Comprehensive Review of the Certificate of Need Program

Report to the Iowa General Assembly

January 15, 2000

Iowa Department of Public Health
Stephen C. Gleason, D.O., Director

Executive Summary

Certificate of Need (CON) is a regulatory review process that requires application to the department of public health for, and receipt of, a certificate of need prior to the offering or development of a new or changed institutional health service. Projects proposed by providers are reviewed by department staff and the State Health Facilities Council, a five-member, governor-appointed body. It is the Council's mandate to assure that growth and changes in the health care system occur in an orderly, cost-effective manner and that the system is adequate and efficient.

Iowa enacted its version of CON in 1977 following the enactment of the National Health Planning and Resources Development Act, a federal act containing the enabling provisions of CON programs. Iowa's CON program has been studied and changed a number of times since its inception, most recently in 1996 by the Governor's Health Regulation Task Force. The recommendations of that task force resulted in legislation that made significant changes to what is reviewed by the Health Facilities Council. This legislation also directed the Department of Public Health to complete a comprehensive review of the CON program and submit a written report of the findings and recommendations as to the continued relevance of the program to the General Assembly by January 15, 2000.

The department established a thirty-member task force to complete this review and make recommendations to the department. Membership of the task force was broad-based. The task force held four meetings and received and reviewed an abundance of information about the health delivery system; CON in Iowa and other states; and health care costs, regulation and reimbursement. One result of this review was the development of a "continuum" of health care services which includes a description of care, regulatory body, CON involvement and payment sources (see Attachment B). The task force also recognized that the delivery of health care has evolved and continues to change.

The task force arrived at three basic options to consider: 1) Repeal CON; 2) Maintain CON with no changes to existing laws or regulations; or 3) Reform CON. All task force members were given the opportunity to put forth various recommendations under each option. All options and recommendations were discussed prior to the decision-making process.

Following this comprehensive review of CON issues, **the task force recommended that Iowa's CON program be maintained with no changes to existing law or regulation**. Upon making this recommendation, the task force concluded that Iowa's CON program continues to be relevant.

A minority report is included in the recommendation section of the full report.

AUTHORITY & PURPOSE OF CERTIFICATE OF NEED

Certificate of Need is a regulatory review process that requires application to the department of public health for, and receipt of, a certificate of need prior to the offering or development of a new or changed institutional health service. Projects proposed by providers are reviewed by department staff and the State Health Facilities Council against the criteria specified in the law. The State Health Facilities Council is a five-member body appointed by the governor and confirmed by the State Senate. Members are appointed to a six-year term. Authority for the State Health Facilities Council is contained in the *Code of Iowa* Chapter 135.61-.83. The responsibility for providing administrative support for the Council rests with the Iowa Department of Public Health. It is the Council's mandate to assure that growth and changes in the health care system occur in an orderly, cost-effective manner and that the system is adequate and efficient.

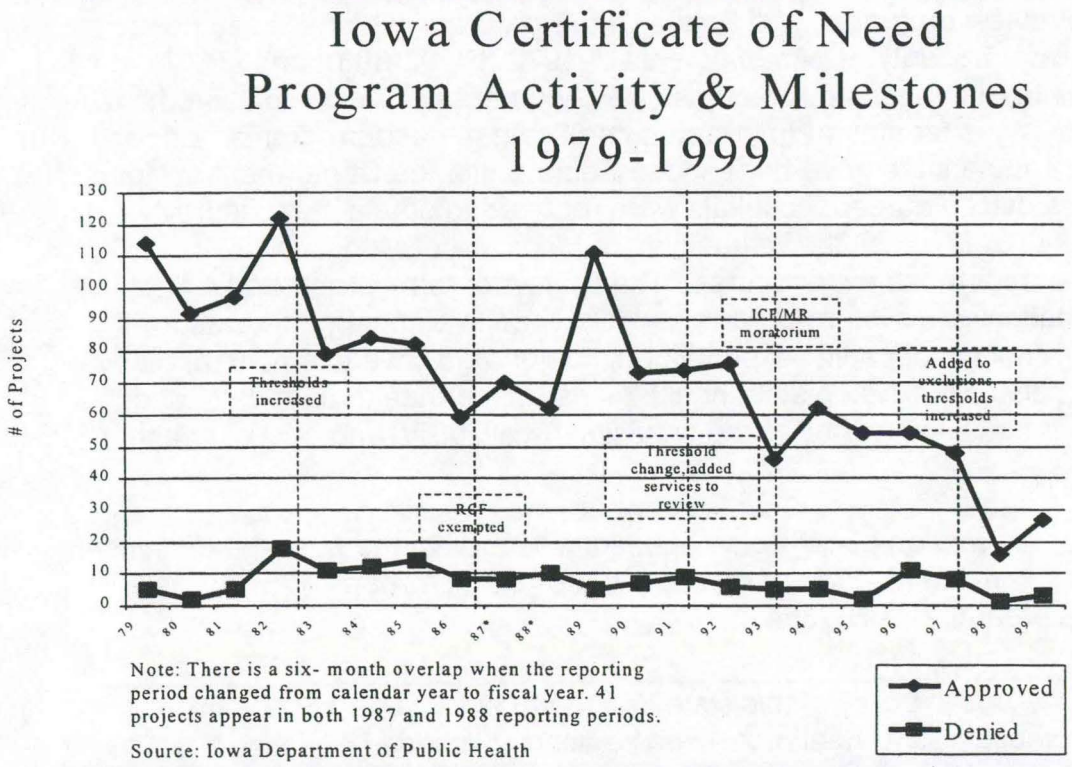
HISTORY OF CERTIFICATE OF NEED

In the early 1970s, the federal government enacted two separate hospital capital expenditure review programs: the Section 1122 program, which was authorized under the Social Security Act Amendments of 1972 (PL 92-603); and the National Health Planning and Resources Development Act which contained the enabling provisions for state-administered certificate of need programs. Under Section 1122, if the state governor and the Secretary of the Department of Health and Human services agreed, hospitals were required to obtain state approval for capital expenditures or risk the withholding of Medicare of Medicaid reimbursement for those expenditures. The CON program established a mandatory nationwide system of state and local health planning agencies to conduct CON review of capital expenditures, major medical equipment, and new institutional services; develop state health plans; gather health care data; and perform other functions related to the provision, availability, and cost of health care.

Iowa enacted its version of certificate of need in 1977 with the passage of House File 354, now codified at *Code of Iowa* sections 135.61 through 135.83. As stated in the preamble of HF 354:

> "It is the public policy of this state that the offering or development of new institutional health services be accomplished in a manner which is orderly, economical and consistent with the goal of providing the necessary and adequate institutional health services to all of the people of this state while avoiding unnecessary duplication of services and preventing or controlling increases in the costs of delivery in these services."

CON in Iowa has been studied and changed a number of times since its inception. In 1981, the Governor's Commission on Health Care Costs evaluated CON and drew conclusions about its effectiveness. In 1985, the Governor's Task Force on Long-Term Care recommended changes to CON. A public hearing was held by the Statewide Health Coordinating Council (SHCC) in 1986 to solicit comments about the future direction of CON, and in 1987 the SHCC appointed a Task Force to explore the issues brought forth at the public hearing. Also, in 1987 Congress discontinued funding of Section 1122 of the Social Security Act under which the United States Department of Health and Human Services contracted with the state to review and comment on health care expenditures as a factor affecting Medicare reimbursement. At the request of Governor Branstad, a committee to recommend changes in the CON law was convened in 1988 by the Director of Public Health. In 1995 CON was part of the Elder Care Services Study requested by the oversight, audit, and government reform appropriations subcommittee. Detail of the recommendations of these groups and major legislative changes can be found in Attachment A.



Note: There is a six- month overlap when the reporting period changed from calendar year to fiscal year. 41 projects appear in both 1987 and 1988 reporting periods.

Source: Iowa Department of Public Health

CON was most recently reviewed in 1996 by the Governor's Health Regulation Task Force, which suggested modifications to Iowa's CON program that were adopted by the Iowa General Assembly in 1997. In addition, the committee that reviewed CON looked at the preamble of House File 354, 1977, as the mission

and purpose of the program and suggested that the term institutional is out of date and that the word quality should be included. The committee also recommended that the department should review areas where one entity is not subject to review for a particular service, but other entities would be subject to review for the service. The committee's wish was to create a level playing field.

The following are highlights of the changes to Iowa's CON law that were effective July 1, 1997:

- Capital threshold increased from $800,000 to $1.5 million.
- New service threshold increased from $300,000 to $500,000.
- Equipment threshold, including new, replacement or mobile, increased to $1.5 million.
- Radiation therapy service was added to list of services reviewable regardless of cost.

The following were added to the items exempt from CON:

- Hemodialysis services, hospital-based or freestanding;
- Hospice services;
- Redistribution of beds by a hospital within the acute care category of bed usage (there are reporting requirements);
- Construction, modification, or replacement of non-patient care services, including parking, heating, ventilation, air conditioning systems, computer, telephone systems and medical office buildings;
- Replacement or modernization of any institutional health facility if it does not add new health services or additional bed capacity;
- Change in ownership, licensure, organizational structure, or designation of the type of institutional health facility if the health services offered by the successor facility are unchanged.

The following table displays the impact of these changes on the number of projects heard by the Council and the category of the projects. The numbers represent a two-year total in each instance.

Summary of Projects Heard in the 2 Years Before 7/1/97 and the 2 Years After 7/1/97

	2 YEARS BEFORE 7/1/97	2 YEARS AFTER 7/1/97
New Facility (i.e.:ASC)	2	9
LTC Beds	30 (25% of total)	21 (46% of total)
Equipment	35	3
Cath/Heart	8	9
Linear Accelerator	(2 in equip count)	3
Capital Expenditure	37	0
Hospital Bed Conversion	5	0
Other	4	1
Total	**121**	**46**

Finally, recognizing the potential impact of the changes on the number of projects reviewed, the 1997 legislation included the following:

- Council shall meet on an as-needed basis instead of monthly.

- *Department of Public Health shall complete a comprehensive review of the CON program and submit a written report of the findings & recommendations as to the continued relevance of the program to the General Assembly by January 15, 2000. Four members of the general assembly shall be appointed to assist the department in completing the review.*

APPROACH

The Department established a Task Force to assist in the comprehensive review and make recommendations to the Department. Membership of the Task Force was broad-based and included a former member of the Health Facilities Council, four legislators, representatives of both rural and urban hospitals, representatives of for-profit and not-for-profit long-term care facilities, physicians, representatives of the insurance industry, business and labor, and consumers. In addition three state agencies involved in the regulation of health care facilities or the payment of care, the Departments of Human Services, Elder Affairs and Inspections & Appeals, each had a representative on the Task Force. A complete list of the Task Force members follows.

Certificate of Need
1999 Task Force Members

Jim Aipperspach	Iowa Association of Business & Industry
David Boarini, MD	Iowa Clinic
Senator Nancy Boettger	Iowa Senate
Larry Breeding	Iowa Association for Home Care
Jim Cousins	John Deere Health Care
Joe DuBray	Wellmark, Inc.
Diana Findley	Iowa Care Givers Association
Jeanine Freeman	Iowa Medical Society
Stephen Gleason, DO **(Ex-Officio)**	Iowa Department of Public Health
Betty Grandquist	American Association of Retired Persons
Cindy Havercamp	Department of Human Services
Bob Holz	Iowa Health Care Association
Diane Howe	The Principal Financial Group
Ed Howell	University of Iowa Hospitals & Clinics
Tom Juckette	Witt & Juckette
Joni Keith	Former Health Facilities Council Member
Janice Laue	Iowa Federation of Labor, AFL-CIO
Debbie Meyers	Iowa Department of Elder Affairs
Cindy Moser	Iowa Bar Association-Health Care
Representative Beverly Nelson	Iowa House of Representatives
Norm Pawlewski	Iowa Osteopathic Medical Association
Dana Petrowski	Iowa Assn. of Homes & Services for the Aging
Paul Pietzsch, **Chairperson**	Health Policy Corp. of Iowa
Jim Platt	Fort Madison Community Hospital
Representative Rebecca Reynolds	Iowa House of Representatives
Mike Richards, MD	Iowa Health System
Nancy Ruzicka	Department of Inspections & Appeals
Senator Mark Shearer	Iowa Senate
Rick Turner, MD	Mercy Clinics
Dave Vellinga	Mercy Hospital Medical Center

Staff:

Barb Nervig	Mark Schoeberl

Comprehensive Information Review

The majority of the first three meetings of the Task Force was spent reviewing and discussing information about Certificate of Need. Background information was provided at the first meeting and then members were given the opportunity to request additional information that they felt would be useful in their review of the program. The task force was interested in what other states had done or were considering to do with their CON programs. This information was provided in two documents: an Issue Brief of the Health Policy Tracking Service, National

Conference of State Legislatures, and the American Health Planning Association's National Directory of Health Planning, Policy and Regulatory Agencies, Tenth Edition. These documents are not included in the attachment because permission was received to share them with task force members only. Information regarding the penetration of managed care and the ratio of for-profit/not-for-profit hospitals of surrounding states was requested and shared with the task force. Also requested was information about Iowa's program, such as the costs of the program and an evaluation of denials and high dollar approvals of the last few years.

The written material provided to the Task Force members and the minutes of their meetings are in the Attachments.

In addition to all the written material that was distributed, information was also presented verbally by staff and others. Representatives from the Iowa Medical Society and the Association of Iowa Hospitals & Health Systems presented their respective positions on CON at the first meeting.

At the second meeting the Task Force heard from the three long-term care associations (Iowa Health Care Association, Iowa Association of Homes & Services for the Aging and Iowa Council for Health Care Centers), the Department of Elder Affairs, the Department of Human Services and a representative from AARP (American Association of Retired Persons). Following these presentations, the group asked for the development of a grid showing the various levels of health care, CON involvement, the regulatory source and the payer. This was developed and presented at the next meeting. A copy may be found in Attachment B.

At the third meeting, two presentations, one by the Iowa Medical Society and one by the Association of Iowa Hospitals and Health Systems, were made on a "Vision of Iowa's Future Health Care System: With and Without CON."

Summaries of the presentations may be found in the Attachments.

FINDINGS OF THE 1999 CON TASK FORCE

The delivery of health care has evolved and continues to change.

The reimbursement systems for health care have changed since the late 1970s.

The Iowa CON program has been reviewed and studied several times, resulting in various Code changes through the years.

The changes made two years ago reduced the number of projects reviewed by more than half.

Multi-million dollar renovations of institutional health facilities occur without review as a result of the 1997 legislation.

The CON process provides the opportunity for public notice and comment for projects that require review by the Health Facilities Council.

The number of assisted living facilities in the state is growing rapidly. Assisted living facilities do not require a CON.

Nursing facilities in Iowa are experiencing lower occupancies and several are failing to maintain an occupancy of 80%, which impacts their Medicaid reimbursement.

Approximately 37 states still have some form of Certificate of Need. This includes some states that repealed CON only to reinstate it later.

The effect of CON program repeal varies among states. CON programs in several other states are being reviewed and studied.

OPTIONS CONSIDERED

The Task Force arrived at three basic options to consider: 1) Repeal Iowa's CON program; 2) Maintain Iowa's CON program with no changes to existing law or regulation;or 3) Reform Iowa's CON program. All task force members were given the opportunity to develop recommendations that could be made under these options. Various recommendations under each option were put forth and can be found in Attachment C. The task force members had the opportunity to discuss the various recommendations.

RECOMMENDATION

Agreement was reached to consider motions and votes on the options in the order presented above. Option #1 failed on a voice vote. Option #2 passed on a roll call vote with 17 in favor, 5 opposed and 3 abstentions. There were no further recommendations acted upon by the Task Force.

The Task Force recommended that Iowa's CON program be maintained with no changes to existing law or regulation.

Upon making this recommendation, the Task Force members concluded that the Certificate of Need program in Iowa continues to be relevant.

Minority Report

The Iowa Medical Society presented testimony and voted in support of repeal of the Iowa Certificate of Need (CON) law. The Iowa Medical Society argued that CON is a failed experiment which no longer achieves the original purposes of the law and which now primarily serves to protect existing facilities and to deter innovative growth and development in health care facilities and services. IMS emphasized that state economic regulation through laws like CON must be focused on the what is best for the consumer, not what is best for existing health care facilities threatened by new entrants into the marketplace. IMS believes that marketplace competition is the best mechanism for assuring high quality, low cost, and efficient health care delivery. Materials presented by IMS in support of its arguments for repeal are found in Attachment D.

As an alternative to its call for repeal, the Iowa Medical Society proposed to amend the existing CON law to exempt from review the offering and development of outpatient surgical centers to be located in communities with populations of 20,000 or more. The Iowa Medical Society argued that movement toward evaluating the potential impact of repeal of CON and movement toward marketplace competition in Iowa must take place. IMS believed that its proposal was narrow in focus and allowed a fair and reasonable basis for evaluating the potential impact of repeal of CON. This proposal, and arguments in support of it. are found in Attachment C, under option # 3.

The Iowa Association of Homes and Services for the Aging, which supports keeping the CON law, developed options for amending the law to allow existing nursing facilities to expand their current bed capacity or to transfer beds to another existing nursing facility absent CON review. IAHSA argued that their proposed initiatives would provide reasonable flexibility under the CON law and fairly meet consumer demand. These proposals are also found in Attachment C, under option # 3.

ATTACHMENTS

A. CON Studies and Legislative Changes
B. Continuum of Health Care
C. Options Considered by Task Force
D. Iowa Medical Society Testimony Regarding Repeal
E. Presentations
This attachment includes written summaries of some of the presentations made to the task force. The remarks of presenters who did not provide written summaries are summarized in the minutes.
F. Minutes of Task Force Meetings
G. Background & Requested Information
1. 1999 *Code of Iowa* 135.61-135.83 (Health Facilities Council)
2. *Iowa Administrative Code* [641] Chapter 202, Certificate of Need Program
3. *Iowa Administrative Code* [641] Chapter 203, Standards for Certificate of Need Review
4. Current membership of State Health Facilities Council
5. Yearly Project Totals and Dollars
6. CON Annual Report for FY 1996
7. Projects reviewed by Council for FY 1996 through FY 1999
8. "Does Removing Certificate of Need Regulations Lead to a Surge in Health Care Spending?", by Christopher J. Conover and Frank A. Sloan, Duke University
9. "Health Care Construction, Competition Booming" by Mary McGrath, *Omaha World Herald*, April 13, 1999
10. "CON Trends in America: A Panorama of Change", interview by AHPA Today in Health Planning with Thomas Piper
11. "Wilson says CON reform not dead", by Scott Smith, The Business Journal of Charlotte, November 3, 1997
12. "Certificate of Need: A Review", by John Steen, director of Georgia's CON program
13. Listing of Nursing Facility Projects heard by the Health Facilities Council, FY 1995 through FY 1999
14. "The Effect of Certificate of Need and Moratoria Policy on Change in Nursing Home Beds in the United States," by Charlene Harrington, Ph.D and others, in *Medical Care,* 1997.
15. "Health Care – Certificate of Need" in Analysis and Perspective, *U.S. Law Week*, 10-14-97.
16. Letter from Joann Nixt, Older Iowans Legislature (OIL) delegate.
17. CON Program costs
18. "Doctors move surgeries into offices," by Scott Hensley in *Modern Healthcare*, September 6, 1999.
19. Principles Behind CON
20. Nursing Facility Bed Data
21. Summary of Projects Heard and Denied, 7/1/95 to 7/1/99
22. For-Profit and Not-for-Profit Hospitals and HMO Enrollment for Iowa and Surrounding States
23. Managed Competition Defined
24. Excerpt from State of Washington Joint Legislative Audit and Review Committee Report 99-1, "Effects of Certificate of Need and its Possible Repeal," January 8, 1999.
25. Iowa Medical Society's Position Statement on CON
26. Iowa Hospital & Health System's Position Statement on CON

ATTACHMENT A

Certificate of Need Program
Studies & Legislative Changes

1982 Governor's Commission on Health Care Costs believed the most effective strategy for controlling health care costs was to endorse market incentives coupled with enabling government regulation where necessary. The Commission believed this strategy would control the rate of increase in spending, and promote efficiency and effectiveness. The Commission's evaluation of the CON program is outlined below:

- The program has had limited success, deterring some types of construction, and preventing some unnecessary duplication of services. Capital expenditures would have been higher had the program not been in place.
- It cannot be expected to have had a major impact on total expenditures since it focused- primarily on capital costs and not operation costs.
- It does not address the "over-utilization" issue.
- The public scrutiny of the review process has resulted in more deliberate and detailed long-run capital planning in institutions.
- The program is reactive, not proactive.
- It is inherently in conflict with incentives of cost-based reimbursement. It is difficult to say "no" when the reimbursement system makes the project financially feasible and when the institution demonstrates that the demand exists (regardless of whether it is being met elsewhere), or that it can be generated.

The Commission concluded that the CON program should be continued, in a simplified form, for at least the next 3 to 5 years. The program could possibly be phased out after the incentives have been restructured to reward cost-effective capital expenditure decisions.

Legislative changes made in 1982 increased the capital threshold for review from $150,000 to $600,000, added a threshold of $250,000 for new health services and increased the equipment threshold from $150,000 to $400,000.

1985 Governor's Task Force on Long-Term Care concluded that barriers to competition should be minimized because competition forces providers to offer quality services. However, regulations should require all competitors offering like services to meet similar standards. This Task Force recommended the following changes to the CON law:

- Exemption of residential care facilities from Con review.
- Exemption of long-term care beds in "lifecare" or "continuing care" communities from CON review.
- Review of the long-term care bed need formula and revision as necessary.

- Establishment of a pilot program for exempting certain counties or areas from CON review for intermediate or skilled nursing care beds.

1986 Legislation passed to exempt residential care facilities and residential care facilities for the mentally retarded from CON for a 2-year trial period from 7/1/86 to 6/30/88. This legislation carried with it a directive for the Department of Public Health to study the impact of the exemption on cost, quality and access to care.

The Statewide Health Coordinating Council (SHCC) held a public hearing on the CON program on 12/3/86 focusing on the future direction the program should take. Ten parties spoke in support of the program and three parties -- the University of Osteopathic Medicine, Health Policy Corporation of Iowa and the Iowa Medical Society -- spoke in terms of transition away from CON.

1987 The SHCC appointed a CON Task Force to explore the issues brought forth at the public hearing and to make recommendations. The Task Force recommended continuation of the program with several changes, including the following:

- Change membership of Council to include a physician, facility representative, a purchaser and 4 consumer members.
- Increase thresholds to $1M for capital, $300,000 for new service and $500,000 for equipment.
- Eliminate review of reductions in bed capacity, discontinuation of services and shifts of acute care beds in acute care category.
- Develop administrative review for non-medical projects and equipment replacements.
- Cap filing fees at $10,000.
- Review program on biennial basis.
- Provide for review of certain new or technologically innovative health services regardless of cost.

Congress discontinued funding of Section 1122 of the Social Security Act beginning 10/1/87. Under this section, the United States Department of Health and Human Services contracted with states to review and comment on health care expenditures as a factor affecting Medicare reimbursement.

1988 Findings from the RCF study show that the exclusion of RCF facilities from CON review has not resulted in a proliferation of RCF facilities. Recommended that exclusion become permanent.

At the request of Governor Branstad, a committee to recommend changes in the CON law was convened by the Director of Public Health. The committee endorsed continuation of the program and made recommendations for changes which became the basis for the legislation passed in 1991.

1991 The passage of House File 668 by the Seventy-fourth General Assembly made changes that were effective 7/1/91. Among the changes were:

- Thresholds were changed -- capital threshold went from $600,000 to $800,000, new service threshold went from $250,000 to $300,000 and replacement equipment stayed at $400,000 while new equipment dropped to $300,000.
- Added to the list of services requiring review were air transportation systems, mobile health services in excess of $300,000, birth center, cardiac catheterization service, open heart surgical service, and organ transplantation service.
- A reduction of beds or deletion of a health service was removed from the formal review process (reporting requirements were put in place).
- Deleted Council option of "approve with conditions," an application must be either approved or denied.
- Added fines as a sanction.
- Included third-party payers in definition of "affected parties."
- Added that staff could make recommendations concerning an application if requested by the Council.
- Included facilities certified or seeking certification as an ambulatory surgical center under the Medicare or Medicaid programs in the definition of outpatient surgical facility for CON review.

1992 Filing fee increased from two tenths of 1% to three tenths of 1% of the capital cost of the proposed project. There was no additional appropriation to the Department as a result of the increase.

1993 Moratorium on new ICF/MR beds put in place.

1995 CON was part of the Elder Care Services Study requested by the oversight, audit, and government reform appropriations subcommittee. This study was conducted by the state auditor's office. Key issues identified in this report included:

- Need to establish a fee structure that is more equitable.
- Recommend that any substantive change in a project be reported to the Council and that a final report be submitted by the applicant when the project is complete.

1996/97 CON was reviewed by the Governor's Health Regulation Task Force in 1996, which suggested modifications to Iowa's CON program that were adopted by the Iowa General Assembly in 1997. In addition, the committee that reviewed CON looked at the preamble of House File 354, 1977 as the mission and purpose of the program and suggested that the term institutional was out of date and that the word quality should be included. The committee also recommended that the department should review areas where one entity is not subject to review for a particular

service, but other entities would be subject to review for the service. The committee's wish was to create a level playing field.

The following are highlights of the changes to Iowa's CON law that were effective July 1, 1997.

- Capital threshold increased from $800,000 to $1.5 million.
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ATTACHMENT B

"CONTINUUM" OF HEALTH CARE SERVICES

WITH DESCRIPTION OF CARE, REGULATORY BODY,
CON INVOLVEMENT & PAYMENT SOURCES

	Description of Care	Regulated By:	CON Involvement	Payment Sources
Independent Living		None (Housing Code)	None	Private Pay
Home & Community-Based Waiver (HCBS)	Provides services at nursing & skilled level of care and must include one of the following: adult day care, emergency response system, home health aide, homemaker services, nursing, respite care, chore services, home-delivered meals, home & vehicle modifications, mental health outreach, transportation, nutritional counseling, assistive devices, senior companion, consumer-directed care. Purpose is to enable individuals to remain in their own home & community.	Department of Human Services. Iowa Administrative Code 441-77.33(249A)	None	Medicaid
Home Health Care (Medicare certified only)	Provides skilled nursing services and at least one of the following other therapeutic services: physical, speech or occupational therapy; medical social services or health aide services to patients in their residences. The services must follow a written plan of treatment established by each patient's attending physician in conjunction with agency staff.	Health Care Financing Administration (HCFA); surveyed by Department of Inspections & Appeals (DIA)	None	Medicare Medicaid Private Insurance Private Pay
Adult Day Care Services	Provides an organized program of supportive care for 16 hours or less in a 24-hour period to persons who require support & assistance on a regular or intermittent basis in a licensed health care facility.	Department of Human Services Iowa Administrative Code 441 Chapter 77	None	Medicaid - Waivers

Respite Care Services	Provides an organized program of temporary supportive care for 24 hours or more to a person in order to relieve the usual caregiver of the person from providing continual care to the person.	Department of Human Services Iowa Administrative Code 441 Chapter 77	None	Medicaid - Waivers
Assisted Living	Provides a safe and home-like environment for individuals of all income levels who require assistance to live independently but who do not require health-related care on a continuous twenty-four-hour day basis.	Department of Elder Affairs certifies and monitors assisted living facilities	None	Private Pay
Residential Care Facility	Provides accommodation, board, personal assistance and other essential daily living activities for a period exceeding 24 consecutive hours. Individuals living here are unable to sufficiently or properly care for themselves because of illness, disease, or physical or mental infirmity, but do not require the services of a RN or LPN	Licensed by the Department of Inspections & Appeals	None	Private Pay SSI (Supplemental Security Income) SSA (State Supplemental Assistance)
Nursing Facility	Provides health-related care and services, including rehabilitation, for individuals who because of mental or physical condition require nursing care and other services, in addition to room and board. Nursing facilities house three or more individuals for a period exceeding 24 hours.	Licensed by the Department of Inspections & Appeals. Certified via HCFA and surveyed by DIA.	Addition of new beds or new service requires CON. Replacement or modernization of facility is exempt.	Medicaid Long-term Care Insurance Private Pay
Chronic Confusion & Dementing Illness (CCDI) Unit in NF	Provides care to persons who suffer from chronic confusion or dementing illness. CCDI is a special license classification for nursing facilities or a special unit within such a facility.	Licensed by the Department of Inspections & Appeals	New beds require CON. If designating existing NF for CCDI, no CON needed.	Medicaid Long-term Care Insurance Private Pay
Long-term Nursing Care in Hospital (Swing Beds)	Provides post-hospital extended-care services.	Certified as swing beds by the DIA. HCFA regulations.	Swing beds are classified as acute care beds. No CON needed to designate as swing.	

Skilled Care in Nursing Facility	Provides a "distinct part" of the facility for skilled nursing care.	Certified for Medicare by the DIA (HCFA regulations)	Skilled care is a designation for payment purposes. These are NF beds. CON not needed for the designation.	Medicare Medicaid Long-term Care Insurance Private Pay
Skilled Care in Hospital	Provides a "distinct part" of the facility for skilled nursing care.	Certified by the Department of Inspections & Appeals	CON needed if converting from acute care to skilled or adding new beds.	Medicare Medicaid Long-term Care Insurance Private Pay
Hospice	Provides alternative care for terminally ill individuals, which stresses palliative care (medical relief of pain) as opposed to curative or restorative care. Hospice care is not limited to medical aspects, but addresses all physical, psychological and spiritual needs of the patient and emotional needs of the patient's family.	Optional state license through DIA. Medicare certification, HCFA through DIA.	None	Medicare Medicaid Private Insurance Private Pay
Acute Care (Hospital)	Provides diagnosis, treatment, or care of individuals suffering from illness, injury or deformity; obstetrical or other medical/nursing care; care of aged or infirm persons requiring or receiving chronic or convalescent care. All care must involve two or more non-related persons for a period exceeding 24 hours.	Licensed by the Department of Inspections & Appeals. Certified for Medicare, HCFA regulations, through DIA.	CON required for establishment of new hospital, single piece of equipment of more than $1.5M, select services. Replacement or modernization of facility is exempt.	Medicare Medicaid Private Insurance Private Pay

OTHER SERVICES IMPACTED BY CERTIFICATE OF NEED

	Description of Care	Regulated By:	CON Involvement	Payment Sources
Physician's Office			Acquisition of single piece of equipment in excess of $1.5 M, certain select services, establishment of ambulatory surgery center requires CON.	Medicare Medicaid Private Insurance Private Pay
Certified Outpatient Rehabilitation Facility (CORF)	Provides diagnostic, therapeutic and restorative services to outpatients for rehabilitation of their injuries or sicknesses at a single fixed location operated by or under the supervision of a physician. CORFs are non-residential facilities established & operated exclusively for this purpose.	Certified by Department of Inspections & Appeals through HCFA rules.	Establishment of a new CORF requires a CON.	Medicare
Birth Center	Provides services for planned births following a normal, uncomplicated, low-risk pregnancy. A birth center is a facility, institution , or place which is not an ASC or hospital, and away from the mother's usual residence.	Licensed by the Department of Inspections & Appeals	Establishment of a birth center requires a CON.	Medicaid Private Insurance Private Pay
Ambulatory Surgery Center (ASC)	Provides surgical services to patients not requiring hospitalization. An ASC is a distinct part entity which operates exclusively for providing these services.	Certified by Department of Inspections & Appeals through HCFA rules.	Establishment of an ASC that will be Medicare certified requires a CON.	Medicare Medicaid Private Insurance Private Pay
Intermediate Care Facility for the Mentally Retarded (ICF/MR)	Provides health or rehabilitative services to three or more individuals who primarily have mental retardation or related conditions.	Licensed by DIA. DHS has rules restricting development by size, location, inclusion in community and no expansion of Medicaid-certified beds.	New ICF/MR beds require a CON.	Medicaid Private Pay
Psychiatric Medical Institution for Children (PMIC)	Provides more than 24-hours of continuous care involving long-term psychiatric services to 3 or more children in residence. The expected periods of stay for diagnosis and evaluation are 14 days or more; and for treatment the expected period of stay is 90 days or more.	Licensed by Department of Inspections & Appeals. Code gives Department of Human Services authority to determine need and location of beds in the state. Bed cap for Medicaid-certified beds is in the Code.	Establishment of a PMIC and new Medicaid-certified PMIC beds requires a CON.	Medicaid Private Pay

ATTACHMENT C

Option #1:
Repeal Iowa's CON program.

Possible Recommendations Under Option 1:

1) Identify policy goals for cost, quality and access and accountability along with alternative methods for attaining these goals. Alternatives might include strengthening the licensing rules for certain services or providers, additional requirements for charity care, or the adoption of a program for continuous quality improvement.
2) Strengthen data collection and reporting to monitor the effects of repeal on quality, general and rural access, and community benefits.

Option # 2:
Maintain Iowa's CON program with no changes to existing law or regulation.

Possible Recommendation Under Option 2:

Review program again in 2-3 years.

(See attached statements from Steve Ackerson of the Iowa Health Care Association, Jim Platt and Dave Vellinga.)

I H C A

IOWA HEALTH CARE ASSOCIATION

950 - 12th Street
Des Moines, Iowa 50309
(515) 282-0666
Fax # (515) 282-4011

October 27, 1999

Barb Nervig
Certificate of Need
Lucas State Office Building
5th Floor South
Des Moines, Iowa 50319

Dear Barb,

The Iowa Health Care Association, a non-profit trade association representing the continuum of long term care services and nearly 80% of all long term care facilities in the state, opposes any changes in the Certificate of Need (CON).

Iowa's long term care facilities are experiencing a decline in census with new health care opportunities for consumers. Iowa currently has the second highest bed ratio for the population of 85 and older in the country.

The State of Iowa is currently reviewing its long term care policy, as it relates to placement of Title XIX (Medicaid) recipients, by considering alternatives to the nursing facility setting. If this changes, it will negatively effect long term care facilities across the state.

The current CON process identifies if there is a need for additional beds in a geographical area by using the current bed formula. IHCA believes the CON process is important to Iowa in keeping costs down for the state and the residents of the facility. IHCA believes no changes should be made to the CON.

Sincerely,

Steve Ackerson
Executive Vice President
Iowa Health Care Association

Alternative Draft (Enclosure 4)

Submitted by Jim Platt
10/20/99

Certificate of Need Task Force

As Iowa enters a new millenium, the state's health care system continues to undergo modest evolution. It is clear that Iowa's reasonable combination of state regulation and market force competition is having a positive effect, absent the penetration of capitated managed care payment systems to any real degree in the state. The charge of the Department of Public Health's 1999 task force deliberations was to determine whether or not Iowa's certificate of need (CON) program is still relevant to Iowa's health care environment. While some view CON programs as barriers to the growth of health care services, others see CON as useful in preventing unnecessary duplication of services, assisting in lowering health care costs, promoting community health planning initiatives, and promoting collaboration between provider groups.

Alternative Option One:

Maintain Iowa's CON program with no changes to existing law or regulation.

(renumber other options 2-4)

RECOMMENDATION: The Task Force supports maintaining Iowa's CON program with no changes to existing law or regulation.

Alternative Draft (Enclosure 5)

Submitted by Dave Vellinga
10/20/99

Findings & Chronology of CON in Iowa

Retain points 1-3.

Strike points 4-10 and replace with the following:

4) In the early 1980s, the Iowa Governor's Commission on Health Care Costs endorsed increased emphasis on market incentives while recognizing the need for enabling government regulation. The Commission concluded this strategy would help control the rate of increase in spending, as well as promoting efficiency and effectiveness. The Commission concluded CON should be continued until market force incentives were restructured.

5) CON was last reviewed by the Governor's Health Regulation Task force in 1996, which suggested modifications to Iowa's CON program that were adopted by the Iowa General Assembly in 1997. These changes included raising some CON dollar thresholds, eliminating nonpatient care services from review, and adding radiation therapy to the list of services which must be reviewed regardless of cost. Modifications made in 1997 resulted in Iowa having one of the least restrictive CON programs in the nation, while recognizing the essential role CON plays in community health planning and supporting Iowa's existing health care infrastructure.

6) The 1997 legislation called for the Department of Public Health's 1999 review of CON largely because of the expectation that capitated managed care reimbursement systems would become more prevalent in Iowa by the end of the century. The movement from traditional fee-for-service reimbursement in Iowa has not progressed as rapidly as anticipated at that time and there is evidence to suggest that the expected evolution to a captitated managed care environment in Iowa may not occur for quite some time to come.

7) While most states still have some form of CON, some states have repealed the program. The effect of CON repeal varies among states, with little data existing regarding charity care concerns and rural health care access issues. It is clear that health care infrastructure does increase in various health care enterprises, with variations from state to state.

8) Following comprehensive review of CON issues, the Department of Public Health's 1999 review of Iowa's CON program came to the following conclusions: (add conclusions)

RECOMMENDED CONCLUSIONS:

1) The CON Task Force concludes that Iowa's certificate of need program is still relevant and useful in Iowa.
2) The CON Task Force supports maintaining Iowa's CON program with no changes to existing law or regulation.

Option # 3:
Reform Iowa's CON program.

Possible Recommendations Under Option 3:

General/Overall Changes:

1) Establish a means for CON to be more responsive to changes in health care system, such as an advisory board composed of experts on Iowa's health care system, representatives of provider organizations, and the broader community.
2) Strengthen the state monitoring of quality, general and rural access, and community benefits such as charity care and community services that are not reimbursed. This should include improved data collection to allow for ongoing monitoring and oversight of general and rural access, and community benefits (including levels of charity care).
3) Provide sufficient staffing and resources for a thorough analysis of CON proposals and their policy implications.
4) Provide for ongoing monitoring of approved CON projects and the effect of new programs and services on cost, quality or access.
5) Establish a means for CON to be based on an analysis of health care system conditions and changes or specific state health planning goals.
6) The Department should review and evaluate the various ideas for improvement of the CON program that were presented but not specifically acted upon by the task force. The Department shall include their findings and recommendations in the report to the legislature.

Specific Changes for Long-Term Care Facilities:

1) Amend Iowa Code 135.63(2) by adding a new subsection:
This division shall not be applicable to:
The addition of 10% of current licensed nursing facility beds or no more than 15 additional beds to an existing nursing facility, notwithstanding any provision in this division to the contrary, if all of the following conditions exist:
(1) The facility has reported occupancy of 90% or greater for the previous four quarters.
(2) The facility reports to the department the number of beds to be added on a form prescribed by the department at least thirty days before the addition.
(3) Such an addition of beds shall be allowed every 3 years for qualifying facilities.
(4) The facility reports the new bed totals on their next annual report to the department.
If these conditions are not met, the nursing facility is subject to review as a "*new institutional health service*" or "*changed institutional health service*" under section 135.61, subsection 18, and subject to sanctions under section 135.73.

(See statement from Iowa Association of Homes & Services for the Aging)

2) Amend Iowa Code 135.63(2) by adding a new subsection:
This division shall not be applicable to:
The redistribution of licensed nursing facility beds among existing providers, notwithstanding any provision in this division to the contrary, if all of the following conditions exist:

(1) The nursing facility reports to the department the number of beds to be redistributed and the geographical location (city and county) of the beds on a form prescribed by the department at least 30 days prior to the redistribution.
(2) The total number of licensed nursing facility beds in the state shall not be increased by such a redistribution of beds.
(3) The nursing facilities report the new bed totals on their next annual report to the department.

If these conditions are not met, the nursing facility is subject to review as a "*new institutional health service*" or "*changed institutional health service*" under section 135.61, subsection 18, and subject to sanctions under section 135.73.

(See statement from Iowa Association of Homes & Services for the Aging)

3) Amend Iowa Code 135.63(2) by adding a new subsection:
This division shall not be applicable to:
The reclassification of current residential care facility licensed beds to nursing facility licensed beds, notwithstanding any provision in this division to the contrary, if all of the following conditions exist:

(1) The residential care facility has been operation for five years or more.
(2) The facility reports to the department the number of beds to be reclassified and the cost that may be necessary to bring the beds to nursing facility standards on a form prescribed by the department at least 30 days prior to the reclassification.
(3) The facility reports the new bed totals on their next annual report to the department.

If these conditions are not met, the nursing facility is subject to review as a "*new institutional health service*" or "*changed institutional health service*" under section 135.61, subsection 18, and subject to sanctions under section 135.73.

(See statement from Iowa Association of Homes & Services for the Aging)

Iowa Association of Homes & Services for the Aging

Principles for Certificate Of Need – Long-Term Care

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Issue

Certificate of Need operates to promote the public interest. It is in the public interest to promote choice among providers of services. The purpose of the program is to assure access to quality health care at a reasonable cost.

Bed need formulae, which are based solely on population, are inadequate. The new and unregulated Assisted Living Facility Programs affect demand.

Position

The more important consideration is occupancy rates. In the case of a facility applying for a CON, an occupancy rate of 90% or more indicates demand, consumer opinion, and indirectly the public interest. Existing nursing facilities with 90% or more occupancy should be allowed to add 10% of current NF beds or no more than 15 beds, every 3 years, without review.

Re-distribution of existing licensed beds among providers should be considered.

Re-classification of current RCF licensed beds to NF should be allowed, when the RCF has been operational for 5 years. In order to continue to assure high quality facilities, the capital threshold for renovation should be removed.

Facilities which desire to open a special unit or facility dedicated to the care of persons with chronic confusion or dementing illness (CCDI) should have review but not be precluded from development of their project in view of the need for such programs.

Recommendation

The existing program needs modification to reflect consumer choice need for uniting treating individuals with dementia.

Specific Changes for Other CON Covered Health Services & Facilities:

1) Amend Iowa Code 135.63(2) by adding a new subsection:
This division shall not be applicable to:
The offering or development of an outpatient surgical facility to be located in a community with a population of 20,000 or more, notwithstanding any provision of this division to the contrary, if all of the following conditions exist:

(1)The person seeking to develop and offer an outpatient surgical facility files with the department at least 120 days prior to beginning construction, renovation, or other site location of the proposed outpatient surgical facility a description of its construction, renovation or other location plans and a statement regarding each of the following:

a. The site location of the outpatient surgical facility;
b. The population of the community in which the outpatient surgical facility is to be located based upon 1990 Iowa census data;
c. The nature of the surgical services to be provided by the proposed outpatient surgical facility;
d. The intent of the person proposing the outpatient surgical facility to serve low-income and other medically underserved patient; and
e. The person has submitted a copy of the proposed project construction, renovation or other location plans to the department of inspections and appeals to assess compliance with applicable life safety codes and to determine the person's intent to seek federal Medicare or Medicaid certification for the proposed outpatient surgical facility.

If these conditions are not met, the outpatient surgical facility is subject to review as a "*new institutional health service*" or "*changed institutional health service*" under section 135.61, subsection 18, paragraph "a" and subject to sanctions under section 135.73.

(2)The department shall report to the general assembly by January 20, 2003, on the results of this exception and its recommendations regarding its continuance, modification, or other action the department deems appropriate for this provision and any other provision of this chapter. The report shall include a listing of all outpatient surgical facilities exempt under this provision as well as a listing of all outpatient surgical facilities that have been offered or developed during the same period that have either received certificate of need review or otherwise were exempted from such review.

(See attached statement from the Iowa Medical Society)

IMS

IOWA MEDICAL SOCIETY

Working for Iowa physicians and their patients

IOWA MEDICAL SOCIETY

Proposed Amendment to Iowa's Certificate of Need Law

Submitted to the
Iowa Department of Public Health's
Certificate of Need Task Force

December 1, 1999

Summary of the proposed amendment:

The Iowa Medical Society presents the following option to amend Iowa's Certificate of Need (CON) law to no longer require CON review of outpatient surgical facilities proposed to be developed and offered in communities with populations of 20,000 or more (see attachment) subject to conditions outlined in the proposed amendment. Conditions include:

- The person seeking to use the exemption must file a report with the Department 120 days in advance of construction, renovation, or other site location of the proposed outpatient surgical center.

- The report must provide a description of the proposed outpatient surgical facility, including:

  a. Site location;
  b. Population of the community in which the proposed outpatient surgical facility is to be located, using 1990 Iowa census data;
  c. Surgical services to be provided; and
  d. Intent to serve low-income and other medically underserved patients.

- A copy of the proposed outpatient surgical facility's construction, renovation, or other site location plans shall be filed with the Department of Inspections and Appeals to assess compliance with applicable life safety codes and to determine the person's intent to seek federal Medicare or Medicaid certification for the proposed outpatient surgical facility.

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www.iowamedicalsociety.org

The Department of Public Health would be required to keep information on outpatient surgical centers developed and offered in this state, whether they are hospital-based or freestanding and whether they are reviewed or exempted under the CON law. The Department shall file a report with recommendations on the impact of this proposed exemption and any other provision of the CON law with the General Assembly by January 20, 2003.

This amendment, if adopted by the General Assembly, would be effective on July 1, 2000.

Impact of this proposal:

- This proposal does not affect the exemption privileges enjoyed by hospital-based ambulatory surgical centers under the existing CON law nor would hospital-based ambulatory surgical centers be required to make the showings set forth in the proposed amendment.

- This proposal creates a more even playing field, consistent with the concepts of a competitive marketplace, by providing a similar *but more regulated exemption* for freestanding ambulatory surgical centers located in Iowa's larger communities.

- Freestanding ambulatory surgical centers located in Iowa's rural communities with a population of less than 20,000 would be subject to CON review in the same way as they are reviewed under existing law. In other words, no change is made to the CON law for Iowa's smaller, rural communities.

- Hospital-based ambulatory surgical centers located in Iowa's rural communities with a population of less than 20,000 would continue to enjoy the exemption privileges of current law *absent* the regulated approach of the proposed amendment.

- *All* other provisions of Iowa's current CON law remain intact and unaffected by this narrow proposal.

Current law:

- An "outpatient surgical facility" is an institutional health facility that must apply for and receive a certificate of need prior to being offered or developed in this state. Iowa Code § 135.63(1), § 135.1(18)(a), § 135.1(14).

- Current law as interpreted by the Department, however, draws a defined distinction between hospital-based outpatient surgical facilities, which are not subject to CON review regardless of location on or off the hospital's main

campus, and freestanding outpatient surgical facilities, which are subject to CON review.

- *"Outpatient surgical facility"* is currently defined by the CON law, Iowa Code § 135.61(21), to mean:

> A facility which as its primary function provides, through an organized medical staff and on an outpatient basis to patients who are generally ambulatory, surgical procedures not ordinarily performed in a private physician's office, but not requiring twenty-four hour hospitalization, and which is neither a part of a hospital nor the private office of a health care provider who there engages in the lawful practice of surgery. *"Outpatient surgical facility"* includes a facility certified or seeking certification as an ambulatory surgical center, under the federal Medicare program or under the medical assistance program established pursuant to chapter 249A.

<u>Proposed statutory amendment:</u>

Amend Iowa Code § 135.63(2) by adding the following new subsection:

This division shall not be ... applicable to:

q. The offering or development of an outpatient surgical facility to be located in a community with a population of 20,000 or more, notwithstanding any provision of this division to the contrary, if all of the following conditions exist:

(1) The person seeking to develop and offer an outpatient surgical facility files with the department at least 120 days prior to beginning construction, renovation, or other site location of the proposed outpatient surgical facility a description of its construction, renovation or other location plans and a statement regarding each of the following:

a. The site location of the outpatient surgical facility;
b. The population of the community in which the outpatient surgical facility is to be located based upon 1990 Iowa census data;
c. The nature of the surgical services to be provided by the proposed outpatient surgical facility;
d. The intent of the person proposing the outpatient surgical facility to serve low-income and other medically underserved patients; and
e. The person has submitted a copy of the proposed project construction, renovation or other location plans to the department

of inspections and appeals to assess compliance with applicable life safety codes and to determine the person's intent to seek federal Medicare or Medicaid certification for the proposed outpatient surgical facility.

If these conditions are not met, the outpatient surgical facility is subject to review as a *"new institutional health service"* or *"changed institutional health service"* under section 135.61, subsection 18, paragraph "a" and subject to sanctions under section 135.73.

(2) The department shall report to the general assembly by January 20, 2003, on the results of this exception and its recommendations regarding its continuance, modification, or other action the department deems appropriate for this provision and any other provision of this chapter. The report shall include a listing of all outpatient surgical facilities exempt under this provision as well as a listing of all outpatient surgical facilities that have been offered or developed during the same period that have either received certificate of need review or otherwise were exempted from such review.

Why support this amendment?

- The evidence before this task force establishes that freestanding outpatient surgical facilities present low-cost, highly-efficient, quality of care alternatives to patients needing certain surgical procedures and that patient satisfaction with these facilities is high.

- The proposed amendment is narrow in scope, affecting only the development of freestanding outpatient surgical facilities in larger urban or regional areas where marketplace competition is alive and well.

- This proposal brings greater equity between like providers under Iowa's CON law. The law as currently interpreted by the Iowa Department of Health does not require CON review of hospital-based ambulatory surgical centers but does require review of freestanding ambulatory surgical centers that carry a heavy burden of proof in gaining CON approval.

- This proposal is a narrow approach to introduction of competition in the healthcare marketplace in an arena that is recognized as the way of the future because of its low-cost, high quality, high patient satisfaction aspects.
- This proposal can assist in keeping freestanding ambulatory surgical centers and their patients in Iowa and not in bordering communities outside of Iowa.

- In no way does this proposal preclude or discourage health care providers such as hospitals and physicians in the marketplace from establishing joint ventures or otherwise working in a cooperative manner to jointly offer and develop ambulatory surgical center services.

- This proposal assures that freestanding facilities are in the regulatory loop, allowing the Department of Inspections and Appeals to learn of the project and to work with the person proposing it to assure compliance with life safety codes and federal certification requirements if such is being sought.

- Freestanding outpatient surgical facilities seeking the benefit of this exemption must indicate an intent to serve low-income and medically underserved patients consistent with this existing review criteria under the current CON law.

- Concerns expressed at task force meetings for the health of Iowa's rural hospitals are addressed by this proposal by its very narrow focus. While it remains questionable whether a fair purpose of CON is to protect any one competitor in the marketplace by creating state regulatory burdens for another, this proposal, nonetheless, does not impact Iowa's rural communities or its rural hospitals. The CON law remains intact for *all* current projects that may be developed and offered in Iowa's rural communities.

- Movement to the competitive marketplace approach is now appropriate. Significant evidence before this task force establishes that certificate of need laws have not achieved their original purposes.

  → "CON has elicited a remarkable evaluative consensus – that it does not work." (McGinley, P., "Beyond Health Care Reform: Reconsidering Certificate of Need Laws in a 'Managed Competition System'," *23 Florida State University Law Review* 141, 148-49 (1995)).

  → "Unlike research in many areas of health policy, research into CON effects on acute care costs provides a rather clear answer: CON has not succeeded in cost containment.... Our empirical analysis of effects of CON on costs revealed that, at best, CON has a modest cost containment influence on hospital and other acute care services. (Conover, *et.al.* "Does Removing Certificate of Need Regulations Lead to a Surge in Health Care Spending?" 23 *Journal of Health Politics, Policy and Law* 456, 476-77, 478 (June 1998).

  → The State of Washington legislative study concluded "that CON has not controlled overall health care spending or hospital costs" and "found conflicting or limited evidence about the effects of ... repealing CON." ("Effects of Certificate of Need and Its Possible Repeal, Report 99-1, *State of*

Washington, Joint Legislative Audit and Review Committee, January 8, 1999, at i).

➔ Similarly, the only comprehensive empirical study of the impact of CON repeal that has been presented to this task force concluded that there is no evidence of a surge in acquisition of facilities, including ambulatory surgery facilities, or in costs following removal of CON regulations. (Conover, *Id.* at 478).

➔ This study concluded: "States that lifted CON did not experience a rise in spending on hospital and physicians' services relative to those that retained it. *The conclusion of lack of surge even holds for facilities such as ambulatory surgery units that have experienced substantial growth in recent years.*" [emphasis added] [*Please note:* The Conover, or Duke, study focused on acute care services, including hospitals, ambulatory surgery centers and physician office visits. *Id.* at 458].

➔ The State of Washington study referenced the Conover study; also recognized (as did the Conover study) that evidence of surge in supply was found in some states, at least immediately following repeal; and generally concluded that such surges have been insufficiently studied to determine if there are any persistent effects on costs, need, or other goals. (State of Washington study at 13.)

- It is important that Iowa begin to move away from the CON regulatory model that protects existing providers and impedes new entry into the marketplace. This proposal is very narrowly-focused but allows a reasonable opportunity to judge Iowa's ability to respond in a competitive health care marketplace fashion in this one area: freestanding ambulatory surgery centers in Iowa's competitive marketplaces.

- As generally suggested by the findings and recommendations of the State of Washington study, data will be collected by the Department on the impact of this amendment and a report with recommendations will be filed with the General Assembly in January of 2003, 30 months after the implementation of the amendment in July of 2000.

IOWA CENSUS DATA
Total Population for Iowa Incorporated Places – 1990
(Excerpt)

Source: U.S. Bureau of the Census
Adapted from information prepared by: State Library of Iowa, State Data Center Program, (515) 281-4350

Population 20,000+

Ames
Bettendorf
Burlington
Cedar Falls
Cedar Rapids
Clinton
Council Bluffs
Davenport
Des Moines
Dubuque
Fort Dodge
Iowa City
Marion
Marshalltown
Mason City
Muscatine
Ottumwa
Sioux City
Urbandale
Waterloo
West Des Moines

ATTACHMENT D

IMS
IOWA MEDICAL SOCIETY
Working for Iowa physicians and their patients

IOWA'S CERTIFICATE OF NEED LAW – A CASE FOR REPEAL

TESTIMONY OF THE IOWA MEDICAL SOCIETY

BEFORE THE IOWA DEPARTMENT OF PUBLIC HEALTH TASK FORCE ON CERTIFICATE OF NEED

June 29, 1999

Introduction – IMS Policy Position in Support of CON Repeal

The Iowa Medical Society appreciates the opportunity to, first, serve on the Department's task force on certificate of need and, secondly, to provide a statement in support of the IMS' position on repeal of Iowa's certificate of need (CON) law. The position of the IMS House of Delegates, adopted in 1998, is clear and unequivocable: repeal certificate of need. This position is consistent with the general policy position of the American Medical Association which states that little evidence exists to suggest the CON programs are effective in restraining health care costs or in limiting capital investment.

Purposes of CON – A Failed Regulatory Experiment

Iowa's certificate of need law, Iowa Code §§ 135.61-.83, was adopted by the 1977 General Assembly consistent with the stated purposes and criteria of the federal National Health Planning and Resources Development Act of 1974. The federal law provided financial incentives to states that adopted CON laws. Many states had passed certificate of need legislation prior to passage of the federal law while others followed; Louisiana is the only state that never passed a CON statute.

Congress adopted the NHPRDA to: 1) restrain skyrocketing health care costs; 2) prevent the unnecessary duplication of health care resources; and 3) achieve equal access to quality health care at a reasonable cost. Congress' purpose, however, was singular and clear: to reduce the nation's aggregate health care costs. The underlying theory of the law focused on underutilization of health care resources as a primary cause of skyrocketing health care costs. It was Congress' belief that the structure and incentives of the health care industry *at that time* lead to overinvestment and that unnecessary and duplicative health care resources contributed significantly to rampant inflation in health care costs. (McGinley, P.,

"Beyond Health Care Reform: Reconsidering Certificate of Need Laws in a 'Managed Competition System'," 23 *Florida State University Law Review* 141, 148-49 (1995)).

The Iowa General Assembly paralleled the congressional statement of purpose in adopting its CON statute. Cost also was the driving factor in Iowa's implementation of its law. "[I]t is the public policy of this state that health care is a right of the people, but the general assembly finds and declares...that rising hospital and health care facility costs may place the services of these facilities beyond the means of the majority of the people of the state." 67 Iowa Acts chapter 75 (1977). The General Assembly further declared that health care services should be developed in an orderly and economical fashion to assure availability of such services to all people in the state "while avoiding unnecessary duplication of institutional health services and preventing or controlling increases in the cost of delivering those services."

In 1986, Congress repealed the NHPRDA and withdrew its support for CON. Congress found that: 1) the law had failed to reduce the nation's aggregate health care costs and 2) it was beginning to produce detrimental effects in local communities. Examination of state laws that remained intact despite Congress' withdrawal of its support has lead to similar conclusions. "CON has elicited a remarkable evaluative consensus – that it does not work." (McGinley, *supra* at 157.) *See also* Conover, C, Sloan, F, "Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?" 23 *Journal of Health Politics, Policy and Law* 456 (June 1998)(detailing the relative ineffectiveness of CON in controlling health care costs in a range of circumstances) and Mendelson, D., Arnold, J., "Certificate of Need Revisited," *Spectrum* 4 (Winter 1993): "Our findings concur...CON did not decrease hospital costs and, in certain instances, CON is associated with modest increases in cost."

This task force has been convened to determine whether the time has come for Iowa's CON law to meet a similar fate – repeal. The Iowa Medical Society believes it has. Findings of the federal government and other reviewers clearly establish that CON laws have failed in achieving their overall mission.

This Task Force and Its Charge

The 1996 Review – No Findings of Fact. Three year's ago, Iowa's CON law was reviewed within the larger context of an examination of the state health regulatory system. The task force charged with examining the CON program concluded, without dissent, that CON should continue and, not always with unanimous agreement, that certain changes should be made to the program. The task force's

final report, however, did *not* include an examination of Iowa-specific data; did not engage in an analysis of whether the program continues to meet the stated goals and objectives of the General Assembly; did not assess whether other purposes should support the program in lieu of those set forth in 1977; and did not ask whether other, more appropriate regulatory alternatives, if any at all, should be considered. There simply were no factual findings in the final report.

Direction from the General Assembly – Comprehensive Review. The 1997 General Assembly adopted many changes to the CON law as suggested by the 1996 task force. The legislature also directed:

> The Iowa department of public health shall complete a comprehensive review of the certificate of need program and shall submit a written report of the findings and recommendations as to the continued relevance of the program to the general assembly by January 15, 2000.

77 Iowa Acts chapter 93 § 11 (1997). In conducting this review, it is imperative that this task force return to the purposes of the CON program enunciated by the 1977 General Assembly and determine, based on empirical evidence directly linked to the CON program, whether certificate of need has and continues to meet its legislative objectives, primarily the control of rising health care costs. This analysis must be done within the context of the realities of this state and of today's current health care marketplace.

Burden of Proof on Proponents of CON. The burden of proof lies with the proponents of the CON law. The test is ***not*** whether there exists good reasons to eliminate the law; rather, the test is whether legitimate public policy reasons, supported by clearly established facts, exist to continue this regulatory program and the administrative costs and burdens associated with it. CON should be repealed unless it can be affirmatively established that it has a direct, positive impact in controlling rising health care costs.

By way of parenthetical note, IMS believes that a review of CON that engages *solely* on a "duplication of services" analysis is fundamentally flawed. Cost control was the goal of the CON program; continued state regulation of duplicative services is relevant to the CON debate only if it is shown that such duplication results in rising health care costs. Absent that finding, the state has no role in regulating service growth, particularly when such growth is a positive, competitive factor in lowering costs and in enhancing quality and efficiency in service delivery.

Iowa's Remarkable Health Care System. The Iowa Medical Society believes that the facts will establish that Iowa is a low cost state for health care services. If Iowans

do not already know it, they should be told of the remarkable job of the health care provider community in this state in providing health care services of excellence at costs that are among the lowest in the nation. IMS will *never* hesitate to sing the praises of the Iowa hospital and health care provider community for doing what needed to be done to best assure access by all Iowans to quality, low cost health care services.

CON: An Ineffective Influence. Certificate of need likely did meet some of its original objectives in the early years of the program, but IMS believes, in the long run that the CON program had little to do with Iowa's success in lowering health care costs. Health care providers and community leaders responded with creativity and focus to difficult, sometimes unconscionable, changes in reimbursement and to the pressures of managed care and other payment and delivery system incentives. CON was not and is not a significant regulatory factor in lowering health care costs in this state. The narrowed focus of the 1997 law makes it even less so.

The time has come for repeal of CON. Quite frankly, it is long overdue.

Focus of CON Review – the Consumer, Not the Competitor

The General Assembly, in adopting Iowa's CON law in 1977, made it clear that this regulatory mechanism was put into place to protect the public, not providers of health care services. "Health care is a right of the *people*...rising hospital and health care facility costs may place the services of these facilities beyond the means of a majority of the *people*." [Emphasis added] This legislative policy statement is consistent with federal and state laws governing competition.

Competition in the marketplace is a fundamental premise of American economics. The antitrust laws are regulatory mechanisms designed to assure a competitive marketplace. Those laws were adopted to protect competition, *not* competitors. "Antitrust legislation is concerned primarily with the health of the competitive process, not with the individual competitor who must sink or swim in competitive enterprise." *Janich Bros., Inc. v. American Distilling Co.*, 570 F.2d 848, 855 (9th Cir. 1977), *cert. denied* 439 U.S. 829 (1978).

Similarly, CON laws were developed to assure access by health care consumers to quality, cost effective health care services through a regulatory mechanism premised on the belief that ordinary competitive forces simply were not at work in the health care marketplace. *Never*, however, have CON laws sought to protect the interests of one health care provider group over the interests of another.

If, indeed, the purpose and intent of the CON law in Iowa has changed, the debate must center on the merits of the new purpose and the General Assembly needs to newly announce as such. The merits of the law, then, must be argued and justified – both from a public policy point of view and constitutional point of view – on the basis of new findings of fact and policy conclusions.

Iowa's CON Law – An Uneven Playing Field

The 1997 amendments to Iowa's CON law significantly narrowed the scope of CON review. At the same time, a preference was created in favor of those providers already in the marketplace by allowing them to avoid CON review while new entrants into the marketplace remain subject to review. In nearly all instances, the protected provider group is hospitals; in nearly all instances, the new entrant that must undergo CON scrutiny is physicians. The 1996 report to the General Assembly recognized this result:

> [T]he Department should review areas where one entity is not subject to review for a particular service, but other entities would be subject to review for that service. The committee's wish is to create a level playing field.

Annual Report (July 1, 1995-June 30, 1996) of the Certificate of Need Program to the Governor and General Assembly, January 1997. *See also Iowa Health Regulation Task Force Final Report*, Appendix E, p. 10 (December 1996).

At the outset, IMS emphasizes its belief that the merits of the CON law should not come down to a battle between hospitals and physicians. Both health care provider groups are critical components of a high quality, efficient, and accessible health care system. No hospital can exist without a medical staff to support it and no physician can effectively practice without the hospital. Both are essential to the economic development efforts of local communities. And both physicians and hospitals have suffered significant financial and other blows that present tremendous challenges in the practice of modern medicine.

At the same time, no law should give preferential treatment to one group within a class over another, especially in an open marketplace. IMS' reason for raising the "uneven playing field" issue is four-fold: 1) the CON law as currently structured creates wedges and encourages divisiveness and power struggles between and among health care providers who need each other to best serve the people of Iowa; 2) a preference in law for existing providers, be they physicians, hospitals, or any other provider group, discourages innovation, negotiation, and new efficiencies to better serve the consumer/public; 3) if the original purpose of the CON law, namely to

control escalating health care costs, is not met by it, then uneven regulation among similarly-situated health care providers is constitutionally impermissible and patently poor public policy; and 4) the 1996 report says this issue should be addressed.

IMS believes that the uneven playing field is particularly marked in two areas of review: 1) reviews of new equipment resulting in the development or offering of a new service and 2) escape from review where an otherwise reviewable project is classified as a renovation or a replacement by an existing health care facility that does not result in the offering or development of a new service or the addition of new beds. The first, relating to equipment purchases, has long been in the law and appears to have been the subject of little debate. Question is fairly asked, however, why review of a major (over $1 million) purchase of equipment is not helpful to the health care system when the purchase is made by an entity already offering the service but is important to the overall system if a new entrant in the service seeks to purchase the equipment? This issue, likely because of the high review threshold (which IMS does not dispute), has not been a source of concern.

Of great concern, however, is the inequity in review responsibilities with respect to outpatient surgery centers. By definition, an outpatient surgical facility is subject to CON review as a new or changed institutional health service. §§ 135.61(18)(a), 135.61(14(d), 136.61(21). No distinction between or among providers that develop an outpatient surgery center exists on the face of the definitions that come into play. However, § 135.63(2)(l), added by the 1997 General Assembly, provides an exception to CON review for the replacement or modernization of any institutional health facility if the replacement or modernization does not result in a new health service or does not add beds. Hospitals (or other existing providers) which already offer outpatient surgery services and have outpatient surgery suites can bypass review altogether if the cost of the proposed outpatient surgery center does not exceed the § 135/61(18)(c)capital threshold of $1.5 million *regardless* of the location of the outpatient surgical center so long as it operates under the hospital's license. Physicians (or other new entrants), however, are subject to review for establishing a new institutional health facility under § 135.61(18)(a) *regardless* of the cost associated with establishing the outpatient surgical center.

Clearly the law has lost sight of its original purpose and has begun to act in ways that were never intended and, more importantly, are not in the best interest of the consumer of health care services. Protecting the economic welfare and assuring the continued marketplace viability of one competitor over another is not, and should not be, the intent or effect of the law. This is particularly so where it can be established that the potential marketplace entrants offer quality, accessible, efficient, convenient, and lower cost health care services – more akin to the original purpose

of the CON law and its existing criteria for review (i.e., "less costly, more efficient, more appropriate alternatives," §135.64(2)(a)).

The focus of the CON debate must remain with its original purpose. Does it control costs? What is best for the health care consumer? Marketplace pressures can challenge competitors to compete on quality and service, something the consumer benefits from. Shielding existing players from competition is not a legitimate goal of the CON law or state regulation.

Arguments Against CON Deregulation – Some Responses

Many fair arguments will be raised in the course of the debate on continued existence of Iowa's CON law. Sometimes honest questions will be posed for which answers may not be readily available. This testimony does not pretend to know all of the issues nor does it offer an exhaustive analysis on any or all of them. The task force process is designed to do that.

Below, however, are some identified issues and initial responsive points relevant to the issue of repeal of the Iowa CON program.

- *Argument: Repeal of Iowa's CON law will result in an unbridled proliferation of health care services and a medical equipment arms race.*

Some states, in repealing their CON statutes, experienced an initial flurry of activity in certain areas. The timing of each state's repeal (many in the 1980s); the regulatory environment in existence at that time in that state; whether stabilization ultimately occurred; and other factors must be examined to determine whether a similar fate can be expected in Iowa.

A 1998 published analysis of the impact of repeal of state CON laws concluded that there is no evidence of a surge in acquisition of facilities, including ambulatory surgery facilities, or in costs following removal of CON regulations. (*Conover, supra* at 456, 457-458, 463, 466, 469). "Further, we have found no evidence of increased cost in the 12 states that repealed their CON programs." There was an expansion in services, however "these results cannot be used to predict the potential consequences of repeal in other states since the regulatory, market and other circumstances in each state are unique." Mendelson, *supra.*

No source could be found that specifically addressed the impact on repeal of CON on medical equipment acquisition but if such purchases had been great enough to impact cost to the system overall, such results should have revealed themselves in the course of general findings. More importantly, under Iowa's current CON law, only

the most expensive medical equipment is now reviewed and only if it results in the offering of a new service. It is unlikely that repeal of CON would wreak significant negative repercussions in a low-cost health care state like Iowa.

- *Argument: Repeal of CON will place Iowa's already beleaguered small community hospitals in greater financial jeopardy.*

IMS is aware of and sympathetic to the financial and operational challenges of Iowa's small community hospitals. Reimbursement and other marketplace incentives have led to a tremendous shift of services from the inpatient to the outpatient setting. IMS also recognizes that hospitals – like *all* health care providers – are subject to an array of major regulatory and environmental challenges: government and third party reimbursement that does not keep up with costs; unreasonable regulatory and payor demands; overly broad regulatory interpretations of laws; and increasing numbers of uninsured who need and should have health care. At the same time, IMS recognizes that ambulatory surgery centers – which seem to be the source of greatest concern to the hospital community – have a proven track record of success in quality, efficiency, convenience, cost effectiveness, and very high patient satisfaction.

IMS is unaware of any state of facts where equal treatment for review purposes under CON or repeal of CON altogether has resulted in the failure of rural or urban hospitals. IMS believes that a closer examination of the review history of the Iowa CON program, particularly since implementation of the 1997 amendments, reveals that competition among hospital-based and free-standing outpatient surgery centers is not a rural hospital issue. Except in the area of long-term care, CON now appears to have little relevance in rural Iowa.

Empirical studies indicate that repeal of CON has little, *long-term* impact upon the existing health care system, just as CON has had little impact over its 20+ years of existence on lowering health care costs. Conclusions include: CON programs have had no detectable effect on diffusion of various hospital-based technologies; it cannot be established that CON has had a measurable impact upon quality of care, positive or negative; there is little empirical evidence to say that CON has improved access. (Conover, "Does Removing Certificate of Need Regulations Lead to a Surge in Health Care Spending," *supra.)* Indeed, all hospitals and other existing health care providers might take some comfort in the fact that the very ineffectiveness of the CON program speaks to the likelihood that little will occur that can harm them upon its repeal.

Physicians and hospitals in rural communities generally have high incentive to work out differences and to cooperate in the provision of health care services. Iowa is a low-cost health care state that is spread out in geography and population. High

financial risk means that a provider or group of providers will not enter this market absent a preliminary analysis of a likelihood of success. A patient population of sufficient size would be necessary to justify expansion of independent outpatient surgical facilities in rural Iowa. IMS believes that such activity is highly unlikely to occur with repeal of CON.

- *Argument: CON laws remain as relevant and effective in the current marketplace environment of managed competition and new payment methodologies as in the fee-for-service marketplace environment of the late 1970s/early 1980s, especially in a state like Iowa where the penetration of managed care is relatively low.*

Probably all parties in this debate would agree that the health care marketplace today is noticeably different than when the Iowa CON law was originally adopted. The underlying purposes of CON were developed in a fee-for-service marketplace, a significant difference in all health care marketplaces today, even in Iowa. Furthermore, managed care in a range of forms, not just traditional HMOs, is a fact of life in all health care sectors, although less so in Iowa's rural communities.

The tide of rising health care costs has been impacted primarily by changing reimbursement methodologies and managed care-like delivery of health care services. Continued existence of CON laws arguably impedes the positive marketplace results of managed competition. Managed competition can continue to be effective only in active, competitive markets; CON laws will continue to raise health care costs by restricting the entry of cost-effective providers into the market. "Managed care competition is doomed to failure unless CON laws are repealed or dramatically scaled back.... The critical factor of managed competition is that market forces, and not regulatory forces, determine the cost of health care." (*McGinley, supra* at 161, 163). *See also,* Hackey, R., "New Wine in Old Bottles: Certificate of Need Enters the 1990s," 18 *Journal of Health Politics, Policy and Law* at 927 (Winter 1993) "CON's limitation as a cost control strategy is related to 'lack of competition for a limited pool of resources'.")

Relative to changing reimbursement mechanisms, the marked move away from fee-for-service clearly has made a difference in the need for CON statutes. As one commentator notes:

> "The concept of CON review was developed at a time when many public and private health coverage payment plans such as Medicare, Medicaid and Blue Cross based reimbursement on the "reasonable cost" method, under which a provider typically could receive full reimbursement of its reasonable costs. The recent trend, however, has been away from reasonable cost reimbursement and towards

> prospective (pre-set) payment amounts for specific diagnoses which place the financial risk of excessive expenditures upon the provider, not the insurer. Consequently, a decision made by a health facility to make capital expenditures or make changes in its services will be based on hard economic decisions as to whether the expenditure is justified. Thus, the CON process is superfluous in the new reimbursement environment.

Shannon, M., "Where It Has Been And Where It Is Going," *Michigan Bar Journal* 593, 595 (July 1988). The market place has changed in ways that allow effective competition in health care and that adequately guards against undue proliferation of services that otherwise might lead to unwarranted costs to the system.

Community Health Planning – Where Has It Gone?

CON legislation and other health planning laws were two-fold in their regulatory impact: 1) the actual regulatory review and 2) community involvement in developing health plans. This latter side of CON law activity has long been abandoned. Certainly, the very limited scope of current review cannot be said to be an effective planning tool in and of itself. IMS has many concerns with the operational impacts of managed care. Retaining CON, however, will do nothing to address those concerns. Managed care is a marketplace reality. CON advances neither its original purposes nor the current marketplace incentives.

Whether community health planning should be reinstituted in some shape or form is a question that IMS is not prepared to answer. IMS notes this facet of the early law to highlight yet another way in which the original intent and value of Iowa's CON law has long been lost.

Conclusion

Iowa's certificate of need (CON) law should be repealed. No state of facts can be found to show that its original purpose has been and continues to be met. The law no longer serves a beneficial public purpose. Marketplace governors are in place to protect against those concerns CON was originally designed to address. Rather, CON fosters divisiveness, encourages good providers to leave this state, and prolongs an archaic regulatory system in a time when creativity and cooperation are called for. Iowa's support for its hospital/health care system is far better lent to positive, dynamic, patient-centered initiatives focused on the needs and hopes of the future, not the ways and fears of the past.

ATTACHMENT E

Association of Iowa Hospitals & Health Systems

June 29, 1999 Presentation

Highlights from Presentation to CON Task Force
June 29, 1999
Greg Boattenhamer
Association of Iowa Hospitals & Health Systems

- Iowa hospital environment is unique; all hospitals are not-for-profit.
- Community focused institutions; approximately ½ are publicly governed (41 are county hospitals receiving local property tax support).
- Iowa's CON law supports community health focus through planning and prevention of unnecessary duplication of health care services.
- Those who would repeal CON point to "free market" competition. Investor owned facilities and ambulatory surgical centers don't " compete" with hospitals for charity care, 24-hour-a-day emergency room service, Medicare/Medicaid shortfalls, or to other services hospitals provide to the community at a dollar loss.
- CON does not in itself prevent the development of investor owned facilities; they simply must demonstrate community need.
- CON repeal would not equate to lower health care costs. Consumers don't spend personal dollars like they do when buying a car. "Savings" go to insurance carriers or business. When positive margin areas (outpatient surgery, heart procedures) taken out of hospital setting, hospitals have to raise charges, taxes to make up shortfalls. System costs don't go down.
- Recognition that Iowa's CON laws are among the least restrictive in the country. Modifications made in 1997 responded to needed change in the program, no further revisions are necessary at this time.
- Most other states have some form of CON; those who have repealed it are attempting to put something back in its place.
- Originally designed to prevent health care "arms races". Still provides framework for health planning.
- No one will ever know full effect of CON on health care costs and services given that it is impossible to determine what Iowa's health care environment would look like after 20 years without CON.
- IH&HS has reviewed CON process several times in last 3 years, beginning with Governor's Health Regulation Task Force in 1996, with last analysis completed last month.

- South Dakota, Nebraska seeing a proliferation of services (Spearfish, SD, for example). Communities of 10,000-20,000 population are most affected.

- Question of long-term commitment of investor owned facilities to local markets and survival rates of new businesses.

- Most primary care physicians rely on local community hospitals to provide equipment and services to help them care for patients in the best possible manner. Repeal of CON would only benefit a small fraction of physician specialists who have the capital reserves or backing to develop competing investor owned facilities.

- Analysis done in 1996-1997 called for a review given "market force" changes. Expectation was that managed care would be much more pronounced than it has become. States with a truly captivated managed care payment system control provider development. Iowa does not have that. It is apparent that low reimbursement levels and other factors will prevent the development of managed care system-wide in Iowa in the near future. (Medicare managed care example).

- Eliminating CON would expand border concerns (i.e., Sioux City) to rest of state.

- Detrimental to a community-focused hospital system already looking at $600 million in Medicare losses in next four years.

- Fundamental question would be Iowa's need/desire to change the structure of how health care is delivered in our state, removing service resources from community institutions and potentially eroding access to services across the state.

- IH&HS maintains the Iowa CON law continues to serve the public good and has no "flaws".

Association of Iowa Hospitals & Health Systems

October 20, 1999 Presentation

Association of Iowa Hospitals & Health Systems
CON Task Force Presentation 10-20-99

Retention of CON

- Relatively easy to predict because it would preserve changes made in 1997. These changes retained what was best about CON for the support of community-focused health care delivery in Iowa, while making our program one of the least restrictive CON programs in the nation.
- CON is still relevant for Iowa, particularly as it revolves around some core high-tech services being provided by community hospitals and other providers.
- If Iowa retains CON with no changes:
  - We KNOW we have a program which insures community input in health planning;
  - We KNOW we have a program which works to prevent unnecessary duplication of health care services.
  - We KNOW we have a program that promotes collaboration between provider groups.
  - We KNOW there is nothing in the CON statute that prevents new services from entering the Iowa health care marketplace.

Repeal of CON

- Some would claim that we cannot know the future and that CON repeal has had varying degree of impact in other states. However, we can be certain of some things if CON were to be repealed or significantly modified:
- We KNOW the impact would be significant in Iowa because of the failure of captitated managed care systems to develop in our state. We KNOW managed care has not evolved in any meaningful way in Iowa, nor is it likely to in the future.
- We KNOW CON repeal would mean increased health care infrastructure. As stated in the January 1999 State of Washington study, "CON repeal has resulted in significant supply surges...such as psychiatric and nursing homes in Utah, nursing homes and open heart surgery in Arizona, home health agencies in Tennessee, and hospitals, ambulatory surgery centers, dialysis, and pediatric services in Ohio." We KNOW there are nearly 20 ambulatory surgical centers under development in Nebraska since that state fully repealed CON earlier this year and that there have been four new specialty

hospitals opened in South Dakota since 1997, with others in the planning stages.

- We KNOW CON repeal would mean investor-owned "cherry picking" of selected services from Iowa's community hospitals, leaving those institutions with little resources to support charity care, government shortfalls, maintenance of emergency rooms, or other services provided to the community at a dollar loss.
- We KNOW that if CON were repealed that the Iowa Legislature would be forced to reconsider this decision in a very short time—because where CON has been repealed, we KNOW that there have been significant efforts in those states to reestablish CON principles.
- We KNOW that CON repeal would not lower health care costs to consumers because it hasn't had that effect anyplace else.
- We KNOW that CON repeal would result in less incentive for health care providers to cooperate and would create more incentive for health care "arms races" to develop.
- We KNOW that CON repeal is indeed a rural issue, with significant negative implications for the delivery of rural health care services in Iowa.
- We KNOW without a doubt that CON repeal would result in significant economic harm to Iowa's community-based hospitals.
- We KNOW that CON repeal would have no positive impact for the delivery of overall health services to Iowans.

NEBRASKA ASSOCIATION OF
HOSPITALS AND HEALTH SYSTEMS

September 14, 1999

Stephen F. Brenton
President
Association of Iowa Hospitals & Health Systems
100 East Grand Avenue, Suite 100
Des Moines, Iowa 50309-1835

Dear Steve,

Since the full repeal of Nebraska's certificate of need (CON) statutes, we are seeing a proliferation of ambulatory surgical center development throughout the state, including much of rural Nebraska. This development includes more that a dozen investor-owned facilities that are either now open, under construction, or in the planning stage as well as some hospital-based expansions that are in direct response to the investor-owned activity.

Many of our members are concerned about "cherry picking," i.e., that investor-owned ambulatory surgical centers will direct the better-reimbursed portion of the patient mix away from community focused, nonprofit hospitals, leaving them with only the Medicare-sponsored, Medicaid-sponsored and indigent patients. For example, no one is interested in developing emergency service capabilities in rural Nebraska, but there appears to be plenty of capital available for the construction of outpatient surgical facilities, of which current capacity is more than adequate.

The Nebraska Association of Hospitals and Health Systems and its members are quite concerned about the potential long-term consequences of the CON repeal upon the State's fragile health care delivery system. Currently, our Association is reviewing and evaluating potential legislative and regulatory remedies to seek a "level playing field" as a response to these recent developments.

Sincerely,

Harlan M. Heald
President

South Dakota
Association of Healthcare Organizations

September 27, 1999

Stephen F. Brenton, President
Association of Iowa Hospitals and Health Systems
100 E. Grand Avenue, Suite 100
Des Moines, IA 50309-1835

Dear Steve:

I am writing to update you on the changing health care landscape in South Dakota since the state failed to enact a moratorium on "specialty hospitals" in 1997.

In 1997 this Association aggressively pursued passage of legislation that would have placed a moratorium on the building of new specialty hospital beds. The bill passed the South Dakota State Legislature but was vetoed by the Governor. The Legislature failed to override that veto by a single vote.

Since that legislative effort, at least four specialty hospitals have been developed in Sioux Falls, Dakota Dunes, Aberdeen and Rapid City. An additional facility is contemplated for Spearfish.

As we have discussed previously, the development of these facilities has created a new and challenging environment for health care providers. Competitive forces have certainly been accentuated in those communities where these specialty hospitals have been built. I expect this policy direction for the state will continue to shape the health care landscape as well as the political discourse of South Dakota for years to come.

Sincerely,

Dave

Dave Hewett
President/CEO

DRH/mla

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Iowa Medical Society

October 20, 1999 Presentation

IOWA MEDICAL SOCIETY

REMARKS BEFORE THE DEPARTMENT OF HEALTH'S CERTIFICATE OF NEED TASK FORCE

October 20, 1999

In 1977, the Iowa General Assembly explained its new CON law:

WHEREAS, it is the public policy of this state that the offering or development of new institutional health services be accomplished in a manner which is orderly, economical and consistent with the goal of providing the necessary and adequate institutional health services to all of the people of this state while avoiding unnecessary duplication of institutional health services and preventing or controlling increases in the cost of delivering those services; and

WHEREAS, it is further the public policy of this state that health care is a right of the people, but the general assembly finds and declares (1) that rising hospital and health facility costs may place the services of these facilities beyond the means of the majority of the people of this state; (2) that is it therefore essential that the general assembly, the governor and the people of the state have access to uniform, timely and accurate data on the costs incurred and the charges established by hospitals and health care facilities; and (3) that a statute should be enacted to provide for uniform systems of reporting by hospitals and health care facilities in this state and for regular compilation, analysis and reporting of financial data relative to hospitals and health care facilities within this state.

67 Iowa Acts chapter 75 (1977)

In 1997, twenty (20) years later, the Iowa General Assembly directed as follows:

The Iowa department of public health shall complete a comprehensive review of the certificate of need program and shall submit a written report of the findings and recommendations as to the continued relevance of the program to the general assembly by January 15, 2000.

77 Iowa Acts chapter 93 §11 (1997)

INTRODUCTION

THE IOWA MEDICAL SOCIETY'S POSITION REGARDING THE IOWA CERTIFICATE OF NEED LAW IS CLEAR: THE LAW HAS OUTLIVED ITS ORIGINAL PURPOSES AND SHOULD BE REPEALED. WE BELIEVE THAT THE EVIDENCE WE PLACED BEFORE THIS TASK FORCE IN OUR AUGUST TESTIMONY SUPPORTS OUR POSITION. WE BELIEVE NO COGENT EVIDENCE HAS BEEN PRESENTED TO SUPPORT A CONTRARY VIEW.

TO KEEP OR NOT TO KEEP CON – AN IMPACT ANALYSIS

THE IOWA MEDICAL SOCIETY ARGUES FOR REPEAL OF CON BECAUSE WE BELIEVE THAT IS THE BETTER POLICY POSITION FOR THIS STATE. A CONTROVERSIAL POLICY DEBATE THAT CALLS FOR CHANGE MERITS A DISCUSSION OF THE LIKELY IMPACT OF THAT CHANGE UPON AFFECTED INTERESTS. WE BELIEVE THAT THE "VISION" REMARKS WE HAVE BEEN ASKED TO MAKE TODAY ESSENTIALL CALL FOR AN "IMPACT" ANALYSIS.

AN ANALYSIS OF THE "ENVIRONMENTAL IMPACT" OF RETAINING OR REPEALING CON STARTS WITH THE CON LAW ITSELF. CONSEQUENTLY, OUR TESTIMONY WILL:

1. IDENTIFY THREE MAJOR AREAS OF PROJECT REVIEW UNDER THE CURRENT CON LAW;
2. DESCRIBE THE PRACTICAL IMPACT OF EACH AREA OF REVIEW ON THE HEALTH CARE MARKET PLACE TODAY;
3. ADDRESS WHETHER THIS AREA OF REVIEW HONORS THE ORIGINAL PURPOSES OF THE CON LAW;
4. ASSESS THE LIKELY IMPACT OF RETAINING CON REVIEW FOR THESE PROJECTS; AND
5. ASSESS THE LIKELY IMPACT OF REPEALING CON REVIEW FOR THESE PROJECTS.

BRIEF BACKGROUND

THE "GUTS" OF THE CON LAW IS § 135.63(1), WHICH STATES IN PERTINENT PART:

> **A NEW INSTITUTIONAL HEALTH SERVICE OR CHANGED INSTITUTIONAL HEALTH SERVICE SHALL NOT BE OFFERED OR DEVELOPED IN THIS STATE WITHOUT PRIOR APPLICATION TO THE DEPARTMENT FOR AND RECEIPT OF A CERTIFICATE OF NEED... .**

A "NEW OR CHANGED INSTITUTIONAL HEALTH SERVICE" IS A TERM OF ART DEFINED IN THE LAW ITSELF. THESE ARE THE PROJECTS THAT ARE "REVIEWABLE" UNDER THE LAW. A PERSON THAT STARTS A "REVIEWABLE" PROJECT WITHOUT FIRST RECEIVING A CERTIFICATE OF NEED IS SUBJECT TO THE SANCTIONS.

A. NEW FACILITIES – IS THERE "PENT-UP" GROWTH?

THE CONSTRUCTION, DEVELOPMENT OR OTHER ESTABLISHMENT OF A NEW HOSPITAL, NURSING FACILITY, ORGANIZED OUTPATIENT HEALTH FACILITY, OR AN OUTPAITENT SURGICAL FACILITY IS SUBJECT TO CON REVIEW. UNDER THE 1997 AMENDMENTS, HOWEVER, THE REPLACEMENT OR MODERNIZATION OF ONE OF THESE EXISTING FACILITIES IS EXEMPT FROM REVIEW EVEN IF THE ENTIRE FACILITY IS REPLACED AND REGARDLESS OF COST SO LONG AS ADDITIONAL BEDS OR NEW SERVICES ARE NOT OFFERED. THE 1997 EXCEPTION HAS BEEN THE BASIS FOR ALLOWING HOSPITAL-BASED SURGERY CENTERS TO EXPAND EVEN WHEN OFFERED OFF-SITE FROM THE HOSPITAL.

1) PRACTICAL IMPACT OF THIS REVIEWABILITY PROVISION AND ITS EXCEPTION.

- EXISTING FACILITIES CAN TOTALLY REPLACE THEMSELVES WITHOUT ANY EXAMINATION BY THE STATE. IT DOES NOT MATTER WHETHER THE FACILITY IS NEEDED, IS COST EFFECTIVE, PROVIDES QUALITY SERVICES, MEETS PATIENT NEEDS, IS THE BEST OR WORST ALTERNATIVE AVAILABLE, OR ANY OTHER FACTOR THAT COMES INTO PLAY UNDER A CON ANALYSIS.

- ON THE OTHER HAND, NEW FACILITIES MUST HAVE PERMISSION FROM THE STATE TO ENTER THE MARKET PLACE. THEY MUST OVERCOME THE STATUTORY BURDEN OF PROVING THEIR NEED AND ESTABLISHING THEIR COST-EFFECTIVENESS, QUALITY, AND OTHER FACTORS OF CON REVIEW. THE NEW ENTRANT MAY BE THE HIGHEST QUALITY, LOWEST COST, MOST CUSTOMER-FOCUSED OPTION AVAILABLE TO THE COMMUNITY, BUT THAT NEW ENTRANT MUST INCUR HIGH COSTS AND EXPEND SIGNIFICANT TIME TO SEEK PERMISSION TO ENTER THE MARKET. FRANKLY, UNDER THE CURRENT LAW, CHANCES ARE VERY HIGH THAT THE NEW ENTRANT WILL NOT BE APPROVED BECAUSE OF EXISTING PLAYERS IN THE MARKET.

2) IS THIS REVIEWABILITY PROVISION CONSISTENT WITH THE ORIGINAL PURPOSES OF THE LAW?

THE "UNIVERSE" OF REVIEW FOR NEW HEALTH FACILITY CONSTRUCTION HAS SHRUNK CONSIDERABLY WITH THE 1997 CHANGES. IN THAT REGARD, THE POLICY OF THE CON LAW SEEMS TO HAVE SHIFTED FROM ASSURING AN "ORDERLY, ECONOMICAL AND CONSISTENT" DEVELOPMENT OF NEW CONSTRUCTION TO "FRANCHISING" EXISTING PROVIDERS AND PROTECTING THEM AGAINST NEW ENTRANTS INTO THE FIELD.

3) **LIKELY IMPACT IN THIS AREA IF CON IS RETAINED?**

- NEW ENTRANTS WILL BE DISCOURAGED FROM DEVELOPING IN IOWA; THEY MAY TAKE THEIR BUSINESS ACROSS IOWA'S BORDERS AND SERVE IOWA PATIENTS THERE.

- NEW ENTRANTS THAT PURSUE CON REVIEW WILL CONTINUE TO PAY CONSIDERABLE DOLLARS AND EXPEND CONSIDERABLE AMOUNTS OF TIME AND RESOURCES ON THE CON PROCESS.

- CONSUMERS WILL BE DENIED ACCESS TO OTHER HEALTH CARE OPTIONS WHICH ARE MORE EFFICIENT, LOWER-IN-COST, HIGHER IN QUALITY, AND VERY HIGH IN CUSTOMER SATISFACTION. WE BELIEVE THIS IS PARTICULARLY THE CASE WITH FREESTANDING AMBULATORY SURGERY CENTERS, OFTEN NOTED AS THE WAY OF THE FUTURE IN HEALTH CARE DELIVERY.

- EXISTING PROVIDERS REMAIN SHIELDED FROM NEW COMPETITION. THE CON LAW PROVIDES NO INCENTIVE FOR IMPROVEMENT OR CHANGE. EXISTING PROVIDERS GROW AND IMPROVE ON THEIR OWN TERMS.

- EXISTING PROVIDERS MAINTAIN A NEGOTIATION EDGE. CON PROVIDES LITTLE INCENTIVE FOR AN EXISTING FACILITY TO COOPERATE OR NEGOTIATE WITH OTHER HEALTH CARE PROVIDERS TO OFFER NEW PROJECTS AND/OR TO RESPOND TO CONSUMER DEMANDS IN A MORE EFFECTIVE, LOW-COST WAY.

4) **LIKELY IMPACT IN THIS AREA IF CON IS REPEALED?**

- EXISTING PROVIDERS WILL CONTINUE TO BUILD NEW PLANTS BUT ALSO COULD – AND WILL -- ADD NEW BEDS AND SERVICES.

- NEW ENTRANTS CAN – AND WILL -- ENTER THE MARKET PLACE.

- NO EMPIRICAL EVIDENCE HAS BEEN FOUND TO SAY THAT SUCH NEW EXPECTED ACTIVITY RESULTS IN NEW, UNCONTROLED COSTS TO THE HEALTH CARE DELIVERY SYSTEM.

- THE MOST LIKELY IMMEDIATE AREA OF NEW ENTRANT ACTIVITY WILL BE FREE-STANDING AMBULATORY SURGERY CENTERS AND, POSSIBLY, LONG-TERM CARE FACILITIES. GROWTH WILL PRIMARILY COME FROM WITHIN IOWA.

- CONTROLS OTHER THAN CON WILL PROTECT AGAINST UNBRIDLED GROWTH AND UNNECESSARY DUPLICATION OF HEALTH FACILITIES. NO NEW VENTURE WANTS TO FAIL.

- MEDICARE AND MEDICAID CERTIFICATION REQUIREMENTS, THIRD PARTY CONTRACT STANDARDS, AND, WHERE APPLICABLE, LICENSING STANDARDS WILL ASSURE THE REQUISITE LEVEL OF QUALITY CARE.

- CURRENT FIXED PAYMENT SYSTEMS MAKE IT IMPERATIVE THAT NO FACILITY, EXISTING OR OTHERWISE, EMBARK UPON A MAJOR CONSTRUCTION PROJECT ABSENT A FINANCIAL AND MARKET ANALYSIS ASSESSING ITS ABILITY TO RECOUP ITS EXPENSES OVER TIME AND TO ASSURE THE OVERALL SUCCESS OF ITS VENTURE. AGAIN, IT IS A RARE PARTY THAT ELECTS TO ENTER A NON-VIABLE MARKETPLACE. SOME NEW ENTRANTS MAY BELIEVE THAT THEY CAN STRUCTURE A SUCCESSFUL, ECONOMICAL, QUALITY PROGRAM OF CARE THAT EXISTING FACILITIES TO DATE HAVE NOT BEEN SUCCESSFUL IN DOING; THEY MAY TAKE CERTAIN FINANCIAL RISKS BECAUSE OF THEIR VISION FOR LONG-TERM SUCCESS. MORE POWER TO THEM. SUCH IS THE STRENGTH OF AN OPEN, COMPETITIVE MARKET PLACE.

- A ONE-TIME, "YES OR NO" REVIEW BY FIVE (5) CONSUMERS WITH LIMITED JURISDICTION OVER PROJECTS COMING BEFORE THEM HAS LITTLE TO DO WITH CONTROLLING COSTS OR UNNECESSARY GROWTH NOR IN ASSURING QUALITY AND ACCESSIBILILITY. CURRENT FACTORS IN THE HEALTH CARE SYSTEM GO FARTHER AND ARE MORE EFFECTIVE IN ASSURING THESE OUTCOMES THAN DOES AN EXPENSIVE, ONE-TIME CON REVIEW PROCESS.

- THE BARGAINING POSITION BETWEEN PARTIES, NOW UNEQUAL UNDER THE CON, LAW WOULD ENCOURAGE PERMISSIBLE NEGOTIATIONS AND REACH REASONABLE RESOLUTIONS REGARDING NEW HEALTH CARE VENTURES TO BE OFFERED IN THE COMMUNITY.

- INITIAL NEW GROWTH WILL BE GREATER IMMEDIATELY AFTER REPEAL OF CON BUT IT WILL THEN STABILIZE. THAT NEW GROWTH WILL PRIMARILY OCCUR IN COMPETITIVE HEALTH CARE MARKETS.

- AN EXISTING FACILITY MAY NEED TO READJUST CURRENT SERVICE OFFERINGS. AS IS THE CASE NOW, WITH CON IN PLACE, AN EXISTING FACILITY MAY FAIL. NEW ENTRANTS THEMSELVES MAY FAIL IT WOULD BE PATENTLY UNFAIR, HOWEVER, TO ASCRIBE SUCH FAILURE SOLELY TO COMPETITION RESULTING FROM REPEAL OF CON. A HOST OF ENVIRONMENTAL FACTORS WOULD COME INTO PLAY.

- NO EMPIRICAL EVIDENCE HAS EVER BEEN PRESENTED TO ESTABLISH THAT REPEAL OF CON RESULTED IN LONG-TERM NEGATIVE REPERCUSSIONS ON A STATE'S HEALTH CARE DELIVERY SYSTEM. THE 1998 CONOVER STUDY OF 12 STATES THAT REPEALED CON (MADE A MATTER OF RECORD BEFORE THIS TASK FORCE) FOUND NO EVIDENCE OF AN UNBRIDLED SURGE IN ACQUISTION OF FACILITIES, INCLUDING AMBULATORY SURGERY CENTERS, AFTER REPEAL OF CON.

- THE HEALTH CARE MARKET PLACE IS DYNAMIC NOW AND WOULD REMAIN SO AFTER REPEAL OF CON. EXISTING AND NEW FACILITIES WILL CONTINUE TO BE CHALLENGED BY TOUGH ENVIRONMENTAL FACTORS INHERENT IN THE CURRENT HEALTH CARE DELIVERY SYSTEM.

- CONSUMERS AND PAYORS OF HEALTH CARE CAN EXPECT TO HAVE ADDITIONAL COST-EFFECTIVE, QUALITY HEALTH CARE OPTIONS AVAILABLE TO THEM.

- NEW OPTIONS GENERALLY ASSURE GREATER ACCESSIBILITY TO HEALTH CARE SERVICES.

B. MEDICAL EQUIPMENT – A "MEDICAL EQUIPMENT ARMS RACE"?

THE CURRENT CON LAW REQUIRES REVIEW OF THE PURCHASE OR REPLACEMENT OF A PIECE OF EQUIPMENT WITH A VALUE IN EXCESS OF $1.5 MILLION. ACQUISITIONS OF NEW EQUIPMENT ARE REVIEWABLE ONLY IF THE PURCHASE OF THE EQUIPMENT RESULTS IN THE OFFERING OF A HEALTH SERVICE NOT PREVIOUSLY PROVIDED.

1) THE PRACTICAL IMPACT OF THIS REVIEWABILITY PROVISION.

EQUIPMENT REVIEWS UNDER CON HAVE BEEN NARROWED BECAUSE OF THE SIGNIFICANT INCREASE IN THE MONETARY THRESHOLDS.

2) IS THIS REVIEWABILITY PROVISION CONSISTENT WITH THE ORIGINAL PURPOSES OF THE LAW?

AGAIN, THE UNIVERSE OF REVIEW HAS SHRUNK. ONE OF THE ORIGINAL PURPOSES OF THE LAW IS CONTROL COSTS BY AVOIDING UNNECESSARY DUPLICATION OF HEALTH SERVICES. MEDICAL EQUIPMENT REVIEWS HAVE ALWAYS BEEN A PART OF THE CON LAW.

3) LIKELY IMPACT ON THIS REVIEW AREA IF CON IS RETAINED?

THIS DOES NOT APPEAR TO BE AN AREA OF SIGNIFICANT CONCERN.

4) **LIKELY IMPACT ON THIS REVIEW ARE IF CON IS REPEALED?**

- NO EMPIRICAL EVIDENCE EXISTS TO ESTABLISH THAT REPEAL OF CON RESULTS IN A "MEDICAL EQUIPMENT ARMS RACE" THAT THE HEALTH CARE SYSTEM CANNOT HANDLE. EXPERIENCES IN OTHER STATES MUST BE EVALUATED IN LIGHT OF WHAT THEIR CON LAWS ACTUALLY REQUIRED PRIOR TO REVIEW AND OTHER DEMOGRAPHICS.

- BECAUSE THE REVIEW THRESHOLDS IN IOWA ARE HIGH, UNFETTERED PROLIFERATION OF NEW MEDICAL EQUIPMENT IS NOT LIKELY.

- CONTROLS ARE INHERENT IN THE HIGH COST OF THE EQUIPMENT: PURCHASERS WILL WANT TO ASSURE THAT THE EQUIPMENT ACQUISTION MAKES GOOD BUSINESS SENSE.

- MEDICAL LIABILITY CONCERNS WILL SERVE TO PROTECT EQUIPMENT PURCHASES WHERE AN INSUFFICIENT PATIENT BASE EXISTS TO SUPPORT ITS USE. SUFFICIENT REPEATED USE IS NECESSARY TO MAINTAIN SKILLS AND, THEREFORE, AVOID LIABIITY.

- FAIR QUESTION MUST BE ASKED: DOES THE CURRENT CON SYSTEM TRULY MAKES A DIFFERENCE IN THIS ARENA OR IS IT A SYSTEM THAT ORDINARILY BLESSES WHAT WOULD HAVE BEEN DONE ANYWAY.

C. HIGH-COST/SPECIALITY SERVICES – IS THERE "PENT-UP DEMAND"?

UNDER THE CURRENT LAW INSTITUTIONAL HEALTH FACILITIES ARE SUBJECT TO REVIEW IF THEY OFFER A NEW SERVICE IN EXCESS OF $500,000. FACILITIES AND HEALTH CARE PROVIDERS ARE BOTH SUBJECT TO REVIEW IF THEY OFFER A NEW SERVICE IN CONNECTION WITH THE ACQUISTION OF MEDICAL EQUIPMENT IN EXCESS OF $1.5 MILLION. IN ADDITION, CERTAIN NEW SERVICES, SUCH AS MOBILE HEALTH SERVICES WITH A VALUE IN EXCESS OF $1.5 MILLION, CARDIAC CATHETERIZATION, OPEN HEART SURGERY, ORGAN TRANSPLANTATION, AND CERTAIN RADIATION THERAPY SERVICES, ARE SPECIFICALLY SUBJECT TO REVIEW.

1) **THE PRACTICAL IMPACT OF THIS REVIEWABILITY PROVISION**

AGAIN, THE "UNIVERSE" OF REVIEW WAS NARROWED THROUGH THE 1997 INCREASE IN NEW SERVICE THRESHOLDS BUT GREATER FOCUS LIKELY ALSO RESULTED IN SPECIFYING REVIEW FOR IDENTIFIED SPECIALIZED SERVICES.

2) **IS THIS REVIEWABILITY PROVISION CONSISTENT WITH THE ORIGINAL PURPOSES OF THE LAW?**

THE CON LAW WAS PASSED TO CONTROL RISING HEALTH CARE COSTS IN PART THROUGH AVOIDING UNNECESSARY DUPLICATIO OF INSTITUTIONAL HEALTH SERVICES.

3) **LIKELY IMPACT ON THIS AREA OF REIVEW IF CON IS RETAINED?**

IT IS DIFFICULT TO ASSESS WHETHER IOWANS, OR COMMUNITIES IN IOWA, ARE BEING DENIED ACCESS TO NEW SERVICES BECAUSE OF CON. THE POSSIBILITY OF IOWANS TRAVELLING ACROSS THE BORDERS TO ACCESS EMERGING TECHNOLOGIES AND SERVICES NOT EASILY ACCESSIBLE TO THEM IN IOWA IS AN ISSUE TO BE SENSITIVE TO.

4) **LIKELY IMPACT ON THIS AREA OF REVIEW IF CON IS REPEALED?**

SOME EVIDENCE EXISTS FROM STATES THAT REPEALED THEIR CON LAWS THAT NEW SERVICE GROWTH WAS IMMEDIATELY EXPERIENCED BUT COMMENTATORS CAUTIONED AGAINST DRAWING EASY CONCLUSIONS, SAYING THAT HEALTH CARE DEMOGRAPHICS IN EACH STATE MUST BE EXAMINED. BECAUSE THE REVIEW FOCUS UNDER IOWA'S CON LAW IS NARROW AND FOCUSED, QUESTION MUST BE FAIRLY RAISED WHETHER THE LAW EVEN MAKES A DIFFERENCE. AGAIN, EXISTING MARKET PLACE CONTROLS ARGUABLY ARE SUFFICIENT TO ASSURE PROTECTION AGAINST UNBRIDLED GROWTH OF NEW SERVICES. SOMETIMES "UNBRIDLED" GROWTH IS IN THE EYE OF THE COMPETITOR BUT NOT IN THE EYE OF THE CONSUMER WHO BENEFITS FROM THE NEW SERVICE IN HIS OR HER COMMUNITY.

CONCLUSION

THE IOWA MEDICAL SOCIETY BELIEVES THAT THE CON LAW NO LONGER IS RELEVANT TO ACHIEVING ITS ORIGINALLY ARTICULATED PURPOSES. MARKET PLACE FORCES ARE EFFECTIVE IN ACHIEVING THOSE GOALS. THE CON LAW SHOULD BE REPEALED.

THE EARLY CON LAW WAS DYNAMIC AND AGGRESSIVE. HEALTHY FINANCIAL SUPPORT FLOWED FROM THE FEDERAL GOVERNMENT TO IOWA FOR ITS CON PROGRAM. STAFFING WAS STRONG. A STRUCTURED, COMMUNITY PLANNING AND REVIEW PROCESS EXISTED. ONGOING COLLECTION OF DATA WAS TO PROVIDE A MECHANISM FOR MONITORING THE HEALTH CARE DELIVERY SYSTEM AS A WHOLE.

THE CON PROGRAM HAS BEEN SIGNIFICANTLY NARROWED. APPLICANTS HAVE ADJUSTED TO IT AND, FRANKLY, SOMETIMES AVOID

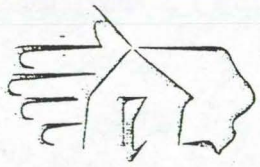
REVIEW BY CAREFUL STRUCTURING OF A PROPOSED PROJECT. STAFFING SUPPORT FOR THE PROGRAM HAS SIGNIFICANTLY DIMINISHED. COMMUNITY HEALTH PLANNING HAS NOT EXISTED FOR MANY YEARS. PROPOSED PROJECTS RECEIVE A ONE-TIME, "YES/NO" REVIEW. WRITTEN FINDINGS ARE DEVELOPED AFTER THE PROCESS TO SUPPORT WHATEVER DECISION IS MADE. SIGNIFICANT HEALTH CARE DOLLARS ARE DIVERTED FROM PATIENT CARE PURPOSES INTO EXPENSIVE APPLICATION AND REVIEW PREPARATIONS.

THE TIME HAS COME TO LET GO OF THIS LAW. IT NO LONGER IS A TRULY EFFECTIVE PROCESS IMPACTING SIGNIFICANTLY AND POSITIVELY ON THE IOWA HEALTH CARE SYSTEM. INADEQUATE JUSTIFICATION EXISTS FOR CONTINUING IT.

Iowa Association of Homes & Services for the Aging

September 1, 1999 Presentation

Iowa Association of Homes & Services for the Aging



Principles for Certificate Of Need – Long-Term Care

100 East Grand Avenue, Suite 140, Des Moines, Iowa 50309-1800 515/283-9380 Fax 515/283-9382
website: ageiowa.org email: iahsa@ageiowa.org

Issue

Certificate of Need operates to promote the public interest. It is in the public interest to promote choice among providers of services. The purpose of the program is to assure access to quality health care at a reasonable cost.

Bed need formulae, which are based solely on population, are inadequate. The new and unregulated Assisted Living Facility Programs affect demand.

Position

The more important consideration is occupancy rates. In the case of a facility applying for a CON, an occupancy rate of 90% or more indicates demand, consumer opinion, and indirectly the public interest. Existing nursing facilities with 90% or more occupancy should be allowed to add 10% of current NF beds or no more than 15 beds, every 3 years, without review.

Re-distribution of existing licensed beds among providers should be considered.

Re-classification of current RCF licensed beds to NF should be allowed, when the RCF has been operational for 5 years. In order to continue to assure high quality facilities, the capital threshold for renovation should be removed.

Facilities which desire to open a special unit or facility dedicated to the care of persons with chronic confusion or dementing illness (CCDI) should have review but not be precluded from development of their project in view of the need for such programs.

Recommendation

The existing program needs modification to reflect consumer choice need for units treating individuals with dementia.

Iowa Health Care Association

September 1, 1999 Presentation

Iowa Health Care Association

Position Summary
Certificate of Need Task Force

Steve Ackerson, Executive Vice President, IHCA
Robert F. Holz, Jr., Davis, Brown, Koehn, Shors & Roberts, P.C.

1. CON requirements have historically been implemented to:

    a) constrain supply
    b) promote occupancy

    with a goal to:

    a) minimize average occupancy costs
    b) avoid unnecessary capital costs

2. The only review by CON of long term care is the addition of new NF beds

    a) RCF is not reviewed
    b) Assisted living is not reviewed

3. IHCA position is that the Iowa CON requirements should remain unchanged for long term care requiring the review of additional NF beds

    a) utilization of NF beds in the state is declining

    - See Schedule 1 - Medicaid recipients
    - See Schedule 2 - Occupancy rates

    i) rise of assisted living

    - See Schedule 3 - Assisted living data
      (as of 8/1/99 68 certified, 106 pending)

ii) rise in Home and Community Based Services (HCBS)

- See Schedule 4 - DHS waiver services

b) continuing state pressure to reduce use of NF

- See Schedule 5 - DHS grant abstract
- See Schedule 6 - *Des Moines Register* article

c) Ladd Report

- Second highest NF beds per 1,000 of 85+
- Eighth lowest occupancy rate
  (Don't need to promote new beds)

4. In states where CON was removed - beds were immediately added in the state (Issue Brief: Arizona, Colorado, Indiana, Kansas, Wyoming)

5. To control beds without CON, states

a) put a moratorium on new beds (Issue Brief: Colorado, Minnesota, North Dakota, South Dakota, Utah, Wyoming)

b) do not allow recovery of capital costs in reimbursement (Issue Brief: New Mexico)

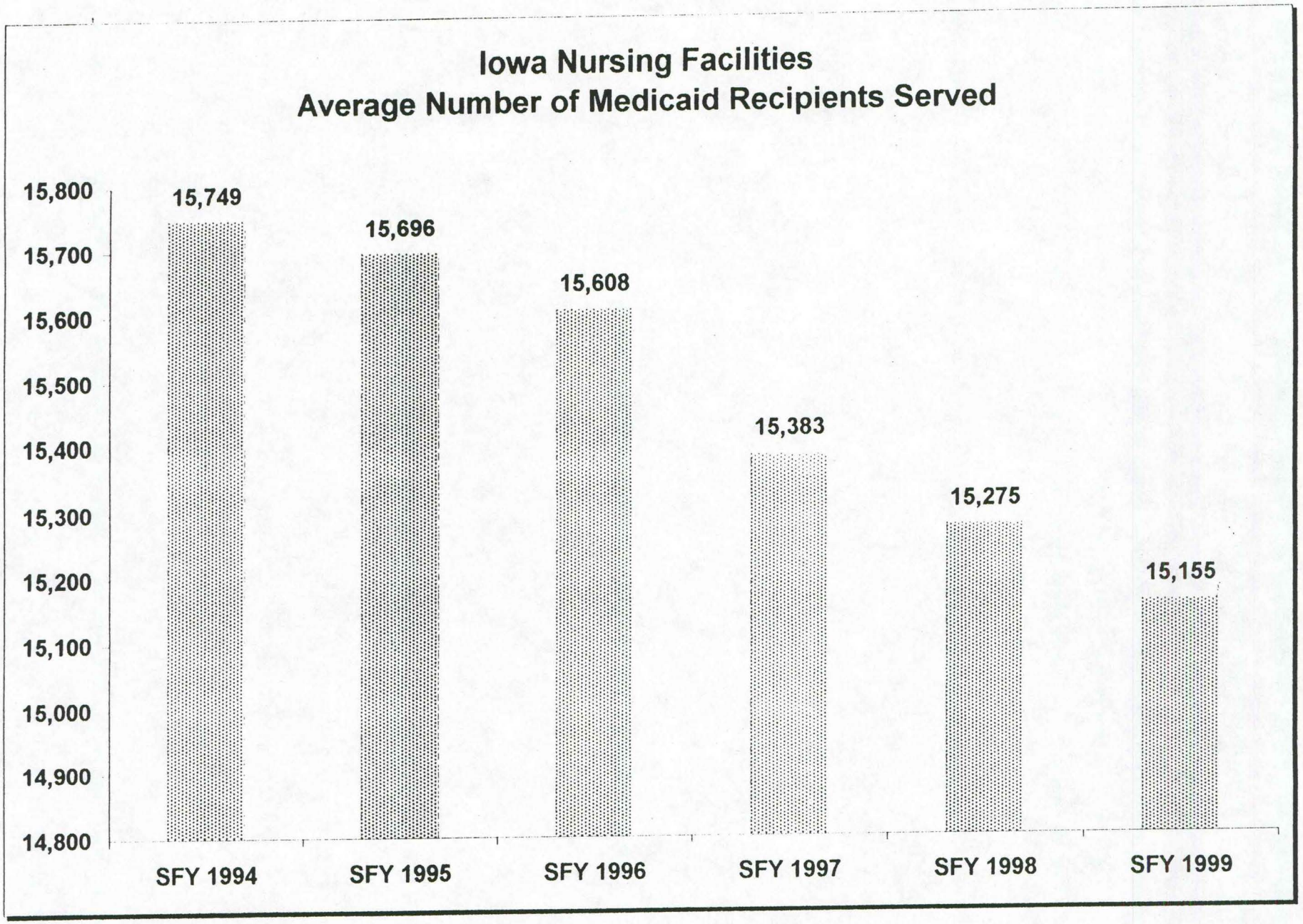
6. Conclusions

a) Removal of CON places no constraints and encourages additional cost
(If you build it, they will come)

b) Prohibitions on new beds or cost recovery do not allow for recognition of need

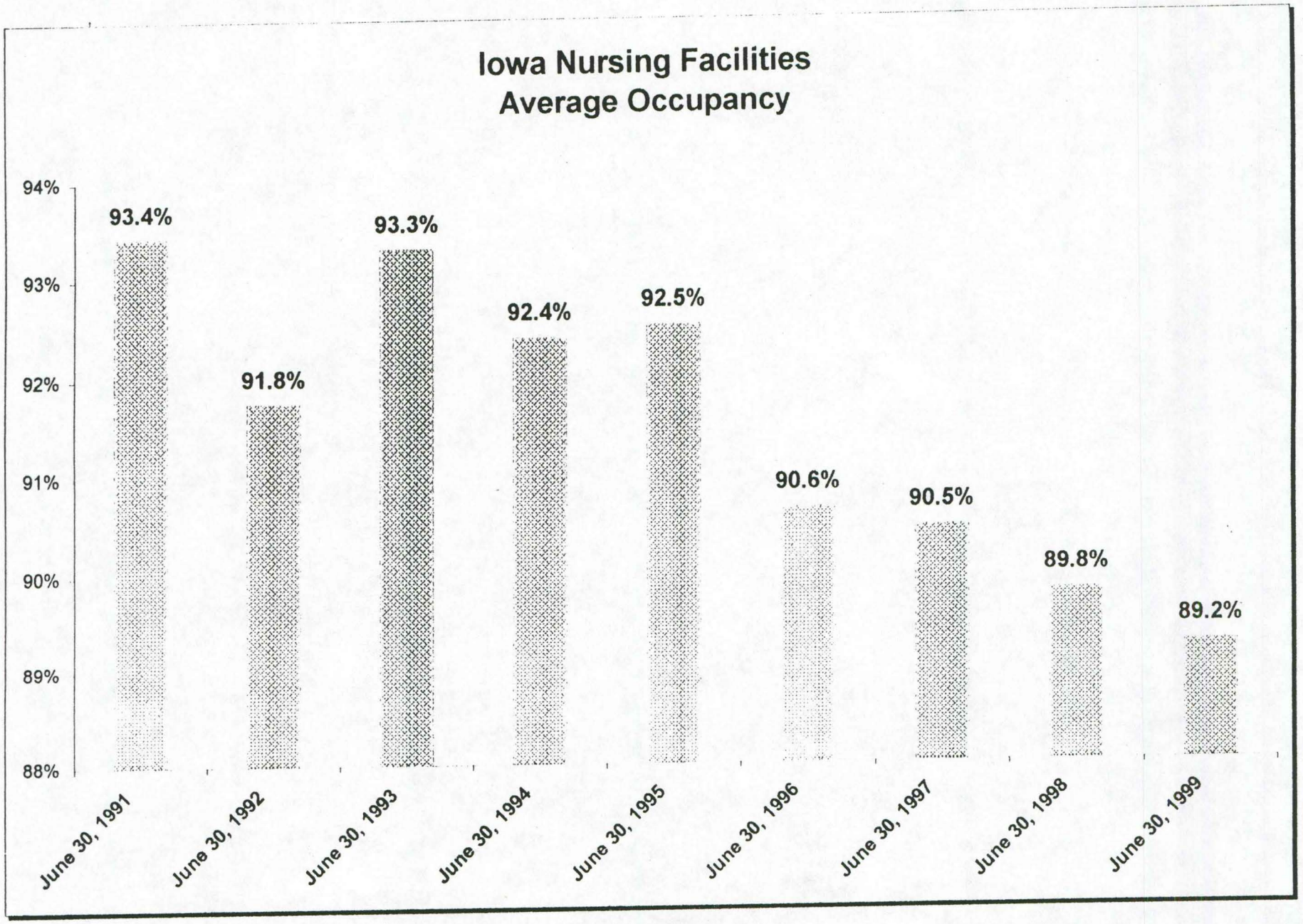
c) CON is a middle ground which places a constraint but permits additional beds where a reviewing body finds that need is demonstrated for that locale.

Iowa Nursing Facilities
Average Number of Medicaid Recipients Served



Data Summarized From IDHS B-1 Series Reports

Iowa Health Care Association



Data Taken From DHS Semi-Annual Compilation Of Cost Statistical Data

Iowa Health Care Association

OFFICIAL MINUTES OF THE LONG TERM CARE COORDINATING UNIT STATE OF IOWA April 16, 1999

TIME AND PLACE OF MEETING:

A business meeting of the Long Term Care Coordinating Unit was held on April 16, 1999 at 9:00 AM in the Conference Room of the Director of the Department of Human Services, 5th Floor, Hoover State Office Building, 1305 E. Walnut, Capitol Complex, Des Moines.

MEMBERS PARTICIPATING:

Dr. Judith A. Conlin, Kevin Techau, Norman Johnson, and Frances Hawthorne. Cathy Andersen (designee for Jesse Rasmussen).

MEMBERS ABSENT:

Mary Weaver

OTHERS:

Beth Bahnson, Joel Olah, Donna Harvey, Patti Esch, Marvin Webb, Michaela Funaro, Mary Oliver, Jennifer Steenblock, Eileen Creager, Carol Boyles, Kyla Lens, Jay Bennett, Gay Highshoe, Lois Houston, Stephanie Laudner and Kathy Farnsworth-Cubit.

Chairperson Conlin called the meeting to order at approximately 9:00 AM.

MINUTES

Chairperson Conlin asked if there were any additions or corrections to the minutes of February 19, 1999. There were none.

MOTION: Kevin Techau moved to accept the minutes as printed and distributed. Frances Hawthorne seconded the Motion. Motion carried unanimously.

HISTORICAL PERSPECTIVE OF THE LONG TERM CARE COORDINATING UNIT

Beth Bahnson provided background and history for new members about the Long Term Care Coordinating Unit.

The Department of Elder Affairs, Human Services, and Public Health and their predecessor departments recognized the need for a coordinated approach to long term care services for individuals. Since 1980 the three departments have been working together with other organizations in the Community-Based Adult Services Committee to develop a common approach to assessment and case management for Iowa.

In August of 1984, Governor Branstad appointed a task force of 14 Iowans to study the long-term care system and identify needs. Among the recommendations ultimately made by this group was the establishment of a "Long Term Care Commission" composed of the Commissioner of the Iowa Department of Human Services, the Director of Public Health, and the Executive Director of the Commission on Aging and a number of at-large members appointed by the Governor.

In response to these recommendations, the 1986 session of the Iowa General Assembly established a Long Term Care Coordinating Unit whose current membership consists of the Executive Director of the Department of Elder Affairs, the Director of the Department of Human Services, the Director of the Department of Inspections and Appeals, and the Director of the Department of Public Health. Two pubic representatives appointed by the governor also serve on the Unit.

The coordinating unit is charge with responsibility for developing:

- Mechanisms and procedures to implement a case-managed system of long-term care service delivery based on the use of a comprehensive assessment tool.
- Common intake and release procedures for long-term care services.
- Coordinated procedures at the state and local levels.
- Rules and procedures for long-term care.
- A long-range plan for long-term care.

The Iowa Department of Elder Affairs has general administrative responsibility for carrying out the policies established by the Coordinating Unit.

Staff support for the Coordinating Unit is provided by the Community Based Adult Services Committee (CBAS) which draws it membership from the Iowa Departments of Elder Affairs, Human Services, Inspections and Appeals, and Public Health, and from the Iowa Association of Area Agencies on Aging, the Iowa Foundation for Medical Care and the Iowa State Association of Counties.

Beth encouraged the Unit members to request that the Community Based Adult Services Committee review and update the Unit's Strategic Plan.

The Unit will also be electing officers at the next meeting scheduled for June 16, 1999.

OASIS TOOL

Chairperson Conlin discussed the meeting she attended with Department staff and other Iowa representatives at the Kansas City Regional Office concerning the OASIS tool.

A summary of concerns regarding the imminent implementation of an unfunded federal mandate from HCFA regarding OASIS was distributed to attendees.

Concerns expressed were:

- lengthy -- the initial assessment is 18 pages,
- expensive -- rules require that an RN complete the initial assessment and follow-up is required every 60 days, and
- unfunded - Medicare is not paying home health agencies anything to do the assessment, follow-up or data entry that is required.

The Legislature recently passed a Resolution requesting HCFA reconsider implementation of the OASIS tool. Senators John Kibbie and Sheldon Rittmer and Representatives Mona Martin and Todd Taylor supported the Resolution.

Discussion followed regarding various avenues agencies could take to inform policymakers of the consequences of implementing the changes in OASIS.

COMBATIVE BEHAVIOR TASK FORCE

Mary Oliver stated that this group needed to focus on Next Steps as outlined in the report and the minutes of February 19, 1999. They are:

1. Begin to seek commitment from members of the legislature for an expansion of care sites for this population.
2. Develop an RFP based on information presented, including the development of eligibility criteria.
3. Examine the possibility of expanding Medicare billings. Establish this change as soon as reasonably possible if the decision is made to expand Medicare billings.
4. Develop a pilot project for a consultation, technical support, and crisis avoidance/intervention program.

Mary Oliver requested that each Department commit staff to working on implementing the "Next Steps" outlined above. The Departments indicated the following staff would be involved:

Mary Ann Smith - Abby Center
DIA - Mary Oliver
DHS - Mike Davis
Public Health - to be assigned
Elder Affairs - to be assigned

The name of the group will be Combative Behavior Work Group and this group will be concluding their work by the end of June 1999.

MOTION: Norman Johnson moved to approve the designation of staff and next steps as recommended. Frances Hawthorne seconded the motion. Motion approved.

REPORTS

Legislative Update: Stephanie Laudner provided an update on Legislative activities.

Case Management Program for the Frail Elderly: Sandy Pennington reported that there are 5,370 CMP clients; 3,154 have been approved for the waiver. All 99 counties are participating as of April 1, 1999.

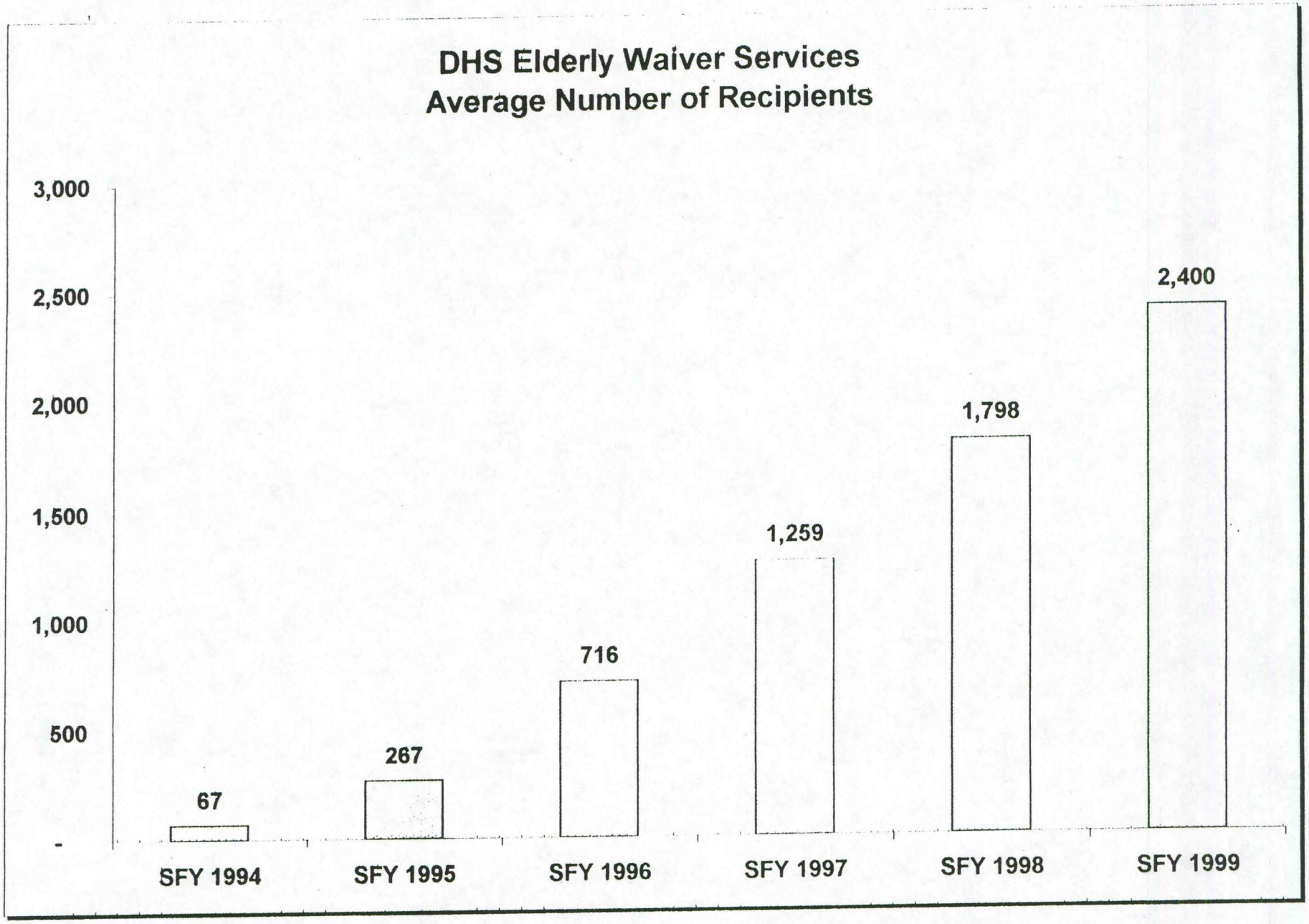
IA OASIS TOOL: Meeting with IFMC to commence implementation. Many requirements for payment procedure.

Assisted Living: Beth Bahnson distributed information on the Assisted Living locations throughout Iowa. Iowa currently has 51 certified facilities and 105 in the development process. This does not include the facilities in the pre-application process.

There was no further business to discuss. The meeting adjourned at approximately 10:30 AM.

_____ _____

Chair **DATE**



Data Summarized From DHS B-1 Series

Iowa Health Care Association

PROJECT ABSTRACT

The overall goal of the project is to enhance choices available to two groups of nursing facility residents: 1) Those whose needs cannot be met in an institutional environment which results in disruptive behavior and frequent transfers from one facility to another. 2) Those who could return home but who lack the financial resources to maintain upkeep of their previous community living arrangement due to the length of their nursing facility stay (beyond six months).

Both of the above populations are at risk for unsuccessful long term nursing facility placement – one group because the nursing facility environment itself exacerbates mental or cognitive difficulties, the other group because they have fewer care needs and posses the ability to return home but are blocked from doing so due to lack of awareness of community services, financial barriers, and lack of assistance with setting-up in-home services.

Under the proposed grant, residents with behavioral problems would transition to specialized community-based elder group homes, while the second group (those who are high functioning with few care needs) would be provided enhanced financial and support services to transition to community placement such as individual homes or subsidized housing.

Covered benefits for both groups would be expanded case management services to locate alternative placement, assist with transition services, and monitoring to ensure that the person's needs continue to be met once they are in the community. Both populations would be eligible for the Elderly Waiver which would fund services such as home health, consumer directed attendant care, nursing, and other services to maintain community placement.

Additional support for those persons who choose their pre-facility living arrangement (e.g., their home) would include financial assistance to cover expenses relating to maintaining their previous living while they were in the nursing facility.

Reimbursement would be through the elderly waiver, an enhanced rent subsidy program, or low rent housing.

INSTITUTIONAL TRANSITION APPLICATION

All states refer to themselves as unique and different from some states. This always has some degree of truth, but, when it comes to long-term care, it may be more true in Iowa than other states. For example:

- Iowa has the highest percentage of the population who are 85 plus in the nation, at 2.14 percent, in 1996 (U.S. average was 1.42%).
- Iowa has the eighth highest percentage of the age 65 plus population living alone in the nation at 30.7 percent, in 1992 (U.S. average was 28.2%).
- Iowa has the second highest number of nursing facility beds per 1,000 persons age 85 plus in the nation at 758.8 beds, in 1996 (U.S. average was 482.2).
- Iowa has the lowest impairment level of nursing facility residents in the nation at 73.7 on the PROPAC acuity scale, in 1995 (U.S. average was 100.4)

All of these statistics have an effect on Iowa's long-term care, and make it unique. However, their is a growing elderly population in most states, whereas the program proposed in this grant could be replicated by other states and lessons learned in Iowa could be of benefit to the rest of the country. Because of the population characteristics of Iowa and nursing home residents, this grant is primarily focused on the elderly.

A. HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER

Waiver Programs	Type of Clients Eligible	Clients
Elderly	65 years of age and older, who would otherwise require care in medical institutions.	2,853
Mental Retardation	have a primary disability of mental retardation, be certified as	3,969

	being in need for long-term care that, but for the waiver, would otherwise be provided in an ICF/MR, under age 65.	
Ill and Handicap	have a disability as defined by the Supplemental Security Income guidelines per Title XVI of the Social Security Act, be under the age of 65, and who would otherwise require care in medical institutions	586
AIDS/HIV	persons with acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection who would otherwise require care in medical institutions	18
Brain Injury	persons with a diagnosis of brain injury, age 1 month to 64 years, and currently a resident of a medical institution and have been for at least 30 consecutive days at the time of initial application for the brain injury waiver.	54
Physical Disability Pending HCFA approval	have a physical disability, be blind or disabled, have the ability to hire, supervise, and fire the provider as determined by the service worker, and be willing to do so; or have a guardian named by probate court who will take this responsibility on behalf of the consumer, be 18 years through 64 years old, currently a resident of a medical institution.	100 slots planned for initial year

As of April 1, 1999, all 99 Iowa counties came under the elderly waiver, with 2,853 clients.. The HCBS elderly waiver reported 2,704 clients as of June 30, 1999. Of this amount 98% were intermediate level of care, and 2% were skilled nursing level of care. Most of these clients, 96%, lived alone. Additional functional status information is collected both on HCBS waiver

clients and nursing home clients. This data is then entered either into a PC-based or a mainframe database system with information reported monthly and annually. The department is also reviewing the ability to utilize the OASIS data for the HCBS population.

Iowa also has a "Frail Elderly Case Management" system (Case Management Program for Frail Elderly CMPFE) that in many respects is similar to those found in other states, but has a couple of features which are generally different. These two features are that case management is available to all elderly clients who have gone through a pre-screening and intake, and show the need for long-term care services, and an interdisciplinary team that holds a staffing on each client.

These two Iowa additions to the case management systems are positive. To date this has been the case as the program has grown from covering about half of the counties in 1995 to covering all 99 counties as of April 1, 1999. In FY 1997, 6,315 were served, and 4,099 were active case management clients. In addition 1,475 (36%) of these clients were served by the HCBS elderly waiver. The program grew substantially in FY 1998 when, 7,577 were served, and 4,877 were active case management clients, and 2,694 (55%) of these clients were served by the HCBS elderly waiver.

A key strength of the elderly waiver home and community based care program package is the number of services provided. Iowa has fifteen services that may be able to assist individuals.

- Adult Day Care
- Assistive Devices
- Chore Services
- Emergency Response Systems
- Home Delivered Meals
- Home Health and Home Health Aide
- Homemaker
- Home and Vehicle Modifications

- Mental Health Outreach
- Nursing Services
- Nutritional Counseling
- Respite Care
- Senior Companions
- Transportation
- Consumer Directed Attendant Care

Many individuals transitioning from the nursing facility will need the type of services such as home health aide and consumer directed attendant care. The current problem with these services is that they may be expensive in comparison to Iowa's nursing homes, and in the case of consumer directed attendant care may be complicated for the client to manage because the client must be able to manage their care. However, with supervision of the case manager it is a viable services. Iowa does fund for services provided in assisted living facilities and elder group homes when the client is eligible for the elderly waiver.

Iowa is reviewing ways to improve its HCBS program in several ways:

- Iowa is considering alternative funding strategies for elder group homes services, instead of indirectly by providing HCBS elderly waiver service through other programs.
- Iowa is considering lowering the capacity of elder group homes from 3 to 5 residents to 1 to 5 residents, but not require all 1 or 2 bed facilities to become elder group homes unless they want HCBS elderly waiver funding.
- Iowa is considering funding assisted living facilities directly, instead of indirectly by providing HCBS elderly waiver service through other programs. If funded directly, assisted living facilities can be an option that nursing facilities could convert to, if their

census drops below profitability. This provides a financial incentive for nursing facilities that convert.

- Iowa continually evaluates the cost cap amounts for the levels of care in comparison to the specific needs of the clients.

PREADMISSION SCREENING

Medicaid recipients making application to either Home and Community Based waiver or a nursing facility must obtain prior medical approval. The Department of Human Services contracts with the Iowa Foundation for Medical Care (IFMC) to perform utilization review for health care provided to Medicaid recipients. Utilization review is completed on individuals admitted to Home and Community Based Waivers, as well as, nursing facility and skilled nursing facility settings. Recipients are reviewed to determine level of care. This process is limited to reviewing for the level of care provided, it does not include identification or assistance if the client's needs could be met outside of the medical institution.

The Medicaid agency will expand its present utilization review program to establish a project to enhance choices to persons considering transition from a nursing facility to a community-based program. The utilization review program will assist in identifying those individuals who may be candidates for transition to the community.

The current databank is based on information collected by nursing reviewers via a "Resident Assessment and Services Evaluation (R.A.S.E.) criteria". The criteria topics for review to locate potential target population are:

- Cognitive, mood and behavior patterns
- Dressing and personal hygiene
- Prior living circumstances

Additional process screens will be developed for use by nurse coordinators to gather data on the target population. The tools will validate care needs, gather data for evaluation of home/support service

availability and identification of supportive service needs that could be met in a less medically focused and restrictive environment. The sixteen screen areas would be:

- Age range
- Length of stay in the nursing facility
- Home/support service availability
- Preparation of meals
- Housekeeping services
- Routine home maintenance service
- Transportation services
- Personal care
- Medication set-up and monitoring
- Assistance with oral medications
- Emergency response services
- Professional nursing services
- Identification of the potential discharge disposition
- Hours required for homemaker services
- Hours required for home health aide services, and,
- Hours required for nursing services.

The individuals identified will have their functional and cognitive status validated. In addition, the informal support availability will be assessed. The individuals will be recognized and referred to the care management teams. The program will compile and develop comprehensive resource information and educational materials for use by individuals and agencies. This information, enhanced case management, and housing options will assist individuals to choose alternatives to the institutional care they are presently obtaining. The information and materials will be made available, but not limited to, residents, families, nursing facility staff, hospital discharge planners, physicians.

TARGET POPULATION

The targeted population will include: 1) Those whose needs cannot be met in an institutional environment which results in disruptive behavior and frequent transfers from one facility to another. 2) Those who could return home but who lack the financial resources to

maintain upkeep of their previous community living arrangement due to the length of their nursing facility stay (beyond six months).

The program will identify the target populations through the Iowa Minimum Data Set and the IFMC utilization review databank. The IFMC's databank includes demographic information and care needs evaluations of Medicaid recipients residing in nursing facilities statewide. The data available through these two systems will describe the functional needs of the individuals residing in Iowa nursing facilities. A combination of both data sets will be utilized to begin the assessment and planning process for a candidate to transition from the nursing facility setting.

Through the current databank NF reported 15,750 clients as of June 30, 1998. Of this amount 15,371 (97.6%) were intermediate level of care, and 379 (2.4%) were skilled nursing level of care. The average age of the NF residents was 83 years, with 90% being over the age of 65. Most clients lived alone (42%) prior to their NF admission, 24% lived with a spouse or other person, and 32% from another institutional setting including hospitals. The databank identified 702 individuals in targeted group number 1, and 2,363 individuals in targeted group number 2. The geographical distribution is widespread throughout Iowa, whereas 408 of the 431 facilities have persons within the identified targeted groups.

NURSING FACILITY REIMBURSEMENT METHODOLOGY

Iowa has the third lowest cost-per-case in the nation. This would indicate that the Iowa nursing facility reimbursement methodology is keeping costs down. However, the effect of, low nursing facility occupancy levels that create competition between providers, especially for private clients, also works toward keeping cost down.

Iowa has a prospective facility specific-adjusted reimbursement methodology. Iowa has set the 70th percentile of adjusted costs as point of maximum payment to nursing facilities. Iowa rebases each year and calculates prospective rates by taking actual cost

reports, then inflating them a common date at the beginning of the rate period, and then adjusting the rates by three factors.

Inflation Factor. Iowa takes the two previous cost reports to determine the average cost increase, then adds this amount to the rate. This increase cannot be larger than the Consumer Price Index for all urban consumers for the preceding calendar year. This is more generous than many other states, and actually adjusts the rates to estimated costs to the end of the next payment period, instead of to the beginning.

Incentive Factor. This add-on to costs is calculated by taking one-half of the difference between the 46th percentile and the 74th percentile of allowable costs. However, this amount cannot be less than $1.00 nor more than $1.75. This is also a generous add-on, not found in many other states.

Occupancy Factor. As explained earlier, this factor reduces the rates of nursing facilities which have less than 80 percent nursing facility occupancy.

The following provides a view of the shift towards balancing our long term care system towards community based services from institutionalization.

FISCAL YEAR 1995

Type of Care	Cases	Expenditures
Nursing Facilities	78.8%	91.6%
Home and Community Based Care	21.2%	8.4%

FISCAL YEAR 1998

Type of Care	Cases	Expenditures
Nursing Facilities	64.5%	85.5%
Home and Community Based Care	35.5%	14.5%

CONTINUUM OF SERVICES

The following are a listing of the services and agencies that are available or may be modified to serve the nursing home transition population.

Adult Day Care

Iowa utilizes adult day care services to a greater degree than most other states, and in 1997 Iowa had 29 adult day care centers operating statewide. These centers had capacities from 1 person to 50.

Assistive Devices

Iowa provides most any practical product or device to assist individuals with activities of daily living. Iowa allows up to $100 per month for this service.

Chore Services

Chore services includes household maintenance other than routine housekeeping, heavy cleaning, lawn work, trash removal, minor repairs, fire hazard removal, and furniture moving.

Emergency Response Systems

Emergency response systems allow a client to remain in electronic contact with a central monitoring station, and to summon help, if they cannot get to, or use, a telephone.

Home Delivered Meals

Home delivered meals means meals prepared elsewhere and delivered to an Elderly Waiver consumer up to 14 meals a week are included.

Home Health And Home Health Aide

This service provides skilled nursing, occupational and physical therapists, and aide services. It is provided in Iowa through federally certified home health agencies, and is funded by Medicare, Medicaid (as a mandatory program through the Department of Human Services), and as a Medicaid home and community based waiver service.

Homemaker

Homemaker services are for doing homemaking chores for people who cannot do them, and live alone, or with a person who is incapacitated or busy providing direct care services. These services include essential shopping, meal preparation, limited house cleaning, and bathing and dressing for clients who can self-direct these services.

Home And Vehicle Modification

This service provides physical modification to a client's home or vehicle which are necessary for the health, welfare, or safety of the client. This service often provides modifications that can mean the difference for some people between remaining at home or having to move to another residential setting. This service has a lifetime maximum payment of $1,000.

Mental Health Outreach

Several studies have shown that the elderly suffer more mental health problems (especially depression and anxiety) than any other age cohort. However, it is generally true that the elderly receive less mental health services than these other age cohorts. This service, which is seldom found in other state's home and community based waivers, provides much needed assistance, and probably means that many elderly people can remain at home.

Nursing Services

This service, similar to home health skilled nursing, is also provided through the Medicaid optional program as "private duty nurse", in several states. It can be a very valuable service in keeping someone in their own home. Up to eight visits are allowed for waiver clients at the intermediate level of care, and unlimited visits are allowed at the skilled level of care.

Nutritional Counseling

Iowa may be the only state offering this service through its home and community based waiver. This service is offered when needed because of medical conditions.

Respite Care

This is a very valuable service that gives caregivers (usually family members) a break. This service very often means the difference between being able to remain home with informal supports and having to move to a nursing facility.

Senior Companions

Senior companions can provide meal preparation, shopping and light housekeeping tasks. This service is much like the homemaker program and of dubious value as a nursing facility alternative. This service is often provided by volunteers when offered through the Older Americans Act, and indeed, Iowa may be the only state in the nation offering senior companions as a home and community based waiver service.

Transportation

Transportation services may be provided for business, shopping and to reduce social isolation. They can also be used for medical services if not already reimbursed through the medical transportation under Medicaid. This is a needed service for those who live alone and cannot arrange transportation.

Consumer Directed Attendant Care

It provides personal care tasks to assist in activities of daily living, and provides support from one to 24 hours. This service can be provided by an individual or an agency for up to every day in the year. Consumer directed attendant care cannot include adult day care, respite care, room and board (for the provider) or case management. Consumer directed attendant care cannot replace a less expensive service, nor can an individual provider be the spouse of the consumer.

Rent Subsidy Program

This program is currently available to persons who participate in a HCBS waiver program who were discharged from a medical institution. Clients approved for rent subsidy payment receive an ongoing monthly payment of rental assistance. Assistance with other purchases may also be

given in the initial two months of eligibility for purchases necessary for household furnishings and supplies. The rent subsidy program will need to be adapted to assist with serving the persons who are in the medical institution awaiting discharge to the HCBS waiver.

Case Management For The Frail Elderly

Iowa has 13 local Area Agencies on Aging (AAA). Case management is done through the AAA's. This case management services provides the long-term care network needed for consumers. Because of the fragmented nature of the network, the competition between providers, and the complexity of many services, it is difficult for clients and their families to be able to make informed choices. Case managers determine what long-term care services could meet the clients needs, provides choices for the client, coordinate multiple services, and provide ongoing monitoring after services begin.

Community Support Services

Centers for Independent Living (CIL) serve people with disabilities of any age with any type of disability to live more independently. CIL provide four core services

- Independent Living Skills Training - formal skills training designed to teach people the skills and attitudes that they need to live independently.
- Peer Support - mentor program which links people with similar or real world experiences with disabilities.
- Individual and Systems Advocacy - teaching people to advocate for themselves, assisting people with their individual advocacy situations and working with the local communities.
- Information and Referral - providing information related to disabilities to people with disabilities, their families, and the whole community.

COMMUNICATION/ACCESS PLAN

The program would utilize a number of different communication avenues in recognition of the fact that people access information in different ways at different times depending upon

their individual circumstances. Communication strategies would be focused on those individuals or entities that residents or their families traditionally seek out when they have a problem. While Iowa has available services through case management and the elderly waiver program, the providers lack awareness and participation in these programs for their clients. Enhancement of the client choices through this grant would also include outreach and education to the provider community, including hospital discharge planners, physicians, and nursing home staff. From this outreach, the additional education will assist both the identification and referral processes for residents considering transitioning to the community following a nursing home stay.

For the target population comprised of persons returning to their previous living arrangements, the initial communication link would be through the hospital discharge planners. It is critical to the program's success that the identification of potential candidates for the program be done as early as possible so that the nursing facility, community providers, and everyone involved in the person's support system understand that the plan is to eventually discharge the person to their home/apartment. As a reflection of the State's commitment to this grant and community-based alternatives in general, administrative rules would be promulgated to direct discharge planners to contact the local Case Management provider when there is an admission that meets pre-defined criteria.

For the target population comprised of persons with behavioral problems arising from facility placement, the nursing facilities themselves represent a key communication link to residents and families. Residents whose behaviors are such that they disrupt other residents and the workings of the facility are residents who the facility normally is anxious to discharge to another setting. Additional referral sources targeted for communication and education would be community mental health centers, adult psychiatric units specializing in geriatric care, and mental health practitioners.

For both populations, a communication program would be put into place to educate Iowa's 3,500 Resident Advocate Committee volunteers. These volunteers are responsible for getting to know each resident in their assigned facility and for initiating contact with family members. Their knowledge of the residents and their philosophical commitment to advocating for the best interests of residents positions them to be excellent information and referral sources for residents and families.

Specific features of the communication plan would be customized based on the most conducive strategies for that particular group. For example, educational materials for nursing facilities would be different than those for residents or family members.

REMOVAL OF BARRIERS

A major barrier inherent in any effort to transition a person out of a nursing facility is resistance from the nursing facility industry itself. Potential loss of revenue, especially in a time of declining occupancy, is a very real concern for facilities which can fuel active resistance to a new initiative designed to remove the light care residents who represent the least costly, most profitable residents to serve.

Under the proposed program, however, facilities would derive both a financial and operational advantage by referring their disruptive residents to the program. A single agitated resident can quickly drain staff resources, upset other residents, and interrupt the routine of the entire facility. Facilities would welcome the creation of a program that would relieve them of the responsibility to care for such persons. Previous task forces have focused on the needs of physically combative residents, but have not addressed the lack of a systemic strategy for residents who are not an on-going physical risk but who clearly do not respond well to an institutional setting. This program would target such individuals.

For those residents who would be transitioning to their homes following a nursing facility stay, there would be less facility resistance because the facility would know from "Day One" that the person would be going home, and would be admitting them under that pretext.

Different types of barriers exist for residents who are functionally capable of living in the community but who lack the ability to put together a viable discharge plan for themselves. Contacting and coordinating with providers outside the facility is difficult for someone in an institution. Even the simple act of making a private phone call and being available for a return call can be problematic in a facility. The involvement of the case manager in working with the resident to arrange community services would remove the barriers inherent in institutional living.

Another barrier that nursing facility residents face is lack of personal resources to pay for upkeep and maintenance of their home or apartment for an extended period of time while they are in the facility. Because Medicaid recipients must spend most of their resources prior to becoming eligible and because they are allowed only $30 per month from their income, there are few dollars available to pay for on-going household expenses such as utilities and grounds maintenance. The result is that frequently residents must prematurely dispose of their homes which, in turn, locks them into facility placement. The proposed program would expand the state's Rent Subsidy program to allow funding for maintenance services, thereby removing a persistent barrier to returning to the community.

WAIVERS

An amendment to the Home and Community Based Elderly waiver will not be necessary. The grant is not adding services not covered by Medicaid. Based upon review of the current services available through the waiver and with changes to the rent subsidy program, the packages contains the services that may be needed by persons transitioning to the community.

PARTNERSHIPS

Successful implementation of the proposed program calls for enhancement of existing partnerships and the creation of new linkages between state agencies, the provider community, advocates, and the aging network. Iowa is in the beginning stages of developing capacity to provide homes and community-based services. The foundation has been laid for expansion through collaboration and strategic planning. Partnerships already exist between the state Medicaid agency, the state Unit on Aging, and the Area Agencies on Aging as part of implementation of the state's Case Management Program for the Frail Elderly (CMPFE).

The proposed program would establish the context for a unique new partnership between institutional providers and community providers who, up to this point, frequently find themselves on opposite sides of the table. Nursing facilities traditionally do not access community resources for their residents except for those residents who are in the facility short term to recover from an acute episode. Community providers traditionally do not view facilities as an avenue who shares their commitment to client-focused service delivery. However, under the grant, both provider groups would gain from mutual association – facilities would benefit from assistance from community providers who would be helping them with their more difficult residents, while community providers would benefit from increased referrals and visibility about their programs among institutional providers, residents, and family members.

Additionally, the proposed program would expand the scope of partnerships among the aging network, the provider community, and the advocacy network. The primary referral network for the Case Management program has been through entities that interact with the elderly who are already in the community, e.g., home health providers, aging network volunteers, etc. This program would introduce into the mix health care professionals who serve nursing facility residents, community mental health centers, and nursing facility advocates. These groups, often comprised of individuals who are already committed to safeguarding the

rights of the elderly, represent an untapped resource that would be utilized for education and referrals into the proposed program.

MONITORING

The local Case Manager will play the pivotal role in ensuring the wellbeing of those transitioning from the nursing facility to the community. Not only will the Case Manager be charged with coordination and implementation of the discharge plan, the Case Manager will also continue to provide active oversight once the person is in the community.

Because of his or her involvement from the very beginning of the planning process, the Case Manager will have the best working knowledge of the client's goals, strengths, needs, support system, and family dynamics. Iowa's Case Management program is philosophically based on maximizing the client's independent decision-making and participation in any planning activity affecting the client.

The interdisciplinary team approach incorporated into the structure of the CMPFE program represents another mechanism for monitoring the client's safety while in the community. Each member of the Case Management team who provides services to the client will have an understanding of the overall goals for the individual client, and can serve as an on-going check that the client's needs are being met.

HOUSING

The proposed program is designed to support those wanting to transition back to a previous living arrangement or into an elder group home. Other state initiatives are underway or being considered that specifically address the state's commitment to more affordable housing options, and as more options become available, they would be folded into this program.

To date, elder group homes have not been an integral part of Iowa's long term care system for a number of reasons including lack of a designated funding source and certification rules. A recent consultant's report recommended Iowa expand the program as an alternative to nursing facilities placement. Grant dollars would be used to define and remove system barriers to expansion of specialized elder group homes and to explore potential funding resources to assist those interested in establishing group homes.

MILESTONES AND WORK PRODUCTS

- Development of partnership between community and institutional providers. (Begin September 1999 and ongoing).
- Client characteristics reports for the HCBS, NF residents, and the targeted population (October 1999 and 2000).
- Development of Communication Plan specific to different individuals and entities, i.e., hospital discharge planners, physicians, and nursing home providers, families, residents, resident advocate committee members, community mental health centers, adult psychiatric units, mental health practitioners. (January - March 2000)
- Modification to the rent subsidy program for enhancements for the nursing home transition population (legislative session, administrative rules) (April 2000 through October 2000).
- Begin development of an identification and referral process between the Case Management program, institutional providers, resident advocate committees, the utilization review organization, and families. (Including process screen development) (April - June 2000).
- Promulgate administrative rules to direct discharge planners to contract the local Case Management provider (July - December 2000).

- Analyze current Elder Group home situations, identity needed changes, promulgate administrative rule changes and budget changes if needed (June - August 2000).
- Implement communication plan (September - October 2000).
- Implement identification process with referrals to Case Management (December 2000).
- Begin contacting targeted population (January 2001), with implementation of the enhanced case management services and rent subsidy program.

PROJECT ORGANIZATION AND STRUCTURE

Iowa has a long-term care system for the elderly that depends heavily on interagency cooperation. The Department of Human Services manages the Medicaid program, including the nursing facilities, home and community based waiver, and home health. It also has an agreement with the Department of Elder Affairs for cooperation between the Home and Community Based waiver program and the case management for the frail elderly program. In addition, the Department of Human Services conducts Medicaid eligibility determinations, and utilizes the Iowa Foundation for Medical Care for assistance with medical eligibility determinations. The Department of Elder Affairs manages a wide variety of home and community services offered through the Older Americans Act.

The development of the communication plan and the infra-structure to be used to make community-based alternatives available to a nursing facility resident are the identification, referral, and case management processes between the providers, advocates, families, DHS, and the AAA, as well as the rent subsidy program.

Central management would be done by the Project Director, Eileen Creager with assistance from Cindy Haverkamp and Michaela Funaro, Department of Human Services.

Technical Assistance would be provided by Joel Olah, Aging Resources of Central Iowa, and Debi Meyers, Department of Elder Affairs. Coordination would be done through the local advisory committee which would also include representatives from the state Medicaid agency and the state Unit on Aging. Partnerships already exist in the designated communities as a result of the current case management structure which would provide a foundation upon which to build a more expansive advisory group. The project is a highly local one, dependent upon dynamics operating in the individual communities. As much as possible, decisions would be made at a local level, which would result in more responsiveness and flexibility to modify the project as it unfolds.

BIOGRAPHICAL SKETCHES:

Eileen Creager, Manager, Bureau of Health Care Purchasing & Quality Management, Iowa Department of Human Services. Eileen is responsible for the unit supervision and implementation of the Long Term Care & Specialty Populations Unit for the State of Iowa. She has been involved with long term care and Medicaid programs including management of Medicaid programs for 25 years such as creating and coordinating partnerships with local, state, and federal officials, agencies, and advocacy groups including working closely with legislators. Eileen has her master's degree in Business Administration and Management Science.

Cindy Haverkamp, R.N.,C. , Institutional Program Manager, Bureau Long Term Care and Specialty Populations Unit, Bureau of Health Care Purchasing & Quality Management, Iowa Department of Human Services. Cindy is responsible for Medicaid program policy as it relates to nursing facilities. She has been involved in long term care for 20 years. Cindy has a bachelor's degree in Nursing and a master's degree in public administration. She is also certified as a Gerontological nurse by the American Nurses Association.

Michaela Funaro, Home and Community Based Elderly Waiver Program Manager, Long Term Care and Specialty Populations Unit, Bureau of Health Care Purchasing & Quality Management, Iowa Department of Human Services. She has over 25 years experience with Human Services. Michaela's degrees are in Education and Child Development.

Andi Dykstra, R.N., C.P.H.Q. is the Assistant Director Medicaid Quality Improvement, Iowa Foundation for Medical Care: Her experience includes health care quality improvement, provider education, program development, and utilization review.

Debi Meyers is the Executive Officer in the Office of Aging and Policy Development and is also serving as the Interim State Long Term Care Ombudsman. Her responsibilities include the identification of issues affecting Iowa's elderly and development of interdepartmental and interagency partnerships to implement necessary changes. Additionally, as the state's Ombudsman she advocates for the rights of residents of nursing facilities and oversees the volunteer Resident Advocate Committee program. Debi has been with state government for over 10 years, and has a master's degree in Health Care Administration.

Joel Olah, Executive Director, Aging Resources of Central Iowa

Joel directs activities for the Area Agency on Aging that serves an eight county area in central Iowa. He is been responsible for the agency's budgeting, personnel, and Case Management program. For over 25 years in his career in aging and health care administration, he has created partnerships with service provider organizations, community organizations, and local, state, and federal officials to plan and deliver services to area seniors. Joel has a doctorate, master's degree and specialist certification in Gerontology.

ENDORSEMENTS

Letters of support are provided as attachments. Endorsements were received from the nursing home association, state agencies, legislators, long-term care ombudsman, area agency on aging, and advocacy group.

PROGRAM BUDGET

Administrative/Development	
Outreach Communication Plan development, production, travel	$65,000
Characteristics and Evaluation Reports	$10,000
Elder Group Homes analysis of community and state policy	$20,000
Identification of target population (data program and screening tool.	$10,000
Program Evaluation	$10,000
Initial case management assessments and transition assistance subsequent case management services will be funded by state funds.	$150,000
Direct Services	
Rent Subsidy program	
State funds $100,000 state funds allocated by Iowa legislature annually	
Enhanced program through grant	$100,000
Total Grant request	$365,000

In summary, the Department of Human Services respectfully submits this grant application for $365,000 to develop and implement a program of an infra-structure and communication plan for enhancing choices available to nursing facility residents. The proposal is designed to develop a program that will provide choices to residents and provide assistance with transitioning from an institution to the community.

ATTACHMENTS

Organizational Structure

Resumes for key project staff

- Eileen Creager
- Joel Olah
- Cindy Haverkamp

Letters of Support

- Department of Elder Affairs
- Aging Resources of Central Iowa
- State Long Term Care Ombudsman
- Senator Maggie Tinsman
- Representative Dave Heaton
- Department of Public Health
- Centers for Independent Living
- Iowa Association of Homes and Services for the Aging

8-30-99

Home care gains in Iowa

Elderly Medicaid recipients benefit

By LYNN OKAMOTO
REGISTER STAFF WRITER

The move to keep the elderly and disabled at home — and out of long-term care facilities — is making headway in Iowa.

The number of Medicaid recipients served by home health care has almost doubled in the last five years, from 8,904 to 17,616. State spending accompanied that growth, from $18.2 million in 1994 to $44.1 million this year.

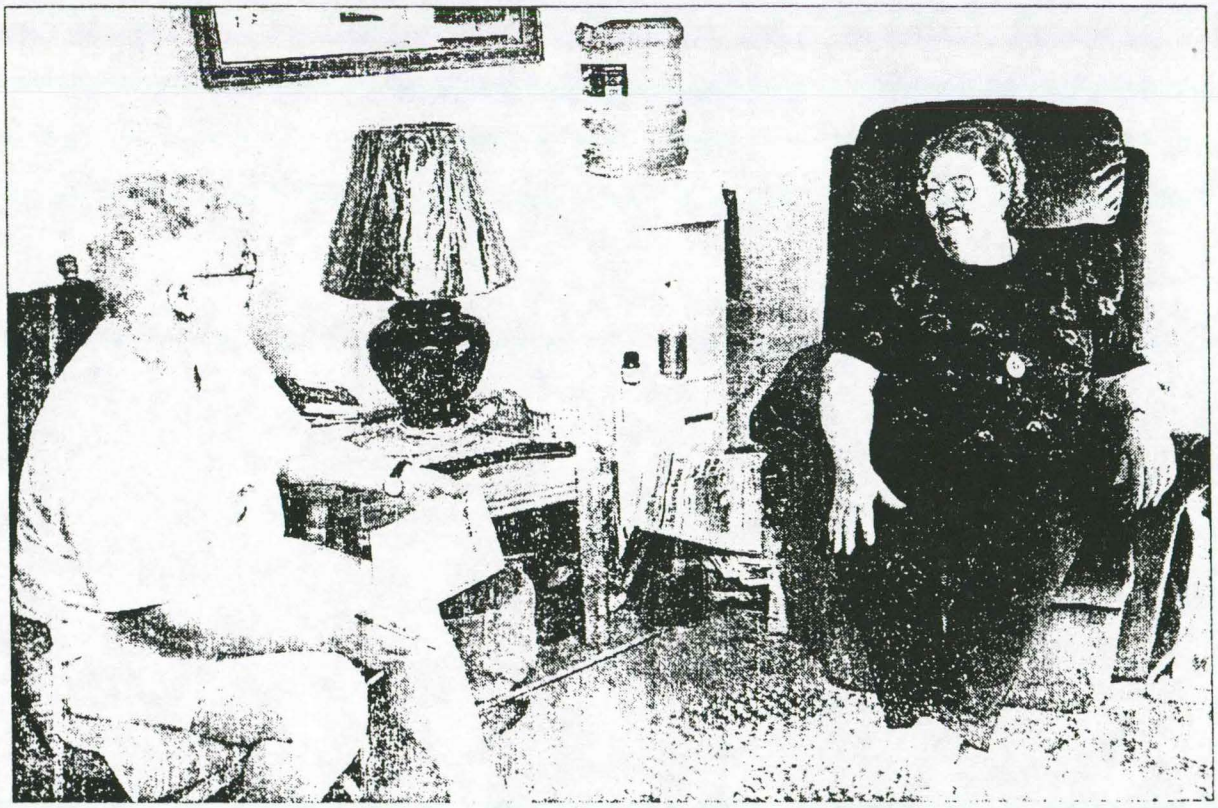
Top dollars

■ A list of Iowa's top Medicaid recipients. **Page 4M**

Expansion of home-based services can be seen as a move away from what some have called the institutional bias of Medicaid, the federal and state government program that guarantees health care for the poor and disabled.

The growth in spending on home health care is one obvious trend in an examination of the Medicaid program. Overall, state spending for the entire Medicaid program grew to a record $1.35 billion for the fiscal year that ended in June. Patti Ernst-Becker, an executive assistant for the state Division of Medical Services, said most of the increase in spending has been for the elderly.

Bruce Koeppl, state director for AARP, formerly known as the American Association of Retired Persons, said the growth in home health-care spending was positive. "People want to stay in their homes as long as they can. Economically, it makes sense."



DAVID PETERSON/The Register

Via Medicaid, and with some help from Medicare, Alice Sholley, 81, receives nursing care and household assistance that has allowed her to live independently in her Altoona apartment for the last five years. Grace Isley, left, Sholley's daughter, stops by regularly to help with bills and appointments.

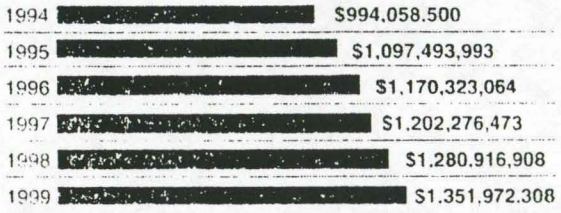
Alice Sholley, 81, is one of those Medicaid recipients being helped by home health care. For five years, she's lived by herself in an Altoona apartment, despite being in a wheelchair, being infected by flesh-eating bacteria and having diabetes, severe arthritis, glaucoma and artificial joints in both knees.

Through Medicaid's waiver program for the elderly and some help from Medicare, Sholley said, she is visited by a nurse every two weeks, a health aide three times a week and a cleaning lady three times a week. She also has a button around her neck for help in case of an emergency.

"I definitely just like being in my own home. I have a fantastic apartment," Sholley said. "I don't feel like I need to be in a nursing home. I'm in pretty good shape physically, only I can't walk."

Medicaid spending

■ **State Medicaid** spending continued to increase during the fiscal year that ended in June, reaching a new height of $1.35 billion.



SOURCE: Iowa Department of Human Services

MATTHEW CHATTERLEY / THE REGISTER

Other Medicaid recipients say that despite what the numbers show, they've seen a decrease in home-nursing services this summer, especially those provided for disabled children.

"What we're experiencing — a client used to have eight, 12 or 16 hours of skilled nursing. Now that same client with the same diagnosis and needs may not get any or very few hours of skilled nursing," said Dick Clock, vice president of operations for Hawkeye Health Services Inc., a home health-care agency with seven Iowa offices.

Advocates for the elderly and disabled say that by investing in home health care, the state avoids the greater expense of placing people in institutions.

Medicaid spending on nursing homes also increased in Iowa over the last five years. While the population of nursing homes remained fairly steady, spending increased from $222.7 million in 1994 to $303.6 million in fiscal 1999, which ended June 30.

Most of those rising costs — about 70 percent — go toward paying salaries, said Steve Ackerson, executive vice president of the Iowa Health Care Association, which represents 347 long-term care facilities.

Ackerson said Iowa nursing homes remain among

MEDICAID *Turn to Page* **4M**

Home care for aged, disabled increases

MEDICAID

Continued from Page 1M

the most poorly reimbursed in the nation. He said some providers are waiting six to nine months to be paid by Medicaid. "We're in a major crisis right now," he said.

Nursing home advocates are asking the state to spend an extra $15 million in Medicaid next fiscal year so nursing homes can be paid according to the level of care required by each patient.

Prescription drug costs also have risen for the program. While the number of prescriptions written in Iowa has remained fairly steady over the last five years, the price tag has gone from $90.9 million to $166.3 million.

Prescriptions for two newer drugs — Zyprexa, used to treat psychotic disorders such as schizophrenia, and Prozac, used to treat depression and obsessive-compulsive disorder — cost Medicaid the most money this past fiscal year.

One of the chief ways the state Division of Medical Services has saved money is by using managed care. Over the past five years, the number of Medicaid recipients served by managed care has more than tripled, from 30,578 to 96,508. Payments for such care increased from $28.4 million in 1994 to $65.3 million in 1999.

Ernst-Becker said the increase in payments to health maintenance organizations means savings elsewhere. "The more prevalent managed care becomes, the more we reduce our hospital costs," she said.

Plans are in the works to further expand state usage of managed care. Ernst-Becker said a pilot project may place some of those receiving Supplemental Security Income on managed-care plans. The project is tentatively slated to start in February in Scott and Pottawattamie counties.

"I definitely just like being in my own home. . . . I don't feel like I need to be in a nursing home. I'm in pretty good shape physically, only I can't walk."

— Alice Sholley
Medicaid recipient

Since welfare reform took effect in October 1993, Iowa has seen a steady decline in the average number of people eligible for Medicaid each month. That could change because of efforts to enroll more children in the program.

"The primary focus is to reduce the number of uninsured kids," said Dan Gilbert, chief of the state's Eligibility Services Bureau. "One of the ways is providing additional coverage under Medicaid."

Income requirements for Medicaid have been changed, and procedures such as face-to-face interviews and resource tests have been eliminated, so an estimated 15,000 additional children can qualify. Yet so far, only about half of those newly eligible children have enrolled.

Reporter Lynn Okamoto can be reached at (515) 284-8131 or okamotol@news.dmreg.com

ATTACHMENT F

Certificate of Need Task Force
Minutes
Wednesday, December 1, 1999
Four Points Sheraton Hotel & Suites
4800 Merle Hay Road
Des Moines, IA

MEMBERS PRESENT:

Jim Aipperspach
David Boarini, MD
Senator Nancy Boettger
Joe Dubray
Pam Biklin (alt for Diana Findley)
Jeanine Freeman
Stephen Gleason, DO (Ex-Officio)
Betty Grandquist
Bob Holz
Diane Howe
Ed Howell
Tom Juckette
Joni Keith
Janice Laue
Debbie Meyers
Cindy Moser
Rep. Beverly Nelson
Norm Pawlewski
Frank Sevarino (alt. for Dana Petrowski)
Paul Pietzsch
Greg Boattenhamer (alt. for Jim Platt)
Rep. Rebecca Reynolds
Tom Evans, MD (alt for Mike Richards, MD)
Nancy Ruzicka
Senator Mark Shearer
Rick Turner, MD
Dave Vellinga

MEMBERS ABSENT:

Larry Breeding
Jim Cousins
Cindy Haverkamp

GUESTS PRESENT:

C. Edward Brown, The Iowa Clinic
Steve Conway, Senate Dem. Staff
Kevin Cunningham, IMS
Stacey Cyphert, UIHC
Carolyn Gaukel, House Dem. Staff
Denise Hill, IMS
Anne Kinzel, IDPH
Kathleen Kregel, Health Facilities Council
Kirk Norris, IH&HS
Joe Ryan, Health Facilities Council

STAFF PRESENT:

Barb Nervig
Mark Schoeberl

The meeting was called to order by Paul Pietzsch, chairperson. There was a roll call taken of Task Force members and visitors introduced themselves. Minutes of the last meeting were distributed and briefly summarized by staff. The agenda for today's meeting was reviewed and approved without change.

Chairperson Pietzsch thanked all task force members and staff for their work on this review of the CON program.

Chairperson Pietzsch suggested that the group start with an understanding of the process to be followed at this meeting. Following the agenda, item "I B." will involve looking at the options and supporting documents and having a discussion around that. The goal is to have everyone informed and fully knowledgeable about everything we have before us, including information about the options. Then, moving to the decision making process, the first step will be a vote on the big options 1, 2, 3. Once there is consensus on one of

those options, the detail and recommendations within that option will be acted upon. After some discussion, there was consensus about this process.

Barb Nervig reviewed the information received since the last meeting. The three main options were determined at the last meeting. Listed under Option 1 are possible policy recommendations that the group could make to monitor the effect of repeal if this option passes. If Option 2 prevails, a possible recommendation would be to review CON again in couple of years. Information submitted by Dave Vellinga regarding this option may be found in the findings of the final report. Barb reminded the group that Option 3, reform CON, can mean relax the criteria, strengthen the criteria or both. The general recommendations (1st six items) under this option relate to the monitoring of projects and sufficient resources to do the monitoring and data analysis. These were presented at the last meeting. Specific recommendations were solicited from the membership and received.

The letter from the Association of Homes & Services for the Aging suggested some changes for long-term care that Barb put into possible Code language and sent to Dana Petrowski for review. No comments were returned. There was a question about the 10%/15 bed maximum bed increase proposal, why 15 beds? Frank Sevarino suspects its historical stating that AHSA has had its own task force looking at CON. Barb & Nancy Ruzicka also pointed out by that few facilities would need the 15-bed cap since the average size of a nursing facility in Iowa is 75. There was a question regarding the proposal about moving beds among facilities as to whether this was only within a parent corporation. It was suggested that this would probably have to be among non-profits.

The recommendation under other facilities was taken out of the Iowa Medical Society document. This proposed exemption from CON was alluded to at the October meeting. Jeanine Freeman stated that they believe there is strong evidence that CON is not meeting its stated objective and there is a need to move to a competitive market system. IMS believes the surgery center proposal is a step toward this. Jeanine stressed the limitation to certain size communities in the proposal. Also, there is a built-in assurance that indigent and charity care be provided in these facilities.

There followed a general discussion of items under option 3: Nancy Ruzicka expressed a need for coordination between IDPH and DIA if the long-term care proposals are passed. She also expressed a need to add the Iowa Department of Public Safety (Fire Marshal's office) to the IMS proposal. Jim Aipperspach commented that the general recommendations (1-6) under Option 3 seem to be good for data collection and evaluation so that there can be an ongoing understanding of the market forces. He asked: Do these provisions strengthen the opportunity to understand the system? Are the resources available to do these? Barb indicated that these are all things we strive to do and perhaps these recommendations were made to reemphasize and strengthen that effort. Greg Boattenhamer stated that these are laudable recommendations, but not very specific and rather open-ended. He suggested more involved discussion on these if Option 3 prevails.

Norm Pawlewski called for the question on Option 1, seconded by Representative Reynolds, motion passed on voice vote. There are 26 voting members present. Option 1: Repeal CON program: Voice vote, nays carried. Pam Biklin abstained.

Senator Shearer moved Option 2, seconded by Norm Pawlewski. There was discussion on the motion. Paul Pietzsch asked for the background and history on hospital-licensed freestanding surgery centers versus ambulatory surgery centers. Barb Nervig explained that the key is the establishment of a new institutional health facility. A surgical facility located off-campus from a hospital, but still under the hospital license is part of the hospital and not a "new facility". There was a question regarding any limitation on distance from the main campus. It was explained that the licensing requirements for hospitals does limit it to 60 miles. The change to exclude modernization from CON did impact this situation, hospitals wishing to establish a surgery site off campus would occasionally hit the capital threshold for review, now this does not happen due to the exclusion for modernization. Jim Aipperspach asked if ownership should be the issue. Freestanding ambulatory surgery centers in Iowa are not licensed. An ambulatory surgery center seeking Medicare certification does require a survey. Greg Boattenhamer points out that in Iowa we are talking about not-for-profit community hospitals. He added that hospitals do not open surgery centers without the cooperation of physicians in the community. Jeanine Freeman responded by saying that essentially, the changes made in 1997 in this area resulted in repeal of CON for hospitals, but a market place competitor does need to be reviewed. She asked what is the health policy of this state?

Bob Holz stated that CON is about looking at the facts and circumstances in a particular area (community) and there is a body (Health Facilities Council) to do this. Betty Grandquist stressed the importance for the Council or somebody to have the resources to look at the whole system to see where a proposed project fits in overall and does it make sense for good, affordable, high quality health care for the state.

Norm Pawlewski moved the question on the motion for option 2. Senator Shearer seconded. Voice vote on motion to move question, ayes carried. Roll call vote on Option 2: 17 yes, 5 no and 3 abstentions. Those voting no were Aipperspach, Boarini, Freeman, Moser and Sevarino. Those abstaining were Biklin, Grandquist and Ruzicka.

Ed Howell commented that Option 2 as worded and voted upon meets the charge of the legislature to determine the relevance of the CON program. He asked if it is fair to conclude that the report from this task force will say that we determined that the CON program is of continued relevance and therefore support its continuation with no changes to existing law or regulation. The issue of relevance is not in any motion, but is part of the charge. Dr. Turner moved, Norm seconded, that comments made by Ed Howell regarding relevance be included in report. Dr. Boarini asked that a minority report be included. Voice vote on relevance motion passed on voice vote, no nays.

Dr. Turner moved, Senator Boettger seconded, that the report includes a minority report. Voice vote on minority vote, no nays.

Jeanine Freeman moved for an ongoing study the program with a report back to the legislature in 2-3 years. Jim Aipperspach seconded the motion. There was discussion on the motion. Greg Boattenhamer stated that this is not called for under the purview of this task force. He feels that the market place has to be allowed to evolve. Betty Grandquist feels the program is relevant as long as it is looked at constantly, because changes are occurring daily. There is a need for a process to look at all the changes that occur in health care. Norm Pawlewski agreed, but feels it is an administrative function for the department of public health, not something to put on the legislature. Jim Aipperspach stated it makes sense to give the highest degree of encouragement to the department to have access to the resources to conduct an ongoing analysis.(items 1-6 under recommendations in option 3). Jeanine Freeman withdrew her motion in favor of approach outlined by Aipperspach. Things can be done under the context of CON that would be helpful to entire state.

New motion: include with option 2 recommendation items 1-6 (that appear under option 3) as general overall administrative changes that Dr. Gleason and his department can implement per their discretion. Jim Aipperspach moved, Jeanine Freeman seconded. There was discussion following the motion around the six items and how they are worded. Jim Aipperspach stated that his intent was to take this opportunity to seize the input of the people around the table and build upon it to continue to serve the people of Iowa in terms of health care. Jim Aipperspach withdrew motion and asked that the good intentions of the task force to support the department as they go about their work be on the record.

Barb reviewed the proposed outline of the final report. Ed Howell urged a separate section for recommendation. It was agreed that the Executive Summary should refer to the minority report and that the minority report will appear in the recommendation section.

Dr. Gleason thanked all members of the task force for their diligent participation and dedication to the task. Dr. Gleason expressed special appreciation for Paul Pietzsch for chairing the group.

This was the last meeting of the Task Force. The final report will be mailed to Task Force members on December 20, 1999 for their review and comment.

Certificate of Need Task Force
Minutes
Wednesday, October 20, 1999
Four Points Sheraton Hotel & Suites
4800 Merle Hay Road
Des Moines, IA

MEMBERS PRESENT:

Jim Aipperspach
Kevin Cunningham, MD (alt. for David Boarini, MD)
Senator Nancy Boettger
Kevin Van Dyke (alt. for Joe Dubray)
Pam Biklen (alt for Diana Findley)
Jeanine Freeman
Betty Grandquist
Cindy Haverkamp
Carla Pope (alt for Bob Holz)
Diane Howe
Ed Howell
Joni Keith
Janice Laue
Cindy Moser
Rep. Beverly Nelson
Norm Pawlewski
Dana Petrowski
Paul Pietzsch
Jim Platt
Tom Evans, MD (alt for Mike Richards, MD)
Nancy Ruzicka
Senator Mark Shearer
Joe LaValley (alt for Rick Turner, MD)
Dave Vellinga

MEMBERS ABSENT:

Larry Breeding
Jim Cousins
Stephen Gleason, DO (Ex- Officio)
Tom Juckette
Debbie Meyers
Rep. Rebecca Reynolds

GUESTS PRESENT:

Greg Boattenhamer, IH&HS
Steve Conway, Senate Dem. Staff
Stacey Cyphert, UIHC
Larry Frazier, DIA
Carolyn Gaukel, House Dem. Staff
Denise Hill, IMS
Maureen Hockmuth, IH&HS
Kathleen Kregel, Health Facilities Council
Joe Ryan, Health Facilities Council
Bill Vanderpool, The Baudino Law Firm

STAFF PRESENT:

Barb Nervig
Mark Schoeberl

The meeting was called to order by Paul Pietzsch, chairperson. Those present introduced themselves. Minutes of the last meeting were mailed to members. A motion by Jim Platt seconded by Senator Shearer to approve the minutes as written carried unanimously.

Barb Nervig distributed three items of information that had been received since the last meeting. The first was a statement from an Older Iowans Legislature (OIL) delegate regarding the difficulty of a local nursing facility in obtaining approval for additional beds. OIL had a legislative platform last session that included the repeal of CON. The second item was a table showing the costs of the CON program for the last four years. The third item was an article from the journal Modern Healthcare, September 6, 1999, about doctors moving surgeries into offices.

There were concerns expressed about the budget and significant resources to support the program. Betty Grandquist expressed a concern about the adequacy of resources to enable the development of an overall plan for the state instead of a case by case review. Jeanine Freeman stated that the dollars budgeted reflect a lack of capacity to meet the original intent of the program. There is not systematic planning.

Barb Nervig reviewed the continuum of services and thanked those from other state agencies who assisted in completing this information. This is a work in progress and any suggested changes are welcome. There was discussion around the question of what is picked for review under CON. Dana Petrowski stated that there has been an impact on nursing facility (CON required) occupancy by alternative services that do not require CON. She also pointed out the change from retrospective payment for Medicare and Medicaid, in place when CON started, to the prospective market and the alternatives to care that exist today. There was also some discussion about an apparent linkage between payer and CON coverage of services. Nancy Ruzicka suggested that if bricks and mortar and payer source were both looked at there may be a relationship to the requirement of CON. It was agreed that the table be titled "Continuum of Health Care Services" and that it should be included in the final report.

The Association of Iowa Hospitals and Health Systems and the Iowa Medical Society were invited to present their vision of Iowa's future health care system with and without CON. Copies of their presentations are attached and made a part of these minutes.

Comments, observations and questions that followed the presentation included the following.

- Norm Pawlewski asked if the number of specialty procedures has increased in states where specialty hospitals are located. Greg Boattenhamer asked whether adding to the infrastructure creates demand for a particular service and then questioned the impact on quality and cost when services are spread out.
- Senator Shearer asked if there was any fiduciary evidence from insurance companies reflecting impact of repeal of CON. Diane Howe answered that in general medical costs are escalating, but it is difficult to point to a particular reason for the increase.
- Dr. Cunningham pointed out that there is no body in Iowa doing community focus on health planning.
- Betty Grandquist asked how we maintain a structure and yet develop options. As an example she used the impact of the new services of assisted living and home & community based waiver services on the existing structure of nursing facilities.
- Dana Petrowski stated that a substantial worry is that core hospital services and charity care will not be supported. Jeanine Freeman responded that this does not seem to be a problem in Iowa, even the physician owned surgery centers accept charity care cases.

Chairperson Pietzsch invited discussion on the three options that had been mailed out prior to this meeting by asking if there are different options or modifications to the current options. Jim Platt presented a different option, to maintain the CON program with no changes to existing law or regulations. Jeanine Freeman expressed the need to have some movement on the CON law. They would propose to maintain the law, but carve out specific services, perhaps on a pilot basis in non-rural areas. This could be an option within an option. She will provide language to staff. Dana Petrowski asked that facilities at 90% occupancy have the ability to add 10% of existing beds without review. She too will provide language to staff.

Jim Platt asked a procedural question regarding the charge of the task force regarding relevance of the CON program. He feels a vote should be taken on the relevance of the program. Senator Boettger indicated there would be value to the legislature if a discussion on the options would occur. There was discussion about taking a vote today on the relevance of the program. It was suggested that options 1 and 3 be combined. It was agreed that the three options may be simply: 1) repeal the program, 2) retain the program with no changes and 3) retain the program with changes, listing the recommendations for change. It was noted that changes could be to relax the program or to strengthen the program. Proposed amendments from Task Force members should be submitted to staff within 10 days of this meeting.

Any additional findings or changes to the current draft should also be submitted to staff.

The next meeting will be Wednesday, December 1, 1999 at the Four Points Sheraton on Merle Hay Road. The agenda will include action on the options.

Certificate of Need Task Force
Minutes
Wednesday, September 1, 1999
Lucas State Office Building,
5th Floor South Conference Room
Des Moines, IA

MEMBERS PRESENT:

Jim Aipperspach
Senator Nancy Boettger
Karen Breeding (alt. for Larry Breeding)
Joe Dubray
Jeanine Freeman
Betty Grandquist (alt for Hanne Harris)
Cindy Havercamp
Bob Holz
Cathy Cory (alt for Diane Howe)
Ed Howell
Tom Juckette
Joni Keith
Janice Laue
Debbie Meyers
Cindy Moser
Rep. Beverly Nelson
Norm Pawlewski
Dana Petrowski
Paul Pietzsch
Jim Platt
Rep. Rebecca Reynolds
Tom Evans, MD (alt for Mike Richards, MD)
Nancy Ruzicka
Senator Mark Shearer
Rick Turner, MD
Greg Boattenhamer (alt for Dave Vellinga)

MEMBERS ABSENT:

David Boarini, MD
Jim Cousins
Diana Findley
Stephen Gleason, DO (Ex- Officio)

GUESTS PRESENT:

Steve Ackerson, Iowa Health Care Assn.
Judy Conlin, Dept. of Elder Affairs
Steve Conway, Senate Dem. Staff
Stacey Cyphert, UIHC
Carolyn Gaukel, House Dem. Staff
Maureen Hockmuth, IH&HS
Kathleen Kregel, Health Facilities Council
Ed Nichols, Health Facilities Council
Jim Zahnd, Iowa Health System

STAFF PRESENT:

Dawn Hughes
Barb Nervig
Mark Schoeberl

The meeting was called to order by Paul Pietzsch, chairperson. The agenda was reviewed and a handout on the principals behind CON was distributed. There was a brief discussion about the public policy direction of the state. Dr. Turner commented that the principals have been laid down by the legislature. Jeanine Freeman expressed the need for an evidence-based report.

Minutes of the last meeting were mailed to members. A motion by Jim Platt seconded by Tom Juckette to approve the minutes as written carried unanimously.

Bob Holz and Steve Ackerson presented the position of the Iowa Health Care Association. Three hundred thirty of the four hundred thirty nursing facilities in the state are members of this association. The Iowa Health Care

Association's position is that the Iowa CON requirements should remain unchanged for long term care. A handout summarizing their position was distributed and follows these minutes for those not in attendance.

Dana Petrowsky presented the position of the Iowa Association of Homes & Services of the Aging, whose membership includes primarily continuing care retirement communities. Their recommendation is to modify the existing program to reflect consumer choice and the need for units treating individuals with dementia. Dana stressed that "acute care and long-term care are very different." A written summary of this association was distributed and is enclosed for those not in attendance.

Tom Juckette spoke on behalf of the Iowa Council for Health Care Centers, whose membership are primarily owners of nursing facilities. They feel that the CON program should not be changed but the bed need formula and the policy that drives the formula should be reviewed. The impact of assisted living and home and community based services on nursing facility occupancy needs to be reflected in the policy.

Debbie Meyers spoke on behalf of the Department of Elder Affairs, stating that the CON program should continue with no changes. She indicated that the program helps provide balance in the system and enhances choice. The Department of Elder Affairs certifies Assisted Living Facilities, which offers a choice for private pay but not for Medicaid recipients.

Cindy Havercamp spoke for the Department of Human Services indicating that they support the continuation of the CON program. She pointed out that 45 states still have CON or something similar regulating long-term care. Regulation of nursing facilities encourages people to seek alternatives to nursing facility care. There are currently 3200 people in the elderly waiver program. The Department of Human Services has an interest in two other areas, intermediate care facilities for the mentally retarded (ICF/MR) and psychiatric mental institutions for children (PMIC), that require a CON to add beds. There are bed limits in place for both of these programs. There is some duplication of regulation that the agencies involved need to continue to discuss.

Betty Grandquist spoke on behalf of the American Association of Retired Persons (AARP). Their overall position is supportive of the CON program, however there needs to be flexibility to respond to change. Quality assurance of nursing facilities and home health needs to be swiftly and vigorously enforced. Reasonable access to reasonable services is crucial to the older population. Ms. Grandquist stated that it is important for each state to have a plan. She also stressed that the public forum provided by the CON program is a plus.

Although the Older Iowans Legislature (OIL) did not submit a statement prior to today's meeting, their issue is around access and lack of flexibility in the program.

Chairperson Pietzsch suggested that a grid displaying the continuum of care and the role of various state agencies in the different levels of care would be valuable and should be included in the final report. He then summarized the presentations on long-term care noting that most are in favor of CON, although some have specific recommendations for change. Some of the suggested changes can be made through the administrative rules process, while others would require statute changes.

Jeanine Freeman asked about new entries to the system and whether the purpose of the program is now to protect what we have.

Barb Nervig reviewed the list of information that was requested by the task force. She distributed information about the number and type of projects reviewed by the Council prior to the Code change in 1997 and since that time. Tables showing requests for reducing nursing facility beds and showing the number of additional beds that have been approved were also distributed and are enclosed for those not in attendance.

There was discussion about the process from here. This included a discussion on the charge of the task force. It was noted that the legislature would like some input from the group and to know the areas of consensus, not just a hand count as to the continued relevance of the program. Chairperson Pietzsch suggested some areas of possible consensus that met with little success. He proposed three options for the group to consider: 1)keep the program with some rule changes, 2)do away with the program and monitor results or 3)keep the program and build on its strengths. There should be a plan that resources are allocated and access is available statewide.

The next meeting will be Wednesday, October 20, 1999 at a location to be determined. The agenda will include a public policy discussion, refinement of findings and action on the options.

Certificate of Need Task Force
Minutes
Tuesday, June 29, 1999
Lucas State Office Building,
5th Floor South Conference Room
Des Moines, IA

MEMBERS PRESENT:

Jim Aipperspach
David Boarini, MD
Senator Nancy Boettger
Larry Breeding
Jim Cousins
Diana Findley
Jeanine Freeman
Stephen Gleason, DO (Ex-Officio)
Hanne Harris
Cindy Havercamp
Bob Holz
Diane Howe
Ed Howell
Tom Juckette
Joni Keith
Debbie Meyers
Norm Pawlewski
Dana Petrowski
Paul Pietzsch
Jim Platt
Rep. Rebecca Reynolds
Larry Frazier (alt. for Nancy Ruzicka)
Senator Mark Shearer
Rick Turner, MD
Dave Vellinga

MEMBERS ABSENT:

Joe Dubray
Janice Laue
Cindy Moser
Rep. Beverly Nelson
Mike Richards, MD

GUESTS PRESENT:

Greg Boattenhamer, IH&HS
Ed Brown, The Iowa Clinic
Judy Conlin, Dept. of Elder Affairs Council
Steve Conway, Senate Dem. Staff
Stacey Cyphert (alt. for Ed Howell)
Carolyn Gaukel, House Dem. Staff
Maureen Hockmuth, IH&HS
Kathleen Kregel, Health Facilities
Jim Zahnd, Iowa Health System

STAFF PRESENT:

Mariette Brodeur
Dawn Hughes
Barb Nervig
Mark Schoeberl
Pierce Wilson

Dr. Gleason called the Task Force to order and extended a welcome to those present. Dr. Gleason then introduced Paul Pietzsch as the chairperson of the group and asked the task force members to introduce themselves.

Mark Schoeberl reviewed the background and charge of the taskforce: to assist the Department in a comprehensive review of the certificate of need program resulting in a written report of the findings and recommendations as to the continued relevance of the program to the general assembly by January 15, 2000.

Mr. Schoeberl then reviewed the ground rules and indicated that Robert Rules of Order would be followed. A quorum will consist of a simple majority of the membership, or 15 members (or designated alternate). Any motions or recommendations will require a simple majority vote of a quorum for passage.

Barb Nervig provided a brief history of the CON program and reviewed the handouts, containing several articles and data pieces regarding CON in Iowa and other states. Copies of the handouts are enclosed with these minutes for those absent from the meeting.

Jeanine Freeman of the Iowa Medical Society presented that organization's position on CON. A written copy of her presentation was distributed at the meeting and is enclosed herewith for those not in attendance.

Dr. Boarini commented that CON regulation results in lack of competition, creating a barrier that is being used to block what is good for patients. Dr. Boarini stated that, speaking on behalf of patients, not the Iowa Medical Society, CON is detrimental.

Dr. Turner drew attention to the end date of the Duke Study, referenced by Ms. Freeman and included in the handouts. The study ended in 1993 and at least three states (Nebraska, North Dakota and Ohio) have repealed CON since then. He stated that Ohio has seen an explosion in growth since the repeal.

Greg Boattenhamer with the Association of Iowa Hospitals and Health Systems presented that organization's position on CON. Highlights of his presentation are attached to these minutes.

Chairperson Pietzsch asked for agreement on the process that the group would use to accomplish their charge. It was agreed that the first two meetings would be used primarily for fact gathering and presentations. It was agreed that a draft of the final report would be sent prior to the December meeting for discussion at that meeting.

All of the Task Force members were given the opportunity to request additional information that would assist the group in their task. Among the comments made was a statement by Norm Pawlewski that the Iowa Osteopathic Medical Association supports CON. Another Task Force member mentioned that the Iowa Academy of Family Practitioners is neutral on the subject. A categorized list of the information requested is attached to these minutes.

Any member of the Task Force able or willing to help gather any of the information requested was encouraged to assist Department staff. Please contact Barb Nervig if you have a source for any of the information.

Future meetings of the Task Force were set for:
Wednesday, September 1, 1999
Wednesday, October 20, 1999
Wednesday, December 1, 1999
Time for all meetings: 2:00 PM to 5:00 PM
All meetings will be in Des Moines. The September and December meetings will be in the 5th floor conference room of the Lucas State Office Building. The site of the October meeting is yet to be determined.

ATTACHMENT G

The information in this attachment was not original material developed by the Task Force and therefore is not being reproduced here. The Task Force reviewed these items as part of their comprehensive review of CON.

For information on how to obtain a copy of any of these items, please contact Barb Nervig at the Iowa Department of Public Health, 515/281-4344 or by e-mail at bnervig@idph.state.ia.us

Background & Requested Information

1. 1999 Code of Iowa 135.61-135.83 (Health Facilities Council)
2. Iowa Administrative Code [641] Chapter 202, Certificate of Need Program
3. Iowa Administrative Code [641] Chapter 203, Standards for Certificate of Need Review
4. Current membership of State Health Facilities Council
5. Yearly Project Totals and Dollars
6. CON Annual Report for FY 1996
7. Projects reviewed by Council for FY 1996 through FY 1999
8. "Does Removing Certificate of Need Regulations Lead to a Surge in Health Care Spending?", by Christopher J. Conover and Frank A. Sloan, Duke University
9. "Health Care Construction, Competition Booming" by Mary McGrath, Omaha World Herald, April 13, 1999
10. "CON Trends in America: A Panorama of Change", interview by AHPA Today in Health Planning with Thomas Piper
11. "Wilson says CON reform not dead", by Scott Smith, The Business Journal of Charlotte, November 3, 1997
12. "Certificate of Need: A Review", by John Steen, director of Georgia's CON program
13. Listing of Nursing Facility Projects heard by the Health Facilities Council, FY 1995 through FY 1999
14. "The Effect of Certificate of Need and Moratoria Policy on Change in Nursing Home Beds in the United States", by Charlene Harrington, PhD and others, in *Medical Care,* 1997.
15. "Health Care – Certificate of Need" in Analysis and Perspective, *U.S. Law Week*, 10-14-97.
16. Letter from Joann Nixt, Older Iowans Legislature (OIL) delegate.
17. CON Program costs
18. "Doctors move surgeries into offices", by Scott Hensley in Modern Healthcare, September 6, 1999.
19. Principles Behind CON
20. Nursing Facility Bed Data
21. Summary of Projects Heard and Denied, 7/1/95 to 7/1/99
22. For-Profit and Not-for-Profit Hospitals and HMO Enrollment for Iowa and Surrounding States
23. Managed Competition Defined
24. Excerpt from State of Washington Joint Legislative Audit and Review Committee Report 99-1, "Effects of Certificate of Need and its Possible Repeal, January 8, 1999.
25. Iowa Medical Society's Position Statement on CON
26. Iowa Hospital & Health System's Position Statement on CON