A REPORT ON
CERTIFICATE OF NEED IN KENTUCKY

Prepared for:

Subcommittee on Health Care Access and Cost Oversight

June 12, 1997

by:

Health Policy and Analysis Branch
Cabinet for Health Services

Certificate of Need Office
Cabinet for Health Services

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INTRODUCTION

The purpose of this paper is to discuss the role and efficacy of Certificate of Need (CON) as a state regulatory mechanism for managing health care costs and access to health care services. The paper will provide observations regarding the impact of CON on health care costs and access to health care services in Kentucky. It will show the rate of CON capital expenditure approvals in Kentucky, and selected state health care expenditures and utilization trends. The paper will serve as a starting point for discussions on specific changes to Kentucky's CON process.

CERTIFICATE OF NEED LAWS

Certificate of Need programs emerged in the late 1960s and early 1970s as an attempt to regulate the growth of health care facilities, services and medical technology. First they were imposed by a few states. Then, in response to requirements in the National Health Planning and Resources Development Act of 1974, almost every state implemented a CON program supported by federal funds. Federal law required that states administer CON programs as a part of their overall health planning function.

The logic of CON regulation rests on the premise that natural market forces will lead to too much hospital or service capacity with undesirable economic consequences. Does any economic rationale exist for this belief? Several studies of the effect of CON laws on hospital costs have appeared in the literature. The first, and perhaps most widely cited, is the study by Salkever and Bice in 1976 using data from the early 1970s. They found that CON laws had succeeded in reducing the rate of hospital bed growth, but that hospitals had increased other assets per bed. This has led to higher health care costs. Sloan and Steinwald in a similar study done in 1980 found that the laws had increased average costs of hospital care.

Political support for CON declined during the 1980s, as did federal funding, partly as a result of such studies. In 1986 the National Health Planning and Resources Development Act was repealed. Today 37 states and the District of Columbia have CON programs in operation. There is considerable variation in the types of capital expenditures, major medical equipment, and institutional health services subject to review. Still, most generally adhere to the original federally established standards and procedures.

HEALTH CARE COSTS

Total national health care expenditures (costs) is the amount spent for all health services and supplies and health-related research and construction activities in the U.S. during a one year period. They include all services and supplies, nursing home, personal health care, private and public expenditures. In 1991, the Federal government, and state and local governments paid 35

percent of all health care expenditures through the provision of Medicare and Medicaid programs for elderly, poor and disabled persons and through employer contributions. Private sources of expenditures including nongovernmental sources such as consumers, insurance companies, private industry, philanthropic, and other non patient care sources paid 65 percent of health care costs. Hospitals and other providers often absorb the cost of providing health care for people not covered by government programs or by private insurance. But ultimately, even these costs are passed onto public and private payers via cost shifting. The ultimate payer of health care costs however, is the taxpayer. We pay for all health care costs through taxation to cover public programs and we share in the payment of insurance premiums for health coverage provided through our employers, and through payment of deductibles, and co-payments. It may even be argued that we pay for health care costs through lost wages and earnings from employers who offer health coverage as an employee benefit. In the U.S., health care costs were 14 percent of GDP in 1995. That number is expected to rise to 17 to 19 percent by the year 2000.

Health economists (see Newhouse) have examined the factors that contribute to "rising costs." There are several factors, including: population aging; more widely available insurance; rising incomes; number of physicians; medical and non-medical price increases; defensive medicine; and increased total and per person volume in use of medical technology. But findings show that all of these factors, with the exception of medical technology, comprise only a small proportion of the actual increases. Aging and physician supply alone account for only 1 percent of the total increase in costs. The majority of health care "cost increases" are a direct result of improved medical technology since 1970. The consistent "rate of increase in costs" in the U.S. has been influenced significantly by the rate of medical technology innovation that has occurred.

The "level of costs" is a function of the increasing volume in use of the technology that has been adopted. This volume increase can be seen when examining the numbers of services that are provided to patients resulting from the availability of new health promoting technologies such as cardiac surgeries, organ transplants, lens implants, and hip/knee joint replacement. The U.S. has similar increases in the "rates of health care costs" compared to other industrialized countries. However, the U.S. has a greater total amount of spending than other countries due to this investment in new technology.

Michael Morrisey, Director of the Lister Hill Center for Health Policy at the University of Alabama provided testimony in Kentucky on December 5, 1996 regarding price competition and CON. Dr. Morrisey testified that hospital health care costs are higher as a result of CON regulation when measured as cost per day per admission or cost per capita. In Kentucky, CON has not curbed the proliferation of hospital and high technology services nor has it controlled capital expenditures. Table 1 below shows that during the ten-year period from 1983-93 there has been an explosion in capital investment for high technology hospital services which include cardiac catheterization, open heart, MRI, organ transplant, and other procedures. During the period, 81 percent of all Hospital CON applications in Kentucky were approved totaling more than $1 billion in capital expenditures. This trend shows that CON has not been effective in limiting the approval of hospital projects which include high technology services discussed

above. Although it is important to recognize that expenditures do not necessarily reflect costs, it is very likely that this trend has also led to higher health care costs.

Table 1
Hospital Certificate of Need Actions 1983-93

Year	# of Approved Applications	% of Total	Expenditures	# of Disapproved / Withdrawn Applications	% of Total	Expenditures
1983	38	55%	$154,810,784	31	45%	$33,989,741
1984	37	84%	$76,333,252	7	16%	$8,468,304
1985	43	96%	$72,378,503	2	4%	$12,389,503
1986	55	77%	$108,254,318	16	23%	$31,918,413
1987	66	89%	$95,797,684	8	11%	$8,315,379
1988	67	85%	$100,142,251	12	15%	$26,355,843
1989	47	85%	$81,958,519	8	15%	$20,547,619
1990	50	86%	$105,406,071	8	14%	$29,319,629
1991	20	71%	$94,350,718	8	29%	$5,576,185
1992	12	86%	$57,320,366	2	18%	$4,007,132
1993	17	94%	$75,225,487	1	6%	$1,050,104
Total	452	81%	$1,021,977,953	103	19%	$181,937,852

Long-term Care

It is possible to argue that CON has been effective at controlling the growth in the number of nursing home beds in Kentucky. Even still, the number of licensed nursing facility beds, those requiring the highest level of nursing care, has increased almost 40 percent since 1983; this in spite of a moratorium on LTC projects during much of the period since that time. Furthermore, there is much evidence to suggest that CON has not adequately controlled the rising per bed Medicaid cost of nursing home care either. The average Medicaid expenditure for Medicaid certified beds in Kentucky has increased an average of 15 percent per year since 1983. Leading national researchers (see Harrington, et.al.) in the area of LTC and CON, have concluded that although LTC costs would have increased even more without CON, it has not been effective at containing the rising cost of care.

Those states that have repealed CON for LTC have experienced a wide variety of increases during the period 1989-93. The highest increase in Medicaid expenditures for one year was 50 percent and occurred in Arizona during the period 1991-92. This points out the need for further development of alternatives to institutional care, such as home and community-based services, and respite care for family and friends providing informal care-giver services, as well as the need for development of managed care for LTC.

Table 2 shows the numbers of approved and disapproved/withdrawn CON actions for Long-term Care projects. During the ten year period, 54% of all LTC CON applications were approved totaling more than $242 million in capital expenditures.

Table 2
Long-term Care Certificate of Need Actions 1983-93

Year	# of Approved Applications	% of Total	Expenditures	# of Disapproved / Withdrawn Applications	% of Total	Expenditures
1983	28	76%	$11,102,713	9	24%	$1,392,500
1984	21	53%	$16,512,623	19	48%	$13,302,163
1985	27	51%	$12,950,563	26	49%	$35,914,359
1986	61	46%	$8,372,845	73	54%	$67,677,170
1987	55	81%	$57,326,375	13	19%	$9,751,575
1988	57	63%	$30,808,284	34	37%	$31,754,970
1989	35	45%	$22,546,290	42	55%	$35,312,529
1990	15	60%	$7,222,868	10	40%	$4,824,344
1991	38	35%	$51,938,241	72	65%	$93,629,019
1992	17	44%	$1,988,773	22	56%	$8,145,863
1993	24	92%	$21,431,662	2	8%	$9,286,386
Total	378	54%	$242,201,237	322	46%	$310,990,878

Home Health Care

Kentucky had 97 home health agencies in 1985. By 1994 there were 119 statewide. The number of total patient visits served during each semi-annual period for 1984-1994 has increased from 230,675 to 898,778, a 290 percent increase. We see a similar pattern here of the effectiveness of CON laws. There have been fewer new home health agencies approved during the ten year period, but the numbers of patient visits these agencies have provided has skyrocketed. Furthermore, the average increase in home health Medicaid payments in Kentucky from 1990-95 was 15.9 percent per year. The average increase climbs to 24.5 percent when durable medical equipment used for home health care is included for the same period.

This means that CON has probably not been very effective at controlling Medicaid costs of home health care. Since Medicare represents an even larger portion of public expenditures for home health care, the same is very likely true for Medicare costs as well. Policy changes in the 1980s expanded eligibility for home heath care coverage under Medicare. Since 1990, those changes, coupled with an aging population, have spurred a 105 percent increase in the number of Medicare patients receiving home care assistance in the U.S., and a 364 percent rise in Medicare payments to providers. Part of the problem of exploding home health care costs is attributable to abuses in the system. Federal government auditors estimate that ten percent of Medicare and Medicaid payments to providers is spent on fraudulent claims. To address this problem the Department for Health and Human Services is implementing "Operation Restore Trust" in five

pilot states. The program is designed to require more audits of Medicare and Medicaid claims by home health care agencies.

Table 3 shows the numbers of approved and disapproved/withdrawn CON actions for all other projects, including home health care. During the ten year period, 72% of all other applications were approved totaling more than $240 million in capital expenditures.

Table 3
Other Certificate of Need Actions 1983-93

Year	# of Approved Applications	% of Total	Expenditures	# of Disapproved / Withdrawn Applications	% of Total	Expenditures
1983	53	74%	$17,952,704	19	26%	$10,779,680
1984	81	80%	$26,821,547	20	20%	$3,445,389
1985	84	81%	$25,694,116	20	19%	$5,737,542
1986	53	60%	$24,753,067	36	40%	$15,145,875
1987	87	80%	$30,784,335	22	20%	$2,681,407
1988	89	76%	$23,761,891	28	24%	$12,463,876
1989	71	72%	$38,782,245	27	28%	$4,112,001
1990	50	68%	$8,353,579	24	32%	$13,634,085
1991	77	61%	$35,214,167	49	39%	$26,294,538
1992	30	81%	$940,791	7	19%	$1,296,048
1993	35	63%	$6,964,817	21	38%	$4,910,674
Total	710	72%	$240,023,259	273	28%	$100,501,115

Other projects include: home health, ambulances, mobile services, and outpatient rehabilitation.

HEALTH CARE UTILIZATION

The U.S. inpatient hospital average length of stay has decreased from 8.9 days in 1964 to 6.3 days in 1994. During the same period, the total number of discharges per 1000 population has declined from 109.1 to 87.5. Hospital occupancy rates also have declined markedly. Kentucky has seen the same rates of decline in inpatient service delivery as well as a decline in the number of acute care beds. New medical technologies such as sophisticated cardiac diagnostic and therapeutic procedures, and computer tomographies have developed at a rapid pace. Such technology has led to improvements in health outcomes and health status while at the same time led to increases in outpatient care. This has helped foster the perception among health care institutions that in order to compete successfully in the health care market place they need to have the newest most technologically advanced facilities and equipment. In some areas of health care, this led to a proliferation of health care technology and services to the point of overcapacity and underutilization.

Outpatient services and settings have largely replaced the traditional hospital stay for certain types of treatment. For example many surgical procedures previously performed under general anesthesia while the patient was admitted to the hospital can now be performed on an outpatient basis. Procedures as invasive as orthoscopy, most types of endoscopy, and medical biopsies are performed in outpatient settings. More hospitals and ambulatory surgical centers are expanding the types of procedures done on an outpatient basis.

In Kentucky, the total number of hospital outpatient procedures rose 64% from 3.4 million in 1985 to 5.6 million in 1995. At the same time, the number of people without access to health insurance coverage has risen. In part, this has led to a dramatic increase in utilization of emergency care for conditions that could be more efficiently treated in a primary or other outpatient care setting. As a result of these and other trends, the impetus for planning for hospital-based service delivery and the subsequent need for controlling growth through government regulation has changed. The implications for CON are clear. It has become increasingly difficult to control the proliferation of services let alone costs in these areas. It is necessary to modify some CON regulations, such as those for surgical services, that have not only outlived their usefulness, but quite simply have not achieved the desired goals.

THE ROLE OF MANAGED CARE AND CON

Managed care plans have the ability and incentive to control costs through formal programs for quality assurance and utilization review. They can provide care at lower costs than traditional fee for service insurance plans. This is leading to significant changes and savings in the health care delivery system. With insurance premium increases averaging just 2.3 percent in 1995, well below the rate of general inflation, the rate of increase in health care costs has declined somewhat. Managed care is now the dominant form of coverage for workers with employer-sponsored benefits in the U.S. An estimated 73 percent of workers in the U.S. are insured through some form of managed care plan which is up from 51 percent in 1993. In Kentucky, the rate is also increasing. An estimated 40% of workers are insured through some form of managed care plan. Managed care plans are now commonplace even among small employers. Level dollar employer contributions, designed to give workers a financial incentive in their choice of plans, are faced by one-third of all workers who have a choice of plans.

As of March 1997 there were 4.5 million Medicare beneficiaries enrolled in managed care for Medicare nationwide. This represents 12% of the total Medicare population with the growth rate for Medicare managed care enrollment at 40% per year. There are over 300 health plans participating in Medicare managed care. At the same time approximately four percent of Medicare entitled beneficiaries in Kentucky are enrolled in Medicare managed care. In the Northern Kentucky and Kentuckiana ADDs the proportion of beneficiaries enrolled in Medicare Managed care is 8.5 percent and 6.3 percent respectively.

Medicaid beneficiaries in Kentucky, especially in urban areas, will soon be enrolled into cost-saving managed care partnerships. As total managed care enrollment rises in Kentucky, the rate

of increase in health care costs may be reduced. Past incentives driving utilization and costs of services will change. Although managed care may not lead to huge decreases in utilization, it will help curb utilization growth rates as well as cost growth rates. Health care providers will continue to realign themselves to survive in the market. These alliances are and will take the form of affiliations, networks, and partnerships and present challenges for state regulators in deciding which facilities and services should be regulated. The significance for CON is that categories that once were distinct and useful have become outdated. Entire new sets of service arrays have arisen that are interdependent and driven by cost allocations, limited financial returns, and managed care utilization review.

These new models of service delivery have outlived the traditional mechanisms of awarding CON. And so as managed care achieves the desired cost savings, there will be less of a role for CON regulation of individual acquisitions and capital expenditures. Costs aside, it is clear that conventional market forces involving competition are manifested differently in health care markets. To the extent that health care markets behave like business markets, there may be gaps in services in areas where profit opportunity is perceived to be low.

The challenge then is to make appropriate changes in state laws that will improve access to health care through limited regulation by CON programs while allowing the health care market to adapt to change. For example, managed care organizations are able to negotiate lower prices when there are more providers and lower occupancy or utilization rates. Historically, CON regulation has had the opposite effect on health care markets. It tends to reduce the number of providers and increase occupancy or utilization rates which may lead to higher prices.

THE ROLE OF QUALITY IN CONTROLLING HEALTH CARE COSTS

Quality is defined a measure of the effectiveness of health services. Essentially, such measures answer questions about health outcomes, whether patients are better or worse off after interaction with the health care system. Quality issues are important in terms of controlling costs. Studies have shown an inverse relationship between levels of costs and quality. Generally, higher quality health plans can provide more efficient and affordable health care services. Controlling inappropriate use of care, assuring that appropriate medical care is provided, and encouraging healthy behaviors are examples of quality assurance activities that lead to lower costs. HMOs have a built-in incentive to develop quality control programs.

Consumers also now have an incentive to shop around for "quality care", however they may be reluctant to shop around for a lower priced provider if they cannot measure quality well. This provides the basis for developing state regulatory models that encourage and even require active quality improvement standards for all health services. Licensure and CON do this but only to a very limited extent. For example, licensure of physicians in Kentucky is conditional upon proving (thorough board certification) that a body of knowledge has been achieved on the part of the physician which implies knowledgeability and the potential to evaluate the need for medical services. Hospitals must meet certain basic licensure and CON conditions to establish a safe

environment for patients and follow generally accepted medical practices. The challenge for any current or subsequent state regulation of health facilities and providers, whether through licensure or CON is to emphasize quality improvement standards that can serve as benchmarks for consumer decision making and will lead to lower costs. There are a number of organizations that research and develop quality improvement standards such as the National Committee for Quality Assurance, and the Agency for Health Care Policy and Research. Such organizations realize the importance of focusing on health outcomes as a viable means for controlling health care costs and improving health outcomes.

CONCLUSIONS

It is clear that government oversight through CON regulation must change to respond to the restructuring of the health care system. If any CON regulation is embodied in Kentucky, it must be tempered by a comprehensive view of the market's needs and capabilities, as opposed to an incremental review of isolated projects.

CON reform is being considered by several other states. Among them, Ohio has eliminiated CON review for MRI, lithotripsy, organ transplantation services, and major medical equipment acquisitions with a cost of less than $2 million and most all other health services except long-term care on a phased-in basis. They have also moved to adopt safety and quality of care standards and data reporting requirments for technology-intensive services. When Kentucky looks at its increases in the volume of outpatient services and costs, particularly outpatient surgeries, it seems evident that the CON process has fallen short its intended purpose.

As managed care continues to develop in Kentucky and works to promote competition and cost containment, the usefulness of CON for certain services will be limited at best. Quality of care and health outcomes should have a greater emphsis in state regulations as policy makers decide what services to spend money for. To the extent that quality of care can be regulated, policy makers should encourage and even require the health care industry to continue to help make consumers aware of health outcomes. The state plays a vital role in assuring this quality, particularly in the area of Medicaid.

CON has done very little to enforce the role of quality in reducing the rate of cost increases. There are guidelines published in some CON regulations that direct facilities to "follow nationally accepted standards of care." However there is no mechanism for enforcing this, aside from somewhat limited licensure laws. Agencies that provide accreditation of health care facilities and promote certain quality requirements as a condition of accreditation can be looked to for ways to build quality assurance into any regulation of health services in Kentucky.

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