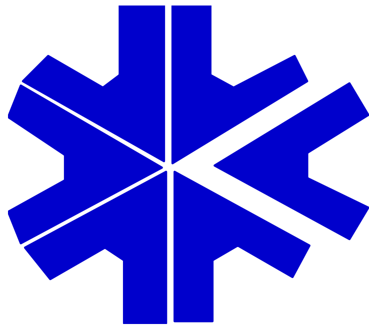

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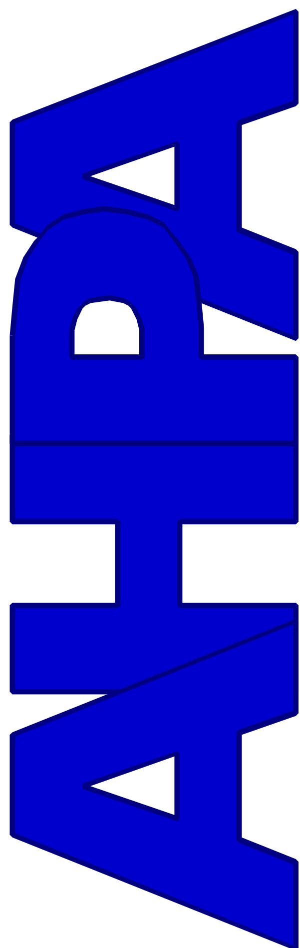

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Gilded Age Planning and Regulation

by Dean Montgomery

Close observers of societal norms and trends concluded some time ago that we have entered a second gilded age. The recent cavalcade of corporate scandal may lack the cachet of Credit Mobilier, the Whiskey Ring, Boss Tweed, and J.P. Morgan, but there is good reason to believe that the number, if not the buccaneer quality, of the current crop of scalawags will eclipse those of a century ago.

Health care increasingly is seen largely in business terms and is behaving accordingly. It accounts for a growing share of the national economy and appears to be happily acclimating itself to the current environment. "Health care fraud" is becoming a term of art.

Nearly a decade ago, the GAO (now the Government Accountability Office) estimated that fraud accounts for between 3% and 10% of health care expenditures. In 2004, the Centers for Medicare and Medicaid Services estimated that fraud accounted for about $85 billion (5%) of the $1.7 trillion in 2003 U.S. health care expenditures. Some other estimates put current losses at between $150 billion and $170 billion annually.

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Gilded Age Planning and Regulation

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Health care fraud comes in service provider and consumer varieties. Reports from a number of insurers indicate that provider pilfering usually involves some variant of:

- billing for services not performed;
- falsifying diagnoses to justify unnecessary tests, surgeries or other procedures;
- misrepresenting procedures to obtain payment for non-covered services (e.g., cosmetic surgery);
- billing for a more costly service than the one performed (e.g., up-coding);
- unbundling, or billing each component of a procedure as a separate procedure;
- self-referral;
- kickbacks for patient referrals; and
- waiving patient co-pays or deductibles in conjunction with over-billing.

Common fraudulent consumer practices include:

- filing claims for services or medications not received;
- forging or altering bills or receipts;
- using someone else's coverage or insurance care; and
- conspiring with service providers to obtain ineligible benefits and payments.

Health service planners and regulators are not in a strong position to affect directly consumer health fraud. They can and should try to reduce the acceptance, if not the incidence, of service provider fraud, however, particularly in states with planning and certificate of need programs.

Analysis of health service use, charges and payments, combined with careful examination of billing practices, corporate history and structure, and contracting policies, often can reveal questionable practices. Even where data are not available to permit what amounts to forensic analysis, there are substantial data in the public arena that can point to problems. These include lawsuits, Medicare corporate integrity agreements, SEC filings and reports, annual reports, investment research, nonprofit corporate tax returns, and media reports of all kinds.

Unfortunately, planners and regulators too often adopt a "see, hear and speak no evil" posture when confronted with corporate health care miscreants. Over the last decade one major national provider of health services after another has faced fraud charges. One only has to reflect on the history of National Medical Enterprises (now Tenet Healthcare), Columbia-HCA (formerly and now Hospital Corporation of America), HealthSouth, Vencor (now Kindred Healthcare), Integrated Health Services, Beverly Healthcare, and a number of lesser lights, to get a feel for the pervasiveness and magnitude of the problem.

Collectively, these organizations provide services in nearly all states with planning and CON programs. Nevertheless, their corporate history and practices are seldom subjected to close scrutiny. Few states have statutory language or regulations that provide explicitly for assessment of corporate character and competence. All publicly supported planning and associated regulation is grounded in protecting and furthering the public interest however. There appear to be ample authority and justification for planners to address the questions raised by unwholesome corporate practices. Only the

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CON: Constitutional Challenge

On December 8, 2005 AHPA filed an *amicus curiae*[1] brief in the US Supreme Court in support of the Commonwealth of Puerto Rico's defense of its Certificate of Necessity and Convenience (CNC), or CON, program. The filing supports Puerto Rico's petition for a writ of certiorari[2], a request that the Supreme Court review the recent U.S. Court of Appeals (First Circuit) ruling invalidating at least part of Puerto Rico's CON program.

The Court of Appeals decision came, in due course, out of a challenge by Walgreen Co. to Puerto Rico's regulation of pharmacies under its CON program. In 2004, Walgreen challenged in US District Court the requirement that it obtain CNC approval to establish a new pharmacy in Puerto Rico. The District Court rejected Walgreen's arguments, finding no constitutional violation on any of the grounds asserted by Walgreen. Walgreen appealed the District Court decision to the U.S. Court of Appeals (First Circuit), again challenging the constitutionality of the CNC program, at least as it applies to the coverage of pharmacies, on multiple grounds, including violation of the commerce clause of the U.S. Constitution. The Court. of Appeals reversed the District Court, holding broadly that the Puerto Rico's CON program, at least with respect to regulation of pharmacies, violates the commerce clause.

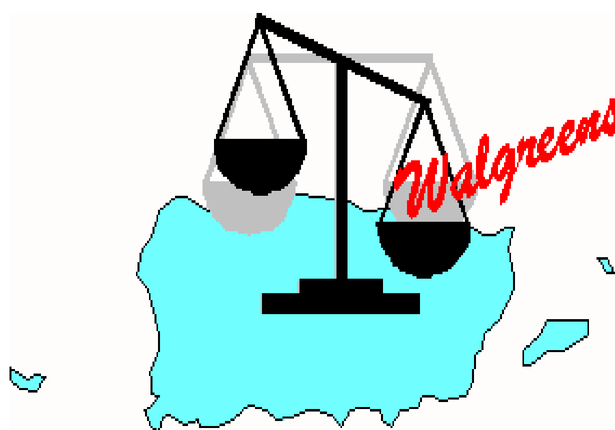
Puerto Rico has petitioned the U.S. Supreme Court to review the Court of Appeals decision. The facts of the case appear to be specific to CON coverage of pharmacies in Puerto Rico, but the First Circuit decision has potential nationwide implications. If permitted to stand, it is probably only a matter of time before the Court of Appeals decision is used in challenges, judicially and otherwise, elsewhere.

AHPA's interest in the case is grounded in its support of certificate of need regulation and state CON programs as useful health service planning tools. The Association's argument in support of Puerto Rico's petition calls the Court's attention to the facts that more than two thirds of the states continue to maintain CON programs, all of which have an interest in the validation of the constitutionality of CON regulation as commonly practiced, that most states instituted CON programs before, and independent of, any federal requirement or incentive to do so, and that the principles, constitutional and otherwise, inherent in and underpinning CON regulation are supported in other federal programs and practices.

For more information, and copies of the judicial decisions in this case, contact AHPA at ahpanet@aol.com or at 703-573-3103.

[1]A "friend of the court," a person or entity who is not a party to a case, but who believes that the court's decision may affect its interest. An *amicus curiae* brief may be filed only if accompanied by written consent of all parties, or with permission of the court, or at the request of the court. In this case, Walgreen did not give consent. As is customary in such cases, AHPA submitted a request for permission to file with the brief.

[2]A request a losing party files with the Supreme Court asking the Court to review the decision of a lower court. The petition includes a list of the parties, a statement of the facts of the case, the legal questions presented for review, and arguments as to why the Court should grant the writ. The Supreme Court usually declines to take the case. It receives thousands of petitions each year, but accepts only about one hundred.



A Fiscal Crisis Revives Statewide Health Planning in New York State

by John Steen

A very provocative initiative was announced by New York State's Governor George Pataki last March. As in other states, New York's Medicaid costs have been escalating beyond its ability to cover them with tax revenues, but the state's Medicaid program has long been the nation's most liberal, and that may now generate the nation's most radical solutions. Medicaid spending now accounts for about 44 percent of the state's $100 billion budget. Needing to trim Medicaid by about a billion dollars a year with respect to the state's funding alone, and knowing that such a reduction would inevitably lead to the demise of some hospitals and nursing homes, the governor proposed that an independent panel determine the fate of New York's hospitals and nursing homes, much as an independent commission appointed by the president decides what military bases are closed or scaled back. He announced that their task would be that of reviewing the finances and utilization of each facility and recommending restructurings and closings, resulting in a more cost-effective and efficient delivery system for health care in New York State. Mr. Pataki and his aides said about 40 percent of hospital beds go unused, while about 10 percent of nursing home beds lie empty.

Michael O. Leavitt, the Secretary of the U.S. Department of Health and Human Services, held out the prospect that the Bush administration would provide an additional $1.5 billion in Medicaid funds to the state over the next three years, provided the state enacts Mr. Pataki's changes.

The governor's panel – the **Commission on Health Care Facilities in the 21st Century** – held its first meeting in July. That it is engaging in health planning was immediately evident in its looking not only at closings, but at consolidating areas of specialty in certain hospitals to increase service volume and provide more expertise, and at preventing duplication of care, even if doing so means more travel for patients. Its chairman made it clear that their task is nothing less than the restructuring of health care delivery, and that the mission and role of some of the state's institutions would be changed. Their first step was to adopt a rating system to start determining which hospitals should close, and that was done in November. The scoring system and data on the state's facilities have been published on the Commission's Web site, nyhealthcarecommission.org. The Commission plans to assign scores to individual hospitals or groups of hospitals in January. Each hospital will be evaluated in six categories, with points given to hospitals

- that serve a mostly poor population,
- without readily available alternatives in their areas,
- that provide high-quality care,
- that are heavily used,
- that are strong financially, and
- that have a major economic impact on their communities.

The guidelines include specific criteria that will go into each of those ratings.

The Commission's meetings will be conducted from now until late next year, and its recommendations are to be made by December 1, 2006. Then those recommendations will be acted upon by the State Legislature. If approved, they will be implemented by 2008.

This politically charged process raises monumental policy questions about the Commission's role. Chief among them are whether there will be a commitment to continuing to meet the health care needs of the uninsured and the poor and how much influence local communities will be given in arriving at recommendations concerning their facilities. The Commission will work with six Regional Advisory Committees (RACs), each of which is charged with issuing its own, non-binding recommendations for "right-sizing" the hospital and nursing home systems in its respective region. A related issue is whether the Commission will attempt to pressure the state's two long-time panels for hospital review and planning to adopt the Commission's newly developed criteria in

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Citizens Health Care Working Group

By John Steen

The Citizens Health Care Working Group is a national panel created by the 2003 Medicare law. Its charge is to engage Americans over the next two years in "a nationwide public debate about improving the health care system to provide every American with the ability to obtain quality, affordable, health care coverage." In March 2005, it began its two-year process of organizing public debate on how to get "Health Care That Works for All Americans." The Working Group will sponsor community meetings nationwide starting this winter as well as electronic means for public input. Its final recommendations are due out in the spring of 2007.

Questions posed by the Working Group for citizen input are:

- What concerns you most about the health care system in America today?
- What health care benefits and services should be provided?
- How should health care be delivered?
- How should it be paid for?
- What have you seen in America's health care system that works well?
- What trade-offs should the American public be willing to make in either benefits or financing to ensure access to affordable, high quality health care coverage and services?
- What is your single most important recommendation to improve health care for all Americans?

It is important that public health advocates participate in these community forums. Meetings now scheduled are:

Kansas City, MO	January 17, 2006
Orlando, FL	January 24, 2006
Baton Rouge, LA	January 26, 2006
Memphis, TN	February 11, 2006
Charlotte, NC	February 18, 2006
Miami, FL	February 22, 2006
Seattle, WA	February 25, 2006
Denver, CO	February 27, 2006
Los Angeles, CA	March 4, 2006
Indianapolis, IN	March 11, 2006
Detroit, MI	March 18, 2006
Phoenix, AZ	March 25, 2006
Des Moines, IA	April 8, 2006
New York, NY	April 22, 2006
Chicago, IL	TBA

Citizens in cities not listed above are encouraged to organize Independently-Sponsored Community Meetings. Downloadable Community Meeting Kits will be available beginning January 15, 2006 on the Working Group's web site:

http://www.citizenshealthcare.gov/.

The Working Group will develop a set of recommendations based on the feedback from community meetings on:

- Health care coverage.
- Ways to improve and strengthen the health care system.

The CHCWG has put up on its website a primer on the sort of national health policy issues it will entertain. It is entitled, "The Health Report to the American People," and it reads like an introduction to America's lack of a health care system, but it completely overlooks public health, and all of its illustrative examples are efforts at state or regional incremental fine-tuning. It is obvious that they are not prepared for any radically thoroughgoing solutions for which the British or Canadian systems might serve as examples. To view the Report:

http://www.citizenshealthcare.gov/healthreport/healthreport.php#6a (HTML)

http://www.citizenshealthcare.gov/healthreport/healthreport.pdf (46 pages; 882 KB)

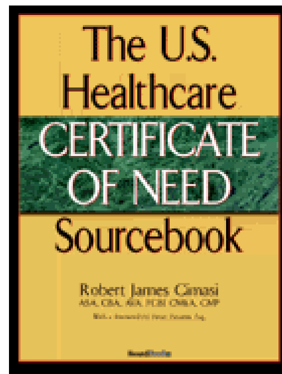
Following a public comment period, the Working Group will submit a final set of recommendations to Congress and the President.

Visit the CHCWG website (see above) for more details, and for a schedule of community meetings. ♦

Publication of Interest

There are medieval sourcebooks, a Saddam Hussein sourcebook, and there was a *Simpsons* sourcebook before Fox Entertainment lawyers did it in. So, why should we not have a certificate of need (CON) sourcebook? Enter: *The U. S. Healthcare Certificate of Need Sourcebook*. [1] Fox has nothing to fear from this one.

Given the close link between community health services planning and CON regulation, some planners may be tempted by this alluring title. The title, packaging, and advertising appear calculated to evoke images of authority, substance, and comprehensiveness. C*aveat emptor*.



The tone and thrust of the document, and presumably the views of the author, are suggested by the quotation from 19th century essayist Thomas Carlyle used to introduce the document: *"We call it a Society; and go about professing openly the totalest [sic] separation, isolation. Our life is not a mutual helpfulness; but rather, cloaked under due laws-of-war, named "fair competition" and so forth, it is a mutual hostility."* The pages that follow are faithful to this spirit.

Whatever your definition of "sourcebook," this 509 page, 2½ pound blunderbuss is largely a book of redundant lists and a source of much nonsense, though amusing nonsense in places. There is an introductory section titled "CON NARRATIVE HISTORY AND BACKGROUND." [2] It is noteworthy principally for its failure to introduce, explain, or otherwise place in context the 488 pages that follow. These pages contain little or no narrative. There is no mention of them in the introduction.

More than one-third of the document consists of three arrays of the approximately 800 lawsuits CON regulation has spawned over the last four decades. These cases are listed first alphabetically, then topically (cause of action), and finally by venue (state) with brief abstracts of each case. So, each case is listed three times.

These listings may be of value to some, but the quality of the writing and editing in the abstracts, which are necessarily brief, is poor. Review of cases in one state (3 of 121 pages) found the term "write" rather than the intended "writ," misleading and incomplete explanatory information in the abstracts, inconsistent titling, and inaccurate pagination. If these three pages are indicative of the other 118 pages in the section, purchasers should ask that their money be returned. All page references in the section are inaccurate, rendering the internal table of contents useless.

Nearly 150 pages are devoted to presenting contact and coverage information on 37 state CON programs. The information is presented clumsily, and there appears to have been generous borrowing from AHPA sources, especially the *National Directory of Health Planning, Policy and Regulatory Agencies*. This section, too, is replete with errors and misinformation. Many of the errors appear to result from misinterpreting data and information gleaned from state CON program websites and the AHPA directory. For example, the entry for the State of Virginia indicates that linear accelerators are not subject to CON review, but radiation therapy services are. A substantial part of the information presented for the state of Virginia is inaccurate or misleading.[3] There are problems throughout the section.

The other sections of *Source* are equally problematic. There is a list of "leading CON health care economists" that is simply puzzling. It is not clear whether this motley list of 29 is by invitation, acclamation, or some inscrutable calculus. It is equally unclear whether anyone on this list would actually consider himself a "CON economist," a dubious distinction at best, much less a leader of the pack.

There is a "book bibliography" with 126 entries. It is debatable whether the majority of the "books" listed are actually books. For example, 16 of the 126 are

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POLICY PERSPECTIVE: An Update on Two Issues

By John Steen

Specialty Hospitals

Arizona heart doctors who are part-owners of cardiac specialty hospitals were more likely than physicians with no ownership stake to treat low-acuity, high-profit cases in their own facilities and refer the more complex, lower-profit cases to community hospitals, according to a study published on the *Health Affairs* website.[1] This study compares practice patterns of physician-owners of limited-service cardiac hospitals and physician-nonowners who treat cardiac patients at competing full-service community hospitals.

Analyses of six years of Arizona inpatient discharge data show that physician-owners treat higher volumes of profitable cardiac surgical DRGs, higher percentages of low-severity cases, and higher percentages of cases with generous insurance compared with physician-nonowners who treat cardiac patients in community hospitals. The study appears to confirm the objections of community hospitals, which have complained that the growth in the number of limited-service specialty hospitals in recent years has diverted profitable cases away from their operating rooms and limited their ability to absorb the costs of uninsured or money-losing patients.

Two accompanying Perspectives offer commentary on physician entrepreneurship and the policy issues involved: One by Jack Hadley and Stephen Zuckerman (Urban Institute), and the other by Allen Dobson and Randall Haught (Lewin Group). They can be read at content.healthaffairs.org/cgi/content/abstract/hlthaff.w5.491 (Hadley/Zuckerman) and content.healthaffairs.org/cgi/content/abstract/hlthaff.w5.494 (Dobson/Haught). ♦

PCI and Cardiac Surgical Backup

Nineteen states currently allow community hospitals to do PCI (percutaneous coronary intervention -- angioplasty) without onsite cardiac surgical backup. The American Heart Association and the American College of Cardiology issued new guidelines in November stating again that angioplasty should never be done except in medical facilities that can do cardiac surgery.

A study of over 16,000 patients in about 10 states undergoing angioplasty in community hospitals without open heart surgical backup is being directed by Dr. Thomas Aversano, a prominent cardiologist at Johns Hopkins University School of Medicine. Hospitals in Alabama, Georgia, Illinois, New Jersey, Ohio and Pennsylvania will participate in the study, and health officials in Connecticut, Maryland, Michigan and New York are considering granting permission for their hospitals to join, according to Dr. Aversano. Already, opposition to the study on the part of medical centers doing open heart surgery has arisen in some of these states, but nowhere so vociferously as in New Jersey, whose health commissioner has decided to allow nine community hospitals to participate. The state has 18 hospitals licensed for cardiac surgery, and their opposition has given rise to a group called the Committee for Safe Angioplasty in New Jersey, which has run newspaper ads, also posted on its Web site (http://www.njhearts.com), showing a mourning boy and black-clad mother standing beside a casket under the words, "Tell him New Jersey didn't think his dad would need a heart surgeon."

Dr. Aversano noted that well under 1 percent of patients undergoing emergency angioplasty, such as after a heart attack, at a community hospital need to be transferred to a bigger one for emergency surgery. This is confirmed in the Dec. 6, 2005 issue of the *Journal of the American College of Cardiology,* in which a new study[2] using data from the Mayo Clinic evaluates the changes in incidence, clinical characteristics, and indications for emergency coronary artery bypass grafting (CABG) in patients undergoing percutaneous coronary intervention (PCI) from 1979 to 2003, indicating that the need to send patients to emergency surgery has dropped sharply in recent years.

"Our review of almost 25 years of data on angioplasty suggests that there has been a dramatic reduction of almost 90% in the incidence of coronary artery bypass graft surgery following angioplasty; and this is despite the fact that more recently we are performing angioplasty on very high risk patients," said

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Fiscal Crisis Revives Statewide Planning

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order to reassess the need for major hospital capital spending projects that they have already approved. Doing so would abrogate the state's long-standing commitment to "good public process."

Referring to its mandate to "right-size the health care system," the Commission will consider the impact closing a facility would have on the delivery of health care services in the geographic area and the local and regional economies, as well as savings generated and capital costs avoided if a facility were closed. This political initiative can be seen as the Bush Administration offering a key state a carrot to encourage it to further dismantle the "safety net." It remains to be seen whether it proves to be a form of appropriateness review at a time of fiscal constraint, or even the rationalization of the state's health care delivery system. Over their tenure of two decades (1976-1996) as a formal part of the state's planning and regulatory system, the eight health systems agencies were never given such a mandate, nor even the kind of influence the new commission will have over the legislative process, but in those decades, the funding of the state's health services was still more of a political priority than their defunding, and open public process still extended right down to, and up from, the community level. ♦

Gilded Age Planning and Regulation

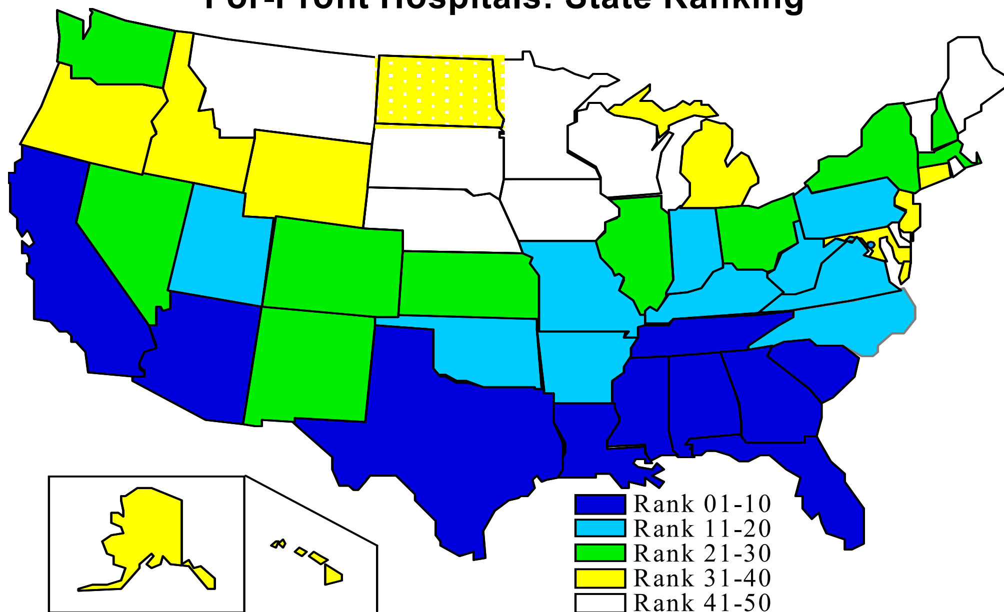
(Continued from page 2)

will appears to be lacking.

Planners need to get serious about confronting these questions lest silence be construed as sanctioning them or, in some cases, complicity. Charges of political cronyism and less than objective planning processes and decisions are common.

The recent indictment of former Alabama Governor Don Siegelman and former HealthSouth CEO Richard Scrushy for bribery, involving payment for Scrushy's appointment to a position on the state certificate of need review board, is a timely reminder. It suggests that similar problems with CON regulation in Louisiana a decade ago and more recently in Illinois may not be the anomalies we hoped.

Scandal has a diverting, voyeuristic attraction until it strikes home, or very close to home. Warning signs abound. Planning and regulation must be virtually scandal proof to survive. To ensure integrity, and maintain public support, planners everywhere need to sing out when corporate health care emperors appear in public unclothed. Risk aversion was not a trait well suited for survival in the first gilded age. Planners may find that it is equally risky in the second. ♦



PCI and Cardiac Surgical Backup

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Mandeep Singh, M.D., F.A.C.C., from the Mayo College of Medicine in Rochester, Minnesota. The bypass surgery rates, which were close to 3% in the "pre-stent era" (1979-1994), came down to 0.3% in the most recent time period (2000-2003). Dr. Singh said the fact that angioplasty is being offered to sicker patients now makes the reduction even more remarkable. Patients requiring emergency surgery in the most recent study period had a higher prevalence of high blood pressure and heart failure, and they were more likely to have undergone previous procedures, compared to patients in the earlier study periods. Dr. Singh said he believes stents may be responsible for much of the reduction in the rate of life-threatening problems during angioplasty procedures.

However, among patients who did suffer serious problems during angioplasty and had to be sent into emergency surgery, the researchers did not see an improvement in survival. Death rates among such patients were statistically similar in all three study periods, ranging between 10% and 14%. In an editorial in the *Journal*, John A. Bittl, M.D., F.A.C.C., from the Ocala Heart Institute, Munroe Regional Medical Center in Ocala, Florida, said that while the sharp decline in emergency bypass surgery on angioplasty patients is welcome news, he is concerned the results may be used by some providers to argue that back-up surgical facilities are no longer needed. "Almost every hospital wants a share of the lucrative coronary intervention market and every physician hopes that in-laboratory deaths and the need for emergency bypass will go away completely, but this ideal situation has not been attained," Dr. Bittl said, adding:

> "The assessment of elective PCI without on-site bypass surgery underway in some states is a step in the right direction. But, choosing the right metrics is challenging. The only meaningful comparison between hospitals with and without on-site surgery is the rate of death or urgent transfer to another facility within a pre-specified period of time after PCI. One proposal that mixes acute events with late endpoints like repeat revascularizations is manipulative and misleading,"

Further complicating the PCI/CABG controversy are the large variations in physician practice patterns across the states. In the November 1, 2005 issue of the *American Journal of Cardiology,* a study of hospital data from 11 states[3] found wide variation in both treatment of heart attacks and patients' short-term death rates. Multivariate regression models were used to examine the association between geographic location (and other factors) and the likelihood of in-hospital mortality while undergoing coronary artery bypass grafting (CABG) or percutaneous coronary interventions (PCIs). New York had the highest average length of stay (8.2 days, $p < 0.01$), rate of patients being transferred (20.7%, $p < 0.01$), and in-hospital case fatality rate (10.7%, $p < 0.01$). PCI was performed 2 times as often as CABG for patients who had acute myocardial infarction (23.9% vs. 11.3%, $p < 0.01$), with patients who underwent CABG being transferred more often. Multivariate analyses showed that state of residence, age, female gender, transfer status, and number of co-morbidities were predictors of in-hospital mortality and the likelihood of undergoing CABG or PCI.

South Carolina, Maryland, and California had mortality rates that were also close to 11%. Arizona, Colorado, Oregon, and Washington had the lowest fatality rates, in the 8% to 9% range. Rates in Florida, Iowa, and Wisconsin were in-between.

Colorado had the highest rate of angioplasty, at 36%, while Maryland had the lowest, at less than 17%. Heart attack patients who underwent angioplasty had a much lower death rate, so differences in angioplasty rates, according to the researchers, may help explain the discrepancies in death rates across the states.

The researchers also surmised that CON/licensure policies were largely responsible for the wide variation in hospital transfer rates. Iowa's rate, without such policies, was only about 11%, half of New York's. In addition, transfers may be relatively uncommon in largely rural states like Iowa, since many heart attack patients may not be stable enough to make the trip to another hospital.

And isn't this where we came in…?

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[1] "Effects Of Physician-Owned Limited-Service Hospitals: Evidence From Arizona," Jean M. Mitchell (http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w5.481).

[2] "Emergency Coronary Artery Bypass Surgery for Percutaneous Coronary Interventions: Changes in the Incidence, Clinical Characteristics, and Indications From 1979 to 2003." Eric H. Yang, Richard J. Gumina, Ryan J. Lennon, David R. Holmes, Jr, Charanjit S. Rihal and Mandeep Singh. Vol. 46, Issue 11, pp. 2004-2009.

[3] "A Multistate Comparison of Patient Characteristics, Outcomes, and Treatment Practices in Acute Myocardial Infarction." Shadi S. Saleh, Edward L. Hannan and Larry Ting. Vol. 96, Issue 9, pp. 1190-1196

Publications of Interest
Continued from page 6

working papers developed by the Maryland Health Care Commission that have been posted on the Commission's website. The full list is a hodgepodge of monographs, planning documents, CON task force reports, CON review criteria and standards, and similar documents.

The lengthier "article bibliography," with more than 2,000 listings, is even more idiosyncratic. It looks and reads like a hastily arranged computer search dump, with citations ranging from the sublime to the ridiculous. Some are outright duplications. Some are multiple listings of the same article published in different places. Others appear to be separate listings for individual pages of multi-page articles. Though there is no indication of intent or design, it appears that this bulky section is intended to have two subsections, one arranged alphabetically by author, the other containing articles without a listed author arranged alphabetically by topic. The intent is unclear because the first grouping simply flows into the second without notice or indication of any kind.

There is little, if anything, positive that can be said of *Source*. But, presumably, it would be of use to some. Jacket blurbs laud the author for his work and assistance in thwarting misguided planning and regulation. One admirer, after asserting that CON "entrenches the status quo, stifles competition and innovations and fails the patient it professes to serve" notes, hopefully, "this carefully researched work provides the facts to overturn it [CON] state by state." That seems a bit optimistic, but there is much equally "carefully researched work" about these days. It ranges from the doctrinal posturing of the FTC to the equally dogmatic ruminations of the author and "leading CON economist" William Custer. Unfortunately, even exotic nonsense gains standing and credibility if unanswered.

Source sells for $199.95. Mailing costs bring the total outlay to $206.90. That is a hefty sum, and we have no way of calculating an expected rate of return. Those contemplating giving *Source* as a holiday gift should be aware that Corsicana, Texas, holiday fruitcake of equal weight (2 7/8 lbs.) is selling for $30.45[4].

But if, as Carlyle says, life is "a mutual hostility," perhaps we should break the downward spiral and buy *Source*. It will remain a useful doorstop long after the fruitcake is gone, if not forgotten.

Those wishing more information on Source may contact AHPA at ahpanet@aol.com.

[1] Robert James Cimasi, ASA, CBA, AVA, FCBI, CM&A, CMP, *The U. S. Healthcare Certificate of Need Sourcebook,* Beard Books, Washington, DC, November 2005.

[2] The author, or perhaps the editor/publisher, is fond of block capital letters. One looking for modesty or understatement must search elsewhere.

[3] As with most chicanery, there is a lesson to be learned here. If come exam time one finds it is necessary to peak at a fellow student's paper, craftiness and seat selection are critical. For reasons that preclude explication here, the AHPA *National Directory* has incorrectly reported a moratorium on development of long-term care beds in Virginia for nearly a decade. Serendipitously, *Source* reports the same stealth moratorium. The moratorium, imposed in 1987, was lifted 1995.

[4] http://www.collinstreet.com/pages/deluxe_fruitcake

AHPA Election Results

The election of four persons to the AHPA Board of Directors was announced at the December 10, 2005 Board meeting in Philadelphia. Those elected to three-year terms beginning January 1, 2006 are:

Karen Cameron, Richmond, VA
Ronald Deprez, Portland, ME
Arthur Maples, Memphis, TN
Paul Parker, Baltimore, MD

The Board also elected officers for 2006. John Steen was elected President, Arthur Maples, President-Elect, Michael Hill, Treasurer, and Deborah Frazier, Secretary.

Norwalk Hospital (www.norwalkhosp.org)
Norwalk, Connecticut
Director of Planning

Norwalk Hospital

- 328-bed acute care non-profit community teaching hospital affiliated with the Yale New Haven Health System.
- 16,000 admissions; 44,000 emergency patients; and 1,700 deliveries annually.
- 2,000 employees; annual revenues exceed $374 M.
- Located in southeastern Connecticut's Fairfield County with large concentration of major corporate headquarters and a well-educated technical and professional population.
- Lovely residential communities complement lively urban areas. Public school systems are among the best in the nation.
- Access to the many cultural and social amenities of the New York metropolitan area.

Director of Planning

- Reports to Vice President of Planning and Business Development.
- Will develop a new department, guide staff and provide operational direction, guidance and support for programs, services and strategic planning activities of the hospital.

The ideal candidate will have the following qualifications:

- Bachelor's degree; Master's degree preferred.
- 4+ years of experience in hospital planning and/or product line business planning.
- Broad understanding of the current issues in health care
- Excellent spreadsheet, database and statistical application skills with demonstrated skills in finance and statistical modeling.
- CON expertise.
- Supervisory experience.
- Political acumen with excellent interpersonal, communication and presentation skills.

A competitive salary and benefit package is provided. Please respond confidentially:

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