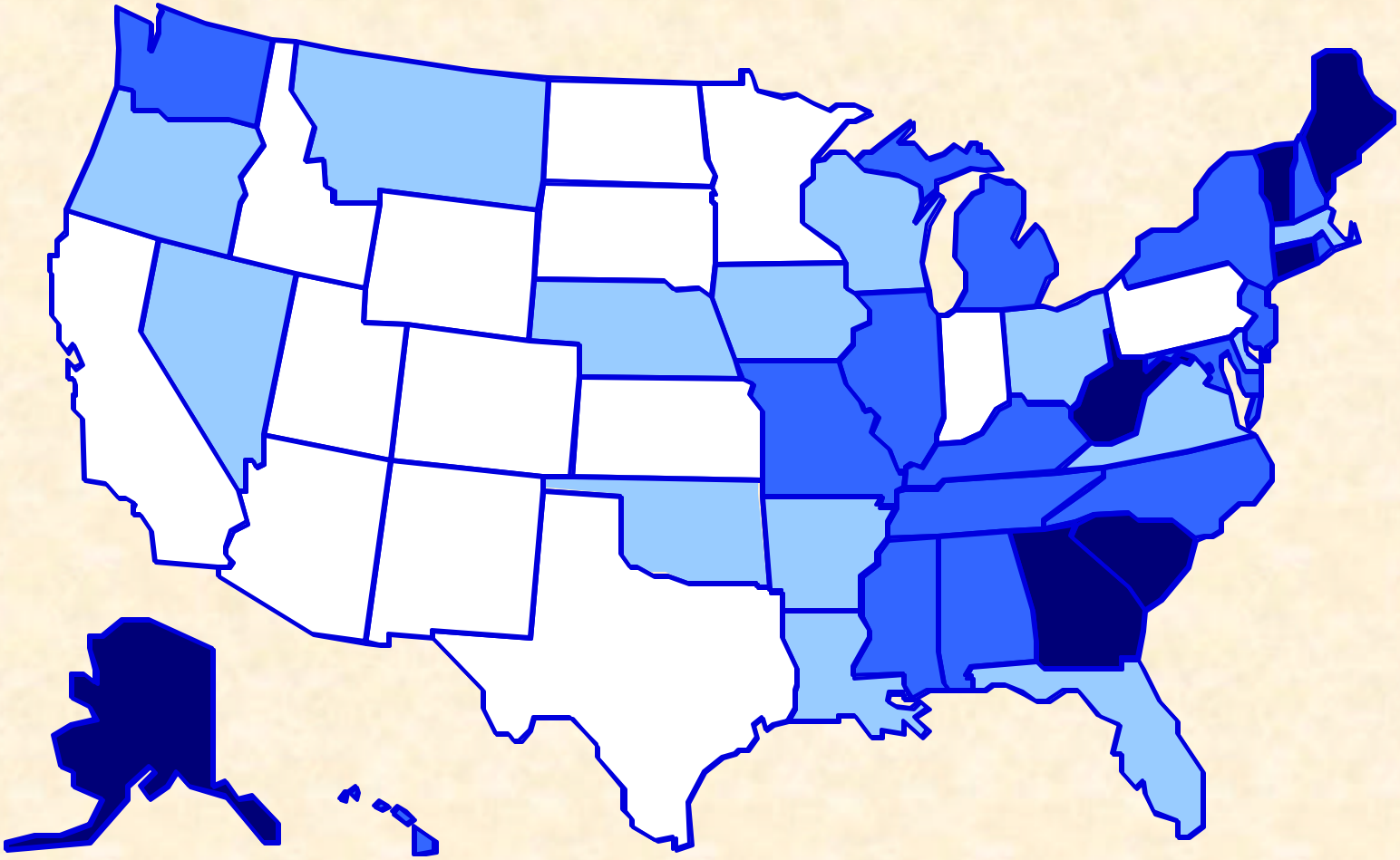
Certificate of Need:
Protecting Consumer Interests



a perspective of
the American Health Planning Association
and a variety of state certificate of need programs

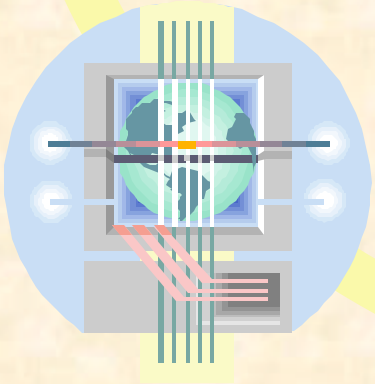
Thomas R. Piper

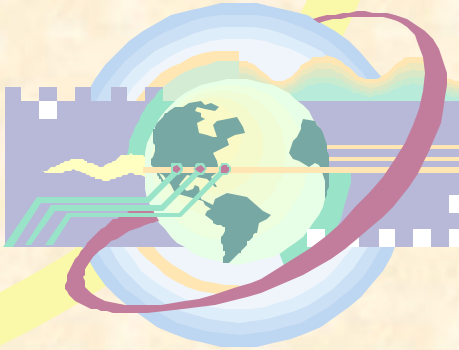
Director, Missouri Certificate of Need Program

as part of a planning panel on

"Federal Trade Commission/Department of Justice
Hearings on Health Care Competition
Quality and Consumer Protection: Market Entry

FTC Conference Center
601 New Jersey Avenue, Washington, DC
Morning Session, Tuesday, June 10, 2003





Topics

CON Background

Contemporary Operations

CON Success

CON and Competition

Certificate of Need:
Protecting Consumer Interests

Assure Public Input

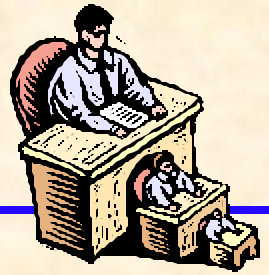
Maximize Accessibility

Improve Quality

Contain costs

Benefits

Milestones in Health Planning



Early History

- pre-WWI: Flexner report (revolutionized medical education)
- pre-WWII: Social Security Act (**universal health ins.**)
- post-WWII: Hill-Burton (develop modern hospital infrastructure)

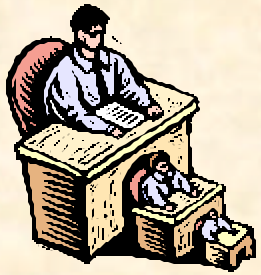
Middle History

- mid-60s: PL 89-97 Soc. Sec. Act : Medicare & Medicaid (Titles 18 & 19)
  PL 89-749 Comp. Health Planning Act (quality, cost, access)
- mid-70s: SSA-1122 Capital expenditure **controls**
  PL 93-641 Nat'l. Health Planning & Res. Dvlpmt. Act:
  new authority for health planning & regulation

Recent History

- mid-80s: DRGs control through purchasing, not supply
  Federal support for planning & CON regulation terminated
  Managed care emerges (popularizes **competition**)
- **Today** : Seeking BALANCE . . . **regulation & competition**

Milestones in Health Planning



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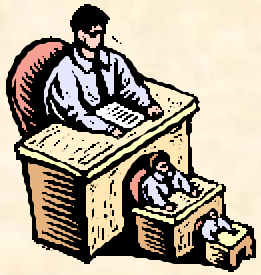

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Milestones in Certificate of Need

The Concept

- **1964: Rochester, New York** (model for the nation)
  Marion Folsom (prev. of DHEW), works with Kodak (and other businesses) and Blue Cross to establish community **health planning council** ("grass roots" movement of payers, consumers and providers who initially evaluated hospital need)

Voluntary Regulation

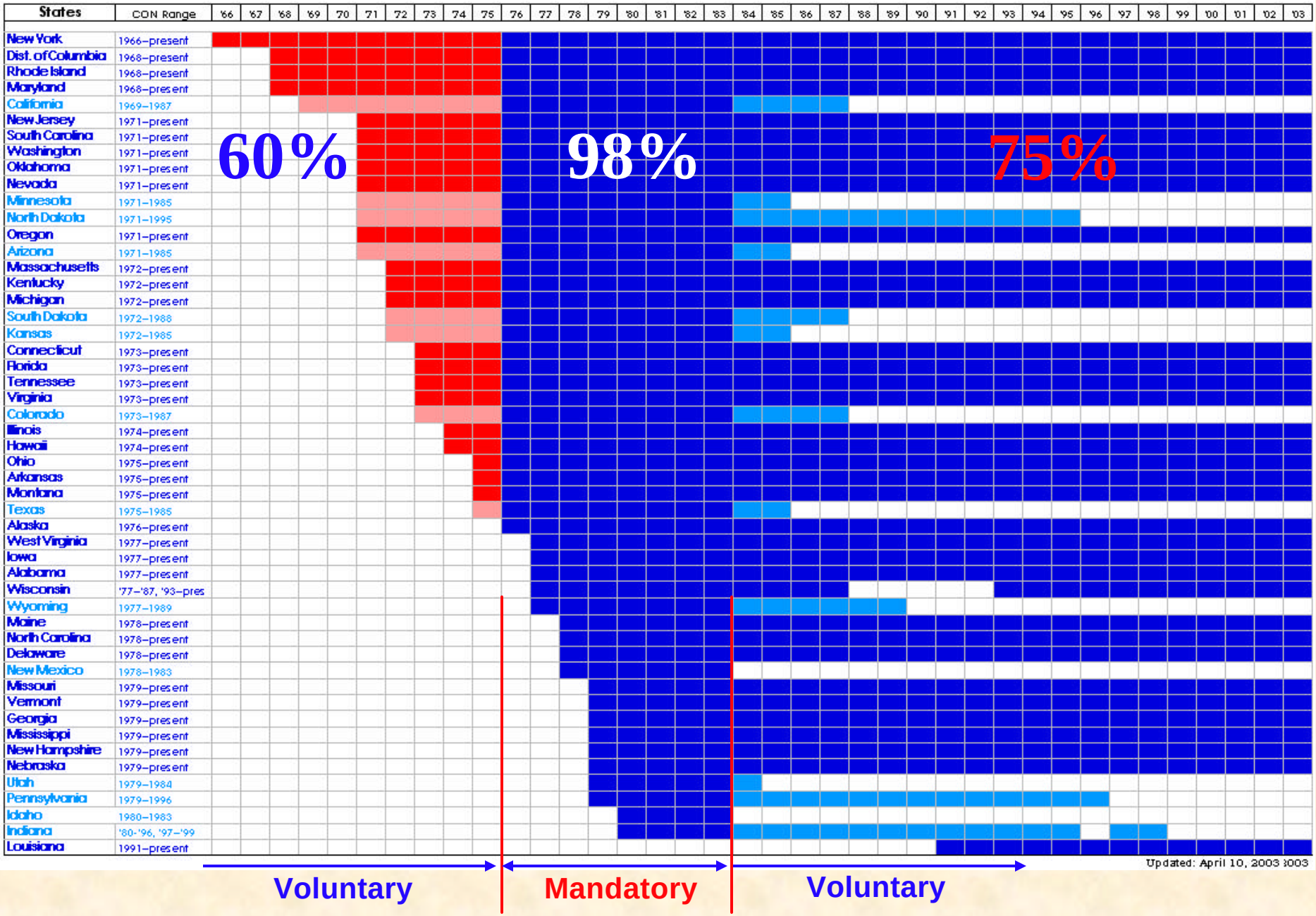
- **1966-1975: New York State**, followed closely by Maryland, Rhode Island and the District of Columbia, lead the establishment of CON programs in 60% of the states before the federal mandate.

Mandatory Regulation

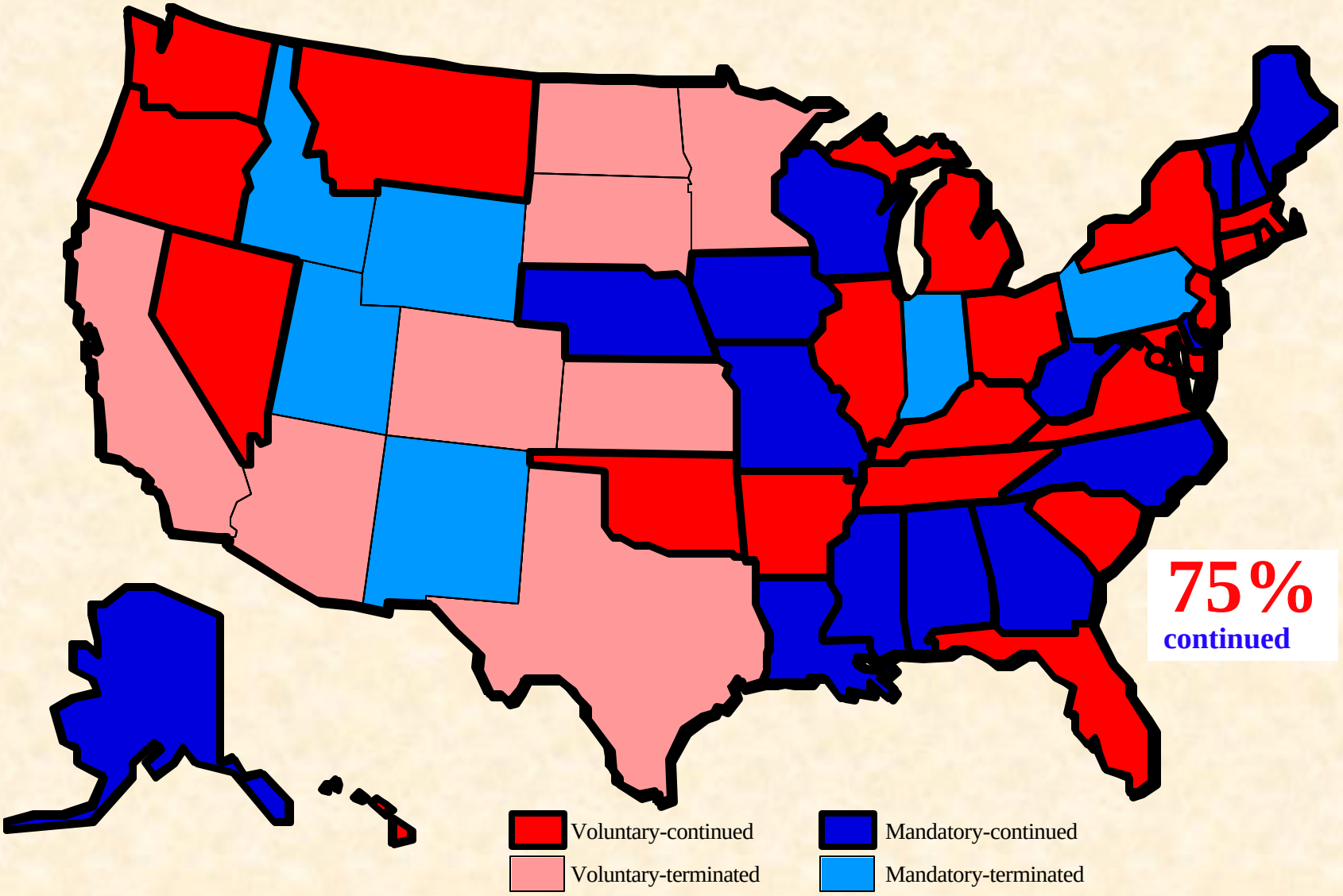
- **1976-1983**: the remaining 19 states (except Louisiana) complied with PL 93-641 Health Planning law

see Chart and Map

Duration of CON Regulation by State



Duration of Voluntary vs. Mandatory CON Programs



2003 Relative Scope and Review Thresholds of CON Regulated Services

(this information is summarized from the 2003 National Directory of Health Planning, Policy and Regulatory Agencies, the twelfthth edition published by the American Health Planning Association)

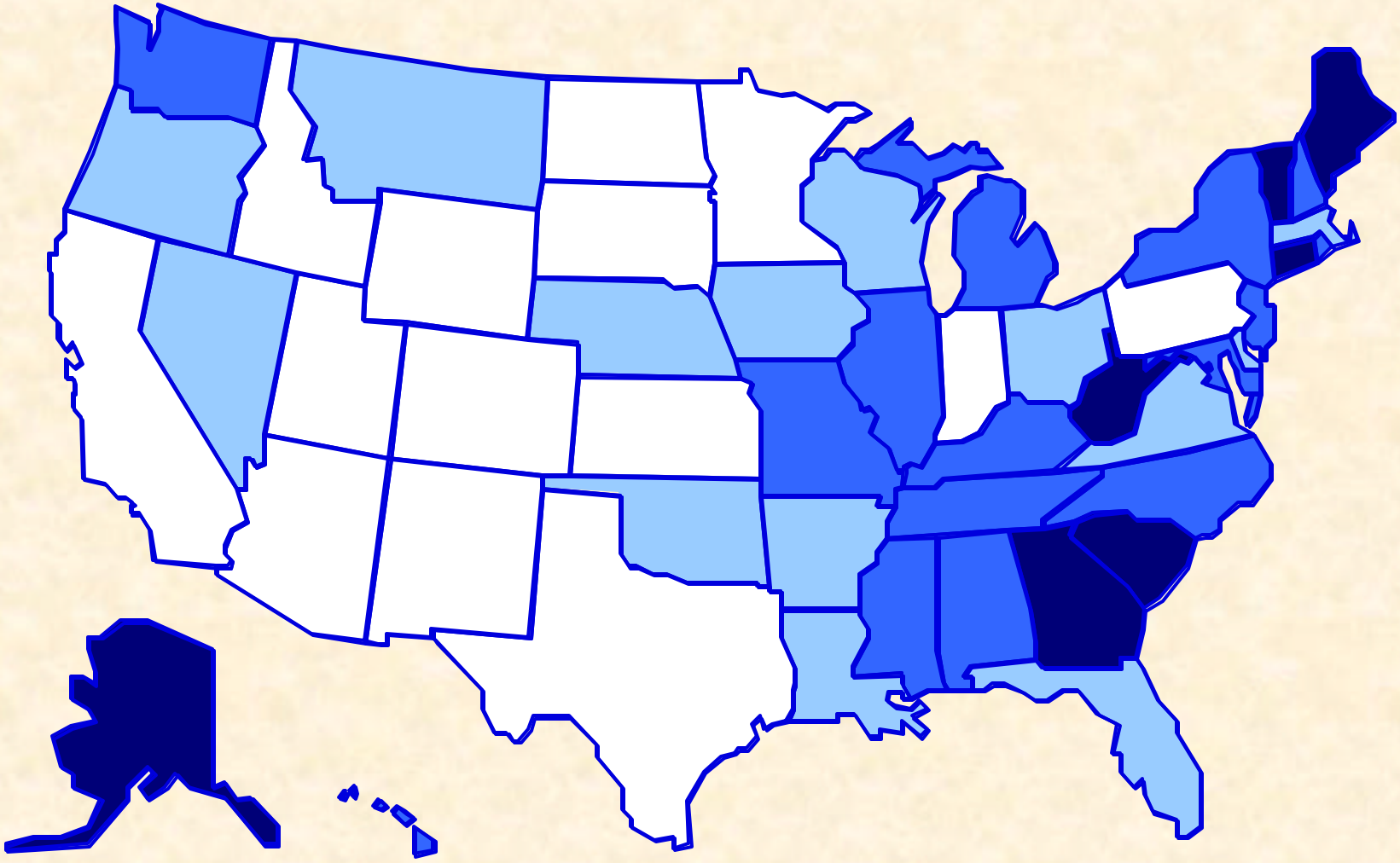
compiled by Thomas R. Piper
Missouri CON program
Jefferson City, MO
573-751-6403

Rank (no. of svcs. x weight)	Categories	Acute Care	Air Ambulance	Amb Surg Ctrs	Burn Care	Business Cmpths	Cardiac Cath.	CT Scanners	Gamma Knives	Home Hlth	ICF/MR	Lithotripsy	Long Term Care	Med Off Bldg	Mobile Hi Tech	MRI Scnrs	Neo-nt Int Care	Obstetric Svcs	Open Heart Svcs	Orgn Transplnt	PET Scnrs	Psychiatric Svcs	Rad Therapy	Rehab	Renal Dialysis	Res Care Fac	Subacute	Substance Abuse	Swing Beds	Ultra-sound	Other (items not otherwise covered)	Count (no. of svcs.)	$ nrsg hm/hosp	Reviewability Thresholds: Capital	Med Eqpt	New Svc	Weight
31.2	Maine	■	■	■	1		■	■	■		■	■	■		■	■	■	■	■	■	■	■	■	■			■	■	■		24		0.5M/2.0M	1,000,000	100,000	1.3
28.8	Connecticut	■	■	■	■		■	■	■			■	■		■	■	■	■	■	■	■	■	■	■			■	■	■		24		1,000,000	400,000	0	1.2
26.0	Alaska	■	■	■	■		■	■	■	■		■	■		■	■	■	■	■	■	■	■	■	■			■	■	■		26		1,000,000	1,000,000	1,000,000	1.0
21.6	Vermont	■	■	■	■		■	■	■	■	■	■	■		■	■	■	■	■	■	■	■	■	■			■	■	■		24		1.5/0.75M	500,000	300,000	0.9
20.9	South Carolina	■		■			■		■	■	■	■	■		■	■	■	■			■	■	■	■			■	■			19		1,000,000	600,000	400,000	1.1
20.9	Georgia	■		■			■	■	■	■	■		■		■	■	■	■			■	■	■	■			■	■			19		1,250,199	694,556	any	1.1
20.7	West Virginia	■		■	■		■			■	■	■	■		■	■	■	■	■	■	■	■	■	■			■	■	■		Beh. Hlth	23		2,000,000	2,000,000	23 svcs	0.9
18.4	North Carolina	■	■	■	■		■		■	■	■	■	■		■	■	■		■	■	■	■	■	■	■			■			IC, others	23		2,000,000	750,000	n/a	0.8
17.6	Tennessee	■	■	■	■		■	■		■	■	■	■			■	■	■		■	■	■	■				■				hospice, meth	22		2,000,000	1,500,000	any beds	0.8
17.0	Mississippi	■		■			■		■	■	■	■	■		■			■		■	■	■	■	■								17		2,000,000	1,500,000	any	1.0
16.8	Alabama	■		■			■		■		■	■	■		■	■	■	■	■	■	■	■	■	■						■	ESRD & ALC	21		3,200,000	1,500,000	any	0.8
16.1	Dist. of Columbia	■		■			■	■	■	■		■		■	■	■	■	■	■	■	■	■	■	■				■	■			23		2,000,000	1,300,000	600,000	0.7
15.2	Rhode Island	■		■			■	■	■	■			■		■	■	■	■	■	■	■	■	■	■				■	■			19		2,000,000	1,000,000	750,000	0.8
15.0	New York	■		■	■		■	■	■	■	■	■	■		■	■	■	■	■	■	■	■	■	■	■	■		■	■	■		25		3,000,000	3,000,000	any	0.6
15.0	Hawaii	■	■	■	■		■	■	■	■	■	■	■		■	■	■	■	■	■	■	■	■	■			■	■	■			25		4,000,000	1,000,000	any	0.6
14.4	Maryland	■		■	■		■			■	■	■	■				■	■	■	■	■	■	■	■			■	■			fed. swing bed	16		1,500,000	n/a	any	0.9
14.4	Michigan	■	■	■			■	■	■		■	■	■		■	■	■		■	■	■	■	■	■					■		Hosp & Surg	18		2,510,000	any	any clin.	0.8
14.4	Kentucky	■		■			■		■	■	■	■	■		■	■	■	■	■	■	■	■	■	■		■	■	■			Mobile svcs	18		1,831,594	1,831,594	n/a	0.8
13.3	Illinois	■		■	■		■		■		■	■	■		■	■	■	■	■	■	■	■	■	■			■	■	■		Other	19		6,326,066	6,175,751	any	0.7
12.8	Washington	■		■	■		■		■	■		■	■		■	■	■	■	■	■	■	■	■	■			■	■	■		Hospice	16		var. by svc.	n/a	any	0.8
12.6	New Hampshire	■		■			■	■			■		■		■	■	■	■	■	■	■	■	■	■			■					14		1,885,179	400,000	any	0.9
12.1	New Jersey	■			■		■			■	■		■		■		■	■	■	■	■	■	■	■								11		1,000,000	1,000,000	any	1.1
10.4	Missouri						■	■	■		■	■	■		■	■					■		■		■	■					New hosp.	13		0.5M/1.0M	0.4M/1.0M	1,000,000	0.8
8.1	Iowa	■		■			■												■	■	■		■									9		1,500,000	1,500,000	500,000	0.9
8.0	Virginia	■		■			■						■		■	■	■	■	■	■	■	■	■					■			MR, SPECT	20		5,000,000	n/a	n/a	0.4
7.7	Florida	■			■								■				■		■	■		■					■	■			Hospice	11		none	none	any	0.7
7.0	Oklahoma										■		■									■					■				psych. chem.	5		500,000	n/a	any beds	1.4
6.3	Montana			■						■	■		■											■				■	■			7		1,500,000	n/a	150,000	0.9
6.0	Arkansas									■	■		■									■				■						5		500,000	n/a	hospice	1.2
4.8	Massachusetts		■	■					■		■	■	■			■	■		■	■	■		■	■				■			ECMO	16		10,392,634	651,209	all	0.3
4.8	Delaware	■		■			■					■	■								■		■								Birthing ctrs.	8		5,000,000	5,000,000	n/a	0.6
4.4	Wisconsin										■		■													■					Others	4		1,000,000	600,000	any LTC	1.1
3.5	Nevada	■		■							■		■											■				■				7		2,000,000	n/a	n/a	0.5
3.0	Nebraska												■											■								2		any LTC	any LTC	any LTC	1.5
2.4	Oregon												■																■			2		any LTC/hs	n/a	LTC/hsp	1.2
0.5	Ohio												■																			1		2M renov	n/a	n/a	0.5
0.4	Louisiana										■		■																			2		n/a	n/a	LTC/MR	0.2

Disclaimer. Rank order relates to volume of items reviewed, NOT intensity of analysis or conclusions which are based on Criteria and Standards and decisions

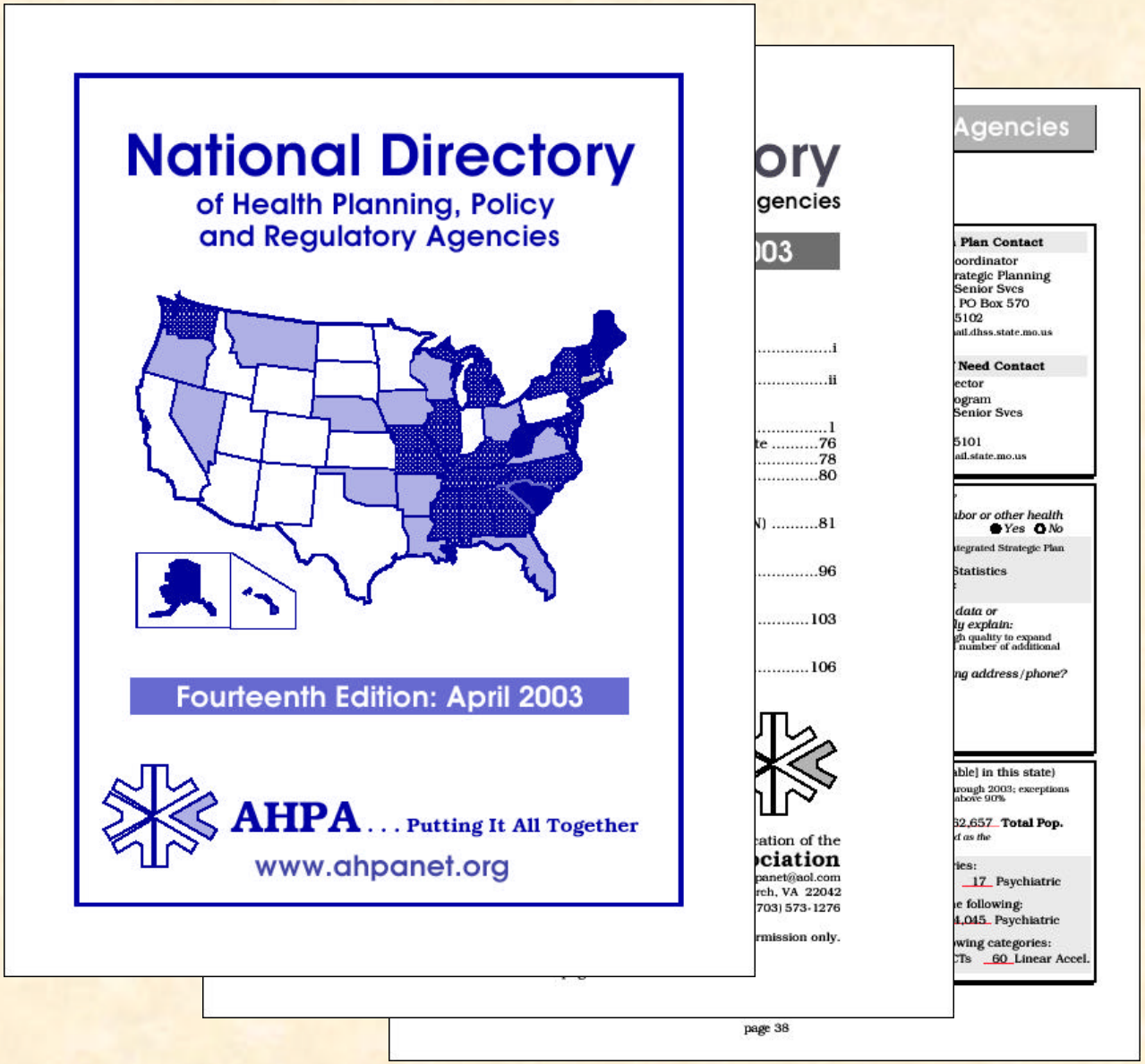
Source. Updated May 30, 2003 using most recent information available

2003 Relative Scope and Thresholds of CON Regulation



revised May 30, 2003

AHPA Source of CON Information



Conceptual Purposes of CON

Functions as a plan implementation tool

Supports community-based health services and health facility planning

Supports community-oriented planning by health service programs, facilities and systems

Provides analytical discipline and goal-orientation in health service and facility planning at all levels

Addresses (and interrupts) the "excess-supply generating excess-demand" phenomenon

Limits unnecessary capital outlays

CON: Unique Regulatory Concept and Tool

- Planning-based, analytically-oriented, fact-driven
- Open process, with provision for direct public involvement
- Structured to compensate for market deficiencies & limitations and foster market efficiency
- Unlike licensure and certification with their leveling effects, designed to highlight and accentuate quality
- Promotes economic and quality competition within the context of health care market realities
- Practical & educational rather than ideological
- Doorway to excellence rather than barrier to market entry

Marketplace Issues Revealed

- Capital costs in health care are passed on to the consumers.

- Competition in health care usually does not lead to lower charges:
  …providers control supply
  …providers determine most demand
  …consumers lack adequate information.

- Consumers do not (and usually can not) “shop” for health care, at least, not based on price.

- Increased costs lead to higher charges.

- Consumers do not pay most of the cost and do not really know the true cost of, and charges for, most care (third-party payers do).

- Providers have no direct incentives to lower charges or utilization.

CON: Unique Regulatory Concept and Tool

Views of the Critics

- CON focuses mostly on **cost control** by restricting market entry, capital outlays and technical innovation.

- CON looks largely at the **geographic aspects** of access rather than broader social and system access questions.

- CON does not assume a role in, or have a concern with, **quality** in health services.

- CON is generally unaware of the uses and limits of **market forces** in health services delivery.

CON: Unique Regulatory Concept and Tool

What the record shows (part I)

- CON focuses on **access and quality** more than cost

- CON seeks to improve economic and social access:

  …promotes **equal access** to health care

  …advocates community, patient and provider **equity**

- CON **elevates quality**: best practices, high standards

- CON promotes **fiscal responsibility** by requiring the use of sound economic and planning principles

CON: Unique Regulatory Concept and Tool

What the record shows (part II)

- CON **responds** to the realities of market forces and related circumstances
- CON uses RFPs and **competitive** reviews
- CON promotes **open-panel** medical staffing
- CON discourages **market segmentation,** "cherry picking" and monopolistic practices
- CON **opposes anti-competitive** forces and actions, such as community abandonment

CON: Unique Regulatory Concept and Tool

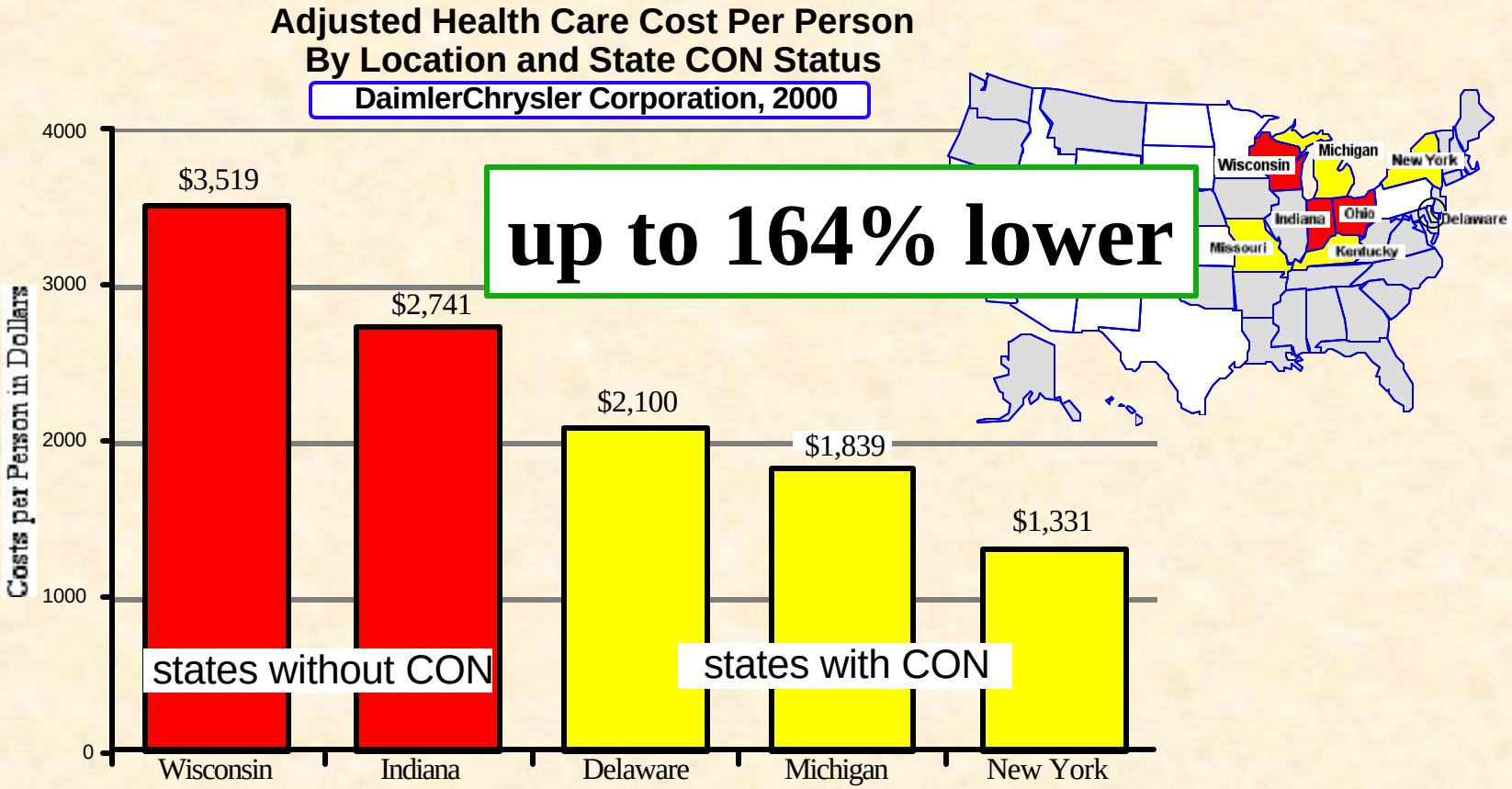
CON Realities: Actual Experience

– Theoretical postulates and arguments, macroeconomic studies, consultant musings are at best inconclusive, at worst doctrinaire

– **Real-life business experience and treatment outcomes demonstrate value and success:**

- Automaker cost monitoring
- Outcome review of Medicare heart patients
- Provider tracking of ambul. surgery centers

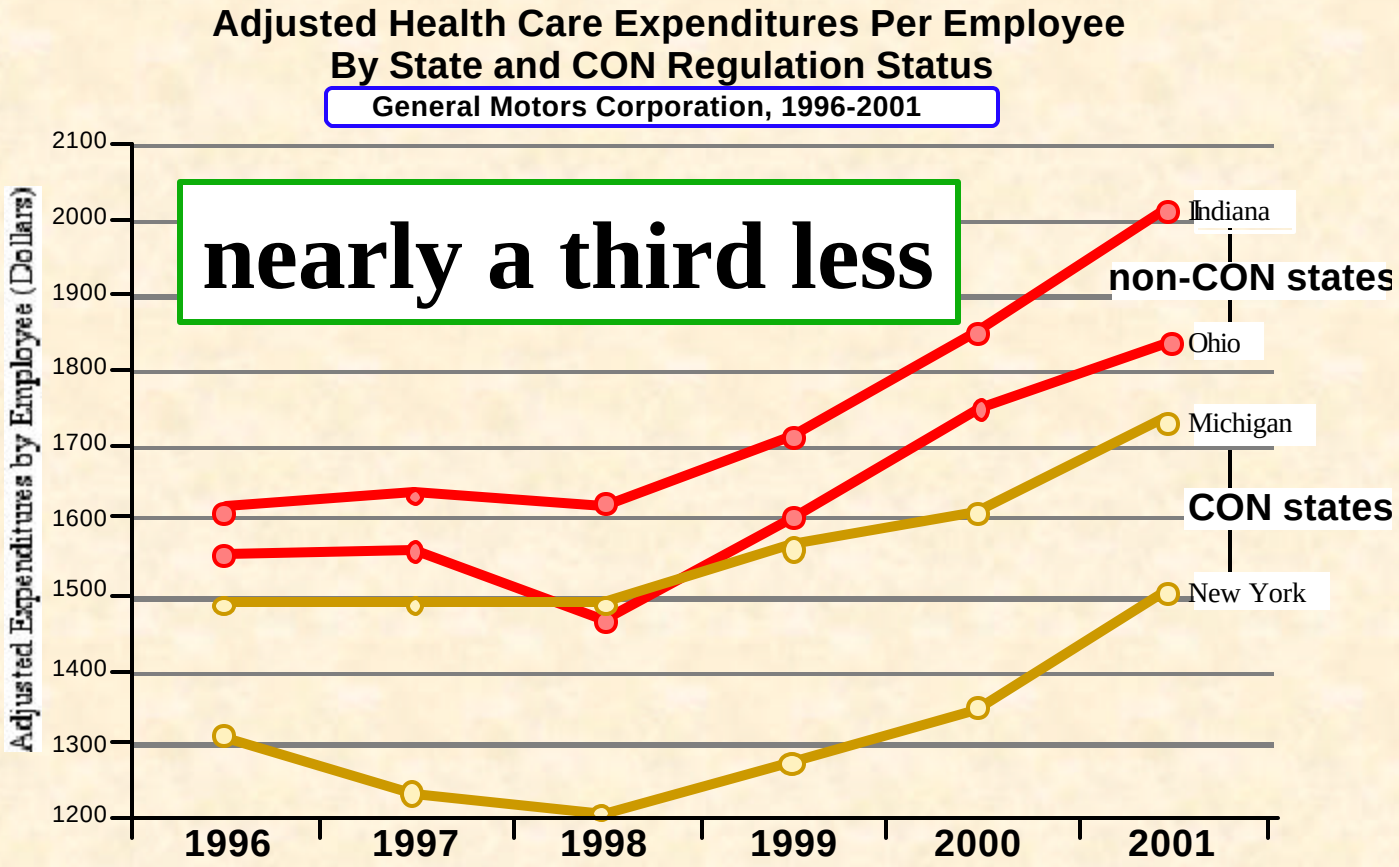
Big-Three Automakers Health Care Costs
non-CON vs. CON states



CON states have lower health care costs than non-CON states!

Big-Three Automakers Health Care Costs

non-CON vs. CON states



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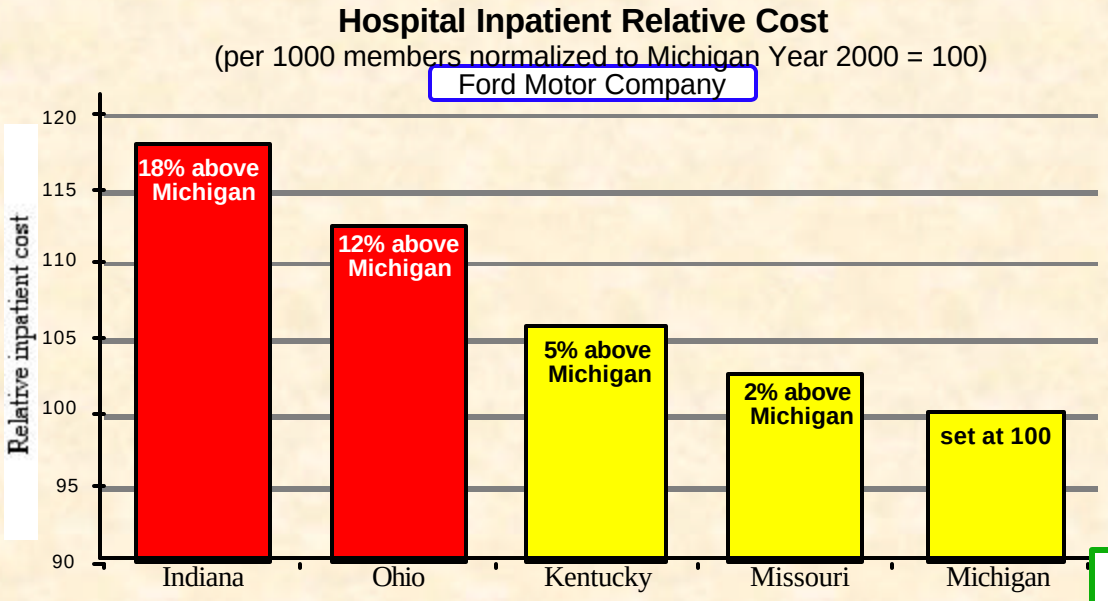
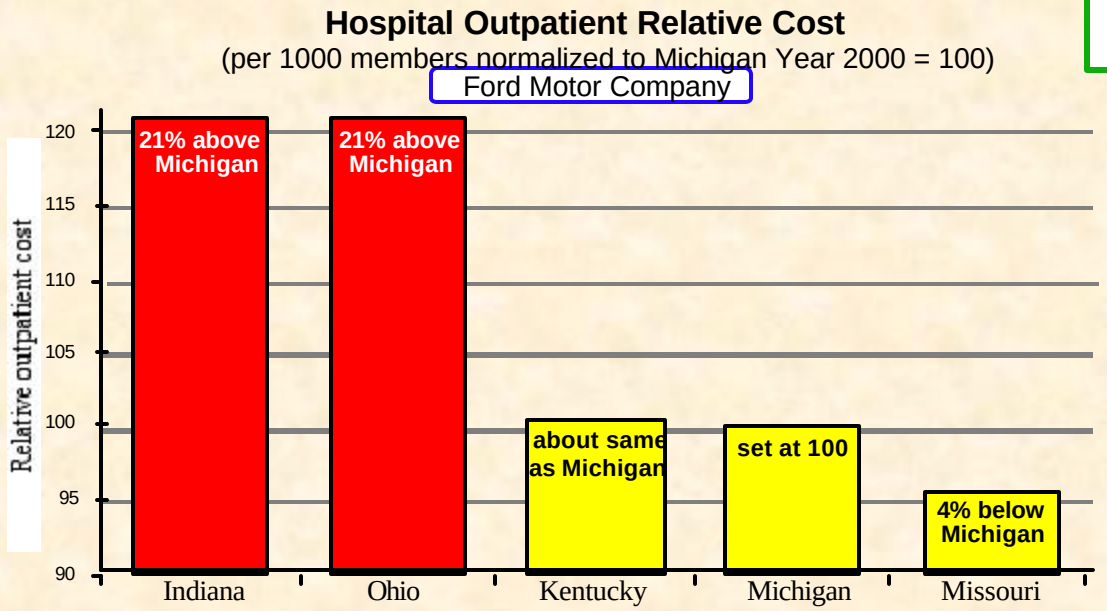




Big-Three Automakers Health Care Costs non-CON vs. CON states

about 20% less

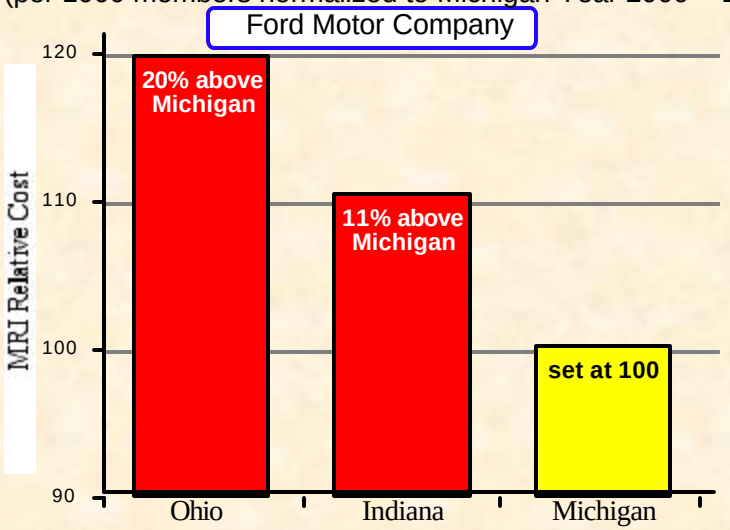
CON states have lower health care costs than non-CON states!

Big-Three Automakers Health Care Costs non-CON vs. CON states

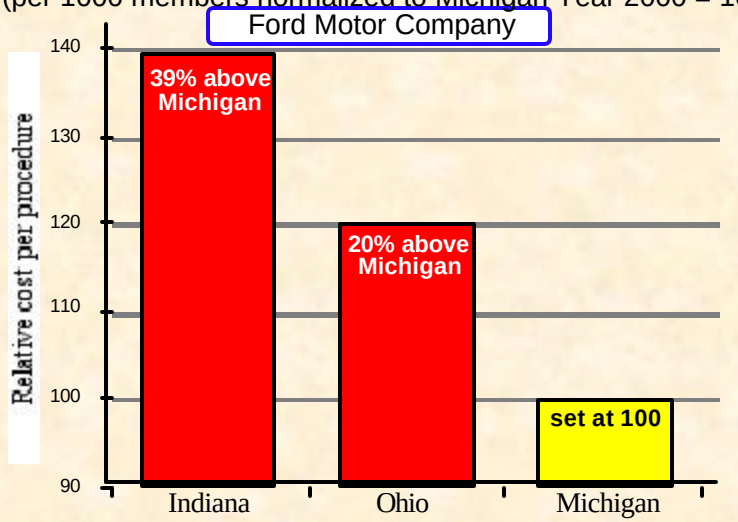
11-39% lower

CON states have lower health care costs than non-CON states!

Magnetic Resonance Imaging (MRI)
Relative Cost Per Service
(per 1000 members normalized to Michigan Year 2000 = 10(

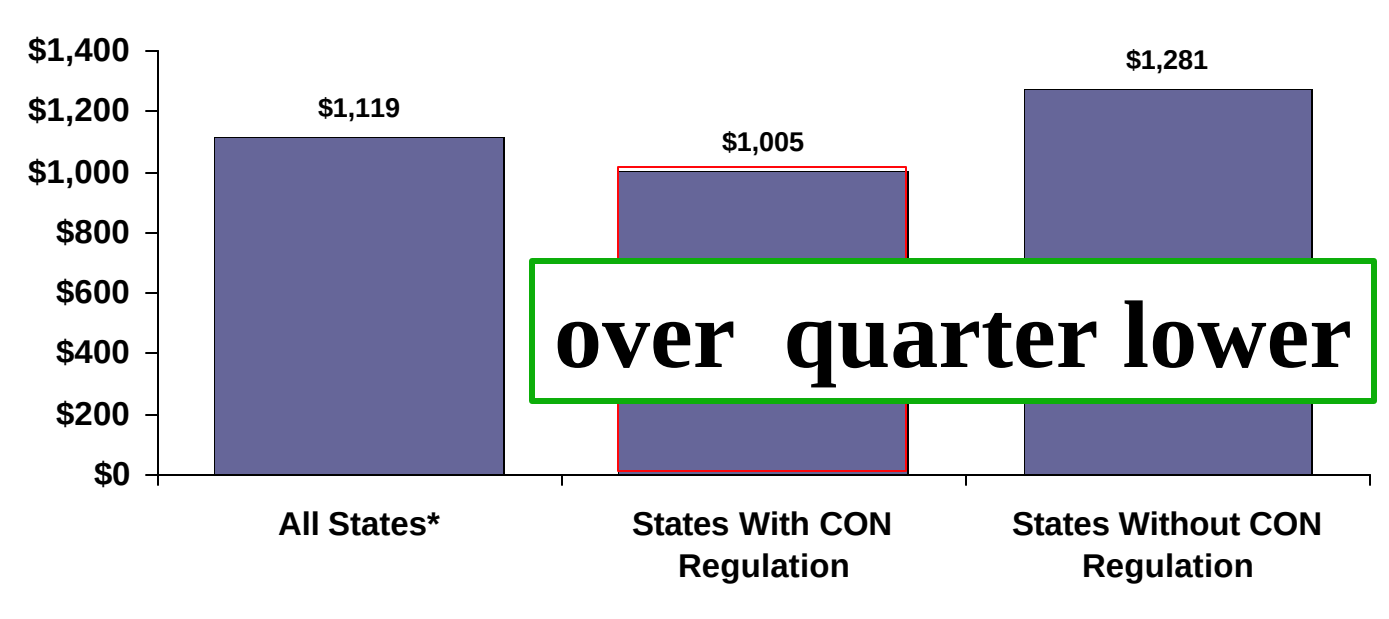


Coronary Artery Bypass Graft (CABG) Surgery
Relative Cost Per Service
(per 1000 members normalized to Michigan Year 2000 = 100



Freestanding Ambulatory Surgery Center Charges non-CON vs. CON states

Ambulatory Surgery Centers
By State CON Regulation Status
Average Charge, 1999



CON states have lower freestanding ASC charges than non-CON states!

IMPACT OF STATE CERTIFICATE OF NEED PROGRAMS ON OUTCOMES OF CARE FOR PATIENTS UNDERGOING CORONARY ARTERY BYPASS SURGERY

REPORT TO THE FLORIDA HOSPITAL ASSOCIATION

PREPARED BY:

GARY E. ROSENTHAL, MD
MARY V. SARRAZIN, PHD
PROGRAM IN HEALTH SERVICES RESEARCH
DIVISION OF GENERAL INTERNAL MEDICINE
UNIVERSITY OF IOWA COLLEGE OF MEDICINE
IOWA CITY VA MEDICAL CENTER
IOWA CITY, IOWA

JANUARY 17, 2002

"... this analysis would suggest that CON regulation is associated with better patient outcomes. Thus, repeal of CON regulations may have negative consequences on patient outcomes."

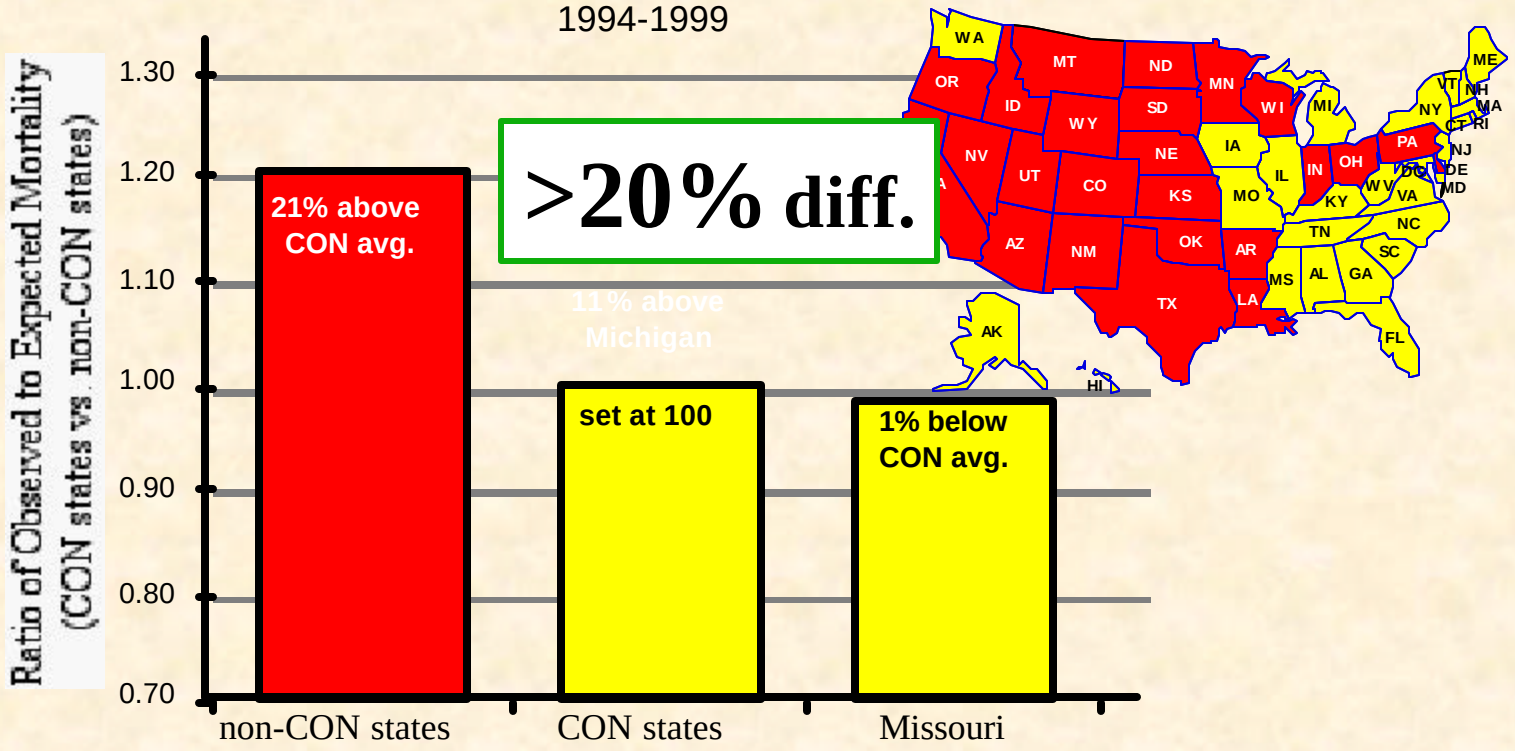
CABG Mortality
non-CON vs. CON states

Coronary Artery Bypass Graft (CABG) Surgery

Risk-Adjusted Mortality by State CON Regulation Status

Medicare Beneficiaries (65 years of age or older)

1994-1999



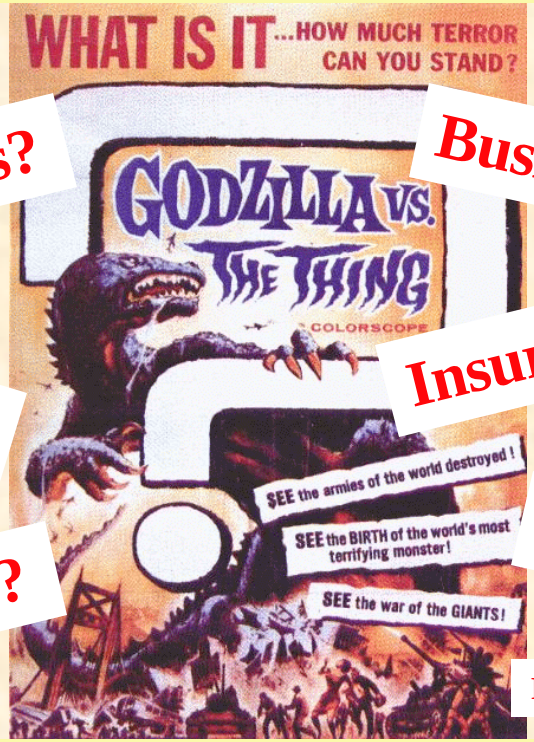
CON states have lower mortality for CABG surgery than non-CON states!

CON: Protecting Consumer Interests

- Public input is assured
- Accessibility is maximized
- Quality is improved
- Costs are contained

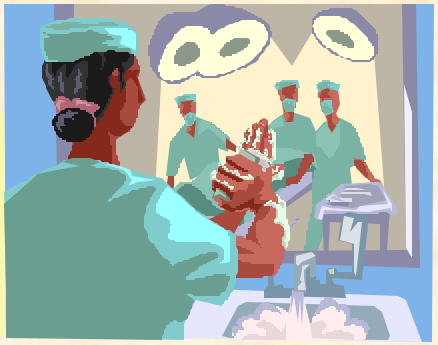
How does certificate of need relate to competition?

Webster's defines competition as "a business rivalry; a competing for customers or markets."



Who are the customers, where are the patients, and what information do they have?

Consequences of Unrestricted Health Care Competition



- **Splinters the provider delivery network** which causes staffing shortages, which in turn lowers quality and fragments the health care support system.
- **Threatens "safety net facilities"** such as trauma centers, medical education institutions, and low-income neighborhood facilities.
- **Creates high-profit niche markets** such as specialty hospitals and outpatient service centers for diagnostic imaging, ambulatory surgery and radiation therapy.
- **Supply drives demand!** "…supply generates demand, putting traditional economic theory on its head. Areas with more hospitals and doctors spend more on health care services per person."

  - *Hospitals & Health Networks* review of the *Dartmouth Atlas, April 5, 1996.*

Balance Regulation and Competition:
Protect Consumer Interests

Promote the development of community-oriented health services & facilty plans

Provide pricing and quality information to consumers so that they have an educated choice

Provide a public forum to ensure that the community has a voice in health care

For more information, contact:

www.ahpanet.org
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