
EVALUATION OF THE PENNSYLVANIA CERTIFICATE OF NEED PROGRAM

Submitted to:

Pennsylvania Legislative Budget and Finance Committee

Submitted by:

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LEWIN-ICF

April 1992

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PERFORMANCE AUDIT

CERTIFICATE OF NEED PROGRAM

VOLUME I*

*A separately bound Volume II of this report contains technical appendices and is available upon request.

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To the Members of the General Assembly:

Under Act 1991-35, the Certificate of Need process is to expire on December 31, 1992, unless reauthorized by the General Assembly. Act 35 also required that the CON process undergo a review pursuant to the procedures set forth in the Sunset Act. An LB&FC performance audit is part of this review procedure.

To assist in this audit, the LB&FC engaged Lewin-ICF, a health and science research and consulting firm with experience in evaluating state CON programs. The Lewin-ICF report is included in Volume I of this two-volume report. Volume II is bound separately and contains Lewin-ICF's technical appendices. Both volumes are available by contacting the LB&FC offices.

Volume I also includes supplemental work done by LB&FC staff pertaining to public input and participation in the CON process, timeliness of CON application reviews, and the status of recommendations made in a 1987 LB&FC report on the CON program. This section, which includes several recommendations, is presented separately after the Lewin-ICF report.

We thank the management and staff of the Department of Health and the many health care providers and provider associations for the cooperation and assistance we received during this project. As with all LB&FC reports, the release of this report should not be construed as an indication that the members of the LB&FC necessarily concur with all the information and recommendations contained in the report.

The Secretary of Health's response to this report begins on page 119.

Sincerely,


Philip R. Durgin
Executive Director

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ACKNOWLEDGEMENTS

We would like to thank the many individuals and organizations who have provided insight into the role of Certificate of Need in Pennsylvania, including the Department of Health and a variety of providers in Pennsylvania. We also thank Philip Durgin, Bob Frymoyer, Maryann Nardone, and Christal Pike from the Legislative Budget and Finance Committee. Within Lewin-ICF, we received valuable guidance on this project from Dr. Robert Rubin, and research assistance from Jeffrey Furman and Jennifer Ryan.

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EXECUTIVE SUMMARY

Pennsylvania's Certificate of Need (CON) law, established under the Health Care Facilities Act of 1979 (P.L. 130, No. 48), is scheduled to expire on December 31, 1992 unless extended by statutory amendment. The Pennsylvania State Legislature will soon face the choice of whether to retain the current CON law, enact a changed version of CON, or allow it to expire. To assist the Legislature in this decision the Legislative Budget and Finance Committee (LB&FC) contracted with Lewin-ICF, a Washington-based health policy consulting firm, to assess the effectiveness of Pennsylvania's CON program, determine its strengths and weaknesses, and estimate the potential consequences of repeal. This review of the CON program was conducted pursuant to the procedure set forth in Act 1981-142, the Sunset Act.

Pennsylvania's CON law establishes a regulatory review process that requires certain health care organizations to obtain prior authorization for major capital expenditures, the purchase of some technological equipment, and the offering of new or expanded services. The law has jurisdiction over both acute care and long-term care facilities, including hospitals, freestanding ambulatory facilities, and nursing homes. Established as a mechanism for facilitating compliance with the State Health Plan, the Pennsylvania law was intended to moderate increase in health care costs, improve the distribution of services, and monitor the quality of care.

Our evaluation of the Pennsylvania CON program assesses the success of the program in promoting the Legislature's cost, quality, and access goals for both the acute and long-term care sectors. Based on our evaluation, we conclude that CON is currently serving many important roles for the Commonwealth, and recommend that it be retained in some form. There are, however, a number of program characteristics that should be changed in order to better address the Commonwealth's policy goals. Below, we present our assessment of the effectiveness of CON in Pennsylvania and the potential consequences of repeal for acute care and long-term care. We then detail our recommendations regarding the future of the CON program in Pennsylvania.

I. CON REGULATION OF ACUTE CARE

The CON program contained provisions that were designed to help control acute care costs; monitor and maintain the quality of services; and expand access to acute care services. We evaluated these program goals using:

- Comparison of costs and diffusion of services in Pennsylvania hospitals and those of facilities in other states under CON programs of varying stringency. For this purpose we used an extensive database and statistical techniques that allowed us to control for non-regulatory differences across states.
- Volume thresholds on the number of procedures anticipated by a facility that are set by the Department of Health (DOH) in the interest of maintaining quality, and data on the number of procedures actually carried out by hospitals after obtaining a CON.
- Description of program goals and administration, based on numerous interviews and site visits. This information is especially important in assessing quality and access goals for which quantitative data were not available.

The CON program succeeded in restricting the diffusion of a variety of acute care services in the Commonwealth. The program was not successful in controlling the rise in overall hospital costs, nor were CON programs in other states. The DOH does use the program to promote the quality of services, especially in cases where higher volume of services is associated with better outcomes. Access goals are emphasized to a lesser extent, and did not appear to be an important component of CON acute care regulation.

A repeal of CON in acute care would mean losing important programs designed to promote the quality of care. Based on the experience of states that have repealed CON, we would also anticipate an increase in the number of cardiac, psychiatric, and rehabilitation facilities. However, we have no empirical evidence that repeal of CON in Pennsylvania would result in an increase in total hospital costs, hospital capital costs, or the costs of technologic advance.

The effect of the program and the anticipated consequences of repeal vary substantially by acute care market area. Below, we discuss salient acute care areas regulated by CON.

A. Cardiac Services

CON successfully restrained the number of facilities offering cardiac catheterization facilities, although a loophole in the program allowed the proliferation of cardiac catheterization at those institutions that had been granted a CON. Nevertheless, we would expect to see an expansion of cardiac catheterization facilities if the law were repealed. Cardiac catheterization tends to be a profitable service, and is thus desired by those facilities currently not offering it. A repeal of CON would also make it difficult for DOH to address quality through the minimum volume standards required in order to obtain a CON.

The CON program also restricted the number of facilities performing open heart surgery, and the average number of cardiac intensive care beds per hospital below states with less stringent programs. Under repeal, we would expect to see some expansion of these service areas as well.

B. Organ Transplants

CON also constrained the number of hospitals performing organ transplants. The presence of such programs also varied by level of CON stringency: stringent programs had fewer facilities and states that repealed CON witnessed an expansion in such programs. Repeal would thus probably result in expansion of the number of hospitals carrying out such services, and would also make it more difficult for the state to achieve its quality goals, as articulated in the recently revised draft State Health Plan Chapter 42.

C. Ambulatory Surgery

Although CON controlled the proliferation of ambulatory surgery in hospitals somewhat, most hospitals had obtained such facilities by 1989. While we do not have comprehensive data on the number of freestanding ambulatory facilities in the state, many CON approvals were granted over the last decade. Some surgical procedures are also increasingly being carried out in physicians' offices. The spread of ambulatory facilities, both hospital-based and freestanding, was part of a conscious effort on the part of the DOH to increase competition. We lack adequate

data to predict the consequences of repeal in this area, however, it appears that a substantial amount of service diffusion has already occurred in the state.

D. Pediatric and Neonatal Intensive Care

CON did control the number of pediatric and neonatal intensive care beds in Pennsylvania hospitals. Our results also showed that diffusion of such services was greater in states that had repealed CON. However, it is important to note that such services are often not profitable for hospitals, especially for hospitals treating a disproportionate share of neonates that are born prematurely with substance abuse problems. We would thus expect some diffusion of pediatric and neonatal intensive care if CON were repealed, but probably not as much as would be expected in cardiac or cost-based reimbursed services.

E. Imaging Technologies

CON controlled the diffusion of MRI somewhat, although the effect of this constraint appears to have been small. The program did not restrain the diffusion of CT scanners, and in fact, recently dropped this service from the list of reviewable technologies. This change is reflective of the Department's conviction that restricting the availability of high-technology services may have anti-competitive effects. The Department has indicated, for example, that the cost of lithotripter services decreased dramatically after they were allowed to diffuse in the Western part of the state.

Control of technology poses difficult challenges for the CON program which should be addressed explicitly in the State Health Plan. The diffusion and operation of such technologies is highly consumptive of resources, and is responsible for a substantial portion of the rise in costs. Yet new technology also brings new clinical benefits that are demanded by patients. A detailed study of the Massachusetts CON program in the early 1980s indicated that restraints on the diffusion of new technology did reduce spending somewhat in Massachusetts, but also resulted in delays in the diffusion of needed therapies to patients. The State Health Plan process in Pennsylvania lends an appropriate forum for dealing with such issues.

F. Alcohol and Chemical Dependency

CON did control the number of alcohol and chemical dependency beds per hospital, and control in states with more stringent CON programs was more restrictive than that in Pennsylvania. Such services are generally profitable for hospitals, especially since the Medicare system reimburses hospitals on the basis of historical costs. If CON were repealed, we would expect substantial increases in service diffusion in this area.

G. Psychiatric Services

CON did not control the growth of hospital-based psychiatric services in either the inpatient or the outpatient setting. Cost-based reimbursement for Medicare patients and favorable reimbursement from commercial payors makes such services profitable for most hospitals. In addition, a number of for-profit psychiatric firms have expressed interest in increasing their presence in Pennsylvania. In the absence of any change in the CON program, or if CON were repealed, we would expect the proliferation of psychiatric services to continue.

H. Rehabilitation Services

Capacity to provide rehabilitation grew substantially over the study period, and would have expanded faster if CON had not been in place. Increased demand for rehabilitation is in part due to technologic advance and a number of new therapeutic uses. Hospitals have also sought to expand rehabilitation care services because of cost-based reimbursement through the Medicare program. Frequent changes in the usage of rehabilitation care, and the likelihood of changes in Medicare reimbursement suggest that the Department should review state goals and policies towards rehabilitation frequently.

II. CON REGULATION OF LONG-TERM CARE

Controlling the growth in long-term care beds has been a primary goal in Pennsylvania. Review of the bed need methodology and changes in total bed supply indicate that the program has restrained the growth in long-term care beds in the Commonwealth. This control is

especially important to the Commonwealth's budgetary concerns, since Medical Assistance pays for over 60 percent of patient days in nursing homes.

CON is also used as a tool to promote access to care for the medically underserved. DOH policy statements indicate that a facility must treat a "fair share" of medically underserved patients, and interviews indicate that this criterion is enforced in the review of applications. The DOH has also indicated a willingness to provide CONs to anyone wishing to develop long-term care services areas that are currently considered to be underserved, e.g., Philadelphia.

Repeal of the CON program would almost certainly result in a substantial increase in Commonwealth spending through the Medical Assistance program. Many developers have expressed interest in building long-term care facilities in areas that are currently considered over-bedded according to the new bed need methodology. These are typically areas in which there would be few low-income patients. Repeal would thus be likely to impede progress towards Commonwealth goals of encouraging construction of facilities in underserved areas. Increases in the number of beds would also result in increases in Medical Assistance spending on long-term care, despite the moratorium on payments for new capital in nursing homes.

III. RECOMMENDATIONS ON THE FUTURE OF CON*

Based on the results of this evaluation, we believe that CON serves many of the Commonwealth's goals, and its functions should be retained in some form in the near future. For long-term care, the CON program is an important component of state policy, controlling the expansion of long-term care beds. In acute care, the program controlled the proliferation of some services, however, these policies did not result in reductions in total hospital spending during the 1980s. CON also appears to have served an important role in promoting a number of access and quality goals in Pennsylvania.

*An asterisk following a specific recommendation indicates that a current legislative initiative, HB-1982, also addresses the issue. See text of report for more details on each recommendation.

While some legislators and health care providers have suggested that the CON program in Pennsylvania be repealed, we believe that sufficient economic discipline is not yet in place, and that repeal of CON would thus lead to many undesirable outcomes. At the same time, it is also important to recognize that while CON can help to address state goals of containing costs, promoting access and maintaining quality, the program cannot and should not be expected to independently achieve all of these goals: most importantly, CON cannot be expected to contain the rise in acute care costs.

The 1989 administrative changes to the CON program streamlined the process to focus on large capital expenditures, cost reimbursable services, and quality considerations. We believe that these changes improved the program substantially, but that a number of improvements are still warranted to better achieve the Commonwealth's goals. Below, we recommend a number of specific changes in the administration of the CON program, and the regulation of acute and long-term care services.

A. Administration and Operation of the CON Program

Many aspects of the CON program have been well-run in recent years, and the Department should strive to maintain these successes. The State Health Plan is conscientiously followed to make need determinations. There is good communication with health care providers. A prioritization process allows the Department to focus on those applications most central to Department goals. However, there are also a number of problems which hinder program effectiveness. Below we address these problems and propose solutions.

1. Alleviate Staffing Shortages and Reduce the Burden on the CON Program.*

Staffing shortages within the Division of Need Review (DNR) have led to long delays in the processing of CON applications. Our interviews with providers indicated that they recognized this problem and some, including the Pennsylvania Hospital Association, indicated a willingness to help fund additional program staff through CON application fees. The DOH has estimated that 4 additional staff are needed to conduct reviews, and 2 additional staff are needed in health

planning. In addition, the burden on reviewers could be reduced somewhat by reducing the scope of the CON program. Specifically, non-clinical services with expenditures below \$18 million could be made non-reviewable, and the rights to appeal a CON decision could be limited to applicants. Revenue to hire additional staff could be raised through a fee schedule for CON applications, as specified in HB-1982.

2. Improve the Process for Updating the State Health Plan*

The usefulness of the CON program depends critically on the quality of the State Health Plan chapter that is being used to determine whether a CON should be granted. These chapters are currently updated on an ad-hoc basis, and a better process is needed to identify chapters in need of revision. We recommend that the DOH annually review the State Health Plan, at which time it should identify the chapters that need revision, and establish a process for updating them. Revisions should be completed no later than one year thereafter.

3. Use CON as a Tool to Enforce Volume Standards

The Commonwealth currently has no mechanism for ensuring compliance with CON volume requirements (except for the recently-adopted cardiac catheterization requirements in the SHP). The expiration of CONs could be used to strengthen the Department's use of CON to promote quality of care. For example, if a provider failed to meet its volume standard after two years the CON could expire, and the need for the service could be reviewed. The types of CONs subject to the expiration provision would be determined by the Secretary of Health.

4. The CON Component of the Health Care Facilities Act Should Not Be Permitted to Sunset More Frequently Than Once Every Five Years*

In a number of states the CON law expires every two to three years. This frequent legislative review has led to a weakening of the program, an increase in legislative exception for specific facilities, and uncertainty among providers regarding the scope of CON review. Given the rapid changes in the health care system, however, the Commonwealth does need an ability to reassess the program periodically and to restructure it as other health system reforms are

adopted. We recommend that the program not sunset more frequently than once every five years.

B. Acute Care Sector Recommendations

A number of recommendations specific to the acute care sector emerge from our findings.

1. The CON Program, as Currently Structured, Should Not Be Expected to Contain the Rise in Acute Care Costs

Our results indicate that although the current CON program slowed the diffusion of selected services, CON did not slow the rise in total hospital costs in Pennsylvania or in other states. If the Legislature wishes to control the rise in acute care costs, options other than CON should be pursued e.g., stringent control of hospital and physician rates and or the promotion of economic discipline through increased market competition. In addition, the CON program could be re-structured as a cost containment tool that would sharply limit the diffusion of selected clinical services and technologies.

2. Limit the Ability of Hospitals to Expand Regulated Services Without CON Review

Under current law, hospitals that have obtained a CON for cardiac catheterization may increase their capacity without CON review if new expenditures do not exceed \$2 million. This provision allows the expansion of existing providers without allowing new market entrants the opportunity to provide services that the DOH has determined are needed. In addition, the DOH is unable to monitor the volume of procedures at additional labs in order to promote quality goals.

3. Eliminate the Ability of Providers to Increase Capacity by 10 Beds or 10 Percent Without CON Review*

The Pennsylvania CON law contains a provision allowing facilities to increase their capacity by 10 beds or 10 percent of total beds. Our analysis of this provision indicates that it allowed existing providers to expand their services substantially over time without being subject to CON review. If the Commonwealth believes that these services are needed, it should permit all providers to compete through CON review or eliminate CON for these services. Although we have no evidence that this action would reduce costs, it would serve to make the law more internally consistent.

4. Develop Consistent Policy on Cost-Based Reimbursed Services

A stated priority of DOH is the control of those services which remain under Medicare cost-based reimbursement (e.g., psychiatric services and rehabilitation). Despite DOH's disapproval of a number of CON applications in this area, analysis of hospital data indicate that Pennsylvania did not control diffusion of these services. The DOH should more precisely determine their goals with respect to these services, and revise policy to reflect the perceived need for these services.

5. Consider Proposals for a "Level Playing Field"*

We believe that the legislature should carefully consider implementing provisions designed to make regulation consistent across all providers. CON regulation often controls the provision of a service by one type of provider (typically hospitals), while allowing the service to proliferate among others (e.g., physician offices). Such statute does not enable the DOH to consistently control the proliferation of a service or to monitor quality. This issue is likely to continue to be highly important, since many new services resulting from technologic advance will be applicable in both the hospital and the physician office setting. We make no solid recommendation on the "level playing field" because we analyzed no data on the expansion of non-hospital services in the state.

C. Long-Term Care Sector Recommendations

The Commonwealth has used the CON program as one element of a coordinated plan to monitor and improve the provision of care to the aged, and the program has succeeded in controlling the number of nursing home beds. The CON program is also critical to controlling escalating Medical Assistance expenditures. Our recommendations specific to the long-term care sector follow.

1. Eliminate the "10 Bed 10 Percent Rule" for Long-Term Care*

Under current law, nursing home providers have the ability to increase bed capacity by the lesser of 10 beds or 10 percent of facility capacity over a two year period without obtaining a CON. We recommend that this provision be eliminated since permitting expansion in counties that have an excess supply of beds is counter to Commonwealth goals of reducing Medical Assistance expenditures and encouraging the development of community-based services.

2. Use CON to Encourage Community-Based Services

Pennsylvania has indicated that one of its central goals in caring for the aged is to reduce the institutional bias towards providing nursing home services at the expense of community-based care. CON should be used to reinforce other efforts to encourage community-based services. For example, in cases where bed need exists, preference for CON approval could be given to providers who plan to offer community-based services, such as adult day care centers, respite care, and support services for caregivers.

EVALUATION OF THE PENNSYLVANIA CERTIFICATE OF NEED PROGRAM

An increasing number of states are re-examining their Certificate of Need (CON) programs as concerns about health care cost containment have become major public policy priorities. In 1991 the Pennsylvania General Assembly created a sunset provision of the 1979 Health Care Facilities Act (P.L. 130, No. 48) requiring that the CON program expire on December 31, 1992 unless extended by statutory amendment. This legislative action requires a sunset performance audit to be performed by the Legislative Budget and Finance Committee (LB&FC). The LB&FC contracted with Lewin-ICF, a Washington, D.C. health policy consulting firm, to assist in conducting specific aspects of the evaluation. This report represents the findings of Lewin-ICF and will be incorporated into the report prepared by LB&FC.

I. INTRODUCTION

This section presents the evaluation questions to be addressed by Lewin-ICF and an overview of the organization of the report.

A. Evaluation Questions

In order to assess the performance of the CON program, the evaluation will answer two major questions:

- What has been the effectiveness of the Pennsylvania CON program in controlling costs, maintaining access, and ensuring quality?
- What are the potential consequences of repealing CON in Pennsylvania?

We will answer these questions through three evaluation techniques: (1) analysis of CON program data and documentation; (2) interviews with state officials, providers, and other interested parties; and (3) econometric analysis.

B. Scope of this Report

The report assesses the administration of the CON program, examines its effectiveness in controlling costs and maintaining access and quality, and presents recommendations for the future of the program. The remainder of the report is organized into five sections:

- Administration and Operation of the CON Program
- Effectiveness of CON in Controlling Costs and Diffusion of Services
- Role of the CON Program in Advancing Access and Quality
- Potential Consequences of Repeal
- Recommendations

Appendix I presents the detailed results of the econometric analysis for acute care services.

II. ADMINISTRATION AND OPERATION OF THE CON PROGRAM

The Commonwealth of Pennsylvania faces the critical challenge of moderating rising health care costs and promoting access to care for its citizens without compromising quality of care. While the legislature, the Administration, business, providers, and consumers generally agree on encouraging the broad goals of cost containment, access, and quality, the priorities among these goals and the mechanisms for achieving them have been, and continue to be, subject to considerable debate.

CON is one mechanism designed to play a role in promoting these state goals. CON is a regulatory review process that requires certain health care organizations (e.g., hospitals, nursing homes, and certain types of free-standing health care entities) to obtain prior authorization from the state for major capital expenditures, the purchase of some high technology equipment, and the offering of new or expanded services. Established as a mechanism for facilitating compliance with state health plans, CON was intended to moderate increases in health care costs by limiting the expansion of facilities and services and to improve the distribution of health care services.

This section presents a brief overview of the CON program. It also details the structure and administration of the program in Pennsylvania compared to other states.

A. Overview of the CON Program

Pennsylvania enacted the CON program in 1979 to "enhance the orderly and economic distribution of health care resources, and to prevent needless duplication of services, make the delivery system responsive and adequate to meet the needs, and to assure that new health services are efficiently and effectively used." Another impetus for enactment was to prevent the loss of federal funds under the National Health Planning and Resource Development Act of 1974. Effectively mandated upon the states due to powerful financial incentives, CON in Pennsylvania was not a stringent program. Although it has not been modified by the legislature since its inception, it has undergone numerous administrative changes. The types of facilities and services subject to review has changed, the dollar thresholds for capital expenditures have increased, and the Health System Agencies (HSAs) have been essentially eliminated.² It has also evolved to promote access and quality considerations in both acute and long-term care.

The CON program in Pennsylvania regulates the development of new acute and long-term care facilities and large capital expenditures, as well as some acute care service expansion and selected medical technology purchases. The State Health Plan is used as a basis for CON program policy. The CON program performs three types of reviews: (1) full reviews, (2) non-substantive reviews, and (3) administrative reviews. Almost all activities to be undertaken by a health care facility fall into one of these three categories. Among those technologies and service expansions not subject to review are CT scanners, additional services for which the hospital obtained a CON (e.g., cardiac catheterization labs with capital expenditures below the threshold), and the addition of the lesser of 10 beds or 10 percent of bed capacity within a two year period. Exhibit 2.1 presents the scope of the current CON program by each of these review categories.

² Only one HSA still remains near New York state and is supported by the New York CON program.

Exhibit 2.1
PURVIEW OF THE PENNSYLVANIA CON PROGRAM

REVIEWABLE ACTIVITY/SERVICE

- Establishment/development/construction of a new health care facility
- Any change in service not provided by the facility in the prior 12 months
- Any change in capacity by more than 10 beds or 10 percent of total bed capacity, whichever is less, over a 2 year period.
- Services subject to review without regard to cost such as:
 - Medical/surgical services
 - Rehabilitation
 - Psychiatric services
 - Long-term care services
 - Organ transplantation
 - PET scanner
 - Cardiac catheterization
 - Open heart surgery
 - Ambulatory surgery
 - Lithotripter
 - Magnetic resonance imaging

FULL REVIEW

- Capital expenditures >\$2,000,000
- New medical equipment > \$2,000,000 for health care facilities and \$400,000 for non-health care facilities.
- New service operation > \$316,873

NON-SUBSTANTIVE REVIEW

- Capital expenditures <\$2,000,000*
- Replacement of previously approved equipment
- Renovations to meet code requirements which do not expand capacity
- Addition of a new health service if the annual operating expense is <\$316,873
- Non-clinical projects >\$18,000,000 (e.g., parking, telephone)
- Refinancing

ADMINISTRATIVE REVIEW

- Non-clinical projects >\$2,000,000 but <\$18,000,000

Source: Compilation from Certificate of Need Regulations and Memorandums, and Interviews with Department of Health Staff.

- * This Figure reflects regulatory language. However, a subsequent CON memorandum does not require review of capital expenditures less than \$2,000,000.

Although not changed by statute, the CON program has undergone some modifications in Pennsylvania. Since the enactment of the Medicare Prospective Payment System, the stated goals of the General Assembly and the Department of Health (DOH) under Secretary Richards were to advance competition and market forces and to employ regulatory tools only in those cases in which the market is not exerting enough discipline on the health care system. Given these goals, the program was streamlined to focus on controlling large capital expenditures, cost reimbursable services, services in which quality of care has been demonstrated to improve with higher volume of services and services that use scarce resources, such as organ transplants. Program changes also raised the dollar thresholds for reviewing capital expenditures from \$760,495 to \$2,000,000 in 1989. As thresholds increased, the list of services subject to review regardless of cost lengthened. This trend parallels CON activity in other states. Current efforts are underway to further streamline the program if it is continued.

Exhibit 2.2 presents the CON review thresholds for the 38 states with CON programs. Only six states (Hawaii, Massachusetts, Nevada, North Carolina, Ohio, and Tennessee) have capital expenditure thresholds at or above Pennsylvania's threshold. These higher thresholds are for full CON reviews. Capital expenditures below \$2,000,000 must still submit a CON application and undergo a non-substantive review. In contrast to a number of other states that have eliminated CON review for most non-clinical services, Pennsylvania has streamlined the review to include non-substantive and administrative reviews. In order to judge the stringency of CON programs, the thresholds should be examined in conjunction with the list of reviewable services regardless of cost. States can operate a stringent CON program with high thresholds if careful consideration guides the selection of services subject to review regardless of cost.

B. The CON Review Process

The CON Review process is operated by the DOH, which has responsibility for: (1) developing the review criteria; (2) establishing whether the project is reviewable and the level of review required; and (3) reviewing the application and rendering the decision. Applicants can appeal the decision to the Secretary of Health and the State Health Facility Hearing Board. The appeals may continue through the Commonwealth court, if necessary. Finally, the legislature also plays a role in the process of CON review, although direct legislative intervention is less

Exhibit 2.2: CON REVIEW THRESHOLDS

	<u>CAPITAL</u>	<u>EQUIPMENT</u>	<u>NEW SERVICE</u>
Alabama	\$1,500,000	\$ 500,000	Any
Alaska ¹	\$1,000,000	\$1,000,000	\$1,000,000
Arizona			
Arkansas ²	Any LTC		Any LTC
California			
Colorado			
Connecticut	\$1,000,000	\$ 400,000	Any
Delaware ³	\$ 750,000	\$ 750,000	\$ 250,000 ⁴
Dist. of Columbia	\$ 600,000	\$ 400,000	\$ 250,000 ⁴
Florida ⁵	\$1,000,000	\$1,000,000	Any, with exemptions
Georgia ⁶	\$ 866,896	\$ 485,819	Specified services
Hawaii	\$4,000,000	\$1,000,000	Specified services
Idaho			
Illinois	\$2,000,000	\$1,000,000	Specified services
Indiana ⁷	Any LTC		Any LTC
Iowa	\$ 600,000	\$ 400,000	\$ 250,000 ⁸
Kansas			
Kentucky	\$1,500,000	\$1,500,000	\$ 600,000 for specified services
Louisiana ⁹			
Maine ¹⁰	\$1,000,000-Hosp \$ 500,000-LTC \$ 350,000-Other	\$1,000,000-Hosp \$ 300,000-LTC \$ 300,000-Other	\$ 155,000 ¹⁰
Maryland	\$1,250,000		Specified Services
Massachusetts ¹¹	\$7,500,000-Acute \$ 800,000-Other	Any-Acute \$ 400,000-Other	Specified Services
Michigan	\$ 750,000	\$ 750,000	\$ 750,000
Minnesota			
Mississippi	\$1,000,000	\$1,000,000	Specified Services
Missouri	\$ 600,000	\$ 400,000	Any ¹²
Montana ¹³	\$1,500,000	\$ 750,000	\$ 150,000 with exemptions
Nebraska	\$1,216,800	\$ 912,600	\$ 557,700/760,000 ¹⁴
Nevada ¹⁵	\$4,000,000	\$1,000,000	Specified Services
New Hampshire ¹⁶	\$1,000,000	\$ 400,000	Specified Services
New Jersey	\$ 600,000	\$ 400,000	Any
New Mexico			
New York ¹⁷	\$ 400,000	\$ 400,000	\$ 400,000
North Carolina	\$2,000,000	\$2,000,000	\$1,000,000 ⁴ plus specified services
North Dakota	\$ 750,000	\$ 500,000	\$ 300,000 ¹⁸
Ohio	\$2,000,000	\$1,000,000	\$ 750,000
Oklahoma ¹⁹	\$ 500,000		Any with beds
Oregon ²⁰	Variable	\$1,000,000	\$ 500,000
Pennsylvania	\$2,000,000	\$ 400,000	Any \$316,873 AOE, plus specified services
Rhode Island ²¹	\$ 600,000	\$ 400,000	\$ 250,000 ⁴
South Carolina	\$1,000,000	\$ 600,000	\$ 400,000 ²²
South Dakota			
Tennessee	\$2,000,000	\$2,000,000	Any with beds
Texas			
Utah			
Vermont	\$ 300,000	\$ 250,000	\$ 150,000 ⁴
Virginia	\$ 700,000	\$ 400,000	\$ 400,000 ²³ for specified services
Washington ²⁴	\$1,202,000		Specified Services
West Virginia	\$1,000,000	\$ 750,000	\$ 500,000 ⁴ plus specified services
Wisconsin ⁷	Any LTC		Any LTC
Wyoming			

Source: American Health Planning Association, July 25, 1990; updated by Alpha Center, November 1990, and Lewin-ICF, March 1992.

Exhibit 2.2: (FOOTNOTES)

- ¹Alaska reviews all expenditures relating to additions of a major type, unit, program, division or department of care for which the total of the associated annual operating costs and capital costs exceeds \$1,000,000.
- ²Arkansas replaced its CON program with a "permit of approval" program which reviews nursing homes, home health services and residential care facilities only.
- ³Delaware also reviews all new facilities and changes in bed capacity which increase or decrease the number of beds by more than ten or ten percent within a two-year period.
- ⁴Threshold refers to annual operating expenses.
- ⁵Florida also reviews all new facilities and changes in licensed bed capacity.
- ⁶Georgia also reviews any addition of beds.
- ⁷Indiana and Wisconsin review nursing homes only.
- ⁸Iowa reviews all new services for which the total of the associated capital and operating expenses exceeds \$250,000.
- ⁹Louisiana does not have a state CON statute, but withholds state Medicaid capital reimbursement from disapproved projects.
- ¹⁰Maine reviews new services with third year operating costs exceeding \$155,000.
- ¹¹Massachusetts uses different thresholds for acute and nonacute care facilities. Additional places of previously approved equipment may be added by a facility without CON review.
- ¹²Missouri reviews all new services for which the associated capital or equipment costs exceed designated thresholds.
- ¹³Montana no longer has coverage by type of facility. Rather, it reviews ambulatory surgery, home health, long term care, inpatient psychiatric and substance abuse treatment, rehabilitation, and personal care services.
- ¹⁴Nebraska reviews new services with annual operating expenses exceeding \$557,700 and substantial changes to existing services with annual operating expenses exceeding \$760,000.
- ¹⁵Nevada also reviews any addition of acute or long term care beds.
- ¹⁶New Hampshire conducts a full CON review of specified services regardless of cost of project, and an administrative review of certain other specified services regardless of cost.
- ¹⁷New York conducts an administrative review of expenditures between \$400,000 and \$4,000,000. New York conducts a full CON review of expenditures exceeding \$4,000,000, any addition of beds, expenditures exceeding one percent of the facility's annual operating budget, and specified services regardless of cost.
- ¹⁸North Dakota reviews any new or expanded services with annual operating expenditures exceeding \$300,000 that involve a capital expenditure of any amount.
- ¹⁹Oklahoma reviews only licensed nursing facilities and psychiatric or chemical dependency services, unit or facilities.
- ²⁰Oregon reviews capital expenditures of any amount for new hospitals and new hospital services with annual operating expenses in excess of \$500,000. All new long term care facilities or services which increase bed capacity by more than 10% or 10 beds, whichever is less, within a two-year period are also subject to review.
- ²¹Rhode Island also reviews all bed additions for inpatient care and all additions in the units of outpatient services (e.g., the number of patients that can participate in a substance abuse treatment program).
- ²²South Carolina also reviews new services for which there are criteria specified in the state health plan that do not involve a capital expenditure and which have annual operating costs exceeding \$400,000.
- ²³Virginia deregulated selected types of major medical equipment and certain clinical services in 1989. Deregulation of general hospitals and ambulatory surgery centers is set for July 1, 1991.
- ²⁴Washington reviews capital expenditures exceeding \$1,202,000 for nursing homes only. Washington also reviews the establishment of all new facilities and changes in bed capacity.

common than in many other states. This section describes the role of DOH, the appeals process, and the legislature.

1. The Department of Health

This section discusses the development of the CON review criteria and the components of the review process. It also analyzes the volume and type of applications received to determine trends in approval rates and types of facilities reviewed.

a. Development of CON review criteria

To operate the CON program DOH must develop both community need estimates for the facilities and services subject to regulation and rules that serve as the criteria for review. In Pennsylvania, the criteria for CON review are contained in the State Health Plan. The Department strictly adheres to the State Health Plan in conducting reviews. All parties involved know the rules, and providers can predict the outcome of their CON applications by reviewing criteria in the State Health Plan.

Given this reliance on the State Health Plan, it is critical that it be current in order to accurately reflect the needs of the community. Maintaining a current State Health Plan has historically been a major problem in Pennsylvania. Prior to 1989, the State Health Plan had not been updated since 1986. Since 1989, a number of chapters have been rewritten and additional chapters will be revised in the near future. As a result, the chapters are of variable quality and the review criteria differ substantially by chapter, with the most recently updated chapters of higher quality. The Commonwealth needs to ensure that chapters of the State Health Plan are updated in a more timely fashion to respond to changes in the health care system. A commitment to updating the State Health Plan will likely require additional resources for DOH.

The process of updating the State Health Plan is widely regarded as a positive aspect of the CON program by state officials and providers alike. It is here that the battles over the CON criteria are fought instead of at the individual application level as occurs in many other states.

As a result, the CON review process is relatively straightforward, with both the providers and the Commonwealth in agreement over the rules guiding the decisions.

The process for updating chapters of the State Health Plan entails three major steps. First, DOH identifies chapters in need of revision. Since no standard policy specifies when chapters are to be reviewed, the impetus for review could be technological advances or reaction to CON applications for which no policy guidance exists.

Second, DOH proposes revisions to the State Health Coordinating Council (SHCC), the advisory body regarding health planning in Pennsylvania. The members of the SHCC are appointed by the Governor, and many have been on the SHCC for years. Members are chosen to be representative of the varied health policy interests in the state as well as the geographical diversity of the state. Both DOH and the SHCC decide jointly whether a chapter should be updated. If the chapter is to be updated, the DOH organizes a task force composed of experts on the topic to draft the chapter within DOH guidelines. After the chapters are complete they are submitted to members of the SHCC, who then hold public hearings in Harrisburg, Philadelphia, and Pittsburgh. Finally, the SHCC approves the chapters and submits them to the Governor.

The task force and public hearing process attempt to reconcile the conflicting policy goals of the varied interests in the CON process. DOH has tended to be less regulatory and has been receptive to promoting a competitive approach favored by the General Assembly, whereas the SHCC has tended to adopt a health planning orientation and favors the consolidation of services. A recent example in which these orientations clashed was the revision to the cardiac catheterization chapter of the State Health Plan.

Observers of that process noted that DOH was interested in relaxing the review criteria for cardiac catheterization, while many SHCC members wanted to strictly control this service. The final chapter was approved by a bare majority of SHCC task force members. A member of the SHCC argued that DOH was trying to weaken the regulations to enable more providers to offer cardiac catheterization, while DOH argued that the task force was trying to protect the providers that currently offered the service. The final regulations require that the applicant

demonstrate that it can perform at least 300 adult procedures per year. This standard is commonly used in many other CON programs.

The Department has an additional tool for revising CON requirements in the CON Memorandums. These memorandums can be written to more clearly state the Department's understanding of the intent of the State Health Plan, revise need estimates as updated data become available, or provide guidance on a specific circumstance that arises from an application. For example, long-term care bed need estimates are revised through CON memorandums because the State Health Plan stipulates that they be revised with the most recent population projections available. The CON memorandums do not reflect policy changes or modifications in CON criteria; these types of changes are the purview of the State Health Plan.

Once the State Health Plan chapters are adopted or CON memorandums written, they become the criteria for the program. DOH is perceived to consistently apply the criteria in reviewing CON applications. Our review of a small sample of CON applications confirms this perception of consistency. The clearly defined criteria also appear to act as a deterrent to submitting CON applications. Providers noted that they can usually predict whether an application will be denied, and in those cases they do not submit the application. One example of the deterrent effect is in the area of open heart surgery where few applications are submitted because providers know that department policy is to contain the expansion of open heart surgery and that approval is unlikely.

b. The review process

This section describes the steps in the CON review process from the submission of a letter of intent to the rendering of a decision. Understanding this process is important to determining whether changes in the structure of the program are warranted. The first step in the CON process is for a prospective applicant to submit a letter of intent to the Division of Need Review (DNR). Within 30 days DOH determines whether the project is subject to review and what level of review is appropriate -- full review, non-substantive review, or administrative review. DOH receives about 1,000 letters of intent each year.

Non-substantive and administrative reviews are not permitted for any controversial projects. CON reviewers informed us that if at least one party shows some objections or concerns about a project, even an administrative review application will be included in the full review category.

DOH has 90 days from the time a full-review application is deemed complete to render a decision. This time frame is misleading since a backlog of applications creates a time lag in deeming applications complete. Due to staffing limitations, a full review application at one time took up to 15 months from the time it was received until it was deemed complete. In the past year DOH has made progress in reducing this delay to about six months. Thus, an applicant may wait about a year from the time the application is submitted for a decision. In a few cases a provider may request that an application be placed on hold. For example, providers requested that their applications for biliary lithotriptors be placed on hold due to expected approval of the service and equipment by the FDA.

Non-substantive and administrative reviews begin about one week after the applications are received and are completed within 30-45 days of receipt. Given the staffing shortages, these applications receive cursory reviews and are usually reviewed in a timely fashion.

About 5.5 FTE planners reviewed approximately 300 CON applications in 1991. This staff complement has decreased from a peak of 50 in the early 1980s. Providers commented that the CON review process experiences long delays due to these staffing shortages, which results in increases in project costs. They also commented that the thoroughness of reviews has decreased. DOH noted that staff priority is placed on the full review applications and the non-substantive and administrative reviews do not receive the appropriate attention. DOH estimates that to meet their current responsibilities, the office would need to increase its staff by six people -- four in need review and two in planning.

Any affected person or appropriate third party payor can request a public hearing within 15 days of the date on which the application is published in the Pennsylvania Bulletin and the local newspaper. Requests for public hearings have increased from 1987 to 1991. In 1987, less than 10 percent of CON applications involved a request for a hearing; by 1991, 14 percent of applications involved a request for a hearing. Hearings are usually called by a potential

competitor of the facility requesting a CON. Hearings are especially common for services in which there is strong competition for profitable patients. The majority of the hearings are in the area of long-term care with some hearings also held on cardiac catheterization and MRIs. Public hearings are becoming more common as providers face increased competition. These hearings also substantially increase the workload of the CON reviewers.

A considerable number of applicants decide not to submit a CON application after they discuss their chances with the Division of Need Review. Pre-application discussions are encouraged and are conducted in about 60-70 percent of the cases. A major reason for not submitting an application is an inability to meet the State Health Plan criteria. Some institutions submit an application and then withdraw it during the review process. Usually applicants who submit an application and allow it to go through the full review process are certain of its approval. The major reason for disapproval of a full review project is the determination of no need.

c. Analysis of the volume and type of applications

Some aspects of DOH program administration can be assessed by examining the volume of applications reviewed and the approval and denial rates of applications. It should be noted, however, that approval and denial rates are generally considered poor measures of the performance of CON programs because interpreting the data often proves inconclusive. High approval rates may indicate either a lenient program, or alternatively, a program that deters applications. Similarly, a high denial rate may reflect a program with stringent criteria or may indicate that the state has not articulated clear goals and review criteria to providers. In theory, an effective program will clarify for providers the types of projects likely to be rejected, thus decreasing the likelihood that inappropriate projects will be proposed. Despite the difficulty interpreting these statistics, approval and denial rates are frequently cited statistics.

A summary of program statistics by number of applications is presented in Exhibit 2.3. The number of applications has remained at roughly the same level during the 1987 to 1991 period. Department staff cited that when the threshold was raised in 1989, DOH did not realize the expected reduction in reviewable projects. At the same time the thresholds were raised, the State Health Plan indicated a need for additional long-term care beds, which led to a surge in

Exhibit 2.3**SUMMARY OF PROGRAM STATISTICS
(Number of Applications)**

1987 - 1991

Year	Number Reviewed	Percent Approved	Percent Denied	Percent Withdrawn
1987	279	92.8%	5.4%	1.8%
1988	307	92.5%	2.0%	5.5%
1989	275	94.5%	2.2%	3.3%
1990	254	88.6%	5.1%	6.3%
1991*	308	56.5%	6.8%	36.7%
1987-1991	1423	84.5%	4.3%	11.2%

* Partial year data.

**SUMMARY OF PROGRAM STATISTICS
(Dollar Volume of Applications - in Millions)**

1987 - 1991

Year	Total Dollars Reviewed	Percent Approved	Percent Denied	Percent Withdrawn
1987	\$1,149.8	98.4%	1.1%	0.5%
1988	\$979.0	92.9%	1.2%	5.9%
1989	\$843.4	96.2%	1.2%	2.7%
1990	\$944.2	88.2%	6.1%	5.6%
1991*	\$1,339.5	50.9%	9.7%	39.5%
1987-1991	\$5,255.8	83.1%	4.2%	12.7%

* Partial year data.

applications. This increase in applications for long-term care beds likely masked any reduction in applications observed from raising the thresholds. Since 1989, the total dollar volume reviewed has increased from \$843 million to \$1.3 billion.

The program has had high approval rates from 1987 to 1990. This high approval rate may be explained by the consistency of the review criteria. In 1991 the approval rates decreased substantially due to the influx of a large number of long-term care applications.

In recent years, the CON program has experienced an increase in denial and withdrawal rates. From 1990 to 1991 the withdrawal rate increased from 6.3 percent to 36.7 percent. This may be explained by the practice of pre-disapproval conferences between the applicant and DOH. Most of these withdrawals were in the area of long-term care.

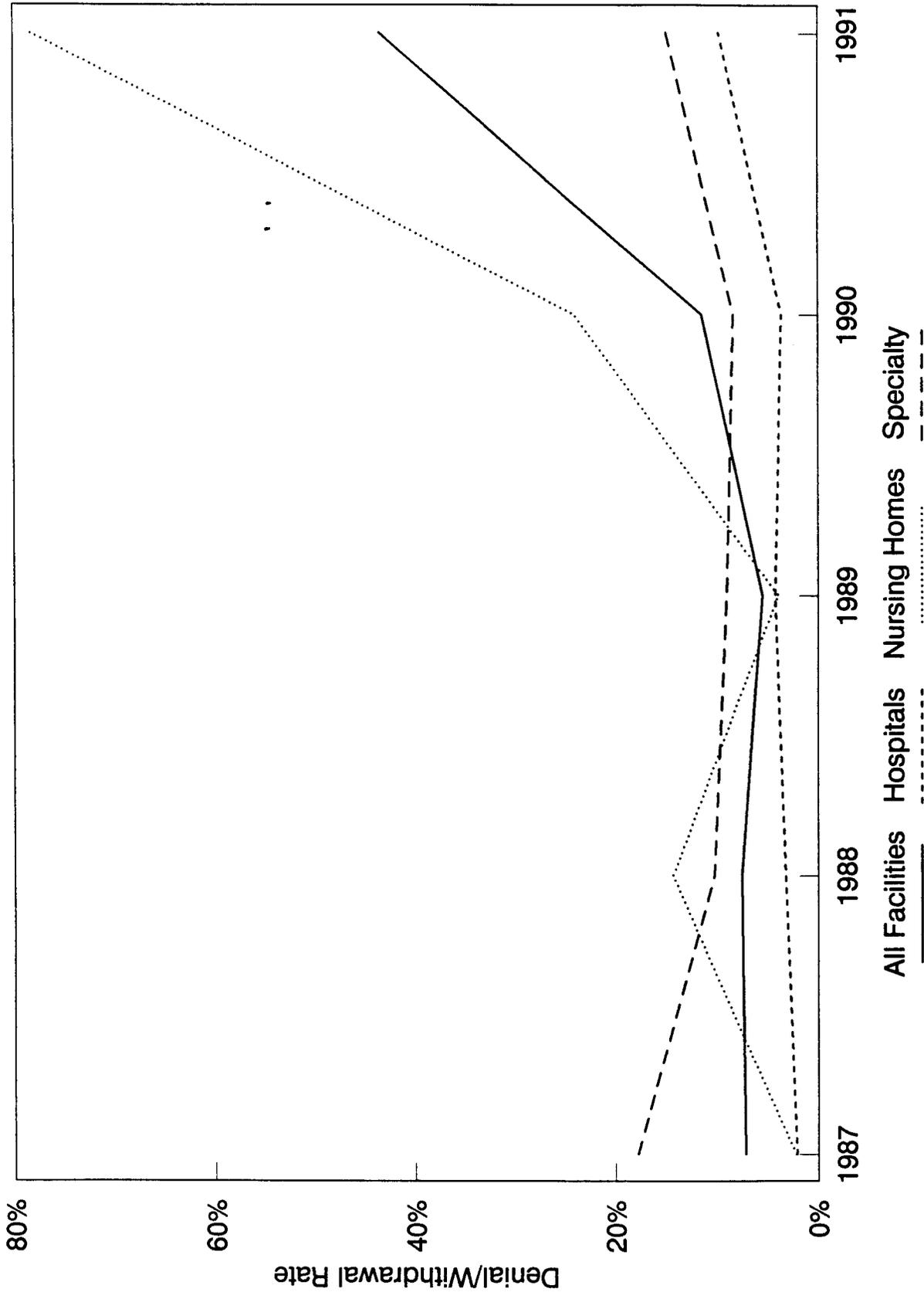
The trend toward higher denial/withdrawal rates results largely from nursing home applications. This is not surprising since each time the state increases its long-term care bed need determination it receives many competing applications for a finite number of beds. Exhibit 2.4 presents the denial/withdrawal rates for all projects, including hospital and nursing home projects, from 1987 to 1991.

When program statistics are desegregated by service between 1987 and 1991 we find wide variation in approval/denial rates (Exhibit 2.5). We find an increase in the denial rates for long-term care services and psychiatric specialty services since 1989. In contrast, denial rates for MRI services and acute psychiatric services declined during this period.

Over the entire 1987 to 1991 period, services experiencing the highest denial/withdrawal rate include lithotripsy, acute psychiatric, long-term care, and specialty psychiatric (Exhibit 2.6). Services with the lowest denial/withdrawal rates are cardiac catheterization, MRI inpatient and specialty, organ transplants, and neonatal level III services. The next section will present data on whether these low denial/withdrawal rates led to a proliferation of these services. Alternatively, few applications may have been submitted for these services since providers knew they would be disapproved.

Exhibit 2.4

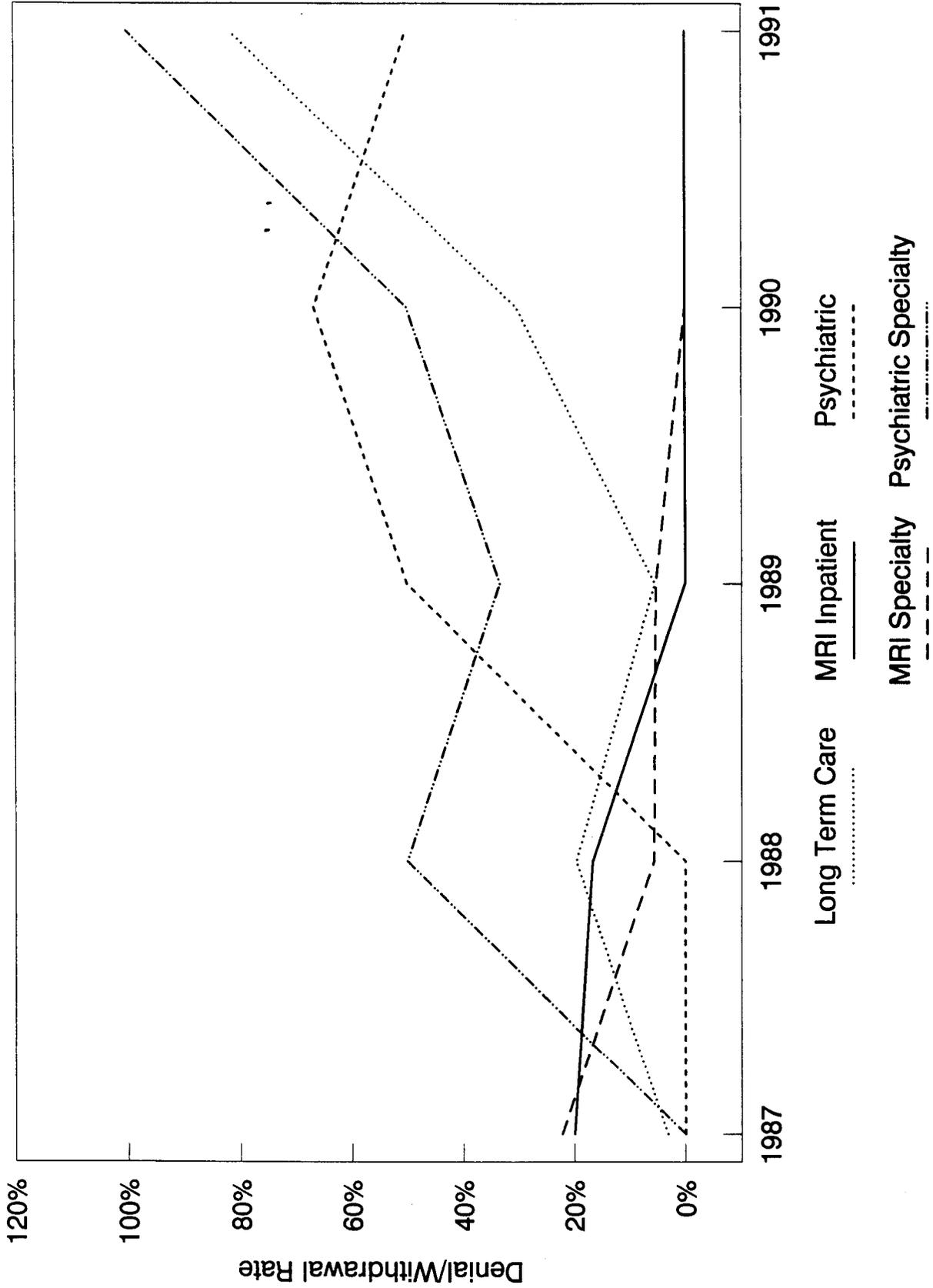
**PERCENT OF APPLICATIONS DENIED/WITHDRAWN
BY TYPE OF FACILITY, 1987 - 1991***



* Partial year data used for 1991.

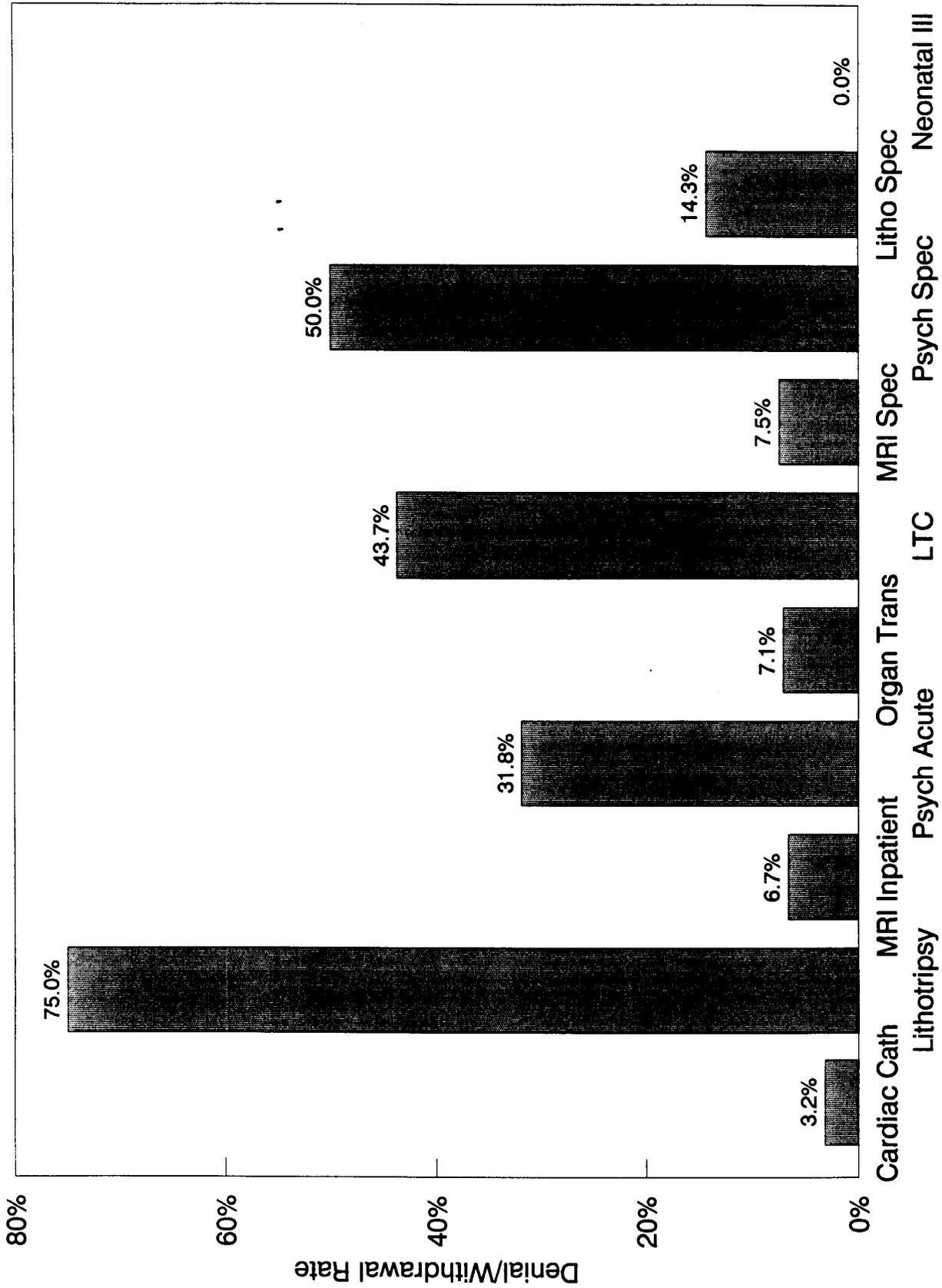
Exhibit 2.5

**PERCENT OF APPLICATIONS DENIED/WITHDRAWN
BY TYPE OF SERVICE, 1987-1991***



* Partial year data for 1991.

PERCENT OF APPLICATIONS DENIED/WITHDRAWN BY TYPE OF FACILITY/SERVICE, 1987 - 1991*



* Partial year data for 1991.

Apart from the CON review process, hospitals and nursing homes may expand capacity through the 10 bed/10 percent rule. Under this provision, beds may be added without CON approval providing capacity is not increased by more than 10 beds or more than 10 percent of total capacity over a two year period.

Review of the number of new beds allowed in Pennsylvania over the period 1987 to 1991 suggest that the 10 Bed/10 percent rule contributed significantly to the proliferation of institutional capacity. The number of beds added under this provision (and the fraction of total allowed beds) varies substantially by service area:

- **Drug and Alcohol Care Beds.** The 10 Bed/10 percent rule allowed nearly as many drug and alcohol care beds as were approved by the CON process. As illustrated by Exhibit 2.7, an annual average of 17 beds were added via the 10 Bed/10 percent rule, while CON approved an addition of 20 beds.
- **Psychiatric Care Beds.** Similarly, nearly as many psychiatric care beds were added through the 10 Bed/10 percent rule as were approved under the CON process. The 10 Bed/10 percent rule permitted average annual additions of 120 beds, while CON approval accounted for 123 new beds annually.
- **Rehabilitation/Comprehensive Medical Care Beds.** More than twice as many rehabilitation care beds were added through the 10 Bed/10 percent rule than were approved under the CON review process. The 10 Bed/10 percent rule allowed an average of 64 new beds annually; the CON process permitted 29. Annual figures reveal that 10 Bed/10 percent expansions grew in years in which few CONs were approved.
- **Long-term Care Beds.** An average of 273 long-term care beds were added via the 10 Bed/10 percent rule, whereas CON approval allowed 2701 new beds (Exhibit 2.8). In contrast to acute care, where the 10 Bed/10 percent rule accounted for greater than 50 percent of all new beds, this represents less than 10 percent of long-term beds added.

2. Reconsideration and Appeals of CON Decisions

After a decision has been rendered by DOH, both the applicant and opponents have 10 days in which they can file for reconsideration with the Secretary of Health, and 30 days in which to appeal to the Health Facility Hearing Board. The time period for both processes runs from the

Exhibit 2.7

**Number of Acute Care Beds Allowed:
CON Approval vs. 10 Bed/10%
Annual Averages, 1987-1991**

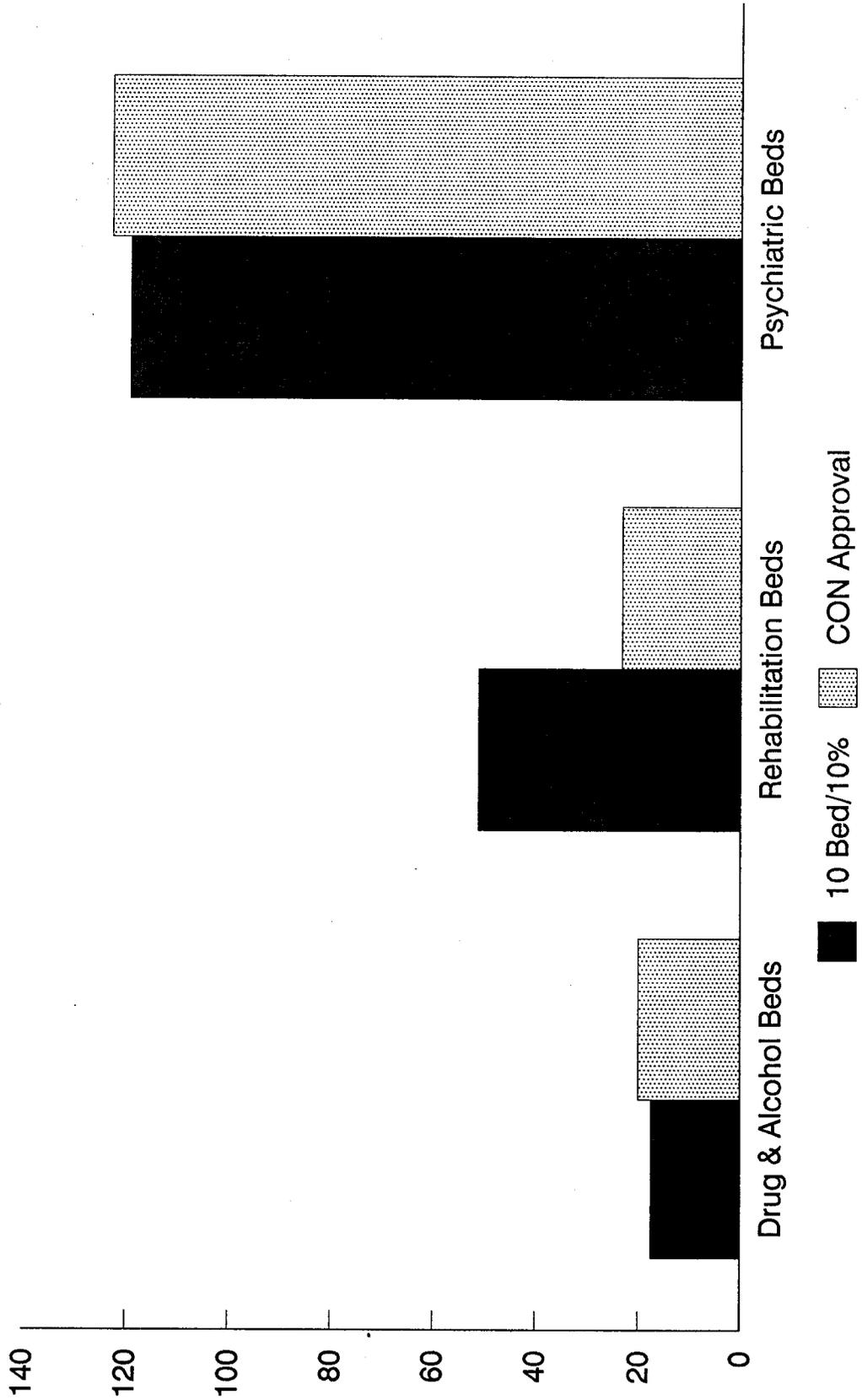
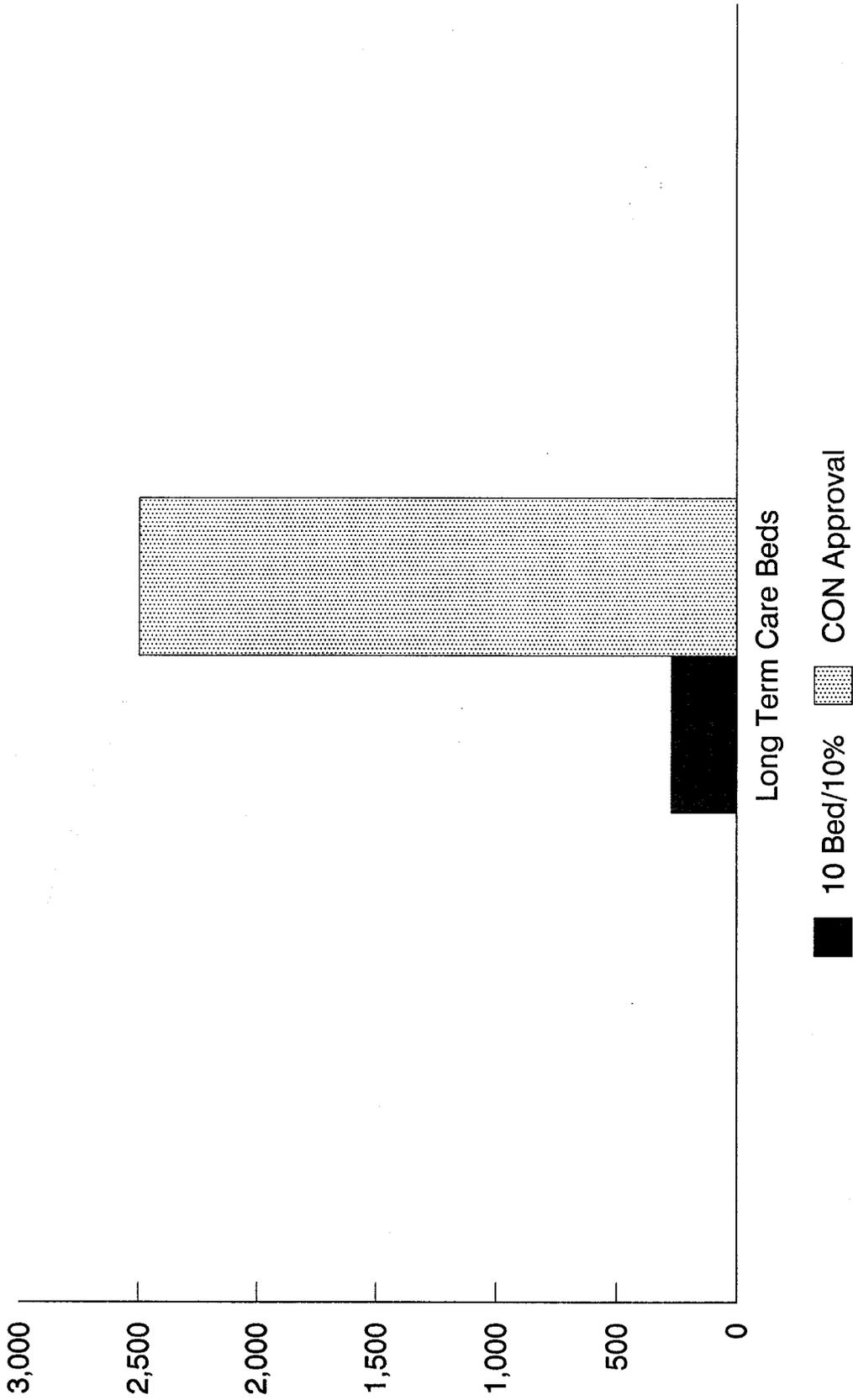


Exhibit 2.8

Number of Long Term Care Beds Allowed: CON Approval vs. 10 Bed/10%

Annual Averages, 1987-1991



date the decision is rendered. Both forms of recourse are usually pursued to ensure that all appeal possibilities have been followed.

To be granted reconsideration by the Department, an applicant must show "good cause," which includes, among other things, significant relevant information not previously considered. According to interviews with DNR staff, in the past two years, no institutions could show sufficient cause to warrant reconsideration of the initial decision. If an institution is successful in showing "good cause," DOH would have a hearing on the matter and its decision could be altered.

About one-third of decisions made on CON full applications are appealed each year to the Health Facility Hearing Board. Only a fraction of these receive a full hearing during a given year; the remainder are either continued, consolidated, or withdrawn. The number of appeals filed and decisions by the Board are contained in Exhibit 2.9. While the number of appeals filed has declined between 1987 and 1990, the number of decisions by the Board has stayed roughly constant. Cases appealed to the Board generally concern psychiatry, rehabilitation, and long-term care facilities. In most cases the Board affirms the decision of the Department. In interviews, DOH staff reported that the number of appeals has recently increased due to the competitiveness of the health care system.

If a party loses its appeal to the State Health Facility Hearing Board, it can appeal that decision to the Pennsylvania Commonwealth Court. About one-half of decisions by the Board are appealed to the Commonwealth Court (Exhibit 2.9), and a review of annual reports from the Board indicates that cases heard by the Court generally raise procedural issues regarding the CON review process. Any party can also request the Pennsylvania Supreme Court to accept an appeal from the decision of the Commonwealth Court.

3. Legislature

In contrast to CON programs in many other states, the legislature does not have a formal role in the processing of CON applications. The program is revised through the State Health Plan and does not routinely sunset and undergo frequent legislative review. Legislators are not represented on the SHCC or on the Health Facilities Hearing Board. However, as in most other

Exhibit 2.9 *

STATE HEALTH FACILITY HEARING BOARD CON APPEALS FILED			
	TOTAL	# FROM DETERMINATION OF REVIEWABILITY	# FILED FOLLOWING SUBSTANTIVE REVIEW
1987	47	11	36
1988	21	2	19
1989	17	4	13
1990	15	2	13

DECISIONS OF THE STATE HEALTH FACILITY HEARING BOARD		
	DEPARTMENT DECISION AFFIRMED	APPEAL STRICKEN
1987	6	3
1988	N/A	N/A
1989	5	2
1990	8	0

APPEALS FROM DECISIONS OF THE STATE HEALTH FACILITY HEARING BOARD FILED IN COMMONWEALTH COURT	
1987	4
1988	4
1989	4
1990	3

*Source: State Health Facility Hearing Board Annual Reports.

states, they may involve themselves in the CON review process by writing letters in support of applications and informally contacting DOH or the Governor's office. According to the DOH, legislative contact is documented and placed in the review file as are comments from any members of the public.

III. THE EFFECTIVENESS OF PENNSYLVANIA'S CON REGULATION IN CONTROLLING COSTS AND THE DIFFUSION OF SERVICES

This section presents our evaluation of the effectiveness of the Pennsylvania CON program in controlling the costs and diffusion of acute and long-term care services. This study was required as part of the LB&FC Sunset Evaluation of CON in Pennsylvania, and is also important for legislators and others considering whether the law should sunset. In addition, our results have important implications for the DOH and legislators concerned with the rise in health care costs over the past decade and the prospects for future state strategies to contain costs. The results of this section will also be important in our later discussion of the potential consequences of a repeal of CON, and state efforts to address quality and access concerns in acute and long-term care.

To accurately evaluate these aspects of the program, we have treated each distinct program area separately below. The CON program has jurisdiction over highly diverse markets, including acute care services and long-term care. Within the acute care sector, the CON program differs by the type of service or facility being reviewed. The issues faced by the State and by providers differ in each of these areas, as do DOH policy objectives.

There are also differences between sectors in the availability of data on which to base our evaluation. For the acute care sector, we have been able to analyze an extensive national database on hospital costs and facilities. We have supplemented these data with information on the volume of services provided where possible. By contrast, no consistent national database is available for long-term care. We have thus relied on aggregate statistics by state, and data on long-term care costs and facility availability in Pennsylvania.

The evaluation results for acute care show that CON did not control the increase in acute care hospital spending from 1980 to 1989, either in Pennsylvania or elsewhere. During this time, however, the CON program in Pennsylvania did control a number of acute care services, including some cardiac care facilities and specialized intensive care beds. Control occurred in areas where a clear mandate in the state health plan was applied stringently by the CON program. By contrast, the program did not restrict the diffusion of other services, such as CT scanners, MRI, and hospital-based psychiatric and rehabilitation care services. More stringent programs in other states effectively controlled some of the cost-based reimbursed services not controlled in Pennsylvania.

In the long-term care sector, the CON program appears to have helped constrain both construction of new beds and the costs of care in the state. However, as measured by the new Weissert bed need methodology, the state is currently over-bedded in many areas and under-bedded in Philadelphia and Pittsburgh, where many Medical Assistance patients are unable to obtain care. Control of long-term care spending is especially important to the state, since the Office of Medical Assistance (OMA) is the dominant payor, covering 62 percent of patient days in nursing homes.

Below we detail our evaluation results of the acute care and long-term care sectors.

A. Acute Care Sector

CON regulation of acute care facilities and services depends critically on the State Health Plan chapter that serves as the basis for regulation. Because each of these chapters is highly specific to the service involved, state goals in the acute care sector vary by facility and service. For this reason, we analyze the primary services regulated by the CON program individually. For each service area, we explore the following sources of information: (1) comparison of Pennsylvania hospitals to facilities in other states under CON programs of varying stringency; (2) available data on the use of services in Pennsylvania; and (3) description of the CON program in Pennsylvania.

Comparison of Pennsylvania hospitals to other facilities under CON programs in other states provides a direct and important measure of the success of the program. However, in order to ensure that this comparison is valid, it is necessary to control for a variety of factors that affect hospital spending and the diffusion of services other than CON legislation. Hospitals in all states have been operating in a rapidly changing environment over the past 10 years; many factors such as changing reimbursement, demographic patterns, and market conditions have affected hospital costs and the diffusion of services. For this reason, it is necessary to use "econometric analysis," a sophisticated statistical technique that enables us to compare Pennsylvania hospitals with other facilities while controlling for a variety of factors other than CON legislation.

To carry out this analysis, we assembled a database on total hospital spending, hospital capital spending, the fraction of hospitals providing specific services, the number of specialty beds devoted to specific services, and a variety of other factors. The database includes observations on 5,072 U.S. hospitals for each year between 1980 and 1989; this geographic and time span of the data allows us to evaluate both static differences between Pennsylvania and other states, and the changes over time observed among each group.

To form meaningful comparison groups against which the Pennsylvania CON program could be assessed, we rated the stringency of CON regulation in each state in each year, and divided the programs into four groups: stringent, moderate, limited, and repealed. Our analysis did not require such an evaluation of the Pennsylvania Program: since we compare Pennsylvania to each of the groups, the state is omitted from them. We rated CON stringency through a review of CON thresholds, services subject to review, and professional judgment about how aggressively the state has used its CON program. We then compared the spending and diffusion of services under the Pennsylvania CON to each of the other categories over time, controlling

for a variety of market and demographic factors that might be expected to influence these factors.³ Complete econometric methods and results are presented in Appendix I.

This database on acute care services and facilities in Pennsylvania and other states describes the number of facilities, but does not give information on how many services are being performed. These data are not available on a hospital-specific basis for all facilities in the country. To supplement our econometric results, however, we present data on the number of services provided by Pennsylvania hospitals wherever such data are available.

Our evaluation of major programmatic areas in acute care follows. We start by considering total hospital spending, and the amount that hospitals spend on capital. We then turn to the diffusion of cardiac services, other surgical services, intensive care beds, and imaging technologies. Finally, we examine the prevalence of inpatient and outpatient alcohol and chemical dependency, rehabilitation, and psychiatric services.

1. Acute Care Hospital Spending

By controlling the expansion of hospital capacity, CON was expected to slow the rate of growth in hospital costs. In fact, many states initially adopted CON primarily to control acute care costs. In Pennsylvania control of hospital spending has clearly been a source of concern to the DOH, the Governor, and legislators at various times over the past decade, and especially currently. However, our interviews suggest that in 1979, CON was adopted more out of the need to satisfy Federal statutory requirements. In addition, Pennsylvania's CON program, like those of most other states, lacks the strict provisions necessary to achieve cost containment, and also lacks a means through which the containment of costs can be balanced with the State's concerns about quality and access to care.

³ Specifically, we control for the differences between hospitals using the following sources of data: the number of beds in hospital; the number of residents per bed (adjusts for differences in teaching status); Medicare case mix index (adjusts for differences in patient severity); HMO enrollment as a fraction of state population; total facility Medicare discharges (adjusts for differences in patient mix and the age of the hospital's population); profit/not-for-profit status; population density; per-capita income; and the number of non-federal physicians and community hospitals in the area.

a. Total Hospital Spending

Exhibit 3.1 summarizes our results for total hospital spending. The data show that the rate of increase in costs in Pennsylvania hospitals and in states with stringent CON programs substantially exceeded that of states with moderate, limited, or repealed CON programs. By the terminal year of the study (1989) total dollar costs of hospitals in Pennsylvania and in states with stringent CON slightly exceeded those with weaker regulation: the Pennsylvania program is associated with total facility spending of \$1.5 to \$3 million higher than moderate, limited, or repealed states. Our analysis of hospital expenses per admission also showed Pennsylvania with costs that exceeded states under other forms of regulation. By 1989, hospitals under stringent CON programs had facility costs that were virtually indistinguishable from those under moderate, limited, or repealed programs.

b. Capital Spending

Our results for hospital capital spending were highly similar to those obtained for total hospital spending, as illustrated in Exhibit 3.2. Pennsylvania hospitals exhibited higher annual growth in total capital expenditures, expenses per admission, and expenses per adjusted patient day than all other reference groups. In 1989 total capital expenses and capital expenses per admission in Pennsylvania exceeded those of most other reference groups.

c. Discussion of Cost Findings

Our econometric analysis shows no evidence that the program has succeeded in controlling hospital spending in Pennsylvania, or among states with more stringent CON programs. There are a number of factors that might serve to explain this finding. First and most important, the CON program is a reactive tool that is not well equipped to restrict overall facility costs. Most of hospital spending, such as the 60 percent of hospital budgets spent on labor, are not covered under the CON program. The health policy literature indicates that reductions in capacity that are not accompanied by reductions in volume save little money. In addition, CON receives little help from other public programs. Medical Assistance has only a relatively small impact on acute care costs in the state since it covers only about 10 percent of all care, and savings from the Medicare program have not decreased total spending, but instead, have shifted costs onto other payors.

Exhibit 3.1

Total Facility Spending

**Performance of Pennsylvania Hospitals Relative to
Hospitals in Other States Under Differing Levels of CON**

	Total Facility Spending (in millions of 1989 dollars)		Expense per Admission (1989 dollars)	
	1985	1989	1985	1989
Pennsylvania	0	0	0	0
Stringent	0	+	-	-
Moderate	+	-	-	-
Limited	+	-	-	-
Repealed	+	-	-	-

The symbols in this table compare the experience of Pennsylvania hospitals to those in other states under the indicated level of CON stringency in 1985 and 1989. These results control for a variety of demographic, market, and other factors, and are obtained the econometric analysis described in Appendix I.

- 0 No substantial difference between Pennsylvania hospitals and hospitals in the given reference group (difference less than 15 percent).
- Less of a given cost or technology in hospitals in this group than in Pennsylvania hospitals (difference over 15 percent).
- + More of a given cost or technology in hospitals in this group than in Pennsylvania hospitals (difference over 15 percent).

Exhibit 3.2				
Capital Expenses				
Performance of Pennsylvania Hospitals Relative to Hospitals in Other States Under Differing Levels of CON				
	Total Capital Expenses (millions of 1989 dollars)		Capital Expense per Admission (1989 dollars)	
	1985	1989	1985	1989
Pennsylvania	0	0	0	0
Stringent	+	-	-	-
Moderate	+	-	-	-
Limited	+	-	-	-
Repealed	+	-	-	-

The symbols in this table compare the experience of Pennsylvania hospitals to those in other states under the indicated level of CON stringency in 1985 and 1989. These results control for a variety of demographic, market, and other factors, and are obtained the econometric analysis described in Appendix I.

0 No substantial difference between Pennsylvania hospitals and hospitals in the given reference group (difference less than 15 percent).

- Less of a given cost or technology in hospitals in this group than in Pennsylvania hospitals (difference over 15 percent).

+ More of a given cost or technology in hospitals in this group than in Pennsylvania hospitals (difference over 15 percent).

Pennsylvania's CON program was designed and organized as a tool to implement the State Health Plan. Because the SHP does not seek to limit the availability of acute care services based on likely patient outcome, we would not expect the CON program to do so. Of course, this could be changed in the future. If the SHP required sharp restrictions on the diffusion of services and technologies, even when some demand was present, we might expect the program to control costs more effectively.

The inability of CON to slow the rise in costs has also sometimes been attributed by some to the notion that CON is an anti-competitive force that will, by restricting market entry, increase the costs of existing facilities. Although this speculative explanation is consistent with our data, there is no causal evidence to support this conclusion.

Finally, in considering our results on costs, it is important to recognize the limitations of spending data in measuring CON outcomes. Although the containment of costs was, nominally, a goal of most CON programs, most programs also lacked specific provisions designed to execute this goal. A more precise indicator of programmatic success can thus be obtained by looking at specific services that CON was designed to control.

2. Hospital Services Expansion

A more direct measure of the impact of CON on each acute care market area in Pennsylvania is obtained by analyzing the extent to which the CON program affected the diffusion of various facilities and services. Because the review criteria, the stringency with which criteria were enforced, and DOH objectives vary by service, we have considered a range of services including:

- Cardiac Services.
- Organ Transplantation.
- Ambulatory Surgery.
- Neonatal and Pediatric Intensive Care Beds.
- Imaging Technologies.
- Alcohol and Chemical Dependency.
- Hospital Rehabilitation Services.
- Psychiatric Services.

As a primary tool to assess program performance in each of these areas, we compare the fraction of hospitals that offer selected services and the number of specialty beds devoted to other services in states under differing levels of CON stringency. To control for potentially confounding factors, we use our econometric analysis of hospital-level data, as described above.

We supplement these data with other information where possible to address two shortcomings of our econometric analysis. First, measures of program outcomes from the econometric analysis focus on the number of facilities available rather than the number of services used. While the presence of facilities is the outcome over which CON has the most direct control, this information does not indicate how often the services are actually used. Second, the analysis considers only hospital inpatient utilization; outpatient services or technologies purchased by physicians are not included in this analysis. Supplementary data are obtained from a variety of sources, as noted below.

a. Cardiac Services

Pennsylvania's CON program regulates the proliferation of a variety of cardiac facilities on both cost and quality grounds. First, cardiac care tends to be expensive and highly profitable for hospitals to own and operate. Second, the medical literature has established links between the volume of cardiac procedures that a facility carries out and patient outcomes. Past regulatory efforts have also required hospitals that operate cardiac catheterization to operate an open heart surgery program as well. As illustrated in Exhibit 3.3, the data suggest that between 1980 and 1989, Pennsylvania successfully restricted the number of facilities carrying out open heart surgery and the number of intensive care beds. Although the state also controlled the number of hospitals offering cardiac catheterization, the law allowed an expansion in facilities within these institutions.

Over the course of the study period, fewer hospitals in Pennsylvania offered open heart surgery services than in states with moderate, limited, or repealed CON programs. The Pennsylvania experience was similar to that observed in states with stringent CON programs. As noted above, this accomplishment is especially important given that many hospitals sought such facilities since it was necessary to have open heart capabilities in order to obtain a CON for cardiac catheterization. The average number of beds per facility devoted to cardiac intensive care decreased in Pennsylvania, as it did in a number of other states. The average number of cardiac intensive care beds per hospital in 1989 was well below that observed in states with limited or repealed CON, and similar to that among hospitals under a stringent CON program.

Pennsylvania had fewer hospitals with cardiac catheterization labs than other states between 1979 and 1989 and also contained the proliferation of such facilities more stringently. As we will discuss below, changes in the CON program subsequent to 1989 and an increase in the number of approvals granted by the Department since that time may have changed this situation.

Exhibit 3.3						
Cardiac Services						
Performance of Pennsylvania Hospitals Relative to Hospitals in Other States Under Differing Levels of CON						
	Cardiac Intensive Care Beds (Number of Beds per Hospital)		Cardiac Catheter Labs (Fraction of Hospitals Providing Facility)		Open Heart Surgery Capability (Fraction of Hospitals Providing Service)	
	1985	1989	1985	1989	1985	1989
Pennsylvania	0	0	0	0	0	0
Stringent	+	0	+	+	0	0
Moderate	+	+	+	+	+	+
Limited	+	+	+	+	+	+
Repealed	+	+	+	+	+	+

The symbols in this table compare the experience of Pennsylvania hospitals to those in other states under the indicated level of CON stringency in 1985 and 1989. These results control for a variety of demographic, market, and other factors, and are obtained the econometric analysis described in Appendix I.

0 No substantial difference between Pennsylvania hospitals and hospitals in the given reference group (difference less than 15 percent).

- Less of a given cost or technology in hospitals in this group than in Pennsylvania hospitals (difference over 15 percent).

+ More of a given cost or technology in hospitals in this group than in Pennsylvania hospitals (difference over 15 percent).

It is important to note that while Pennsylvania succeeded in restricting the number of facilities licensed to provide cardiac catheterization, the law also allowed facilities with one approved cardiac catheterization lab to add additional labs without another CON, provided that the cost of such labs does not exceed a \$2 million capital expense threshold. Thus, while the number of hospitals with services appears to have been controlled between 1980 and 1989, the number of facilities expanded beyond that which was mandated in the State Health Plan. In 1989, the SHP mandated 71 labs, whereas 104 were actually operating in the State.

Finally, a number of important changes in the SHP and the CON program since 1989 have led to an increase in the number of facilities since 1989. In the past two years, a number of new facilities have been approved. In addition, the Department has adopted a stance in favor of mobile cardiac catheterization. As discussed earlier in this report, these new policies have generated a considerable amount of controversy on the part of those opposed to the proliferation of cardiac catheterization services.

b. Organ Transplantation

Organ transplantation capabilities grew among all groups, although the rate of growth was least in states with stringent CON programs, and highest among states that had repealed their CON programs (Exhibit 3.4). The growth in the number of transplantation programs in Pennsylvania exceeded that observed in stringent programs, but was less than that in states that had repealed CON. In 1989, the terminal year of the study, the fraction of hospitals offering such services was highest in states that had repealed CON, lowest in states with stringent CON, and Pennsylvania was in between these two extremes.

Data on the number of transplants carried out in the state show that a disproportionate number of U.S. transplants are carried out in Pennsylvania (Exhibit 3.5). However, it is likely that this resulted, at least in part, from national use of the unique expertise of the major teaching hospitals in Pittsburgh and Philadelphia as recognized in the State Health Plan, such "border crossing" is common for sophisticated services, and does not necessarily reflect over-use.

Exhibit 3.4**ORGAN TRANSPLANTATION****Performance of Pennsylvania Hospitals Relative to
Hospitals in Other States Under Differing Levels of CON****Organ Transplants
(Fraction of Hospitals Providing Service)**

	1985	1989
Pennsylvania	0	0
Stringent	0	-
Moderate	+	+
Limited	+	+
Repealed	+	+

The symbols in this table compare the experience of Pennsylvania hospitals to those in other states under the indicated level of CON stringency in 1985 and 1989. These results control for a variety of demographic, market, and other factors, and are obtained the econometric analysis described in Appendix I.

0 No substantial difference between Pennsylvania hospitals and hospitals in the given reference group (difference less than 15 percent).

- Less of a given cost or technology in hospitals in this group than in Pennsylvania hospitals (difference over 15 percent).

+ More of a given cost or technology in hospitals in this group than in Pennsylvania hospitals (difference over 15 percent).

Exhibit 3.5

**Organ Transplants in Pennsylvania and the U.S.
Per 1 Million Population**

Type of Transplant	Number in United States	Number in Pennsylvania
Kidney	38.51	56.06
Heart	8.40	13.37
Liver	10.70	53.57
Pancreas	2.21	5.23
Heart/Lung	0.20	0.33
Lung	1.06	1.16

Source: Statistics on organ transplants from State Health Plan, Chapter 42, revision as of 11/26/91. Corrected for population in 1989, from the Statistical Abstracts of the U.S.

c. Ambulatory Surgery

Although more hospitals in Pennsylvania had ambulatory surgery programs than among controls at the outset of the study period, the CON program effectively halted the growth of ambulatory surgical services in Pennsylvania through 1989 (Exhibit 3.6). While all other reference groups experienced limited growth, this growth was not observed in Pennsylvania. By the terminal year of the study, the fraction of hospitals offering ambulatory surgical services in Pennsylvania was similar to that in states with stringent and repealed CON.

It is important to note that most hospitals currently offer ambulatory surgery capabilities. An area of higher growth in most states is freestanding ambulatory facilities, which have provided competition for many hospital outpatient facilities. Unfortunately, our database focuses only on hospital facilities, so we do not have econometric results that describe this area of the program. We also lack data on the proliferation of surgical and diagnostic procedures in physician offices, much of which is not currently covered under the CON program.

d. Neonatal and Pediatric intensive care beds

Intensive care services have received a great deal of attention in recent years because they are high in costs, but also because the number of procedures performed by a given physician or hospital has been associated with the quality of the outcomes. CON programs have attempted to limit the number of hospitals that could offer these services with the expectation that these limits would control utilization (and indirectly costs) and assure an adequate volume to meet minimum quality standards. The services examined in this analysis are neonatal intensive care and pediatric intensive care.

The number of neonatal and pediatric intensive care beds grew under all levels of regulatory stringency between 1980 and 1989, as new therapeutic capabilities have been added. However, the data suggest that Pennsylvania did effectively moderate the expansion of intensive care services, as illustrated in Exhibit 3.7. The average number of neonatal intensive care beds per hospital in Pennsylvania grew at a rate similar to that observed in states with stringent CON

Exhibit 3.6

AMBULATORY SURGERY

**Performance of Pennsylvania Hospitals Relative to
Hospitals in Other States Under Differing Levels of CON**

**Ambulatory Surgical Services
(Fraction of Hospitals Providing Service)**

	1985	1989
Pennsylvania	0	0
Stringent	-	+
Moderate	-	+
Limited	-	0
Repealed	-	-

The symbols in this table compare the experience of Pennsylvania hospitals to those in other states under the indicated level of CON stringency in 1985 and 1989. These results control for a variety of demographic, market, and other factors, and are obtained the econometric analysis described in Appendix I.

0 No substantial difference between Pennsylvania hospitals and hospitals in the given reference group (difference less than 15 percent).

- Less of a given cost or technology in hospitals in this group than in Pennsylvania hospitals (difference over 15 percent).

+ More of a given cost or technology in hospitals in this group than in Pennsylvania hospitals (difference over 15 percent). Estimated Differences in Hospital Performance by Level of CON Stringency¹

Exhibit 3.7

NEONATAL AND PEDIATRIC INTENSIVE CARE BEDS

**Performance of Pennsylvania Hospitals Relative to
Hospitals in Other States Under Differing Levels of CON**

	Neonatal Intensive Care Beds (Number of Beds per Hospital)		Pediatric Intensive Care Beds (Number of Beds per Hospital)	
	1985	1989	1985	1989
Pennsylvania	0	0	0	0
Stringent	0	-	+	+
Moderate	+	+	+	+
Limited	+	+	+	+
Repealed	+	+	+	+

The symbols in this table compare the experience of Pennsylvania hospitals to those in other states under the indicated level of CON stringency in 1985 and 1989. These results control for a variety of demographic, market, and other factors, and are obtained the econometric analysis described in Appendix I.

0 No substantial difference between Pennsylvania hospitals and hospitals in the given reference group (difference less than 15 percent).

- Less of a given cost or technology in hospitals in this group than in Pennsylvania hospitals (difference over 15 percent).

+ More of a given cost or technology in hospitals in this group than in Pennsylvania hospitals (difference over 15 percent).

programs, and in 1989, the level observed in Pennsylvania was somewhat lower than that in states that had repealed CON, or had limited programs.

Hospitals in Pennsylvania had substantially fewer pediatric intensive care beds than did hospitals under any form of CON. This difference was present in 1980 and was maintained over the entire study period. By 1989, hospitals in states that had repealed CON had more pediatric intensive care beds than any other group.

e. Imaging Technologies

Expensive new technologies represent a highly important target for CON programs for a variety of reasons. First, new technologies and associated operating costs account for a substantial portion of rising hospital costs. Second, there are important issues regarding access and quality that are linked to ensuring that sufficient supply exists to meet demand, and that oversupply does not exist. If oversupply does exist, such technologies are likely to add to costs since small benefits can be gained by applying the technology to patients who might not otherwise need the service. Finally, it has also been shown that hospitals may save money by delaying the implementation of such technologies, although delay may also result in loss of benefits to patients during this time.

In this section, we look at econometric results on Pennsylvania's experience controlling two imaging technologies in hospitals: MRI and CT scanning. While these technologies are no longer new, they were adopted under the CON program. As indicated in Exhibit 3.8, the data show that Pennsylvania's record on these two types of technology is mixed: the program appears not to have controlled CT scanning but may have controlled MRI somewhat. This analysis is based on hospital data, and does not include proliferation of technologies outside the hospital setting.

The growth in the number of CT scanners between 1987 (the first year for which data are available) and 1989 exceeded that observed under any of the reference groups. As a result of this growth, by the terminal year of the study a substantially larger number of Pennsylvania hospitals offered CT scanning than any of the reference groups. This resulted in part from the DOH's decision to eliminate CT scanners from the list of reviewable services, in order to make the service widely available, and to put hospitals on equal footing with physician groups, which

Exhibit 3.8

IMAGING TECHNOLOGIES

**Performance of Pennsylvania Hospitals Relative to
Hospitals in Other States Under Differing Levels of CON**

	MRI Imaging Facility (Fraction of Hospitals Providing Facility)		CT Scanner (Fraction of Hospitals Providing Facility)	
	1985	1989	1985	1989
Pennsylvania	0	0	0	0
Stringent	0	+	-	-
Moderate	+	+	-	-
Limited	+	+	-	-
Repealed	+	+	-	-

The symbols in this table compare the experience of Pennsylvania hospitals to those in other states under the indicated level of CON stringency in 1985 and 1989. These results control for a variety of demographic, market, and other factors, and are obtained the econometric analysis described in Appendix I.

- 0 No substantial difference between Pennsylvania hospitals and hospitals in the given reference group (difference less than 15 percent).
- Less of a given cost or technology in hospitals in this group than in Pennsylvania hospitals (difference over 15 percent).
- + More of a given cost or technology in hospitals in this group than in Pennsylvania hospitals (difference over 15 percent).

were subject to no restrictions on purchasing this technology. The growth in number of facilities offering MRI imaging was similar across the different CON program categories. In 1989, fewer Pennsylvania hospitals offered such services, although the differences are small.

f. Alcohol and Chemical Dependency

Alcohol and chemical dependency services was one of the few areas for which hospitals received cost-based reimbursement from the Medicare program during the period studied. For this reason, we would expect that market discipline would be especially lacking for such services, and that CON would thus be more important. As illustrated in Exhibit 3.9, Pennsylvania does appear to have constrained growth in the average number of alcohol/chemical dependency beds and presence of outpatient services.

Our results suggest that hospitals in states with stringent CON programs experienced less growth in alcohol/chemical dependency capacity. Although the number of alcohol/chemical dependency acute care beds grew across all categories, the rate of growth was highest among states that had repealed CON. By 1989, Pennsylvania had fewer alcohol/chemical dependency beds than in states with moderate, limited, or repealed CON programs. States with stringent CON programs had still fewer of these beds per hospital.

For outpatient services the patterns are somewhat more complicated, but still suggest that control was effective. In the early years of the study, Pennsylvania had substantially more hospitals with outpatient alcohol/chemical dependency services. However, over the course of the study period the number in Pennsylvania fell relative to other states. By 1989, Pennsylvania had about the same number of facilities as did states with limited CON regulation. It is interesting to note, however, that hospitals in states with stringent regulation had the largest fraction of hospitals with outpatient alcohol/chemical dependency programs. This could be due in part to the fact that some states with stringent regulation in the inpatient sector did not effectively regulate the outpatient sector.

g. Rehabilitation Services

The growth of rehabilitation services is a controversial subject that should be frequently monitored by the State if control is retained. The expansion in rehabilitation care beds reflects

Exhibit 3.9

ALCOHOL AND CHEMICAL DEPENDENCY

**Performance of Pennsylvania Hospitals Relative to
Hospitals in Other States Under Differing Levels of CON**

	Alcohol/Chemical Dependency Beds (Number of Beds per Hospital)		Alcohol/Chemical Dependency Outpatient Services (Fraction of Hospitals Providing Service)	
	1985	1989	1985	1989
Pennsylvania	0	0	0	0
Stringent	-	-	+	+
Moderate	+	+	0	+
Limited	+	+	-	0
Repealed	+	+	-	+

The symbols in this table compare the experience of Pennsylvania hospitals to those in other states under the indicated level of CON stringency in 1985 and 1989. These results control for a variety of demographic, market, and other factors, and are obtained the econometric analysis described in Appendix I.

0 No substantial difference between Pennsylvania hospitals and hospitals in the given reference group (difference less than 15 percent).

- Less of a given cost or technology in hospitals in this group than in Pennsylvania hospitals (difference over 15 percent).

+ More of a given cost or technology in hospitals in this group than in Pennsylvania hospitals (difference over 15 percent).

an increased demand for these services stemming from fundamental changes in the need for these services and evolution in the type of services provided. On the other hand, cost-based Medicare reimbursement has also undoubtedly added to demand.

The increase in rehabilitation beds observed in Pennsylvania over the past decade was in part due to an inadvertent change in the review criteria which created a window of opportunity for expansions in rehabilitation (Exhibit 3.10). This loophole was closed by the Department with a new State Health Plan Amendment, approved in May 1991. As we showed earlier, however, there has also been a substantial expansion in inpatient capacity through the provision that allows hospitals to increase existing capacity by 10 beds or 10 percent of facility size.

Exhibit 3.10

Hospital Rehabilitation Services

**Performance of Pennsylvania Hospitals Relative to
Hospitals in Other States Under Differing Levels of CON**

	Rehabilitation Care Beds (Number of Beds per Hospital)		Rehabilitation Outpatient Services (Fraction of Hospitals Providing Service)	
	1985	1989	1985	1989
Pennsylvania	0	0	0	0
Stringent	-	-	0	-
Moderate	-	-	-	-
Limited	-	-	-	-
Repealed	-	-	-	-

The symbols in this table compare the experience of Pennsylvania hospitals to those in other states under the indicated level of CON stringency in 1985 and 1989. These results control for a variety of demographic, market, and other factors, and are obtained the econometric analysis described in Appendix I.

- 0 No substantial difference between Pennsylvania hospitals and hospitals in the given reference group (difference less than 15 percent).
- Less of a given cost or technology in hospitals in this group than in Pennsylvania hospitals (difference over 15 percent).
- + More of a given cost or technology in hospitals in this group than in Pennsylvania hospitals (difference over 15 percent).

More recently, Chapter 37 of the State Health Plan was changed to replace the bed need methodology with an occupancy standard for new services. Although industry representatives believe that this standard is more reflective of need than the previous criteria, the occupancy standard is still problematic because it enables existing providers to exert some control over the number of new entrants into the rehabilitation care market. The less quantitative provisions used by DNR to assess the size of existing waiting lists should thus be seriously considered in measuring the existence of need.

h. Psychiatric Services

The proliferation of psychiatric services was not controlled in Pennsylvania, as illustrated in Exhibit 3.11. The number of acute care beds grew rather quickly during the study period, and by 1989, the average hospital had substantially more beds devoted to psychiatric services than did hospitals from any of the reference groups. The fraction of hospitals offering outpatient services did not grow substantially during the period of study, but remained high relative to other groups throughout. The same applied to the fraction of hospitals providing consultation services.

B. Long-term Care Sector

The OMA is the dominant payor for long-term care in Pennsylvania: OMA covers about 62 percent of the patient days in nursing homes. Moreover, nursing home payments comprise about five percent of the total state budget. Long-term care expenditures are also the fastest growing component of Pennsylvania's Medical Assistance (MA) budget; from 1985 to 1989, state MA expenditures for long-term care increased 31 percent. This rate of increase is consistent with the rate of increase in the neighboring states of New York and Maryland, but significantly slower than the rate of increase in Ohio.

Pennsylvania's publicly financed long-term care system has been heavily skewed towards institutional services. The proportion of revenue devoted to institutional services is higher than in other states in the region with the exception of Ohio. The institutional focus of the program appears to be changing as the development of community-based services has become a policy priority.

Exhibit 3.11

Psychiatric Services

**Performance of Pennsylvania Hospitals Relative to
Hospitals in Other States Under Differing Levels of CON**

	Psychiatric Acute Care Beds (Number of Beds per Hospital)		Psychiatric Outpatient Services (Fraction of Hospitals Providing Service)		Psychiatric Consultation (Fraction of Hospitals Providing Service)	
	1985	1989	1985	1989	1985	1989
Pennsylvania	0	0	0	0	0	0
Stringent	-	-	+	0	0	-
Moderate	-	-	-	-	-	-
Limited	-	-	-	-	-	-
Repealed	-	-	-	-	-	-

The symbols in this table compare the experience of Pennsylvania hospitals to those in other states under the indicated level of CON stringency in 1985 and 1989. These results control for a variety of demographic, market, and other factors, and are obtained the econometric analysis described in Appendix I.

- 0 No substantial difference between Pennsylvania hospitals and hospitals in the given reference group (difference less than 15 percent).
- Less of a given cost or technology in hospitals in this group than in Pennsylvania hospitals (difference over 15 percent).
- + More of a given cost or technology in hospitals in this group than in Pennsylvania hospitals (difference over 15 percent).

Controlling the growth of long-term care beds has been a primary goal of CON in Pennsylvania. Limiting the supply of long-term care beds through CON is expected to slow the growth of the state MA budget and encourage appropriate placement in institutional settings. This section begins with a discussion of the long-term care bed need methodology, introduced in 1991, since it determines the need for additional nursing home capacity and is the benchmark against which the program can be assessed. It then assesses the effectiveness of the CON program in controlling the total nursing home bed supply and encouraging the expansion of community-based services.

1. Long-term Care Bed Need Methodology

Pennsylvania requires a CON for nursing home development, expansion, or renovation. "Nursing home" is defined to include: skilled nursing (SNF) and intermediate care facilities (ICF) participating in Medicare and Medical Assistance; any nursing home licensed in Pennsylvania; and hospital beds licensed as long-term care beds. A nursing home can, however, increase its capacity by the lesser of 10 beds or 10 percent over a two year period without obtaining a CON.

The bed-need methodology, and the resulting calculation of needed and/or excess nursing home beds, is the primary parameter within which CON operates in the long-term care sector. Pennsylvania recently revised the long-term care chapter of the State Health Plan and changed the bed-need formula from the Hill-Burton demand-based formula to a need-based formula for determining bed need. The demand-based formula incorporates the utilization rates of existing facilities into the estimates. The formula provided more beds to counties with high utilization, regardless of population base and need. Application of this formula is believed to have resulted in a maldistribution of nursing home beds across the state. As of 1989, bed/population ratios for counties ranged from 19.1 to 161.4 per 1,000 population over age 65.

The revised bed-need methodology is based on an assessment of need rather than on traditional demand approaches. The methodology is based on one developed by Dr. Weissert at the University of North Carolina, which projects nursing home bed need from estimates of the number of residents who are functionally impaired and dependent with respect to activities of daily living and with respect to mobility in a given area. Most state officials and providers

reported that the new bed-need methodology more accurately reflects the long-term care needs in Pennsylvania than the prior demand-based methodology. The steps for calculating bed need are:

- Estimate the total number of functionally dependent persons in the population by age, race, and sex using measures developed by the University of North Carolina. These estimates are applied to the population cohorts in Pennsylvania.
- Select a target percent of the functionally dependent elderly population who will require nursing home services. Pennsylvania assumes that 18.5 percent of these persons in urban areas and 20.5 percent in rural areas will require institutional services. Urban residents are assumed to have greater access to alternative forms of care than rural residents. These percentages are applied to future estimates of the number of functionally dependent elderly persons to arrive at an unadjusted bed need estimate.
- Two adjustments are made:
 - An adjustment is made for the under age 65 population that is likely to require nursing home services.
 - An adjustment for 95 percent occupancy is made.

A comparison of the projected 1992 bed need estimates from the two methodologies is shown in Exhibit 3.12. The new methodology reduced the 1992 projected bed need from 102,111 beds to 98,535 beds.

In 1991, 99,148 beds existed or were approved under CON. The new methodology projected that a total of 98,535 beds would be required by 1995, resulting in a statewide excess of 613 nursing home beds. At the same time the methodology projected need for 13,479 additional beds in identified counties. This phenomenon stems from the use of the individual county as the unit for analyzing bed need or excess. In addition, beds needed in an individual county are not offset against excess beds in another county.

One rationale for projecting need on a county-by-county basis is to ensure access for inner city residents. When bed need was estimated by HSA, the state experienced expansion in the suburbs at the expense of inner city areas and the minority elderly. The lack of nursing

**EXHIBIT 3.12
COMPARISON OF THE DEMAND AND NEED-BASED
LONG-TERM CARE BED NEED METHODOLOGIES**

County	1992 Projected Bed Need		LTC Beds Still Needed	
	Demand-Based	Need-Based	Demand-Based	Need-Based
Bucks	2,902	2,891	0	0
Chester	1,814	1,952	0	93
Delaware	4,762	4,592	0	0
Montgomery	4,870	5,466	0	231
Philadelphia	12,796	16,609	4,304	7,825
HSA 1 Totals:	27,144	31,511	4,304	8,150
Berks	2,897	2,695	0	62
Carbon	507	511	0	0
Lehigh	2,776	2,077	0	0
Monroe	844	668	9	133
Northampton	1,782	1,966	0	
HSA 2 Totals:	8,806	7,916	9	195
Lackawanna	2,804	2,184	501	0
Luzerne	4,389	3,324	676	0
Pike	261	197	0	0
Schuylkill	2,071	1,585	208	0
Wayne	379	401	41	0
Wyoming	190	201	66	77
HSA 3 Totals:	10,094	7,893	1,492	77
Adams	881	495	0	0
Cumberland	2,153	1,353	0	0
Dauphin	1,976	1,825	0	0
Franklin	1,092	826	86	0
Lancaster	3,884	2,830	274	0
Lebanon	1,208	907	0	0
Perry	274	258	0	0
York	2,592	2,239	37	0
HSA 4 Totals:	14,060	10,733	397	0
Centre	863	614	117	0
Clearfield	846	721	114	18
Clinton	363	333	45	0
Columbia	750	510	90	0
Jefferson	476	463	43	0
Juniata	278	159	43	0
Lycoming	1,112	893	61	0
Mifflin	522	408	80	0
Montour	340	188	30	0
Northumberland	1,202	939	7	0
Snyder	299	262	58	0
Tioga	288	323	20	0
Union	452	272	52	0
HSA 5 Totals:	7,791	6,085	760	94

EXHIBIT 3.12 (Continued)
COMPARISON OF THE DEMAND AND NEED-BASED
LONG-TERM CARE BED NEED METHODOLOGIES

County	1992 Projected Bed Need		LTC Beds Still Needed	
	Demand-Based	Need-Based	Demand-Based	Need-Based
Allegheny	9,223	12,323	0	3,191
Armstrong	1,027	797	373	23
Beaver	1,927	1,553	107	108
Butler	1,216	1,034	0	0
Fayette	1,345	1,388	418	716
Greene	280	335	48	0
Indiana	682	587	108	13
Lawrence	1,312	936	45	0
Washington	1,789	1,870	0	504
Westmoreland	3,027	2,924	0	69
HSA 6 Totals:	21,828	23,748	1,099	4,626
Cameron	84	62	44	22
Clarion	398	308	4	0
Crawford	917	671	0	0
Elk	418	318	160	12
Erie	2,545	1,925	0	0
Forest	58	43	0	0
McKean	565	437	0	0
Mercer	1,378	1,067	7	0
Potter	208	157	0	0
Venango	629	410	181	0
Warren	500	351	41	0
HSA 7 Totals:	7,700	5,750	437	34
Bradford	513	***	52	0
Sullivan	64	***	0	0
Susquehanna	332	***	69	0
HSA 8 Totals:	909	868	121	0
Bedford	342	399	17	74
Blair	1,112	1,107	0	0
Cambria	1,323	1,448	0	141
Fulton	91	97	34	40
Huntingdon	273	323	46	48
Somerset	638	657	0	0
HSA 9 Totals:	3,779	4,031	97	304
Pennsylvania	102,111	98,535	8,716	13,479

*** NYPENN HSA Long-Term Care Plan Projections effective through June 1993.

Source: Pennsylvania State Health Plan

home beds in inner-city areas is evidenced by the need for 11,016 beds (about 82 percent of total bed need) in Philadelphia and Pittsburgh alone.

In addition to the bed-need methodology, the CON rules permit approval of beds above the need estimate in special circumstances. Beds may be approved in a county with excess beds if the average annual occupancy rate in that county exceeds 95 percent for three years or if waiting lists are exceptionally long. Beds may also be approved if the project will serve a special need that otherwise would go underserved, such as severely disabled persons.

The criteria also include two provisions encouraging long-term care providers to make available alternative services in addition to nursing home beds. Applicants must demonstrate linkages between services offered by the institutional nursing home and services offered by community-based social service and home health care programs and agencies and demonstrate participation in community service coordination efforts.

2. Changes in Total Bed Supply

The number of approved beds increased from 87,711 in 1989 to 99,148 by 1991, a total increase of 13 percent. Between 1987 and 1991 the CON program approved 12,197 nursing home beds, 3,418 more than the projected number to be required by 1992 according to the old bed-need methodology. However, under the revised bed-need estimates the Commonwealth needed 13,479 additional beds by 1992. Much of this increase in bed need represents an attempt to correct the maldistribution of nursing home beds in Pennsylvania.

The Commonwealth has experienced difficulty encouraging providers to build nursing homes in Philadelphia despite the large bed need in that area. The residents are primarily Medical Assistance recipients, and, given the moratorium on new capital reimbursement from Medical Assistance and the low Medical Assistance reimbursement rate, providers have not been interested in locating in Philadelphia. The Department of Public Welfare has granted exceptions to the moratorium for beds to be added in Philadelphia and Schuylkill counties; these exceptions total about 1200-1500 beds.

It is difficult to assess the extent to which increases in the number of beds have been moderated due to the independent impact of CON. Other factors have been important in constraining growth. For example, since construction of nursing home and alternative facilities are constrained by the availability of capital, tight capital markets may have imposed some limits irrespective of CON. The Medical Assistance moratorium likely affected the growth in the bed supply. Since Medical Assistance funds cover 62 percent of all nursing home patients, a moratorium on Medical Assistance beds effectively limits operating revenues.

Despite these factors, a considerable number of CON applications continue to be filed for nursing home beds. Relevant experience of other states indicate two possible explanations. First, business competition among providers in an area leads to the likelihood that most will apply for new beds when they are made available in order to avoid a potential competitive disadvantage. Second, nursing home beds tend to fill rapidly once built due to persistent demand.

3. Expansion of Community-based Care

CON was intended to moderate increases in the number of nursing home beds and thus promote demand for alternative community-based services. The underlying theory is that by constraining increases in nursing home beds, demand is created for community-based services. Conversely, allowing increases in nursing home beds increases the demand for institutional care and does not encourage adequate community-based service development. The Commonwealth estimated through its OPTIONS program (a pre-admission screening program) that 35 percent of potential nursing home admissions can be diverted to alternative care settings when appropriate alternatives are present.

Pennsylvania has lagged behind other states in its development of community-based services. The CON criteria require applicants to demonstrate linkages with community-based services, but these services have been slow to develop in the Commonwealth due to funding constraints. Pennsylvania's OPTIONS program is expected to encourage utilization and growth of community-based care. Studies have shown that the existence of community-based care is not sufficient to reduce institutionalization.

IV. THE ROLE OF CON IN ADVANCING ACCESS AND QUALITY

In this section, we discuss the role of CON in promoting access and maintaining quality of care. Although many legislators in Pennsylvania consider control of costs to be the primary function of the CON program, access and quality have an important place in the state's approach to CON. Both access and quality issues appear in DOH direction of the CON program, review criteria, and decisions. As we will discuss below, the role of the CON program in Pennsylvania differs for acute and long-term care.

Advancing access and quality in health care has historically been the dominant goal of the Pennsylvania DOH. As stated by a Work Group chaired by former Secretary of Health Richards:

The Department should focus its regulatory function on its primary mission of assuring both the quality of and access to health services.⁴

Although the current leadership of the Department appears to place more emphasis on cost containment, ensuring access and quality are important goals of the Department and the CON program.

It is difficult to measure both quality and access, since there are few valid comparative measures of outcomes in these areas. Our analysis will thus rely largely on assessments of DOH goals and observations of the CON process. We also report statistics on the volume of services provided in selected acute care service areas, although this is not a direct measure of the quality of services being provided.

⁴ N. M. Richards. Interim Report of the Health Services Planning Policy Work Group. November 28, 1989.

A. Acute Care

In the acute care sector, the Department has used CON as a tool to promote quality, and has expressed an interest in keeping CON for services where "volume and quality are related and where current quality standards are insufficient to prevent service proliferation and/or over utilization which might be harmful to patients."⁵ Although statute indicates that CON should also be used to promote access to acute care, this goal does not appear to translate directly into DOH policy.

1. Quality of Care

According to officials within the DOH, quality assurance is one of the primary goals of the CON program. A number of aspects of the program are intended to promote this goal, including (1) provider and Departmental input into the State Health Plan; (2) review of applications by specialists within the Department; and (3) specification of volume standards for selected acute care procedures. Each is discussed below.

It is important to note, however, that CON is a limited tool for promoting quality acute care services. 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 and staffing.

a. Input Into SHP

The Department has established a collaborative process for revising and updating the SHP (described in detail in Section II). A variety of providers are encouraged to participate in the development of the SHP. In addition, the Bureau of Quality Assurance and any other affected Bureaus have input into revisions to the State Health Plan. Because the SHP is closely followed in rendering CON decisions, policies that promote quality of care can be expected to influence

⁵ Ibid.

need determinations for new facilities and services. Of course, such input will not influence existing services.

b. Review of CON by DOH

Review of CON applications by the Department serves two quality control functions. First, CON is currently the only way that the state is able to monitor the opening of new acute care services. The licensure program only monitors the establishment of new facilities and beds and does not license new services. For example, a licensed hospital could open up a cardiac catheterization lab without informing the licensure unit in the Department of Health.

Second, applications for selected types of facilities are also reviewed by experts in the field to assess the competency of those operating them. The CON review criteria specify that the reviewer must consider "whether, in the case of existing services or facilities, the quality of care provided by services or facilities in the past has been considered." For example, psychiatric facilities are also reviewed by the Department of Public Welfare, Office of Mental Health. Applications for substance abuse facilities are reviewed by the DOH, Office of Drug and Alcohol. If providers are found by these members of the Department to be deficient, a CON can be denied.

c. Relationship Between Quality and Volume

Pennsylvania's CON program also intends to promote quality of care by ensuring that minimum volume standards are met. The goal of the program in these cases is to promote the concentration of services in a limited number of high-volume hospitals. Minimum volume standards are specified as elements of the SHP. In order to be granted a CON for such services, hospitals must show that demand exists so that minimum volume thresholds will be met without drawing patients from those other institutions that currently have the service.

The medical literature on the relationship between quality and volume focuses on surgical procedures and has indicated that a higher volume of patients undergoing some procedures is associated with lower mortality and complication rates. Higher-volume hospitals also have

shorter average postoperative lengths of stay and fewer patients with very long lengths of stay. Although the relationship between volume and quality for some surgical procedures has been clearly established, there is no consensus on why this relationship exists, and it is also unclear whether consolidation of services will result in better outcomes. Nevertheless, quality-volume relationships have led professional and specialty societies to call for minimum volume standards, and Pennsylvania has chosen to do likewise.

The DNR typically relies on hospital estimates of patient base when ensuring compliance with these provisions. It is difficult for the DNR to assess whether these estimates are accurate or whether a facility's estimate may double count the market share of another provider.

The volume data for open heart surgery and cardiac catheterization suggest that DOH has been successful in limiting services to providers with adequate volume. Three hospitals have volumes of open heart surgery below 100 procedures per year, and two hospitals perform fewer than 300 cardiac catheterizations per year. The department does not have a mechanism for ensuring compliance with the volume standards. This may create a problem in the future since hospitals that currently have an approved service (e.g., cardiac catheterization) can add another lab without CON review.

The Department hopes to use CON as a tool to ensure compliance with volume standards in the future. The Department needs statutory and regulatory authority to take away CONs if a facility is found to be out of compliance with the terms of its CON, or if there has been a substantial change in circumstances. The statute and regulations also authorize the Department to withdraw a CON if the project has not been implemented within a given time period. DOH hopes to increase the use of CON as a tool to hold hospitals accountable to the volume figures that they present in order to obtain the CON for services such as cardiac catheterization and open heart surgery. Because CON has historically been a reactive policy tool, such monitoring of compliance would represent an innovative use of CON policy.

2. Access to Care

Access to care is also a primary concern of the Department that is addressed in the CON guidelines. The CON review criteria specify that "consideration shall be given to whether the proposed new institutional health service meets or contributes to the health related needs of members of medically underserved groups." However, it does not appear that access to care is a primary determinant of CON eligibility in the state or that the state ties CON decisions to access considerations as is common in many other states. There are two types of access problems: geographic (difficulty obtaining services due to their location) and financial (services are not available to those unable to pay for them).

The DOH indicated that geographic access is considered in acute care CON decisions and mandated in the review criteria. However, this is only one of a number of criteria for approval, and it is not generally incorporated into acute care SHP chapters or the checklist used by planners to determine whether a CON should be granted. The Director of the DNR indicated that access would not be sufficient grounds on which to approve or deny a CON in acute care. The HAP confirmed that geographic access is sometimes mentioned, but that it is not widely used as a basis for decisions in urban acute care decisions.

Currently, CON policy statements require that hospitals granted a CON must treat a "fair share" of medically indigent patients. Based on interviews with DNR staff, however, it does not appear that this criterion is critically appraised by staff reviewing applications. They indicated further that financial access is difficult to measure, and, as such, will generally not constitute grounds for either granting or disapproving a CON. The CON program does not use conditional approvals and thus does not have the leverage available to some states to approve a service conditional on the acceptance of an agreed-upon fraction of indigent patients.

The Department has proposed to increase the presence of the financial access criteria by using percentages to judge whether the hospital is accepting a "fair share" of medically indigent patients. The HAP is opposed to the use of percentages, pointing out that CON is a reactive tool and that the use of CON to promote access to care for the poor discriminates against those hospitals that are entering the market since it cannot affect existing hospitals.

B. Long-Term Care

For long-term care, the quality dimension of CON review is limited, but is sometimes used to judge the appropriateness of the provider. By contrast, access to care is more important. The policy statement indicates that a facility must treat a "fair share" of medically underserved patients, and this criteria appears to be enforced in review of applications. Geographic access is addressed through the bed need methodology, which is used to determine whether need exists in a given location.

1. Quality of Care

The CON program specifies that the prior track record of providers be considered in CON reviews, but the program has not played a large role in promoting quality of long-term care. One instance in which DNR officials did feel that the program had functioned in this way was the treatment of a recent group of applications from an Ohio architectural firm. The Department found that this firm, which submitted applications for a large number of facilities, did not provide sufficient information for DOH to assess its ability to provide long-term care services.

2. Access to Care

Both geographic and financial access are important determinants of CON approvals of long-term care facilities. The primary basis for CON approvals in long-term care is the State Bed Need Methodology, as discussed in Section III above. This formula is fundamentally a determinant of geographic access, with adjustments designed to address non-institutional care and other state goals. Geographic access is also addressed in another provision, which allows CON approval if the occupancy for all facilities in the area exceeds 95 percent for the last three years, or if wait lists in the area are exceedingly long. In such cases, the burden of showing that demand exists rests on the applicant, and departmental procedure for granting CONs is ad-hoc.

DOH policy currently states that in order to obtain a CON, a long-term care facility must show that it will take a "fair share" of medically underserved patients. In interviews, the Division of Need Review indicated that they expect about a third of any new facility must be devoted to treating the medically underserved. The Division also expects that financial feasibility estimates

should be based on the assumption that a third of the residents should be medically underserved or participants in the Medical Assistance program. These informal guidelines are not part of the statute or the regulation, and we were not able to determine how consistently they were applied.

Nursing homes that propose to care for a disproportionately large share of medically indigent patients can also gain preferential treatment. The Department indicated that it has granted CONs to nursing homes when there is not a sufficient need demonstrated if the target population is the medically indigent. The OME, which administers the Medical Assistance program, has input into such decisions. The OME has made some exceptions to the Medicaid moratorium in order to promote access to care in Philadelphia and Allegheny County, the areas in which a high demand among indigent patients currently exists.

V. POTENTIAL CONSEQUENCES OF REPEAL

As we have shown, Pennsylvania's CON program was intended to address health care costs, the quality of services, and access to care. Repealing CON, or allowing the law to sunset, might thus have important consequences in each of these areas. In this section, we estimate the potential consequences of repeal for both the acute and long-term care sectors in Pennsylvania.

Our estimates of the potential consequences of repeal are based on a review of the effectiveness of the program in controlling costs and the diffusion of services, analysis of the role of CON in furthering access and quality, an assessment of market discipline in Pennsylvania, and interviews with members of DOH as well as health care providers in the state. In some acute care market areas, we draw on detailed comparisons of the diffusion of services in Pennsylvania to states that have repealed CON. For other state goals, such as improvement of quality and access to care, our discussion is more speculative.

We believe that a repeal of CON would have serious consequences for health spending and service diffusion in Pennsylvania, and that the effect would differ substantially across market areas. For acute care, repeal of CON would mean abandoning important state programs designed to promote quality of care. Based on the experience of states that have repealed CON, we would also anticipate an increase in the number of cardiac, psychiatric, and rehabilitation

facilities. However, we have no empirical evidence that overall acute care costs, the costs of capital improvement, or new technologic costs would increase in the state due to repeal. For long-term care, repeal of CON would almost certainly result in a substantial increase in state spending through the MA program. Repeal would also make it more difficult for the state to continue to address the maldistribution of nursing home beds.

These projections, detailed below, also serve as the basis for many of our recommendations in the following section. It is important to note that, while we have confidence in our projections, it is impossible to know the consequences of repealing CON in Pennsylvania with certainty. Health care services are provided in a dynamic market, and we cannot anticipate future medical and financial changes that are likely to affect the rise in costs and the speed of technologic diffusion. Spending will also depend on exogenous factors such as the state of the Pennsylvania economy and future initiatives by the federal government to address health care priorities. This uncertainty is especially applicable to new acute care services, which have historically been reviewable regardless of cost.

Finally, through our interviews, it appears likely that a repeal of CON in Pennsylvania could well be accompanied by administrative actions on the part of DOH, and possibly also OMA, to salvage elements of the program. Both of these agencies rely on CON to help address concerns about health care costs and access. In addition, a repeal of CON, with accompanying increases in costs and services in selected markets, might hasten further state legislative action to address health system problems.

A. Acute Care

The Department of Health has expressed the desire to phase out CON for acute care in service areas that show economic discipline and do not require CON as a quality control. This emerged in our interviews and was also expressed by the Department as follows:⁶

The Department feels that competition should be encouraged where it brings about good results, such as holding down consumer prices while maintaining high quality, and where consumers could be offered a wider choice of cost-effective diagnostic and treatment alternatives.

The consequences of repeal in each acute care service area depends critically on whether economic discipline currently exists in Pennsylvania and whether the CON program has been successful in controlling costs or diffusion of services.

We begin this section with a discussion of whether economic discipline currently exists in Pennsylvania. We believe that despite some improvement over the last decade, market forces alone cannot currently be expected to control the rise in acute care costs or the diffusion of services. Although the DOH has often espoused a pro-competitive stance on acute care regulation, the legislature has done little to encourage competitive markets. For example, the state retains restrictive HMO regulation. We conclude that the State cannot rely on a competitive marketplace to contain the costs of acute care services.

Next, we consider the potential consequences of repeal on overall costs and the proliferation of each acute care service area. This section relies on our econometric analysis to provide a comparison to states that have repealed CON, and also considers other Pennsylvania-specific data that we have obtained. As we will show, we would expect repeal to result in the further diffusion of a variety of acute care services in the State.

⁶ N. M. Richards. Interim Report of the Health Services Planning Policy Work Group. November 28, 1989.

1. Economic Discipline and Other State Health Goals

The DOH has demonstrated an understanding of economic discipline, as evidenced in the 1989 streamlining of the CON program. The intention of this action was to take away supply controls from markets that exhibited sufficient discipline without such regulation.

An economically disciplined market is one in which neither providers nor consumers of health care services may pass the cost of their mistakes on to others with impunity. Health care markets have been characterized by the absence of economic discipline where providers and consumers are held financially accountable for their actions. A number of factors contribute to the lack of discipline in health care markets, most notably the presence of insurance and third-party reimbursement, which shield consumers from the true costs of their care.

A variety of factors have increased market discipline over the past decade, including the growth of managed care and new limits on availability of capital for hospitals. In addition, the Federal government has taken effective steps to bring Medicare costs under control, and Pennsylvania has sought to control MA and other state spending on acute care. Despite the past decade's gains, however, the market for acute care as currently configured cannot alone be expected to restrain the rise in costs. After a brief respite gained by reducing the number of hospital days, hospital costs in Pennsylvania are again rising at double digit rates.

Finally, it is important to recognize that even in a disciplined market, the state will ultimately face a trade-off between rising costs, and access to care and quality. After inefficiency is reduced, restricting costs will affect access to care or the quality of care received. In addition, while many states are equally concerned about rising health care costs and growing access barriers, they have been reluctant to enact major expansions in access without first controlling costs. For these reasons, we believe that the problems of cost, quality, and access need to be addressed simultaneously through integrated strategies.

a. HMO Regulation

Self discipline in health care markets is encouraged by the presence of managed care. By assuming responsibility for both the medical and the fiscal aspects of care, HMOs, PPOs, and other such plans are well-positioned to make decisions about cost-effective care. HMOs are typically lower in cost than fee-for-service plans; in addition, there is evidence that as HMO enrollment in an area increases, price competition is fostered, and fee-for-service costs are reduced.

Although the legislature has indicated an interest in promoting market discipline, HMOs and PPOs have not established a large presence in Pennsylvania. With the exception of Philadelphia, in which one dominant HMO has emerged, HMO enrollment in Pennsylvania is smaller than the national average. This appears to be due to: (1) restrictive regulation of HMOs in the state; (2) geographic dispersion of much of the Pennsylvania population; and (3) the strong presence of dominant payors in the state.

i. HMO Penetration in Pennsylvania

HMO penetration in Pennsylvania has not been highly successful. About 12.5 percent of Pennsylvania residents are enrolled in HMOs, one percent below the national average, and 2.5 percent below the average for northeast states.⁷ The steady growth in enrollment over the last decade mirrored the national pattern.⁸ The number of HMOs in Pennsylvania increased rapidly in the 1980s, peaked in 1987, and then declined (Exhibit 5.1).⁹ The latter decline, also observed nationally, is due to closures and mergers.

⁷ Interstudy. Managed Care: A Decade in Review. 1991.

⁸ Ibid.

⁹ The Hospital Council of Western Pennsylvania. The HMO/PPO Report. July 1991.

Exhibit 5.1	
Number of HMOs in PA	
Dec. 1980	8
Dec. 1984	13
Sept. 1987	31
April 1988	30
April 1989	24
April 1990	23
April 1991	19

The level of HMO penetration varies greatly in different parts of the state. The Philadelphia area has the highest HMO penetration level, due mostly to the HMO of Pennsylvania, the dominating HMO in the state, with enrollment close to 600,000.¹⁰ Almost 40 percent of all HMO enrollees are enrolled in HMO of Pennsylvania. It is an aggressive plan that has grown rapidly and has legitimized the idea of an HMO to many consumers and providers. It is the fifth largest HMO in the country, although its rate of growth has leveled off since 1987. In the 1980s many new HMOs formed in the Philadelphia area, but none have been very successful, and several have failed.

Of the 21 HMOs in the state as of December, 1990, 13 were based in eastern Pennsylvania, six were based in western Pennsylvania, and two were operating in both regions. The majority of the HMOs in western Pennsylvania are located in the Allegheny County area, while the majority of the HMOs in eastern Pennsylvania are located in the Philadelphia County area. Market penetration by HMOs in the Philadelphia area was significantly greater in the Philadelphia area than in the Allegheny County area: the Philadelphia area had an HMO penetration rate of 21 percent, compared to Pittsburgh's 10 percent.

ii. Regulation of HMOs in Pennsylvania

All states and the federal government have regulations regarding the operation and establishment of HMOs; this legislation grew out of the perception that HMOs carry an insurance

¹⁰ ibid.

risk, and also that a business-oriented organization providing health care should be regulated. Pennsylvania has one of the most rigid regulating systems for HMOs in the country, which has limited the ability of HMOs to maneuver, set rates, and enhance their competitive positions.

Pennsylvania's HMO regulations are modeled after the original federal HMO regulations. The federal government has since reduced its regulatory stringency, however, while Pennsylvania has not. HMOs are required to file rates with the Insurance Department every year, limiting their ability to rate flexibly and to get rate increases. Pennsylvania imposes strict limits on open-ended enrollment, although a policy change has recently been proposed that would allow HMOs to have point-of-service plans. HMOs must also be certified by both the Insurance and the Health Departments; providers have indicated that this process is slow.

iii. Market Forces Retarding HMO Growth

A number of market forces also affect HMO growth in Pennsylvania. HMOs in Pittsburgh and western Pennsylvania have been less successful than those in Philadelphia because the development of HMOs has been hindered by the depressed economy in the area. The western Pennsylvania area is also dominated by Blue Cross, which has about a 70 percent market share. This dominance is largely a result of the strong unionization of the area; generous levels of benefits have already been negotiated into union contracts.

HMOs have also not been successful in the rural areas of western and central Pennsylvania; this part of the state consists of much smaller markets. HMOs tend to do less well in areas where the population is dispersed geographically, and in areas that lack a competitive medical market.

b. Hospital Capital Markets

A major objective of CON was to contain the rise in capital spending. CON was implemented during a time when there were few limits on the ability of hospitals to gain access to capital. Hospitals were assured of easy financing of nearly all capital projects because of guaranteed reimbursement under Medicare and other insurance programs, and because

favorable terms of depreciation and tax exemption made hospital bonds readily available. However, hospital capital markets have changed markedly in recent years, and hospitals no longer have ready access to capital. It is thus important to look at the capital market and to assess whether there is now sufficient self-discipline to control capital spending in the absence of regulation.

In the private sector, market forces are increasingly restricting access to capital. Credit institutions currently do an in-depth analysis of the hospital and its financial prospects, including population trends, income of potential patients, the epidemiology of the area, and market conditions. Commercial insurers and HMOs also have been increasingly scrutinizing hospital capital costs. Furthermore, payments for capital projects have been restricted by Medicare's prospective payment for capital, which is currently reimbursing hospitals for 90 percent of such costs. In addition, the credit ratings of many hospitals have been downgraded as occupancy rates have declined, and hospitals have been forced to close. As a result, currently only those institutions that show promise of being able to increase their billings or their market share are likely to have ready access to capital.

This situation has resulted in reductions in both the volume of bond placements, and the downgrading of existing bonds and new issues. This situation has caused some hospitals to obtain funds from banks, to release ungraded issues, borrow on existing capital, and obtain technologic equipment under lease/purchase arrangements. It is also the perception of experts that these new requirements have affected small community hospitals more than prestigious teaching hospitals, which can generally obtain favorable bond ratings by illustrating that projects will be financially viable.

While it might be more difficult for hospitals to obtain capital, this has not prevented a substantial expansion in the hospital-based centers for psychiatric treatment, rehabilitation, and other services in the state. The current capital situation thus imposes increased discipline on hospitals, in that they must demonstrate that the proposed project will be economically viable. However, the test imposed by the capital markets is strictly one of financial viability: the bond markets care whether the hospital will repay its debt, not whether it will be providing low cost care to indigent populations that might otherwise have no access to care. Because a new facility

will be profitable, this does not guarantee that it will be a positive influence on the health care system in Pennsylvania.

c. Restraints on Federal Spending

Programs adopted by the Federal government set a precedent for strict control of government outlays on acute care. Facing annual double digit increases in the costs of hospital care, the Federal government decided that such increases could not be sustained. The result was the enactment of the Prospective Payment System, which set hospital rates prospectively through the familiar system of diagnostically related groups (DRGs). Ample evidence has shown that such controls have worked. Between 1976 and 1982, real Medicare costs rose at about twice the rate of the private sector; between 1982 to 1988 the situation was reversed. Medicare expenditures under prospective payment fell steadily over this period so that by 1987 and 1988 the rise averaged only 0.6 percent per year.¹¹

Increased Federal control can be expected to effectively solve the Medicare cost problem in other areas of acute care in the near future. Effective 1992, the Federal government has enacted a new system of physician reimbursement that is based on the resources used by physicians in delivering services. This legislation also grants Congress strict control over the increase in physician expenditures for each year. Recent capital regulations have also increased financial control, and regulation of hospital outpatient services will serve to increase control in the future.

While PPS controlled the costs to the federal government, however, there is evidence that hospitals did little to restrict the rise in their spending during this period. While the rise in Medicare expenditures in 1987 and 1988 averaged only 0.6 percent per year, the rise in non-Medicare expenditures increased to almost 9 percent per year during this period: Medicare costs were thus shifted to other payors. In addition, Medicare physician expenditures increased

¹¹ Schwartz WB, Mendelson DN. Hospital cost containment in the 1980s: hard lessons learned and prospects for the 1990s. New England Journal of Medicine, April 11, 1991.

rapidly during this time, presumably due to the shifting of patients out of hospitals into the physician sector.

In summary, the Federal government is moving toward establishing more comprehensive controls on Medicare expenditures. However, these controls are not likely to reduce systemwide costs. Although the Federal government may adopt global budget limits for hospitals or a National Health Insurance system at some point, this does not appear likely in the short run.

d. Pennsylvania Efforts to Promote Market Discipline

The Commonwealth has adopted a few programs to promote disciplined health care markets. Control of acute care MA spending has been a priority for the Office of MA, although such programs can be expected to have little effect on overall spending since MA spending composes less than 10 percent of all acute care spending. The state has attempted to contain physicians' fees through legislation limiting the maximum charges for Medicare visits. However, none of these programs would be expected to address the issues targeted by the CON program should the law sunset.

2. Likely Consequences of Repeal on Acute Care Costs and Service Diffusion

In this section, we estimate the likely changes in the acute care sector that would result from a repeal of CON. Our econometric analysis allows us to compare Pennsylvania's experience over the past 10 years with that of states that repealed their CON programs. We supplement these data with relevant information about changes in market environments.

a. Hospital Spending

Empirical evidence does not suggest that repealing CON in Pennsylvania will result in increased hospital costs. Our econometric analysis showed that CON had not controlled acute care hospital spending, spending per admission, capital spending, or capital spending per admission. Further, programs in repealed states did not exhibit an increase in overall per-facility costs after CON had been repealed.

b. Cardiac Services

CON successfully restrained the fraction of hospitals offering cardiac catheterization facilities through 1989, although a loophole in the program allowed the proliferation of cardiac catheterization at those institutions that had been granted a CON. Nevertheless, we would expect to see an expansion of cardiac catheterization facilities if the law were repealed. Cardiac catheterization tends to be a profitable service and is thus desired by those facilities currently not offering it. A repeal of CON would also make it difficult for DOH to address quality through the minimum volume standards required in order to obtain a CON.

The CON program also restricted the number of facilities doing open heart surgery, and the average number of cardiac intensive care beds per hospital. Under repeal, we would expect to see some expansion of these service areas as well.

c. Organ Transplants

CON also constrained the number of hospitals performing organ transplants. The presence of such programs also varied by level of CON stringency: stringent programs had fewer facilities, and states that repealed CON witnessed an expansion in such programs. Thus, repeal probably would result in expansion of the number of hospitals carrying out such services, and would also make it more difficult for the state to achieve its quality goals, as articulated in the recently revised State Health Plan Chapter 42.

d. Ambulatory Surgery

Although CON controlled the proliferation of ambulatory surgery in hospitals somewhat, most hospitals had obtained such facilities by 1989. While we do not have comprehensive data on the number of freestanding ambulatory facilities in the state, many CON approvals were granted over the last decade. In addition, some surgical procedures increasingly are being carried out in physicians' offices. The spread of ambulatory facilities, both hospital-based and freestanding, was part of a conscious effort on the part of the DOH to increase competition. In

summary, we lack adequate data to predict the consequences of repeal in this area. It appears, however, that a substantial amount of service diffusion has already occurred in the state.

e. Pediatric and Neonatal Intensive Care

CON did control the number of pediatric and neonatal intensive care beds in Pennsylvania hospitals. Our results also showed that diffusion of such services was greater in states that had repealed CON. However, it is important to note that such services are often not profitable for hospitals, especially for hospitals treating a disproportionate share of neonates that are born prematurely to mothers with substance abuse problems. We would thus expect some diffusion of pediatric and neonatal intensive care if CON were repealed, but probably not as much as would be expected in cardiac or cost-based reimbursed services.

f. Imaging Technologies

CON controlled the diffusion of hospital-based MRI (e.g., the area under CON jurisdiction) to a limited extent. The program did not restrain the diffusion of CT scanners and ,in fact, recently dropped this service from the list of reviewable technologies. This change is reflective of Departmental policy that restricting the availability of high-technology services may have anti-competitive effects. The Department cites the example of lithotriptors: the cost of these services decreased dramatically after they were allowed to diffuse in the Western part of the state.

Control of technology poses difficult challenges for the CON program, which should be addressed explicitly in the State Health Plan. The diffusion and operation of such technologies is highly consumptive of resources and is responsible for a substantial portion of the rise in costs. Yet new technology also brings new clinical benefits that are demanded by patients. A detailed study of the Massachusetts CON program in the early 1980s indicated that restraints on the diffusion of new technology did reduce spending somewhat in Massachusetts, but also resulted in delays in the diffusion of needed therapies to patients. The State Health Plan process in Pennsylvania lends an appropriate forum for dealing with such issues.

g. Alcohol and Chemical Dependency

CON did control the number of alcohol and chemical dependency beds per hospital, and control in states with more stringent CON programs was more restrictive than that in Pennsylvania. Such services are generally profitable for hospitals, especially since the Medicare system reimburses hospitals on the basis of historical costs. If CON were repealed, we would expect substantial increases in service diffusion in this area.

h. Rehabilitation Services

CON did not control proliferation of rehabilitation beds or rehabilitation outpatient services. Reimbursement for such services also tends to be favorable, and rehabilitation thus diffused rapidly in the state between 1980 and 1989. In the absence of any change in the CON program, or if CON were repealed, we would expect the proliferation of rehabilitation services to continue.

i. Psychiatric Services

CON did not control the growth of hospital-based psychiatric services in either the inpatient or the outpatient setting. Cost-based reimbursement for Medicare patients and favorable reimbursement from commercial payors makes such services profitable for most hospitals. In addition, a number of for-profit psychiatric firms have expressed interest in increasing their presence in Pennsylvania. In the absence of any change in the CON program, or if CON were repealed, we would expect the proliferation of psychiatric services to continue.

B. Long-Term Care

This section projects the consequences of repealing CON for long-term care in Pennsylvania. Because we lack access to detailed quantitative data of the type that served as a basis for our acute care evaluation, we draw on program data and a comparison to the experience of other states that have repealed CON in long-term care. We start by assessing the extent to which economic discipline exists in the long-term care sector, and then estimate the potential effect of repeal.

We believe that repeal of CON for long-term care would result in an acceleration of building, especially in areas that are already considered over-bedded according to the new bed need methodology. Thus, repeal would be likely to impede progress towards the state's goals of encouraging construction of facilities in underserved areas. Increases in the number of beds would probably also result in increases in MA spending on long-term care, despite the moratorium on payments for new capital in nursing homes.

1. Economic Discipline and Access to Long-Term Care

The long-term care sector is characterized by a lack of economic discipline. The dominant feature of long-term care payment is the fact that over 60 percent of patient days are paid for by the state. The presence of Medicaid reimbursement for nursing home care and the ability of private pay patients to spend down to Medicaid contributes to the lack of economic discipline in the long-term care sector. In addition to CON, the state has two mechanisms in place to address the lack of economic discipline and the potential for large increases in long-term care spending: pre-admission screening, and stringent rate-setting by MA; but neither of these important tools can be expected to take the place of CON.

Pennsylvania's OPTIONS program has begun to encourage monitoring of the severity of nursing home admissions. This program, however, cannot be relied upon to impose economic discipline in isolation. First, a study conducted through the OPTIONS program indicated many nursing home admissions could still be diverted to alternative care settings if appropriate alternatives were present. This study suggests that while pre-admission screening may have begun to encourage efficient utilization, progress in this area has been slow.

The state has also sought to control MA spending through implementation of restrictive reimbursement rates for long-term care. The MA moratorium and low rates for operating costs have contributed to the restraint of MA spending in the state. Restricting rates can reduce the price paid for services, however, it will not stop increases in the quantity of patients paid for by the program. Demand for CONs remains high, and with an appropriate mix of patients, nursing homes continue to be profitable. Because of the Medicaid spend-down provisions, the expansion in beds that would be expected under repeal would also result in an increase in

Medicaid patients who became indigent through the spend-down process. Finally, legal challenges to the Medicaid moratorium suggest that this policy tool might not always be available to the state.

Ensuring access to long-term care continues to be a goal for the state. According to both the bed-need estimates and our interviews, under-served areas remain in Philadelphia, and to a lesser degree, in some other areas. It is unlikely that the market will address these access problems, since these areas are heavily populated with indigent patients. Despite the state's willingness to pay for facilities located in such areas, they remain underserved. In order to provide care to these populations, the state must either raise levels of reimbursement or provide services directly.

2. Potential Effect of Deregulation

Experience in other states such as Arizona and Utah has suggested that elimination of CON results in increased bed construction. After Arizona eliminated CON regulation of nursing homes in 1982, the state experienced a surge in construction, with the number of nursing homes growing from 79 to 118. As a result, nursing home bed/population ratios increased 50 percent from 20.9 per 1,000 persons over age 65 in 1982 to 33.5 in 1986. Occupancy rates dropped to 70-75 percent by 1987, and many nursing homes closed in the late 1980s because of low occupancy. By 1989 the bed availability had stabilized, but occupancy rates are lower than desired at 85 percent. In 1989 Arizona enacted Medicaid reimbursement for long-term care resulting in an increase in nursing home occupancy rates. We do not know the extent to which the availability of Medicaid reimbursement or the closing of some nursing homes raised occupancy rates in the state. Nor do we know whether tight Medicaid reimbursement policies or an excess of nursing home beds has prevented the occupancy rates from rising above 85 percent.

Utah repealed CON in 1984. From 1984 to 1990 the number of nursing home beds grew from 5,395 to 7,145. Occupancy rates declined significantly after the repeal of CON. Nursing home occupancy rates hovered near 89 percent from 1980 through 1984, the final year of CON. In 1985 occupancy dropped to 88 percent as new construction began to occur. By January

1990, occupancy rates were at about 75 percent. These lower occupancy rates resulted in reduced profitability for nursing homes. Nursing home profit margins declined from about 8 percent in 1984 to a negative 6 percent by 1988.

It is unlikely that Pennsylvania would experience a surge in bed construction of this magnitude for a number of reasons. First, as discussed in section III, Pennsylvania already has far more nursing home beds per 1,000 population than either Arizona and Utah. Second, the MA capital moratorium and the low rates for reimbursement of operating costs discourage facilities from building in the state. Third, it is currently more difficult for long-term care facilities to obtain capital than it was under deregulation in Arizona and Utah; in fact, even a number of nursing homes in Pennsylvania that were granted CONs have recently been unable to raise sufficient funds through the capital markets.

A number of factors suggest, however, that there would be a substantial increase in nursing home beds if CON were lifted. A large number of CON applications are submitted each year, suggesting that despite the lack of MA availability and tightening capital markets, the industry has access to capital and believes it can build financially viable projects. The recent batch of applications submitted by a PA architectural firm suggests that the interest in building is not restricted to those specializing in the care of the elderly.

Available evidence suggests that the building that would not occur in the areas that are currently under-bedded according to the state bed-need methodology. The Department has already indicated a willingness to grant CONs in Philadelphia and Schuylkill county, and OMA has issued waivers excepting some facilities from the MA moratorium on capital for new facilities locating in these areas. Despite these incentives, few beds are being built in these areas. Lifting CON would not be expected to change this, and the increase in beds following repeal would likely be built in areas that are currently over-bedded according to the state bed-need methodology.

VI. POSITIONS OF PAYOR, PROVIDER, AND OTHER GROUPS INTERESTED IN CON¹²

The Department of Health supports continuation of the CON program and has been integrally involved with legislative initiatives to realize this through H.B. 1982. Moreover, the Statewide Health Coordinating Council, the Commonwealth's health planning advisory group, supports continuation of the CON program.

During the course of the evaluation, Lewin-ICF and LB&FC staff also conducted numerous interviews with representatives of other major Pennsylvania purchasers of health care, health care provider associations, officials of state agencies affected by the CON program, and other organizations with an interest in health care cost and quality. Several of these organizations furnished position statements developed in response to the sunset performance audit. Others reaffirmed long-standing positions on CON.

With the exception of one health care provider association, the official position of all the third-party payors, state officials, provider associations, and other organizations interested in health care costs contacted concurred on the need for some aspects of the CON program and related state health planning. Within these organizations, however, some individual members dissent from the official position and believe that CON should be repealed or substantially streamlined. These organizations include:

- Blue Cross/Blue Shield Organizations of Pennsylvania
- AFL-CIO of Pennsylvania
- Pennsylvania Chamber of Business and Industry
- Pennsylvania Public Health Association
- Department of Public Welfare
- Delaware Valley Hospital Council
- Hospital Association of Pennsylvania
- Pennsylvania Association of County Affiliated Homes
- Pennsylvania Association of Non-Profit Homes for the Aging
- Pennsylvania Association of Rehabilitation Facilities

¹² This information was developed by the LB&FC staff for purposes of providing information on the perspective of a broad spectrum of health care organizations that are affected by or have an interest in the operation of the CON program. The absence of the views of any organization or official is unintentional. The information provided was current as of February 1992.

The Pennsylvania Medical Society's (PMS) long-standing position contrasts with the positions of these organizations in that it supports "a free and competitive...market relative to certificate of need," which, according to the Society, implies opposition to the continuance of a CON program in Pennsylvania. A medical society representative reported that, while the PMS Board of Directors is currently reviewing this stance, the Board is likely to reaffirm its previous position.

Several organizations have reaffirmed their previously issued official positions on CON. For example,

- The Pennsylvania Chamber of Business and Industry supports the CON program until such time as there is a competitive market health care system.
- The Hospital Association of Pennsylvania (HAP) is committed to supporting a streamlined CON program. Two of HAP's suggestions for streamlining the program are discussed below.
- The Pennsylvania Association of Non-Profit Homes for the Aging supports the concept of a CON program to provide constraints on licensed long-term care facility-based providers and other health facility capital expenditures through demonstration of need and a formal review process.
- The Pennsylvania Association of Rehabilitation Facilities supports the continuation of the CON program in Pennsylvania, although it believes the process can be streamlined.

Several other organizations with an interest in the CON process developed positions on CON in response to this sunset audit. Briefly stated, the positions of these organizations as of February 1992 are:

- The Blue Cross/Blue Shield Organizations of Pennsylvania strongly support continuation of the CON program and believe that it must be strengthened.
- The Delaware Valley Hospital Council supports administrative streamlining of the CON program and requiring that other health care providers in addition to hospitals be covered under the program. Its recommendations for streamlining the program are discussed below.

- The Pennsylvania Association of County Affiliated Homes believes that the CON review process should continue. It does not believe the nursing home industry should be allowed to have unregulated growth available without a formal state supervised review process.
- According to the Department of Public Welfare's (DPW) Deputy Secretary for Medical Assistance Programs, Pennsylvania needs strong health planning and a CON program and, therefore, the program should not be allowed to sunset but instead be strengthened. The Director of the Bureau of Long-Term Care Programs indicated that the CON program continues to be necessary and should be improved and strengthened rather than allowed to sunset. He also stated that the CON program has provided additional control over the increase of long-term care beds, and, as a result, the nursing home institutional reimbursement costs of the Medicaid Program have not been as great as they would have been without the CON program.

Among those organizations in support of the CON program, a number differ in their recommended approaches to improve the CON process. Some organizations believe the CON program should be strengthened. Others, however, recommend various ways to streamline or simplify the process.

Officials of the Department of Public Welfare (DPW) have provided recommendations for strengthening CON. DPW's Deputy Secretary for Medical Assistance Programs believes the DOH should consider enhancing its health care planning activities, with greater emphasis on planning to address health care needs and cost containment. The Deputy Secretary suggested, for example, limiting the proliferation of new technology such as magnetic resonance imaging (MRIs). He also noted that PA's current "optimal" level of acute care beds may be too high and cited low acute care occupancy rates in some areas of the Commonwealth. DPW's Director of the Bureau of Long-Term Care Programs stated that a greater emphasis should be placed on cost containment efforts and restricting the development of long-term care beds only to where there is a demonstrated need.

Nursing home provider associations took the position that the CON program should generally be continued as is, but with some changes. The Pennsylvania Association of Non-Profit Homes for the Aging believes that the CON process should include a provision requiring review and comment on the need for facilities and services at the area-wide level, based on

community need criteria established by the area-wide planning agency. The Pennsylvania Association of County Affiliated Homes made a similar recommendation that the CON process should include additional provisions for initial review at the local level, so there is greater opportunity for community input from consumers and health care professionals. The Association believes, however, the final approval for the CON should take place at the state level.

The hospital provider associations contacted supported a less stringent CON program. However, the suggested actions necessary for streamlining the process differ slightly. For example, the Delaware Valley Hospital Council is in favor of a modified ten-bed or ten percent rule which allows a hospital to increase its total capacity by up to ten beds each licensure period, with any increase or redesignation of beds for a given service (i.e., psychiatric and rehabilitation services) not to exceed ten beds or ten percent of the beds in that service, whichever is less. HAP supports continuing the ten-bed or ten percent exemption provisions as a way to enable facilities to expand or convert to meet expressed community demand. HAP also recommends establishing a single project threshold of \$5 million with annual adjustments made on the basis of the Department of Commerce Construction Cost Index and elimination of the annual operating expenditure threshold. The Delaware Valley Hospital Council supports the current threshold of \$2.0 million for reviewable capital expenditures, but indexed annually for inflation.

VII. RECOMMENDATIONS*

Based on the results of the evaluation, we believe that CON should not be allowed to sunset in Pennsylvania. It has been effective in controlling the expansion of long-term care beds. It also has been effective in controlling the expansion of some acute care services, but these restrictions did not translate into reductions in total hospital expenditures during the 1980s. CON also has played an important role in promoting access and quality considerations in Pennsylvania.

*An asterisk following a specific recommendation indicates that a current legislative initiative, HB-1982, also addresses the issue. See text of report for more details on each recommendation.

Sufficient economic discipline is not yet in place to permit a repeal of the CON program in Pennsylvania. Over the past ten years greater economic discipline has been achieved in the Pennsylvania health care system through the cost control efforts of third party payors and tightened capital markets. However, these efforts are not exerting enough pressure on the system to achieve the state's goals of cost containment, access, and quality. Thus, we conclude that additional tools are still needed if the state's goals are to be realized.

The DOH and many providers are interested in promoting market forces in Pennsylvania. Despite this orientation, they recognize an important role for CON in controlling those services that are not being constrained by market forces and for maintaining quality of care by preventing the proliferation of some high technology services. The 1989 administrative changes to the CON program streamlined the process to focus on large capital expenditures, cost reimbursable services, and quality considerations. Additional changes to the program are required to increase the effectiveness of the program to achieve these goals.

This section presents recommendations for the future of CON in Pennsylvania based on our assessment of its administration and effectiveness over time. It first presents the overall program recommendations and then presents specific recommendations for each sector of the health care system.

A. Overall Program Structure and Administration

The CON review process successfully serves to ensure compliance with the State Health Plan. The process of updating and revising the State Health Plan is one of the most positive features of the program and results in a consistent review process. The major problem with the administration of the program is that it is understaffed. This understaffing results in long time lags to deem applications complete and erratic revisions to the State Health Plan. Our specific program recommendations are:

Recommendation 1: Reduce the Burden on the CON Program and Alleviate Staffing Shortages *

As noted above, the CON program is understaffed. To correct this problem the program can be streamlined in two ways:

- **Render non-clinical services with expenditures below \$18,000,000 non-reviewable.** This change would mirror the trends in many other CON programs. It would eliminate the administrative review function in and reduce the items subject to non-substantive reviews.
- **Specify that only the applicant may file an appeal on a CON decision.** A large number of the appeals are filed by competitors in an attempt to stop or slow the development of a new facility/service. Limiting the ability to appeal to the applicant would reduce the number of appeals and the burden on DOH staff.

Even if these changes are made, additional staff are needed to review CON decisions and update the State Health Plan:

- **Additional revenue should be provided to the CON program to hire additional staff for reviews and planning.** Our interviews with providers and their representatives indicated a clear consensus that the DNR is acutely understaffed. DOH estimates that 4 additional staff are needed to conduct reviews and 2 additional staff are needed in health planning. Revenue may be provided through general revenues or through the establishment of fees for submitting CON applications. Most CON programs have a fee schedule for applications both to raise revenue for the program and to deter some applications. For example, the Ohio CON program has an application fee of \$20,000. A fee schedule is recommended in H.B. 1982, a CON bill under consideration in the General Assembly. This policy appears to be supported by most providers in the state.

Recommendation 2: Improve the Process for Updating the State Health Plan *

Currently, the chapters to the State Health Plan are updated on an ad hoc basis, and a better process is needed to identify chapters that need revision. The usefulness of the CON program depends critically on the quality of the chapter being used. The frequency of updating should be determined by the nature of the service under review. We recommend that the DOH annually review the SHP, at which time it should identify the chapters that need to be revised and

establish a process for updating the chapter. The revised chapter would be completed in no later than one year.

Recommendation 3: Use CON as a Tool to Enforce Volume Standards

The Commonwealth does not have a mechanism for ensuring compliance with the CON volume requirements. The expiration of CONs could be used to strengthen the Department's use of CON to promote quality of care. For example, if a provider fails to meet its volume standard after two years the CON could expire, and the need for the service could be reviewed. The types of CONs subject to the expiration provision would be determined by the Secretary of Health.

Recommendation 4: The CON Component of the Health Care Facilities Act Should Not Be Permitted To Sunset More Frequently Than Once Every Five Years*

In a number of states the CON law expires every two to three years. This frequent legislative review has led to a weakening of the program, an increase in legislative exceptions for specific facilities, and uncertainty among providers regarding the scope of CON review. Given the rapid changes in the health care system, however, the Commonwealth does need an ability to reassess the program periodically and to restructure it as other health system reforms are adopted. We recommend that the program not sunset more frequently than once every five years.

B. Sector-specific Recommendations

In addition to overall program recommendations, we have several recommendations that apply to specific sectors of the health care system.

1. Acute Care

In the acute care sector Pennsylvania's CON program did contain the expansion of some services, but it did not slow the rise in overall hospital expenditures. If the state has cost control

as a principal concern, it needs to develop other mechanisms to augment its reliance on CON and existing market forces. We recommend that Pennsylvania continue the CON program for acute care services with a focus on cost-reimbursable services and services with a quality-volume relationship. The specific recommendations for acute care are:

Recommendation 1: CON, as Currently Structured, Should not Be Expected to Contain the Rise in Acute Care Health Costs

Our results indicate that the current CON program has not slowed the rise in total hospital costs in Pennsylvania. The state should consider pursuing other options that more directly affect costs. For example, the state can impose controls on reimbursement for all payors in all settings (e.g., rate review, physician fee schedules) or impose limits on expenditures through regional budget caps. It might also provide incentives to promote economic discipline such as relaxing its stringent HMO regulation, permitting HMOs to negotiate favorable discounts, reforming state employee health benefits to increase price sensitivity of consumers, and encouraging prudent purchasing by insurers. In addition, the CON program could be re-structured as a cost containment tool that would sharply limit the diffusion of selected clinical services. Until either the public sector or private purchasers apply greater discipline, the state will not achieve significant reductions in the rate of increase in acute care expenditures.

Recommendation 2: Limit the Ability of Hospitals to Expand Services Without CON Review

Under current law, hospitals that have obtained a CON for a service such as cardiac catheterization may add another lab without CON review if the expenditures are below \$2,000,000. We view this provision as contrary to the state's goals of controlling services with quality-volume considerations.

Recommendation 3: Eliminate the Ability of Providers to Increase Capacity By 10 Beds or 10 Percent Without CON Review*

The Pennsylvania CON law contains a provision allowing facilities to increase their capacity by 10 beds or 10 percent of total beds. Our analysis of this provision indicates that it allowed existing providers to expand their services substantially over time without being subject to CON review. If the Commonwealth believes that increased services are needed, it should either permit all providers to compete through CON review, or eliminate CON for these services. Although we have no evidence that this action would reduce costs, it would serve to make the law more internally consistent.

Recommendation 4: Re-consider Policy Goals on Cost-Based Services

A stated priority of DOH is the control of those services that remain under Medicare cost-based reimbursement such as rehabilitation and psychiatric services. Despite DOH's disapproval of a number of CON applications in this area, analysis of hospital data indicate that Pennsylvania did not control diffusion of these services. The DOH should more precisely determine their goals with respect to these services and revise policy to reflect the perceived need for these services.

Recommendation 5: Consider Proposals for a "Level Playing Field"*

We believe that the legislature should carefully consider implementing provisions designed to make regulation consistent across all providers. CON regulation often controls the provision of a service by one type of provider (typically hospitals), while allowing the service to proliferate among others (e.g., physician offices). Such statute does not enable the DOH to consistently control the proliferation of a service or to monitor quality. This issue is likely to continue to be highly important, since many new services resulting from technologic advance will be applicable in both the hospital and the physician office setting. We make no solid recommendation on the "level playing field" because we analyzed no data on the expansion of non-hospital services in the state.

2. Long-term Care

Given rapidly escalating Medical Assistance expenditures, Pennsylvania should retain its CON program as one control on the long-term care sector. The state has been successful in constraining the number of nursing home beds through CON. The specific long-term care recommendations are:

Recommendation 1: Eliminate "10 Bed/10 Percent Rule" for Long-Term Care*

Under current law, nursing home providers have the ability to increase bed capacity by the lesser of 10 beds or 10 percent of facility capacity over a two year period without obtaining a CON. We recommend that this provision be eliminated since permitting expansion in counties that have an excess supply of beds is counter to Commonwealth goals of reducing Medical Assistance expenditures and encouraging the development of community-based services.

Since in the long-term care area, a bed added is a bed filled, expanding the number of nursing home beds has a direct impact on the Medical Assistance budget. Even if the beds are designated as private pay beds, ultimately many of these persons will spend down to Medical Assistance for their care. A larger pool of private pay patients will increase Medical Assistance expenditures even if the expansion is accompanied by more stringent reimbursement policy. Since Medical Assistance reimbursement is already low, it is unlikely that reimbursement would be reduced further.

Recommendation 2: Encourage the Development of Community-Based Long-Term Care Services

Pennsylvania has stated that one of its goals in the long-term care areas is to reduce its strong institutional bias in long-term care by promoting the development of community-based care. Within the context of a broad based policy to promote a mix of services, CON can be used to reinforce the development of community-based care. It is important to note that CON, alone, cannot encourage the development of community-based services. The state must provide the financial incentives to establish these services.

With adequate financial support present to develop community-based services, CON can be used to reinforce this effort. In cases in which bed need existed, preference for CON approval could be given to providers who plan to offer community-based services. Community-based alternatives that might be given preference are adult day care centers, respite care, and support services for caregivers.

II. BACKGROUND AND SUPPLEMENTARY AUDIT INFORMATION

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II. BACKGROUND AND SUPPLEMENTARY AUDIT INFORMATION

This section, developed separately by LB&FC staff, presents an overview of the legal and operational background of the Certificate of Need (CON) program. It also provides additional information on three issues: (1) the extent of public input and participation in CON decision-making, (2) the timeliness with which Department of Health (DOH) staff respond to CON applications, and (3) the status of the implementation of previous LB&FC report recommendations.

A. LEGAL BACKGROUND

Pennsylvania's CON program was established in 1979 with the enactment of the Health Care Facilities Act, Act 1979-48, as amended, 35 P.S. §448.101 et seq. The CON program was established to comply with the federal National Health Planning and Resources Development Act of 1974 (NHPDA), Pub. L. 93-641, which established the CON process as national policy. The NHPDA did not specifically require states to adopt a CON program; however, grants and contracts to state, local, and private entities under numerous other federal health programs were threatened with abrupt cancellation if the state did not institute such a program. The NHPDA was subsequently repealed by Congress, effective January 1, 1987. The Pennsylvania Health Care Facilities Act has not been subsequently amended to reflect the repeal of the NHPDA, particularly regarding the role of the now defunct local Health Systems Agencies in the CON process (see page 97).^{1/}

The primary purpose of Pennsylvania's CON program, as stated in the Health Care Facilities Act, is to enhance the health and welfare of Pennsylvania's citizens by the orderly and economical distribution of health care resources to prevent needless duplication of services and to make the delivery system responsive and adequate to the needs of its citizens. By enacting the Health Care Facilities Act, it was the General Assembly's intent that "the Department of Health foster a sound health care system which provides for quality care at appropriate health care facilities throughout the Commonwealth."

B. CON PROGRAM INFORMATION

The Pennsylvania Department of Health approves or denies CONs based on its evaluation of applications submitted by health care

^{1/}House Bill 1982 would, however, amend the Health Care Facilities Act to address various technical and substantive issues raised by the repeal of the NHPDA.

facilities. Such proposals are typically placed into one of the following categories: the acquisition of major medical equipment, the offering of a health care service not previously offered by a health care facility within the past year, a capital expenditure of over \$2 million, or the expansion of a health care facility by more than 10 beds or 10 percent of the total bed complement.

The DOH's primary objectives for issuing CONs are:

- To encourage orderly and economic distribution of health care resources to prevent needless duplication of services.
- To make the health care delivery system responsive and adequate to the needs of the citizens.
- To ensure that new health care services and facilities are effectively and efficiently used.
- To ensure that health care services meet the qualitative and quantitative criteria set forth in the State Health Plan.
- To encourage innovation, coordination, and competition where appropriate.

Certificate of Need Expenditure Thresholds

The National Health Planning and Resources Development Act initially set three types of minimum expenditure thresholds for CON review. The minimum capital expenditure requiring review as a new institutional health service was set at \$150,000, the minimum capital expenditure for medical equipment was set at \$150,000, and the minimum annual operating expense associated with the addition of a health service was set at \$75,000. Pennsylvania's Health Care Facilities Act provides that as higher expenditure limits for CON reviews are set by the federal government, those limits apply immediately to Pennsylvania upon the effective date of the new federal thresholds. After the repeal of the federal act, the DOH set the minimum expenditure limits through Department memoranda. Currently, the minimum capital expenditure requiring review as an institutional health service is \$2 million, the minimum capital expenditure for medical equipment is \$400,000, and the minimum annual operating expense associated with the addition of a health service is \$316,873. (Exhibit 2.1 on page 4 contains more detailed information concerning the criteria used to determine services requiring a Certificate of Need review.)

Types of Review

According to Department of Health officials, there are currently three types of CON reviews:

1. Full Review - A comprehensive evaluation that requires an applicant to submit a detailed application demonstrating a need for a clinical project.
2. Nonsubstantive Review - A less involved evaluation of applications, typically for capital expenditures with an upper limit of \$18 million.
3. Administrative Review - A substantially shortened application for nonclinical capital expenditure projects, such as the refinancing of hospital debt or repairing a hospital parking garage. These projects are subject to a \$2 million threshold.

Types of Health Services and Facilities Subject to Review

The Health Care Facilities Act defines health services subject to CON review as any clinically related (e.g., diagnostic, treatment, or rehabilitative) service, including alcohol, drug abuse, mental health, and long-term care services provided by health care facilities. In June 1981 the DOH issued a CON memorandum listing 103 services which the Department determined were within the statutory definition of services reviewable under the CON process when offered by an inpatient health care facility.^{2/} The most recent revision of the list occurred in June 1991 and resulted in 31 services remaining on the list (please see Exhibit 3 on page 111 for a current Discrete Health Services List and Exhibit 4 on page 112 for a list of services that were eliminated from the Discrete Health Services List since 1981).

Under the Health Care Facilities Act, major medical equipment not owned by or located in a health care facility (typically a hospital) is only reviewable if the equipment is used to provide services to inpatients of a health care facility. Specifically excluded from the definition of a health care facility are offices used exclusively for private or group practice by physicians or dentists, unless the office is located within a health care facility or the services of the practice are offered by or through a health care facility.

Powers and Duties

The CON review process involves several agencies; however, the DOH has the primary responsibility for issuing CONs. The Health Care Policy Board, the State Health Facility Hearing Board, and the Statewide Health Coordinating Council all can be involved

^{2/}Ambulatory surgery services, when provided by a facility which is not an inpatient care facility, are also included on the listing of reviewable services.

in various stages of the CON process. Please see Exhibit 5 on page 113 for an overview of the roles of the DOH and these other entities in the CON process.

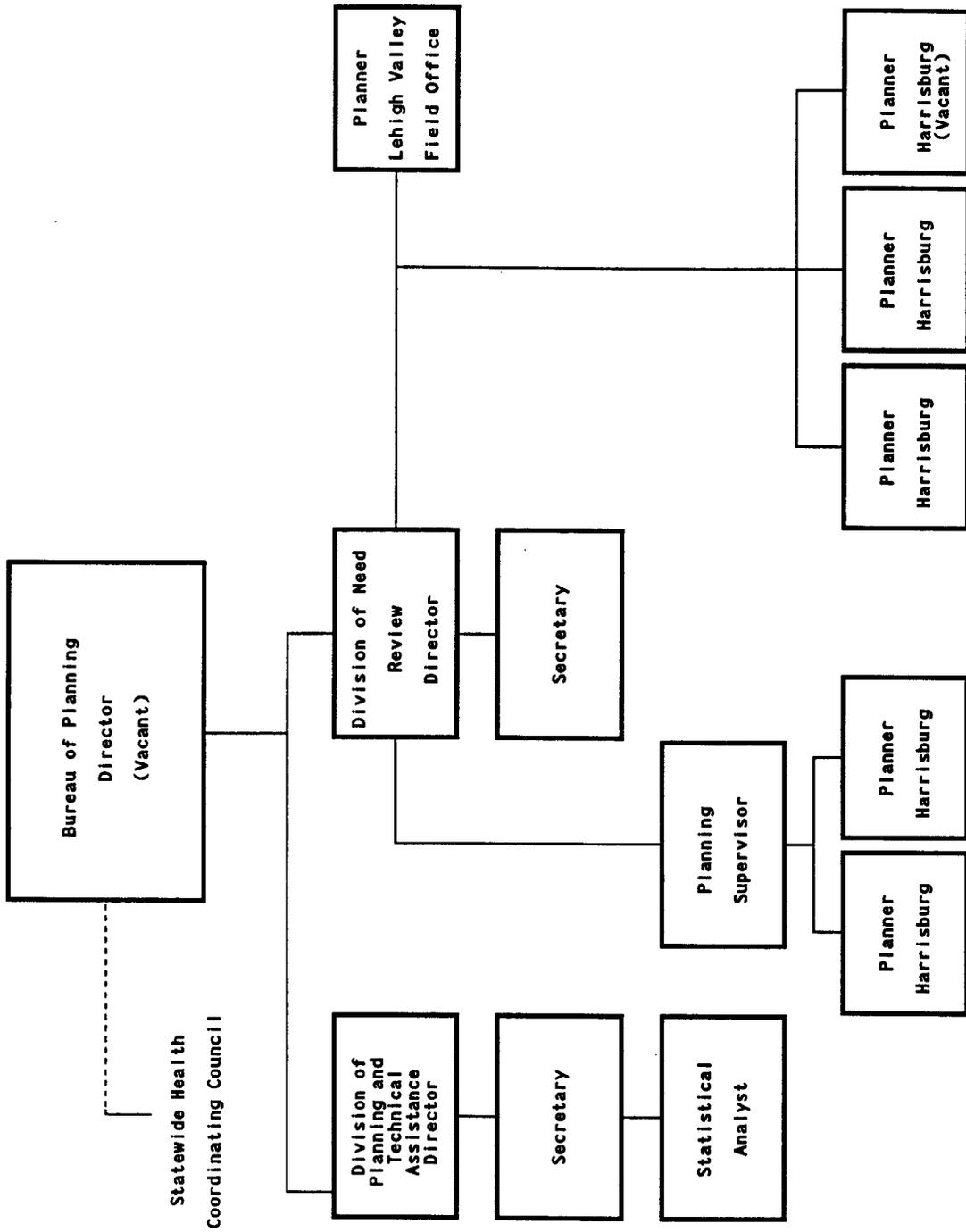
Personnel Information

CON reviews are conducted by the DOH's Bureau of Planning. The Bureau is comprised of the Division of Need Review, responsible for reviewing applications, and the Division of Planning and Technical Assistance, primarily involved with developing the State Health Plan. Currently (i.e., as of February 1992), the Bureau of Planning has 13 staff positions, of which 11 are filled. The two vacant positions were those of the Bureau Director and a planner. The 11 remaining personnel are the Director of the Division of Need Review, the Director of the Division of Planning and Technical Assistance, a planning supervisor, five planners (one of whom works in the Lehigh Valley Field Office), two secretaries, and one statistical analyst. The Bureau's organizational chart is shown in Exhibit 1. Additionally, DOH's Office of the Chief Counsel has the equivalent of two full-time employees dedicated to the CON program.

Fiscal Information

The operational cost for the Bureau of Planning for carrying out the functions of the CON program for FY 1990-91 was \$508,153. This represents a 31 percent increase over the costs for FY 1988-89 and a 19 percent increase over the costs for FY 1989-90. According to a DOH official, the primary reason for the cost increases between FY 1988 and 1989 and between FY 1989 and 1990 can be attributed to two managerial position vacancies being filled within the DOH, including the Director of the Bureau of Planning and the Director of the Division of Need Review. Any additional increases occurred as a result of general salary increases. The CON program does not have a specific line item budgetary allocation but is instead funded through DOH's general government appropriations. Table 1 shows the Bureau's expenditures for the CON program over a three-year period from FY 1988-89 to FY 1990-91.

EXHIBIT 1. ORGANIZATIONAL CHART OF THE BUREAU OF PLANNING, WHICH ADMINISTERS THE CERTIFICATE OF NEED PROGRAM*



*/The Department of Health, Office of the Chief Counsel, also has the equivalent of two full-time employees dedicated to the CON program.

Source: Department of Health, Bureau of Planning

TABLE 1. BUREAU OF PLANNING EXPENDITURES FOR THE CON PROGRAM

<u>Fiscal Year</u>	<u>Expenditures</u> ^{a/}
1988-89	\$387,635
1989-90	427,033
1990-91	508,153

a/Expenditure figures include those Bureau of Planning, Division of Need Review, and Division of Planning and Technical Assistance costs directly related to the CON program. Costs associated with the activities of the Statewide Health Coordinating Council, the Health Care Policy Board, and the State Health Facility Hearing Board as well as general administrative support services (e.g. DOH Comptroller services or computer services) are not included.

Source: Information from the DOH and Commonwealth accounting documents.

C. PUBLIC INPUT AND PARTICIPATION

Summary: The CON program employs various methods to encourage public input and participation in its rule-making and decision-making processes. These procedures provide reasonable opportunities for public input and participation. The primary vehicle for receiving public input for the State Health Plan, which guides the CON program, is through the activities of the Statewide Health Coordinating Council (SHCC), which includes a majority (13 of 25) of consumer members. The Council has generally been active in performing its functions in recent years. Additionally, Council member vacancy rates have been low, and meeting attendance has been good. However, the Council was established through an executive order, and its continued existence is not required by state statute. Other sources of public input include State Health Plan amendment task force meetings, State Health Plan amendment public hearings, and public hearings on individual CON applications.

Recommendations: The General Assembly should consider:

1. Establishing in statute a SHCC or similar body, such as the Health Policy Board called for in HB 1982, to ensure

a formal mechanism for public input into state health planning and the Certificate of Need program.

2. Requiring in statute that the Department of Health publish regulations, which would thereby require a public comment period, to establish criteria for adding or deleting a reviewable service.
3. Removing references in the Health Care Facilities Act to the now defunct Health System Agencies, which had been mechanisms for public involvement in CON application review and decision making.

Statewide Health Coordinating Council (SHCC)

The SHCC is the major means by which the public can have input into the CON process. The SHCC's primary responsibilities are to assist the Department in determining health needs in the Commonwealth and approving the State Health Plan. Although the SHCC was created under a federal law which has since been repealed, the Council, comprised predominantly of consumers (13 of 25), continues to act as DOH's health planning advisory group. The SHCC, however, is established under a Governor's executive order and is not specifically required by state law. In conjunction with the DOH, the SHCC holds meetings that are open to the public, designates task forces for updating State Health Plan chapters, and convenes public hearings on proposed chapter amendments in Harrisburg and two other locations. Additionally, the SHCC comments on the chapters based on issues discussed at the hearings, and the DOH seeks the SHCC's concurrence with the State Health Plan amendments before they are forwarded to the Governor for approval.

During the course of the audit, SHCC members contacted by LB&FC staff expressed concern that a previous Secretary of Health did not appear to place a high priority on citizen input into the State Health Plan. For example, the SHCC met only once between January 1, 1987, and December 1, 1988. The SHCC has, however, met more frequently in recent years.

SHCC Sunshine Act compliance. Records of SHCC meetings held from January 1990 to November 1991 indicate general compliance with the Sunshine Act. In part, this act requires an agency to hold deliberations and take official actions at open meetings and to keep minutes of the meetings. Minutes were maintained for all five of the meetings held during the review period. Additionally, votes were taken and recorded in the minutes.

The Sunshine Act also requires that after its first meeting of the calendar or fiscal year an agency give public notice of the place, date, and time of all its remaining regular meetings. Although DOH did not publish such a schedule, it has generally

published notices on a meeting-by-meeting basis throughout the year. Of the five meetings held during the review period, four were publicized in a local newspaper of general circulation at least three days before the meetings were held.

SHCC composition and meeting attendance. The SHCC consists of 25 members, including an ex officio member representing a Department of Veterans' Affairs hospital. Each member serves a three-year term, with about one-third of the terms expiring annually in any given three-year cycle. Of the 25 SHCC members, 13 are consumers who are not health care providers, 10 are direct providers of health care, and 2 are indirect providers or health insurers. As of February 24, 1992, there was only one vacancy on the SHCC, a consumer vacancy. Please also see Exhibit 6 for information on the affiliation of SHCC members.

House Bill 1982, which DOH generally supports, would replace the SHCC with an entity called the Health Policy Board. Three of the 11 positions on the proposed Board would be for citizen consumers; one to represent business; one to represent organized labor; two to represent health insurers; three health care providers, including one physician and a hospital; and the Secretary of Health.

LB&FC staff reviewed SHCC meeting attendance for the five meetings held from 1990 to November 1991. At least 60 percent of the members were present at each of the meetings, with an overall average attendance of 71.2 percent. Of consumer members, the majority attended at least three of the five meetings.

Health planning task force meetings. The State Health Plan chapters are updated with input from task forces designated by the Secretary of Health. The task forces consist of individuals, oftentimes including members of the SHCC, with expertise in specific health service areas as well as lay-persons with an interest in health care issues.

Task force meetings are open to members of the public. According to a DOH official, public input is obtained through an informal process whereby any member of the public attending a meeting may ask that the chairperson recognize him/her for purposes of providing comment. Please see Exhibit 7 for a list of the task force meetings held from December 1987 through February 1992.

Health planning public hearings. After a State Health Plan draft chapter is complete, the task force submits it to the SHCC, which then holds public hearings on the chapter in Harrisburg, Philadelphia, and Pittsburgh. The DOH publishes a notice announcing the public hearings in the Pa. Bulletin.

According to a DOH official, the announcement acts as an invitation for any affected party or member of the public to

testify at one or more of the public hearings. The official also noted that those who testify are given ample opportunity to express their comments either in oral or written form. Please see Exhibit 8 on page 118 for a list of health planning public hearings held from December 1987 to date.

Public Hearings on CON Applications

The Health Care Facilities Act contains provisions regarding the operation of Health Systems Agencies (HSAs), which were once an integral part of the Commonwealth's CON process. Pennsylvania had eight HSAs, whose primary purpose was to assess a CON application in terms of community need, financial feasibility, expected quality of care, availability of less costly alternatives, and accessibility of the project to underserved and indigent populations. Following this review, which was to include a public hearing, if requested, the HSA made a recommendation to the Department of Health to approve or deny the project.

The HSAs were federally funded, but Congress decided to provide no additional federal funds to HSAs past September 30, 1986. Seven of the Commonwealth's eight HSAs ceased operations soon afterwards; the only remaining HSA, in the extreme northeastern corner of the Commonwealth, also serves counties in New York and receives funding from New York State.

With the demise of HSAs, the public's opportunity for input on specific CON applications has diminished. However, under the Health Care Facilities Act and its regulations, any affected person or third-party payor can still request a public hearing within 15 days of the publication of a notice of a full or non-substantive application being deemed complete. From January 1987 to November 4, 1991, a total of 59 such public hearings were held for full review applications and three for nonsubstantive review applications.

After a hearing is scheduled, the DOH is required by the act to publish a notice of its date, time, and location in both the Pa. Bulletin and a newspaper circulated in the area in which the project will be located at least two weeks prior to scheduled hearing. According to a DOH official, any member of the public who attends a hearing and requests that he/she be allowed to testify is given the opportunity to comment. Citizen groups and interested organizations/associations may also participate.

The DOH provided 14 days notice of public hearings in the Pa. Bulletin and the appropriate newspapers as required by the act. Additionally, an LB&FC staff member who attended a public hearing observed members of the public being given the opportunity to testify about an application being discussed at the hearing.

Although the Health Care Facilities Act provides an opportunity for members of the public to request a public hearing on a CON application, the act does not require hearings to be granted in all cases. Unlike the PUC, which has a policy statement requiring public hearings to be held when "substantial public interest" has been shown, DOH does not have additional written guidelines to provide criteria for when to grant a request for a public hearing. However, according to a DOH official, the Department has granted all requests for public hearings (approximately 60 from January 1987 to December 1991), as the DOH prefers to address all potential issues at the public hearings rather than risking the chance that new issues will arise at the appellate stage.

CON Policy Statements

Periodically the DOH develops policy statements known as CON memoranda. Policies covered include, among others, the types of health services subject to CON review.

According to a program official, CON memoranda are developed by program staff, reviewed by Counsel for legal implications, and signed by the Deputy Secretary for Planning and Quality Assurance and the Department's legal counsel as statements of policy. Therefore, input from the public is not formally required in developing these policies. Additionally, though the CON memoranda are published in the Pa. Bulletin as notices, public comments are not solicited. CON memoranda have been used to revise a statutory provision regarding CON review thresholds and a regulatory definition. A DOH official confirmed that the DOH increased the minimum capital expenditure threshold for institutional health service, which had been set at \$150,000 in the Health Care Facilities Act, to \$2 million through a CON memorandum in 1989.

One hospital association has recommended strengthened public accountability for the addition or deletion of a health service subject to CON review. The Delaware Valley Hospital Council would like DOH to solicit public input into proposed changes to the Department's list of covered services. This could be accomplished through the use of the regulatory process to obtain public input for the list of reviewable services. Department of Health officials, however, expressed concern that this would limit their ability to quickly add new medical technologies to the list. Alternatively, as recommended in the LB&FC's 1987 report on the CON program, the regulatory process could be used to obtain public input for proposed criteria to be followed by DOH when making such additions or deletions from the list of reviewable services.

Regulatory Review Compliance

The DOH's Health Care Policy Board has proposed CON program-related regulations on three separate occasions, most recently in

November 1986. In the case of all three proposed regulatory packages, DOH properly sought and received public comments. Changes were made to the proposed regulations as a result of the public comments in two of the cases. The DOH appeared to provide adequate justification for why it decided not to incorporate the suggestions made in the third case.

D. TIMELINESS OF DOH'S RESPONSE TO CON APPLICATIONS

Summary: Prior to beginning in-depth reviews of CON applications, program staff review applications and inform applicants in writing of any necessary items that must be provided in order to deem an application complete. Both statute and DOH regulations require that it respond to incomplete applications within 20 business days (approximately 30 calendar days) of receiving the application. LB&FC staff sought to assess whether the DOH provides written responses to incomplete applications in a timely fashion and whether it follows its policy that the applications received earliest be responded to first. Our review of two services, cardiac catheterization and long-term care, found that the DOH often did not respond promptly to the CON applications it received. For the two services sampled, cardiac catheterization and long-term care, often over 200 calendar days passed before DOH first responded to inform the applicant that additional information was necessary before the application could be deemed complete. The timeliness of the DOH's response to applications for cardiac catheterization may not, however, be representative of other services because the State Health Plan Chapter pertaining to cardiac catheterization underwent major revisions in 1990. Additionally, applications are not always handled on a first-come, first-serve basis. The DOH generally attributes this performance to staffing shortages, supervisory staff turnover, the loss of experienced staff because of furloughs, and to its inability to control the volume and quality of applications submitted given the absence of a fee schedule.

Recommendations:

1. Please see page vii for the LEWIN-ICF recommendation concerning the need for additional staff and fees for CON applications.
2. The General Assembly should consider establishing a statutory time frame more realistic than 20 business days for Department of Health staff to respond to CON applications. For example, House Bill 1982 provides 45 business days for the Department to

inform the applicant that additional information is needed before the application can be deemed complete.

3. The Department of Health should establish an internal system for monitoring and reporting the timely and sequential processing of CON applications from the time they are received through key decision steps in the process.

Overview

Timely processing of Certificate of Need applications is important to health care providers because delays in a CON approval can delay implementing proposed new services and can increase the cost of capital construction projects. CON regulations at 28 Pa. Code §401.5(b) specify that DOH staff are to review CON applications for completeness. Regulations further state that if it is determined that an application is incomplete, DOH must, within 20 business days of receipt of the application (about 30 calendar days), advise applicants in writing of any additional information required to complete the application. LB&FC staff reviewed adherence to this "20-day" requirement because interviews and preliminary audit work led us to believe the length of time required for the DOH to determine whether additional information is needed to deem the application complete can cause significant delays in the CON approval process. Also, this step in the process is within the control of the DOH and is not dependent on the responsiveness of the CON applicant.

According to a DOH official, the DOH views the time frames for various steps in the review process specified in statute and regulation as guidelines and not mandates. The courts have held that whether a statutory time frame is directory or mandatory "depends on whether the thing directed to be done is the essence of the thing required." However, none of the decisions by the courts on this matter have been specific to the CON statute, although the State Health Facility Hearing Board has held that the statutory time frames for review of CON applications are directory, not mandatory.

Regulations also require that certain categories of projects, including cardiac catheterization services and long-term care (skilled nursing and intermediate) services, be subject to simultaneous and comparative review.^{3/} Although the simultaneous and

^{3/}Simultaneous and comparative review refers to a review system, also known as "batching," whereby applicants may only submit certain categories of applications at a specified time and these applications are then reviewed at the same time. According to DOH officials, these regulations were intended for the HSAs.

comparative review regulation was published in 1987, the Department published a notice in the Pa. Bulletin in 1987 indicating its intent to defer the implementation of these regulations. Such a system was never implemented. According to a DOH official, the low number of staff available to the CON program made such a simultaneous and comparative review process virtually impossible. Currently, DOH program staff reported that they follow an in-house unwritten first-in, first-out rule.

Days Until DOH First Response to an Incomplete Application

LB&FC staff reviewed all 40 cardiac catheterizations and a sample of 149 long-term care applications to assess whether DOH responded to incomplete applications in writing within 20 business days of receiving the application.⁴ Timeliness was measured by determining the number of days between the date an application was received and the date on which DOH forwarded its first letter outlining the additional information needed to deem the application complete. Such letters were not found in 32 percent of the sampled records. According to Department staff, these applications may have contained all the required information or the information to complete the application may have been requested over the telephone by DOH staff. These applications were excluded from the LB&FC analysis. Additionally, 24 percent of the initial sample was excluded from the analysis because the facility's application could not be located in the Department's filing system or because necessary information for the analysis was missing from the Department's records. The LB&FC analysis, therefore, is based on 23 cardiac catheterization and 61 long-term care applications.

For the 23 cardiac catheterization applications reviewed, the DOH required an average of more than 200 calendar days to provide written questions to obtain the additional information needed before the Department could deem an application complete. For example, an average of 269 calendar days (see Table 2) were required for the DOH staff's initial request for additional information for cardiac catheterization applications approved between January 1987 and February 27, 1990, when the new State Health Plan Cardiac Catheterization Chapter was adopted. For approved cardiac catheterization applications received between February 28, 1990, and November/December 1991, the Department required an average of 213 calendar days before informing the applicant in writing that

⁴/Cardiac catheterization and long-term care services were chosen for the timeliness review because both are listed in regulations as requiring simultaneous and comparative review. The two services also account for 45 percent of all approved applications which underwent a full review during the period January 1987 through November 1991. The applications reviewed by LB&FC staff were full reviews rather than non-substantive or administrative reviews which are less complex. (See definitions on page 91.)

TABLE 2. TIMELINESS OF INITIAL DOH RESPONSE TO CARDIAC CATHETERIZATION LAB CON APPLICATIONS*

Applications Received January 1, 1987, to February 27, 1990				
<u>Disposition</u>	<u>Written Action Taken</u>	<u>Average</u>	<u>Range</u>	<u>Median</u>
Approved	15	269	71-427	281
Disapproved	0	0	0	0
Withdrawn	1	309	-	-

Applications Received February 28, 1990, to November/December 1991				
<u>Disposition</u>	<u>Written Action Taken</u>	<u>Average</u>	<u>Range</u>	<u>Median</u>
Approved	7	213	125-273	235
Disapproved	0	0	0	0
Withdrawn	0	0	0	0

*/Timeliness is defined as the calendar days between the date the Department of Health (DOH) received a cardiac catheterization lab application and the date that the DOH first informed the applicant in writing of the additional information necessary to deem the application complete. This analysis is based on 23 of the universe of 40 cardiac catheterization lab CON applications which were processed as full reviews during the period. It does not include CON applications which fall into the category of non-substantive or administrative reviews. The applications are divided into two groups because the Department adopted a new State Plan Chapter pertaining to cardiac catheterization on February 28, 1990.

Source: Developed by LB&FC staff through a review of CON application files.

additional information was needed before the application could be deemed complete. According to a Department of Health official, because a major change was made in the State Health Plan Chapter pertaining to cardiac catheterizations in February 1990, the Department deferred action on many cardiac catheterization laboratory applications pending approval of the new chapter. These averages, therefore, may not be representative of the Department's response time for other types of applications.

The DOH's response time to inform applicants of additional items needed to deem an application complete was somewhat less for long-term care applications. For long-term care applications approved between January 1987 and November/December 1991, the average response time was 133 calendar days (see Table 3). The time required for DOH to provide such written responses ranged from 11 to 230 days.

For the cardiac catheterization and long-term care applications reviewed, the time required by the Department to request the information needed to deem the application complete represents a third or more of the average total time required to process applications and render a decision. The average total time required to process these applications (from receipt of the application to a decision by the Department) was 689 days for cardiac catheterization lab applications received before February 28, 1990, and 408 days for those received after that date. For long-term care applications, the average total time for the 61 applications reviewed was 522 days. The average total time required to process the approved applications in the LB&FC analysis is slightly less than the time for similar applications. (See Tables 4 and 5.)

LB&FC staff focused on the timeliness of the Department's review of cardiac catheterizations and long-term care applications. The Department maintains statistics on the timeliness of its review of CON applications on all services. The Department's reports show that for all applications approved since January 1987, it required an average of 349 days to complete full reviews, 147 days for non-substantive reviews, and 43 days for administrative reviews. Thus, CON applications for cardiac catheterization services would appear to be among those requiring the longest time for DOH review and approval. As noted earlier, this may be partially the consequence of the new State Health Plan Chapter pertaining to cardiac catheterization which was approved in February 1990.

Review Procedures

LB&FC staff also sought to determine whether the DOH appears to respond to applications in a sequential fashion, i.e., whether the Department's unwritten "first come, first response" rule is consistently followed. The analysis indicates that eight of the 23 cardiac catheterization applications in the LB&FC sample were responded to more quickly (i.e., the written response informing

TABLE 3. TIMELINESS OF INITIAL DOH RESPONSE TO LONG-TERM CARE CERTIFICATE OF NEED APPLICATIONS (JANUARY 1987 TO NOVEMBER/DECEMBER 1991)*

<u>Disposition</u>	<u>Written Action Taken</u>	<u>Average</u>	<u>Range</u>	<u>Median</u>
Approved	16	133	11-230	171
Disapproved	12	212	182-249	214
Withdrawn	<u>33</u>	<u>225</u>	<u>60-296</u>	<u>234</u>
All	61	198	11-296	214

*/Timeliness is defined as the calendar days between the date the Department of Health (DOH) received a long-term care application and the date that the DOH sent the applicant the first letter outlining a list of questions pertaining to outstanding information necessary to formally deem the application complete. This analysis is based on 61 of the universe of 253 long-term care applications which were processed as full reviews during the period (see page 101 for explanation of the sample methodology). It does not include non-substantive or administrative reviews.

Source: Developed by LB&FC staff through a review of CON application files.

TABLE 4. AVERAGE DECISION TIMES FOR APPROVED CARDIAC CATHETERIZATION APPLICATIONS*

For LB&FC Analysis (Full Reviews Only)	599
All Full ^{a/}	632
All Non-Substantive ^{a/}	321
All Administrative ^{a/}	42

*/From date application received to date DOH granted the CON. Data for disapproved and withdrawn applications were available for those applications included in the LB&FC analysis. However, similar data for all cardiac catheterizations disapproved and withdrawn applications were not available. Therefore, withdrawn and disapproved applications were excluded from this analysis.

a/Includes all DOH-approved cardiac catheterization lab applications approved from January 1987 through November 1991.

Source: LB&FC analysis based on DOH data.

TABLE 5. AVERAGE DECISION TIME FOR APPROVED LONG-TERM CARE APPLICATIONS*

For LB&FC Analysis (Full Reviews Only)	293
All Full ^{a/}	314
All Non-Substantive ^{a/}	135
All Administrative ^{a/}	44

*/From date application received to date DOH granted the CON. Data for disapproved and withdrawn applications were available for those applications included in the LB&FC analysis. However, similar data for all long-term care disapproved and withdrawn applications were not available. Therefore, withdrawn and disapproved applications were excluded from this analysis.

a/Includes all DOH-approved long-term care applications decided between January 1987 and November 1991.

Source: LB&FC analysis based on DOH data.

the applicant that additional information is needed before the application can be deemed complete) than other applications received on an earlier date. Often this difference was well over 100 days. Forty of the 61 long-term care applications in the LB&FC sample were processed in a similar manner, i.e., these 40 applications were responded to more quickly than other applications received on an earlier date. These differences were also often well over 50 days.

DOH Comments

DOH officials noted that staffing shortages, coupled with the loss of trained employees because of furloughs and frequent changes in supervisory staff, can account for the length of time required to respond and some of the nonsequential reviews. Additionally, because the program does not charge fees for the submission of applications, DOH has no control over the volume and quality of applications submitted. In addition, they note that if they had not delayed processing the cardiac catheterization lab applications received prior to February 28, 1990, these applications would have been disapproved under the old State Plan Chapter.

E. IMPLEMENTATION OF PRIOR LB&FC AUDIT RECOMMENDATIONS

In February 1987 the LB&FC released its Report on a Study of Pennsylvania's Certificate of Need Program, which addressed the effectiveness of the CON program, made recommendations for improving the CON process, and assessed the future role of the CON program in light of other cost containment efforts within the Commonwealth. The report had nine findings containing 11 audit recommendations, of which only one required action by the DOH in the absence of prior action by the General Assembly.

As a follow-up on the status of the implementation of these prior audit recommendations, LB&FC staff reviewed what steps, if any, the DOH and the General Assembly have undertaken to implement the 1987 recommendations. These steps are outlined in Exhibit 2.

EXHIBIT 2. FOLLOW-UP ON THE STATUS OF IMPLEMENTATION OF LB&FC 1987 AUDIT RECOMMENDATIONS

Recommendation

1. The General Assembly should provide for the continuation of the Certificate of Need (CON) program for a three- to five-year period.

2. If the General Assembly continues the CON program, it should consider the following provisions to provide for local input and participation: (a) public notification (in a major local newspaper) of the receipt and nature of all CON applications; (b) a public comment period, including a public hearing(s) to be held in the local area for CON applications of substantial public interest; and (c) allow certification of voluntary, independently funded local health care councils. The General Assembly should provide for broad-based representation, including both consumers and health care providers, for any local council which might receive state certification.

3. The General Assembly should consider establishing a sliding scale application fee, with provisions for minimum and maximum fees. The DOH should develop and have available for the General Assembly's consideration its recommendation for a CON application fee schedule, projected revenues from such fees, and projected expenditures for the CON program during FY 1987-88. Further, if projected revenues do not cover all costs, the DOH should develop and have available for the General Assembly's consideration a second fee schedule which would yield adequate projected revenues to make the CON program fully self-supporting.

Action Taken

1. The CON program was continued. Act 1991-35 amended the Administrative Code to provide for the expiration of the CON process unless extended by the General Assembly pursuant to the procedures in the Sunset Act. */

2. No such amendments have been made to date. However, the current practice of the Department of Health (DOH) is that when it deems certain applications complete, it publishes a notice, both in the Pa. Bulletin and a newspaper circulated in the area in which the project will be located. Additionally, although it does not hold public hearings in the local area for CON applications, it does hold such hearings in Harrisburg. */

3. No such amendments have been made to date. DOH's proposed fee schedules are contingent upon the General Assembly amending the act to allow it to establish such fees. */

EXHIBIT 2 (CONTINUED)

Recommendation

4. The General Assembly should consider increasing the capital and major medical equipment review threshold to a level between \$1.5 and \$2 million and deleting the review threshold for annual operating expenses.

5. The General Assembly should consider amending the Health Care Facilities Act to include under CON review only those health services and new technology additions which (a) exceed a relatively high threshold for capital or major medical equipment expenditures, e.g., between \$1.5 and \$2 million, or (b) which may potentially compromise the quality of care through insufficient volume to support needed specialized staff or maintain skills.

6. The DOH, in conjunction with the Statewide Health Coordinating Council (SHCC), should develop specific criteria to be approved through the regulatory process for determining what new services should be reviewed without regard to cost. Any list developed should be subject to periodic review using the promulgated criteria.

Action Taken

4. No such amendments have been made to date. However, the DOH increased its minimum capital review expenditure threshold for a new institutional health service to \$2 million through a CON memorandum in 1989. In the memorandum, DOH noted that it was acting upon an LB&FC recommendation. */

5. No such amendments have been made to date. */

6. DOH reports having implemented this recommendation on a modified basis. Its estimated percentage of implementation was 60 percent as of September 24, 1991, with completion anticipated in December 1992.

A Health Services Policy Workgroup, representing various agencies with an interest in health care related issues, was convened by the Secretary of Health in 1989. The Workgroup developed four criteria for determining which new health services should be subject to continued CON review: (a) services which are not subject to the market disciplines imposed by prospective payment systems and services for which the Commonwealth itself is a major payor; (b) services where there is

EXHIBIT 2 (CONTINUED)

Recommendation

Action Taken

a strong relationship between the volume of services provided and the quality of the outcome and where qualitative standards are insufficient to discourage harmful proliferation of the service or overuse of the service which may prove harmful to patients; (c) services which use expensive new technologies for which cost effectiveness has not been demonstrated; and (d) services which use scarce resources. The DOH notes that services that do not meet any of the above criteria would be reviewed without regard to cost, usually through the administrative review process.

The DOH, in conjunction with the SHCC, implemented the above four criteria through a series of twelve State Health Plan (SHP) chapter amendments. The DOH and SHCC are currently in the process of carrying out two additional SHP chapter amendments. However, the DOH reportedly does not plan to have the criteria approved through the regulatory process.

7. The General Assembly should consider amending the Health Care Facilities Act to require that all major medical equipment purchases, regardless of ownership, be subject to CON review.

8. The General Assembly should amend the Health Care Facilities Act to specify the maximum time frames for various phases of the CON process. This would include establishing a maximum period of time in which DOH or, if applicable, any contracted agency providing services to the DOH may request additional further information subsequent to receiving the facility's

7. No such amendments have been made to date. */

8. No such amendments have been made to date. */

EXHIBIT 2 (CONTINUED)

Recommendation

application; a maximum time period in which to respond to the additional request(s); and a maximum time period after the facility's response period has ended during which the DOH should render its decision for approval or denial.

9. If the DOH fails to render its decision within the established period, it should only be eligible for one extension subject to the agreement of both parties and the project should be deemed automatically approved if the DOH fails to render a decision within the extension period.

10. The General Assembly should consider amending the Health Care Facilities Act to require, in approximately three to five years, a comprehensive reevaluation of the continued need for the Commonwealth's CON program, possibly in the form of a "sunset" provision, and that the DOH also consider requiring that the DOH determine and collect information pertinent to the evaluation of the effectiveness and continued need for the CON program.

11. The General Assembly should consider suggestions made to LB&FC staff by the DOH, the SHCC, and the State Health Facility Hearing Board in any amendments made to the Health Care Facilities Act.

Action Taken

9. No such amendments have been made to date.

10. Act 1991-35 amended the Administrative Code to provide for the expiration of the CON process unless extended by the General Assembly pursuant to the procedures in the Sunset Act. However, DOH is not required to collect pertinent related information. */

11. No amendments have been made to the Health Care Facilities Act. HB 1982 addresses some of these suggestions in part or in whole but does not address others.

*/An asterisk next to a specific recommendation indicates that a current legislative initiative, HB 1982, may also address this issue in some manner. The provisions in HB 1982, however, may not necessarily address the issue in the substantive manner in which it was recommended.

EXHIBIT 3. HEALTH SERVICES SUBJECT TO CON REVIEW

DISCRETE HEALTH SERVICES

Alcohol and Other Drug Rehabilitation Program - Inpatient
Ambulance - Air Unit
Ambulatory Surgery - Single/Specialty
Ambulatory Surgery - General/Multi-Specialty
Cardiac Catheterization - Diagnostic
Cardiac Catheterization - Therapeutic
Chronic Maintenance Dialysis
Comprehensive Medical Rehabilitation - Inpatient
Emergency Room
Intermediate Care for Mentally Retarded
Intermediate/Skilled Nursing Care
Lithotripsy - Biliary
Lithotripsy - Renal
Magnetic Resonance Imaging (MRI)
Medical/Surgical Beds
Obstetrics
Open Heart Surgery
Organ Transplant - Heart/Lung
Organ Transplant - Kidney
Organ Transplant - Liver
Organ Transplant - Other
Pediatrics
P.E.T. Scanning
Psychiatric - Child or Adolescent Inpatient
Psychiatric - Adult Inpatient
Special Care - Intensive Care/Cardiac Care
Special Care - Neonatal Intensive Care Units
Special Care - Neonatal Intermediate Care Units
Special Care - Pediatric Intensive Care
Special Care - Other
Surgical Services

NOTE: This list is not intended to be all inclusive. It is intended as a general guideline to assist the Department of Health in making determinations of reviewability. All health care facilities are reminded that the Department of Health issues the determination of reviewability. Letters of Intent must be submitted to the Division of Need Review and a copy sent to the Health Systems Agency where one exists.

Source: Department of Health CON Memorandum, June 22, 1991.

EXHIBIT 4. SERVICES REMOVED FROM THE DISCRETE HEALTH SERVICES LISTING SINCE 1981*

Advanced Life Support/MICU/MCCU	Organ Bank
Alcohol and Other Drug	Oral Surgery
Detoxification - Inpatient	Orthopedic Services
Ambulance - Basic Life Support	Outpatient Department
Angiography Laboratory	Pathology Services
Audiology Service	Pharmacy
Autopsy	Physical Therapy
Birthing Services	Podiatric Services
Blood Bank	Poison Control Services
Cardiopulmonary Laboratory	Pregnancy Termination
Chemotherapy	Premature Nursery
Clinical Laboratory	Prosthesis
Clinical Psychology	Psychiatric - Partial
Day Care Services	Hospitalization
Dental Services	Psychiatric - Emergency Services
Electrocardiology	Pulmonary Function Lab
Electroencephalography	Radiology - CT Scanning
Family Planning Services	Radiology - Diagnostic
Family Practice	Radiology - Diagnostic/ Fluoroscopic
Genetic Counseling Services	Radiology - Diagnostic/ Thermography
Histopathology	Radiology - Nuclear Medicine
Home Health Services	Rape Crisis Services
Hospice Program	Social Services
Hyperbaric Oxygen Therapy	Special Care Burn
Inhalation Therapy	Speech Therapy
Neurology	Therapeutic Radiology
Nursery	Tissue Typing
Occupational Therapy	
Oncology	

*/Some services on the 1981 list and/or subsequent lists were collapsed to form one or more renamed service categories on later lists.

Source: Developed by LB&FC staff through a review of CON memoranda issued subsequent to the June 30, 1981, memorandum.

EXHIBIT 5. CON RELATED FUNCTIONS OF THE DOH, HEALTH CARE POLICY BOARD, STATE HEALTH FACILITY HEARING BOARD, AND THE STATEWIDE HEALTH COORDINATING COUNCIL

Department of Health

The DOH reviews applications for CONs and issues such certificates in accordance with the provisions of the Health Care Facilities Act. In considering applications for CONs, the Department is to consider a number of factors including whether the proposed project for construction, renovation, or the establishment of new services:

- Meets a community need.
- Is financially feasible.
- Meets quality standards.
- Offers access to care for the poor.
- Enhances the orderly and economical distribution of health care resources to prevent needless duplication of services.

Health Care Policy Board

The Health Care Policy Board was created within the DOH to provide for broad consumer and professional representation, in the development and review of regulations for the CON program.¹⁷ The Policy Board consists of the Secretary of Health and 12 members appointed by the Governor with the consent of the Senate as follows:

- Seven consumers, including one representative of organized labor and one representative of industry.
- One hospital representative.
- One skilled nursing or intermediate care representative.
- One physician.
- Two representatives of third-party payors.

EXHIBIT 5 (CONTINUED)

State Health Facility Hearing Board

The State Health Facility Hearing Board, established within the Office of General Counsel, consists of three members appointed by the Governor and confirmed by a majority of the Senate. The Hearing Board hears appeals of, among other matters:

- Departmental decisions on applications for CONs or amendments thereto.
- Departmental decisions which require a person to obtain a CON for major medical equipment or the acquisition of an existing health care facility.
- Objections to published regulations, criteria, or standards of the Department as to its policies and, where appropriate, to request reconsideration of the same.

Statewide Health Coordinating Council

The Statewide Health Coordinating Council was established to carry out functions designated in federal law. Although this federal law has been repealed, the Statewide Health Coordinating Council continues to:

- Consult with the Department in determining the statewide health needs of the Commonwealth.
- Approve the State Health Plan prepared by the Department of Health.
- Consult with the DOH and make recommendations as to carrying out the Department's functions in acting as a single state agency under the Health Care Facilities Act.

1/The Health Care Policy Board also reviews regulations relating to the licensure of health care facilities.

Source: Developed by LB&FC staff from a review of the Health Care Facilities Act and information provided by the Department of Health.

EXHIBIT 6. AFFILIATION OF STATEWIDE HEALTH COORDINATING COUNCIL
MEMBERS (AS OF FEBRUARY 1992)

<u>Member</u>	<u>Affiliation</u> ^{a/}
Judith Y. Anderson	Consumer
Loy W. Appleman	Consumer
Catherine B. Bauer	Consumer
Scott A. Berlucchi	Provider
Thomas Clemens, M.D. ...	Provider
Carmen A. DiCello, R.Ph.	Provider
William O. Fogle	Consumer
Jose' S. Galura	Indirect Provider
William A. Gannon	Consumer
Edward N. Hibberd, Jr. .	Consumer
Merrill C. Horine	Consumer
Michael Karpf, M.D.	Provider
Christine F. Klejbuk ...	Provider
Robert J. Lerner	Consumer
William C. Livingood, Jr., Ph.D.	Indirect Provider
Thomas J. McElvogue	Consumer
John E. McGrady, Jr. ...	Provider
Bonnie Carolan-McNulty, R.N.	Provider
Mary Ann Meloy	Consumer
Clayton O. Pesillo, D.M.D.	Provider

EXHIBIT 6 (CONTINUED)

<u>Member</u>	<u>Affiliation</u> ^{a/}
Carolyn Rome, R.N.	Provider
Edward L. Scurry	Consumer
George J. Vogel, Jr. ...	Consumer
Leonard Washington, Jr.	Provider

a/The federal National Health Planning and Resources Development Act defined the three affiliation categories as follows: Consumer - consumers of health care who are also not providers of health care; Indirect Provider - an individual who holds a fiduciary position with, or has a fiduciary interest in, any entity engaged in the provision of health care or engaged in producing drugs or other such articles; Provider - a direct provider of health care (including a physician, dentist, nurse, podiatrist, optometrist, or physician assistant) in that the individual's primary current activity is the provision of health care to individuals or the administration of facilities or institutions in which such care is provided.

Source: Developed by LB&FC staff from information provided by the Department of Health.

EXHIBIT 7. HEALTH PLANNING TASK FORCE MEETINGS: DECEMBER 1987
TO FEBRUARY 1992

Acquired Immune Deficiency
Syndrome (AIDS):

1. February 18, 1988
2. March 18, 1988
3. April 8, 1988
4. May 13, 1988
5. August 19, 1988
6. December 2, 1988
7. February 14, 1989

Cardiac Catheterization Services:

8. May 18, 1988
9. June 24, 1988
10. August 5, 1988
11. March 27, 1989
12. July 18, 1990

Cardiac Catheterization Oversight
Committee:

13. July 18, 1990
14. January 9, 1991
15. March 20, 1991
16. May 1, 1991

Long Term Care Services:

17. December 18, 1987
18. March 25, 1988
19. March 29, 1989
20. August 21, 1989
21. October 5, 1989
22. June 4, 1990
23. July 16, 1990
24. November 19, 1990

Magnetic Resonance Imaging
Services:

25. September 30, 1988
26. November 10, 1988
27. August 16, 1989

Acute Psychiatric Services:

28. February 10, 1989
29. March 23, 1989
30. May 10, 1989
31. August 16, 1989
32. September 26, 1989
33. October 18, 1989
34. November 9, 1989

Extracorporeal Shock Wave
Lithotripsy (Renal and Biliary):

35. December 20, 1989
36. January 19, 1990
37. February 16, 1990
38. March 23, 1990

Comprehensive Medical
Rehabilitation:

39. July 19, 1990
40. September 13, 1990
41. October 18, 1990
42. November 27, 1990

Organ Transplantation Services:

43. October 15, 1991
44. November 14, 1991
45. January 9, 1992
46. February 6, 1992
47. February 27, 1992

Source: Developed by LB&FC staff from information provided by the
Department of Health.

EXHIBIT 8. HEALTH PLANNING PUBLIC HEARINGS: DECEMBER 1987 TO
FEBRUARY 1992

Acquired Immune Deficiency
Syndrome (AIDS):

1. August 23, 1989 (Hbg)
2. August 24, 1989 (Phila)
3. August 25, 1989 (Pgh)

Cardiac Catheterization Services:

4. November 15, 1988 (Pgh)
5. November 18, 1988 (Hbg)
6. November 21, 1988 (Phila)
7. August 14, 1989 (Pgh)^{a/}
8. August 17, 1989 (Phila)^{a/}
9. August 18, 1989 (Hbg)^{a/}

Long Term Care Services,
Comprehensive Medical
Rehabilitation, and Overview of
the Nursing Home Chapter:

10. January 28, 1991 (Hbg)
11. January 30, 1991 (Pgh)
12. February 1, 1991 (Phila)

Magnetic Resonance Imaging
Services:

13. November 13, 1989 (Pgh)
14. November 14, 1989 (Phila)
15. November 16, 1989 (Hbg)

Acute Psychiatric Services:

16. January 31, 1990 (Phila)
17. February 5, 1990 (Hbg)
18. February 12, 1990 (Pgh)
19. March 5, 1990 (Hbg)

Extracorporeal Shock Wave
Lithotripsy (Renal and Biliary)
and Continuing Care Retirement
Committee:

20. August 5, 1990 (Phila)
21. August 9, 1990 (Hbg)
22. August 10, 1990 (Pgh)

Open Heart Surgery:

23. May 6, 1991 (Pgh)
24. May 8, 1991 (Hbg)
25. May 10, 1991 (Phila)

Radiation Therapy Services:

26. November 16, 1991 (Phila)

a/Testimony on CAT scanners was also heard during this hearing.

Source: Developed by LB&FC staff from information obtained from
the Department of Health.

III. SECRETARY OF HEALTH'S RESPONSE TO THIS REPORT

Commonwealth of Pennsylvania



DEPARTMENT OF HEALTH

HARRISBURG

THE SECRETARY

March 30, 1992

Mr. Philip R. Durgin
Executive Director
Legislative Budget and Finance Committee
Room 400 Finance Building
P. O. Box 8737
Harrisburg, PA 17105-5487

Dear Mr. Durgin:

The Department of Health welcomes this opportunity to comment on the Legislative Budget and Finance Committee's performance audit of the Certificate of Need program pursuant to Act 1991-35. We are most gratified to see the conclusion that the Certificate of Need (CON) program is currently serving many important roles for the Commonwealth. We are further pleased with the overall conclusion of the report that the CON program be retained in some form.

The Department of Health will focus its comments on the report primarily on the actual findings and text of the report. As you know, we have been in touch with your staff and have verbally noted a few inaccuracies within the report to facilitate correction prior to final printing. We are most grateful for the careful and thoughtful analysis rendered by both the staff of the Legislative Budget and Finance Committee and by Lewin/ICF Associates who assisted in the audit.

The Department of Health found the series of recommendations most helpful. Within the first recommendation, under overall program structure and administration, reference is made to limiting the rights of

appeal to a CON decision. This proposal is included in House Bill 1982 which was constructed to streamline the CON process, and if passed would significantly reduce the administrative burden on the CON program. We believe this point to be sufficiently important as to merit separate mention.

The Department believes that the third recommendation of using CON as a tool to enforce volume standards is worth exploring as an option.

We also concur with the fourth recommendation that the CON program not be subject to frequent sunsets, but be periodically reviewed. The time frame encompassed in House Bill 1982 is every five years.

The recommendations on acute care services are well stated. The first recommendation recognizes that CON is but one tool to contain the escalation of acute health care costs. The second recommendation focuses on the proliferation of cardiac catheterization laboratories which occurred throughout the 1980s while the number of hospitals offering this service remained constant. While this was true for cardiac catheterization laboratories, it was also true for other services. The recommendation is a good one, but we would note that the cardiac catheterization example is illustrative of what happened in other services.

Regarding the fourth recommendation, (develop a consistent policy on cost-based reimbursed services), the Department has taken important steps to control diffusion of psychiatric and rehabilitation services. The State Health Plan chapters on psychiatric services (amended December 10, 1990) and on medical rehabilitation (amended May 23, 1991) set forth a consistent policy toward these cost based services.

We particularly concur with the recommendation, found in both the acute care and the long term care sections, about the elimination of the 10 bed 10 percent rule. This finding is most critical for the long term care sector, as well as for psychiatric services and medical rehabilitation services.

While the Department does not have a mechanism to enforce volume standards as such, the Department does have some authority to reopen a CON if there is a substantial

change in circumstances. Current regulations allow the Department to require a second full review where there is a substantial change after a CON has been issued.

In conclusion, the Department would emphasize the fact that CON now has a twelve year history. While the Health Care Facilities Act has not changed during this time, the Department of Health has undergone change at all levels of decision making. Through these changes, the Department has adopted changing criteria for review through State Health Plan amendments, to keep CON as responsive as possible. However, the Department recognizes that some statutory changes are required to keep CON current and responsive to the needs of Pennsylvania. Because of that recognition, we have worked to help address those changes with the sponsors of House Bill 1982. One prime example of the need for change is the physician's loophole in the act which allows many of these technologies to be established outside the CON review process. This problem would be rectified by adopting the concept of a "level playing field" as contained in House Bill 1982.

We appreciate this opportunity to comment on the CON performance audit. The Department believes that the reenactment of CON is essential to continue to address health care costs, access and quality. Further we believe that House Bill 1982 embodies many of the features needed to streamline the program, as well as reauthorize it.

Sincerely,



Allan S. Noonan, M.D., M.P.H.
Acting Secretary of Health