



*The* LEWIN GROUP

# **An Evaluation of Illinois' Certificate of Need Program**

*Prepared for:*

**State of Illinois  
Commission on Government Forecasting and  
Accountability**

*February 15, 2007*

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**Governors State University Health Administration Program**

**Senate Republican Task Force**

## EXECUTIVE SUMMARY

The State of Illinois' Commission on Government Forecasting and Accountability commissioned The Lewin Group to conduct a certificate of need (CON) study in response to House Resolution 1497.

House Resolution 1497 Appendix A cites the USA Today news report (January 3, 2006) that states the United States is "in the middle of the biggest hospital construction boom" in more than 50 years, a trend that likely will increase use of "high-tech medicine and add fuel to rising health care costs." CON laws were originally created to reduce duplication of services thereby decreasing or controlling spiraling health care costs. Since their original inception, the effectiveness of CON programs has been repeatedly challenged.

In response to this, the Illinois House of Representatives resolved that the Illinois Commission on Government Forecasting and Accountability shall "conduct a comprehensive evaluation of the Illinois Health Facilities Planning Act, including a review of the performance of the Illinois Health Facilities Planning Board, to determine if it is meeting the goals and objectives that were originally intended in the enactment of the law and the establishment of the Board, and as the law has been amended along with the Board policies and procedures that have been revised since that time, with special consideration for its affect on controlling unnecessary and excessive capital expenditures that may be contributing to health care inflation."<sup>1</sup>

### Scope of work

In order to address the concerns of the Illinois House of Representatives, The Lewin Group performed:

1. An analysis on Illinois' CON program;
2. Interviews with industry stakeholders and leaders to determine how effective the Illinois Health Planning Board has been, and what impact Illinois' CON program has had, since it was first instituted in 1974, from varying industry standpoints;
3. An analysis on other state CON programs;
4. A review of literature as it pertains to cost, quality, and access; and
5. A limited original analysis of the impact of CON on access to certain types of care and on the margins of safety-net and other hospitals.

### Conclusions

Arguments that are made in favor of CON laws focus on three areas: control of costs, especially unneeded capital costs; assurance of quality for selected services; and maintenance of access, particularly for underserved populations. Because nearly a third of the states in the United States have terminated their CON programs, it is reasonable to look at other states' experience to consider the risks and benefits of terminating the program. Based on our review of relevant literature and our independent analysis, it is clear that the evidence on cost containment is

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<sup>1</sup> House Resolution 1497.

weak, but the evidence suggests that the CON process does affect spending patterns in a state. Expecting the CON process to reduce overall expenditures, however, is unrealistic.

Regarding the second argument, that CON laws increase quality of care, even the strongest supporters of maintaining the program agree that the area where CON can directly influence quality is narrow. Substantial research shows a positive correlation between volume and quality in certain tertiary procedures such as cardiac surgery and transplant programs. Restricting new services certainly leads to fewer providers to perform a given number of procedures. However CON laws impact on quality and care is limited.

The remaining argument, maintenance of access, particularly for the underserved, deserves careful consideration. The health care market place has changed in many ways since CON laws were initially established in 1974; one of the most important changes has been the increase in competition among providers for specific patient types – especially cases involving interventional procedures for patients who are covered by commercial insurance. Community hospitals and academic medical centers that, by virtue of their location and/or reputation, are able to maintain a high proportion of these well insured patients tend to fare very well financially, and those who cannot are at risk of failure.

In the last several years, community hospitals have faced increased competition from specialty hospitals and ambulatory surgical centers. Both are concerning because they often focus on attracting the more profitable patients to the exclusion of less profitable patients, leaving traditional hospitals with a less profitable overall mix of patients. For many hospitals this new competition would represent the prospect of poorer financial results and may spark an effort to find new economies or other new strategies to compete, which would generally be considered beneficial to society. Further, specialty providers and ambulatory surgery centers may be more efficient than most hospitals. By injecting competition into the hospital market place, they may enable payers to lower unit payment.

Of greatest concern to us is the financial health of safety-net hospitals. For some of these providers, who may be struggling to survive already, these new pressures could lead to failure. This failure could force the remaining providers to serve an ever-larger number of less profitable patients, which could lead to a cascade of failures, starting in the inner city and potentially radiating out to more distant areas and rural communities. CON laws have been used in Illinois and other states to help protect those hospitals. Realistically, the greatest effect that CON laws have is that it retards the shift of relatively profitable services from the inner-city into the suburbs. Through our research and analysis we could find no evidence that safety-net hospitals are financially stronger in CON states than other states. Illinois already has several programs that explicitly fund safety-net hospitals: the Cook County Intergovernment Transfer (IGT) Program, the Hospital Assessment Program, and the Critical Hospital Adjustment Payment (CHAP) program. The legislature should judge whether the present funding level in aggregate is adequate or whether the funding should be increased. If such policies are adequately funded, it would be appropriate for Illinois to consider the usefulness of its CON program.

In time, more will be known on these topics. Since December 2003, federal policy has restrained specialty hospital development first through a legislative moratorium and later through

administrative action. As such, comparative data on the effect of specialty hospital development on safety-net providers and community hospitals generally, as well as on access issues for the disadvantaged in general, is not yet definitive.

## Recommendations

The traditional arguments for CON are empirically weak, and based on the preponderance of hard evidence, the recommendation should be to allow the program to sunset. However, given the potential for harm to specific critical elements of the health care system, we would advise the Illinois legislature to move forward with an abundance of caution. *Nontraditional arguments for maintaining CON deserve consideration, until the evidence on the impact that specialty hospitals and ambulatory surgery centers may have on safety-net providers can be better quantified.*

Our recommendations are as follows:

1. Extend the CON program for an additional three year period. Before the end of this time period, review the available evidence regarding the effect that CON has on safety-net providers prior to making a final decision on allowing it to sunset.
2. Evaluate non-CON related means of supporting safety-net providers, such that CON protection may not be necessary in three years. Examples could include hospital tax transfer schemes, various disproportionate share hospital (DSH) programs, and the like.
3. Consider establishing a more proactive charter for the Health Facilities Planning Board, to include a blueprint for health facilities development that would promote specific needed initiatives and provide guidance on need throughout Illinois in advance of applicants' requests.
4. Address issues related to board size and structure. The board size should be increased, and individuals with direct experience and expertise in the acute care and long-term care industries should be sought out and confirmed as board members.
5. Similarly, reasonable compensation should be considered for board members for the extensive time they are required to spend in fulfilling their functions. While there are concerns with paying board members in the course of any governmental function, remedies used with other boards (such as urging term limits, overlapping election cycles, et.) should be pursued.
6. The Health Facilities Planning Board's workload should be focused more specifically on areas that appear to make the most difference to the healthcare community: projects involving new hospitals, new nursing facilities, major expansions, and volume-sensitive service offerings. As such, the current capital expenditure and new service threshold is already relatively high, and could reasonably be maintained. Over this three year trial period, however, Illinois may consider following the lead of Florida in requiring CONs only for new facility start-ups and not for expansion of current facilities. In addition the Health Facilities Planning Board should continue to monitor and influence, if possible, the closure of inner city hospital components.

## A Context for Considering the Future of CON

CON was initially mandated in 1974 to control health care expenditures by planning for additional beds and medical equipment in hospitals. Given that the framework of the health

care system has changed over the past 30 years, it is reasonable to ask if CON is a useful regulatory tool as of 2007.

Since 1974, physicians have obtained greater access to the capital market and technologies creating a new market for independent physician owned free-standing facilities that are separate from community hospitals (e.g., single specialty hospitals, ambulatory surgical centers, and diagnostic imaging centers). In light of the increase in the number of uninsured people, the financial stability of inner city and rural hospitals has also become more precarious. As a result, a shift in the focus of CON from a broad control of capital costs to a more narrow and eclectic focus on facilities driven by physician self-referral could represent a more effective use of CON as a regulatory tool. In addition, a CON focus on access to care in the inner city and rural areas may be appropriate.

A possible role for CON might be to take a broader planning perspective and decide how much inner city and rural accesses is appropriate and identify the mechanisms to ensure this outcome. Perhaps one way to accomplish this is by blending finance with planning ensuring that community hospitals get the subsidies required to continue operating. This would further safe guard access to health care and planning when other competing free-standing health care facilities are built to ensure that community hospitals are compensated for adverse selection in poorer, sicker patients who may have an inability to pay for services.

At the end of the day there are two different worlds to consider. One is the world with CON (as we have outlined above) that reduces physician self-referral, and the other is the world rife with competition. Each has its advantages. Competition can increase access, reduce unit costs, and provide a wider variety of competitors in the market place. A focused CON, on the other hand, could preserve inner city hospitals' mission, reduce physician self-referral activities, and possibly reduce health care expenditures.

Ultimately, in determining the usefulness of CON processes, the state may consider what role it needs the CON process to play. If the CON process is used to control for market forces, an underlying concern will be the possible detrimental effects on specialty hospitals, as well as what impact there will be on safety-net hospitals. Unfortunately, the use of CONs to control emerging market forces is still such a new process that it is too early to understand the implications. Those states that have ended their CON laws are still adjusting to the lack of regulations, making the "fall out" or "benefits" yet to be determined. Until the role of competition from physician referral based health care can be determined it might be prudent to keep CON in place, focusing the program on new start-up facilities and safety-net hospital closures. CON can be applied more aggressively if competitive markets prove highly problematic in providing care to the uninsured and underinsured, especially in inner city and rural areas.



## I. INTRODUCTION

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In response to this, the Illinois House of Representatives resolved that the Illinois Commission on Government Forecasting and Accountability shall "conduct a comprehensive evaluation of the Illinois Health Facilities Planning Act, including a review of the performance of the Illinois Health Facilities Planning Board, to determine if it is meeting the goals and objectives that were originally intended in the enactment of the law and the establishment of the Board, and as the law has been amended along with the Board policies and procedures that have been revised since that time, with special consideration for its affect on controlling unnecessary and excessive capital expenditures that may be contributing to health care inflation."<sup>2</sup>

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<sup>2</sup> House Resolution 1497.

## II. BACKGROUND

CON was mandated under the National Health Planning and Resources Development Act of 1974 and certain federal health care funds were conditioned on states enactment of CON laws. In 1987, Federal requirements for CON laws were repealed. By mid-2006, 36 states, Puerto Rico, and the District of Columbia retained some form of CON program, law or agency.<sup>3</sup> Exhibit 1 lists those states that currently maintain CON programs and summarizes the number and percent of regulated services for each state. The total number of regulations that exist across state CON programs is 42 (see Appendix A).

The underlying principle behind CON is that the regulation of institutional providers and medical equipment will result in reduced health care costs by controlling supply of hospital beds and the over-purchasing of medical equipment.<sup>4</sup> To ensure the appropriate implementation of the programs, each state developed their own mechanism to regulate, approve, and fund this program. Many policymakers contended that CON requirements could prevent the construction of unnecessary capacity and help control health care costs. CON opponents argued that such requirements could stifle competition and lead to higher health care costs.<sup>5</sup>

Exhibit 1: CON Regulated Services by State

State	State	Number of Services Regulated	Percent of Services Regulated
AL	Alabama	24	57%
AK	Alaska	28	67%
AR	Arkansas	8	19%
CT	Connecticut	28	67%
DE	Delaware	9	21%
DC	District of Columbia	24	57%
FL	Florida	12	29%
GA	Georgia	26	62%
HI	Hawaii	26	62%
IL	Illinois	19	45%
IA	Iowa	8	19%
KY	Kentucky	21	50%
LA	Louisiana	2	5%
ME	Maine	25	60%
MD	Maryland	20	48%
MA	Massachusetts	18	43%
MI	Michigan	20	48%
MS	Mississippi	19	45%
MO	Missouri	17	40%
MT	Montana	7	17%
NE	Nebraska	2	5%
NV	Nevada	10	24%
NH	New Hampshire	16	38%
NJ	New Jersey	13	31%
NY	New York	27	64%
NC	North Carolina	28	67%
OH	Ohio	2	5%
OK	Oklahoma	7	17%
OR	Oregon	1	2%
PR	Puerto Rico	10	24%
RI	Rhode Island	20	48%
SC	South Carolina	21	50%
TN	Tennessee	22	52%
VT	Vermont	26	62%
VA	Virginia	22	52%
WA	Washington	16	38%
WV	West Virginia	27	64%
WI	Wisconsin	4	10%

Source: National Council of State Legislatures

Note: Percentages equal the number of services regulated in a particular state divided by the number of regulations that exist across all CON states. See Appendix A for an expanded table of regulations by state.

<sup>3</sup> Certificate of Need: State Health Laws and Programs. In *National Conference of State Legislatures*. Retrieved January 3, 2007, from <http://www.ncsl.org/programs/health/cert-need.htm>.

<sup>4</sup> McGinley, PJ. Beyond health Care Reform: Reconsidering Certificate of Need Laws in a Managed Competition System. 1995. In *Florida State University Law Review*. Retrieved January 21, 2007, from <http://www.law.fsu.edu/journals/lawreview/issues/231/mcginley.html>

<sup>5</sup> Government Accountability Office. Specialty Hospitals: Geographic Location, Services Provided, and Financial Performance. October 2003.

## A. Differing Views on CON

The National Conference of State Legislatures provides a table on their website (shown below) that provides a comprehensive outline of the differing supporting and opposing views on CON programs.

**Exhibit 2: Differing Views on CON**

CON SUPPORTERS' VIEWS	CON OPPONENTS' VIEWS
<p>Advocates of CON programs say that health care cannot be considered as a “typical” economic product. They argue that many “market forces” do not obey the same rules for health care services as they do for other products. In support of this argument, it is often pointed out that, since most health services (like an x-ray) are “ordered” for patients by physicians, patients do not “shop” for these services the way they do for other commodities. This makes hospital, lab and other services insensitive to market effects on price, and suggests a regulatory approach based on public interest.</p> <p>The American Health Planning Association (AHPA) is the professional group of state agencies responsible for regulation and planning. They identify three factors that suggest the need for CON programs.</p> <ul style="list-style-type: none"> <li>• The primary argument is that CON programs limit health-care spending. CONs can promote appropriate competition while maintaining lower costs for treatment services. The AHPA argues that by controlling construction and purchasing, state governments can oversee what expenditures are necessary and where funds will be used most effectively. This helps eliminate projects that detract attention from more urgent and useful investments and reduces excessive costs.</li> <li>• AHPA also asserts that CONs have a valuable impact on the quality of care. When facilities and equipment are monitored, hospitals and other treatment centers can acknowledge what sort of services are in demand and how effectively patients are being taken care of.</li> <li>• Additionally, according to supporters, the programs distribute care to areas that could be ignored by new medical centers. CON programs are a resource for policymakers.</li> </ul> <p>CON regulations are described as a reliable way to implement basic planning policies and practices, and aid in distributing health care to all demographic areas. The CON process can call attention to areas in need because planners can track and evaluate the requests of</p>	<p>CON programs also have been subject to wide criticism. To start, it is not clear that these state-sponsored programs actually controlled health care costs. For example, by restricting new construction, CON programs may reduce price competition between facilities, and may actually keep prices high. Barriers to new building were seen as unfair restrictions, sometimes by both existing facilities and their potential new competitors. There is little direct broad proof that overcapacity or duplication leads to higher charges. In 2004 the Federal Trade Commission (FTC) and the Department of Justice both claimed that CON programs actually <i>contribute</i> to rising prices because they inhibit competitive markets that should be able to control the costs of care and guarantee quality and access to treatment and services.</p> <p>Some opponents felt that changes in the Medicare payment system (such as paying hospitals according to Diagnostic Related Groups - “DRGs”) would make external regulatory controls unnecessary, because health care organizations would be more subject to market pressures.</p> <p>Some pointed out that the CON programs are not consistently administered. A 'flexible' program could allow development, to the dismay of competitors. A 'restrictive' program could limit competition, with the same effect. Many argued that health facility development should be left to the economics of each institution, in light of its own market analysis, rather than being subject to political influence.</p> <p>Some evidence suggests that lack of competition paradoxically <i>encouraged</i> construction and additional spending. Some opponents of CON programs believe an open health care market, based on quality rather than price, might be the best principle for containing rising costs.</p> <p>Proponents of CON programs disagree. This debate rests on the same arguments as many other “Regulated market” vs. “Open market” discussions.</p> <p>In theory, Certificates of Need are granted based on objective analysis of community need, rather than the</p>

<p>hospitals, doctors and citizens and see which areas are underserved or need to be improved and developed.</p>	<p>economic self-interest of any single facility. However, opponents of CON programs claim that the programs have not worked this way. They cite examples in which CONs were apparently granted on the basis of political influence, institutional prestige or other factors apart from the interests of the community. Furthermore, it is sometimes a matter of debate what sort of development is actually in the community's interest, with people of good will sharply divided on how to determine this.</p>
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Source: Certificate of Need: State Health Laws and Programs. In *National Conference of State Legislatures*. Retrieved January 3, 2007, from <http://www.ncsl.org/programs/health/cert-need.htm>.

Given these diverse policy perspectives, CONs have maintained a controversial role within health care planning and community development.

### III. ILLINOIS CON PROGRAM

The Health Facilities Planning Act (20 ILCS 3960) was implemented in 1974 to establish a process designed to slow the trends of increasing costs of health care resulting from unnecessary construction or modification of health care facilities. The Act provides that the procedure shall represent an attempt by the State of Illinois to improve the financial ability of the public to obtain necessary health services, and to establish an orderly and comprehensive health care delivery system which will guarantee the availability of quality health care to the general public.<sup>6</sup> Since its inception, The Health Facilities Planning Act has undergone several changes through Public Acts outlined in Exhibit 3.

The Health Facilities Planning Act also established the Health Facilities Planning Board to help control rising health care costs by issuing CONs. CONs allow health facilities to modify or construct facilities and to acquire major medical equipment in order to improve their services to health care consumers.

Illinois' program is solely funded by application fees, but the amount paid is conditional on the total cost of the project.

#### Exhibit 3: A Review of Illinois CON Legislation

##### **Illinois Health Facilities Planning Act of 1974 (20 ILCS 3960)**

- 13-member Health Facilities Planning Board to review the necessity of capital expenditures for the establishment or modification of health facilities and the procurement of medical equipment.

##### **Public Act 91-0782 [2000]**

- Made the following changes to the Health Policy Act<sup>1</sup>:
  - Raised dollar thresholds for review;
  - Excluded non-clinical service areas from review;
  - Included a provision to Sunset the Act on July 1, 2003;
  - Included ethics laws requirements; and
  - Prohibited ex parte communications.

##### **Senate Bill 1332 (P.A. 93-0041) [2003]**

- 93<sup>rd</sup> General Assembly restructured the Board, replacing the 13-member board with 9-member board appointed by the Governor, with no requirements that they represent particular interests.
- Changed various operating policies and procedures of the Board and established a CON "Sunset" date of July 1, 2008.

##### **House Bill 7307 (P.A. 93-889) [2004]**

- Restructured the Health Facilities Planning Board, reducing the Board to 5 entirely new members.
- CON laws were to be reconsidered under a new "Sunset" date of July 1, 2006, allowing time to evaluate the Board's operations, streamline and clarify existing review processes and analyze the law's performance and effectiveness.

##### **Senate Bill 2436 (P.A. 94-983) [2006]**

- Extended the "Sunset" date again to April 1, 2007, allowing time for further evaluations of the rising health facility capital expenditures, trends in health care regulation and increasing health care costs.

Source: House Resolution 1497 Appendix A; State of Illinois, Office of the Auditor, General Program Audit of the Illinois Health Facilities Board. September 2001.

<sup>6</sup> State of Illinois, Office of the Auditor General, Program Audit of the Illinois Health Facilities Board. September 2001.

## A. Requirements and Regulations

The Illinois CON program requires a CON for:

- *Capital expenditures by health care facilities*, defined as hospitals, long term care facilities, ambulatory surgical treatment centers, and dialysis facilities, when a proposed capital expenditure is greater than statutory thresholds. In 2000, the Illinois Health Facilities Planning Act was amended to exclude non-clinical capital expenditures and include out-of-state hospitals making capital expenditures for surgical services.
- *Bed expansions in existing facilities*. Hospitals must obtain a CON to increase or redistribute beds between categories of service by more than 10 beds or 10 percent of its total facility capacity, whichever is less. Bed changes under this provision cannot be made more often than every two years.<sup>7</sup>

In addition, the Illinois CON program regulates the addition or discontinuation of certain services, called Categories of Service, regardless of cost. Current categories include: <sup>8</sup>

- Medical/surgical;
- Obstetrics;
- Pediatrics;
- Intensive care;
- Comprehensive physical rehabilitation;
- Acute mental illness;
- Neonatal intensive care;
- Open heart surgery;
- Cardiac catheterization;
- Chronic renal dialysis;
- Non-hospital based ambulatory surgery;
- General and specialized long-term care; and
- Kidney and selected other organ transplant.

Projects proposed under Illinois' Alternative Health Care Delivery Act are also reviewed as Categories of Service. These include:<sup>9</sup>

- The Sub-acute Care Hospital Model;
- The Postsurgical Recovery Care Center Alternative Health Care Model;
- The Children's Respite Care Alternative Health Care Model; and
- The Community-Based Residential Rehabilitation Center Alternative Health Care Model.

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<sup>7</sup> Illinois Hospital Association Perspective on the Need to continue Certificate of Need in Illinois. Prepared for The Lewin Group January, 2007

<sup>8</sup> Illinois Hospital Association.

<sup>9</sup> Illinois Hospital Association.

## B. Illinois CON Application and Review Process

Currently, health care facilities must obtain a CON prior to making a capital expenditure greater than \$7.8 million for construction or modernization. This capital expenditure threshold for construction or modernization is one of the highest in the country. Massachusetts and Maryland have higher thresholds at \$12.5 and \$10 million, respectively.<sup>10</sup>

The Health Facilities Planning Act details the types of projects requiring review. A project is subject to review and requires a permit if the project meets one of the following criteria:<sup>11</sup>

- Requires a total capital expenditure in excess of the capital expenditure minimum;
- Substantially changes the scope or changes the functional operation of the facility;
- Results in the establishment of a health care facility;
- Changes the bed capacity of a health care facility by increasing the total number of beds or by distributing beds among various categories of service or by relocating beds from one physical facility or site to another by more than ten beds or more than ten percent of total bed capacity over a two year period;
- Involves a change of ownership; or
- Results in the discontinuation of an entire health care facility or category of service.

Exhibit 4 below illustrates the CON process. The process begins when a health facility applies for a CON permit by submitting an application to the Department of Public Health. The application is then reviewed and application fees are submitted. Application fees range from \$2,000 for projects less than \$1,250,000 to \$100,000 for \$50 million or more projects.<sup>12</sup>

Once a completed application is received there is an opportunity for a public hearing, which is published in a general circulation newspaper in the area or community to be affected. Any interested party can request a public hearing to be held in the proposed project site. Interested parties can present their views or arguments in writing or orally, and a record of the testimony is sent to the Board to be considered before making a decision.<sup>13</sup>

After the Board denies the application the first time, the applicant has the right to three appeals, followed by a final decision.

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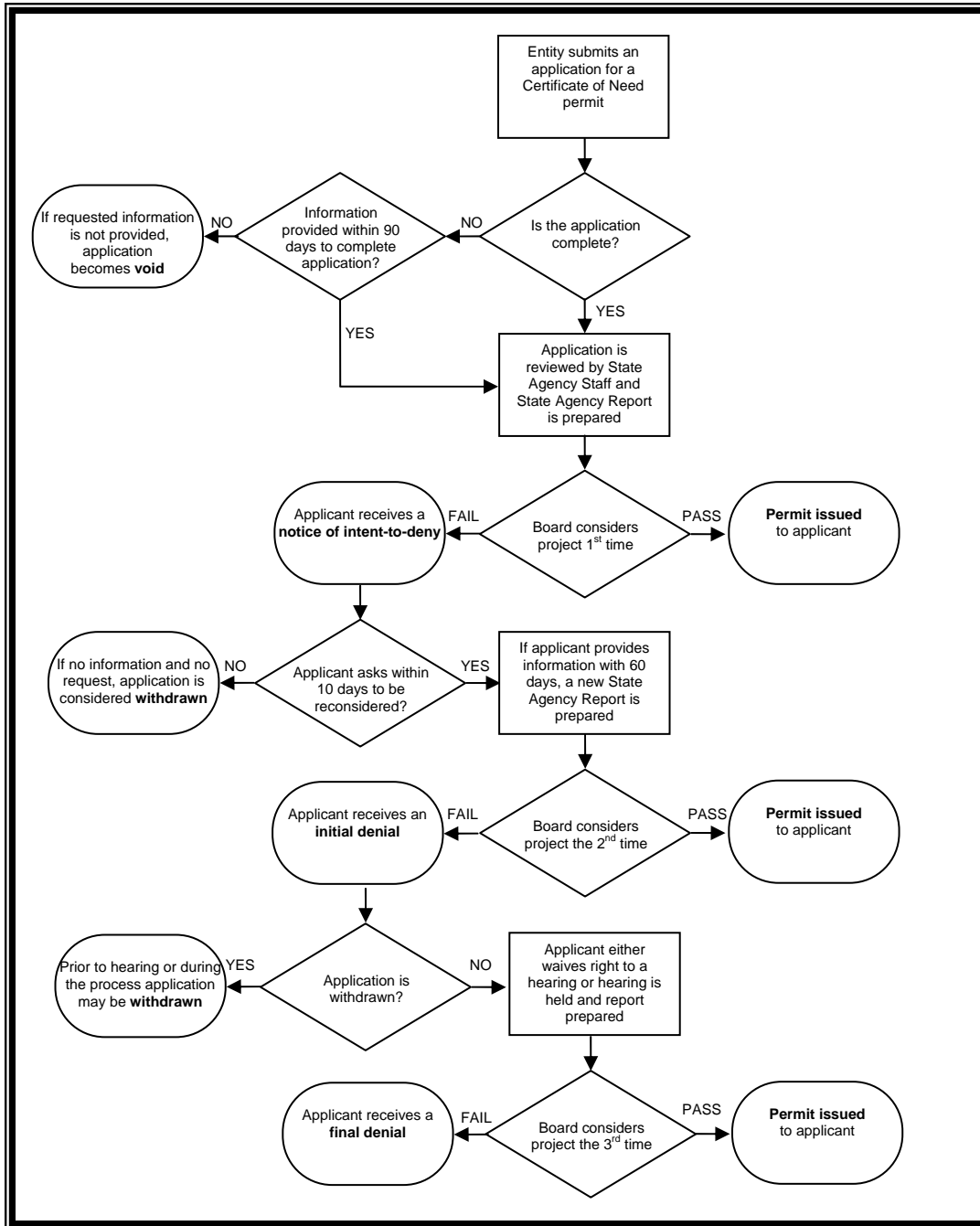
<sup>10</sup> Illinois Hospital Association Perspective on the Need to continue Certificate of Need in Illinois. Prepared for The Lewin Group January, 2007

<sup>11</sup> State of Illinois, Office of the Auditor General, Program Audit of the Illinois Health Facilities Board. September 2001.

<sup>12</sup> Project Evaluation. Illinois Health Facilities Planning Board. 2006.

<sup>13</sup> State of Illinois, Office of the Auditor General.

### Exhibit 4: Certificate of Need Process



Source: OAG Analysis of Planning Board Process

Illinois' review period was the 8th lengthiest compared to the 33 other states for which data were available. In addition, the rules include elements that can lengthen the process.<sup>14</sup>

<sup>14</sup> State of Illinois, Office of the Auditor General, Program Audit of the Illinois Health Facilities Board. September 2001.



## C. Approvals

The Planning Board approved 92.1 percent of proposed project dollars that it reviewed between Fiscal Years 2002-2006. However, because of a potential deterrent effect, the CON process may have avoided more costs than a simple analysis of this figure would suggest. Exhibit 5 below shows the dollar amount of projects approved during Fiscal Year 2002-2006 and the percent of approved project dollars for each year.

**Exhibit 5: Dollar Value of Projects Proposed vs. Projects Approved**

Fiscal Year	Total Projects Proposed	Total Projects Approved	Difference	Percent of Approved Project Dollars
2002	\$573,025,886	\$536,421,811	\$36,604,075	93.6%
2003	\$969,720,753	\$944,145,788	\$25,574,965	97.4%
2004*	\$1,677,943,340	\$838,823,430	\$839,119,910	50.0%
2005	\$1,404,178,007	\$1,328,439,017	\$75,738,990	94.6%
2006**	\$2,222,599,891	\$1,951,530,472	\$271,069,419	87.8%
<b>Totals*</b>	<b>\$5,169,524,537</b>	<b>\$4,760,537,088</b>	<b>\$408,987,449</b>	<b>92.1%</b>

Source: Illinois Health Facilities Planning Board, 2006.

\* The functions of the State Board were temporarily halted by the Governor and 2004 was not used to calculate "Totals" across 2002-2006.

\*\*FY 2006 has projects still pending and not included in these dollars.

The average number of days for project approval, between the fiscal years 2002-2006, was 116.7 days.<sup>15</sup>

For more information on Illinois' CON program's project evaluation, please refer to Appendix B.

## D. Interview Findings

The Lewin Group interviewed ten individuals familiar with the CON program in Illinois in order to gain insight about the program from the perspective of individuals either knowledgeable of or directly affected by its process and ultimate decisions. The list of interviewees (provided in Appendix C) included representatives of the Illinois Hospital Association, two independent hospitals in metropolitan Chicago, the Illinois Medical Society, a trade association for long-term care providers, staff representatives from the Department of Health, a former Commissioner, as well as a consultant and health economist. Each interviewee was asked a series of questions to assess their perception of the program's effect in terms of cost, quality, and access on the system, as well as suggestions and recommendations regarding elimination or continuation of CON. We present our findings below:

Current institutional providers recognize that, in practice, the CON program protects their interests. The major trade associations of both the acute care and long-term care industries have formal positions of support for continuing the program. Inner city hospitals, in particular, believe that maintaining a CON program is essential to protect them from providers who might

<sup>15</sup> Project Evaluation. Illinois Health Facilities Planning Board. 2006.

be inclined to develop competitive facilities in proximity of the current providers. More generally, “cherry picking” behavior (i.e., targeted marketing of profitable services and patients to the exclusion of other patients) is believed to have been minimized in Illinois compared to states with no CON, such as Indiana.

The medical society, on the other hand, has a formal position opposing the continuation of CON in Illinois. This position is based on a belief that competition for new services is healthy, and that physicians should be allowed to compete with current institutional providers by providing more efficient and higher quality services through such mechanisms as ambulatory surgery centers and specialty hospitals.

Most respondents recognized that previous studies do not support the contention that overall spending was depressed by CON programs, but felt that in individual circumstances it had made a significant impact on spending patterns in Illinois. All respondents cited instances where multiple parties wished to develop competing services in the same market area, and the facilities board was asked to determine which should be approved. Generally, those who favored continuation of the program felt that absent CON, most of these projects would have been built, with considerable waste in terms of dollars allocated to capital. Others doubted whether such a dynamic would truly have ensued, and whether other forces (i.e., speed to market, financial factors, community support or opposition) may have been sufficient to select out which projects move forward and which are shelved without the burden of CON. Similarly, many interviewees pointed to the number of projects, mostly in the Chicago area, that never came before the CON Board because potential applicants were advised that Board approval was problematic. That deterrent trip wire would not be in play in non-CON states.

There was less ambiguity in terms of quality and access. Regarding quality, nearly all respondents pointed to the minimum volume thresholds in approving new cardiac services as an example of how the CON program could be used to ensure and enhance quality. Specific examples beyond this were rare. Questions of access, on the other hand, emerged as one of the leading points raised in support of continuing the program. Hospital representatives feel that access to disadvantaged population groups is enhanced by ensuring that inner city hospitals and hospitals with relatively undesirable payer mix profiles are protected to some degree from aggressive competition for their remaining commercial patients, in order to maintain needed overall profitability levels. This competition may come from any direction – single specialty hospitals, ambulatory surgery centers, as well as from other or neighboring hospitals. When asked about the merits of essentially slowing capacity expansion in areas of population growth in order to force suburban residents to use facilities that are less accessible, respondents felt that this was a necessary trade-off, under the current system.

Another argument for continuation of the program involved the desirability of maintaining a public forum for consideration of major health care initiatives. Without CON, the argument holds, important issues would not receive an adequate level of community input prior to moving forward.

Even those who favored continuation of the program urged certain changes to its functioning. Among the major suggestions noted were:

1. While the most recent board structure changes made were necessary to provide an adequate level of public confidence, the board size is now too small, the demands on individual board members' time are too overwhelming, and the expectation of board members' competence, given the size of the board, on such a wide variety of matters is unfounded.
2. The CON function is too reactive. At a minimum, imposition of batch processing of similar projects in competitive markets should be considered. More broadly, some questioned whether the CON function could be truly effective without a more vigorous community-wide health facility planning function, which would outline public preferences and define needs prior to reviewing individual providers' applications for those meeting those needs.
3. There was a "split decision" in terms of whether CON authority should be extended beyond the initial go/no go decision. CONs are often granted under certain conditions (e.g., if approved, an applicant will agree to provide minimum levels of charity care, etc.). Following up to ensure that the successful applicants have met their conditions after the project is completed is haphazard at best. Some ongoing accountability function has been suggested by some. Other respondents feel that the CON program has already moved too far in the direction of licensing, and should be restricted to the initial decision.
4. The review function for new technologies drew additional comments. Some felt it unfair that a tremendously expensive new technology (proton beam therapy drew frequent comment) may not require CON if it was not being provided by an institutional provider, because it is the provider that requires a CON, not a service. Additionally, it was suggested that the Board establish a mechanism for developing review criteria for new technologies and service types within a more reasonable period of time (60-90 days) than is currently the case.

#### IV. COMPARISON OF ILLINOIS TO BENCHMARK STATES

In the absence of federal CON regulation, 36 states, plus Puerto Rico and the District of Columbia, maintained their CON programs for health care services and capital equipment. The wide variation of design makes the comparison of CON laws between states difficult. States have continued to alter their CON program regulation stringency and often contemplate the eliminating of their CON program. In comparison to select benchmark states, Illinois represents a “middle of the road”<sup>16</sup> approach when referring to the structure, process and acceptance rates for its CON program, with many similarities to Michigan’s and Washington’s program.

CON programs were created as a mechanism to control growing health care costs, increase quality of health care, and ensure access to care for uninsured and underinsured in urban and rural areas. To ensure the appropriate implementation of the programs, each state developed their own mechanism to regulate, approve, and fund this program. According to reviews of numerous states programs, literature suggests that overall CON laws do not have a large effect on controlling overall health care costs, the quality of health care, and access to care for indigent populations. Additionally, most states do not have appropriate mechanisms to track their progress in these areas, making the outcomes of the CON programs unknown.

Data was collected through literature reviews, independent outcome analyses of the programs, and performance audits for the following benchmark states: Washington, Michigan, Virginia, and New York. Each state was researched on the following elements: CON process, structure, approval rates, and outcome measures such as cost, quality and access. The summary of our findings are found in Exhibit 6.

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<sup>16</sup> Illinois Hospital Association Perspective on the Need to continue Certificate of Need in Illinois. Prepared for The Lewin Group  
January, 2007

**Exhibit 6: Summary of State Findings**

State	Regulating Agency	Funding CON	Application Process	Acceptance Rates	Outcomes		
					Cost	Quality	Access
Washington	Department of Health (DoH)	Application fees by project type; range from \$8,423 to \$30,293	Regular review and concurrent review for project types with more than 1 application. Expedited review for certain situations with a 5 month review rather than 6 months for regular review.	2005: 88% approval rating for 120 applications.	Does not effectively control overall health care spending, but does restrict the supply of health care providers.	Conflicting/inconclusive: CON may concentrate services to specialized sites of service increasing quality, and may limit under-qualified providers in hospice and home health facilities.	Conflicting: CON protects existing facilities in inner city but restricts access by limiting new facilities
Michigan	Department of Health (DoH)	Application fees supplemented by general appropriations	Conducts substantive (regular; 120 days), nonsubstantive (specific projects only; 45 days) and comparative (project types with many applications) reviews.	Range from 98.9% in 1999 to 93.9% in 2001, from 552 applications across these years	Little evidence that CON reduces health care costs, with some evidence on the contrary.	Weak evidence: Specialization caused by high volume may increased overall health care quality. Significant quality outcome measures were evident in cardiac catheterization and open-heart surgeries	Slight evidence: CON helped reach un- and under-insured, but is modest compared to the state's 1 million uninsured
Virginia	Department of Health (DoH) and regional Health System Agencies (HSA)	General appropriations supplemented by application fees	DoH and HSA conduct separate reviews with the Commissioner making final decisions.	2005: 91% approval rating, with 83% concordance rating between the HSA and the DoH.	Inconclusive: CON not linked to reduction in aggregate spending but shows tangible savings in specific medical technologies	No direct effect: Licensure, requirement processes, and quality measures increase quality, but are not related to CON regulation	Two programs aim to equalize the burden of uncompensated care across hospitals with only marginal effects.
New York	Department of Health (DoH)	General appropriations supplemented by application fees	DoH and State Hospital Review and Planning Council conduct separate reviews, depending on the type of project. Allows for expedited reviews for specific situations	N/A	N/A	N/A	N/A

Note: See section below for appropriate table sources

## A. Comparison of CON Structure

As a state regulated program, CON programs show a wide variation in structure across states. We compared the CON program for the benchmarked states to Illinois based on the regulatory agency supporting the program and the methods used to fund the program.

### 1. Regulation of CON Programs

States have different ways of regulating their CON program. Consistent with Illinois, Michigan, Washington and New York's programs, are regulated by the Department of Health, which is responsible for approving all applications within the state.<sup>17,18</sup> Virginia, on the other hand, developed a program under the joint administration of the Virginia Department of Health and regional health planning agencies known as Health System Agencies (HSAs).<sup>19</sup> These departments are responsible for identifying regulated services, overseeing the review process, and monitoring the facilities that were created under the review process.

### 2. Funding CON Programs

Depending on the program structure, financial responsibility for maintaining the programs falls with the provider and/or the state. In Washington, the CON program is solely supported by application fees paid by the applicant. These fees are established in the rule and vary by type of project. For example, application fees range from \$8,432 for hospice care centers to \$30,293 for nursing homes.<sup>20</sup> Illinois' program is solely funded by application fees, but the amount paid is conditional on the total cost of the project. Application fees range from \$2,000 for projects less than \$1,250,000 to \$100,000 for \$50 million or more projects.<sup>21</sup>

More often, CON programs are funded by a combination of general appropriation funds and small applications fees. Michigan primarily supports the program through application fees with general appropriations covering the remainder of the costs. From fiscal year 2004-2005, direct appropriations for the project totaled \$1,007,600, of which \$900,200 was met by fee income.<sup>22</sup>

Virginia and New York are primarily funded by appropriation fees and uses application fees to cover the remainder of the costs. In fiscal year 2002, Virginia HSAs received \$651,951 in appropriations and \$481,939 in CON (specifically called COPN - "certificate of public need" - in Virginia) application fee revenues. The reliance on General Fund appropriations, however, has been steadily decreasing in 2003 and 2004 from \$403,687 to \$333,072<sup>23</sup>. New York requires filing fees dependant on the type of review. Certain reviews require \$1,250 plus, if approved, 0.45 percent of the total capital value of the application<sup>24</sup>.

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<sup>17</sup> Citizens Research Council of Michigan, *The Michigan Certificate of Need Program: Report 338*, February 2005.

<sup>18</sup> State of Washington Joint Legislative Audit and Review Committee (JLARC), *Performance Audit of the Certificate of Need Program: Preliminary Report (Revised)*, May 24, 2006.

<sup>19</sup> Commonwealth of Virginia, Report of the Joint Commission on Health Care, House Document No. 82, *Study of Virginia's COPN pursuant to HB 1302 of 1996, 1997*.

<sup>20</sup> WAC 246-310-990, Certificate of need review fees. Washington State Legislature.

<sup>21</sup> Project Evaluation. Illinois Health Facilities Planning Board. 2006.

<sup>22</sup> Citizens Research Council of Michigan, *The Michigan Certificate of Need Program: Report 338*, February 2005.

<sup>23</sup> Joint Legislative Audit and Review commission of the Virginia General Assembly (JLARC), *Special Report: State Spending on Regional Health Planning Agencies*, Staff Briefing, June 9, 2003.

<sup>24</sup> *Certificate of Need Requirements for Article 28 Facilities*, Prepared by GNYHA, April 2005.

## B. Comparison of CON Process and Acceptance Rates

### 1. Process

Each state is under its own discretion to review and approve CON applications. Michigan, Washington and Illinois have a single process to review the applications, while Virginia and New York have two concurrent reviews. Virginia's application reviews are done by the Department of Health, and separately done by the HSAs. Virginia's system requires the Commissioner to review the decisions of each branch and reach one final decision, which is presented to the applicant.<sup>25</sup> New York application reviews are done by the New York State Department of Health and separately done by the State Hospital Review and Planning Council. The type of project determines which agency (if not both) review the application.<sup>26</sup> These joint processes ensure that each application is reviewed independently and objectively, but does require duplication of effort.

The overall processes for the benchmark states are quite similar to Illinois' regarding the steps each application goes through. Typically a letter of intent to the regulatory department is filed by the applicant. This is followed by submitting the application and, if needed, the agency's request for more information. Each state also holds a public hearing to hear the concerns and opinions of the state residents. The program then develops a summary report and makes its decision. At the end of each process, the applicant can appeal the decision if they are unsatisfied.<sup>27,28,29,30,31</sup>

Michigan and Washington use a different application process for applicants that file for the same project type at the same time. This concurrent, or comparative review, allows the program to compare the applications to each other, ensuring that they approve the most effective project. Additionally, Michigan, Washington and New York have provisions that allow for expedited, or non-substantive reviews for certain projects. Washington's decisions are to be made within 5 months, rather than the 6 months required for regular review, while Michigan's decision is made with in 45 days, rather than the 90 days required for regular review.<sup>32,33</sup>

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<sup>25</sup> Joint Legislative Audit and Review commission of the Virginia General Assembly (JLARC), *Special Report: State Spending on Regional Health Planning Agencies*, Staff Briefing, June 9, 2003.

<sup>26</sup> *Certificate of Need Requirements for Article 28 Facilities*, Prepared by GNYHA, April 2005.

<sup>27</sup> Citizens Research Council of Michigan, *The Michigan Certificate of Need Program: Report 338*, February 2005.

<sup>28</sup> Michigan Department of Community Health, Certificate of Need Commission, *Performance Audit of the Certificate of Need Program*, April 2002.

<sup>29</sup> Washington Policy Center, Policy Brief: Failure of Government Central Planning Washington's Medical Certificate of Need Program, January 2006, available from <http://www.washingtonpolicy.org/HealthCare/PBBARNESCON.htm>; accessed 17 January 2007.

<sup>30</sup> Joint Legislative Audit and Review commission of the Virginia General Assembly (JLARC), *Special Report: State Spending on Regional Health Planning Agencies*, Staff Briefing, June 9, 2003.

<sup>31</sup> State of Illinois Office of the Auditor General, "Program Audit of the Illinois Health Facilities Planning Board," September 2001.

<sup>32</sup> State of Washington Joint Legislative Audit and Review Committee (JLARC), *Performance Audit of the Certificate of Need Program: Preliminary Report (Revised)*, May 24, 2006.

<sup>33</sup> Citizens Research Council of Michigan, *The Michigan Certificate of Need Program: Report 338*, February 2005.

In addition to the substantive and non-substantive review, Illinois allows for emergency reviews if there is an imminent threat to the structural integrity of the building or to safe operations.<sup>34</sup>

The approval rate for Illinois from fiscal year 2002-2006 is consistent with these reviewed states, with an overall approval rating of almost 85 percent from a total of 446 applications.<sup>35</sup>

## **2. Acceptance Rates**

Our review demonstrated that states were consistent among their approval ratings for CON applications. From applications filed around 2001, Michigan and Washington had approval ratings of 82 percent and 88 percent, respectively. Virginia, for 2005, approved 91 percent of all CON applications. Additionally, for Virginia, there was an 83 percent concordance rating between the two separate reviews: the HSA and the Department of Health.<sup>36</sup>

## **C. Comparison of CON Outcomes**

CON program goals of controlling growing health care expenditures due to duplicative services and unnecessary capital costs, as well ensuring quality and access for all are rarely met for each state. A review of literature concludes that there is weak evidence that CON reduces health care cost, increases quality as a result of specialization of high volume services, and maintains and increases access for indigent populations in the benchmark states. For Illinois, however, there is a potential for slight tangible cost savings, but studies either do not consider, or do not show any positive effect on quality or access to care.

### **1. CON Effect on Cost**

A review of the evidence indicates that CONs rarely reduce health care costs, and on occasion, increase cost in some states. The extent to which results are mixed is evidenced in Michigan. A performance review of Michigan's CON program conducted by Center for Health Policy, Law and Management at Duke University found little evidence that CON results in a reduction of health care costs, and even found some evidence on the contrary.<sup>37</sup> Yet another independent analysis showed that per capita health care costs are lower in CON states, supporting the continuation of CON in Michigan.<sup>38</sup> Yet again, while reviewing national and Michigan-specific data, others have found that there "is little evidence that CON results in a reduction in costs and some evidence to suggest the opposite."<sup>39</sup> Michigan has not conducted any analyses of the health care costs or compared them to other states that have repealed or deregulated their CON programs.<sup>40</sup>

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<sup>34</sup> State of Illinois Office of the Auditor General, "Program Audit of the Illinois Health Facilities Planning Board," September 2001.

<sup>35</sup> Project Evaluation. Illinois Health Facilities Planning Board. 2006.

<sup>36</sup> Joint Legislative Audit and Review commission of the Virginia General Assembly (JLARC), *Special Report: State Spending on Regional Health Planning Agencies*, Staff Briefing, June 9, 2003.

<sup>37</sup> Duke University, Center for Health Policy, Law and Management, Terry Sanford Institute of Public Policy, *Evaluation of Certificate of Need in Michigan, Volume 1: Final Report*, May 2003.

<sup>38</sup> The findings are available on the Department of Community Health Web page as Addendum J to the Conover/Sloan report. [www.michigan.gov/documents/CON](http://www.michigan.gov/documents/CON) Volume II Appendices J - L 81600 7.pdf.

<sup>39</sup> [www.michigan.gov/mdch/0,1607,7-132-2945\\_5106\\_5409-83771--,00.html](http://www.michigan.gov/mdch/0,1607,7-132-2945_5106_5409-83771--,00.html) (p.127)

<sup>40</sup> Michigan Department of Community Health, Certificate of Need Commission, *Performance Audit of the Certificate of Need Program*, April 2002.



Similarly, Washington State Joint Legislative Audit Committee (JLAC) found strong evidence that CON does not effectively control overall health care spending, but can slow the growth of health care costs.<sup>41</sup> Instead of reducing costs, Washington's program essentially "redirects" expenditures to other areas<sup>42</sup>. This study did, however, find that CON has restricted the supply of health care providers, and that the repeal of CON in many states has resulted in surplus supply.

Virginia's CON program has not been linked to reductions in aggregate health care costs, but has shown "tangible savings" on the actual costs of specific medical technologies. Additionally, evidence shows that CON has controlled costs for services that are covered under this program.<sup>43</sup> National economic impact studies additionally suggest that limited entry into the health care market would drive providers to offer fewer services and charge more. While CON programs are intended to control costs, evidence shows that these programs can actually increase prices by fostering anticompetitive barriers to entry.<sup>44</sup>

The lack of strong cost savings from CON programs is consistent with Illinois's performance audit. Findings indicate that the only tangible cost savings are identified in annual reports as the difference between dollars proposed and dollars approved. These savings, however, may be overstated due to withdrawn projects by the applicants.<sup>45</sup>

## **2. CON Effect on Quality**

Outcome evaluations on quality have been difficult for many states, since most do not have mechanisms to monitor and assess the quality of care at approved facilities.<sup>46,47</sup> Many states, however, have utilized quality assurance requirements, certifications and accreditations for their facilities.<sup>48,49</sup> Overall, slight quality improvements have been acknowledged for some states in varying sites of services.

By regulating high-risk, high cost procedures, states can create a specialized provider community that has high volume and provides quality care. This attempt has been found useful in Michigan, Virginia and Washington. While Michigan has found weak evidence that CON

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<sup>41</sup> State of Washington, Joint Legislative Audit and Review Committee, *Effects of Certificate of Need and Its Possible Repeal*, Report 99-1, January 8, 1999.

<sup>42</sup> Federal Trade Commission and Department of Justice, "Improving Health Care: A Dose of Competition", July 2004, chapter 8.

<sup>43</sup> Commonwealth of Virginia, Report of the Joint Commission on Health Care, House Document No. 82, *Study of Virginia's CON pursuant to HB 1302 of 1996*, 1997.

<sup>44</sup> Virginia Department of Planning and Budget, Economic Impact Analysis, 12 VAC 5-230 – *Certificate of Public Need State Medical Facilities Plan*, Virginia Department of Health, August 11, 2004.

<sup>45</sup> State of Illinois Office of the Auditor General, "Program Audit of the Illinois Health Facilities Planning Board," September 2001.

<sup>46</sup> Michigan Department of Community Health, Certificate of Need Commission, *Performance Audit of the Certificate of Need Program*, April 2002.

<sup>47</sup> Application figures cover the period August 27, 1971 through July 7, 2005, "Certificate of Need Action Log," Office of Certificate of Need, Washington Department of Health, July 7, 2005, based on Luft, Harold S., Deborah W. Garnick, David H. Mark, and Stephen J. McPhee, *Hospital Volume, Physician Volume, and Patient Outcomes: Assessing the Evidence*, Ann Arbor, MI, Health Administration Press, 1990; Conover, Christopher, and Frank A. Sloan, "Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?", *Journal of Health Politics, Policy, and Law*, Volume 23, No. 3, June 1998.

<sup>48</sup> Duke University, Center for Health Policy, Law and Management, Terry Sanford Institute of Public Policy, *Evaluation of Certificate of Need in Michigan, Volume 1: Final Report*, May 2003.

<sup>49</sup> Commonwealth of Virginia, Report of the Joint Commission on Health Care, House Document No. 82, *Study of Virginia's CON pursuant to HB 1302 of 1996*, 1997.

overall created high volume facilities that generally accompany specialization and achieve better health outcomes<sup>50</sup>, quantifiable differences in quality occur in cardiac catheterizations and open heart surgeries. Data suggest that there is a “solid volume-quality relationship for both cardiac catheterization and open heart surgeries, with mortality rates for the latter being reduced by 20 percent or more in high-volume facilities.”<sup>51</sup>

Similarly, Virginia has found that outcomes for highly specialized services are higher when they are regionally controlled and volumes are kept high. Data indicate that “it is in the best interest of the public for providers to cooperate and share limited capital and trained staffed resources” to make sure the highest quality of care is maintained.<sup>52</sup> Studies argue that the use of licensures and quality measures used in Virginia are helpful mechanisms to ensure quality, but do not reflect the changes and regulation of CON.<sup>53</sup> Additionally, under the current system, it is expressed that if increased quality was the intended benefit of CON, the program would never have been developed the way it has been.

Washington’s concentration of care to specialized sites of service is weakly linked to increased quality. On the contrary, CON has been found to possibly protect quality of care in hospice and home health facilities by limiting under-qualified providers. As seen in Michigan and Virginia, independent studies conclude that CON “concentrates volume, and the research evidence is strong that higher volumes of certain surgical procedures can lead to better outcomes”.<sup>54</sup>

### **3. CON Effect on Access**

Attempts to maintain health care access to all populations have been only marginally beneficial in the reviewed states. Access is essential to a good CON program but there is little evidence that CON is fulfilling this need. It is built into Michigan’s CON standards that applicants cannot deny services based on ability to pay or source of payments, provide services to all individuals based on the clinical indication of need for the services, and maintain information by payor and non-paying sources to indicate volume from each source provided annually.<sup>55</sup> These provisions yield slight evidence that the Michigan CON program has a beneficial impact on serving uninsured and underinsured. The impact, however, “is relatively modest in the context of the state’s 1 million uninsured”.<sup>56</sup>

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<sup>50</sup> Duke University, Center for Health Policy, Law and Management, Terry Sanford Institute of Public Policy, *Evaluation of Certificate of Need in Michigan, Volume 1: Final Report*, May 2003.

<sup>51</sup> [www.michigan.gov/mdch/0,1607,7-132-2945\\_5106\\_5409-83771--,00.html](http://www.michigan.gov/mdch/0,1607,7-132-2945_5106_5409-83771--,00.html)

<sup>52</sup> Commonwealth of Virginia, Report of the Joint Commission on Health Care, House Document No. 82, *Study of Virginia’s COPN pursuant to HB 1302 of 1996*, 1997.

<sup>53</sup> Virginia Department of Planning and Budget, Economic Impact Analysis, 12 VAC 5-230 – *Certificate of Public Need State Medical Facilities Plan*, Virginia Department of Health, August 11, 2004.

<sup>54</sup> Application figures cover the period August 27, 1971 through July 7, 2005, “Certificate of Need Action Log,” Office of Certificate of Need, Washington Department of Health, July 7, 2005, based on Luft, Harold S., Deborah W. Garnick, David H. Mark, and Stephen J. McPhee, *Hospital Volume, Physician Volume, and Patient Outcomes: Assessing the Evidence*, Ann Arbor, MI, Health Administration Press, 1990; Conover, Christopher, and Frank A. Sloan, “Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?”, *Journal of Health Politics, Policy, and Law*, Volume 23, No. 3, June 1998.

<sup>55</sup> Citizens Research Council of Michigan, *The Michigan Certificate of Need Program: Report 338*, February 2005.

<sup>56</sup> Duke University, Center for Health Policy, Law and Management, Terry Sanford Institute of Public Policy, *Evaluation of Certificate of Need in Michigan, Volume 1: Final Report*, May 2003.

Access to care for indigent populations is an additional and inequitable burden across facilities. The two programs in Virginia that try to address this additional burden only provide minimal support to hospitals that provide a high amount of uncompensated care.<sup>57</sup>

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<sup>57</sup> Commonwealth of Virginia, Report of the Joint Commission on Health Care, House Document No. 82, *Study of Virginia's COPN pursuant to HB 1302 of 1996, 1997.*

## V. IMPACT OF CON: LEWIN'S INTERPRETATION OF THE LITERATURE

In analyses of markets, economists typically make the distinction between the structure of the market and its outcomes, such as price and innovation. The first section of this chapter discusses the impact that CON has on the structure of medical markets and the next three discuss its impact on outcome: expenditures, quality of care, and access to care. The next section discusses these issues in the context of a CON termination. Because access to care is closely associated with the financial strength of safety-net hospitals, CON's impact on their margins has important implications for CON policy, which are discussed in the last section.

### A. Market Structure

CON is required for new facilities (including new units within existing facilities). CON boards cannot close existing facilities in order to replace them with a better set of facilities and have limited ability to forestall the closure of facilities. So their ability to proactively impact health care markets is limited and their impact is largely limited to new facilities. These facilities fall into three categories: specialty hospitals, free-standing facilities such as ambulatory care centers, and community hospitals in rapidly growing suburbs. Given this, we initially discuss trends and CON's impact on specialty hospitals and ambulatory surgical centers.

#### 1. Specialty Hospitals

Compared to (i.e., full service) community hospitals, specialty hospitals are disproportionately for-profit and have physician owners. Although not an inherent characteristic of specialty hospitals, physician-ownership is the source of much of the attention given these hospitals.

The Medicare Modernization Act of 2003 (MMA) imposed an 18-month moratorium on specialty hospitals. CMS, in effect, extended the moratorium through administrative action. Enacted in Feb. 2006, the Deficit Reduction Act required that this CMS policy remain in effect until CMS develops a plan on this topic.

##### a. Criteria and Description

Specialty hospitals typically fall into one of three categories: cardiac, orthopedic, or general surgery.<sup>58</sup> GAO defined specialty hospitals as hospitals with at least two-thirds of its discharges in either: (1) one or two major diagnosis categories or (2) surgical DRGs. Medicare Payment Advisory Committee's (MedPAC's) definition included a measure of concentration but was limited to physician-owned hospitals.

Nationally, the number of specialty hospitals has tripled between 1990 and 2003, with more in development at the end of that period. Despite this growth, in 2003 they constituted only 2 percent of acute care hospitals.<sup>59,60</sup>

<sup>58</sup> Consistent with the literature, long-term care and children's hospitals are excluded from our definition of "specialty hospitals."

<sup>59</sup> Government Accountability Office. "Specialty Hospitals: Geographic Location, Services Provided, and Financial Performance," October 2003, GAO-04-167, pp. 8, 16, and 18.

<sup>60</sup> Government Accountability Office. "Specialty Hospitals: Information on National Market Share, Physician Ownership, and Patients Served," April 18, 2003, GAO-03-683R, pp. 6, 8.

Specialty hospitals differ from community hospitals in several ways. Most specialty hospitals are for-profit. Of those that opened in 1990 or later, 93 percent are for-profit, in contrast to 20 percent of all community hospitals. Physicians collectively had a slight majority of the ownership shares in the 70 percent of specialty hospitals with physician ownership. Moreover all community hospitals have emergency departments, slightly less than half of specialty hospitals have them.

Specialty hospitals are substantially smaller than the typical urban or suburban community hospital. Orthopedic and surgery hospitals average about 15 beds, while cardiac hospitals average about 50 beds.

#### *b. Physician Ownership and Self-Referral*

The fundamental issues revolving around specialty hospitals pertain to physician demands for more clinical autonomy and control over their income and physician self-referral. The Medicare self-referral (e.g., Stark) law prohibits physicians from referring Medicare patients to facilities in which they or their immediate family members may have financial interests. There are several exceptions to this law, one of which applies directly to specialty hospitals. This exception permits physicians who have invested in an entire hospital to refer patients to that hospital, the reasoning being that the physician's incentive is sufficiently diluted by other owners.

Whether ownership influences a physician's referral pattern is a key issue. Most of the evidence to date comes from a CMS report to Congress. CMS analyzed the referral patterns of physician-owners across 11 specialty hospitals, finding that the majority of the physician cases were referred to the specialty hospital. However, a sizeable minority were referred to a community hospital competitor. Physicians, in general, are constrained in where they refer patients by several factors, especially: patient preferences; managed care networks; hospital location; and emergency department admission. CMS found that "patients responded very favorably to specialty hospitals and value very highly the amenities and services" they provide.<sup>61</sup> These findings indicate that specialty hospital patient case mix is the result of numerous factors aside from economic intent.

#### *c. Profitable Patients*

A hospital's competitive advantage is enhanced to the extent that its patients have the following characteristics – insurance coverage, health severity, and procedure--making them profitable for any provider. First, patients with private insurance subsidize patients without insurance and those with insurance with low payment rates (e.g., Medicaid). Second, profits from well-paid services, such as cardiac care, subsidize services that operate at a loss, such as emergency rooms. Third, patients with less severity of illness (given their procedure) subsidize those with greater severity.<sup>62</sup>

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<sup>61</sup> Centers for Medicare and Medicaid Services. Study of Physician-Owned Specialty Hospitals Required I Section 507©(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, May 2005, p. ii.

<sup>62</sup>Choudhry S, et al. "Specialty Versus Community Hospitals: What Role for the Law?" *Health Affairs* W5 (Aug. 9, 2005): 361-372.

Medicaid patients constitute a lower percentage of patients at specialty hospitals than at community hospitals. The percentage of cardiac patients that were Medicaid was 3 percent in specialty hospitals but 6 in community hospitals in the same metropolitan areas. Among orthopedic patients, the percentages were 8 percent and 10 percent, respectively.<sup>63</sup> Given this pattern, the percentage uncompensated care for specialty hospitals is probably less than for community hospitals.

Similarly, severely ill patients constitute a lower percentage of patients at specialty hospital than at community hospitals. The percentage of cardiac patients that were severely ill was 17 percent in specialty hospitals but 22 percent in community hospitals. The analogous figures for orthopedic patients were 5 and 8 percent, respectively.<sup>64</sup>

A third characteristic associated with profitability is diagnosis related group (DRG). For each patient Medicare makes a prospective payment to a hospital based on the patient's DRG. Despite CMS efforts to the contrary, some DRGs are, on average, more profitable than others. Relative to community hospitals, specialty hospitals have a greater percentage of their patients in profitable DRGs for cardiac DRGs but a lower percentage for orthopedic DRGs. In the latter case, low patient severity more than compensates for low DRG profitability.<sup>65</sup> The Medicare program, in moving to cost based DRG weights, will reduce the relative profitability of cardiac and orthopedic DRGs.

Overall, relative to community hospitals, specialty hospitals serve fewer of the underinsured, fewer patients with severe cases, and more patients receiving well-paid procedures.

#### *d. Location*

Most of the specialty hospitals established since 1990 have been in the states of Arizona, California, Kansas, Louisiana, Oklahoma, South Dakota, and Texas. Virtually all specialty hospitals opened since 1990 (96 percent) and have been in non-CON states, which have 55 percent of community hospitals.

#### *e. Efficiency*

Evidence on efficiency is mixed. Results from a MedPAC study indicate higher case costs for cardiac specialty hospitals than for community hospitals providing community care, while The Lewin Group estimates for cardiac hospitals show lower case costs after adjusting for start-up capital and interest expenses. MedPAC did not find evidence that specialty hospitals affect community hospitals financially.<sup>66</sup>

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<sup>63</sup> Government Accountability Office. "Specialty Hospitals: Geographic Location, Services Provided, and Financial Performance," October 2003, GAO-04-167, p. 21

<sup>64</sup> Government Accountability Office. "Specialty Hospitals: Information on National Market Share, Physician Ownership, and Patients Served," April 18, 2003, GAO-03-683R, p. 13.

<sup>65</sup> MedPAC, Report to the Congress: Physician Owned Specialty Hospitals (Washington: MedPAC, March 2005), p. 33.

<sup>66</sup> Dobson, A, et al. "The Rise of the Entrepreneurial Physician," *Health Affairs - Web exclusive*. October 25, 2005.

## f. Quality

The early evidence on quality suggests that cardiac specialty hospitals have quality of care that is at least as good as, if not better than, that of “peer hospitals”. The Lewin Group studies have consistently found lower case-mix-adjusted mortality rates and higher quality on numerous dimensions for cardiac specialty hospitals. A study by Peter Cram and colleagues shows that outcomes of such hospitals are as good as those of other high-volume hospitals.<sup>67,68</sup>

The role of specialty hospitals in promoting competition, as discussed earlier in this report, is an important consideration in assessing the overall impact of physician self referral on local health care markets.

## 2. Ambulatory Surgery Centers

Ambulatory surgical centers were first established in the 1970s and have continuously grown in number. Illinois currently has 135 ambulatory surgical centers.<sup>69</sup> Because of the development of minimally-invasive surgery, many surgeries that previously had to be performed on an inpatient basis can now safely be performed in a facility with less equipment for medical emergencies. Similarly, imaging and endoscopy services can be safely performed in a free-standing facility.

To estimate the impact of CON laws on the numbers of ambulatory surgical centers, we analyzed the place of service for procedures that are commonly performed in ambulatory surgical centers. Consider cataract removal, the most frequently performed ambulatory surgical center service in Medicare. As Exhibit 7 (page 35) shows, 45 percent of these were performed in hospitals outpatient departments in states with CON laws but only 36 percent were performed in hospitals in states without such laws. In Illinois, a slight majority (52%) of these cases are performed in hospitals, whereas in neighboring Indiana, which lacks a CON law, only a quarter (26%) is performed there. Overall, CON had a demonstrable impact on the movement of surgeries from hospital outpatient departments to ambulatory surgical centers.

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<sup>67</sup> Dobson, A, et al. “The Rise of the Entrepreneurial Physician,” *Health Affairs – Web exclusive*. October 25, 2005.

<sup>68</sup> Cram, P, et al. “Cardiac Revascularization in Specialty and General Hospitals,” *New England Journal of Medicine* 352, no. 14 (2005): 454-462.

<sup>69</sup> IHA – prepared for the Lewin Group.

**Exhibit 7: Hospitals' Share of the Medicare Market for Selected Ambulatory Procedures:  
CON vs. Non-CON States, 2004**

Rank	CPT Code	Description	Market Share: Percent of Procedures Performed in Hospitals, Medicare						
			CON States (A)	Non-CON States (B)	Difference (A-B)		Illinois (C)	Indiana (D)	Difference (C-D)
1	66984	Cataract removal	45%	36%	9%		52%	26%	26%
2	45378	Diagnostic colonoscopy	75%	68%	7%		88%	72%	16%
3	43239	Upper GI endoscopy	76%	70%	7%		90%	74%	15%
4	52000	Cystoscopy	14%	12%	2%		19%	16%	3%
5	62311	Inject spine	56%	50%	6%		62%	62%	0%
6	29881	Knee arthroscopy/surgery	76%	70%	6%		82%	53%	29%
7	15823	Revision of Upper Eyelid	41%	29%	12%		38%	31%	7%
8	26055	Incise finger tendon sheath	68%	61%	6%		67%	44%	23%
9	64622	Destr paravertebrl nerve I/s	49%	34%	15%		67%	31%	35%
		<b>Total</b>	<b>54%</b>	<b>47%</b>	<b>7%</b>		<b>64%</b>	<b>43%</b>	<b>21%</b>

These procedures--which are performed primarily in hospitals, ambulatory surgery centers and physicians' offices--are among the highest volume procedures for the specialties active in ambulatory surgical centers. They are ordered here by Medicare expenditures (highest at the top).

**Sources:**

Market share: The Lewin Group analysis of Medicare Part B Physician Supplier Procedure Summary file, 2004.  
CON laws governing ASCs: "Background Report on Certificate of Need Programs," CGFA, December 2006, based on <http://www.ncsl.org/programs/health/cert-need.htm>.



### **3. Excess Bed Capacity**

CON laws were initially implemented to control costs by regulating capacity in the market. To test whether CON has been effective in this regard, we analyzed national data on surplus beds.<sup>70</sup> We found that the number of surplus beds is relatively higher in non-CON states. The proportion of surplus beds (surplus beds/actual number of staffed beds) is about 5 percentage points (37 percent versus 32 percent) higher in non-CON states than in CON states. This simple analysis suggests that CON has been effective in controlling capacity, at least in terms of number of beds.

### **4. Fast-Growing Suburbs**

Because the influence of CON boards is largely reactive to applications for new or expanded facilities, CON impacts geographic areas with rapidly growing population much more than areas with little population growth. In Illinois as well as other states, population growth is concentrated in certain outer suburbs. The Chicago metropolitan area is a good example of this pattern. In the period 2000-2004, Cook County lost more population than any county nationally except for Los Angeles County. Will County, contiguously to the southwest of Cook County, gained more population than all but five counties.<sup>71</sup>

### **5. Competitiveness of Markets**

The Federal Trade Commission (FTC) and Department of Justice (DOJ) believe that, on balance, CON programs are not successful in containing health care costs, and that they pose serious anticompetitive risks that usually outweigh their purported economic benefits. Market incumbents can too easily use CON procedures to forestall competitors from entering an incumbent's market and the vast majority of single specialty hospitals – a new form of competition that may benefit consumers – have opened in states that do not have CON programs. The FTC and DOJ conclude that there is considerable evidence that CON programs can actually increase prices by fostering anticompetitive barriers to entry. Other means of cost control appear to be more effective and pose less significant competitive concerns.

As a result of the above views, the DOJ believes that States should decrease barriers to entry into provider markets and that States with Certificate of Need programs should reconsider whether these programs best serve their citizens' health care needs.<sup>72</sup>

## **B. Cost Containment**

The original rationale of CON laws was to reduce capital expenditures in order to reduce health care expenditures per capita. Although several analyses were published more than a decade ago, little work has appeared more recently. The most useful work on CON's impact pertained

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<sup>70</sup> For each hospital, the number of surplus beds is calculated as the difference between actual and optimal number of beds, which is the product of the actual number and an "ideal" occupancy rate. This ideal rate is a function of average daily census of the hospital.

<sup>71</sup> U.S. Census Bureau, "Domestic Net Migration in the United States: 2000 to 2004," P25-1135, April 2006, pp. 10, 13, 14. <http://www.census.gov/prod/2006pubs/p25-1135.pdf> (assessed Feb. 13, 2007).

<sup>72</sup> Federal Trade Commission and Department of Justice. Improving Health Care: A Dose of Competition. July 2004.

to a period ending in 1993.<sup>73</sup> It found that the ability of CON to reduce health care costs is limited. CON appears to reduce acute care costs by 5 percent, but it does not appear to reduce total health care costs. States that removed CON did not experience a rise in spending on costs relative to other states.

### C. Quality of Care

The arguments that CON increases quality of care are focused on increasing the concentration of the volume of procedures in few facilities. The argument goes as follows: CON restricts the number of facilities that perform certain tertiary and quaternary procedures such as cardiac surgery and transplant programs. Given a demand for these services that is insensitive to availability, this restriction leads to a greater percentage of services performed in high-volume facilities. Substantial research shows that high-volume facilities have lower rates of complications and mortality – that is, practice makes perfect. So this greater concentration has the potential to increase quality of care. However, the research shows that volume for a surgeon is more important than volume for a hospital, and surgeons often operate at multiple sites.

The evidence to date is largely limited to cardiac procedures, especially coronary artery bypass graft (CABG). Patients in CON states are more likely than patients elsewhere to have cardiac procedures performed in high-volume facilities. However, in general, mortality is not lower in CON states. CON laws have limited impact on quality of care.<sup>74,75,76,77</sup>

### D. Access to Care and Safety-Net Hospitals

Access to care is closely associated with the financial strength of safety-net hospitals, which may be affected by the number of specialty hospitals and ambulatory surgical centers. Although CON laws clearly have an impact on the number of these specialty providers, the case for having CON laws in order to protect safety-net hospitals would be strengthened if those hospitals were in better financial conditions in states with CON laws than states without them.

To that end, we analyzed Medicare Cost Report data from 2003 to 2005 on hospital margins. For nonprofit hospitals, margins – the difference between revenues and costs, divided by revenues – are analogous to profit margins. Ideally, safety-net hospitals would be defined using uncompensated care.<sup>78</sup> As the publicly available national Medicare data lack reliable information on uncompensated care, we defined those hospitals to be hospitals in which Medicaid discharges constituted at least a quarter of discharges. The non safety-net hospitals included hospitals with Medicaid discharges less than a quarter of discharges and co-located in metropolitan areas with safety-net hospitals. As shown in Exhibit 8, the three year rolling

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<sup>73</sup> Conover CJ and Sloan FA, “Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?” *J of Health Politics, Policy and Law* 23 (June 1998): 455-481.

<sup>74</sup> Robinson JL, et al. “Certificate of Need and the Quality of Cardiac Surgery,” *Am J of Medical Quality* 16 (2001): 155-160.

<sup>75</sup> Vaughan-Sarrazin MS, et al. “Mortality in Medicare Beneficiaries following Coronary Artery Bypass Graft Surgery in State with and without Certificate of Need Regulation,” *JAMA* 288 (Oct. 16, 2002): 1859-66.

<sup>76</sup> Popescu I, et al. “Certificate of Need Regulations and Use of Coronary Revascularization after Acute Myocardial Infarction,” *JAMA* 295 (May 10, 2006): 2141-7.

<sup>77</sup> DiSesa VJ, et al. “Contemporary Impact of State Certificate-of-Need Regulations for Cardiac Surgery: An Analysis using the Society of Thoracic Surgeons’ National Cardiac Surgery Database,” *Circulation* 114 (Oct. 30, 2006): 2122-9.

<sup>78</sup> Bazzolli G, et al. “An Update on Safety-Net Hospitals: Coping with the Late 1990s and early 2002s,” *Health Affairs* 24 (July/August 2005): 1047-1056.

aggregate margins for the safety-net hospitals in states with CON is considerably lower than safety-net hospitals in non-CON states (1.3% compared to 3.2%).

Nationally, safety-net hospitals had margins substantially below those of other hospitals. Among non-CON states, non-safety-net hospitals had margins of 5.8 percent, while safety-net hospitals had margins of 3.2 percent, for a difference of 2.6 percentage points. Among CON states, those categories had margins of 4.0 percent and 1.3 percent, the difference having shrunk to 2.7 percentage points.

**Exhibit 8: Comparison of Three Year Rolling Aggregate Total Margins Between Safety-Net Hospitals and Non- Safety-Net Hospitals in CON versus Non-CON States, 2003 - 2005**

CON Status	Non-Safety-Net		Safety-Net	
	n	Total Margin	n	Total Margin
Non-CON	1,254	5.8%	375	3.2%
CON	1,299	4.0%	384	1.3%
ALL	2,553	4.8%	759	2.1%

Source: The Lewin Group analysis of Medicare Cost Report data, 2003 - 2005

Given that total margins can be influenced by several other factors, we performed regression analysis to control for other drivers of total margins (Refer to Exhibit 9). Our model specification controlled for regions, payer mix, proportion of uninsured population in the state, Herfindahl index for the hospital market concentration, occupancy rate, bed size and teaching status. These results again show safety-net hospitals in non-CON states with higher margins than safety-net hospitals in CON states (0.69% compared to -0.02%).

**Exhibit 9: Estimates of Total Margins for Safety-Net and Non-Safety-Net Hospitals in CON versus Non-CON States based on Coefficients derived from Regression Analysis**

	Non-Safety-Net	Safety-Net
Non-CON	4.00%	0.69%
CON	1.91%	-0.02%
R2	0.1093	

Collectively, these results do not support the argument that CONs provide a protective effect for safety-net hospitals' financial status.

These results raise questions about the degree to which CON operates as expected by its supporters. First, the finding that hospital margins are lower across the board in CON states. Hospitals generally favor such laws in the belief that they restrict competition, allowing them to raise prices, but the results do not appear to support this belief. Second, taken at face value, safety-net hospitals have somewhat lower margins in CON states. Again this finding is contrary to the expectation that CON is protective of safety-net hospitals. It may be possible that CON is protective and our analyses are not powerful enough to show this result. However, our results are consistent with a body of literature that indicates CON rarely achieves its stated objectives.

Finally, while financial strength is important, CON could arguably be used to preserve safety-net functions through its ability to question closures or otherwise maintain safety-net missions in the community.

## **E. Implications for CON Policy**

### **1. Financing Care for the Indigent**

For the typical good and service, there is a consensus among both the American public and economists that competition is good, because it lowers prices and encourages technological improvement. However, medical services are not considered to constitute a typical service. Consider the two vignettes: a hungry person appears at the door of a supermarket, and a person with a heart attack appears at the door of a hospital. The societal consensus is that the supermarket is not obligated to give food to the hungry but the hospital is obligated to give medical care to the sick.

This obligation is all well and good, but how will these medical services be financed if the patient lacks insurance? The financing comes from a patchwork of public policies and other arrangements, including:

1. Health insurance (Medicaid being the largest) for categories of indigents;
2. Medicare's special payment to hospitals that disproportionately serve the indigent; and
3. Cross-subsidization within each community hospital.

In a perfectly competitive market, cross-subsidization would not be sustainable, as only those hospitals who avoided unprofitable patients would survive. Fortunately from this perspective, the hospital services market is imperfectly competitive, because geography usually limits the number of options facing a patient selecting among hospitals. However, the rise of specialty hospitals and ambulatory surgical center constitute a potential threat to community hospitals. The fear is that these entities disproportionately serve profitable patients.

### **2. CON as a Strategy to Support Safety-Net Hospitals**

There are several categories of public policies that support safety-net hospitals:

- Additional public dollars;
- Regulations of the hospital market, such as CON laws; and
- Taxing facilities that do not meet a threshold of Medicaid plus uncompensated care, with the revenue being distributed to safety-net providers.

At the state level, the tax-appropriations strategy primarily involves these public policies:

- Increase Medicaid payment rates to hospitals and physicians;
- Decrease in the number of uninsured by expanding coverage under Medicaid and related programs; and
- Appropriate funds to underwrite uncompensated care provided by hospitals.

The CON strategy is to limit the establishment of specialty hospitals and free-standing facilities, and to require firms that want to build new hospitals in fast-growing suburbs to maintain their facilities in the inner city. Limiting entry of specialty facilities may protect community hospitals,

both safety-net and others. Implicit negotiations with hospital firms expanding into new suburbs is much more focused on preserving inner-city safety-net hospitals.

The CON strategy can also attempt to help to finance safety-net hospitals.<sup>79</sup> Consider two states in which population is shifting out of the inner city into the suburbs. One state has a CON law, the other does not. In the non-CON state, a new hospital is constructed in the suburbs. Some patients who otherwise would have been admitted to the inner city hospitals now are admitted into the new suburban hospital, which has lower rates because it does not need to subsidize Medicaid patients and to cover uncompensated care. The dollars that CON directs into safety-net hospitals need to come from somewhere. To the extent that inner city hospitals have higher unit costs than suburban ones, CON is likely to increase health insurance premiums for the middle-class and its employers.<sup>80</sup> If the unit costs are the same, the impact of CON will probably involve inconvenience for suburban patients but not higher premiums.

Optimistically, the CON strategy transfers resources into hospitals with a poor payer mix. An alternative view is that it transfers resources into hospitals that have financial problems, perhaps because of poor management. The ability of the CON board to distinguish between financial problems due to poor payer mix as opposed to poor management has not been well researched. Nor it is clear that Illinois CON board has the procedures or expertise to explicitly and carefully weigh such considerations.

Advocates of competition tend to favor tax-appropriations strategy.<sup>81</sup> Despite the economic advantages of this approach, it has the political disadvantage of requiring higher taxes.

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<sup>79</sup> In Florida in the 1980s, a hospital's probability of obtaining CON approval of its application went up substantially if it provided a level of indigent care. Campbell E and Fournier G, "Certificate-of-Need Deregulation and Indigent Hospital Care" *Journal of Health Politics, Policy and Law*, 18(4): 905-925, Winter 1993.

<sup>80</sup> Medicare payment is prospective, that is, not influenced by the hospital's current cost. Medicaid payment largely is determined by appropriations of the legislature.

<sup>81</sup> Havighurst CC "Monopoly is not the Answer" *Health Affairs, Web Exclusive*, w5: 373-375, August, 2005.

## VI. CONCLUSIONS AND RECOMMENDATIONS

### A. Conclusions

Arguments that are made in favor of CON laws focus on three areas: control of costs, especially unneeded capital costs; assurance of quality for selected services; and maintenance of access, particularly for underserved populations. Because nearly a third of the states in the United States have terminated their CON programs, it is reasonable to look at other states' experience to consider the risks and benefits of terminating the program. Based on our review of relevant literature and our independent analysis, it is clear that the evidence on cost containment is weak, but the evidence suggests that the CON process does affect spending patterns in a state. Expecting the CON process to reduce overall expenditures, however, is unrealistic.

Regarding the second argument, that CON laws increase quality of care, even the strongest supporters of maintaining the program agree that the area where CON can directly influence quality is narrow. Substantial research shows a positive correlation between volume and quality in certain tertiary procedures such as cardiac surgery and transplant programs. Restricting new services certainly leads to fewer providers to perform a given number of procedures. However CON laws impact on quality and care is limited.

The remaining argument, maintenance of access, particularly for the underserved, deserves careful consideration. The health care market place has changed in many ways since CON laws were initially established in 1974; one of the most important changes has been the increase in competition among providers for specific patient types – especially cases involving interventional procedures for patients who are covered by commercial insurance. Community hospitals and academic medical centers that, by virtue of their location and/or reputation, are able to maintain a high proportion of these well insured patients tend to fare very well financially, and those who cannot are at risk of failure.

In the last several years, community hospitals have faced increased competition from specialty hospitals and ambulatory surgical centers. Both are concerning because they often focus on attracting the more profitable patients to the exclusion of less profitable patients, leaving traditional hospitals with a less profitable overall mix of patients. For many hospitals this new competition would represent the prospect of poorer financial results and may spark an effort to find new economies or other new strategies to compete, which would generally be considered beneficial to society. Further, specialty providers and ambulatory surgery centers may be more efficient than most hospitals. By injecting competition into the hospital market place, they may enable payers to lower unit payment.

Of greatest concern to us is the financial health of safety-net hospitals. For some of these providers, who may be struggling to survive already, these new pressures could lead to failure. This failure could force the remaining providers to serve an ever-larger number of less profitable patients, which could lead to a cascade of failures, starting in the inner city and potentially radiating out to more distant areas and rural communities. CON laws have been used in Illinois and other states to help protect those hospitals. Realistically, the greatest effect that CON laws have is that it retards the shift of relatively profitable services from the inner-city

into the suburbs. Through our research and analysis we could find no evidence that safety-net hospitals are financially stronger in CON states than other states. Illinois already has several programs that explicitly fund safety-net hospitals: the Cook County Intergovernment Transfer (IGT) Program, the Hospital Assessment Program, and the Critical Hospital Adjustment Payment (CHAP) program. The legislature should judge whether the present funding level in aggregate is adequate or whether the funding should be increased. If such policies are adequately funded, it would be appropriate for Illinois to consider the usefulness of its CON program.

In time, more will be known on these topics. Since December 2003, federal policy has restrained specialty hospital development first through a legislative moratorium and later through administrative action. As such, comparative data on the effect of specialty hospital development on safety-net providers and community hospitals generally, as well as on access issues for the disadvantaged in general, is not yet definitive.

## **B. Recommendations**

The traditional arguments for CON are empirically weak, and based on the preponderance of hard evidence, the recommendation should be to allow the program to sunset. However, given the potential for harm to specific critical elements of the health care system, we would advise the Illinois legislature to move forward with an abundance of caution. *Nontraditional arguments for maintaining CON deserve consideration, until the evidence on the impact that specialty hospitals and ambulatory surgery centers may have on safety-net providers can be better quantified.*

Our recommendations are as follows:

1. Extend the CON program for an additional three year period. Before the end of this time period, review the available evidence regarding the effect that CON has on safety-net providers prior to making a final decision on allowing it to sunset.
2. Evaluate non-CON related means of supporting safety-net providers, such that CON protection may not be necessary in three years. Examples could include hospital tax transfer schemes, various disproportionate share hospital (DSH) programs, and the like.
3. Consider establishing a more proactive charter for the Health Facilities Planning Board, to include a blueprint for health facilities development that would promote specific needed initiatives and provide guidance on need throughout Illinois in advance of applicants' requests.
4. Address issues related to board size and structure. The board size should be increased, and individuals with direct experience and expertise in the acute care and long-term care industries should be sought out and confirmed as board members.
5. Similarly, reasonable compensation should be considered for board members for the extensive time they are required to spend in fulfilling their functions. While there are concerns with paying board members in the course of any governmental function, remedies used with other boards (such as urging term limits, overlapping election cycles, et.) should be pursued.
6. The Health Facilities Planning Board's workload should be focused more specifically on areas that appear to make the most difference to the healthcare community: projects involving new hospitals, new nursing facilities, major expansions, and volume-sensitive



service offerings. As such, the current capital expenditure and new service threshold is already relatively high, and could reasonably be maintained. Over this three year trial period, however, Illinois may consider following the lead of Florida in requiring CONs only for new facility start-ups and not for expansion of current facilities. In addition the Health Facilities Planning Board should continue to monitor and influence, if possible, the closure of inner city hospital components.

### **C. A Context for Considering the Future of CON**

CON was initially mandated in 1974 to control health care expenditures by planning for additional beds and medical equipment in hospitals. Given that the framework of the health care system has changed over the past 30 years, it is reasonable to ask if CON is a useful regulatory tool as of 2007.

Since 1974, physicians have obtained greater access to the capital market and technologies creating a new market for independent physician owned free-standing facilities that are separate from community hospitals (e.g., single specialty hospitals, ambulatory surgical centers, and diagnostic imaging centers). In light of the increase in the number of uninsured people, the financial stability of inner city and rural hospitals has also become more precarious. As a result, a shift in the focus of CON from a broad control of capital costs to a more narrow and eclectic focus on facilities driven by physician self-referral could represent a more effective use of CON as a regulatory tool. In addition, a CON focus on access to care in the inner city and rural areas may be appropriate.

A possible role for CON might be to take a broader planning perspective and decide how much inner city and rural accesses is appropriate and identify the mechanisms to ensure this outcome. Perhaps one way to accomplish this is by blending finance with planning ensuring that community hospitals get the subsidies required to continue operating. This would further safe guard access to health care and planning when other competing free-standing health care facilities are built to ensure that community hospitals are compensated for adverse selection in poorer, sicker patients who may have an inability to pay for services.

At the end of the day there are two different worlds to consider. One is the world with CON (as we have outlined above) that reduces physician self-referral, and the other is the world rife with competition. Each has its advantages. Competition can increase access, reduce unit costs, and provide a wider variety of competitors in the market place. A focused CON, on the other hand, could preserve inner city hospitals' mission, reduce physician self-referral activities, and possibly reduce health care expenditures.

Ultimately, in determining the usefulness of CON processes, the state may consider what role it needs the CON process to play. If the CON process is used to control for market forces, an underlying concern will be the possible detrimental effects on specialty hospitals, as well as what impact there will be on safety-net hospitals. Unfortunately, the use of CONs to control emerging market forces is still such a new process that it is too early to understand the implications. Those states that have ended their CON laws are still adjusting to the lack of regulations, making the "fall out" or "benefits" yet to be determined. Until the role of competition from physician referral based health care can be determined it might be prudent to

keep CON in place, focusing the program on new start-up facilities and safety-net hospital closures. CON can be applied more aggressively if competitive markets prove highly problematic in providing care to the uninsured and underinsured, especially in inner city and rural areas.

# Appendix A:

## CON Restrictions by State

State	Acute Hospital Beds	Air Ambulance	Ambulatory Surgical Centers	Assisted Living	Behavioral Health	Birth Centers	Burn Care	Business Computers	Cardiac Catheterization	Scanners	Gamma Knives	Home Health	Hospice	Hospital	Intensive Care	Intermediate Care Facilities/Mental Retardation (ICF/MR)	Long Term Acute Care	Lithotripsy	Long Term Care	Medical Office Building	Mobile Services for Indigent (MSI)	Mobile Medical Services (CYMRU/PET etc)	Magnetic Resonance Imaging (MRI) Scanners	Obstetrics Services	Open Heart Services	Organ Transplants	Positron Emissions Tomography (PET) Scanners	Radiation Services	Rehabilitation	Renal Failure/Dialysis	Assisted Living & Residential Care Facilities	Subacute Emission Computed Tomography (SPECT)	Substance Abuse	Surgery	Swing Beds	Ultra-sound	Other (not otherwise covered)	Total	Percent of Services Required						
AL	x	x	x					x	x	x	x	x																												24	57.1%				
AK	x		x					x	x	x	x	x																													28	66.7%			
AR			x					x	x	x	x	x																													8	19.0%			
CT	x	x	x			x	x	x	x	x	x	x																													28	66.7%			
DE	x		x					x	x	x	x																														9	21.4%			
DC	x		x					x	x	x	x																														24	57.1%			
FL	x							x	x	x	x																														12	28.6%			
GA	x		x					x	x	x	x	x																													26	61.9%			
HI	x	x	x			x		x	x	x	x	x																													26	61.9%			
IL	x		x					x	x	x	x																														19	45.2%			
IA	x		x					x	x	x	x																														8	19.0%			
KY	x		x					x	x	x	x																														21	50.0%			
LA																																									2	4.8%			
ME	x	x	x					x	x	x	x																														25	59.5%			
MD	x		x					x	x	x	x																														20	47.6%			
MA		x	x					x	x	x	x																														18	42.9%			
MI	x	x	x					x	x	x	x																															20	47.6%		
MS	x		x					x	x	x	x																														19	45.2%			
MO	x		x					x	x	x	x																														17	40.5%			
MT			x																																						7	16.7%			
NE			x																																						2	4.8%			
NV	x		x																																						10	23.8%			
NH	x		x					x	x	x	x																														16	38.1%			
NJ	x		x					x	x	x	x																														13	31.0%			
NY	x		x					x	x	x	x																														27	64.3%			
NC	x	x	x					x	x	x	x																														28	66.7%			
OH								x	x	x	x																														2	4.8%			
OK																																									7	16.7%			
OR																																									1	2.4%			
PR	x		x					x	x	x	x																														10	23.8%			
RI	x		x					x	x	x	x																															20	47.6%		
SC	x		x					x	x	x	x																															21	50.0%		
TN	x	x	x					x	x	x	x																															22	52.4%		
VT	x	x	x					x	x	x	x																															26	61.9%		
VA	x		x					x	x	x	x																															22	52.4%		
WA	x		x					x	x	x	x																															16	38.1%		
WV	x		x					x	x	x	x																															27	64.3%		
WI																																									4	9.5%			
38	28	9	28	1	1	1	13	3	26	16	0	17	18	16	2	1	25	29	21	38	3	1	17	1	21	23	16	27	23	24	26	25	26	26	13	12	1	16	23	1	23	5	15	635	
Percent	74	24	74	3	3	3	34	8	68	42	0	45	47	42	5	3	66	76	55	100	8	3	45	3	55	61	42	71	61	63	68	66	68	34	32	3	42	61	3	61	13	39			

# Appendix B:

## Illinois CON Project Evaluation

## PROJECT EVALUATION

The Illinois Health Facility Planning Board hear on average approximately 90 applications per year (average since FY 2002). The Board uses the amount of dollars declined as a definition of cost savings. Charts 2 & 3 below show the application approvals and denials from FY 2002 to FY 2006, as well as, dollars approved and denied.

<b>Chart 2</b>		<b>Projects Approved/Denied/Withdrawn</b>		
<b>Fiscal Year</b>	<b>Total Projects</b>	<b>Total Approved</b>	<b>Total Denied</b>	<b>Total Withdrawn</b>
2002*	83	77	1	5
2003	89	82	0	7
2004**	114	96	5	13
2005	81	62	4	15
2006	79	61	2	6
<b>Totals</b>	<b>446</b>	<b>378</b>	<b>12</b>	<b>46</b>
* Five projects were approved by the State Board and the abandoned in later years.				
** The functions of the State Board were temporarily halted by the Governor.				
FY 2006 still has projects pending.				
Source: Illinois Health Facilities Planning Board				

As evident in chart 2, over the last five fiscal years the IHFPB has approved 84.8 percent of the projects that were brought before the board.

In dollar terms, since FY 2002 the IHFPB has approved \$5.6 billion in total projects. During the same time period \$6.8 billion in projects were brought before the board. Over the five year span of data submitted to the Commission, the IHFPB declined \$1.2 billion in hospital projects. Chart 3 below shows the total dollars proposed versus the total dollars approved by the board.

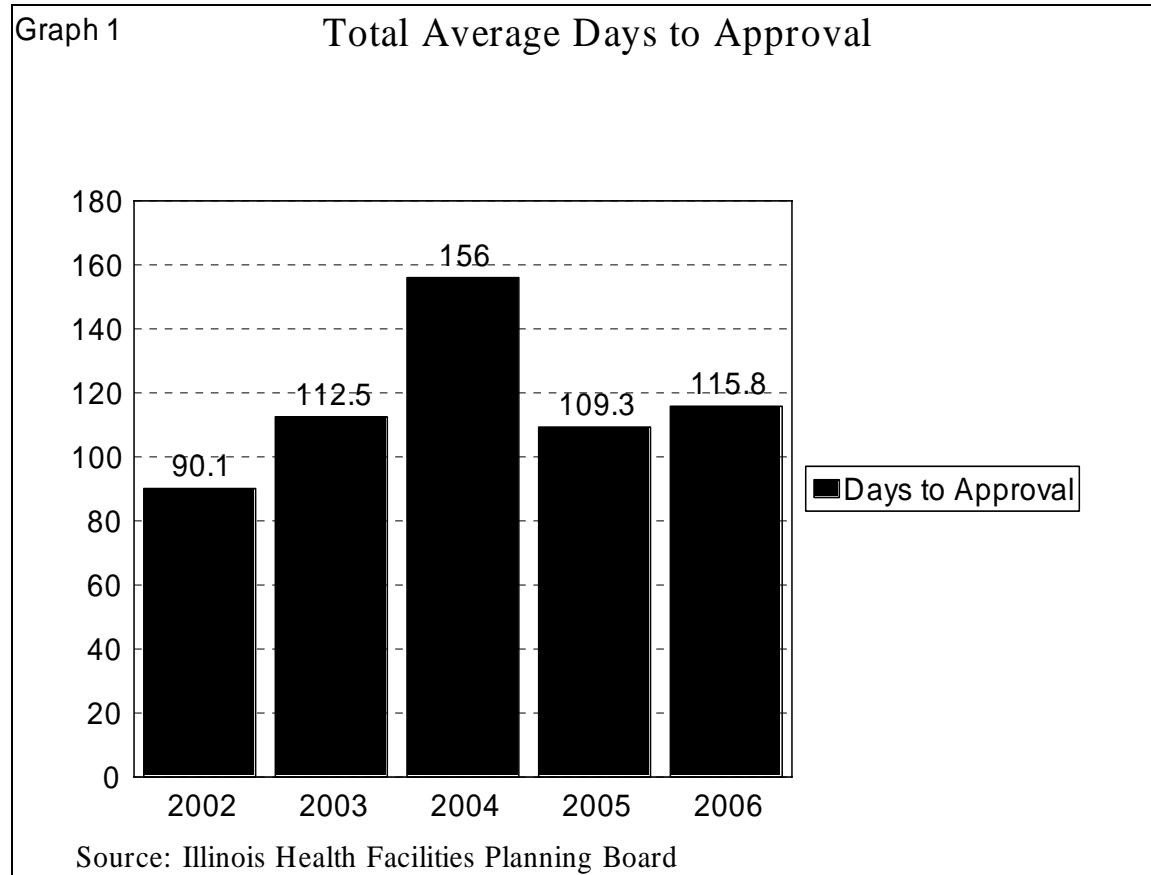
<b>Chart 3</b>				<b>Dollar Value of Projects Proposed Vs. Projects Approved</b>			
<b>Fiscal Year</b>	<b>Total Projects Proposed</b>		<b>Total Projects Approved</b>		<b>Difference</b>		
2002	\$573,025,886		\$536,421,811		\$36,604,075		
2003	\$969,720,753		\$944,145,788		\$25,574,965		
2004	\$1,677,943,340		\$838,823,430		\$839,119,910		
2005	\$1,404,178,007		\$1,328,439,017		\$75,738,990		
2006	\$2,222,599,891		\$1,951,530,472		\$271,069,419		
<b>Totals</b>	<b>\$6,847,467,877</b>		<b>\$5,599,360,518</b>		<b>\$1,248,107,359</b>		

Chart 4, on the following pages details the number of projects approved by type. There are still ten projects that are awaiting approval for FY 2006, and they are not included in the following chart.

Chart 4	Number of Projects by Type				
	Category	2002	2003	2004	2005
PET Scanners	1	1			
MRI	1				
Therapeutic Radiology	2	1		1	
Diagnostic Imaging				1	
Obstetrics	1	2	1		
Rehabilitation	1	1	3	1	
Discontinue Hospital Services	8	2	5	9	4
Discontinue Long Term Care	5	6	7	1	
Skilled (Hospital)	1	3		1	3
Open Heart		2	2		1
Cardiac Catheterization	3	3	3	4	2
ESRD	19	14	28	17	14
ASTC	12	13	18	6	11
Modernize LTC Beds/Units		1	1	2	
Swing Beds LTC		8	3	1	
Modify Hospital Patient Areas	4	10	11	10	8
Modify Hospital Ancil/Support	5	4		1	1
Discontinue Facility	4	7	4	8	5
State Facility Projects	2				1
Establish LTC Facility	3	1	6	5	5
Establish Hospital	1		6	3	6
Establish ICF/DD	1		1		1
Establish ICF 16 & Under			1	2	1
Medical Office	5		9	2	2
Master Design Projects					2
Post-Surgical Recovery	1				1
Respite Care Center					1
AMI		4	3	5	3
Intermediate or Skilled	3	2			2
Med/Surg/Peds		1			3
Neonatal ICU			1		
ICU		2	1	1	2
Other		1			
<b>Totals</b>	<b>83</b>	<b>89</b>	<b>114</b>	<b>81</b>	<b>79</b>

Note: There are still 10 projects pending in FY 2006.  
Source: Illinois Health Facility Planning Board

Since FY 2002, the total average days until a project was approved was 116.6 days. According to the IHFPB, the average days to approval is calculated from the date the project is deemed complete, and includes applicant deferrals and multiple IHFPB consideration where applicable to the date the project was approved by the IHFPB. Graph 1 below shows the total average days to approval for fiscal years 2002 through 2006.



## FEES

All applicants, except those with projects that are not subject to a fee, are required to submit an application processing fee. An initial fee deposit of \$2,500 must accompany each application for permit submitted to IHFPB. Upon the application being deemed complete, the full amount of the fee is determined.

Fees are assessed based upon the total estimated project costs. For each project having a total estimated project cost of:

- less than \$1,250,000, then the application fee shall be \$2,500;
- above \$1,250,000, then the application fee shall be 0.2 of 1 percent of the total estimated project cost (total estimated project costs X .002 = Application Processing Fee);
- more than \$50,000,000, the maximum application fee shall be \$100,000.



# Appendix C:

## Illinois CON Interview List

## Illinois CON Interviews: Final List

<b>Name</b>	<b>Organization</b>
David Voepel	IL Health Care Association
Ken Ryan	IL State Medical Society
Howard Peters	IL Hospital Association
Jeff Mark	IL Health Facilities Planning Board
Mark Mayo	IL Freestanding Surgery Center Association
Sister Sheila Lyne	Mercy Hospital
Alan Channing	Mt. Sinai Hospital
David Carvalho	Department of Public Health
Glenn Poshard	Southern Illinois University
Jack Axel	Axel and Associates
David Dranove	Northwestern University

# Appendix D:

## Illinois CON Interview Protocol

**SENATE**  
Jeffrey M. Schoenberg  
Co-Chairman

Bill Brady  
Don Harmon  
Christine Radogno  
David Syverson  
Donne Trotter

**EXECUTIVE DIRECTOR**  
Dan R. Long



**State of Illinois**  
**COMMISSION ON GOVERNMENT**  
**FORECASTING AND ACCOUNTABILITY**  
703 Stratton Ofc. Bldg., Springfield, IL 62706

**HOUSE**  
Terry R. Parke  
Co-Chairman  
Mark H. Beaubien, Jr.  
Frank Mautino  
Robert Molaro  
Richard Myers  
Elaine Nekritz  
**DEPUTY DIRECTOR**  
Trevor J. Clatfelter

## **The Lewin Group Interview Guide for Illinois CON Project**

Name: \_\_\_\_\_

Organization: \_\_\_\_\_

Contact Information: \_\_\_\_\_

Date/Time: \_\_\_\_\_

- 1) What has been your exposure to the Illinois CON program?
- 2) What do you consider to be the principal purpose of the program?
- 3) In your experience, what has been the effect (positive or negative) of the CON program on:
  - a) Amount of overall capital expenditures
  - b) Timing of capital expenditures
  - c) Access to care for underserved population
  - d) Access to care for any other definable population
  - e) Quality of health care services provided
  - f) Range or depth of health care services provided
  - g) Competitive position and effect on pricing of current providers:
    - i) Urban
    - ii) Suburban
    - iii) Rural

iv) Niche providers

- 4) On a scale of 10, with 1 being lowest and 10 being highest, what degree of impact does the CON program have on relevant decision making within your organization/member organization?
- 5) What would be the effect of eliminating the program?
- 6) If the CON program is maintained, what changes would you recommend be made to the program relative to:
  - a) Type of projects/facilities covered
  - b) Program process
  - c) Other
  - d) In each case, why? What benefits might be expected? Any negative consequences to be expected?

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**Appendix E:**

**Illinois CON**

**Recommendations by:**

**Governors State University  
Health Administration Program**

**Senate Republican Task Force**

## Governors State University Health Administration Program

### Capital Financing: Financial and Operating Metrics Analysis

September 2004

Prepared for: The Illinois Health Facilities Planning Board

In a study the Governors State University Health Administration Program performed for The Illinois Health Facilities Planning Board, they identified several issues that they thought warranted further investigation.

- For the purpose of comparability and to aid in its assessment of an institution's economic and financial condition, the Board may wish to further segregate it[s] (sic) standards to provide additional criteria for:
  - For-profit versus non-for-profit facilities
  - Rural versus urban facilities
  - Rural hospitals designated as critical access facilities
  - Disproportionate share facilities (with high Medicaid and indigent care populations)
- Establish and review its position on the development of specialty hospitals. Currently there is an eighteen month federal moratorium on construction of physician-owned specialty hospitals. These facilities could siphon lucrative business from community hospitals, thereby deteriorating their financial condition. Refer to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Section 507.
- Assess the impact of advancing medical technology and delivery of care on future utilization of nursing homes and dialysis centers. Refer to the nursing home and end stage renal (dialysis) centers portions of this report.
- Require audited final construction project reports. Enforce timely filing of the final construction project reports. Enforce penalty provisions for delinquent filings and unjustified cost overruns. Update data bases to reflect final cost construction data.
- Review the Federal Trade Commission's 2004 report on health care competition. It discusses the impact of certificate of need legislation on "free trade" competition.
- Consider modification of the certificate of need application to include analysis of the facility's Medicare capital prospective payment versus its projected capital expenses. Capital expenses include depreciation, interest, and amortization expenses. New projects may cause a facility to not be fully reimbursed for its actual capital expenses. This deficit would then have to be subsidized by additional fundraising, additional operating cost containment, and/or cost-shifting to other payors.
- Review the provisions of the Sarbanes/Oxley Act (SOX). Consider certificate of need (CON) application information requirements for self-disclosure of potential conflict of interest statements, mandatory disclosure of adverse material events during the application, approval, and construction process, mandatory disclosure of financial statement restatements during the CON and construction process, and mandatory disclosure of sentinel events relating to Office of Inspector General and other governmental and regulatory (JCAHO) investigations during the CON and construction process.
- Update the State bed inventory survey.
- Update determination of need criteria.

- Update new population statistics to include the results of special censuses performed by the U.S. Bureau of the Census.
- Develop an interactive database that would allow users to “mine” data collected from certificate of need applications, staff reports, and final decisions.



## **Senate Republican Task Force**

### **Health Facilities Planning Board: Task Force Report**

November 2006

[T]he members of the Senate Republican Health Facilities Planning Board Task Force make the following recommendations to add stability, efficiency, predictability, and greater accountability to the health facilities planning process:

#### **Reform Board Procedures**

1. Adopt a model that shifts the burden of proof. Instead of assuming that new facilities are not needed and requiring an applicant to prove that a need exists for a new facility, create a presumption that new and expanded facilities should be approved unless the Board provides documentation that a facility will either add to the costs of health care or curtail access.
2. Require the Board to provide written decisions of all substantive actions taken by the Board (similar to other regulatory agencies, such as the Illinois Commerce Commission).
3. Require at least one Board member to be present at each public hearing.
4. Require the Board to convene a sub-committee to regularly review rules and make annual recommendations for rule revisions.
5. Require the Board to promulgate rules that identify high-growth areas of the state and give special consideration to those areas when a request from those areas is pending before the Board.

#### **Improve Board Operations**

1. Increase Board membership from five members (currently four members serve with one vacancy) to nine members.
2. Reinstate categorical membership to the Board (one physician, one hospital representative, one nursing representative, one nursing home representative, one representative with health-care financing expertise).
3. Reduce Board membership restrictions (relative ties to health-care industry should not preclude service on the Board).
4. Extend Board Sunset Date to June 30, 2011.
5. Exempt the Illinois Health Facilities Planning Fund from Section 8(h) of the Illinois State Finance Act (fund chargeback authority).

#### **Prepare for the Future**



Convene a Task Force of the General Assembly to examine and report on future recommendations concerning the Board.