RESEARCH MEMORANDUM NO. 440

A STATUS REPORT ON CERTIFICATE OF NEED

Prepared for:

Interim Joint Committee on Health and Welfare

Prepared by

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Legislative Research Commission

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LEGISLATIVE RESEARCH COMMISSION
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MEMORANDUM

TO: Vic Hellard, Jr.
Director

FROM: Karen Main, Legislative Analyst
Committee on Health and Welfare

SUBJECT: Study Directed by House Resolution 181

DATE: April 20, 1990

During the 1988 Session of the General Assembly, the House adopted House Resolution 181, which directed the Interim Joint Committee on Health & Welfare to study the Certificate of Need process.

This memorandum is a presentation of the work of the Committee, which considered the information contained here in August, 1989. The document includes a history of the Certificate of Need program in Kentucky, activities of other states with regard to Certificate of Need, and recommendations presented to the Committee.

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A STATUS REPORT ON CERTIFICATE OF NEED

Introduction

When the final figures are in for Fiscal Year 1989, it is expected the United States will have spent $618.4 billion on health care. Of this amount, approximately 40 percent is paid by government (federal-30%, and state-10%), 30 percent by employer-sponsored health insurance, and 30 percent by individuals. These billions represent an enormous increase in spending from when major public health financing programs, Medicare and Medicaid, were begun. In 1965 total national health expenditures were about $42 billion.

Although that amount pales in light of today's costs, observers were concerned and within a very few years initiated a number of programs designed, at least in part, to control health care costs. One of these initiatives was health planning and certificate of need. Following relatively modest precursors, in 1974 Congress enacted the **National Health Planning and Resources Development Act** (P.L. 93-641), which was intended to give coherence to the earlier laws encouraging states to get a grip on the helter-skelter growth of hospitals, nursing homes and other health facilities.

The program was a reaction to the health care community's version of Parkinson's law: A new bed usually gets occupied. Put another way, in the health care business, supply often drives demand. Health planning was meant to counteract this tendency and prevent unnecessary new building and equipment purchases. To that end, the law required states to pass "certificate of need" (CON) laws, providing for review of new institutional health services and major capital expenditures for facilities and equipment. It also established state health planning agencies to oversee the CON law and a host of local voluntary planning agencies (health systems agencies), whose job it was to coordinate local planning and make recommendations to the states.

KRS Chapter 216B is the **Certificate of Need Law.** Under its provisions, any agency seeking to establish a new health service or facility, obligate a capital expenditure which exceeds an annually established threshold, or purchase major medical equipment must complete an application for a "certificate of need". The fee for processing the application is relative to the dollar cost of the proposal. These applications are evaluated on the basis of consistency with plans (primarily the State Health Plan), need and accessibility, interrelationships and linkages, costs and economic feasibility, and quality of services. Health maintenance organizations are given special consideration. If the application is approved by the Commission for Health Economics Control in Kentucky (CHECK—see discussion below), it is reviewed by Licensure and Regulation to determine whether it meets health and safety standards prescribed in administrative regulations. If it does, the project becomes licensed. A license cannot be issued without a certificate of need. A health service operating without a license or certificate of need is subject to

severe financial penalties. Services provided in physicians' offices are exempt from certificate of need.

In October 1986, Congress elected not to renew P.L. 93-641. With that step, federal funds for state and local planning activities were terminated, as were federal prescriptions and potential sanctions governing state reviews of proposed capital expenditures.

A year later, the **Section 1122 program**—the vehicle through which states review capital spending projects eligible for reimbursement under Medicare and Medicaid—was effectively ended as well. Beginning October 1, 1987, the federal Department of Health and Human Services cancelled its agreements with states to conduct these types of reviews. Although many states still have their Section 1122 programs on the books, removing the threat of losing Medicare and Medicaid reimbursement has taken most of the teeth out of the program. In Kentucky, the Section 1122 program has been dropped, but in a separate process related to licensure, the Licensure and Regulation division must certify that the service meets federal standards before they can be certified to receive Medicare and Medicaid reimbursement.

With no more federal involvement, states are now solely responsible for deciding whether and how to continue capital expenditure review programs. The question the legislatures are grappling with is: in the absence of control over health services expansion, will there be unnecessary development leading to underutilization or the provision of unnecessary medical care? Advocates of deregulation argue that competition is the way to avert these problems—that underutilization would not be economically feasible, that prices could be contained by "comparison shopping", and that consumers would not submit to unnecessary procedures. Pro-regulation forces claim that competition could not develop in health care because the physician is the purchaser and seller of services to patients and that he stands to gain from providing/ordering more services, not less. This year, the legislatures in more than 40 states considered bills relating to CON review or to the statewide planning systems; of that number, at least 25 approved changes in those programs ranging from minor revisions in the process to elimination of the program.

As anticipated, the trend continues to be toward deregulation—either outright, by repealing CON laws, or less directly, by reducing the authority vested in the review agencies. In addition, studies are underway in a number of states to evaluate the effectiveness of current programs and to identify alternative methods of streamlining the planning structure, controlling costs and improving availability and access to health care.

The purpose of this report is to review the CON-related actions of other states, to review the CON program in Kentucky and to present recommendations from interested parties in Kentucky regarding the program in the Commonwealth.

Activities in Other States

The end of federal financial support for health planning has given momentum to states doing away with CON programs. Before 1988, eight states had completely eliminated CON: Arizona, Idaho, Kansas, Minnesota, New Mexico, Texas and Utah. During 1988, California, Colorado and Wyoming repealed their programs or allowed them to sunset, bringing the total number of states without any CON review requirements to 10.

Short of repeal, several states have revised their programs, for example, limiting the CON process to long-term care facilities only. **Table 1** is a summary of the more popular strategies. In Indiana, for example, a new law exempts acute care facilities from review, requiring prior approval for long-term care and psychiatric facilities only. In Montana, the legislature enacted provisions requiring hospitals that want to use their beds to provide skilled or intermediate nursing care (including those for the developmentally disabled) to apply for a CON. Wisconsin also now requires review of long-term care services only.

Louisiana, the only state that never established a CON program, also considered legislation to establish such a review process for long-term care. Although the measure failed to pass, the legislature did vote to restructure the Section 1122 program, which the state has used in place of CON. Under the new program, capital expenditure reviews will be done only for those projects that receive funds from Medicaid; the state will not reimburse for capital expenses for projects that are disapproved. In addition, the Medicaid agency now requires new nursing home services to be approved under the revised capital expenditure review program, in order to be eligible for reimbursement.

Local planning agencies have virtually disappeared, without federal financial help. According to the American Health Planning Association, only about 40 health systems agencies remain, compared to 204 nationwide in 1981; all but three of those are east of the Mississippi River. Two of the states most committed to maintaining the agencies are New York and Florida.

TABLE 1

Strategies for CON Other than Repeal

Strategy	States
Limit the type of service covered by CON, e.g., nursing homes or hospitals.	Indiana, Montana, Wisconsin, Louisiana, Delaware, South Dakota, Nevada, Hawaii, Mississippi, Ohio
Reorganize the CON/health planning program.	Florida, Maine, New Jersey, Vermont Arkansas, Connecticut, Oregon
Evaluate program	Delaware, Hawaii, Illinois, Maine, Michigan, Montana, New Jersey, Virginia
Increase dollar threshold of projects subject to CON.	Delaware, Hawaii, Nevada, North Carolina, Arkansas, Connecticut, Maine, Ohio, West Virginia
Streamline process.	Florida, Oregon, Arkansas, Massachusetts, Mississippi
Moratoriums	Arkansas, Mississippi, Missouri, Minnesota

Many states, however, are attempting to keep the planning process intact, in some cases by restructuring the review programs or creating new agencies to oversee activities. Others have authorized studies to evaluate the effectiveness of existing programs in controlling costs without compromising access to health care.

In Florida, for instance, the legislature has reorganized the CON program, establishing local and statewide health planning councils and authorizing funds for their operation. Maine lawmakers established a Health Policy Council to work with other departments and agencies, the legislature and consumer groups in developing health planning strategies. In New Jersey, local health planning programs have been authorized, with an appropriation of $250,000 to sustain them. Vermont's legislature has created a CON Review Board, changed the name of the Health Policy Corporation to the Health Policy Council and appropriated $182,000 to support health planning and CON review. Connecticut and Oregon followed the lead of Arkansas and eliminated the state health planning and development agencies and local health systems agencies (HSAs), designating the health department as the lead agency for public health planning.

Program evaluations are ongoing in many states, including Delaware, Hawaii, Illinois, Maine, Michigan, Montana, New Jersey and Virginia. The report coming out of Michigan will help legislators in their evaluation of various legislative proposals to raise thresholds, eliminate services from review and generally streamline the planning process. In New Jersey, lawmakers established a commission to study the development of "regional

health enterprise zones" and their impact on reimbursement and the CON program. The zones would be used as incentives for hospitals and other health care providers to establish, on a joint or shared basis, specified programs and services to a specific region in the state.

A recent Virginia report lays out several options for revamping the planning process. They include: (1) total deregulation of major medical equipment associated with new services; (2) continued reviews of projects (relocation, expansion or new construction) that will result in adding to the available bed supply; and (3) limiting reviews to long-term care facilities. One other recommendation—creating local health services advisory boards to assist in the planning process—was embodied in a bill approved by the legislature last March.

Many states committed to maintaining CON are attempting to streamline the process. One of the principle strategies for attaining that goal has been the deregulation of services. In Delaware, for example, the legislature eliminated home health agencies and projects not directly related to patient care from CON review. South Dakota and Nevada have also eliminated non-patient-related expenses from review requirements. In Hawaii, dental surgery centers and dental clinics have been eliminated from review requirements. Mississippi legislators exempted establishment of HMOs from CON oversight, while in Ohio, lawmakers deregulated Medicaid-certified intermediate care facilities for the mentally retarded (ICFs/MR) from CON review requirements, provided they are licensed.

Another popular deregulation strategy has been to increase the dollar threshold of projects subject to CON review. Delaware, for example, has increased review thresholds for capital expenditures for both plant and equipment from $150,000 to $750,000. Hawaii increased review minimums from $600,000 to $4 million for capital expenditures and from $400,000 to $1 million for major medical equipment and provided a new $400,000 review threshold for purchase of used medical equipment. Capital expenditure review thresholds in Nevada have been increased from $400,000 to $2 million for both hospitals and other health facilities. And in North Carolina, capital expenditure review thresholds have been increased from $1 million to $2 million and new institutional health services must be reviewed only if their cost exceeds $1 million. Other states that raised capital review thresholds include Arkansas, Connecticut, Maine, Ohio and West Virginia.

In an effort to streamline the regulatory process, states are using a variety of standards to evaluate program performance. These performance contingencies may apply to such things as Medicaid participation and occupancy rates, amount of service to underserved populations, extent of indigent care provided or history of compliance with quality standards. For example, Florida's legislature has added a criterion to the revised CON review process that takes into account the applicant's past and proposed provision of health services to Medicaid patients and the medically indigent. A new law in Oregon waives CON requirements for capital projects or new medical services in rural hospitals

that meet criteria established by the state's Office of Rural Health. And in Arkansas, a provision eliminating head injury retraining facilities from CON review is tied to a requirement that such facilities not apply to take part in Medicare or Medicaid.

An Indiana law governing review of comprehensive care nursing home beds requires applicants to show that the utilization rate for all beds in the county will not go below 84 percent. In Massachusetts, long-term care facilities are now exempt from review requirements, provided they will be located in an underserved area and that at least 70 percent of their resident population are Medicaid recipients. And in Mississippi, CONs for changes in ownership of nursing homes will not be granted if the change will increase Medicaid costs or exceed the established caps on the number of allowed beds.

Finally, moratoriums on new construction continue to be a popular tool to hold down capital spending. In addition to restructuring the planning process, for instance, the Arkansas legislature established a moratorium on new hospitals, home health agencies and nursing homes through June 1, 1989, to allow the state time to develop and implement new regulations.

Mississippi extended an existing moratorium for two more years, although only for ICFs/MR and home health agencies. Missouri continued a moratorium currently in place on new nursing home construction until July 1991. And Minnesota, which repealed its CON program in 1984, has also extended a moratorium on hospital capacity expansion through 1991. An indefinite moratorium on nursing home construction is in place there as well.

Results in Other States

Unfortunately, **quantifiable results of these programmatic changes are not available**. However, in 1988, the American Hospital Association did conduct a limited survey of the states which had eliminated their CON programs. Using anecdotal data obtained in that survey from the states with any information, the following results appear: three states reported no new capital growth or declining capital growth, although one of those anticipates an increase in long-term care and psychiatric beds, four states reported an increase in psychiatric and/or substance abuse beds, two states have had an increase in long-term care beds, four states reported an increase in specialty services (primarily cardiology), and only one state reported an increase in general acute care beds, which was generally seen as appropriate. **Table 2** is a summary of selected effects.

TABLE 2

Selected Effects of Eliminating CON

	Arizona	California	Colorado	Idaho	Kansas	Maine	New Mexico	Texas	Utah	Wyoming
Date CON eliminated	3/85	1/87	7/87	6/83	7/85	6/84	7/83	9/85	1/85	5/87
Other regulation enacted	No	No	No	No	Limited acute care moratorium	Limited acute care moratorium	No	No	No	No
Capital growth	Acute care & bypass	LTC, ambulatory care, modernization	Psychiatric beds	No data	Psychiatric facility equipment	No	Little expansion	Psychiatric & substance abuse	LTC and psychiatric specialty hospitals	LTC and psychiatric beds
Positive results of deregulation	Development time shorter, better hospital planning, more services available	More emphasis on alternatives and flexible use of services	Less regulation	More level playing field among providers	Reduced red tape	Market controlling capacity	Eliminate unnecessary government barriers to expansion	Eliminate CON costs	More flexible response to consumers	More flexibility in market
Negative Results of deregulation	Some unnecessary expansion, difficult to maintain quality	Worse disproportionate charity care, tiered system developing	Protectionism of some types of providers	None noted	Loss of data	None noted	Some duplication (cardiology)	Overbedding	Less data	Impact on Medicaid budget

Certificate of Need in Kentucky

In 1972, Kentucky established an elaborate system of 15 local councils, a state health planning council and a separate certificate of need and licensure board. These were augmented in 1976 by a third level of planning and review, health systems agencies (HSAs). In Kentucky, there were three HSAs, covering eastern, western and northern Kentucky. What is notable about this system was that decisions about what services and facilities should be established were made by voluntary citizens groups appointed by the Governor and were representative of a majority of provider groups and a limited number of consumers of health care. These groups generally met bimonthly and made decisions on the basis of reports prepared by staff and testimony from applicants. In 1984, the 16-member Certificate of Need Board was abolished and a full-time three-member commission appointed by the Governor replaced it. Although the name has changed over the years, this system using professional decision makers remains and is currently known as the Commission for Health Economics Control in Kentucky (CHECK). When reviewing the data presented below, it is important to remember this change from a citizen review board with many providers to a professional panel.

Following are three summaries of certificate of need activity from 1980 to the present, covering hospitals, long-term care and other projects. This information is not a complete picture of program impact, however, in that it does not reflect the deterrent effect which results from the state health plan and from consultation with program staff.

TABLE 3

HOSPITALS

	Approved			Disapproved/Withdrawn		
Year	Number of Applications	% of Total	Expenditures*	Number of Applications	% of Total	Expenditures
1980	91	95%	$133,371,999	5	5%	$21,005,654
1981	79	95%	193,750,048	4	5%	54,286,400
1982	83	99%	399,880,088	1	1%	316,651
1983	36	64%	154,210,784	20	36%	27,463,711
1984	38	88%	78,139,252	5	12%	7,269,384
1985	39	95%	66,211,974	2	5%	5,142,613
1986	39	71%	82,127,217	16	29%	31,389,163
1987	42	84%	63,151,250	8	16%	8,315,379
1988	29	71%	51,168,476	12	29%	23,782,992
February & March 1989	14	52%	12,305,747	13	48%	7,081,946

*Expenditures refers to the estimated cost of the proposed project as provided in the project applications.

TABLE 4

LONG-TERM CARE

	Approved			Disapproved/Withdrawn		
Year	Number of Applications	% of Total	Expenditures	Number of Applications	% of Total	Expenditures
1980	108	91%	$16,768,564	11	9%	$ 5,540,000
1981	116	75%	12,646,935	38	25%	34,112,371
1982	51	91%	5,622,305	5	9%	0
1983	20	80%	6,941,040	5	20%	1,386,500
1984	28	70%	18,699,296	12	30%	4,670,500
1985	26	55%	11,721,143	21	45%	33,926,039
1986	58	45%	5,967,274	71	55%	66,386,388
1987	45	78%	37,685,885	13	22%	9,203,079
1988	45	57%	29,532,564	34	43%	27,753,303
February & March 1989	10	43%	7,494,562	13	57%	7,081,946

The original moratorium on long-term care was effective with the July 16, 1980 board meeting. There were also two injunction periods: November 10, 1983 through November 1, 1984 and July 2, 1985 through May 21, 1986. There were also three "windows," during which time the moratorium had lapsed. These dates were: December 2, 1985 through December 25, 1985; January 1, 1987 through January 26, 1987; and July 1, 1988 through September 20, 1988. The injunctions prevented any long-term care applications from being acted upon, while the "windows" allowed some long-term care applications to be approved. The total approved for hospitals for 1982 was increased by $31,104,100, after two projects which were under judicial review were officially approved.

TABLE 5

OTHER

	Approved			Disapproved/Withdrawn		
Year	Number of Applications	% of Total	Expenditures	Number of Applications	% of Total	Expenditures
1980	30	88%	$ 6,179,070	4	12%	$ 0
1981	29	66%	4,523,604	15	34%	100,000
1982	29	88%	7,696,694	4	12%	257,500
1983	46	88%	17,835,079	6	12%	3,828,000
1984	89	82%	25,127,972	19	18%	6,864,212
1985	94	90%	39,171,777	11	10%	4,186,707
1986	49	57%	23,364,267	37	43%	14,580,975
1987	67	77%	27,610,749	20	23%	1,701,882
1988	83	75%	23,141,829	28	25%	11,065,439
February & March 1989	19	79%	2,451,250	5	21%	758,200

*Other projects include such things as outpatient rehabilitation agencies, MR/DD group homes, special health clinics, ambulances, primary care clinics, mobile services, wellness centers, home health agencies, and freestanding diagnostic centers.

In reviewing these data, two trends emerge, the increase in application disapprovals, following the creation of the three-person panels, and the decrease in numbers of applications submitted. It should also be recalled that a traditional mission of this program is to assure that needed services become available.

The following tables illustrate health care cost savings resulting from certificate of need actions since the review process and decision making were assumed by a full-time commission. As is indicated in **Table 6**, the Commission has averted $188,139,656 in capital expenditures since 1986.

In addition to capital expenditures, negative actions by the Commission have saved substantial operational costs. For instance, most of the long term care bed applications were for intermediate care beds or for personal care beds which could later be converted to intermediate care. Eighty percent of intermediate care is paid for by Medicaid. Assuming, as a rough rule of thumb, that each 100 beds costs a million dollars a year, then it can be estimated that approximately 68 million dollars in Medicaid expenditures have been averted since 1986.

Again, it should be emphasized that these figures only account for formal applications. There is no way to measure the deterrent effects resulting from decisions

not to spend the time and money involved in the formal application process based on conversations with the Commission, or information in the State Health Plan which discouraged application.

TABLE 6

Commission for Health Economics Control
Capital Expenditure - Disapprovals/Withdrawals/Reductions
January 1986 - April, 1989

Year		Hospital	Long-Term Care	Other[1]	Totals
1986	Disapprovals	$ 44,149,863	$ 52,545,377	$ 1,502,616	$ 98,197,856
1987	Disapprovals	8,315,379	9,203,079	1,501,882	19,020,340
	Reductions	0	548,496	0	548,496
1988	Disapprovals	23,782,992	27,753,303	11,065,439	62,601,734
	Reductions	0	1,685,161	1,115,043	2,800,204
1989	Disapprovals	156,892	7,081,946	1,080,888	8,319,726
	Reductions	0	631,575	0	631,575
Totals	Disapprovals	$76,405,126	$96,583,705	$15,150,825	$188,139,656
	Reductions	0	2,865,232	1,115,043	3,980,275

[1] Other projects include outpatient rehabilitation agencies, MR/DD group homes, special health clinics, mobile services, wellness centers, home health agencies and freestanding diagnostic centers.

TABLE 7

Commission for Health Economics Control
Beds and Other Projects - Disapprovals/Withdrawals/Reductions
January 1986 - April, 1989

Year	Hospital Beds	Long-Term Care Beds	Other[1] Projects
1986	428	1,437	50
1987	292	529	36
1988	346	1,384	46
1989	0	508	9
Totals	1,066	3,858	141

[1] See note to Table 6

Discussion and Recommendations from Interested Groups for Kentucky

From the outset, there have been questions about the effectiveness of certificate of need. As health care costs accelerated to full gallop, skeptics pronounced the planning system a failure. Defenders pointed out that costs might have been even higher had the program not been in place, but no reliable benchmarks existed against which to measure either set of claims.

Supporters argued that restraining costs was not the sole criterion for success. Health planning, they said, also gave the public a say in the way the system functioned and kept concerns about access to health care for the poor and uninsured on the agenda. Critics continue to hammer away at the program, saying it has been obviated by the new cost consciousness evident in both public and private health insurance programs. As proof, they cite declining hospital occupancy rates, shorter patient stays and the fact that 1985 brought the lowest increase in health care cost inflation in two decades.

But a deregulated system is not without shortcomings. In a frantic bid to carve out their market share, many hospitals are embarking on expansions and expensive equipment purchases that might otherwise appear to fly in the face of wise allocation of resources or even consumer demand. Planning advocates point out that since Utah repealed its CON law at the end of 1984, hospitals there have gone on a building spree, despite the fact that existing beds were slightly more than half-full. And, they note, Congress has yet to devise an alternative to its blank-check reimbursement for hospitals' capital costs under Medicare.

Furthermore, while penny-wise payment for services by government and business buyers of health care does seem to be squeezing fat from the system, no one seems sure how far the savings will go and at what point the squeezing will hurt the quality of care. It's also not clear that savings in some areas of health spending aren't being offset by increased costs in others. In fact, despite the slower increase, health care inflation continues at twice the rate of general inflation.

In addition, the new approach to health care spending has exacerbated the problems faced by the poor. Wasteful though the fat in the system was, it also provided a cushion for those who couldn't pay their own way.

Health planning may be a questionable solution, but many of the problems it addresses are still around. The controversy it spawned may have had less to do with competing visions of how best to realize agreed-upon goals than with failure to resolve some deeper questions: Is health care in an affluent society indeed a business like any other, or a universal right? How much are we willing to spend for it? What are we willing to sacrifice in order to cut costs?

In accord with provisions of 1988 House Bill 516, the Biennial Budget, the state Cabinet for Human Resources surveyed all licensed health facilities and services, as well as other interested groups, in March, 1989, to solicit their opinions about health planning, certificate of need and other state health programs. They received 48 responses relating to a wide variety of issues. The results in terms of health planning and certificate of need are presented in **Table 8.**

TABLE 8

Type of Provider	Retain	Repeal
Hospital*	12	1
Long-term care facility	2	0
Other	9	3
Total	23	4

*Included under "hospital" are Kentucky Hospital Association, Appalachian Regional Hospitals, and Alliant, Inc., all of which were speaking for several hospitals. Humana had the only negative position, which was phrased in terms of supporting competition versus regulation.

Specific hospital recommendations had to do with (a) streamlining the process; (b) broadening coverage (most notably including HMOs); (c) increasing the review thresholds; and (d) more timely and frequent updates of the State Health Plan.

Although 11 long-term care representatives responded, only two took a stand on CON/health planning. Almost all of the facilities commented on (a) dropping or easing the current moratorium on long-term care beds; (b) increasing reimbursement, especially for personal care; and (c) improving the inspection process.

In the "other" category were (a) durable medical equipment companies, especially favoring a repeal; (b) several home health/hospice agencies, which were strongly supportive of CON and health planning; and (c) Blue Cross/Blue Shield, which is strongly supportive.

The most extensive recommendations with regard to repeal or maintaining and streamlining were submitted by hospitals, although several respondents endorsed one or more of the recommendations. These are represented below.

Recommendations to Repeal—Humana, Inc.

Humana believes that Kentucky should repeal the Certificate of Need hospital provisions for the following reasons:

(1) Competition—not regulation—is the most effective and appropriate means of controlling health care costs. By creating barriers to the entry of competitive services and competitive pricing, the CON program protects the monopoly of existing providers and enables them to charge for services indiscriminately. An open competitive market is a much more effective mechanism to control cost than arbitrary government controls.

(2) Third party payors through managed care methods, not CON regulations, are controlling health care costs. Through utilization controls, preadmission review, gatekeepers, and directed care, Humana, like other insurers, has been able to control costs for its health benefits plan members. As our insurance business grows, if we are forced to purchase technology or services from facilities that have been given a monopoly franchise through the CON process, the premium costs to our members will increase.

(3) A consumer-driven marketplace will effectively control the allocation of hospital beds. The CON process was created to control capital spending and the number of beds in the health care industry. With all the programs in today's health care delivery system designed to keep people out of the hospital, i.e., outpatient surgery, home health services, hospices, drug therapies, etc., regulatory controls are no longer necessary.

(4) Virtually all projects submitted for CON approval are ultimately granted. The CON process does not prevent a project from being implemented; it only increases health

care costs through enormous legal fees, higher construction costs due to inflation from delays, and the direct cost to government from program administration.

(5) Government's responsibility is to assure the public that quality services are provided through licensure, certification, registration and inspection of health care facilities. The marketplace is better equipped to determine the availability of services to meet the consumer's needs.

Recommendations to Revise—Alliant, Inc.

We strongly urge the continuation and improvement of Certificate of Need in the Commonwealth of Kentucky. Certificate of Need, in our opinion, is an essential vehicle to help assure that health facilities and services are developed with necessary oversight by government. Certificate of Need should focus on (1) the need for a facility or service; (2) the efficacy and efficiency of the service; (3) the quality impact of the service; and, of course, the cost implications.

Certificate of Need has been subject to criticism and we recognize that it requires modification. However, the basic principles underlying Certificate of Need are sound and should not be abandoned simply because the process is cumbersome. Public and government oversight of areas which are of vital public interest, such as health care, is appropriate and should continue.

While recommending the fundamental principles of Certificate of Need be maintained, we recognize the process is inefficient and should be streamlined.

From Alliant's viewpoint, several specific recommendations are offered:

(1) **Scope of Review**

We recommend that CON apply equitably to all providers of health care services and cover the following: (1) new facilities; (2) major bed expansions; (3) extremely high cost items, such as medical equipment and new technology; and (4) specialized services where volume of procedures (or lack of volume) can be linked to quality.

We believe that practicing physicians should be subject to the same CON requirements as hospitals, but only in the case where cost of a project exceeds the capital expenditure threshold minimums, or if physicians desire to implement a service which is deemed as reviewable addressed in the State Health Plan.

We also recommend that private physicians be exempted from facilities' licensure and regulation, except where a particular service offered by the physician is subject to licensure under the State Health Plan (e.g., surgical operating rooms in a physician's

office, therapeutic radiology equipment, breast mammography, lithotripsy, magnetic reasonance imaging equipment, etc.).

(2) **Dollar Thresholds for Review**

The current dollar capital expenditure thresholds should be increased to allow health care providers greater flexibility to respond to marketplace forces. This would help make the entire review process much more efficient by eliminating the need to review low impact decisions. We recommend the review threshold for new capital expenditures be increased from the current $663,000 to $1.5 million per project.

We also recommend that the minimum thresholds for the review of major medical equipment be increased from the existing $442,000 to $1.5 million.

Today, new institutional health services are currently reviewed if the service has an annual operating cost of $276,000 or above. We recommend that this provision be completely deleted. The operating cost of a new health service is, for the most part, a meaningless indicator of the impact of a new health service or program. As an alternative, we recommend that the State Health Plan define the specific health services that should be reviewable.

(3) **Clinical Services Review**

We recommend that Certificate of Need review only clinical (patient care) related services. Presently, all capital expenditures exceeding the threshold require review. We believe that such projects as parking facilities, telephone systems, computer or management information systems, ventilation/heating and air conditioning systems, correction of code violations in non-clinical areas, etc., need not be reviewed under CON.

(4) **HMO Exemption**

We strongly urge that the HMO exemption now in effect in the Certificate of Need be repealed immediately. Under current law, Health Maintenance Organizations can build new health facilities and acquire major medical equipment without review. HMOs are well established in the health care marketplace and do not merit preferential treatment under CON.

(5) **Bed Conversions**

Current law requires a review of a "substantial change" in bed capacity, meaning the addition, reduction, relocation or redistribution of beds by licensure classification within a hospital. We believe that such additions, reductions, relocations and

redistributions should be permitted without review up to 10% of the facility's licensed bed capacity or 20 beds—whichever is less in any two-year period.

(6) **The Placing of Conditions on a Certificate of Need Application**

In the past, somewhat arbitrary conditions have been placed on Certificate of Need applications as a condition of approval. We believe that this is inconsistent with the purpose of CON.

We recommend that the statute be changed, so that the Commission is prohibited from placing any conditions on CON approval.

(7) **The Hearing Process**

The hearing process of CON is often cumbersome, time-consuming, unnecessarily costly, and ultimately, unnecessarily litigious.

We respectfully request that the amount of time to request a public hearing be reduced from the current 30 to 15 days. Also, the length of hearings should be reduced, as they are unnecessarily time consuming and extraordinarily expensive.

We also recommend that a hearing officer be required to attend the pre-hearing conference and all hearings to rule on matters of law.

(8) **Substantial Changes in Projects**

Current Certificate of Need requires review of capital expenditure obligations under an approved Certificate of Need if there has been substantial change in the project. To date, the term "substantial change" has not been defined.

We recommend that this term be specifically defined in statute. Substantial change should mean one or more of the following: (1) the addition of a service for which there is a component in the State Health Plan; (2) a "substantial change" in bed capacity; (3) a change of location; (4) an increase in beds or services proposed; or (5) an increase in cost greater than the allowable threshold.

(9) **Non-Substantive Review**

Current law gives the authority to the Cabinet for Human Resources to grant non-substantive review status and to issue Certificates of Need for non-substantive projects. We suggest that the Commission be the only authorized agency responsible for granting non-substantive review status, holding hearings, and issuing Certificates of Need.

Recommendations to Revise—Kentucky Hospital Association

(preliminary, written by William Conn, President, to Secretary Harry J. Cowherd, March 31, 1989)

As I previously advised you, the near utility nature of health care accessibility should dictate that careful, deliberate consideration be given to public need through the process of demonstrating need in an open public forum against pre-established need criteria. It is our judgment that this is best provided by continuation of a streamlined Certificate of Need process.

As you are aware, KHA established a membership task force last year to reevaluate the necessity and function of CON in light of elimination of federal funding of CON functions, repeal or sunset of CON in a few states, and suggestions from limited special interest sectors recommending sunset or repeal of CON based on allegations of non-cost effectiveness. As it currently exists, CON, in fact, has served as a barrier to a significant number of potentially unnecessary projects, which, however difficult it may be to quantify, has in fact, we believe, resulted in significant cost savings. We believe a streamlined CON process is needed and could be accomplished through such changes as increasing the dollar threshold for review and elimination of CON review of non-clinically-related services (i.e., parking facilities, telephone systems, and management information systems). The application of such a process needs to be broadened to all health care providers, including HMOs, and enforcement strengthened by the state to ensure that approved projects fulfill the purposes for which they were granted. The KHA Task Force, committee, and staff have expedited efforts and it is anticipated that we will be able to forward our detailed position statement on CON within the next few weeks.

Recommendations to Maintain—Blue Cross/Blue Shield of Kentucky

Health planning and the certificate of need process are vital to our corporation's efforts toward providing cost-efficient health benefits plans. In fact, our reimbursement system specifically requires certificate of need and licensure for a facility to be eligible for reimbursement. We are aware of at least one organization's efforts to eliminate the CON process and we urge the Cabinet to actively oppose any such movement. Further, in assessing the needs of the citizens of Kentucky we urge the Cabinet to consider pursuing ways to strengthen the CON process in order to reduce or eliminate duplicative services. By determining what our population's health needs are and providing a public forum for decision making we can help control costs.

Our corporation has long been involved in working with state officials on boards, committees and commissions which address the health needs of the Commonwealth. In recent years much attention has centered on the needs of the medically indigent . . . those individuals who do not qualify for Medicaid, yet cannot afford

traditional health insurance. We applaud the KenPAC program as a very positive first step toward addressing the needs of the medically indigent and support further initiatives in this area. Considering the overwhelming cost of developing and implementing a broad-based system of health care for the medically indigent, we support the establishment of priorities (in the manner currently being pursued by the Kentucky Health Care Access Foundation). This could be put into place as financing becomes available, with child and maternal health care among top priorities.

Blue Cross and Blue Shield of Kentucky, other third-party insurers and private payors currently subsidize the majority of indigent health care. Bad debt and charity write-offs will amount to more than $150 million this year. Further, since the Medicare and Medicaid programs do not fully recognize a dollar as budgeted by Kentucky hospitals, an additional subsidy of more than $340 million will be paid by third-party and private payors to cover the shortfall created by these two government programs. It is our belief that broad-based funding for the medically indigent would be a fairer and more equitable means of payment for this much needed care.