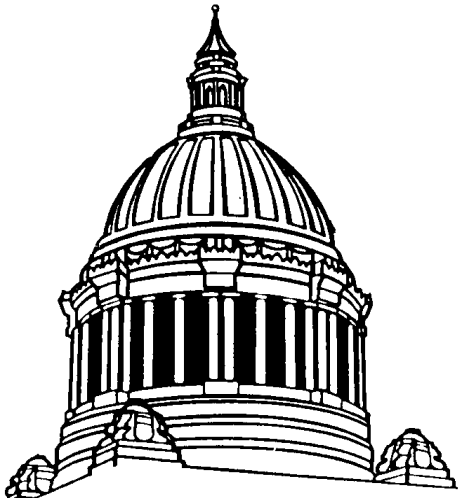


State of Washington
Joint Legislative Audit and Review Committee

Effects of Certificate of Need and Its Possible Repeal

Report 99-1

Prepared by the Health Policy Analysis Program of the University of Washington's School of Public Health and Community Medicine for the Joint Legislative Audit and Review Committee

January 8, 1999

Upon request, this document is available in alternative formats for persons with disabilities.

Members of
The Joint Legislative Audit and Review Committee

SENATORS	REPRESENTATIVES
Al Bauer, Vice Chair	Tom Huff
Valoria Loveland	Cathy McMorris, Chair
Bob Oke	Val Ogden, Secretary
Harriet Spanel	Debbie Regala
Val Stevens	Helen Sommers
James West, Asst. Secretary	Mike Wensman
R. Lorraine Wojahn	(2 Vacancies)
(1 Vacancy)	

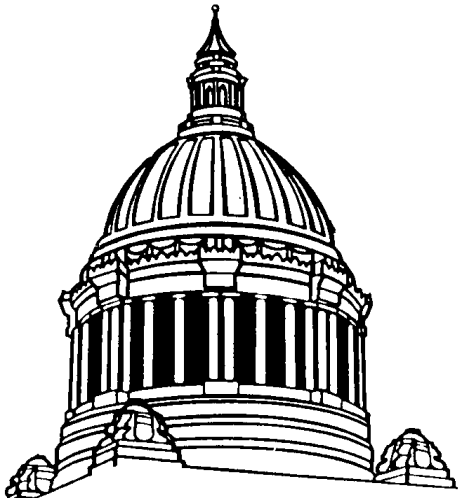
Thomas M. Sykes, Legislative Auditor

• •

Facts About
The Joint Legislative Audit and Review Committee

Established by Chapter 44.28 RCW, the Joint Legislative Audit and Review Committee (formerly the Legislative Budget Committee) provides oversight of state funded programs and activities. As a joint, bipartisan legislative committee, membership consists of eight senators and eight representatives equally divided between the two major political parties.

Under the direction of the Legislative Auditor, committee staff conduct performance audits, program evaluations, sunset reviews, and other types of policy and fiscal studies. Study reports typically focus on the efficiency and effectiveness of agency operations, impact of state programs, and compliance with legislative intent. As appropriate, recommendations to correct identified problem areas are included. The Legislative Auditor also has responsibility for facilitating implementation of effective performance measurement throughout state government.



State of Washington
Joint Legislative Audit
and Review Committee

506 16th Ave SE, Olympia, WA 98501-2323
Campus Mail - PO Box 40910
Phone (360) 786-5171 - Fax (360) 786-5180
http://jlarc.leg.wa.gov

Effects of Certificate of Need and Its Possible Repeal

Report 99-1

Prepared by the Health Policy Analysis Program of the University of Washington's School of Public Health and Community Medicine for the Joint Legislative Audit and Review Committee

January 8, 1999

Upon request, this document is available in alternative formats for persons with disabilities.

TABLE OF CONTENTS

EFFECTS OF CERTIFICATE OF NEED AND ITS POSSIBLE REPEAL

SUMMARY

OVERVIEW

The Certificate of Need (CON) program, administered by the Washington State Department of Health, regulates the development and expansion of certain acute and long-term health care services. The Joint Legislative Audit and Review Committee (JLARC) contracted with the Health Policy Analysis Program (HPAP) of the University of Washington's School of Public Health and Community Medicine to conduct a legislatively mandated study of the CON program. This study examined the effects of CON and its possible repeal on the cost, quality, and availability of five health services – hospitals, ambulatory surgery, kidney treatment, home health, and hospice – as well as on charity care and health services in rural areas. Nursing homes were excluded from the study. The results of the study were based on a literature review, information gathered from service providers and other experts in Washington, and analyses of states where CON has been completely or partially repealed.

The study found that CON has not controlled overall health care spending or hospital costs. The study found conflicting or limited evidence about the effects of CON on the quality and availability of other health care services or about the effects of repealing CON. The study also identified strengths and weaknesses of the state's CON program.

Three policy options are presented for consideration: (1) reform CON to address its current weaknesses, (2) repeal parts or all of the program while taking steps to increase monitoring and ensure that relevant goals are being met, and (3) conduct another study to identify more clearly the possible effects of repeal in Washington State. Proposals for the additional study, which can

Policy options

be conducted in tandem with either of the first two options, are presented. The legislature may also choose to leave the program unchanged.

BACKGROUND

The main purposes of Washington's CON program are to restrain health care costs by regulating the supply of services and facilities, guide health service development to avoid undue duplication or fragmentation, promote quality of care and access, and provide adequate information about the health care system. The program controls the creation or expansion of certain health care facilities and services. For a CON to be granted, applicants must show that the current or projected need cannot be met by existing providers and that new services will not adversely affect access or charity care.

CON programs arose in the early 1970s in a health care system that paid for services using cost-based, fee-for-service reimbursement. Insurers, purchasers, and providers had few concerns about or methods to control rising costs. In addition, hospitals were the focus of medical care, consuming the largest portion of resources. Today, most health care is provided under the strong controls of managed care plans that, themselves, are under pressure from public and private purchasers to control costs. In addition, new technologies and innovations have pushed many services out of the hospital into office-, home-, or community-based programs. What services are provided, who provides them, and where they are provided is changing more rapidly than ever before.

Objectives and approach

HPAP conducted the study of the CON program to examine the effects of CON and its possible repeal on the cost, quality, and availability of five health services – hospitals, ambulatory surgery, kidney treatment, home health, and hospice – as well as on charity care and health services in rural areas. The results of the study were based on a broad literature review of CON research, information gathered from service providers and other experts in Washington, and analyses of selected states where CON has been repealed. Two expert peer reviewers contributed suggestions regarding relevant literature and provided feedback on study methods and draft reports.

FINDINGS

The findings of this study are based on an analysis of other states' experiences informed by views and expertise of individuals and organizations in Washington's health system. Because the state of Washington has not repealed certificate of need or conducted a detailed analysis of CON in the context of local health care markets, these findings may not reflect the actual or likely effects of repealing CON in this state.

COST The study found strong evidence that CON is not an effective mechanism for controlling overall health care spending. While CON laws can be effective in slowing the expansion of some services, other factors affect health care costs that CON laws do not control. In addition, CON has not been very effective in controlling hospital costs. Not all hospital services are covered by CON, and the program is not always effective in controlling supply. The study also found that CON has restricted the supply of some specific services and that the repeal of CON has been associated with supply surges in some states. The study found no convincing evidence that CON programs restrict the growth of managed care.

CON has not controlled costs . . .

QUALITY Evidence about the effect of CON on quality is inconclusive. The evidence is weak regarding the ability of CON to improve quality by concentrating volume of specialized services. Indirect evidence suggests that CON may protect quality in home health and hospice by keeping out unprepared or unqualified providers. Weak, conflicting evidence exists regarding the effect of CON on the market share of for-profit providers and any resulting impacts on quality. CON does not provide an ongoing mechanism to monitor quality.

. . . other effects are inconclusive

ACCESS Conflicting evidence was found regarding the effect of CON or its repeal on access to health services. In some instances, CON has been used to protect existing facilities in inner city areas or to prompt providers to locate in those areas. In other instances, CON appears to restrict access by preventing the development of new facilities. Evidence from other states shows that the relationship between CON and access varies state by state as well as service by service. CON does not provide an ongoing mechanism to monitor access.

Little known about effect on charity care and rural care

CHARITY CARE CON provides some initial screening regarding a facility's likelihood of providing charity care, but the program in Washington and most other states does not include monitoring for compliance. Some states are more likely to grant a CON to facilities offering more charity care, and CON can improve the operating margins of existing providers. These factors *may* increase the likelihood that the providers will offer more charity care, but no studies have been conducted to measure the effect of CON in increasing levels of charity care. Also, financial and market pressures make it increasingly difficult for all types of providers to offer charity care.

RURAL CARE Weak and conflicting evidence was found regarding the effect of CON on access to services in rural areas. One analysis showed that CON did not affect the development of rural networks. Repeal of CON appears to have had no effect in some states, while at least one state has experienced some disruption of rural health care after repeal.

In addition to these findings, the study identified various strengths and weaknesses of Washington's CON program.

POLICY OPTIONS

Based on the findings of this study, policymakers may want to consider three policy options for the future of Washington's CON program: reform the program, repeal the program, and conduct additional economic analyses. We make no recommendation about whether CON should be repealed or retained, because the available evidence does not support such a recommendation.

1. **REFORM THE PROGRAM** If policymakers choose to retain CON review for some or all services, weaknesses of the current system should be addressed by (a) reassessing its goals in light of the current health care system, (b) establishing a means for CON to be more responsive to changes in the health care system, such as an advisory board, and (c) strengthening state monitoring of quality, general and rural access, and community benefits such as charity care and unreimbursed community services.

2. **REPEAL THE PROGRAM** If policymakers choose to repeal CON review for some or all services, two actions should also take place: (a) reevaluate state health policy goals and identify alternative methods of attaining those goals; and (b) strengthen data collection and monitoring programs to improve oversight of costs, quality, access, and community benefits.

3. **CONDUCT ADDITIONAL ECONOMIC ANALYSES** An economic study would provide greater understanding of the effects that various changes in the CON program would have in Washington. Such a study could model the simulated impacts should the state decide to repeal or reform the program. The scope of the study could be limited or comprehensive, depending on the resources available. The estimated costs for the proposed studies range from $200,000 to $300,000.

The above options need not be mutually exclusive. For example, the legislature may choose to repeal certain portions of the program while reforming others, or may choose to reform the program while also conducting a study of the economic effects of repeal. The legislature can also choose to make no change to the program; the study found little support for the "no change" option.

AGENCY RESPONSES

Comments were solicited from the Department of Health and the Office of Financial Management. Their formal comments are included in Appendix 2.

Agencies and organizations represented by advisory group members (listed on the following page) provided written comments, which are included in Appendix 2 of this report. Submitting comments were:

- Children's Hospital & Regional Medical Center
- Home Care Association of Washington
- Washington State Hospice Organization
- Washington State Hospital Association
- Washington State Medical Association

ACKNOWLEDGEMENTS

In addition to the individuals noted below, the study team is grateful for the oversight and guidance provided by Peter Bylsma and Ron Perry of the Joint Legislative Audit and Review Committee staff.

Study Team

The following individuals made up the University of Washington Health Policy Analysis Program team responsible for conducting all aspects of the study:

Health Policy Analysis Program **School of Public Health**	Dept of Family Medicine **School of Medicine**
Aaron Katz, C.P.H. (study director)	George Wright, Ph.D.
Jack Thompson, M.S.W.	Gary Hart, Ph.D.
Carolyn Madden, Ph.D.	Amy Hagopian, M.H.A.
Mark Gardner, Ph.D.	Peter House, M.H.A.

Advisory Group

An advisory group made up of representatives of key organizations and industries involved in issues concerning CON provided important guidance and feedback to the study team. The advisory group included the following individuals:

Ken Bertrand, Kaiser/Group Health
Chris Blagg, M.D., Northwest Kidney Centers
Andy Davidson, Washington State Hospital Association
Len Eddinger, Washington State Medical Association
Bill Hagens, House Health Care Committee
Linda Hull, Northwest Kidney Centers
Gail McGaffick, Home Care Association of Washington, Washington State Hospice Organization
John Neff, M.D., Children's Hospital & Regional Medical Center
Mark Rake-Marona, Washington State Hospice Organization
Jonathan Seib, Senate Health and Long Term Care Committee
Lisa Thatcher, Washington State Hospital Association
Greg Vigdor, Washington State Hospital Association
Cliff Webster, Washington State Medical Association

Peer Reviewers

The Joint Legislative Audit and Review Committee contracted with two national experts to provide guidance to the study team in the course of the project and to review analyses and draft reports. The peer reviewers were:

Michael A. Morrisey, Ph.D.
Professor and Director
Lister Hill Center for Health Policy
University of Alabama at Birmingham

Thomas Rice, Ph.D.
Professor and Chair
Department of Health Svcs.
School of Public Health
University of California-
Los Angeles

Department of Health – Certificate of Need Unit

The DOH Certificate of Need Unit—and especially its director, Janis Sigman—provided the study team with invaluable data, information, and guidance concerning the history and operation of the state's CON program.

Thomas M. Sykes
Legislative Auditor

On January 8, 1999, this report was approved by the Joint Legislative Audit and Review Committee and its distribution authorized.

Representative Cathy McMorris
Chair

INTRODUCTION

Chapter 1

BACKGROUND

Purpose and scope of CON

As stated in RCW 70.38.015, the purposes of Washington's CON program are to (1) restrain health care costs by regulating the supply of services and facilities; (2) to guide the development of health services to avoid undue duplication or fragmentation; (3) to promote quality of care and access; and (4) to provide for adequate information about the health care system.

Washington State's program controls the creation or expansion of certain health care facilities and services, including nursing homes, hospitals, home health, hospice, kidney dialysis, ambulatory surgery centers, and hospital-based tertiary services, such as transplants and open heart surgery. Only those home health and hospice providers seeking Medicare and Medicaid reimbursement are required to have a CON. Criteria for review are set out in legislation or in the Washington Administrative Code. In order for a CON to be granted, new facilities, or those wishing to expand, must demonstrate that current or projected need cannot be met by existing providers, and that new services will not adversely affect access or charity care.

Program origins

Washington's Certificate of Need program was created in 1971 primarily as a response to rapid medical cost inflation. The program sought to regulate the development of new health care facilities and services in an effort to restrain costs. By requiring that a CON be granted before services could be added or expanded, the program sought to avoid unnecessary duplication of equipment and services, restrain growth in hospital and nursing home bed supply, and prevent excessive reliance on in-patient facilities. The program evolved to respond to federal legislation in 1972 tying Medicare reimbursement to capital spending reviews, and later to bring the program into compliance

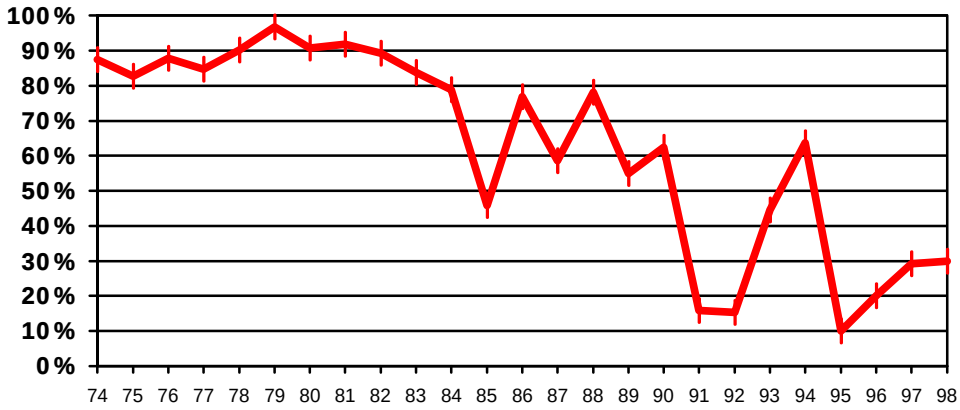
with the federal 1974 National Health Planning and Resources Development Act (PL 93-641).

After 1975, CON programs were the joint responsibility of the state and regional health planning agencies created by PL 93-641. Four "health systems agencies" conducted financial and need-based analyses, held public hearings, and made recommendations to the state for approval or denial of CON applications.

Health care context has changed

CON programs arose in the early 1970s in a health care system that paid for services using cost-based, fee-for-service reimbursement. Insurers, purchasers, and providers had few concerns about or methods to control rising costs. In addition, hospitals were the focus of medical care, consuming the largest portion of resources. Today, most health care is provided under the strong controls of managed care plans that, themselves, are under pressure from public and private purchasers to control costs; the market penetration of managed care plans varies considerably among the state's 39 rural and urban counties. In addition, new technologies and innovations have pushed many services out of the hospital into office-, home-, or community-based programs. What services are provided, who provides them, and where they are provided is changing more rapidly than ever before. Figure 1, which shows the declining proportion of CON decisions involving hospitals, reflects these broad changes in the health system.

Figure 1: Hospitals as a Percent of All CON Decisions
(Not including nursing homes)



Source: HPAP analysis of data from WA Certificate of Need Program.

In 1986, Congress repealed the legislation encouraging local health planning and requiring CON review. From that year until 1997, 11 states repealed their certificate of need programs. Two states repealed and then re-regulated. In the west, Alaska retains a relatively extensive CON program, Idaho and California have eliminated their programs, and Oregon retains a program that regulates only two service areas.

Some service areas – especially nursing homes – remain heavily regulated because of a concern that cost or quality problems would arise after repeal. Washington retains its CON program, administered by the Washington State Department of Health, but has eliminated local health systems agencies and most state-level health planning bodies.

Program changes occurred over time

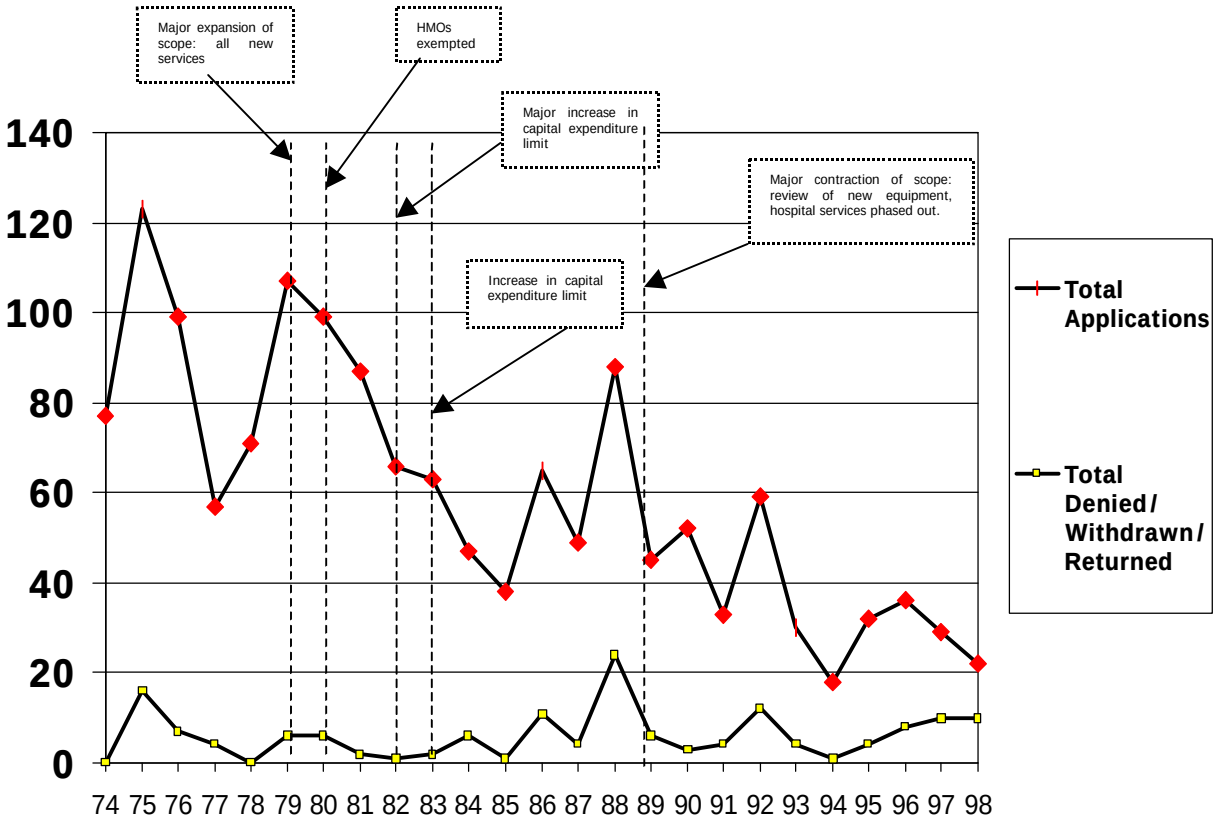
The strength and comprehensiveness of Washington's CON program has changed over time. In 1979, the program was significantly expanded to require review of all new health care services. In the 1980s the scope of the program contracted in some areas but expanded in others. In 1980, HMOs were exempted from CON review, but home health agencies were added. In 1982 and 1983, the capital expenditures limit for review was raised substantially, exempting many projects from review. Also in 1983, review of hospices was added to the program. In 1989, many hospital activities were exempted from CON, including the purchase of major medical equipment and new, nonspecialized services.

Figure 2 displays the volume of CON decisions and notes significant changes in the scope of the program. The total volume of decisions has declined over time, and the number of denials has fluctuated between 0 and 20 per year for more than two decades. The reasons for this decline in CON program activity are not known and may be due to a number of factors:

- The CON program is too expensive or time-consuming for some possible sponsors of new services.
- Health care providers have learned over time what proposals are likely to be approved and, thus, have reduced the number of applications.

- Demand for new services covered by CON has declined.
- New services are being developed in ways that are outside the purview of CON regulations.

Figure 2: Certificate of Need Program Activity and Major Milestones, 1974-1998



Source: HPAP analysis of data from WA Certificate of Need Program.

The certificate of need program in Washington operates within a health care system characterized by a relatively low use of inpatient hospital services, long-time experience with managed care, and the predominance of not-for-profit organizations in the health insurance, hospital, kidney dialysis, home health, and hospice industries. Table 1 shows some indicators of the health care system in Washington compared with the U.S. as a whole.

Table 1: Comparison of Health Care System Indicators, Washington State and the U.S.

Indicator	WA	US	Year
Total Health Care Spending Per Person	$2,743	$3,068	1994
Hospital Care Spending Per Person	$1,192	$1,492	1994
Hospital Admissions Per 1,000 Population	96	127	1995
Hospital Beds Per 1,000 Population	2.0	3.3	1996
Hospital Occupancy Rates	55%	62%	1996
Average Medicare Home Health Payments Per User	$3,055	$4,473	1995
Percentage of Population Enrolled in HMOs	27%	31%	1997
Percentage of Non-Elderly Population Uninsured	13%	16%	1996

Sources of Data: Health care spending per person, hospital spending per person, hospital admissions per 1,000 population: American Association of Retired Persons, *Reforming the Health Care System: State Profiles, 1997*, Washington, D.C., American Association of Retired Persons, 1997. Hospital Occupancy Rates, Beds per 1,000 population, percent of non-elderly uninsured: National Center for Health Statistics, *Health United States, 1998*, NCHS, Hyattsville, MD, 1998. Home health costs: Georgetown University Institute for Health Care Research and Policy; HMO penetration: Hoechst Marion Roussel, *Managed Care Digest Series 1998*, Hoechst Marion Roussel, Kansas City, 1998.

APPROACH AND METHODS

This report analyzes and integrates information gathered from research literature, a review of select states that have repealed CON, and focus groups and key informants from Washington State. The literature and examination of selected states allowed the study team to discover national and state-specific effects of CON, or its repeal, and to identify both national and state-specific issues. Information collected from focus groups and key informants assisted HPAP in applying state-specific and national findings to Washington State.

Study based on multiple perspectives

- **Literature Review** HPAP conducted an extensive search of the trade, professional, and research literature, examining 150 articles, ranging from research papers to opinion articles. Four major state studies and several smaller state-specific

studies were also examined. Appendix 4 provides a list of the literature reviewed.

- **State Analyses** HPAP examined six states (Indiana, Ohio, Pennsylvania, Tennessee, Utah, and Wisconsin) that had repealed all or parts of their CON laws in order to gain additional insights into how markets respond to repeal. The study team conducted interviews with key informants in government and various interest groups in these states, and examined articles and other written documents about these states' experiences.

- **Focus Groups** The study team conducted five focus groups composed of Washington State service providers in the service areas under study (hospital, ambulatory surgery, kidney treatment, home health, and hospice). The focus groups provided first hand information about how the CON program affects each service area, and identified arguments and evidence for retaining or repealing the program.

- **Key Informants** HPAP conducted interviews with ten experts chosen for their knowledge of the state's CON program and the overall health policy environment in Washington State. Informants were chosen to represent consumer, business, labor, academic, and government perspectives.

- **Advisory Group** An advisory group, consisting of representatives of stakeholder organizations, provided suggestions and feedback over the course of the study.

- **Peer Review** Two national expert peer reviewers with divergent views of health sector regulation provided suggestions regarding relevant literature, and provided feedback on draft reports. These independent reviewers were under contract with JLARC.

The study reveals significant variation among states in how markets and service providers respond to CON and deregulation. These variations, many of which are not explained by existing research, may be due to differences in market conditions, in CON implementation, in other policies (e.g., licensure), or other factors.

Therefore, the findings of this study cannot be applied directly to *predict* the effects of repealing the CON program in Washington.

Predicting the effects of CON repeal in Washington would require an understanding of how state-specific factors (e.g., types and distribution of providers, market conditions) interact with the CON program to affect outcomes. As part of the charge of this study, HPAP was asked to propose an economic study that would answer some of these questions (see Chapter 3).

Study does not predict effects of repealing CON here

FINDINGS

Chapter 2

OVERVIEW OF FINDINGS. The study found strong evidence that CON has not controlled overall health care spending or hospital costs. The study found conflicting or limited evidence about the effects of CON on the quality and availability of health care services and about the effects of repealing CON. The study also identified strengths and weaknesses of the state's CON program. Three policy options are presented for consideration: (1) reform CON to address its current weaknesses, (2) repeal parts or all of the program while taking steps to increase monitoring and ensure that relevant goals are being met, and (3) conduct another study to identify more clearly the possible effects of repeal. The study found little support for a "no change" option. Several options for the additional study, which could be conducted in tandem with either of the first two options, are presented in Chapter 3.

The findings of this study are based on an analysis of other states' experiences informed by views and expertise of individuals and organizations in Washington's health system. Because the state of Washington has not repealed certificate of need or conducted a detailed analysis of CON in the context of local health care markets, these findings may not reflect the actual or likely effects of repealing CON in this state.

COST

INTRODUCTION CON programs attempt to control cost by limiting the supply of medical facilities and services, which is in turn meant to reduce service use. Proponents also argue that CON leads to fewer, larger firms able to provide services below federal Medicare and Medicaid spending caps for services such as dialysis or home health. Opponents argue that CON increases prices by reducing competition, increases costs by constraining

lower-cost alternatives, and impedes the development of managed care (which controls costs).

FINDINGS Our research leads to four general conclusions. First, CON is not an effective mechanism for controlling *overall* per capita health care spending. While CON laws can be effective in slowing the expansion of some services, many other factors affect health care costs (e.g., labor, physicians services) that CON laws have not attempted to control.[1] Second, CON has not been very effective in controlling *hospital* costs. Not all hospital services are covered by CON, and the program is not always effective in controlling supply. In cases where bed supply was controlled, expenditures per bed tended to increase.[2] Third, CON has been shown to restrict the supply of some specific services, and repeal of CON has been associated with supply surges in some states. Fourth, we found no evidence that CON programs restrict the growth or operations of managed care.

CON has not controlled overall hospital costs

The above conclusions are based in part on the following research findings related to cost issues.

- The weight of the research evidence is that CON has not restrained *overall* per capita health care spending.[3]

- Numerous studies have shown that CON has not controlled overall *hospital* spending.[4] One study found that CON actually increased hospital expenditures.[5]

- One recent study found that CON programs have been associated with a small reduction (5 percent) in the *acute care* portion of hospital costs. The same study found that overall hospital costs were not controlled, however.[6]

- The majority of Washington State key informants thought that the existing CON program has had no effect on costs or expenditures, but were in less agreement about the potential effect of repeal on costs.

- CON may limit *supply* in some service areas. For example, a study in Pennsylvania (before repeal) showed that CON controlled cardiac services, organ transplants, and neonatal and pediatric intensive care services.[7] An Ohio study (before

repeal) found that CON controlled the supply of neonatal and pediatric intensive care services.[8] Whether these supply restraints also reduced costs is unclear from these studies.

Effects of repeal vary among states

- CON repeal has resulted in significant supply surges in some states: psychiatric and nursing homes in Utah;[9] nursing homes and open heart surgery in Arizona;[10] home health agencies in Tennessee;[11] and hospitals, ambulatory surgery centers, dialysis, and pediatric services in Ohio.[12]

- Not all states experience surges after repeal.[13] When surges do occur, they tend to moderate over time.[14]

- CON does not appear to affect the growth of managed care.[15]

- No evidence was found bearing on the question of whether CON reduces costs by allowing firms to charge less than allowable federal Medicare and Medicaid spending caps.

DISCUSSION Within the body of research on the effects of CON, the findings on costs are the most definitive. The weight of findings over the last three decades is that CON laws have had little or no effect in controlling general health care expenditures or hospital costs. Some studies have even presented evidence that CON raises overall costs.

The most extensive research on the cost effects of CON concerns hospitals. A number of studies completed in the 1970s demonstrated that CON had little effect in controlling hospital costs, in part because hospitals often increased their expenditures per patient even when bed supply was controlled.[16] Later, Sloan reviewed the literature through the mid-1980s and concluded that "CON has not achieved the goal of cost containment."[17] In a more recent reading of the literature, Custer reviewed 16 studies, with only one showing a relationship between CON and decreased hospital costs.[18]

Another recent article by Conover and Sloan, using a statistical analysis of all 50 states, showed no overall effects of CON on per capita health care spending. They did find that the acute care portion of hospital costs was reduced by 5 percent, but this

reduction did not translate into overall (i.e. including outpatient) hospital cost savings.[19]

Reasons why CON may not affect costs

Various authors present a number of reasons why CON has not controlled costs. First, many aspects of health care spending are not controlled by CON. For example, a 1987 survey of state CON laws showed that only six states applied the regulations to physicians' practices.[20]

Also, providers often accelerated investment in anticipation of the implementation of a CON law. One study found a 1.4 percent additional increase in bed supply growth caused by the anticipatory effects of CON implementation. After the implementation of CON laws, providers tended to shift investment to those areas not covered by a CON, such as hospital equipment.[21] This contributes to the increase of expenditures per bed.

Mendelson and Arnold note that CON targets only a small portion of hospital budgets and does not affect the prices hospitals can charge. They also note that bed capacity reductions do not necessarily translate into fewer services, and that restraining the growth of inexpensive facilities may lead to a shift of patients to more expensive facilities.[22]

The primary mechanism through which CON might control costs is through controlling supply. Some studies have shown that CON has been ineffective in restraining the growth of service supply. For example, Conover and Sloan found that no surge in spending was detected in most states that repealed CON, leading to the inference that the laws did not effectively control the provision of health care services.[23]

Some quantitative studies of particular states show that CON did restrain supply in specific service areas, however. For example, a study of Pennsylvania by the consulting firm Lewin-ICF provides evidence that the CON program was effective in restraining the supply of cardiac catheterization, open heart surgery, organ transplants, ambulatory surgery, pediatric and neonatal services, alcohol and chemical dependency beds, and long-term care beds.[24] An Ohio study found that CON controlled the supply of neonatal and pediatric intensive care services.[25]

Our examination of states that repealed CON provides evidence of a surge in supply in some states, at least immediately following repeal, which suggests that CON indeed restricted supply of some services. Surges were experienced in the following services: psychiatric hospitals and nursing homes (Utah[26]); nursing homes and open heart surgery (Arizona[27]); home health (Tennessee[28]); hospitals, ambulatory surgery centers, dialysis, and pediatric services (Ohio[29]); hospitals and psychiatric hospitals (Wisconsin[30]). In Texas, nursing homes increased, and the number of psychiatric hospitals went from 48 to 86 in the first year after repeal.[31]

Some states experienced supply surges after CON repeal

CON skeptics have downplayed the evidence of surges in supply. For example, Conover and Sloan claim that any such surges are temporary and are often the result of a supply level that was lower than the national rate before repeal. They argue that some surges – for example, in Utah and Arizona after the repeal of nursing home CON – were a result of abnormally low use rates in those states to begin with.[32] In addition, initial surges are sometimes followed by periods of shakeout and stabilization. Therefore, while short term supply increases do appear at times after CON repeal, such surges have been insufficiently studied to determine if there are any persistent effects on cost (or on other goals such as quality and access).

CON and Managed Care

Some CON opponents make the argument that the program increases costs in the current market dominated by managed care. These arguments are predicated on the notion that CON does restrict supply. If CON limits the number of hospitals and other providers, it potentially reduces the ability of managed care organizations to bargain for reduced rates.[33] Morrisey argues that early research showed that while more hospitals in a particular market led to *increased* costs, studies examining recent years show that more hospitals lead to *decreased* costs per admission. He attributes this to the ability of plans in hospital-rich areas to force hospitals to compete on price.[34] Consonant with such an argument, Lanning, Morrisey, and Ohsfeldt found that CON actually raised hospital prices, which they attributed to the stifling of hospital competition by CON.[35] However, a number

of studies have demonstrated no connection between CON laws and the penetration of managed care in a state.[36]

CON does not restrict growth of managed care

In a related argument, opponents of CON note that under managed care, hospitals need to provide a full range of services if they are to win managed care contracts. Opponents argue CON programs may make a hospital uncompetitive by preventing the development of some new services.[37] As a result, hospitals in some states are demanding the repeal of CON, arguing that CON restricts their ability to compete for managed care contracts.[38] However, while anecdotal evidence of such an effect exists, we found no systematic studies that would demonstrate the existence or prevalence of such effects.

Opponents also argue that CON impedes the development of low cost alternatives. For example, ambulatory surgery centers are likely to be able to offer lower cost surgical services since they can be operated with lower overhead and staffing than most hospitals. One comparative review of states found that CON did not restrict the supply of ambulatory surgery centers.[39] However, a Pennsylvania study found that CON controlled ambulatory surgery centers in that state.[40] Also, our examination of individual states does suggest a surge in these facilities after repeal in some instances. For example, approximately 75 new ambulatory surgery centers were built (or planned) in Ohio since they were deregulated in May 1996.[41] The evidence is inconclusive regarding the effect of CON in substantially restricting such low-cost alternatives.

QUALITY

INTRODUCTION CON programs attempt to protect health care quality in a number of ways. First, CON may serve a "gatekeeper" function by screening the quality records of those who wish to provide new or expanded services. Second, providers may be judged according to their ability to meet conditions associated with quality care (e.g., adequacy of staff and equipment). Third, CON laws attempt to improve quality by increasing numbers of surgeries in services (e.g., organ transplants) where higher volumes are associated with better outcomes (the theory that “practice makes perfect”). Fourth, CON may improve quality by stabilizing markets where ease of

entry may lead to the proliferation of firms that are financially or professionally unprepared (e.g., home health). Fifth, some argue that CON restrains the growth of for-profit providers which are likely to offer lower quality care. Conversely, opponents of CON argue that it reduces quality by slowing the diffusion of technology, protecting low-quality providers, and preventing innovative providers from entering the market.

FINDINGS Evidence about the role of CON in promoting quality is mixed. First, research findings are inconclusive regarding the ability of CON to improve quality by concentrating volume of specialized services at certain facilities. Second, indirect evidence suggests that CON may protect quality in home health by keeping out unprepared or unqualified providers. Third, evidence is mixed regarding CON's effect on the market share of for-profit providers and any resulting impacts on quality. Finally, CON does not provide an ongoing mechanism to monitor quality.

Evidence of CON's effect on quality is mixed

The above conclusions are based in part on the following research findings related to quality issues.

- The research evidence is strong that higher volumes of certain surgical procedures lead to better outcomes.[42]

- CON has a mixed record in concentrating volume. For example, studies show that CON was not effective in Ohio and Delaware in increasing volume, but did concentrate volume for some services in Pennsylvania.[43]

- CON may indirectly improve quality for some services with easy-to-enter markets, such as home health and hospice. CON is likely to lead to fewer, larger providers with more financial stability. For example, states with CON have had fewer home health agency failures after Medicare severely cut provider payments.[44]

- Some studies have shown that for-profit kidney dialysis providers offer lower quality care than not-for-profits.[45] However, other research shows that for-profit kidney dialysis centers may provide a *given* level of care more efficiently.[46] Apart from kidney dialysis, no evidence was found to suggest type of ownership is related to quality.

- The evidence is mixed regarding CON's role in affecting the market shares of for-profit and not-for-profit providers.[47] Washington State focus group participants said that for-profits are deterred from expanding capacity in CON states.

- Some experts report that CON may have indirectly reduced quality of dialysis in Connecticut by reducing access.[48]

- Key informants in Washington had varying opinions about the effect of the existing CON program on quality, saying either that it has had no effect or that it has improved quality. They also thought repeal would either reduce quality or have no effect.

DISCUSSION The literature regarding the effects of CON on quality is more limited than that on cost. While many states do include quality criteria in their CON programs, the consideration of quality by states in their CON reviews appears to vary significantly. Early research found quality was rarely a factor in CON reviews.[49] Later studies showed that a provider's track record on quality was a significant factor in some states' CON reviews, such as Pennsylvania.[50]

Research conclusions are not definitive

CON is most frequently used to influence quality in the areas of specialized surgical services such as organ transplants, pediatric surgeries, and other technically difficult procedures. Research shows that quality, as measured by mortality or surgical complications, is lower in facilities that perform fewer procedures. Facilities with higher volumes of various procedures also tend to discharge patients more quickly than low-volume facilities.[51] A study commissioned by the state of Delaware noted that more than 100 studies have been conducted on the volume-quality relationship, and "The vast majority of these studies show higher rates of good outcomes in higher volume facilities."[52]

Research on the relationship between physician volume and quality is less definitive, with less than a third finding a positive relationship and most showing no relationship.[53] However, one recent study of New Jersey heart surgeries found that a patient receiving bypass surgery from a surgeon who performed at least 126 bypasses a year was three times less likely to die than a

patient operated on by a surgeon who performed less than 126 operations.[54]

In part because of these research findings, many CON programs attempt to ensure that volumes do not drop below certain levels in each specific area. For example, in Washington State, facilities wishing to start a new open heart surgery service must show that within three years they can meet 110 percent of the minimum volume standard, which is 250 procedures per year per facility. Also, physicians must perform at least 125 surgeries annually. New facilities must also show they will not cause the volumes of other facilities to drop below the standards.[55]

CON has a mixed record in concentrating volumes of surgeries and other specialized procedures. For example, studies show that CON was not effective in Ohio and Delaware in increasing volume, but did concentrate volume for some services in Pennsylvania.[56]

In some cases, CON may improve quality

Some supporters argue that CON improves quality by encouraging fewer, larger firms in industries that are easy for new competitors to enter, such as home health and hospice. They claim that, in these industries, CON screens out unstable or unqualified providers and leads to larger firms more able to provide a broader range of services. The effect of CON in stabilizing markets appears to play some role in guaranteeing "continuity of care" for at least some services. For example, we found some circumstantial evidence that CON may lead to larger home health facilities more able to weather the financial storm caused by the new Medicare prospective payment system. A comparison of CON coverage with firm failures or withdrawals from the home health market reveal fewer such withdrawals in CON states.[57] This increased size may not translate into service improvements, however. A study conducted in 1986 by the Federal Trade Commission found that home health CON did not result in facilities better able to offer a diverse range of services.[58]

CON proponents argue that for-profits offer lower quality of care, and that CON is effective in restraining the market share of for-profits in a state. While agreeing with their arguments, Kuttner notes that very little systematic research has been completed in the area.[59] One area in which some research has been conducted

concerning the quality-profit relationship is kidney dialysis. Various studies have shown that for-profit kidney dialysis providers offer lower quality care than not-for-profits.[60]

However, another study showed that for-profit kidney dialysis centers may provide a *given* level of care more efficiently.[61] Complicating the picture still further, reports exist that CON may have indirectly reduced quality of dialysis in Connecticut by reducing access.[62] Apart from kidney dialysis, we found no strong evidence to document connections between type of ownership and quality.

The evidence is also mixed regarding CON's role in affecting the market shares of for-profit providers, with some studies showing an increased market share with CON and others lower.[63] Washington State focus group participants thought that for-profits are deterred from expanding capacity in CON states.

Another mechanism by which CON may improve quality is by allowing quality concerns to be raised and discussed during the review process. To the extent CONs are embedded in larger state health planning institutions, a forum may be provided where broader quality concerns can be aired. Even in the absence of health planning, public hearings required by the CON process allow for a debate over the quality effects of new programs and services.[64] Comments by other providers or state agencies regarding the quality record of providers and their capacity to provide new services adequately *may* have an effect in improving new services or preventing low quality services from being approved. However, the effects of these public processes on quality improvement have not been researched systematically.

Program does not monitor quality

Strong agreements exist among both supporters and opponents that CON does not provide a means to monitor quality after a certificate is granted. Many Washington State key informants as well as focus group members said that this was a major weakness in the program regarding quality. This problem has been noted in other states as well. For example, a study noted that in Pennsylvania, "Although the program can promote the concentration of services or the construction of facilities by responsible parties, it cannot be expected to monitor physician

performance or patient outcomes without a major change in program focus or staffing."[65]

ACCESS

INTRODUCTION CON laws are designed to improve access in several ways. CON may potentially be used to prevent entry of new competitors who may undermine the ability of existing providers to sustain unprofitable services, such as trauma centers or burn units. Second, by restricting expansion of facilities in overbuilt areas, CON may prompt providers to build facilities in underserved areas, such as inner cities. Opponents of CON argue that it restricts access by preventing the development of needed new services.

FINDINGS Limited and conflicting evidence was found regarding the effect of CON or repeal on access. In some instances, CON has been used to protect existing facilities in inner city areas or to prompt providers to locate in those areas. In other instances, CON appears to restrict access by preventing the development of new facilities. Evidence from other states shows that the relationship between CON (and repeal) and access varies state by state and service by service. CON does not provide an ongoing mechanism to monitor access.

Findings on access are limited and conflicting

The above conclusions are based in part on the following research findings related to access issues:

- Many state CON laws contain language that emphasizes access considerations. However, not all programs actually use such considerations in decision-making.

- A number of authors have noted that CON laws are not designed to encourage continual monitoring of access concerns.[66] Washington key informants and focus groups agreed with this assessment.

- Some experts argue that CON restricted access to kidney treatment in Connecticut. However, no research was conducted to corroborate this claim. [67]

- CON had been used in Ohio to deny new facility applications that threatened the financial viability of inner city hospitals.[68]

- In Pennsylvania, access concerns were not generally part of CON review, except to encourage the location of nursing homes in inner city areas. In New York, CON has been used to encourage the development of long-term care beds for AIDS patients.[69]

- Repeal of CON in Ohio may be both improving access and raising long-term access concerns. Expansion of new services after repeal may have improved access to dialysis and maternity care and increased access to hospital services in suburban areas. However, since inner city hospitals are opening up new facilities in suburban areas, some observers are concerned that some urban hospitals may eventually close.[70]

- Most key informants thought the Washington CON program has had no effect on access. However, opinions on the likely effect of repeal were mixed, with most thinking there would be no effect or saying they did not know what the effect might be. A significant number of informants thought that access to ambulatory surgery and kidney disease treatment would *increase*, although many also thought access to hospital care would *decrease*.

DISCUSSION Many states have sought to improve access to health services through the CON regulatory process, including general access – whether patients in a particular area needing some treatment have access to that treatment – or access for particular populations that may be medically underserved.[71] Washington State's health planning legislation states that one goal of health planning and the CON program is to ". . . provide accessible health services . . ."[72]

The literature provides inconsistent findings about the effect of CON on access. Several articles conclude that CON has had a limited ability to affect access.[73] Others, such as Hackey, support such programs for their ability to provide a forum where public concerns regarding access can be aired.[74]

A state-sponsored study of the Delaware CON program concludes that CON may have a beneficial effect on access, but it is relatively modest compared to other government interventions to improve access. The report questions if the additional benefit is worth the cost of the CON program.[75]

In some states, CON may not have enhanced access

A Pennsylvania study noted that while advancing access and quality were stated objectives of the CON program, geographic or financial access criteria were seldom used by staff in their CON reviews. Pennsylvania's regulation of access was minimal with the exception of actions taken to distribute long-term care facilities in rural or inner city areas.[76] In the neighboring state of Ohio, CON had been used to deny new facility applications that threatened the financial viability of inner city hospitals.[77]

Proponents of CON argue that it provides financial stability to existing providers, allowing them to extend access to populations that are expensive to serve. While the arguments regarding such "cost-shifting" seem plausible, no studies have been completed to show that CON or its absence has a direct effect on the ability of facilities to cross-subsidize expensive or unreimbursed care. CON repeal, at least in the short run, is associated with surges in facility construction or service expansion. Research has not been conducted to demonstrate how these supply surges effect the financial situation of existing providers or their ability to cross-subsidize, however.

Anecdotal information from specific states provide examples of contradictory effects of deregulation on access. Several Ohio hospitals are "satelliting" their hospitals (moving some of the beds and services to new suburban sites while retaining the existing hospital at the existing site); this may improve suburban access, but has also raised concerns that eventually the downtown hospitals will either be closed altogether or will retain an outpatient presence only. At the same time, increases in pediatric and dialysis facilities may be improving access.[78] Some experts argue that CON restricted access to kidney treatment in Connecticut. However, no research was conducted to corroborate this claim.[79]

CHARITY CARE

INTRODUCTION Proponents of CON make four arguments about CON and charity care. First, CON laws may explicitly require that a specific level of charity care be provided as a condition of receiving a CON. Second, CON enhances charity care *indirectly* by increasing the financial margins of existing providers, making it possible for them to afford to provide money-losing services, such as care for the indigent. Third, in the absence of CON, new providers will enter a market and "cherry-pick" lucrative services, overburdening existing providers with the bulk of charity care and other financially marginal services. Fourth, CON helps to maintain the market share of not-for-profit providers, which are more likely to provide charity care. CON opponents argue that the need for charity care can be met through charity requirements uniformly applied to certain facilities.

Limited evidence on CON's effect on charity care

FINDINGS Limited evidence was found regarding the effect of CON on charity care. First, CON programs do provide some initial screening regarding a facility's likelihood of providing charity care, but do not provide for monitoring of compliance after a CON is granted. Second, evidence exists that some states are more likely to grant CONs to facilities offering more charity care. Third, CON proponents claim that it protects not-for-profit hospitals, which are likely to offer more charity care. Fourth, CON has also been shown to improve the operating margins of existing providers, which *may* increase the likelihood they will offer more charity care.

The above conclusions are based in part on the following research findings related to charity care.

- Pennsylvania was more likely to grant a CON to marginal facilities if they agreed to provide more charity care.[80]

- CON had been used in Ohio (before repeal) to deny applications that threatened the financial viability of inner city hospitals, which are a main source of charity care for such areas.[81]

- Two studies examining Florida and California showed that these states were more likely to grant CONs to facilities offering higher levels of charity care.[82] The *direct* effect of CON in increasing levels of charity care in Florida and California was not documented by these studies, however.[83]

- For-profits tend to provide less charity care, while public and teaching hospitals provide the most.[84] The evidence regarding CON's effect on the mix of for-profit and not-for-profit providers is conflicting, with some studies showing lower for-profit share and others higher as a result of CON.[85] Washington State focus group participants thought that CON restricts the expansion of for-profit providers.

- Higher revenues appear to be correlated with higher levels of charity care.[86] CON in turn has been shown to enhance the revenues of existing providers.[87] However, we found no studies that directly link CON with higher levels of charity care.

- HPAP's review of selected states provided no evidence that repeal of CON negatively affected provision of charity care.

- Most Washington key informants thought repeal of CON would either reduce or have no effect on charity care.

DISCUSSION Increasing the provision of charity care is a goal of some state CON programs. Linkages between CON and charity care have been documented, but the findings in this area are not particularly strong.

Mendelson and Arnold note that CON was used in Ohio to deny applications that threatened the financial viability of inner city hospitals likely to offer more charity care.[88] Hackey also concludes that CON has been at least somewhat effective in increasing or preserving levels of charity care and access.[89] Similarly, Lewin's 1991 study of the Ohio CON program presents evidence that the program denied applications that would have had adverse effects on access for vulnerable populations. In other cases CONs were tied to provision of charity care.[90] Pennsylvania's CON program also looked more favorably on marginal facilities if they agreed to provide more charity care.[91]

Linkages between CON and charity care were most thoroughly explored in studies in Florida and California, with mixed results. Campbell and Fournier studied certificate of need applications in Florida from 1983-89 and found that the state tended to grant CONs in part in response to a facility's record of providing charity care. By rewarding such facilities with expansion, their ability to cross-subsidize between profitable services and charity care patients was increased.[92] Campbell and Ahern found similar patterns in California using 1983-87 records.[93]

Hackey, however, questions these findings, noting that the Florida study did not account for the high thresholds for CON review in that state or the effect of a hospital's status as a teaching hospital or the sole community provider.[94] Conover and Sloan note that "The most important limitation of the California and Florida studies is that neither demonstrates a direct connection between CON activities and actual provision of indigent care."[95]

Linkages between CON and charity care were mixed

CON proponents argue that the program increases the proportion of not-for-profit providers which are likely to offer more charity care. For-profits tend to provide less charity care, while public and teaching hospitals provide the most.[96] However, the evidence regarding CON's effect on the mix of for-profit and not-for-profit providers is conflicting, with some studies showing lower for-profit share and others higher in CON states.[97] Washington State focus group participants thought that CON restricts the expansion of for-profit providers.

The argument regarding cost-shifting again arises with regard to charity care. Some evidence exists that cost-shifting is used to pay for indigent care. For example, Delaware is one of a few states with no public hospitals, and therefore all indigent care must be financed by cost-shifting. Delaware hospitals charge private pay patients 51 percent more than the actual cost of care in 1993, higher than any state except South Carolina.[98]

Lanning, Morrisey, and Ohsfelt showed that CON has been shown to enhance the revenues of existing providers.[99] Higher revenues have in turn been correlated with higher levels of charity care.[100] While these findings are suggestive, we found no

studies that directly linked the presence of CON programs with higher levels of charity care.

RURAL ACCESS

INTRODUCTION CON laws and their implementation may affect access in rural areas in a number of ways. First, CON laws may require that providers serve all patients needing care in a particular geographic area (e.g., county), potentially improving access in remote areas. Second, by restricting the expansion of services in overbuilt areas, CON may prompt providers to expand into underserved rural areas. Third, CON is meant to protect existing rural facilities and networks from disruption caused by new suppliers. Opponents argue that CON restricts access by preventing the development of facilities and services that would otherwise be built, and that it prevents joint ventures and consortia among rural providers that would improve access.

Little evidence on how CON affects rural health care

FINDINGS The evidence is limited concerning the effect of CON on access to services in rural access. One statistical analysis showed that CON did not affect the development of rural networks. Repeal of CON appears to have had no effect in some states, while at least one (Wisconsin) has experienced some disruption of rural health services after repeal.

The above conclusions are based in part on the following research findings related to rural access:

- No studies were found that examined the effect of CON requirements that all patients be served in specific geographic areas.

- CON was not a major factor in encouraging the development of facilities in rural areas in Ohio and Pennsylvania.[101]

- One study found that while the CON process was a burden for some rural providers, it did not affect the ability of rural hospitals to form consortiums with other providers.[102]

- Examination of select states that have repealed CON revealed no evidence of disruption of rural networks in some states (e.g., Pennsylvania, Ohio, Utah). Conversely, in Wisconsin

some rural networks may have been disrupted as a result of repeal, as urban hospitals or health care networks opened clinics in rural areas that siphoned patients away from local hospitals.

- Most key informants thought repealing CON would have no effect on access to facilities and services in rural areas.

DISCUSSION Evidence is mixed regarding the effectiveness of CON in enhancing the provision of services in rural areas. Some authors argue that CON reduces access by limiting the spread of facilities and services.[103] However, Kiel concludes that CON has not affected access in rural areas much or at all. The same study also found that CON did not affect the ability of rural hospitals to form consortia. Kiel also argues that smaller rural hospitals are burdened by the cost of CON compliance, while noting that they had fewer needs for CON-regulated services.[104] Since research in this area is limited, it is not possible to draw firm conclusions from the available evidence.

HPAP's examination of focus states revealed mixed effects of CON repeal on rural networks. In Utah, Ohio, and Pennsylvania, no disruption was reported as a result of repeal. However, in Wisconsin, CON repeal resulted in the development of some new facilities that are siphoning patients from rural hospitals. In response, the state is encouraging rural hospitals to add services, such as home health and nursing facilities, in order to shore up their patient base.[105]

CON in Context: A Tale of Two States

The experiences of two states that recently repealed their certificate of need laws, Pennsylvania and Ohio, illustrate the complexity of trying to predict the effects of repeal.

	Pennsylvania	**Ohio**
Date of Repeal	December 1996	Phased 1995 – 1998
Changes in Supply	• Some new open heart surgery units.	• 6 new open heart surgery units • 54 new imaging facilities • 75 new ambulatory surgery centers • 312 new inpatient psychiatric beds • 430 new rehabilitation beds • 847 new dialysis stations • Some new specialty hospitals planned
Other Effects	Unknown	Unknown

The Pennsylvania Process

After the sunset of the Pennsylvania CON law, heart surgery providers and nursing home operators announced intentions to add capacity. The state Department of Welfare instituted a *de facto* moratorium on nursing homes by refusing Medicaid reimbursement for new homes or bed additions pending the development of new regulations. The Pennsylvania Department of Health promptly convened 13 groups, made up of experts and stakeholders, to review areas where quality concerns had been raised by CON repeal. The groups greatly strengthened licensing, in many cases by adopting the clinical standards of various professional organizations.

The Ohio Process

Ohio also moved to strengthen its quality regulations and added licensing requirements for free-standing facilities; hospitals remain unlicensed. Unlike Pennsylvania, Ohio used a more traditional approach to developing new rules – with less involvement of stakeholders – which *may* have reduced buy-in by affected industries.

The Implications

The fact that Pennsylvania has, to date, avoided the capacity surges experienced by Ohio may be a result of the former state's highly participatory rule-making process and its adoption of professionally developed clinical standards. However, the divergent experiences of these two states may also be due to differences in managed care penetration, overall market structure, the strengths of their original CON laws, or some other factor entirely. The stories of deregulation in Ohio and Pennsylvania point to the importance of state-specific analyses for understanding the effects of repealing CON.

STRENGTHS AND WEAKNESSES OF CON IN WASHINGTON

The findings in this section derive from state focus groups and interviews with service providers and experts in Washington State. Supporters and opponents of CON volunteered information about its weaknesses, and both supporters and opponents emphasized the importance of the goals the program attempts to achieve. These strengths and weaknesses represent the prevailing views of key stakeholders and may provide some guidance to policymakers considering changes to the program.

The perceived strengths of Washington's CON program are as follows:

- The program has prevented some bad proposals for new or existing facilities from moving forward.
- CON promotes planning and foresight in the development of the state's health system—a method of deliberately considering the market and community in which a service is planned.
- CON creates an opportunity for the public to find out about and participate in decisions regarding health care facilities and services.
- CON provides a way of considering quality and access issues.

The perceived weaknesses of Washington's CON program are as follows:

- The program is understaffed and has insufficient resources for analyses of CON proposals and their policy implications.
- CON has not evolved to reflect changes in the health care system.
- CON is a one-shot review that does not provide for ongoing monitoring of the effect of new providers or new services on cost, quality, or access.

- CON is not based on an analysis of health care system conditions and changes, or specific state health planning goals.

POLICY OPTIONS

The following policy options are based on the findings of this study. We make no recommendation about whether CON should be repealed or retained, because the available evidence does not support such a recommendation. However, the experiences of other states and the perspectives of experts and stakeholders both in Washington and elsewhere suggest specific options for policymakers whether CON is retained or repealed.

Three policy options

Policymakers may want to consider three policy options concerning the future of Washington's CON program: reform the program, repeal the program, and conduct additional economic analyses. Leaving the program unchanged is also within the prerogative of the legislature.

A. Reform the Program

Given the weaknesses identified above, if all or part of the program is retained, the following actions should take place:

- The legislative and regulatory goals should be reassessed in relation to new conditions and needs in the health care system.

- A mechanism to make CON more responsive to changes in the health care system should be established. One option is to create a policy oversight or advisory board composed of experts on Washington's health care system, representatives of provider organizations, and the broader community.

- Data collection should be improved to allow for ongoing monitoring and oversight of quality, general and rural access, and community benefits (including levels of charity care).

B. Repeal the Program

If CON is repealed for some or all services, the following actions should also take place:

- Policy goals for cost, quality, access, and accountability should be identified, along with alternative methods of attaining those goals. Alternatives might include strengthened licensing rules for certain services or providers, additional requirements for charity care, or the adoption of a program for continuous quality improvement.

- Data collection and reporting should be strengthened to monitor the effects of repeal on quality, general and rural access, and community benefits.

C. Conduct Economic Analyses to Guide Policy Changes

Economic analyses would build on the findings of this CON study by estimating the effects of deregulation in Washington State on the supply and price of services and by simulating the effects of deregulation on the operating margins of service providers in Washington State. The study could be conducted in conjunction with, or as a prelude to, either of options A or B above. The scope of the study could be limited or comprehensive, depending on the resources available. The estimated costs for the proposed studies range from $200,000 to $300,000. (See Chapter 3 for details on the proposed analyses.)

Discussion

Options not mutually exclusive

The above options need not be mutually exclusive. For example, the legislature may choose to repeal certain portions of the program while reforming others, or may choose to reform the program while also conducting a study of the economic effects of repeal. The legislature can also choose to make no change in the program; this study found little support for the “no change” option.

Carrying out one or more of the policy options may entail additional activities not included in the scope of this study. First, to fully analyze possible reforms to CON would require an in-depth examination of the policy goals for, and operation of, Washington's program. Second, any alternatives to CON—such as strengthened licensure regulations—would need to be studied to determine whether they would further accepted policy goals. Third, the resources necessary to carry out any reforms or alternatives to the CON program would need to be estimated.

NOTES

[1] Mendelson, Daniel M., and Judith Arnold, "Certificate of Need Revisited," *Spectrum*, Winter 1993.

[2] Salkever, D.S., and T.W. Bice, "Certificate of Need Legislation and Hospital Costs," in *Hospital Cost Containment*, M. Zubkoff, I.E. Raskin, and R.S. Hanft, eds., New York City, Prodist, 1978.

[3] Conover, Christopher, and Frank A. Sloan, "Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?", *Journal of Health Politics, Policy, and Law*, Vol. 23, No. 3, June 1998; Mendelson, Daniel M., and Judith Arnold, "Certificate of Need Revisited," *Spectrum*, Winter 1993; Delaware Health Care Commission, "Evaluation of Certificate of Need and Other Health Planning Mechanisms," Volume I, Final Report, May 1996; Custer, William S., Ph.D., "Certificate of Need Regulation and the Health Care Delivery System," Center for Risk Management and Insurance Research, Georgia State University, February 1997.

[4] Conover, Christopher, and Frank A. Sloan, "Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?", *Journal of Health Politics, Policy, and Law*, Vol. 23, No. 3, June 1998; Mendelson, Daniel M., and Judith Arnold, "Certificate of Need Revisited," *Spectrum*, Winter 1993; Delaware Health Care Commission, "Evaluation of Certificate of Need and Other Health Planning Mechanisms," Volume I, Final Report, May 1996; Arnold, Judith and Daniel Mendelson, (Lewin ICF) "Evaluation of the Pennsylvania Certificate of Need Program," submitted to the Pennsylvania Legislative Budget and Finance Committee, April 1992; Custer, William S., Ph.D., "Certificate of Need Regulation and the Health Care Delivery System," Center for Risk Management and Insurance Research, Georgia State University, February 1997.

[5] Lanning, Joyce A., Michael E. Morrisey, Robert L. Ohsfeldt, "Endogenous Hospital Regulation and Its Effects on Hospital and Non-Hospital Expenditures," *Journal of Regulatory Economics*, Vol. 3:137-154, 1991.

[6] Conover, Christopher, and Frank A. Sloan, "Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?", *Journal of Health Politics, Policy, and Law*, Vol. 23, No. 3, June 1998.

[7] Mendelson, Daniel M., and Judith Arnold, "Certificate of Need Revisited," *Spectrum*, Winter 1993; Arnold, Judith and Daniel Mendelson, (Lewin ICF) "Evaluation of the Pennsylvania Certificate of Need Program," submitted to the Pennsylvania Legislative Budget and Finance Committee, April 1992.

[8] Lewin/ICF and Alpha Center, "Evaluation of the Ohio Certificate of Need Program," Executive Summary, June 28, 1991.

[9] Mendelson, Daniel M., and Judith Arnold, "Certificate of Need Revisited," *Spectrum*, Winter 1993; McFall, Dennis N., "Utah Providers Hurting From Unchecked Growth," *Provider*, December 1987.

[10] The Advisory Board Committee, "Effects of the Deregulation of Certificate of Need (CON) Requirements," November, 1996; Mendelson, Daniel M., and Judith Arnold, "Certificate of Need Revisited," *Spectrum*, Winter 1993.

[11] Eli's Home Health Care Report, "Certificate of Need: Republican Legislatures Attempting CON Roll-Back, *Eli's Home Health Care Report*, Volume IV, 1995.

[12] Interviews with key informants in Ohio.

[13] Delaware Health Care Commission, "Evaluation of Certificate of Need and Other Health Planning Mechanisms," Volume I, Final Report, May 1996; Interviews with key informants in Pennsylvania.

[14] Delaware Health Care Commission, "Evaluation of Certificate of Need and Other Health Planning Mechanisms," Volume II, Technical Appendices, May 1996; Conover, Christopher, and Frank A. Sloan, "Does Certificate of Need Constrain Long-Term Care Spending?," undated, unpublished manuscript.

[15] Lewin-VHI Inc., Barbara B. Manard, Sally J. Kaplan, Alison Keillor, and Rosemary Camerson, "The Georgia Certificate of Need Program," December 1995; Conover, Christopher, and Frank A. Sloan, "Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?", *Journal of Health Politics, Policy, and Law*, Vol. 23, No. 3, June 1998; Delaware Health Care Commission, "Evaluation of Certificate of Need and Other Health Planning Mechanisms," Volume II, Technical Appendices, May 1996.

[16] Salkever, D.S., and T.W. Bice, "Certificate of Need Legislation and Hospital Costs," in *Hospital Cost Containment*, M. Zubkoff, I.E. Raskin, and R.S. Hanft, eds., New York City, Prodist, 1978.

[17] Sloan, Frank A., "Containing Health Expenditures: Lessons Learned from Certificate of Need Programs," in Frank A. Sloan, James F. Blumstein, and James M. Perrin, eds., *Cost, Quality, and Access in Health Care; New Roles for Health Planning in a Competitive Environment*, San Francisco, Jossey-Bass, 1988.

[18] Custer, William S., Ph.D., "Certificate of Need Regulation and the Health Care Delivery System," Center for Risk Management and Insurance Research, Georgia State University, February 1997.

[19] Conover, Christopher, and Frank A. Sloan, "Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?," *Journal of Health Politics, Policy, and Law*, Vol. 23, No. 3, June 1998.

[20] Cited in Sloan, Frank A., "Containing Health Expenditures: Lessons Learned from Certificate of Need Programs," in Frank A. Sloan, James F. Blumstein, and James M. Perrin, eds., *Cost, Quality, and Access in Health Care: New Roles for Health Planning in a Competitive Environment*, San Francisco, Jossey-Bass, 1988.

[21] Sloan, Frank A., "Containing Health Expenditures: Lessons Learned from Certificate of Need Programs," in Frank A. Sloan, James F. Blumstein, and James M. Perrin, eds., *Cost, Quality, and Access in Health Care: New Roles for Health Planning in a Competitive Environment*, San Francisco, Jossey-Bass, 1988.

[22] Mendelson, Daniel M., and Judith Arnold, "Certificate of Need Revisited," *Spectrum*, Winter 1993.

[23] Conover, Christopher, and Frank A. Sloan, "Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?," *Journal of Health Politics, Policy, and Law*, Vol. 23, No. 3, June 1998.

[24] Judith Arnold and Daniel Mendelson, Lewin-ICF, "Evaluation of the Pennsylvania Certificate of Need Program," and Appendix I, "Econometric Analysis of CON in Pennsylvania," submitted to the Pennsylvania Legislative Budget and Finance Committee, April 1992.

[25] Lewin/ICF and Alpha Center, "Evaluation of the Ohio Certificate of Need Program," Executive Summary, June 28, 1991.

[26] Mendelson, Daniel M., and Judith Arnold, "Certificate of Need Revisited," *Spectrum*, Winter 1993; McFall, Dennis N., "Utah Providers Hurting From Unchecked Growth," *Provider*, December 1987.

[27] The Advisory Board Committee, "Effects of the Deregulation of Certificate of Need (CON) Requirements, November, 1996; Mendelson, Daniel M., and Judith Arnold, "Certificate of Need Revisited," *Spectrum*, Winter 1993.

[28] Eli's Home Health Care Report, "Certificate of Need: Republican Legislatures Attempting CON Roll-Back, Volume IV, 1995.

[29] Interviews with key informants in Ohio.

[30] Interviews with key informants in Wisconsin.

[31] Jee, Melissa, "Certificate-of-Need Laws Back in Style Again," *Journal of American Health Policy*, March/April, 1993.

[32] Conover, Christopher, and Frank A. Sloan, "Does Certificate of Need Constrain Long-Term Care Spending?," undated mss.

[33] McGinley, Patrick John, "Beyond Health Care Reform: Reconsidering Certificate of Need Laws in a Managed Competition System," *Florida State University Law Review*, 1995.

[34] Morrisey, Michael A., "State Health Care Reform: Protecting the Provider," unpublished manuscript, August 22, 1997.

[35] Lanning, Joyce A., Michael E. Morrisey, Robert L. Ohsfeldt, "Endogenous Hospital Regulation and Its Effects on Hospital and Non-Hospital Expenditures," *Journal of Regulatory Economics*, Vol. 3:137-154, 1991.

[36] Lewin-VHI Inc., Barbara B. Manard, Sally J. Kaplan, Alison Keillor, and Rosemary Camerson, "The Georgia Certificate of Need Program," December 1995; Conover, Christopher, and Frank A. Sloan, "Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?," *Journal of Health Politics*, Policy, and Law, Vol. 23, No. 3, June 1998; Delaware Health Care Commission, "Evaluation of Certificate of Need and Other Health Planning Mechanisms," Volume II, Technical Appendices, May 1996.

[37] Moore, Duncan J. Jr., "CON Survival Struggle. Gone in Many States but Not Dead Yet," *Modern Healthcare*," August 11, 1997; Weaver, Judith A., "Certificate of Need: What Role Does it Have in a Managed Care Environment?" in Ellis G. Gosfield, ed., *Health Law Handbook*, 1995, pp. 409-429.

[38] Preston, Jennifer, "States Ease Restrictions on Hospitals," *New York Times*, July 27, 1998.

[39] Cost Containment Committee, "Evaluation of Certificate of Need and Other Health Planning Mechanisms," Volume I: Final Report; and Volume II, Technical Appendices, Delaware Health Care Commission, May 1996.

[40] Arnold, Judith and Daniel Mendelson, (Lewin ICF), "Evaluation of the Pennsylvania Certificate of Need Program," submitted to the Pennsylvania Legislative Budget and Finance Committee, April 1992.

[41] Interviews with key informants.

[42] Luft, Harold S., Deborah W. Garnick, David H. Mark, and Stephen J. McPhee, *Hospital Volume, Physician Volume, and Patient Outcomes: Assessing the Evidence*, Ann Arbor, MI, Health Administration Press, 1990; Conover, Christopher, and Frank A. Sloan, "Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?", *Journal of Health Politics, Policy, and Law*, Vol. 23, No. 3, June 1998.

[43] Delaware Health Care Commission, "Evaluation of Certificate of Need and Other Health Planning Mechanisms," Volume I, Final Report, May 1996; Lewin/ICF and Alpha Center, "Evaluation of the Ohio Certificate of Need Program," Executive Summary, June 28, 1991; Arnold, Judith and Daniel Mendelson, (Lewin ICF) "Evaluation of the Pennsylvania Certificate of Need Program," submitted to the Pennsylvania Legislative Budget and Finance Committee, April 1992.

[44] HPAP inferred this point from a comparison of state CON coverage of home health, and data from the following: U.S. General Accounting Office, "Medicare Home Health Benefit: Impact of Interim Payment System on Agency Closures and Access to Services," Washington, D.C., U.S. General Accounting Office, September 1998; *National Home Care Association Newsletter*, "More Than 1,100 Agencies Close; Full Effects of IPS Still Not Felt," July 1998.

[45] Irvin, Renee A., "Quality of Care Differences by Ownership Form: Implications for Cost Efficiency Studies," draft prepared for the American Society for Artificial Internal Organs annual conference, April 1998; Delmez, James A., David W. Windus, and the St. Louis Nephrology group, "Hemodialysis Prescription and Delivery in a Metropolitan Community," *Kidney International*, Vol. 41, 1992; A. Collins, J. Ma, W. Keane, (research abstract), "Reuse of Hemodialyzers: Is there a Risk in 1994?, *Nephrology Dialysis Transplantation*, Vol. 12 no. 9, 1997.

[46] Griffiths, Robert I., Neil R. Powe, Darrell J. Gaskin, Gerard F. Anderson, Gregory V. de Lissovoy, and Paul K. Whelton, "The Production of Dialysis by For-Profit versus Not-For-Profit Freestanding Renal Dialysis Facilities," *Health Services Research*, Vol. 29 No. 4, October 1994.

[47] Conover, Christopher, and Frank A. Sloan, "Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?", *Journal of Health Politics, Policy, and Law*, Vol. 23, No. 3, June 1998; Lanning, Joyce A., Michael E. Morrisey, Robert L. Ohsfeldt, "Endogenous Hospital Regulation and Its Effects on Hospital and Non-Hospital Expenditures," *Journal of Regulatory Economics*, Vol. 3:137-154, 1991.

[48] Brown, Eric, J. Douglas Smith, and Jody Sindelar, "Can We Regulate the Quality of Care?: The Case of Dialysis in Connecticut," *American Journal of Kidney Diseases*, Vol. XIX, No. 6, 1992.

[49] Hershey, Nathan and Deborah Robinson, "Health Planning and Certificate of Need," The Quality Dimension," *Health Policy Quarterly*, Vol. 1, No. 4, 1981.

[50] Judith Arnold and Daniel Mendelson, Lewin-ICF, "Evaluation of the Pennsylvania Certificate of Need Program," and Appendix I, "Econometric Analysis of CON in Pennsylvania," submitted to the Pennsylvania Legislative Budget and Finance Committee, April 1992.

[51] Judith Arnold and Daniel Mendelson, Lewin-ICF, "Evaluation of the Pennsylvania Certificate of Need Program," submitted to the Pennsylvania Legislative Budget and Finance Committee, April 1992.

[52] Delaware Health Care Commission, "Evaluation of Certificate of Need and Other Health Planning Mechanisms," Volume I, Final Report, May 1996.

[53] Delaware Health Care Commission, "Evaluation of Certificate of Need and Other Health Planning Mechanisms," Volume I, Final Report, May 1996.

[54] Study findings summarized in Stacey Burling, "New Jersey Minimums of Bypass Surgery May be Up in July," *Philadelphia Inquirer*, April 26, 1998.

[55] Washington Administrative Code 246-310-261.

[56] Delaware Health Care Commission, "Evaluation of Certificate of Need and Other Health Planning Mechanisms," Volume I, Final Report, May 1996; Lewin/ICF and Alpha Center, "Evaluation of the Ohio Certificate of Need Program," Executive Summary, June 28, 1991; Arnold, Judith and Daniel Mendelson, (Lewin ICF) "Evaluation of the Pennsylvania Certificate of Need Program," submitted to the Pennsylvania Legislative Budget and Finance Committee, April 1992.

[57] See U.S. General Accounting Office, "Medicare Home Health Benefit: Impact of Interim Payment System on Agency Closures and Access to Services," Washington, D.C., U.S. General Accounting Office, September 1998; National Home Care Association Newsletter, "More Than 1,100 Agencies Close; Full Effects of IPS Still Not Felt," July 1998.

[58] Federal Trade Commission, "Certificate of Need Regulation of Entry Into Home Health Care Markets," Washington, D.C., Federal Trade Commission, 1986.

[59] Kuttner, Robert, "Columbia/HCA and the Resurgence of the For-Profit Hospital Business," Special Report, Part One *New England Journal of Medicine*, August 1, 1996; Kuttner, Robert, "Columbia/HCA and the

Resurgence of the For-Profit Hospital Business," Special Report, Part Two, *New England Journal of Medicine*, August 8, 1996.

[60] Irvin, Renee A., "Quality of Care Differences by Ownership Form: Implications for Cost Efficiency Studies," draft prepared for the American Society for Artificial Internal Organs annual conference, April 1998; Delmez, James A., David W. Windus, and the St. Louis Nephrology group, "Hemodialysis Prescription and Delivery in a Metropolitan Community," *Kidney International*, Vol. 41, 1992; A. Collins, J. Ma, W. Keane, (research abstract), "Reuse of Hemodialyzers: Is there a Risk in 1994?, *Nephrology Dialysis Transplantation*, Vol. 12 no. 9, 1997.

[61] Griffiths, Robert I., Neil R. Powe, Darrell J. Gaskin, Gerard F. Anderson, Gregory V. de Lissovoy, and Paul K. Whelton, "The Production of Dialysis by For-Profit versus Not-For-Profit Freestanding Renal Dialysis Facilities," *Health Services Research*, Volume 29 No. 4, October 1994.

[62] Brown, Eric, J. Douglas Smith, and Jody Sindelar, "Can We Regulate the Quality of Care?: The Case of Dialysis in Connecticut," *American Journal of Kidney Diseases*, Vol. XIX, No. 6, 1992.

[63] Conover and Sloan found that CON may increase for-profit share, while Lanning et. al. argued that CON reduced it. See Conover, Christopher, and Frank A. Sloan, "Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?," *Journal of Health Politics*, Policy, and Law, Vol. 23, No. 3, June 1998; Lanning, Joyce A., Michael E. Morrisey, Robert L. Ohsfeldt, "Endogenous Hospital Regulation and Its Effects on Hospital and Non-Hospital Expenditures," *Journal of Regulatory Economics*, Vol. 3:137-154, 1991.

[64] Hackey, Robert B., "New Wine in Old Bottles: Certificate of Need Enters the 1990s," *Journal of Health Politics, Policy, and Law*, Vol. 18, No. 4, Winter 1993.

[65] Judith Arnold and Daniel Mendelson, Lewin-ICF, "Performance Audit, Certificate of Need Program," Harrisburg, Pennsylvania, April 1992.

[66] Mendelson, Daniel M., and Judith Arnold, "Certificate of Need Revisited," *Spectrum*, Winter 1993; Hackey, Robert B., "New Wine in Old Bottles" Certificate of Need Enters the 1990s," *Journal of Health Politics, Policy, and Law*, Vol. 18, No. 4, Winter 1993.

[67] Brown, Eric, J. Douglas Smith, and Jody Sindelar, "Can We Regulate the Quality of Care?: The Case of Dialysis in Connecticut," *American Journal of Kidney Diseases*, Vol. XIX, No. 6, 1992; Rettig, Richard A., Ph.D., "Dialysis in Connecticut," *American Journal of Kidney Diseases*, Vol. XIX, No. 6, June 1992

[68] Mendelson, Daniel M., and Judith Arnold, "Certificate of Need Revisited," *Spectrum*, Winter 1993.

[69] Mendelson, Daniel M., and Judith Arnold, "Certificate of Need Revisited," *Spectrum*, Winter 1993.

[70] Interviews with key informants in Ohio.

[71] Weaver, Judith A., "Certificate of Need: What Role Does it Have in a Managed Care Environment?" in Ellis G. Gosfield, ed., *Health Law Handbook*, 1995, pp. 409-429.

[72] Revised Code of Washington 70.38.015.

[73] Sloan, Frank A., "Containing Health Expenditures: Lessons Learned from Certificate of Need Programs," in Frank A. Sloan, James F. Blumstein, and James M. Perrin, eds., *Cost, Quality, and Access in Health Care: New Roles for Health Planning in a Competitive Environment*, San Francisco, Jossey-Bass, 1988; Delaware Health Care Commission, "Evaluation of Certificate of Need and Other Health Planning Mechanisms," Volume I, Final Report, May 1996.

[74] Hackey, Robert B., "New Wine in Old Bottles" Certificate of Need Enters the 1990s," *Journal of Health Politics, Policy, and Law*, Vol. 18, No. 4, Winter 1993.

[75] Cost Containment Committee, "Evaluation of Certificate of Need and Other Health Planning Mechanisms," Volume I: Final Report; and Volume II, Technical Appendices, Delaware Health Care Commission, May 1996.

[76] Judith Arnold and Daniel Mendelson, Lewin-ICF, "Evaluation of the Pennsylvania Certificate of Need Program," and Appendix I, "Econometric Analysis of CON in Pennsylvania," Submitted to the Pennsylvania Legislative Budget and Finance Committee, April 1992.

[77] Mendelson, Daniel M., and Judith Arnold, "Certificate of Need Revisited," *Spectrum*, Winter 1993.

[78] Interviews with key informants in Ohio.

[79] Brown, Eric, J. Douglas Smith, and Jody Sindelar, "Can We Regulate the Quality of Care?: The Case of Dialysis in Connecticut," *American Journal of Kidney Diseases*, Vol. XIX, No. 6, 1992; Rettig, Richard A., Ph.D., "Dialysis in Connecticut," *American Journal of Kidney Diseases*, Vol. XIX, No. 6, June 1992.

[80] The Advisory Board Committee, "Effects of the Deregulation of Certificate of Need (CON) Requirements, November 1996.

[81] Mendelson, Daniel M., and Judith Arnold, "Certificate of Need Revisited," *Spectrum*, Winter 1993.

[82] Campbell, Ellen S., and Gary M. Fournier, "Certificate-of-Need Deregulation and Indigent Hospital Care," *Journal of Health Politics, Policy, and Law*, Vol. 18, No. 4, Winter 1993; Campbell Helen S., and Melissa W. Ahern, "Have Procompetitive Changes Altered Hospital Provision of Indigent Care?," *Health Economics*, Vol. 2, 1993.

[83] Hackey, Robert B., "New Wine in Old Bottles" Certificate of Need Enters the 1990s," *Journal of Health Politics, Policy, and Law*, Vol. 18, No. 4, Winter 1993.

[84] Campbell Helen S., and Melissa W. Ahern, "Have Procompetitive Changes Altered Hospital Provision of Indigent Care?," *Health Economics*, Vol. 2, 1993.

[85] Lanning, Morrisey, and Ohsfeldt (1991) argue that CON reduces for-profit share. Conover and Sloan (1998) found the opposite result.

[86] Campbell Helen S., and Melissa W. Ahern, "Have Procompetitive Changes Altered Hospital Provision of Indigent Care?," *Health Economics*, Vol. 2, 1993.

[87] Lanning, Joyce A., Michael E. Morrisey, Robert L. Ohsfeldt, "Endogenous Hospital Regulation and Its Effects on Hospital and Non-Hospital Expenditures," *Journal of Regulatory Economics*, Vol. 3:137-154, 1991.

[88] Mendelson, Daniel M., and Judith Arnold, "Certificate of Need Revisited," *Spectrum*, Winter 1993.

[89] Hackey, Robert B., "New Wine in Old Bottles" Certificate of Need Enters the 1990s," *Journal of Health Politics, Policy, and Law*, Vol. 18, No. 4, Winter 1993.

[90] Lewin-ICF and Alpha Center, "Evaluation of the Ohio Certificate of Need Program, Executive Summary," Submitted to the Certificate of Need Study Committee and Ohio Department of Health, June 28, 1991.

[91] The Advisory Board Committee, "Effects of the Deregulation of Certificate of Need (CON) Requirements, November 1996.

[92] Campbell, Ellen S., and Gary M. Fournier, "Certificate-of-Need Deregulation and Indigent Hospital Care," *Journal of Health Politics, Policy, and Law*, Vol. 18, No. 4, Winter 1993.

[93] Campbell Helen S., and Melissa W. Ahern, "Have Procompetitive Changes Altered Hospital Provision of Indigent Care?," *Health Economics*, Vol. 2, 1993.

[94] Hackey, Robert B., "New Wine in Old Bottles: Certificate of Need Enters the 1990s," *Journal of Health Politics, Policy, and Law*, Vol. 18, No. 4, Winter 1993.

[95] Conover, Christopher, and Frank A. Sloan, "Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?", *Journal of Health Politics, Policy, and Law*, Vol. 23, No. 3, June 1998.

[96] Campbell Helen S., and Melissa W. Ahern, "Have Procompetitive Changes Altered Hospital Provision of Indigent Care?," *Health Economics*, Vol. 2, 1993.

[97] Lanning, Morrisey, and Ohsfeldt (1991) argue that CON reduces for-profit share. Conover and Sloan (1998) found the opposite result.

[98] Cost Containment Committee, "Evaluation of Certificate of Need and Other Health Planning Mechanisms," Volume I: Final Report; and Volume II, Technical Appendices, Delaware Health Care Commission, May 1996.

[99] Lanning, Joyce A., Michael E. Morrisey, Robert L. Ohsfeldt, "Endogenous Hospital Regulation and Its Effects on Hospital and Non-Hospital Expenditures," *Journal of Regulatory Economics*, Vol. 3:137-154, 1991.

[100] Campbell Helen S., and Melissa W. Ahern, "Have Procompetitive Changes Altered Hospital Provision of Indigent Care?," *Health Economics*, Vol. 2, 1993.

[101] Lewin/ICF and Alpha Center, "Evaluation of the Ohio Certificate of Need Program," Executive Summary, June 28, 1991; Arnold, Judith and Daniel Mendelson, (Lewin ICF) "Evaluation of the Pennsylvania Certificate of Need Program." submitted to the Pennsylvania Legislative Budget and Finance Committee, April 1992.

[102] Kiel, Joan M., "How State Policy Affects Rural Hospital Consortia: The Rural Health care Delivery System," *The Milbank Quarterly*, Vol. 71, No. 4, 1993.

[103] McGinley, Patrick John, "Beyond Health Care Reform: Reconsidering Certificate of Need Laws in a Managed Competition System," *Florida State University Law Review*, 1995.

[104] Kiel, Joan M., "How State Policy Affects Rural Hospital Consortia: The Rural Health care Delivery System," *The Milbank Quarterly*, Vol. 71, No. 4, 1993.

[105] Interviews with key informants in Ohio, Pennsylvania, and Wisconsin.

PROPOSED DESIGN FOR AN ECONOMIC STUDY

Chapter Three

A central theme of our analysis of the literature and study of selected states that have repealed CON is that responses to deregulation differ significantly from state to state. These variations may be due to differences in market structures, regulatory programs, or other factors. Therefore, the experiences of other states cannot directly or clearly tell us how the health care system in Washington State would respond to CON repeal.

HPAP was asked to design an economic analysis that would help policymakers better understand what might occur in Washington if the CON program were fully or partially repealed. This section describes the benefits and scope of the study, presents three optional designs and corresponding costs, and discusses study limitations.

BENEFITS AND SCOPE

The proposed economic analysis would build on the findings of this CON study by (1) estimating the effects of deregulation in Washington State on the supply and price of services and (2) simulating the effects of deregulation on the operating margins of service providers in Washington State.

Study would estimate economic impacts of deregulation on 3 services

We propose that the economic analysis focus on three service sectors that were included in the CON study: ambulatory surgery, kidney disease treatment, and home health. Taken together, these three services represent a wide variety of patients, levels of specialty, payment sources, and market structures. Therefore, we think an analysis of the economic effects of repealing CON for

these services will provide lessons that may be applicable to many other services.

OPTIONAL STUDY DESIGNS AND COSTS

Three options for study . . .

We developed three design options for analyzing the economic effects of CON repeal in Washington State. Each option would require approximately 12 months to complete and would include all three services (ambulatory surgery, kidney disease treatment, and home health). **The scope and costs of the options would vary according to the number of questions to be answered – and, thus, what data are required and what data analyses are performed**. Cost differences are primarily due to the costs of analyzing the various data sets involved in answering each question.

Low Option [$200,000]

1. How many new suppliers would enter the market?
2. Would service volume (utilization) change for existing service providers?
3. Do new providers have lower costs?
4. What effect would increased competition have on operating margins and financial stability of existing providers?

. . . scope of review governs total cost

Benefits from the low option: An understanding of the nature of new competition and its effect on the financial well-being of providers.

Medium Option [$250,000]

The medium option would answer the same questions as the low option, with the following additional questions.

1. Would unit prices change?
2. What effect would increased competition have on fixed and variable costs of new and existing providers?

Additional benefits from the medium option: A more detailed analysis of the new competitive market and of the ability of providers to serve their communities.

High Option [$300,000]

The high option would answer the same questions as the low and medium options, with the following additional questions.

1. What would the characteristics of new market entrants be?
2. What effect would increased competition have on operating margins and financial stability of existing providers?
3. Would total expenditures, out-of-pocket spending, and the costs of regulation change?

Additional benefits from the high option: The most in-depth picture of the deregulated market; the ability of providers to offer charity care, serve at-risk populations, and provide specialized services; and, the effects of deregulation on payers and consumers.

LIMITATIONS

An economic analysis of CON repeal cannot answer all questions. In fact, such a study can directly help us understand only some of the many effects of deregulation—economic and financial effects—and we can only infer how these impacts might affect quality, access, and charity care. In addition, since Washington has not repealed CON, we cannot study the actual effects of deregulation on health care markets in this state. Therefore, the proposed analysis must develop assumptions based on experiences in other states with similar health care markets and policy environments, and must simulate how markets and providers in Washington would react if CON is repealed.

Another limitation of the proposed economic study is the availability and cost of useful data for the three services. Standardized national cost and utilization data for home health and kidney dialysis are readily available from the federal Health Care Financing Administration, since both types of services are certified and largely paid for by Medicare. Similar data for ambulatory surgery are not available, because such surgeries are performed by many different types of providers (e.g., hospitals, physicians, freestanding clinics) and paid for by many different public and private programs. For simulating the responses of

providers in Washington State, proprietary data may be required; our ability to obtain such data is not known with certainty. In cases where useful data are not available, the study would have to rely on the views and projections of experts.

SCOPE AND OBJECTIVES

Appendix 1

SCOPE

Pursuant to the 1998 Supplemental Appropriations Act, (ESSB 6108, sec. 103), the Joint Legislative Audit and Review Committee (JLARC) will study the Certificate of Need (CON) program under Chapter 70.38 RCW. The study will examine the effects of the program on the cost, quality, and accessibility of various health services and the possible effect of repealing the program for those services.

OBJECTIVES

- Examine the effect of CON on the cost, quality, and accessibility of: (a) hospital, (b) ambulatory surgical, (c) home health, (d) hospice, and (e) kidney disease treatment services.

- Examine the effect that a repeal of CON for these services would have on their cost, quality, and accessibility.

- Examine the effect that such a repeal would have on access to charity care and to health facilities and services in rural areas.

- Design a study that would examine economic and other effects that a repeal of CON would have on the cost, quality, and accessibility of these services.

AGENCY RESPONSES

Appendix 2

Comments were solicited from the Department of Health and the Office of Financial Management. Their written comments are included in this appendix.

Agencies and organizations represented by advisory group members also provided written comments, which are included in this appendix. Submitting comments were:

- Children's Hospital & Regional Medical Center
- Home Care Association of Washington
- Washington State Hospice Organization
- Washington State Hospital Association
- Washington State Medical Association

Changes were made in the final report in response to these and other comments. In general, additional background information was provided on the CON program and the characteristics on Washington's health care system. For example, a table was added in Chapter 1 comparing Washington with the U.S. on various indicators of health care use and costs, and rates of HMO penetration and insurance coverage. Two charts were added to Chapter 1 describing the volume of CON activity over time and trends in the relative proportion of hospital and non-hospital services.

In addition to these changes, Chapter 2 was expanded to include discussion sections that elaborated on the findings.

To link to this appendix, click here.

STUDY MANDATE

Appendix 3

As defined in ESSB 6108, the purposes of the project are to study:

(a) The effect of the CON program under RCW 70.38 on the cost, quality, and availability of hospital, ambulatory surgery, home health, hospice, and kidney disease treatment services; and

(b) The effect the repeal of the program would have on the cost, quality, and availability of any of these services, and on the availability of charity care and of health facilities and services in rural areas, including the experience of other states where such programs have been fully or partially repealed.

BIBLIOGRAPHY

Appendix 4

- ***Journal Articles and General Reports:***

The Advisory Board Committee, "Effects of the Deregulation of Certificate of Need (CON) Requirements," November 1996.

Berliner, Howard S., Sc.D., and Joanne Fucello, M.S.W., "The Relationship Between Certificate of Need, Long-term Care, and Medicaid Expenditures: A National Analysis," The Center for Metropolitan Area Health Policy Studies, New School for Social Research, November 1995.

Brown, Lawrence D., "Common Sense Meets Implementation: Certificate-of-Need Regulation in the States," *Journal of Health Politics, Policy, and Law*, Vol. 8, No. 3, Fall 1983.

Campbell, Eaton, "Antitrust and Certificate of Need: A Doubtful Prognosis," *Iowa Law Review*, Vol. 69 No. 5, 1984.

Campbell, Ellen S., and Gary M. Fournier, "Certificate-of-Need Deregulation and Indigent Hospital Care," *Journal of Health Politics, Policy, and Law*, Vol. 18, No. 4, Winter 1993.

Campbell, Helen S., and Melissa W. Ahern, "Have Procompetitive Change Altered Hospital Provision of Indigent Care," *Health Economics*, Vol. 2, 1993.

Christakis, Nicholas A., M.D., M.P.H., and Jose Escarce, M.D., "Survival of Medicare Patients After Enrollment in Hospice Programs," *New England Journal of Medicine*, July 18, 1996.

Cleary, Paul D., Mark Schlesinger, and David Blumenthal, "Factors Affecting the Availability and Use of Hemodialysis Facilities," *Health Care Financing Review*, Vol. 13, No. 2, Winter 1991.

Codner, Sandra, "Certificate of Need Laws: Still Alive and Costing," Matthew Bender and Co., Inc., Publication No. 349, March 1994.

Cohen, Joel W., and William D. Spector, "the Effect of Medicaid Reimbursement on Quality of Care in Nursing Homes," *Journal of Health Economics*, Vol. 15, 1996.

Conover, Christopher, and Frank A. Sloan, "Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?", *Journal of Health Politics, Policy, and Law*, Vol. 23, No. 3, June 1998.

Conover, Christopher, and Frank A. Sloan, "Does Certificate of Need Constrain Long-Term Care Spending?," Undated Mss.

Custer, William S., Ph.D., "Certificate of Need Regulation and the Health Care Delivery System," Center for Risk Management and Insurance Research, Georgia State University, February 1997.

Deemez, James A., David W. Windus, and the St. Louis Nephrology group, "Hemodialysis Prescription and Delivery in a Metropolitan Community," *Kidney International*, Vol. 41, 1992.

Donahue, John X., Donald C. Williams, William J. Waters, and Barbara A. DeBuono, "Affordability Considerations in Certificate-of-Need Hospital Capital Expenditures Review Determinations," *Rhode Island Medicine*, August 1992, Vol. 75.

DuNah, Richard Jr., Charlene Harrington, Ph.D., Barbara Bedney, M.S.W., and Helen Carillo, M.S., "Variations and Trends in State Nursing Facility Capacity," *Health Care Financing Review*, Vol. 17. No. 1, Fall 1995.

Easton, John, "Underuse of Hospice Care Hurts Patients, Wastes Money," press release, University of Chicago, undated.

Eli's Home Health Care Report, "Certificate of Need: Republican Legislatures Attempting CON Roll-Back," Vol. IV, 1995.

Everton, Angus R., "Health Resources Planning Commission regulation of Ambulatory Surgical Care," *Maryland Medical Journal*, February 1995.

Friedman, Eli A., M.D., "End-Stage Renal Disease Therapy: An American Success Story," *JAMA*, Vol. 275, No. 14, April 10, 1996.

Garella, S., "The Costs of Dialysis in the USA," *Nephrology Dialysis Transplantation*, 1997, No. 12, Supplement 1.

Garrison, Louis P. Jr., "Assessment of the Effectiveness of Supply-Side Cost Containment Measures," *Health Care Financing Review*, 1991 Annual Supplement.

General Accounting Office, "Medicaid and Nursing Home Care: Cost Increases and the Need for Services," report to the Chair of the Subcommittee on Health and the Environment, October 31, 1983.

Griffiths, Robert I., Neil R. Powe, Darrell J. Gaskin, Gerard F. Anderson, Gregory V. de Lissovoy, and Paul K. Whelton, "The Production of Dialysis by For-Profit versus Not-For-Profit Freestanding Renal Dialysis Facilities," *Health Services Research*, Volume 29 No. 4, October 1994.

Gross, Benjamin, "Certificate of Need: Background and Review of Recent Changes in Florida's Law," *University of Florida Journal of Law and Public Policy*, No. 2, 1988.

Haas Erwin J., MD, FACP, "Certificate of Need Laws Increase Medical Care Costs," letter to the editor, *Michigan Medicine*, March 1993.

Hackey, Robert B., "New Wine in Old Bottles" Certificate of Need Enters the 1990s," *Journal of Health Politics, Policy, and Law*, Vol. 18, No. 4, Winter 1993.

Hamilton, Reed, "Barriers to Hospital Diversification: The Regulatory Environment," *Duquesne Law Review*, Volume 24 No. 2, 1985.

Harrington, Charlene, Ph.D., James H. Swan, Ph.D., John A. Nyman Ph.D., and Helen Carillo, M.S., "The Effect of Certificate of Need and Moratoria Policy on Change in Nursing Home Beds in the United States," *Medical Care*, Vol. 35, No. 6., 1997.

Harrington, Charlene, Ph.D., Michael Curtis, C. Phil., Helen Carillo, M.S., Barbara Bedney, C.Phil., James H. Swan, Ph.D., and John A. Nyman, Ph.D., "State Regulation of the Supply of Long Term Care providers," Department of Social and Behavioral Sciences, University of California, San Francisco, August 1996.

Harrington, Charlene, Ph.D., Richard DuNah Jr., M.A., and Michael Curtis, B.A., "Trends in State Regulation of the Supply of Long Term Care Services," December 1994.

Havighurst, Clark C., *Deregulating the Health Care Industry: Planning for Competition*, Ballinger Publishing Company, Cambridge, Massachusetts, 1982.

Health Care Alabama, "Pros and CONS: Is There Still a Need for Certificate of Need?," *Healthcare Alabama*, May/June 1992.

Health Policy Analysis Program, University of Washington, "Health Services Volumes Project," Final Report to the State Health Coordinating Council and Office of State Health Planning, Department of Social and Health Services, June 30, 1989.

Held, Philip J, Frederick K. Port, Robert A. Wolfe, David D. Stannard, Caitlin E. Carroll, John T. Daugirdas, Wendy E. Bloembergen, Joel W. Greer, Raymond M. Hakim, "The Dose of Hemodialysis and Patient Mortality," *Kidney International*, Vol. 50, 1996.

Hirth, Richard A., "Competition Between For-Profit and Non-Profit Health Care Providers: Can it Help Achieve Social Goals?" *Medical Care Research and Review*, Vol. 54, No. 4, December 1997.

Home Care Association of Washington, "Survey of the States Regarding Certificate of Need," July 1996.

Hudson, Terese, "State Laws: A Stumbling Block for Systems Integration," *Hospitals and Health Networks*, April 20, 1994.

Irvin, Renee A., "Does Quality Differ by Ownership Form in Health Care?" draft mss., December 12, 1997.

Irvin, Renee A., "Quality of Care Differences by Ownership Form: Implications for Cost Efficiency Studies," draft prepared for the American Society for Artificial Internal Organs annual conference, April 1998.

James, A. Everette, Seymour Perry, Susan E. Warner, John E. Chapman, Richard M. Zaner, "The Diffusion of Medical Technology: Free Enterprise and Regulatory Models in the U.S.A.," *Journal of Medical Ethics*, No. 17, 1991.

James, A. Everette Jr. Frank Sloan, James Blumstein, Alan C. Winfield, and Henry Pendergrass, "Research Note: Certificate-of-Need in an Antitrust Context," *Journal of Health Politics, Policy, and Law*, Vol. 8 No. 2, Summer 1983.

Jee, Melissa, "Certificate-of-Need Laws Back in Style Again," *Journal of American Health Policy*, March/April 1993.

Katzman, Mitchell, "Freestanding Emergency Centers: Regulation and Reimbursement," *American Journal of Law and Medicine*, Vol. 11, No. 1, 1985.

Kendix, Michael, Ph.D., "Dialysis Modality Selection among Patients Attending Freestanding Dialysis Facilities," *Health care Financing Review*, Vol. 18, No. 4, Summer 1997.

Kendix, Michael, "Provision of Home Dialysis by Freestanding Renal Dialysis Facilities," *Health Care Financing Review*, Vol. 17, No. 2, Winter 1995.

Kiel, Joan M., "How State Policy Affects Rural Hospital Consortia: The Rural Health Care Delivery System," *The Milbank Quarterly*, Vol. 71, No. 4, 1993.

Kuttner, Robert, "Columbia/HCA and the Resurgence of the For-Profit Hospital Business," Special Report, *New England Journal of Medicine*, August 1, 1996 [part one].

Kuttner, Robert, "Columbia/HCA and the Resurgence of the For-Profit Hospital Business," Special Report, *New England Journal of Medicine*, August 8, 1996 [part two].

Ladd and Associates, "Long-Term Care in Alaska: Recommendations for Reform," Austin, Texas, Ladd and Associates, March 1996.

Lanning, Joyce A., Michael E. Morrisey, Robert L. Ohsfeldt, "Endogeneous Hospital Regulation and Its Effects on Hospital and Non-Hospital Expenditures," *Journal of Regulatory Economics*, Vol. 3:137-154, 1991.

Leeds, Helen S., "Certificate of Need: Up for Revision," *Health Systems Review*, January/February 1996.

Lewin-VHI, Inc., "An Analysis of the Cost Savings of the Medicare Hospice Benefit," May 2, 1995.

Luft, Harold S., Deborah W. Garnick, David H. Mark, and Stephen J. McPhee, *Hospital Volume, Physician Volume, and Patient Outcomes: Assessing the Evidence*, Ann Arbor, MI, Health Administration Press, 1990.

Lynk, William J., "Antitrust Analysis and Hospital Certificate-of-Need Policy," *Antitrust Bulletin*, Spring 1987.

McFall, Dennis N., "Utah Providers Hurting from Unchecked Growth," *Provider*, December 1987.

McGinley, Patrick John, "Beyond Health Care Reform: Reconsidering Certificate of Need Laws in a Managed Competition System," *Florida State University Law Review*, 1995.

Mendelson, Daniel M., and Judith Arnold, "Certificate of Need Revisited," *Spectrum*, Winter 1993.

Morrisey, Michael A., Ph.D., "State Health Care Reform: Protecting the Provider," unpublished paper, August 22, 1997.

National Hospice Organization, "New Study Shows Hospice Benefits Save Medicare Money," undated.

National Association for Home Health Care, "State Licensure and Certificate of Need Survey," September 1995.

Pallarito, Karen, "States Targeting CON Laws, But Few Changes Expected," *Modern Healthcare*, May 1, 1995.

Protective Payment Assessment Coalition, "Report and Recommendations to the Congress," Chicago, Commerce Clearing House, Inc., March 1, 1996.

Rettig, Richard A., Ph.D., "The Social Contract and the Treatment of Permanent Kidney Failure," *JAMA*, Vol. 275, No. 14, April 10, 1996.

Salkever, D.S., and T.W. Bice, "Certificate of Need Legislation and Hospital Costs," in *Hospital Cost Containment*, M. Zubkoff, I.E. Raskin, and R.S. Hanft, eds., New York City, Prodist, 1978.

Swan, James H., Ph.D., Charlene Harrington, Ph.D., Leslie Grant, Ph.D., John Luehrs, Ph.D., and Steve Preston, "Trends in Medicaid Nursing Home Reimbursement, 1978-89," *Health Care Financing Review*, Vol. 14, No. 4, Summer 1993.

Swan, James, Ph.D., and Charlene Harrington, Ph.D., "Certificate of Need and Nursing Home Bed Capacity in States," *Journal of Health and Social Policy*, Vol. 2 No. 2, 1990.

Thamer, Mae, Ph.D., Nancy F. Ray, M.S., Christian Richard, M.S., Joel W. Greer, Ph.D., Brian C. Pearson, and Dennis Cotter, M.E., "Excluded From Universal Coverage: ESRD Patients Not Covered by Medicare," *Health Care Financing Review*, Vol. 17, No. 2, Winter 1995.

Tierney, John M., William J. Waters, and Donald C. Williams, "Controlling Physical Oversupply Through Certificate of Need," *American Journal of Law and Medicine*, Vol. 6, No. 3, 1980.

Weaver, Judith A., "Certificate of Need: What Role Does it Have in a Managed Care Environment?" in Ellis G. Gosfield, ed., *Health Law Handbook*, 1995, pp. 409-429.

Weissman, Joel, Ph.D., "Uncompensated Hospital Care: Will it be There If We Need It?," *JAMA*, Vol. 276, No. 10, September 11, 1996.

Woolhandler, Steffie, M.D., M.P.H. and David U. Himmelstein, M.D., "Costs of Care and Administration at For-Profit and Other Hospitals in the United States, *New England Journal of Medicine*, March 13, 1997.

- ***General Washington State Studies:***

Health Policy Analysis Program, University of Washington, "Certificate of Need: An Assessment of Current Programs and Policy Issues," Health Policy Analysis Program, March 1978.

Health Policy Analysis Program, University of Washington, "Certificate of Need in Washington: An Examination of Federal Requirements and State Options for Change," Health Policy Analysis Program, October 1975.

Washington State Department of Health, "Charity Care in Washington Hospitals," Washington State Department of Health, Office of Hospital and Patient Data Systems, March 1997.

Washington State Department of Social and Health Services, Aging and Adult Services Administration, 'Program Summary and Service Description," January 1996.

- ***Studies/Articles on Other States:***

Arnold, Judith and Daniel Mendelson, "Evaluation of the Pennsylvania Certificate of Need Program," submitted to the Pennsylvania Legislative Budget and Finance Committee, April 1992.

Arnold, Judith and Daniel Mendelson, "Appendix I: Econometric Analysis of CON in Pennsylvania," submitted to the Pennsylvania Legislative Budget and Finance Committee, April 1992.

Associated Home Health Industries of Florida, memo on Certificate of Need for Medicare Home Health Agencies, "AHHIF Plan to Present the Issue to Our Legislators," June 29, 1994.

Associated Home Health Industries of Florida, "Medicare Home Health Certificate of Need," position paper, undated.

Brown, Eric, J. Douglas Smith, and Jody Sindelar, "Can We Regulate the Quality of Care?: The Case of Dialysis in Connecticut," *American Journal of Kidney Diseases,* Vol. XIX, No. 6, 1992.

Delaware Health Care Commission, "Evaluation of Certificate of Need and Other Health Planning Mechanisms," Volume I, Final Report, May 1996.

Delaware Health Care Commission, "Evaluation of Certificate of Need and Other Health Planning Mechanisms," Volume II, Technical Appendices, May 1996.

Indiana State Board of Health, "Evaluation of Certificate of Need Program in Indiana," Indiana State Board of Health, August 1991.

Lewin/ICF and Alpha Center, "Evaluation of the Ohio Certificate of Need Program," Executive Summary, June 28, 1991.

Lewin-VHI Inc., Barbara B. Manard, Sally J. Kaplan, Alison Keillor, and Rosemary Camerson, "The Georgia Certificate of Need Program," December 1995.

May, Troy, "Hospital Group Wants Building Moratorium," *Business N*ews, December 15, 1997.

McFall, Dennis N., "Utah Providers Hurting From Unchecked Growth," *Provider*, December 1987.

McKay, Jim, "Pennsylvania Lawmakers Undermine Health-Care Cost Containment Program," *Pittsburgh Post-Gazette*, Nov. 28, 1996.

Medical Society of New Jersey, "Health Access New Jersey," Position of the Medical Society of New Jersey, Vol. 87, Number 10, October 1990.

Miller, Andy, "Health Care Key Topic for Georgia Legislature," *Atlanta Journal and Constitution*, January 13, 1997.

National Association for Home Care, "State Licensure and Certificate of Need Survey, September 1995," National Association for Home Care, 1995.

Niehaus, John, "Hospitals Feeling CON's Demise," *Business News*, June 2, 1997.

Parker, Hudson, Rainer and Dobbs, and Jennings Ryan and Kolb, "Comparison of Community-Owned Not-for-Profit Hospitals and Columbia/HCA Facilities in Six Florida Markets," Based on data reported to the Florida Agency for Health Care Administration, 1997.

Pennsylvania Legislative Budget and Finance Committee, "Review of the Certificate of Need Program," Legislative Budget and Finance Committee, Harrisburg, November 1996.

Pennsylvania Society of Physicians, "1991-92 in Review: Physicians, Lobbyists Work for Good of All," *Pennsylvania Medicine*, January 1993.

Rettig, Richard A., Ph.D., "Dialysis in Connecticut," *American Journal of Kidney Diseases*, Vol. XIX, No. 6, June 1992.

Tennessee Association for Home Care, "Position Statement on Certificates of Need," TAHC Regulatory and Legislative Update, January 5, 1992.

Urban Health Care Coalition of Pennsylvania, letter from Paul Boehringer, Chairman, COM Subcommittee, to James Jordan, Deputy Secretary, Pennsylvania Department of Health.

Utah Health Systems Agency, "Status of Development Under Deregulation," Report to Utah State Legislature Health Interim Committee, November 19, 1986.

Zeik, Michael, "What Physicians Need to Know; New State CON Law," *Pennsylvania Medicine*, March 1993.

- ***Advocacy Pieces, Washington State:***

Home Care Association of Washington, memo to members and board of Washington State Medical Association on Home Health and Hospice Services in Washington State, April 10, 1998.

Home Health Care Association of Washington, "The Facts on Certificate of Need for Home Health and Hospice."

Home Health Care Association of Washington, "Retain Certificate of Need for Home Health and Hospice," October 25, 1998.

Group Health Cooperative, "Reasons to Repeal Certificate of Need for Outpatient Dialysis Centers," October 31, 1997.

Marsh, Peter, "A Certificate to Fleece Health Consumers," *Seattle Times*, February 25, 1998.

Northwest Kidney Centers, copy of questionnaires and survey analysis, September 1996.

Washington State Hospital Association, "Briefing Certificate of Need," Washington State Hospital Association, August 1997.

Washington State Medical Association, memo from Cliff Webster to members of the Washington State Senate, March 24, 1997, with attached letters.

Washington State Not-for-Profit Dialysis Providers, Legislative Action Core Group.

- ***News Clips:***

Ad Hoc Committee to Defend Health Care, "For Our Patients, Not For Profits: A Call to action," *JAMA*, December 3, 1997, Vol. 278, No. 21.

Greene, Jay, 'Ga. Report Stirs the Pot on Charity Care Debate," *Modern Healthcare*, June 24, 1996.

Greene, Jay, "Ga. Not-for-Profits Win CON Battle," *Modern Healthcare*, March 25, 1996.

Hensley, Scott, "The Ghost of CON," *Modern Healthcare*, February 17, 1997.

Hudson, Terese, "Make No Little Plans," *Hospitals and Health Networks*, May 5, 1996.

Japsen, Bruce, "Ownership Counts, VHA Study Says," *Modern Healthcare*, November 24, 1997.

Moore, Duncan J. Jr., "CON Survival Struggle; Gone in Many States but Not Dead Yet," *Modern Healthcare*," August 11, 1997.

Moore, J. Duncan, "Is JAMA Playing Politics? Plan to Publish Attack on Profits Anger Managed Care Execs," *Modern Healthcare*, December 1, 1997.

Morrissey, John, 'Conditional Approval; Mass. Activists Win Changes in Hospitals Consolidation," *Modern Healthcare*, May 11, 1998.

Neurath, Peter, "Kidney Centers Rekindle Certification Debate," *Puget Sound Business Journal*, December 1, 1997.

Neurath, Peter, "Home Health Care Biz Reels from Cuts," *Puget Sound Business Journal*, September 21, 1998.

Pallarito, Karen, "N.J. Drops Most CON Reviews," *Modern Healthcare*, July 6, 1998.

Preston, Jennifer, "States Ease Restrictions on Hospitals," *New York Times*, July 27, 1998.

Scott, Lisa, "Turnabout in Nebraska: State's Repeal of CON Law a Return to Open Market," *Modern Healthcare*, June 30, 1997.

Scott, Lisa, "Communities Strike Back: Residents Oppose Ceding Control to Outside Not-for-Profit Chains," *Modern Healthcare*, April 28, 1997.

Smith, Carol, "A Fight for Young Hearts; Competition Endangers Care System, Hospital Says," *Seattle Post-Intelligencer*.

Snow, Charlotte, "Miss. Rivalry Grows: Hospitals, Home Care Agencies at Odds Over State's CON Laws," *Modern Healthcare*, April 28, 1997.

State Health Notes, "CON and Managed Care: Can the Concepts Coexist?", *State Health Notes*, Intergovernmental Health Policy Project, George Washington University, March 31, 1997.