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Commentary

New Wine in Old Bottles: Certificate of Need Enters the 1990s

Robert B. Hackey
University of Massachusetts

Abstract Although state certificate-of-need (CON) programs have been the subject of intense criticism over the past decade, recent evidence suggests that CON programs may be more effective than commonly believed. While many state programs have yielded disappointing results, the CON process can also be used to achieve other important policy objectives, such as increasing access to care for the uninsured and increasing lay participation in health policy planning. In sum, rather than fading away after the termination of federal support for health planning in 1986, state CON programs are poised to assume new roles during the 1990s.

After a decade in which regulatory solutions to rising health care costs, and certificate-of-need (CON) regulation in particular, fell out of favor among academics, policymakers, and health providers, health planning and capital expenditure controls have resurfaced on the health policy agenda in the 1990s. Two articles in this issue of the *Journal of Health Politics, Policy and Law* take a look at these trends. In their study, Charles and DeMaio offer a fresh look at citizen participation—once an integral part of CON regulation in the U.S., but now a largely overlooked topic—while Campbell and Fournier discuss the impact of CON on the provision of indigent hospital care. Together, they provide an opportunity to reexamine the future prospects of health planning and certificate-of-need regulation in the United States. In the eyes of their critics, CON programs have failed to control costs, stifled competition (Burda 1991), and had little impact on access to health care for either the poor or geographically underserved regions (Sloan 1988). Indeed, according to Bovbjerg (1988:

206), "the evidence that CON in practice has accomplished any useful social objectives is very weak."

Current perceptions of CON's failure as a cost control strategy, however, are largely based on assessments of program performance during the 1970s; more recent evidence suggests that the performance of many CON programs has improved over time. Furthermore, despite their emphasis on controlling costs, CON programs have always had multiple goals. Campbell and Fournier's discussion of Florida's CON program, coupled with experience from other states, suggests that CON programs may serve an important role in increasing access to health care. Finally, the growing influence of the "outcomes movement" (Epstein 1990) on both payers and providers in recent years points to a new role for state CON programs in the 1990s, for recent studies of the appropriate utilization of health care services offer improved guidance for regulators in determining the "need" for new health care facilities.

The Limitations of CON as a Cost Control Strategy

Widespread dissatisfaction with the cost control record of state CON programs produced a large range of responses among the states after the expiration of Pub. L. No. 93-641: twelve states abandoned CON altogether, while some raised the threshold for CON review and others strengthened their programs. No state, however, has abolished CON since 1989 (Burda 1991), and at least one state (New Jersey) has taken steps to recreate local planning agencies to review capital projects (Brandon 1992).

On the surface, Campbell and Fournier's claim that "protecting profits is the core of what CON regulation is all about" is consistent with studies of entry regulation in other industries, where business groups either supported regulation as a means to avert destructive competition or "captured" government regulatory agencies (Stigler 1971; Lowi 1969). Upon closer inspection, however, the authors' contention that states adopted CON programs for reasons besides controlling costs is not persuasive. Although hospitals often supported CON review as a less onerous process than prospective rate-setting programs, several states that pioneered CON legislation prior to the passage of federal health planning legislation in 1974 were also early leaders in hospital rate regulation (e.g., Massachusetts, New Jersey, New York, and Rhode Island). Confronted by rapidly escalating Medicaid costs, state governments seized upon CON as an imperfect but easily implemented tool to control the explosion of hospital capital expenditures and state Medicaid budgets in the late 1960s. Rather

than accommodating providers' interests, both CON and hospital rate setting programs are examples of what Brown (1982) labels "rationalizing politics," as state governments sought new ways to cope with the fiscal consequences of expanding entitlement programs and endemic inflation in the health sector.

Early assessments of program performance generally concluded that CON had little impact on overall hospital cost inflation, but more recent evidence suggests that the performance of many programs improved over time, particularly in states with a strong commitment to controlling costs (Donahue et al. 1992; Morone 1990; Scott et al. 1987).¹ In part, the perceived failure of CON is the result of unrealistic expectations. Federal health planning initiatives under Pub. L. No. 93-641 placed too much reliance on indirect approaches to controlling costs (e.g., capital expenditure controls), reflecting Morone's (1990: 272) observation that "when the incoherent American state faces vexing problems, it reflexively musters up [the] hope of rationalization without fundamental change." Since CON programs must cope with multiple, often conflicting goals (Brown 1983) and intense opposition from both providers and local communities, the inability of state regulators to reduce system-wide hospital expenditures (Sloan 1988) is not surprising. However, the experiences of several states that implemented capital expenditure caps over the past decade suggests that CON's limitations as a cost control strategy is related to "the lack of competition for a limited pool of resources" (Young 1991: 272). Under an open-ended CON review process, an unlimited number of projects could be approved if applicants could demonstrate that the proposed services were "needed." A ceiling on capital expenditures, however, forces decision makers to prioritize programs and choose those projects which are most beneficial (Young 1991; Donahue et al. 1992). Since the merits of each institution's application are judged relative to others, the implementation of a capital cap creates a zero-sum game for providers, in which the approval of one project automatically reduces the funds available for others.

Even in the absence of a capital cap, however, a singular focus on the rate of project denials or the savings in capital and operating costs associated with rejected CON applications understates the impact of capital expenditure controls on providers' behavior. Since the deliberations that accompany the CON review process often lead to concessions by

1. See Sloan 1988 for an excellent review of evaluations of state CON programs' performance during the 1970s.

providers, modifications of proposed projects offer a viable alternative to achieving regulators' desired objectives (e.g., expanding care for the uninsured, lowering operating costs by requiring a higher equity contribution by applicants). Furthermore, as Tierney et al. (1982) argue, effective communication between state regulatory agencies and providers should minimize the number of denials. The existence of CON may also deter providers from submitting weak proposals for review, for "few institutions are likely to expend the time, energy, and money to traverse the complex certificate of need process for a project that cannot withstand the test of public scrutiny" (Tierney et al. 1982: 178).

CON and the Uninsured

By the mid-1980s, the health policy agenda had changed: while controlling costs remained the central goal of both state and federal policymakers, the growing number of persons without health insurance and hospitals' mounting fiscal losses from uncompensated care brought concerns about access to health care back to the health policy agenda. While other states developed uncompensated care pools or all-payer rate-setting programs or flirted with universal health insurance, Florida's legislature favored implicit rather than explicit solutions to the state's growing indigent care problem (Jones 1989). In Florida, the ability of hospitals to fund indigent care through cost shifting was limited by extensive penetration by HMOs into the market, an above-average number of for-profit hospitals, and Medicare's status as the largest third-party payer in the state. As a result, Campbell and Fournier argue that "hospital regulators had a conscious policy of protecting the interests of hospitals that provide large amounts of indigent care" during the 1980s. Although Campbell and Fournier claim that regulators' emphasis on the provision of indigent care limited competition in the state's hospital industry, the practice reflects the desire of state officials to preserve access to care for the uninsured using the institutional resources at their disposal.

Two issues, however, limit the authors' ability to generalize their finding to the CON programs of other states. First, since Florida's threshold for CON review (\$1 million for capital costs, \$500,000 for operating costs) is higher than many other states, projects subject to review in other states may be excluded from the analysis. Second, the authors' empirical analysis does not control for the effect on the CON process of a hospital's teaching status or the institution's status as a sole community provider; teaching hospitals, in particular, typically offer a wider range of services

and have different capital requirements than smaller community hospitals. Since a number of studies have documented that teaching hospitals provide a disproportionate amount of uncompensated care, the authors' observation that CON approvals are "a reward to hospitals providing large amounts of indigent care" may reflect a bias toward teaching institutions affiliated with university medical schools rather than discrimination against hospitals with a poor record of providing care for the indigent (see Sloan 1988).

In the absence of other institutional levers, CON offered officials in Florida both a carrot and a stick to modify providers' behavior. While Campbell and Fournier lament the fact that regulators possessed "unprecedented power to pursue objectives other than cost control," Florida's CON legislation (and that of other states) offers multiple criteria for policymakers to use in making decisions. Indeed, as the authors note, the criteria for project review described in the rules and regulations governing the CON process "enumerate roughly a dozen aims that are unweighted and potentially conflicting."² Confronted by a growing indigent care problem and restrictive Medicaid eligibility requirements, public officials in Florida used their regulatory mandate to encourage hospitals to provide care for the uninsured.

Outcomes Assessment and CON

A renewed emphasis on the assessment of patient outcomes also points to new roles for state CON programs over the next decade, for, as Relman (1988: 1221) notes, "the chief cause of the cost crisis [in American medicine] is not so much the price as the ever-increasing volume and intensity of medical services being provided in outpatient settings and hospitals."³ As the cost of health care continued to climb, business groups and third-party payers have increasingly sought to link reimbursement to patient outcomes. Businesses' interest in "buying right" was also sparked by the appearance of studies that documented considerable geographic

2. The authors' claim that the principal purpose of CON was to avoid unnecessary duplication of services and to control costs is inconsistent with their earlier observation that Florida's CON statute did not prioritize among criteria for project review. In addition, several other states have incorporated the level of uncompensated care into the CON process for both profit and nonprofit hospitals (see Sloan 1988).

3. For example, the number of persons undergoing coronary angioplasty in the U.S. grew almost tenfold over the past decade, from fewer than 30,000 nationwide in 1983 to more than 285,000 in 1990, while the number of coronary artery bypass grafts more than doubled in the same period (see Grayboys et al. 1992).

and racial differences in the use of health care services, without corresponding differences in patient outcomes. In particular, recent studies of several surgical procedures (e.g., cardiac catheterization, carotid endarterectomy, coronary angiography) by Chassin et al. (1987), Grayboys et al. (1992), and others found that many surgical procedures were either "inappropriate" or of "uncertain" clinical value. Such studies, and the public's interest in them, are likely to accelerate in the future, as states follow the lead of Pennsylvania's Health Care Cost Containment Council, which has published outcomes data from each of the state's acute care hospitals since 1989.⁴ Oregon recently passed legislation to link the approval of new capital projects to an institution's patient outcomes. Under the new criteria, an institution must demonstrate sufficient patient volume for proposed services, so that "if a new transplant center is proposed, or if a medical facility wants to buy magnetic resonance imaging equipment, questions will be asked about whether the patient base will support it, and whether its purchase will affect patient outcomes" (Alter and Holtzman 1992: 20).

Oregon's example points the way toward a new role for state CON programs in what Relman (1988: 1220) dubs the "third revolution in medical care." While health planners' initial definition of the "need" for new facilities was both vague and imprecise, the growing literature on the appropriate utilization of health services offers concrete clinical standards to regulators, with which they can evaluate applications. Using recent studies as a benchmark, state regulators are already beginning to apply the guidelines developed by outcomes researchers in evaluating CON applications based on the appropriate utilization of existing services. Recent studies show that the utilization of cardiac catheterizations, coronary angioplasties, and other specialized diagnostic and therapeutic procedures in recent years is driven, at least in part, by the process of reimbursement, because payer status (whether the patients have private insurance or Medicaid or will themselves pay) is strongly associated with patients' use of health services (Wenneker et al. 1990). Wennberg (1987) notes that the steady growth in the number of specialists trained in invasive technologies has contributed to continued inflation in the per capita cost of health care. The CON process may be used to identify potentially

4. The Joint Commission on the Accreditation of Health Care Organizations (JCAHO) recently decided to incorporate patient outcome measures and other quality-of-care indicators into its accreditation criteria over the next decade. In addition, New York's Commissioner of Health, Mark Chassin, recently proposed linking hospital reimbursement to quality-of-care measures in the 1993 renegotiation of the state's prospective hospital reimbursement system (Darby 1993: 1).

unnecessary and expensive facilities and discourage the overutilization of specialized procedures when there is evidence that the proposed services have no significant impact on patient outcomes.

CON and Public Accountability

Despite its limitations in controlling systemwide costs, CON review remains one of the few institutional forums for public participation in health policy decision making. As Charles and DeMaio note, citizen participation in planning and allocating health services and facilities provides an institutional arrangement to “increase public accountability for decisions on the allocation of health care resources, in order to make providers more accountable to the communities that they serve.” While citizens’ ability to influence policy choices are limited by the imbalance of resources between health providers and lay participants (Morone and Marmor 1981), the CON process offers payers, legislators, and other nonproviders a “foot in the door” to assess the need for new facilities and services. In this respect, regardless of the limitations of capital expenditure review for controlling health care costs, state CON programs have an important role as a public forum to provide public input into health care policy-making. Since decisions affecting the price and availability of health care services emerge as the byproduct of a quasi corporatist bargaining process (Hackey 1992; Bergthold 1988), in the absence of other institutional arrangements, the CON process allows for public comment on proposed health care resource allocation decisions at meetings which are open to the public.

Conclusion

Two decades after they first appeared on a wide scale, state CON programs are poised to assume new roles in the 1990s. Relieved of their unrealistic role as the principal means of controlling health care costs, CON programs have found new niches since the expiration of federal health-planning legislation in 1986. In particular, the proliferation of new medical technologies provides a constant reminder that in the absence of regulatory controls, new diagnostic and therapeutic services will continue to provide health providers with an incentive to boost revenues by increasing the volume of specialized services. While a number of states imposed moratoria on the construction of new health care facilities after 1987 (Young 1991), such an approach is a blunt tool for controlling the

diffusion of new technologies, since it does not discriminate between projects with proven clinical benefits and less essential proposals. In contrast, while CON programs have been criticized for discouraging innovation, reforms to the review process in Rhode Island and other states demonstrate that it is possible for state regulators to assume a proactive role in capital expenditure reviews by issuing requests for proposals for identified areas of need. Despite its limitations, CON remains one of the few tools policymakers have at their disposal to evaluate the need for new facilities, using objective criteria, and to encourage the regionalization of health care services.

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