical staffs alike for greater amenities and better outcomes while serving the entire cross-section of their communities. Specialty hospitals in general offer more favorable staffing ratios than larger hospitals, with increased job satisfaction for nurses and the ability to offer personalized care to a smaller number of patients. Nurses typically care for only one or two patients on any given shift, and 4-to-1 during the evenings. Most boutique hospitals allow patients to remain in one room throughout their hospital stay and to see the same nurses daily. As a result, the hospital stay for the already healthier patients at a specialty hospital is often shorter than that of a standard hospital.

States with CON programs in place covering the establishment of hospitals and ambulatory surgery centers have a public process for planning and review that can address their community issues in the public interest. Realizing this, legislators in states without CON are reconsidering its potential role in seeking equitable solutions that best serve all parties.

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**Commentary**

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In the absence of CON, the issues are being aired in the press while local officials are powerless to intervene and state legislators are torn between constituencies. For example, Pennsylvania's CON program sunsetted at the end of 1996. In Butler, a community of about 15,000 in Western Pennsylvania, Butler Memorial Hospital has plans to build a separate for-profit specialty outpatient surgery center. Its own nurses argue that the new facility could affect the existing hospital's finances, patient safety and nursing jobs. They have raised the issue that, if the facility is constructed on a separate site, patients could be placed at greater risk should an emergency occur during a surgical procedure.

Answers to the issues raised here must be sought in the larger society that decides how to fund health care, for whom, and with how much equity. Ultimately, it is a question of how we perceive health, and how we perceive ourselves in relation to everyone else.

**For additional information, go to the following websites:**

- U.S. General Accounting Office. Specialty hospitals: Information on national market share, physician ownership and patients served. April 18, 2003. Available from <<http://www.gao.gov>>.
- U.S. General Accounting Office. Specialty hospitals: Geographic location, services provided, and financial performance. October 2003. Available from <<http://www.gao.gov>>.
- Casalino LP, Devers KJ, Brewster LR. Focused factories? Physician-owned specialty facilities. Hospitals must decide whether to cooperate or compete with their specialists who own specialty facilities; either choice is fraught with dangers. *Health Affairs*. 2003;22:56-67. Available from <<http://www.healthaffairs.org>>.
- Devers KJ, Brewster LR, Ginsburg PB. Center for Studying Health System Change. Specialty hospitals: Focused factories or cream skimmers? Issue Brief. No.62. April 2003. Available from <http://www.hschange.com>>. 🍏

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## Hospital Execs Encouraged to Get in the Action

by Sandra A. Walczak, Vice President

Partnership for Health and Accountability, Georgia Hospital Association

With assistance from the Partnership for Health & Accountability (PHA), Georgia's hospital executives are making a point to be in the middle of the action. Walk-arounds are gaining popularity in Georgia's hospitals, whether they are used as part of a structured patient safety program process, an innovative way to join doctors in their morning rounds, or as a casual means to stay in touch with employees.

**"Patient safety is the focus and of the utmost importance"**

The executives at Albany's Palmyra Medical Centers implemented a walk-around program last summer as a means to further enhance patient safety. All of the officers in the hospital are on-call one week a month in which they are responsible for doing at least

one patient safety executive walk-around. "The purpose of these walk-arounds is to encourage a culture of reporting and to downplay the feeling that people will be disciplined if they report errors," explained Shawn Strash, Chief Operating Officer at Palmyra. When the executives are on their walk-arounds, they use a script of questions and take notes on their employees' responses. Two weeks later, the executives send a follow-up questionnaire to the department they visited to assess changes that have been made. Through this patient safety program, Strash and his colleagues have been successful in creating a forum for Palmyra's employees to be open and honest about errors.

The program has shown the executives at Palmyra what they need to correct. "We've learned that our process of reporting errors

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*Hospital Executives Encouraged . . .  
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was broken and we are fixing that," said Strash. In addition to making an effort to see the hospital staff at all hours of the day and night, Strash advises executives to do walk-arounds that are convenient to the staff's schedule. "You definitely do not want to do your walk-arounds during shift changes because hand-offs are taking place and it is hectic," he explained.

Although Palmyra's walk-around focus is patient safety, the walk-arounds are not all business. "We talk about all sorts of things. I'll know if someone's son made the varsity ball team or something like that," said Strash. "It is more than just patient safety, but patient safety is the big focus for sure."

**"It gives us a little more friendly face."**

Candler County Hospital Chief Executive Officer Michael Alexander makes it a habit to walk around the hospital four or five times a day. "I make sure I see the employees and they see me," he said. "It keeps me in touch with people and them in touch with me." Alexander's belief is that if he is out in the hall, it reminds his employees and the patients that he is accessible and willing to answer their questions.

These daily walk-arounds have allowed Alexander to develop stronger relationships with his employees. "We are a small hospital. I like that atmosphere and I want it to stay that way," he said. "It gives us a little more friendly face."

Walk-arounds allow Alexander to keep in touch with various operational challenges. "A lot of times I just happen upon things that may need to be taken care of," he said. "I can't sit and wait for people to tell me things all of the time."

One lesson that Alexander has learned is that he is able to set an example of hospital pride and ownership. "Part of what I like is that if I walk up on a mess in the hall, I'll stop and clean it up. I notice that the more they see me doing things, the more likely they are to do it instead of waiting for somebody else to come by and do it."

**"With a little effort on everybody's behalf, patient care improves."**

It is not just doctors who prepare for hospital rounds. "All of our doctors make rounds together in the morning," explained Rita Culvern, Jefferson Hospital Administrator and Chief Executive Officer. "Our pharmacist, social service person, respiratory therapist, rehabilitation person, director of nurses and team leaders all [now] join the rounds. There is a lot of input and conferring; it is multi-disciplinary so that you have the input of all of the different health care professionals. Doctors can take care of issues and get them resolved before they even leave the floor."

The program, which was initiated in 2003, was a hard sale for Culvern, who tried for years to put it into action. "Everybody was resistant to it, but as soon as we put it into place, the doctors loved it," she said. "Everybody can see the advantage for the patient and the improvement in outcomes."

More importantly, patients appreciate the team approach. "Our patient satisfaction rate is at 98%," said Culvern. "That is the highest it has ever been."

"I have learned that people will change even though they are kind of resistant to it," she said. "Their eyes can be opened to the fact that with a little effort on everybody's behalf, patient care improves. They get the value of sharing ideas with others."

For information, contact:

Sandra A. Walczak, Vice President  
Partnership for Health and Accountability  
Georgia Hospital Association  
1675 Terrell Mill Road  
Marietta, GA 30067  
Phone: 770-249-4538  
Fax: 770-955-6849

The PHA is a statewide, voluntary patient safety program. Active since 2000, all 151 of the acute care hospitals in Georgia actively participate in the collection and submission of data. Recently, self-assessments identified the need for management involvement and PHA provided hospitals education on methods for improvement through teleconferences and seminars. 🍏

# Wizard's Corner



## **“Supernatural Health Spending”**

“A country’s health care system . . . continually gives society the option of purchasing, through health care, additional quality-adjusted life years (QALYs) at increasingly higher prices.”

“For a brief moment in the early 1990s it seemed that the combination of “managed care” embedded in “managed competition” would allow the United States to keep its annual growth of health care spending roughly in step with the annual growth of gross domestic product (GDP). It was a short-lived illusion.”\*

“In retrospect, and taking a longer-run view, the cost control of the early and mid-1990s merely represents an abnormal period in the history of U.S. health care.”\*

“Recent data on health spending published by the Organization for Economic Cooperation and Development (OECD) . . . [shows] U.S. health spending towers over that of other countries with much older populations.”\*

“Americans pay much higher prices for the same health services than citizens in other countries pay . . . ”\*

“. . . Canada, with a health care delivery system and medical practice styles fairly similar to those in the United States, spent only 57% as much per capita as the United States.”\*

“The relatively greater market power on the demand side of health systems in other countries can explain why so many countries allocate a lower fraction of their GDP to health care even though they appear to be more heavily endowed with hospital capacity and health professionals than the United States.”\*

“. . . in recent years the United States has had a relatively low supply of computed tomography (CT) scanners and magnetic resonance imaging (MRI) devices [and] a relatively small endowment of hospital beds per capita compared with most other OECD countries”\*

“. . . a sizable fraction of higher U.S. health spending . . . can be traced to the higher administrative overhead required by such a complex system . . . administrative expenses for private insurance in the United States are two-and-one-half times as high as those for public programs.”\*

“. . . while these [U.S. health care spending] trends are not an imminent burden on the macro economy, they will place an increasing burden on the members of lower-income groups even within the coming decade.”\*

“At its core, then, the debate over health care, in the United States as elsewhere, is less a pure macroeconomic issue than an exercise in the political economy of sharing.”\*

\* For more see: UE, Reinhardt, PS Hussey, GF Anderson. “U. S. Health Care Spending in an International Context,” *Health Affairs*, Vol. 23, No. 3, 10-25, May/June 2004. 🍏



## **AHPA Sanctioned Education Events**

### *Administrative Policies and Procedures*

- I. All proposals for education events seeking endorsement from AHPA, or to be presented at AHPA conferences or workshops, should be submitted to the AHPA Education Committee. Submissions must contain the following information:
  - Coordinator and entity responsible for event;
  - Title, location and brief description of the event;
  - The target audience and how the event will be advertised to reach them;
  - The goals of the event, including how the target audience is expected to benefit from attending and how the event will complement and further the mission of AHPA;
  - Identity and resumes of presenters, panelists, speakers, moderators and facilitators;
  - A budget that includes the costs of the room, materials, audio/visual, advertising, copying and refreshments and the source of payment whether from in-kind or event fees;
  - The estimated attendance and fees that will be charged, including both AHPA members and non-members;
  - A description of the material and handouts that will be used;
  - An evaluation form to be completed by the participants; and
  - A calendar of key event dates, including mailing registration and other information to intended audience, confirming presenters/speakers, review and copy materials, and follow-up activities.
- II. The Committee will review and comment on all proposals for education events that seek AHPA endorsement and/or support recommend approval or denial of such to the Board.
- III. Following each seminar or workshop, a written report from the event coordinator will be presented to the Education Committee. The Committee will review the report and present it to the Board with comments. 🍏

## Preamble to and Commentary on the Addendum

by John Steen and Dean Montgomery

This edition of *Health Planning TODAY* contains a special article on Certificate of Need (CON) titled **“Putting on the Brakes: Certificate of need regulations try to steer health-care supplies, but it is hard to keep them from fishtailing.”** It is one of two lengthy health care articles in the Spring edition of *RegionFocus*, a publication of the Federal Reserve Bank of Richmond (Federal Reserve District Five). Electronic versions of both articles can be found at <http://www.rich.frb.org/pubs/regionfocus>.

We have chosen to reprint the article here, rather than simply refer readers to the web site where it can be downloaded, to make it readily available to members, to recognize the contributions of several AHPA members who talked with or otherwise provided information to the author, and to take advantage of the opportunity to extensively comment on the substance and accuracy of the article.

As might be expected in a Federal Reserve Bank publication, the author, a business writer at the bank, is appropriately skeptical of CON. Within the confines of the text, the article is reasonably balanced, presenting both favorable and unfavorable views and arguments. The larger difficulty comes from the underlying bias against regulation that the frequently-referenced economists bring to the subject, from the determination to apply standard economic and market theory and methods to a field that reflects neither and does not respond to competition as economic theory predicts.

The most troublesome idiosyncrasy, and a major concern, is the recommended reading list at the end of the article. None of the author's many references to the views and findings of economists and other study results are sourced. Readers are likely to infer that the recommended readings are the source of these assertions, and perhaps they are. Of the eight documents listed, only one—the Maryland Health Care Commission report—can be construed as reasonably favorable to regional planning and CON. The others are largely or entirely negative. Most are problematic in that they are weak analytically, and some were produced with the specific underlying goal of weakening a specific CON program.

The most intriguing study listed is titled “Certificate of Need Regulation and Health

Outcomes”. It is a graduate student paper that purports to show that, as measured by average APGAR scores, states with CON programs have less healthy newborns than states with CON programs. It is worthy of examination not for any underlying merit or analytical prowess, but rather as an example of the extraordinary length to which some will go to try to discredit regulation in general and CON in particular. The recommendation of such readings is, perhaps, reflective of the underlying view and orientation of the author. Academic and journalistic friends of CON are few.

The editors of *Health Planning TODAY* know that our readership is keenly interested in CON, and how it is being perceived, as well as practiced throughout the country. The article on CON by Charles Gerena in *Region Focus* offers a historical overview from the perspective of economists, but it doesn't stop there. It goes on to question the purposes and the efficacy of CON programs, an area in which its author is ill-qualified to comment.

Oddly enough, the author makes a serious error at the very beginning, one that is never resolved throughout the article. He equates the introduction of additional health care services with increased competition offering better prices to consumers (fourth paragraph). We all recognize that as a failure to understand the conditions under which health care services are marketed, accessed, and reimbursed. Most health care services are not competing in a marketplace as known to economic theory. While there is some competition among them, it is virtually never price competition, and the consumer/patient is rarely the one to select them. For these and other good reasons, his discussion about monopolies is misplaced here. In his conclusion, he actually writes, “why not let health-care markets figure out the best combination of supply and demand?” He then goes on to provide a good explanation of some of the factors that make that an unwise goal for public policy, but returns once again to his belief that health care can face “unfettered market competition.”

The author's account of CON's history emphasizes economic issues appropriately, for it was developed nationally in the 1970s when rapidly rising inflation in the federal budget became of overriding concern to Congress. A decade earlier, Medicare and Medicaid had been designed without any effective controls on their utilization. CON began with cost containment as its primary goal, but it was never

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Preamble to Addendum  
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given effective power to contain costs. Under federal mandate and funding, CON developed in the states according to its features, but these had little to do with costs, and more to do with meeting unmet needs, avoiding duplication, and fostering community acceptance, access, and quality. For these reasons, CON cannot be dismissed as a failed mechanism for cost control.

Missing this, the author also misses CON's real aims. He states that "CON programs have had a mixed record when it comes to increasing patient volume at facilities and their impact on outcomes hasn't been proven." Such a statement belies the increasing number of major national studies reported in *JAMA* and *NEJM* within the last two years that testify to the effectiveness of the regionalization-volume-outcome-cost phenomenon. (also see Policy Perspective on page 3). For example, Vaughn-Sarrazin and other researchers found that coronary artery bypass graft (CABG) surgery volume by service was 84% higher in states with CON, and CABG mortality was 22% higher in states without CON. A follow-up article in *JAMA* reported that in New York State, CABG mortality was 100% higher in hospitals performing <100 than in those performing >600.

Though never sanctioned as a cost control measure, there is some provocative evidence to the effect that states with effective CON programs may be experiencing lower health care costs per resident. The author appears unaware of this. In February 2002, when the Michigan legislature was considering weakening or repealing its CON program, all three big automakers testified to the same effect: the costs for healthcare of their covered lives were substantially greater in states without CON compared to those with CON. Taken together, the costs of insuring employees and dependents in eight states were analyzed, five having CON programs, three lacking them.

GM's study was by far the largest, looking at the experience of 1.2 million employees over six years (1996-2001). It determined that the cost of health care rose at a much higher rate over that time in the states without CON (Indiana, Ohio) than in those with CON (Michigan, New York). In the Ford study for the year 2000, costs were determined separately for inpatient and outpatient hospital services, as well as for MRI scanning and CABG surgery. Comparing Michigan (having CON) with Indiana (lacking CON), it found that inpatient costs were 18% higher, outpatient costs were 21% higher, MRIs were 11% higher, and CABG was 39% higher.

For a much more detailed and better-documented report on CON, see the AHPA's "**Certificate of Need: Protecting Consumer Interests.**" It was prepared for and presented at the Federal Trade Commission/Department of Justice Hearings on Health Care Competition, Quality, and Consumer Protection: Market Entry in Washington, DC on June 10, 2003. It is accessible at: <http://www.AHPAnet.org/conissues.html>. 🍏

## REGION FOCUS

### Putting on the Brakes

**Certificate of need regulations try to steer health-care supplies, but it's hard to keep them from fishtailing**

By Charles Gerena



Every month, members of the board of directors for the Central Virginia Health Planning Agency Inc. gather in a blue-gray meeting room. The conservative color scheme is everywhere, even in the speckled fabric of the chairs where the board members sit. Only one thing sticks out: the honey-colored wooden podium where health-care providers pitch their proposals for new facilities and equipment.

In Virginia and throughout the rest of the Fifth District, providers must obtain a certificate of need (CON) before making major capital investments. They have to demonstrate that the expenditure is necessary to fulfill the needs of the community, which are determined by state health officials and detailed in a formal plan. At the January meeting of Central Virginia's health planning board, three groups explained why the region needs additional diagnostic

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imaging equipment. Their proposals faced the scrutiny of the board, which makes its recommendations to the state health commissioner. After an hour of presentations, reports, and intense questioning, two of the three CON applicants were rebuffed. A fourth applicant withdrew from consideration before the meeting.

Many economists question the necessity of regulating the health-care supply so closely. Their view is that companies introduce goods and services only when they expect to be rewarded with higher revenue and profits. Meanwhile, consumers usually benefit from the increased competition in the form of broader choices and better prices. In short, markets tend to work pretty well by themselves.

But state health planners and other CON supporters counter that health care isn't a typical market. They believe that government must intervene to minimize unnecessary development and improve the accessibility and quality of care.

"We are coping with an imperfect system," notes Pamela Barclay, deputy director of health resources for the Maryland Health Care Commission, which reviews CON applications. Instead of consumers buying health care directly, government- and employer-provided insurance pays for it. But some medical services are reimbursed at higher rates than others and not everyone has the same level of coverage, creating distortions in the market.

The CON process is also imperfect, but states have used it to address problems in an industry that affects everyone's well-being.

**CON to the Rescue**

Health-care planning dates back to the 1940s. During the Great Depression and World War II, few hospitals were being built or updated, and the supply of medical facilities was inadequately distributed among and within states.

Communities responded to this crisis by financing and planning hospital development themselves, sometimes with the help of government agencies. In 1946, their efforts were aided by federal subsidies.

States began regulating the supply of health care through certificate of need reviews in the 1960s and '70s, partly in response to lobbying from

hospital operators who favored centralized health planning. By 1974, Congress required states to have a CON program in order to receive federal dollars for psychiatric, substance abuse, and other health services. It also approved direct funding of CON programs.

"States weren't seen as micromanaging health-care markets. It was routine for communities to be involved in planning," says John Steen, a New Jersey-based medical consultant who serves on the board of directors for the American Health Planning Association (AHPA).

Also, "states and federal officials were really concerned about rising costs," notes Frank Sloan, director of Duke University's Center for Health Policy, Law, and Management. "CON was the first major cost-containment program implemented."

The idea was that by controlling the expansion of health-care supplies, fewer development costs would be placed on the shoulders of consumers. At the time, cost-based reimbursement systems — especially the massive Medicaid and Medicare programs created in the 1960s — enabled health-care providers to pass along most of the expense of new equipment and services to third parties. Since capital improvements could translate into increased revenue with little downside risk, providers were perceived as having an incentive to over-invest.

Lastly, state and federal lawmakers were concerned about health-care quality and access. By using CON reviews to steer new development, they aimed to prevent providers from expanding only in affluent areas that were already well served. According to Lee Hoffman, chief of the CON program at the North Carolina Division of Facility Services, if there is no designated need for additional services in a metropolitan area, "providers prefer to take their chances in a rural area [rather than have] nothing at all. It gets their foot in the door."

CON programs proliferated until the early 1980s when the federal government changed how it paid health-care providers. Under a new per-case prospective payment system, providers received a predetermined amount of money for each patient treated, regardless of the cost of the services required. The amount paid depended primarily on the diagnosis-related group into which the patient was classified.

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Private health insurers adopted this payment system as well, which removed the incentive to over-invest that many policymakers had been concerned with. Meanwhile, market-based approaches such as managed care emerged as alternatives for containing medical costs, which were still rising despite the widespread usage of CON reviews.

In 1986, the federal government stopped funding CON programs and 14 states eventually abandoned their programs. Today, 36 states and the District of Columbia regulate health-care supplies to varying degrees. Virginia lawmakers backed off from eliminating the state's CON regulations in 2001, while West Virginia, Maryland, and the Carolinas have reviewed or revised their regulations over the last five years instead of eliminating them.

Why does more than two-thirds of the nation still conduct CON reviews? Part of the reason is political pressure, particularly from health-care providers with an established market presence.

State lawmakers also believe that CON reviews give communities a voice in health-care development. Public hearings are usually held before a CON application is considered and whenever a state's health plan is being updated. "It's a process in which providers and consumers of services can get together, examine problems, and exercise their best judgement," says Dean Montgomery, current AHPA president and executive director of the Health Systems Agency of Northern Virginia.

States have another motive for trying to maneuver health-care supplies: They have a big stake in containing medical costs. In communities with a low concentration of businesses, a big chunk of medical services are reimbursed through Medicaid and insurance provided to state employees.

And there is reason to be worried about health-care providers gaining more pricing power and increasing their capital investments. Despite the changes in medical reimbursement, insurers have less power to negotiate lower rates with providers. "In the late '80s and early '90s, they were able to [reduce costs] the easy way because there was fat in the system," says medical consultant John Steen. But managed care has reached its limits in

cost reduction and people have been demanding more services.

**The Verdict**

Has this faith in the certificate of need process been justified? It depends on what criteria you use.

Constraining the health-care supply via CON review may have tempered growth in hospital beds and nursing home development. But it hasn't been conclusively shown to slow growth in overall per-capita medical spending.

"While CON laws can be effective in slowing the expansion of some services, many other factors affect health-care costs (e.g., labor, physicians services) that CON laws have not attempted to control," noted a January 1999 study by the University of Washington. Furthermore, a 1998 study by Duke University's Frank Sloan and Christopher Conover didn't find a marked increase in health-care expenditures in states that dropped CON reviews.

Meanwhile, CON regulations may sometimes constrain supplies too well, making it difficult for health-care providers to respond to market changes. Let's say an imaging center wants to buy another MRI machine because its existing equipment is operating 18 hours a day and on weekends to keep up with demand. The center may fail to get a CON because there is underutilized capacity elsewhere, even though that capacity may be in a less-populated area, inconvenient to patients, or outdated.

Additionally, hospitals can be prevented from moving capacity to high-growth areas or redesigning it for services that are in greater demand. Charlotte Lynch, manager of business planning at Gaston Memorial Hospital near Charlotte, N.C., recalls how she struggled to obtain a CON to redistribute its unused bed capacity to the hospital's Women Center. Initially, the state wanted to de-license 40-plus acute care beds in the hospital's inventory before it would approve the CON. Rather than relinquish capacity that was needed to accommodate future growth, the hospital eventually gave up some of its psychiatric beds.

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"As soon as you want to expand . . . and you're not at the target occupancy, their thinking is 'Let's take some of this excess capacity away from them because they don't need it,'" complains Lynch.

Health-care providers can make adjustments to the CON process or the state health plan via the public review process. But some states take at least a year to update their plan, while other states have much longer planning horizons. And there's no guarantee that providers will get the changes they want. Lynch says it took years before North Carolina recognized a need for acute care beds.

State officials would be hard-pressed to admit these shortcomings in CON programs. Instead, they have moved cost containment down their list of policy goals and emphasized CON's role in meeting an equally important goal: to intervene in health-care markets when accessibility and quality take a backseat to profits.

How much state governments intervene in markets depends on how many medical services they regulate and how large a capital investment must be before it is subject to CON review. Maryland and West Virginia regulate a wide range of medical services under CON and have relatively low capital cost thresholds, plus they review hospital rates. The Carolinas, Virginia, and the District of Columbia have comprehensive programs as well, while the latter two still have regional health planning agencies that evaluate CON applications.

An agency under the state's department of health typically evaluates applications to determine how proposed projects meet the state's health plan. The plan identifies the quantity and type of services needed in certain regions based on population growth, utilization rates, and other data. Then anyone can apply for a CON to meet these needs.

Other criteria are also used to determine if a proposed project is in the public interest. They include the project's economic impact on existing facilities, the applicant's history of providing charity care, and the geographic accessibility of the project.

With the latter, one would think that the development of health-care infrastructure should follow population growth. "In some respects that's true," says Ken Cook, president of

Roanoke, Va.-based Vantage Healthcare Consulting Group Inc. and former executive director of southwest Virginia's health planning agency. "But we also want to force [development] to move out into surrounding areas." For example, Lynchburg has more nursing home beds per thousand seniors compared to the four rural counties surrounding the city.

Have these market interventions worked? A recent General Accounting Office report found that states with CON programs appear to have better access to health care because they have fewer specialty hospitals than states without CON. Such facilities are less likely to have an emergency room and to accept Medicaid patients. On the other hand, states without CON have slightly more general hospitals than non-CON states, and these facilities have to serve everyone. (See pie charts.)

On the whole, "it is very difficult to steer" the development of medical services, notes Frank Sloan. There have been some attempts to prevent hospitals from moving from the inner city to the suburbs, but they have failed to prevent health-care providers from chasing population growth.

### **It's Good at Playing Monopoly**

Most health-care economists, consultants, and regulators would agree that certificate of need regulations have been good at one thing — producing markets with varying levels of protection. Such markets affect access and quality of medical care, both positively and negatively.

"Health care is a service where a significant portion of the population cannot afford to pay for it because they are underinsured or uninsured," explains Lynn Bailey, a consulting economist in Columbia, S.C. By awarding a limited number of CONs for particular services in a geographic area, states essentially create franchised territories for general hospitals in exchange for them serving the entire population. "It is a social contract."

In general, protected markets have a high cost of entry. The CON application process can take several years, especially if there are appeals, and require tens of thousands of dollars to pay for consultants, lawyers, and processing fees. But once a health-care provider gets its "franchise" for offering a certain service, it's in a better position to charge higher prices and generate a reliable

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revenue stream because others can't readily follow. "If you have a monopoly in a town, an insurer has to negotiate with that monopolist. It's not going to get the same price as an insurer who has the ability to take its business elsewhere," explains Sloan. This probably doesn't help contain costs, but it does make it easier for providers to acquire credit and invest in new technology and staff training.

Another benefit of market protection is that it supposedly prevents a specialty facility from entering a community and cherry picking profitable outpatient services like ambulatory surgery and cardiac catheterization. While cherry picking is a savvy business move, it could hurt long-established general hospitals that use moneymaking outpatient services to pay for money-losing inpatient services like the emergency room. Hospitals must compete to hold on to their best customers while caring for the indigent and uninsured whom they are legally required to serve regardless of their ability to pay.

On the other hand, companies usually have less incentive to be innovative and efficient if they don't have to face the constant challenges of competition. So health planners perform a delicate balancing act. "If you design your CON program right so that you allow enough competitors to get in, you won't make an inefficient system. ... Providers will have to compete on quality," says Cook.

Finally, limiting the growth of new medical capacity may help build up the volume of procedures at existing facilities. This would enable providers to spread out the cost of equipment over more patients. It also would enable medical professionals to gain experience that helps them improve patient outcomes, which is why malpractice insurers often refuse to provide coverage unless providers reach a certain threshold of patient utilization.

However, CON programs have had a mixed record when it comes to increasing patient volume at facilities and their impact on outcomes hasn't been proven. Furthermore, such benefits of limiting medical capacity would have to be balanced against making services available to the greatest number of people, notes Sloan.

### **Watch Where You Swing That Thing!**

In the final analysis, the certificate of need has been a blunt instrument of public policy. So why not let health-care markets figure out the best combination of supply and demand? Then state governments could deal with quality and access problems by establishing standards for care and expanding public medical facilities.

CON advocates argue that health-care markets can't fix themselves because they are dysfunctional. For one thing, patients usually depend on health-care providers to tell them what services they need, so providers are in the position of redirecting patient care to utilize any new capacity. "It's not like buying a car where you can determine the best quality you can get for the lowest price. We really depend on doctors to advise us what facility to go to and what services we need," says Joel Grice, director of the South Carolina Bureau of Health Facilities and Services Development, which manages the Palmetto State's CON program.

Health-care markets malfunction for a less sinister reason as well: They have little price competition, which tends to encourage overproduction. Normally, suppliers produce more as prices increase until their services become too expensive for buyers. But prices for certain medical services can continue to rise without patients demanding less.

Why? The demand for many medical services is very price inelastic. Patients care more about getting the best care available than about how much they'll pay, especially in an emergency situation or when treatment options are limited. Also, patients don't know the actual costs of their care. Market information is not readily available, plus insurers act as a third party that separates patients from providers in transactions.

Even if these market malfunctions could be fixed, broad regulation of health-care markets is more politically desirable than deregulation. If a nursing home closed down as a result of market competition, the cost of relocating former residents would make the front page of local newspapers. In contrast, the shortcomings of CON programs impact everyone, so it's not as obvious to individuals.

Still, government regulation is considered a necessary evil to protect patients from the ups

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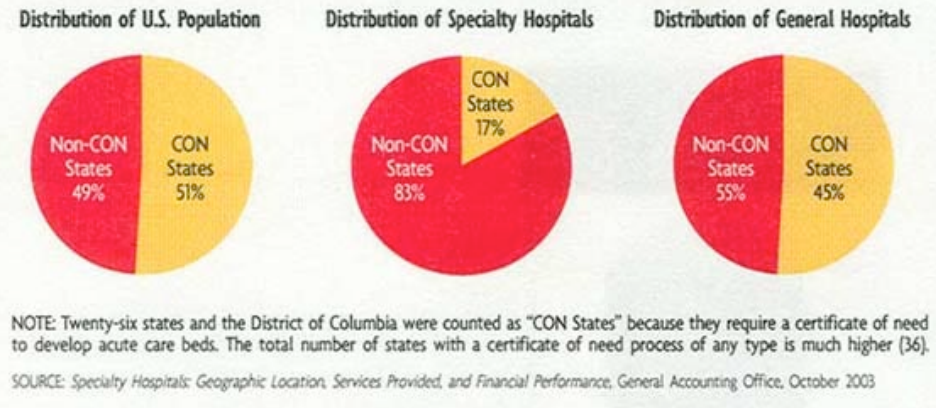
and downs of unfettered market competition. In fact, some lawmakers and health-care experts believe that health care shouldn't be a profit-making business.

Notes economist Lynn Bailey, "We haven't resolved the issue of whether health care is a private good regulated by market forces — those who pay for it get it and those who can't pay for it don't — or a public good that benefits the entire community." European countries have long considered health care a public good, but following the same path in the United States — via universal health insurance or a government-run hospital system — wouldn't be cheap.

Until our society decides how health-care markets should function, CON programs will continue trying to steer supplies in the Fifth District and throughout the nation.

### Path of Least Resistance

Specialty hospitals tend to stay away from states where medical facilities have to obtain a certificate of need to add capacity, as shown below. Is that good or bad? Specialty hospitals outperform general hospitals in terms of costs, but they are less likely to have an emergency room and they treat a smaller percentage of Medicaid patients.



### Readings

- Conover, Christopher J. and Frank A. Sloan. "Does Removing Certificate-Of-Need Regulations Lead To A Surge in Health Care Spending?" *Journal of Health Politics, Policy, and Law*, June 1998, vol. 23, no. 3, pp. 455-481.
- *Effects of Certificate of Need and its Possible Repeal*. University of Washington School of Public Health and Community Medicine, January 8, 1999.
- McGinley, Patrick. "Beyond Health Care Reform: Reconsidering Certificate of Need Laws in a Managed Competition System." *Florida State University Law Review*, Summer 1995, vol. 23, no. 1, pp. 141-188.
- *Report of the Special Joint Subcommittee Studying Certificate of Public Need to the Governor and the General Assembly of Virginia*. Senate Document No. 6, 2001.
- Schneiter, Ellen Jane, Trish Riley and Jill Rosenthal. *Rising Health Care Costs: State Health Cost Containment Approaches*. Portland, Maine: National Academy for State Health Policy, June 2002.

### Web Links

- Certificate of Need Study Reports – Maryland Health Care Commission  
<[http://www.mhcc.state.md.us/certificateofneed/study\\_report/\\_studyreport.htm](http://www.mhcc.state.md.us/certificateofneed/study_report/_studyreport.htm)>
- Effects of Certificate of Need and Its Possible Repeal – State of Washington Joint Legislative Audit and Review Committee  
<<http://jlarc.leg.wa.gov/Reports/99-1CofN.pdf>>
- Certificate of Need Regulation and Health Outcomes  
<<http://www.pubchoicesoc.org/papers/hankins.pdf>>

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