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Medical care facility planning and regulation in Virginia through certificate of public need

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MEDICAL CARE FACILITY PLANNING AND REGULATION IN VIRGINIA
THROUGH CERTIFICATE OF PUBLIC NEED

by

RONALD STEPHEN WEBB
M. A. in Political Science

University of Richmond

May 1989

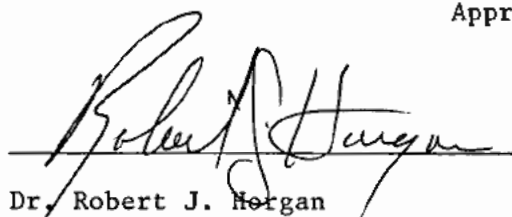
Thesis Director: Dr. Robert J. Horgan

It is the central argument of this thesis that the cost of medical care has been the most salient political consideration in the evolution of certificate of public need in Virginia. Certificate of need is a regulatory mechanism that public officials use to achieve health planning goals by controlling medical facility capital expenditures. This thesis sets the development and implementation of certificate of need in Virginia against the broad background of medical facility public policy in this country, as well as significant political movements in Virginia.

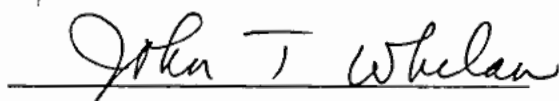
Several themes are evident from this analysis. Over time, the center of medical facility planning and assistance has shifted from the private sector to state and local governments, and then to the federal government. More recently, governmental activity in this area has reverted to the states. Secondly, the nature of this activity has changed

from health facility construction assistance to health planning, and finally to health facility regulation. Group interaction has played an important role in the overall development and administration of the certificate of public need in Virginia. The review process itself has numerous points of entry for public participation. Finally, several facets of the ever-changing healthcare environment have influenced and are influenced by Virginia's certificate of public need program.

Approval Page



Dr. Robert J. Morgan



Dr. John T. Whelan

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PLANNING AND REGULATION IN VIRGINIA
THROUGH CERTIFICATE OF PUBLIC NEED

By

RONALD STEPHEN WEBB

B.S., James Madison University, 1985

A Thesis

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TABLE OF CONTENTS

| | | |
|----------------|---|-----|
| CHAPTER ONE: | FORMATIVE POLICY DEVELOPMENTS | 1 |
| CHAPTER TWO: | ENACTMENT OF VIRGINIA'S CERTIFICATE OF PUBLIC NEED LAW | 49 |
| CHAPTER THREE: | VIRGINIA CERTIFICATE OF PUBLIC NEED PROCESS | 75 |
| CHAPTER FOUR: | VIRGINIA CERTIFICATE OF PUBLIC NEED ENVIRONMENT | 106 |
| CHAPTER FIVE: | CONCLUSION | 166 |
| BIBLIOGRAPHY | | 173 |

CHAPTER 1 FORMATIVE POLICY DEVELOPMENTS

Major changes in the provision of hospital services have occurred during the twentieth century. Gone are the days when visits to the hospital were remedies of last resort. Significant advancements in medical technology, and in the training of medical professionals have transformed the hospital into the centerpiece of the American medical system.

Over the years, various social, political, and economic factors have led to greater governmental involvement in the hospital sector. What had once primarily been the domain of the nation's charitable and philanthropic organizations, hospital care has become increasingly influenced by all levels of government. Government's role in hospital care evolved in this century in response to the needs as perceived by various groups in society, and by the various levels of government. Hence, the goals of the various legislative remedies that have been put forth have changed to reflect the concerns prevailing at a given time.

Just as the goals of governmental policy have changed over time, so too, have the policy instruments that government has developed. During the early decades of this century, governmental activity consisted primarily of the disbursement of construction and operating assistance funds by the federal government, while state and, especially local governments initiated local hospital

planning authorities to insure the viability of these institutions. With the end of World War II, health officials renewed their efforts to increase the nation's stock of hospital beds. At this time the federal government took the leading role by initiating a hospital construction program. By the mid-1960's, the federal government instituted a comprehensive health planning program as a means of integrating medical facility and physician services. Also at about the same time, New York and several other states began to experiment with a little-known regulatory instrument known as certificate of need, which required prior state approval for medical facility capital expenditures as a means of implementing health planning goals.¹

By the early 1970's the costs for health care were rising dramatically. Federal and state officials were especially concerned because of their burgeoning fiscal burdens under the Medicare and Medicaid programs. In an effort to stem the rise in costs Congress passed a national health planning program which included a certificate of need provision. Already concerned about rising medical bills, the Virginia General Assembly instituted its own certificate of need program. In so doing, Virginia and Congress transformed what had previously been

¹Most of the early hospital planning activities, and literature pertaining to those activities, focused on acute care, general hospitals. However, later medical facility planning and regulatory efforts in the post-war period incorporated other types of facilities, such as nursing homes and intermediate care facilities for substance abuse. Therefore, except when referring to a particular type of facility, the terms health care facility and medical facility shall refer to the range of facilities covered under a particular program.

essentially private decisions regarding medical facility expansion and service changes into inherently political decisions.

Certificate of need continued to be a federal, state and local health planning and regulatory mechanism through the early 1980's. However the Reagan Administration's anti-regulatory posture resulted in the gradual reduction and ultimate dissolution of the federal health planning program. Virginia and other states are once again free to alter or abolish their individual health planning and regulatory programs, should they choose to do so. Indeed, the Virginia General Assembly is currently considering alterations to its certificate of need program. At issue is the proper role for government in the medical facility industry. What follows is essentially a case study of medical facility planning and regulation through certificate of need in Virginia, set against the broader historical and political evolution of medical facility public policy in the U. S. generally. Particular attention will be paid in chapter 2 to the health care environmental factors that influenced the emergence and evolution of certificate of need in Virginia. The third chapter shall focus on Virginia's certificate of need review process and the opportunities for political influence that it offers. The fourth chapter provides an overview of the health care environment in which Virginia's certificate of need currently functions. And, the final chapter focuses on the broad political and social themes that have shaped

medical facility public policy nationally and in Virginia, as a means of ascertaining the current status of medical facility public policy in Virginia.

Private Sector Initiatives in Hospital Planning and Assistance

Private sector initiatives to render assistance to hospitals evolved at about the same time as local government efforts. Philanthropic foundations, such as the Commonwealth Fund, based in New York City, the Duke Endowment, headquartered in Durham, North Carolina, and the Kellogg Foundation of Battle Creek, Michigan, rendered financial and organizational assistance to hospitals. While they did act as a stabilizing influence to many institutions, the expansion of this experience on a wider scale was not considered feasible by health care professionals at the time.²

A number of voluntary affiliations arose by which smaller hospitals became affiliated with larger hospitals through interlocking directorates. These affiliations facilitated the flow of personnel and services from large hospitals to small hospitals, while patients tended to gravitate toward large hospitals. Voluntary affiliations also permitted the flow of information between hospitals of various sizes.³ These

²Commission on Hospital Care, Hospital Care in the United States (New York: The Commonwealth Fund, 1947), p. 351.

³Commission on Hospital Care, p. 352.

arrangements appear to have been designed to instill a measure of stability.

In spite of these efforts to improve the general condition of hospital care in the United States, it became apparent to professionals within the health care field, as well as concerned private citizens, that further action would be necessary. Hence in 1942, the American Hospital Association (AHA) organized the Commission on Hospital Care to analyze the then-current hospital situation, and to make recommendations for remedying these inadequacies⁴. The Commission's findings and recommendations would

⁴V.M. Hoge, "Hospitals and Health Centers, the Federal Government Role in Providing Financial Aid For Hospital Construction Since 1946," Annals of the American Academy of Political and Social Science (January 1951) p. 35. Members of the Commission were: Thomas S. Gates of the University of Pennsylvania, chairman; vice-chair, Edward L. Ryerson, chairman of the board of Inland Steel Co.; Sarah Gibson Blanding, president of Vassar College; Katharine J. Densford, R.N., Director of the School of Nursing, University of Minnesota; Albert W. Dent, president of Dillard University; Joseph W. Fichter, Master of Ohio State Grange; Clinton S. Golden, assistant to the president, United Steelworkers of America; Evarts A. Graham, chairman, Department of Surgery, Washington University School of Medicine; Wilton L. Halverson, M. D., Director of Public Health, State of California; Herbert Hoover, trustee, Stanford University; Charles F. Kettering, vice president and director, GMC; Ada Belle Mc Cleery, R.N., former administrator of Evanston Hospital, Evanston, Ill; James Alexander Miller, M.D., professor of Clinical Medicine, Columbia University; Leroy M.S. Miner, M.D., D.M.D., former dean, School of Dentistry, Harvard College; Claude W. Munger, M.D., director, St. Luke's Hospital, New York City; Rt. Rev. Msgr. Thomas O'Dwyer, director of Catholic Charities and Hospitals, Archdiocese of Los Angeles; William F. Ogburn, Ph. D., chairman, Department of Sociology, University of Chicago; Clarence Poe, editor, Progressive Farmer; Willard C. Rappleye, M.D., dean, College of Physicians, Columbia University; J. Barrye Wall, editor, Farmville Herald (VA), president, Southside Community Hospital; Frank J. Walter, administrator, Good Samaritan Hospital (Portland, OR); Matthew Woll, vice president, American Federation of Labor.

set the tone for subsequent legislative developments.

The Commission analyzed the status of American hospitals from a variety of perspectives, and the Commission's membership reflected this diversity. The Commission was composed of twenty experts representing the fields of hospital administration, medicine, nursing, farming and labor, the general public, and included a professional support staff.⁵

The primary focus of the study was the evaluation of the nation's hospitals at that time, and the recommendation of reforms. It was decided that a census of hospitals and public health facilities was necessary, in order to evaluate their condition. Criteria for evaluating the condition of and need for hospitals were also developed. A national hospital plan was devised, along with strategies to implement that plan. A review of historical and more recent trends in hospital development, as well as a survey of administrative procedures, was included as well.⁶

The Commission on Hospital Care concluded that there were serious shortcomings with respect to the availability and quality of American hospitals. The study revealed that some hospitals were in poor condition, and that there was a general shortage of beds, particularly in rural areas. To remedy these problems, the Commission recommended the initiation of a federal hospital construction program, and the development of regional hospital

⁵Hoge, p. 36.

⁶Commission on Hospital Care, p. 5.

plans, within which hospitals would be constructed.⁷ The continuation of need surveys by the individual states was considered a means by which more accurate assessments could be made. Stimulating local, public support for this planning process was considered essential.⁸ This was a tacit acknowledgement that, no matter how well planned whatever kind of system emerged would be dependent upon public support if it was to have a chance of being truly successful.

State and Local Government Hospital Sector Activity

During the 1930's state and local governments became active in the medical facility sector of the health care industry. Activity at the state level consisted largely of providing funds for facility construction while localities, especially municipalities, experimented with hospital planning.

Although there was little, if any, conformity among state agencies with respect to administrative responsibility for dispensing construction assistance, funds were made available. Often, states assigned responsibility for dispensing construction aid according to the types of facilities that existed. For instance, most states placed tuberculosis hospitals under the jurisdiction of state health departments, although Indiana assigned this responsibility to its welfare department and,

⁷Hoge, p. 36.

⁸Commission on Hospital Care, p. 6.

Alaska, Connecticut, Florida, Maryland, Michigan, Louisiana, and New Hampshire created special commissions to oversee these facilities.⁹ The scope of duties assumed by these bodies ranged from regulation to the direct operation of facilities.¹⁰

There was also inconsistency among states with respect to the manner in which state funds were allocated to health care facilities. In some cases, state legislatures made direct grants to hospitals, while other states funneled funds to facilities through local health or welfare departments. Hospital construction assistance represented the largest portion of state aid for health activities. Over eighty percent of the funds for health activities came from state sources.¹¹

While state level activity in the hospital industry was largely confined to the distribution of funds, local, and especially, municipal governments, took the lead in hospital planning. Indeed, local planning efforts have their origin in the early 1930's.¹² Nationally, county governments contributed operating and construction assistance amounting to ninety-eight cents per capita in 1943. Large cities subsidized patient care

⁹Joseph Mountin and Evelyn Flook, "Distribution of Health Services in the Structure of State Government," Public Health Bulletin, 3d ed., no. 184, (Washington, D. C. : Government Printing Office, 1943), pp. 7-12.

¹⁰Commission on Hospital Care, p. 557.

¹¹Commission on Hospital Care, pp. 557-558.

¹²U. S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Resources Development, Office of Health Planning, The Changing Role of Health Planning, (Washington, D. C. : Government Printing Office, 1986), p. 10.

in voluntary, non-profit hospitals, with particular emphasis on providing funds for patients requiring specialized care.¹³ Cities also created voluntary, city-wide hospital councils to improve hospital care. While successful on some fronts, these local planning efforts had their shortcomings. City-wide hospital councils improved communication between hospitals but, they were not very effective at assuring high quality of care, or at attaining their planning goals.¹⁴ Nonetheless, it was at the local level of government that the first efforts at health facility planning occurred.

National Hospital Policy Activity Prior to World War II

Although the impetus for the health facility planning movement occurred at the local level of government prior to World War II, the federal government also played a role in medical facility industry. This role had consisted primarily of the provision of construction and operating assistance funds. The level of federal assistance during the pre-war period tended to ebb and flow with the level of economic prosperity of the times. During the first two and a half decades of this century, the number of hospitals grew considerably, as a result of rapid

¹³Commission on Hospital Care, p. 563.

¹⁴Paul L. Joskow, Controlling Hospital Costs: The Role of Government Intervention (Cambridge: MIT, 1981), p. 77.

advances in modern medicine and general economic prosperity.¹⁵ From 1909-1941 the number of all types of hospitals increased 45 percent, while the number of beds increased 300 percent. The marked increase in the supply of beds was due to additions to existing facilities, and to the fact that most of the newer facilities were larger than those that existed previously.¹⁶

However, a closer examination of the evidence indicates that these increases were not constant through this period. The number of public-sector hospital beds increased seventy percent over the period 1928-1941, while there was only a slight increase in the number of beds in private, non-profit hospitals. There was even a slight decrease in the number of beds in private, for-profit(propriety) hospitals.¹⁷ In fact, from 1929-1937 over 700 hospitals were forced to close their doors, largely due to a shortage of funds during the Depression, and to problems of duplication and poor distribution of facilities and services.¹⁸ Thus, the Depression had a considerable negative impact on hospitals overall.

That negative impact is also reflected in the levels of federal aid that were available to hospitals during this period. Prior to the onset of the Depression, federal aid was on the rise. From 1923-1928, total federal contributions to all types

¹⁵Commission on Hospital Care, p. 63.

¹⁶Commission on Hospital Care, p. 2.

¹⁷Commission on Hospital Care, p. 55.

¹⁸Hoge, p.34.

of hospitals averaged \$200 million per year. By 1930, however, that average fell to \$132.5 million. And, the total amount of federal aid for the period 1929-1933 was only \$450 million.¹⁹ Congressional appropriations for hospitals during this period tended to be directed toward specific facilities or specific types of facilities. For instance, Congress appropriated \$10 million in 1925 for Veterans' hospitals,²⁰ and another \$25 million in 1931 for Veterans' hospitals.²¹

Even though federal aid to hospitals during the Depression experienced a general decline, aid to non-profit hospitals actually increased. Under the auspices of the Public Works Agency, Works Progress Administration, and the Reconstruction Finance Corporation, the federal government made loans for the construction of new hospitals, and for additions and renovations to existing facilities.²² Most of this aid resulted in the enlargement of existing facilities.²³ Thus there appears to have been a bias in the distribution of federal aid during this period toward existing, voluntary, non-profit hospitals. Voluntary,

¹⁹U.S. Department of Commerce, Bureau of the Census, Historical Statistics of the United States, Colonial Times to 1970, pt. 2, Series N-60 (Washington, D.C.: U. S. Department of Commerce), p. 621.

²⁰(P. L. 68-587) Statutes at Large, vol. 43, 2nd sess., ch. 469, pp. 1212-1213, (1925).

²¹(P. L. 72-361) Statutes at Large, vol. 49, pt. 1, 3d sess., p. 1551, (1931).

²²Commission on Hospital Care, p. 530.

²³Hoge, p. 35.

non-profit hospitals were largely dependent upon private contributions, and were therefore viewed in a more benevolent light than public or proprietary hospitals.

National Hospital Policy Developments During the War Years

Concern in the federal government about hospital care in the United States began to mount during the late 1930's and early 1940's. It was during this period that federal involvement began to overshadow state and local medical facility planning efforts. Among the first concrete examples of this concern at the federal level is a message to the Congress from President Roosevelt in January 1940.

There is still need for the Federal Government to participate in strengthening and increasing the health security of the Nation ... I now propose for the consideration of the Congress a program for the construction of small hospitals in needy areas of the country, especially in rural areas of the country not now provided with them.

The provision of hospitals in the areas to which I refer will greatly improve existing health services, attract competent doctors, and raise the standards of medical care in these communities... These hospitals should only be built where most needed; in the poorest communities which cannot afford to maintain their own. The operation of these hospitals should be a local responsibility with the Federal Government holding the title. Treatment is to be made available to those unable to contribute to their own expenses.²⁴

²⁴Franklin Delano Roosevelt, President of the United States, "Message From the President of the United States Transmitting Recommendations For Enabling Legislation and an Appropriation For the Public Health Service," H. Doc. No. 604, 76th Congress, 3d sess., 30 January 1940.

Although the bill that was under consideration at the time of this message was not enacted, this message laid important conceptual and ideological groundwork for future federal legislation. As shall be seen shortly, many of the ideas expressed in this communication, such as the emphasis on hospitals for poor, rural areas, would be incorporated into later legislation. The list of witnesses appearing before a subcommittee of the Senate Committee on Education and Labor attests to its wide appeal. Among those appearing before the subcommittee, or submitting documents in support of this bill were representatives of the various hospital associations, the National Education Association, and federal and state health officials.²⁵

The onset of World War II prompted the passage of an act which, although not focused on hospital services, did contain a provision related to the enhancement of hospitals in the U. S. Title II of the amendments to the Lanham Housing Act (P.L. 77-137) provided for the construction of hospitals, as well as other community projects in those areas where the population was growing substantially during the war, as a result of population

²⁵U.S. Senate, Subcommittee of Committee on Education and Labor, 76th Congress, 3rd, Hearings on A bill to promote national health and welfare through appropriation of funds for construction of hospitals. March 18-19, 1940 (Washington, D.C.: Government Printing Office, 1940) III-IV. Some of the witnesses appearing before the subcommittee were Dr. Reginald M. Atwater, secretary of the American Public Health Association; Dora Barney, Director of Education, Oklahoma Farmers Union; Nelson H. Cruikshank, American Federation of Labor; D. K. Este Fisher, Jr., American Institute of Architects; Dr. George S. Stevenson, National Commission on Mental Hygiene; Dr. Thomas Parran, Surgeon General of the United States; Dr. Victor Johnson, secretary, Council on Medical Education and Hospitals, AMA.

relocation efforts.²⁶ In this instance, then, hospital care was not only linked with the betterment of health for the medically needy, but also with national defense.

The federal government played the major role in financing and administering P.L. 77-137. Administered by the Federal Works Agency (FWA), the program required applicants for assistance (governmental or nongovernmental entities) to submit applications to the FWA. Upon receipt of an application, the FWA requested the Public Health Service to conduct a need study in the area to be served. The need criteria were based on the occupancy rate and the additional usable beds that were available in general and special (disease or condition-specific) hospitals. Final authority for the approval of requests was vested in the Executive Office of the President.²⁷

The federal government not only assumed administrative responsibility for Title III of the Lanham Housing Act, but most of the financial burden as well. The federal government assumed 100 percent of the construction costs for federally-owned projects, while the hospital title was vested in the federal government, and leased to the applicant. Non-federally-owned projects were eligible to receive up to seventy-five percent of their construction costs from grants or loans made under

²⁶Lanham Housing Act Amendments, (P. L. 77-137) Statutes at Large, vol. 55, Title II, p. 363 (1941).

²⁷Commission on Hospital Care, p. 534.

amendments to the Lanham Housing Act.²⁸

While assistance for the construction of hospitals was but one of the provisions of the Lanham Act, it had considerable impact on the hospital supply. From June 1941 when the law was enacted, through June 30, 1945, 810 hospitals were substantially or entirely completed. Total expenditures for these hospitals amounted to \$118,063,638, of which the federal government contributed \$91,327,540. By July 1, 1946, 851 hospitals were virtually completed.²⁹ These figures indicate that while federal assistance languished under fiscal constraints during the Depression, the advent of World War II helped to spur significant federal activity in this area.

The Hospital Survey and Construction Act of 1946

At the end of World War II, the nation was able to devote more of its energy to domestic concerns. While the hospital construction that had been undertaken pursuant to the Lanham Act had resulted in some improvements in the supply of hospitals, it had become evident that still more needed to be done. Thus, the movement for a hospital reconstruction program was rekindled.

Legislation was introduced in Congress in 1946, to address this very issue. There seems to have been a connection between the Commission on Hospital Care study and the introduction of national hospital construction legislation. Although this

²⁸Commission on Hospital Care, p. 535.

²⁹Commission on Hospital Care, pp. 534-535.

legislation was introduced after the Commission had completed its report, the Commission attempted to anticipate federal requirements, sensing that federal legislation would be forthcoming.³⁰

The Hospital Survey and Construction Act of 1946 (Hill-Burton Act) established a federal-state partnership as a means of assisting states in determining their hospital needs, and in providing assistance toward addressing those needs. States were required to devise a comprehensive hospital plan to be approved by the U.S. Surgeon General, who, in conjunction with a National Advisory Committee, was responsible for devising a national hospital plan. Congress, in 1946, appropriated three million dollars in federal grants to fund the state surveys, to be allocated among the states according to a state's population.³¹ Factors that were often considered when determining the suitability of existing facilities included obsolescence, improper design, fire and health hazards.³² Once these surveys were conducted and the plans approved, states became eligible to apply for construction assistance.

The initial federal hospital construction appropriations were considerable. Congress appropriated seventy-five million dollars for each of the first five years of the program. The federal assistance was apportioned so that the neediest areas

³⁰Commission on Hospital Care, p. 12.

³¹Hoge, p. 37.

³²Hoge, p. 39.

received the greatest amount of money. The amount of money that each state received was determined by utilizing a weighted formula that took into account population and per capita income.³³

The U.S. Surgeon General of the Public Health Service developed a set of criteria for determining "need". This formula was based on five-year population projections, current utilization and occupancy rates, and a predetermined standard of bed adequacy. Researchers generally established a figure of approximately four beds per 1,000 population as being adequate.³⁴ Congress hoped that this formula would ensure that the largest amounts of construction funds would be channeled to areas where the need was greatest.

The federal government stipulated that funding priority was to be given to poor, rural areas, where the need was perceived to have been the greatest. Along with improving the distribution of hospital facilities, Congress hoped that the new facilities would help attract physicians to these underserved areas.³⁵

The Hill-Burton Act enjoyed wide, bipartisan support in Congress. The initial proposal for a hospital construction came from President Truman as part of a five-point national health

³³Paul A. Brinker and Burley Walker, The Hill-Burton Act 1948-1954, " Review of Economics and Statistics 44 (May 1962), p. 208.

³⁴Hoge, p. 37.

³⁵Judith Lave and Lester Lave, The Hospital Construction Act: An Evaluation of Hill-Burton Programs: 1948-1973 (Washington, D. C. : American Enterprise Institute, 1974), p. 10.

program that he transmitted to Congress on November 19, 1945.³⁶ As was the case with the hospital construction legislation originally proposed by President Roosevelt in 1940, the list of witnesses appearing before the Senate Education and Labor Committee reveals a similarly wide base of support. This support, while widespread, was not universal. There was a great deal of concern expressed during the hearings about the powers of the Surgeon General and the Federal Advisory Council. The size of federal expenditures was also worrisome to members of Congress.³⁷ In general, the fear seems to have been that the federal government would dominate what was to have been a federal-state partnership.

With the passage of the Hill-Burton Act, the nation embarked on a new era in health care policy. Federal aid to hospitals had been dispensed before. However, the Hill-Burton Act represented the first attempt to create a coordinated, national hospital plan.³⁸

Over the next eighteen years, from 1946-1964, a number of amendments were made to the Hill-Burton Act. Most of these

³⁶Congressional Quarterly (2) 4 (October-December 1946), (Washington, D. C. : Congressional Quarterly, Inc.), p. 658

³⁷U.S. Congress, Senate, Committee on Education and Labor, Hearing: A bill to amend the Public Health Service Act to authorize grants to the states for surveying their hospitals and public health centers, and for planning construction of additional facilities, and to authorize grants to assist in such construction. Feb. 26, 27, 28, and Mar. 12, 13, 14, 1945. 79th Cong., 1st sess., p. 21.

³⁸Grace Budrys, Planning For the Nation's Health (New York: Greenwood Press, 1986) p.14.

amendments expanded the scope of the program. In 1954, the Act was broadened to include outpatient diagnostic and treatment centers, chronic and long-term care facilities, and rehabilitation centers.³⁹ An amendment enacted in 1964 prohibited funds from going to areas where the bed supply equaled or exceeded those which were needed, as determined by the Public Health Service formula. The 1964 amendment also permitted funds to be used specifically for facility modernization, in some cases.⁴⁰ This was an effort to allow greater flexibility in the allocation of Hill-Burton funds, so as to reflect changes in the nature of patient care.

Impact of the Hill-Burton Act

The Hill-Burton Act had a substantial impact on the provision of medical services in this country, although the nature of these effects tended to change over time. Initially, general hospitals accounted for seventy-five percent of the Hill-Burton assistance applications, while public health centers claimed sixteen percent, and chronic disease centers accounted for less than one percent.⁴¹ By 1971, however, this relationship had

³⁹Medical Facilities Survey and Construction Act of 1954, (P. L. 83-482) Statutes at Large, vol. 68, secs. 641-654, p. 461, (1954).

⁴⁰Hospitals and Medical Facilities Amendments of 1964, (P. L. 88-443) Statutes at Large, vol. 78, sec. 602, p. 448 (1964).

⁴¹Hoge, p. 37.

changed. General hospitals' share of the total percentage of projects had fallen to almost fifty-four percent; although the proportion of Hill-Burton funds devoted to projects in this category (70.9 percent) was still quite high (see Figure 1.1).⁴² These figures suggest that, while the reduction in the number of general hospital projects was considerable, the dollar value of those projects was still much greater than the dollar value of projects for other facilities. This may have been due to the technologically sophisticated equipment found in general hospital facilities, as compared to other types of facilities.

The Hill-Burton Act was definitely a factor in the general increase in the number of hospital beds in this country. Brinkley and Walker observed that, by 1954, the total number of hospital beds had increased to such an extent that the "percent of need met" ratio had increased considerably.⁴³ This ratio represents the total number of acceptable beds in existence divided by the total bed need, as determined by need surveys. The 388,144 beds in existence in 1948 represented fifty-nine percent of the total bed need. By 1954, however, the total number of acceptable beds had risen to 515,934, which represented seventy-three percent of the total bed need.⁴⁴

However not all of this increase was directly attributable to the Hill-Burton Act. During this period, Hill-Burton funds

⁴²Lave and Lave, p. 14.

⁴³Brinker and Walker, p. 210.

⁴⁴Brinker and Walker, p. 211.

accounted for twenty-three percent of the total value of all non-federally-owned medical facility construction projects. Brinkley and Walker felt that "...it would be proper to conclude ... that Hill-Burton money was an aid in the construction of more hospital facilities, and that such aid was partially instrumental in providing for a more adequate hospital system in 1954 than we had in 1948."⁴⁵ Thus, while the Hill- Burton Act did not contribute a majority of the hospital funds from 1948-1954, federal contributions still represented a substantial portion of hospital construction funds.

Conclusions reached by observers of the hospital scene during the early 1970's also suggested that the Hill-Burton funds had a considerable impact on health facility construction. By 1971, 10, 748 total projects, valued at \$3.7 billion, had been approved (See Tables 1.1 and 1.2). While the initial emphasis had been on the construction of hospitals, the late 1960's saw greater emphasis on long-term care facilities, mental hospitals, and rehabilitation facilities. There was also a shift away from the construction of new facilities toward the modernization and renovation of existing facilities.⁴⁶ These findings are further evidence of the flexibility of the Hill-Burton program.

It will be recalled that another of the Hill-Burton Act's original goals was to focus on hospital and health facility needs in poor, rural areas. This goal appears to have been adhered to

⁴⁵Brinker and Walker, p. 211.

⁴⁶Lave and Lave, pp. 13-14.

Table 1.1

HILL-BURTON PROJECTS APPROVED, BY TYPE, 1 JULY 1947-30 JUNE 1971

| Type of Facility | Total Projects | | Inpatient Care Beds Provided | | Outpatient and Other Health-Care Facility Projects | | Cost | | |
|------------------------------------|----------------|---------|------------------------------|---------|--|---------|----------------------|-----------------------|---------|
| | | | | | | | Hill-Burton funds | | |
| | Number | Percent | Number | Percent | Number | Percent | Total (\$ thousands) | Amount (\$ thousands) | Percent |
| Total | 10,748 | 100.0 | 470,329 | 100.0 | 3,083 | 100.0 | 12,765,900 | 3,717,979 | 100.0 |
| Short-term hospitals | 5,787 | 53.8 | 344,453 | 73.2 | 131 ^a | 4.2 | 9,322,392 | 2,635,494 | 70.9 |
| Long-term care | 1,733 | 16.1 | 97,358 ^b | 20.7 | — | — | 1,613,808 | 523,111 | 14.1 |
| Units in hospitals | 1,097 | 10.2 | 51,983 | 11.1 | — | — | 904,409 | 312,499 | 8.4 |
| Nursing homes | 528 | 4.9 | 37,884 | 8.1 | — | — | 571,057 | 171,648 | 4.6 |
| Chronic disease hospitals | 108 | 1.0 | 7,491 | 1.6 | — | — | 138,342 | 38,964 | 1.0 |
| Mental hospitals | 198 | 1.8 | 21,034 | 4.5 | — | — | 246,734 | 78,493 | 2.1 |
| Tuberculosis hospitals | 78 | .7 | 7,484 | 1.6 | — | — | 75,228 | 27,661 | .7 |
| Outpatient facilities ^c | 1,078 | 10.0 | — | — | 1,078 | 35.0 | 708,952 | 204,083 | 5.6 |
| Rehabilitation facilities | 552 | 5.1 | — | — | 552 | 17.9 | 440,019 | 135,010 | 3.6 |
| Public health centers | 1,281 | 11.9 | — | — | 1,281 | 41.6 | 289,049 | 99,689 | 2.7 |
| State health laboratories | 41 | .4 | — | — | 41 | 1.3 | 69,718 | 14,438 | .4 |

^a Public health centers built in combination with short-term hospitals and not reported as separate projects.

^b Excludes 7,209 long-term care beds built in conjunction with short-term and other hospital projects, for which funds cannot be separated from total project costs. These beds are reported in the following categories of facilities: general hospitals—7,113 beds, mental hospitals—60 beds, tuberculosis hospitals—36 beds.

^c Previously designated "diagnostic or treatment centers."

Source: U.S. Department of Health, Education and Welfare, *Hill-Burton Project Register* (Washington, D. C.: U.S. Government Printing Office, 1972), p. 2

Table 1.2
HILL-BURTON AS A SOURCE OF CONSTRUCTION
FUNDS, SELECTED YEARS, 1949-70

| Year | Hospital Construction | | | Medical Facility Construction | |
|------|--------------------------|---|--|-------------------------------|-----------------------------------|
| | Total cost (\$ millions) | % of total financed by Hill-Burton grants | % of Hill-Burton projects financed under Hill-Burton program | Total cost (\$ millions) | % supported by Hill-Burton grants |
| 1949 | 679 | 6.0 | 18.2 | — | — |
| 1953 | 686 | 10.6 | 26.5 | — | — |
| 1957 | 879 | 8.9 | 28.8 | — | — |
| 1960 | 1,005 | 15.5 | 47.2 | — | — |
| 1962 | 1,322 | 13.9 | 38.6 | 1,382 | 12.4 |
| 1966 | — | — | — | 1,960 | 8.5 |
| 1968 | 1,101 | 14.5 | — | 2,260 | 11.4 |
| 1969 | 1,250 | 14.7 | — | 3,056 | 7.2 |
| 1970 | — | — | — | 3,420 | 5.6 |

Source: Hospitals data for 1949-62 from U.S. Department of Health, Education and Welfare, *Trends* (Washington, D. C.: U.S. Government Printing Office, 1963), p. 35; data for 1968 from R. Foster and D. McNeil, "How Hospitals Finance Construction," *Hospitals*, Journal of the American Hospital Association, vol. 45 (July 1, 1971), p. 47, and for 1969 from "AHA Research Capsules No. 5," *Hospitals*, vol. 46 (March 1, 1972). The data for 1968 and 1969 were obtained from a survey of hospitals and underestimate the total value of hospital construction. The researchers asked for percent of total construction costs covered by federal grants, not necessarily Hill-Burton grants. The Hill-Burton grants program is, however, by far the most important federal grant program.

Medical facilities data were obtained directly from the Hill-Burton agency.

Taken from: Judith Lave and Lester Lave, The Hospital Construction Act: An Evaluation of the Hill-Burton Program: 1948-1973 (Washington, D.C.: AEI, 1974), p. 16.

Further impetus was given to the movement toward the expansion of local health planning efforts in 1966. This movement was motivated, not only by concern about the provision of hospital services specifically, but also the improvement of health services generally. Greater emphasis was placed on the need for a more centralized approach to health planning, in the wake of the rapid escalation of public-sector health care costs. Thus the Comprehensive Health Planning Act of 1966 (CHP) (P.L. 89-749), was passed as an amendment to the Public Health Service Act. Also passed at about the same time was the Heart Disease, Cancer, and Stroke Act (P.L. 89-239). The passage of P.L. 89-239 was prompted by recommendations of the President's Commission on Heart Disease, Cancer and Stroke. This Commission advocated the regionalization of medical services in an effort to combat these and other diseases. Each region was to be centered around a major university medical facility, which was to serve as the regional focal point for medical research and care. Fifty-six regions were created nationwide, and were sponsored by university institutions, non-profit organizations, and medical societies.⁵¹ However this program was largely overshadowed by the CHP.

The primary intent of the CHP was to develop local health planning programs according to local and regional needs, subject

⁵¹Budrys, pp. 16-17.

to federal approval.⁵² By passing this law, Congress hoped to address some of what it perceived to be inadequacies, such as lack of comprehensive health services coordination, and poor intergovernmental cooperation. To that end, the Act provided for the establishment of a system of regional areawide planning agencies, statewide agencies, and a national advisory council.⁵³ The decision to create areawide agencies that did not conform to existing political boundaries was an acknowledgement that health related problems did not conform to political boundaries.⁵⁴

The areawide planning agencies were intended to be independent of other local political institutions. They were essentially independent, non-profit corporations, which were largely dependent upon federal funding. The areawide agencies received at least one-third but not more than two-thirds of their funding from the federal government, depending upon the area's per capita income.⁵⁵ The rest of the money came from local sources, often hospitals themselves.⁵⁶

⁵² West Publishing Co., U.S. Comprehensive Health Planning and Public Health Service Amendments of 1966, U.S. Congressional and Administrative News, 89th Congress, 2nd session, vol. 3, p. 3832.

⁵³ 42 U.S.C.A. sec. 246.

⁵⁴ West Publishing Co., Comprehensive Health Planning and Public Health Service Amendments of 1966, p. 3833.

⁵⁵ Arthur Jacobs and Richard Froh, "Significance of PL 89-749 and Comprehensive Planning," New England Journal of Medicine 279 (12 December 1968) p. 1315.

⁵⁶ Budrys, pp. 52-53.

During the early years of the CHP program, lawmakers and health officials paid a great deal of attention to the composition of the state and areawide policy-making boards. Budrys asserts that the social agitation for greater political participation during the late 1960's was a factor in the stipulation that consumers be represented on the areawide councils.⁵⁷ Lowi observed that lawmakers made a conscious effort during the 1960's to include ordinary citizens and the poor in the political process.⁵⁸ While there were concerns that consumers might be intimidated by providers, due to consumers' lack of expertise, there were also fears that health care professionals might feel threatened by apparent challenges to their expertise and interests.⁵⁹ In spite of these concerns, however, there appears to have been a conscious effort by Congress to create a planning system based on group participation as part of a larger political movement to expand participation in the political process.

Before long, interagency conflicts surfaced at the state and local levels of government, involving the areawide agencies. In many states, planning under the CHP was subordinate to the state health department's overall planning agenda. Other states placed

⁵⁷Budrys, pp. 52-53.

⁵⁸Theodore Lowi, The End of Liberalism (New York: W. W. Norton and Co., 1969), p. 69.

⁵⁹William Curran, "Present at the Creation: Health Planning and the Inevitable Reorganization," Health Care Management (1) 1 January 1976), p. 35.

CHP responsibility within the domain of comprehensive state planning agencies. Disputes often arose between state health departments and the planning bodies.⁶⁰

While state and local government relations were, at times, tense, the federal government also added to the confusion. Under the CHP, federal authorities were inclined to place greater emphasis on the needs of metropolitan areas, so as to maximize the impact of its support. However metropolitan areas frequently experienced difficulty in organizing their local planning efforts, and in raising the necessary share of local funds. This difficulty may be attributed to a lack of commitment to health planning among various groups, especially in light of vague goals and limited federal funding.⁶¹

Impact of the Comprehensive Health Plan on Hospitals

In addition to the problems noted above, there were a number of other factors that combined to mitigate the impact of the CHP on hospital planning and regulation. Vague federal guidelines hampered the efforts of the areawide agencies. Indeed, federal officials of the Bureau of the Budget and the Department of Health, Education, and Welfare still did not feel that the states and localities had the capacity to plan effectively; a fact which

⁶⁰Curran, pp. 36.

⁶¹Symond R. Gottlieb, "A Brief History of Health Planning in the United States" in Regulating Health Facilities Construction, Clark C. Havighurst, ed. (Washington, D.C. : American Enterprise Institute, 1974), p. 21.

resulted in the stipulation that these agencies be established on a voluntary basis, and that their approval of projects was not mandatory.⁶² This weakened the areawide agencies' authority considerably. That lawmakers and health officials focused much of their attention on the structural aspects of the CHP program diverted attention away from the specification of health planning activities and goals.⁶³

Relations between health facilities and the area CHP agencies were often close. However, the areawide agencies' control over the supply and distribution of health facilities was essentially limited to the allocation of Hill-Burton funds to applicants. It will also be recalled that these agencies were partially dependent upon local funding sources, many of whom were hospitals. This dependency provided a major justification for health facilities to strengthen ties with the area CHP agencies. Additional factors that diluted the impact of this law were the dominance of providers on the planning boards, and the absence of sanctions against those who violated areawide health planning decisions.⁶⁴

While it would be tempting to conclude that the Comprehensive Health Planning Act of 1966 was largely ineffectual, certain factors should be borne in mind. In addition to poorly articulated federal guidelines, a frequent

⁶²Curran, p. 34.

⁶³Gottlieb, p. 19.

⁶⁴Joskow, p. 78.

criticism was that federal funding for the area and statewide agencies was woefully inadequate, given the enormity of the task.⁶⁵ That there was little federal interest in area health planning efforts also hindered the CHP.⁶⁶ Finally, it should be realized that the CHP was not intended to supplant existing planning efforts, such as the Hill-Burton program. Rather, it was to provide a means for the imposition of order in the provision of health care services.⁶⁷ Thus, the focus of this legislation was still on the provision of adequate health services for as great a number of people as possible.

However the rapid escalation of public outlays for health care toward the end of the 1960's raised the issue of health care cost control. The growing concern over health expenditures, especially incurred under the Medicaid and Medicare programs, provided the impetus for the passage of the Social Security Act of 1972 (PL 92-603).⁶⁸ Of particular relevance to the hospital sector was section 1122 of this act. This legislation provided for an optional mechanism for the review of hospital capital expenditures, under the belief that unnecessary capital expenditures were at least partly to blame for the rapid rise in medical costs. Those services not receiving prior approval from

⁶⁵Curran, p. 35

⁶⁶Joskow, p. 78.

⁶⁷Budrys, p. 18.

⁶⁸Social Security Act of 1972, (P. L. 92-603) Statutes at Large vol. 86, Title III, p. 1386 (1972).

area and statewide health planning agencies were denied capital cost reimbursement for services rendered under the auspices of the Medicare, Medicaid, and Maternal and Child Health programs.⁶⁹ States were still not required to adopt section 1122.

By the late 1960's a relatively new regulatory and planning scheme was emerging at the state level that would ultimately influence national health care cost control efforts - especially hospital costs. This new regulatory scheme came to be known as the certificate of need. By the early 1970's fifteen states had already enacted their own certificate of need statutes.⁷⁰

Discussion of Certificate of Need

General nature and scope

Certificate of need (CON) is a mechanism by which government may control the supply, cost, quality, and distribution of health facilities, their services and equipment. Such control is maintained by requiring prior approval from a regulatory/planning agency for any construction of new facilities, modifications to existing facilities, purchases of equipment, or addition of new services, the cost of which exceeds a statutorily prescribed threshold, or expands the bed capacity of existing facilities beyond a threshold. Those projects that

⁶⁹Social Security Act of 1972, sec.282, pp. 1386-1388.

⁷⁰Chayet and Sonnereich, P.C., Certificate of Need: An Expanding Regulatory Concept (Washington, D. C. : Medicine in the Public Interest, 1978), p. 5.

do not meet or exceed the statutory threshold are not required to undergo review. CON is a regulatory mechanism with which health officials strive to achieve health planning goals.

All of this is not to say that a great deal of uniformity has existed among the various state CON programs. Initially, CON laws applied to hospitals, nursing homes, diagnostic laboratories, and outpatient clinics.⁷¹ However the breadth of coverage generally expanded over time, covering a wider range of facilities.

Since these CON reviews are regulatory in nature, and occur in a planning setting, the process is one in which various groups have a voice in the approval and disapproval of projects.⁷² As shall be seen shortly, this fact forms the basis for one of the central criticisms of the CON process.

Theoretical perspectives

At the heart of the debate over the merits of the certificate of need process is the question of whether health care resources would be most equitably, efficiently, and inexpensively allocated in a market setting, or in the regulatory/planning arena. In a free-market setting, consumers would be able to choose from among various providers and

⁷¹David S. Salkever and Tim W. Bice, Hospital Certificate-of Need Controls: Impact on Investment, Cost and Use (Washington, D. C. : American Enterprise Institute, 1978), p. 5.

⁷²Salkever and Bice, p. 5.

services, based on their individual needs and resources. In a regulatory or planning setting, individual choice is reduced, as the regulatory or planning process becomes the arbiter for reconciling the differences between competing interests.

Proponents of the certificate of need process argue that, unlike many goods and services, medical services do not respond to traditional market forces. The existence of substantial third-party payment systems, which rest on cost-based reimbursement is said to insulate hospitals and health facilities from the consequences of inefficient, uneconomical, or ineffectual investment decisions.⁷³ It has also been postulated that the mere existence of hospital beds and sophisticated technology generates its own demand - the so-called "Roemer effect."⁷⁴ In their attempts to lure physicians' services, hospitals have become overly concerned with facility size and the acquisition of extravagant services and equipment.⁷⁵ This insulation of hospitals and health facilities from market forces provides the principal rationale for certificate of need programs. If, through certificate of need, medical facility resource expansion can be controlled, then government officials would be able to check the unwarranted growth of facility

⁷³Clark C. Havighurst, Deregulating the Health Care Industry, Planning for Competition (Cambridge, MA: Ballinger Co., 1982), p. 54.

⁷⁴Clark C. Havighurst, "Regulation of Health Facilities and Services By Certificate of Need," Virginia Law Review 59 (October 1973), pp. 1158-1159.

⁷⁵Havighurst, "Regulation of Health Facilities," p. 1162.

resources, and thereby exert some measure of control on medical facility care costs.

Advocates of CON hope that certificate of need programs will address these deficiencies. By placing the authority for the location of health facilities and services within the public policy arena, health care providers should become more sensitive to consumers' needs, and the needs of the community as a whole. Regulatory control over the supply of facilities and services may result in the more efficient use of existing facilities, by rationing them to the neediest patients, and providing incentives for other consumers to utilize less expensive alternatives.⁷⁶ Even opponents of the CON process concede that resources would be diverted away from poorly conceived, or unnecessary plans.⁷⁷ In essence, then, proponents of CON regulation and planning argue that the political arena will allocate health facilities and services more efficiently and equitably than an unfettered free market.

However, it is the political nature of the CON process that its opponents find most disturbing. There is an implicit assumption in the arguments for certificate of need that the political arena will gravitate toward optimal solutions. However, dominance by health care providers, and the incremental nature of the political bargaining process would supposedly result in the maintenance of the status quo; or at best,

⁷⁶Salkever and Bice, pp. 11-13.

⁷⁷Havighurst, "Regulation of Health Facilities," p. 1221.

incremental changes.⁷⁸

An even more fundamental criticism of the CON process is that it combines two mutually incompatible tasks - planning and regulating. Planning is said to require the "authoritative use of authority, law, choice, priorities, and moralities",⁷⁹ while "regulation is a political process involving political actors seeking political ends."⁸⁰ If CON agencies become dominated by health care providers, they may become overly concerned with the welfare of existing providers, or "captured".⁸¹ If this were to occur, new providers could experience difficulty in entering the market, and regulators/planners may lose sight of the public interest.

In addition to concerns about the political ramifications of the CON process, there are also concerns about the costs that this mechanism imposes. Perhaps the most obvious cost is that which is incurred in the administration of the program. Project delays resulting from the various stages of the CON process are said to inhibit the rate of technological innovation, and the responsiveness of providers to changes in market forces will be reduced.⁸² These arguments depict a cumbersome, stifling, and

⁷⁸Havighurst, "Regulation of Health Facilities," p. 1215.

⁷⁹Havighurst, "Regulation of Health Facilities," pp. 1197-1198.

⁸⁰Kenneth J. Meier, Regulation: Politics, Bureaucracy, and Economics (New York: St. Martin's, 1985), p. 8.

⁸¹Salkever and Bice, pp. 14-15.

⁸²Havighurst, "Regulation of Health Facilities," pp. 1221-1225.

sluggish process whose potential for rationalizing the health care industry would seem to be outweighed by inhibitive effects on health care. However, as shall be seen below, certificate of need did indeed become a part of the public health policy fabric of this country.

Emergence of Certificate of Need

The emergence of the certificate of need was not the result of a momentous piece of federal legislation. Instead, it was the product of a movement at the state level in the late 1950's toward health planning with regulatory sanctions. The culmination of this early movement was the passage of the McCloskey-Metcalf Act of 1964 by the New York legislature. This law required mandatory certificate of need approval prior to any new construction, renovation, or modifications to new or existing hospitals or nursing homes. In making decisions on CON applications, the Health Commissioner was to consider the availability of alternatives, the possibility of joint ventures, and existing utilization rates.⁸³

At its inception, certificate of need was warmly received by medical and political leaders. Regulating hospitals and health facilities was regarded as a stabilizing influence, and a means of assuring the orderly development of physical plants and

⁸³Edward H. Forgotson, "1965: the Turning Point in Public Health Law," American Journal of Public Health 57(June 1967) p. 942.

equipment.⁸⁴ Certificate of need was also regarded as a radical departure from prior concepts related to the organization and regulation of health services,⁸⁵ since many governmental interventions in health care were organized to combat specific diseases or conditions.

Certificate of need gathered momentum during the late 1960's. In 1968 and 1969 Connecticut, Rhode Island, California, and Maryland also enacted CON statutes.⁸⁶ The spread of the certificate of need concept was largely due to increasing concern over the growth of state health care budgets.⁸⁷ However CON was hardly met with unbridled enthusiasm within the health planning community. Some health planners feared that this regulatory scheme would result in a litigious atmosphere, as providers and consumers would contest agency decisions. Of equal concern was the idea that this process would divide the agencies' attention between planning and regulation.⁸⁸ In spite of these concerns, however, the movement toward a new health planning and regulatory apparatus featuring CON continued to grow.

By the late 1960's, changes in the utilization of health care began to emerge. Ambulatory (outpatient) facilities became increasingly popular with consumers. Tensions had also been

⁸⁴Forgotson, p. 942.

⁸⁵Forgotson, p. 943.

⁸⁶Havighurst, p. 1151.

⁸⁷Salkever and Bice, pp. 4-5.

⁸⁸Salkever and Bice, pp. 4-5.

growing between urban and rural areas over the allocation of Hill-Burton funds. As a result of these changes in the health care environment, Congress amended the Hill-Burton Act in 1970. These amendments stipulated that impoverished areas, and requests for assistance in the construction of diagnostic and ambulatory facilities be given the highest priority.⁸⁹

Changes were also occurring within the CHP and RMP programs. In 1970, Congress enacted legislation that encouraged "cooperative arrangements" between these two programs, by permitting the CHP agencies to review RMP proposals.⁹⁰ There seems to have been an effort to consolidate these programs by allowing the CHP to, at least partially, absorb the RMP.

However the impression that these programs were not effectively addressing the health facility cost, accessibility, and quality issues become more evident to members of Congress. In 1972, the Government Accounting Office and the Department of Health, Education and Welfare (HEW) concluded that federal guidelines and oversight efforts of the CHP agencies needed to be intensified, and the staffing and funding levels of these agencies needed to be increased.⁹¹ Presidential regard for the

⁸⁹Public Health Service Act Amendments, Statutes at Large vol. 84 Title I, sec. 101-102, p.337 (1970).

⁹⁰West Publishing Co., National Health Planning and Resources Development Act of 1974, U.S. Code Congressional and Administrative News, vol. 4, 93d Congress, (St. Paul, MN: West Publishing Co., 1974), p. 7854.

⁹¹West Publishing Co., National Health Planning and Resources Development Act of 1974, pp. 7852-7853.

RMP was clearly on the wane, when, in preparing his budget for FY 1974, President Nixon failed to request renewed funding for the RMP. Although Congress appropriated funds sufficient to continue the program into 1974, HEW recommended phasing out the RMP in 1975.⁹²

These events suggest that federal policy-makers were becoming increasingly cognizant of the problems in the health care industry, and particularly, the hospital sector. Even though programs existed to correct the imbalances and inadequacies within the hospital industry, it had become clear to Congress that these measures alone would be insufficient. A renewed emphasis in Congress was placed on the creation of a strong, centralized planning and regulatory apparatus to correct deficiencies within the health care industry. The stage was set for the creation and enactment of the next major piece of health legislation.

The National Health Planning and Resources Development
Act of 1974

The effort to create a newer, stronger health planning and regulatory apparatus attracted support in both houses of Congress. In fact, both the House and the Senate passed similar bills that had to be reconciled in conference committee.⁹³ The

⁹²West Publishing Co., National Health Planning and Resources Development Act of 1974, p. 7854.

⁹³Curran, p. 38.

final outcome was the National Health Planning and Resources Development Act of 1974 (PL 93-641).

The legislative history of P. L. 93-641 suggests that many of the concerns mentioned above surrounding the provision of health care in this country impelled Congress into action. While bills were introduced in each house of Congress, it was the Senate version that was finally adopted. The Senate Committee on Labor and Public Welfare's fundamental justification for this legislation was the concern that "... the health care industry does not respond to marketplace forces."⁹⁴ The highly technical nature of health services, the prominence of third-party payers, and the notion that high-technology services create their own demand, all contributed to the Committee's finding. While a longer-term trend toward increased use of outpatient facilities was evident, the Committee was alarmed by more recent indications of a reversal of this trend.⁹⁵ Economic factors clearly played a major role in prompting Congress to take this legislative action.

Added to the economic arguments for new legislation, was the acknowledgement of the shortcomings of previous federal legislative efforts in this area. The inadequacies in health planning activities at the time were attributed to vague congressional mandates, insufficient funding, and inadequate implementation authority. Also, a number of evaluative studies

⁹⁴West Publishing Co., National Health Planning and Resources Development Act of 1974, p. 7878.

⁹⁵West Publishing Co., National Health Planning and Resources Development Act of 1974, pp. 7897-7898.

conducted during the late 1960's and early 1970's provided evidence of rising health care costs.⁹⁶ While all of these factors provided the most conspicuous justifications for renewed legislation, members of Congress had also hoped that a strong national health planning system might ultimately lead to a national health insurance program.⁹⁷ Health care was once again a national issue.

As enacted, PL 93-641 provided for a three-tier health planning system that was to control the distribution, quality, and cost of health facility services, in addition to coordinating a variety of other health activities. Agencies were created at the federal, state, and regional levels to perform these functions. This new plan supplanted the Comprehensive Health Plan, Regional Medical Plan, and the Hill-Burton Act.⁹⁸ P. L. 93-641 also altered the conception of the health care problems by declaring that its purpose was to ensure "equal access to quality health care at a reasonable cost."⁹⁹ This marked the first time that health care costs had factored explicitly into federal health planning legislation.

The legislation even went so far as to establish a list of

⁹⁶Budrys, pp. 56-59.

⁹⁷West Publishing Co., National Health Planning and Resources Development Act of 1974, p. 7879.

⁹⁸West Publishing Co., National Health Planning and Resources Development Act of 1974, pp. 7842-7843.

⁹⁹National Health Planning and Resources Development Act of 1974, Statutes at Large, vol. 88, pt. 2, sec. 2, p. 2226 (1974).

national health priorities. A review of these priorities reveals that the emphasis on meeting the basic health needs of those citizens in economically depressed areas was still a major concern to Congress. For instance, the statute specifically identifies the provision of medical services for rural or economically depressed areas.¹⁰⁰ There was also considerable interest in consolidating and coordinating existing health resources through voluntary arrangements between institutions, promoting preventive education, the training of physicians' assistants, and the establishment of a geographically-centered strata of health activities. This appears to have been a major effort to construct a unified health planning system.

In order to achieve such a goal, the law created a three-tiered planning system. At the national level, the National Council on Health Planning and Development was created to advise the Secretary of Health, Education, and Welfare (HEW) on matters pertaining to the development and implementation of national guidelines.¹⁰¹ The Council's function was largely advisory, since policy-making authority was vested in the HEW Secretary. Council membership included federal officials (all non-voting members), health providers, areawide agency representatives, and representatives of the State Health Coordinating Councils. There seems to have been an effort to create a body representative of

¹⁰⁰National Health Planning and Resource Development Act of 1974, sec. 1502, p. 2227.

¹⁰¹National Health Planning and Resource Development Act of 1974 sec. 1503, p. 2228.

the national health care community. By mandating a diverse membership for the commission, Congress realized that health care concerns affect people in different settings and people are affected by health care issues in many different ways.

At the state level, the Act contained provisions for creating a policy-making body and an advisory body. The governor in each state were authorized to designate State Health Planning and Development Agencies (SHPDA), which were governmental bodies charged with administering state plans pertaining to the quality, cost, and distribution of health facilities, and to gather and analyze data from the areawide agencies. These state plans were to be submitted annually to the HEW Secretary for approval.¹⁰² This law established a system of accountability to the federal government by authorizing the HEW Secretary to withhold federal health planning funds until he had received and approved each state health plan.

The SHPDAs were assisted in their tasks by the State Health Coordinating Councils (SHCC). These councils served in an advisory capacity, and were comprised of health care providers and consumers from within the state, as well as representatives from each areawide agency within the state.¹⁰³ The SHCCs were responsible for annually reviewing and coordinating Annual Implementation Plans so as to realize the goals set forth in the

¹⁰²National Health Planning and Resource Development Act of 1974, sec. 1523, p. 2246.

¹⁰³National Health Planning and Resource Development Act, 1974, sec. 1524, p. 2248.

State Health Plan.¹⁰⁴ Essentially then, two statewide bodies were created to review and coordinate area plans, so as to affect a balanced statewide health resources plan.

At the focal point of the new health planning system were 205 regional health systems areas whose health plans were developed by health systems agencies(HSA). These areas did not necessarily conform to existing political boundaries, except in the case of some of the larger metropolitan areas. Instead, the health systems areas were drawn by the governor of each state to conform to the geographic characteristics of each state, just as the areawide agencies under the CHP had been.

Congress intended that the HSA's assume the place of the CHP areawide agencies. However, the governor of each state was given the authority to alter these boundaries if it were deemed necessary to do so.¹⁰⁵ HSA boundaries were drawn to include from one-half to three million people, and a major medical facility.¹⁰⁶ HSAs were charged with developing five-year Health System Plans, as well as yearly Annual Implementation Plans, based on a survey of the area's health care needs and

¹⁰⁴National Health Planning and Resources Development Act of 1974, sec. 1524 (b)(2)(A), p. 2248.

¹⁰⁵West Publishing Co., National Health Planning and Resources Development Act of 1974, p. 7883.

¹⁰⁶National Health Planning and Resources Development Act of 1974, sec. 1511 (a)(3), p. 2232.

resources.¹⁰⁷ HSAs were conceived as public or private, non-profit entities that were independent of any other political body, and whose sole purpose was health planning.¹⁰⁸ Congress did not want the HSAs to become co-opted by local or state governments.

Each HSA was supported by a professional staff.¹⁰⁹ The statute provided for governing bodies in each HSA, ranging in size from fifteen to thirty members, to oversee the individual HSA's operation.¹¹⁰ In some respects, then, the new program retained some of the features of the CHP program. However, there were important differences. The most important difference was the provision for certificate of need program. CON was intended to be a tool with which to achieve state health plans. Therefore, Congress vested authority for administering state CON programs in the SHPDA.¹¹¹ Approvals or denials of CON requests were to be made within the context of each area plan, and the penalties for violating CON decisions were left up to the states. Failure to enact a CON statute would result in the HEW Secretary withholding federal funds for health programs. By allowing for

¹⁰⁷National Health Planning and Resources Development Act of 1974, sec. 1513 (b)(2), p. 2236.

¹⁰⁸National Health Planning and Resources Development Act of 1974, sec. 1512 (b)(1)-(2), p. 2232.

¹⁰⁹Curran, p. 40.

¹¹⁰National Health Planning and Resources Development Act of 1974, sec. 1512 (b)(3), p. 2232.

¹¹¹National Health Planning and Resources Development Act of 1974, sec. 1523 (b)(4)(A), p. 2246.

the imposition of sanctions, and by threatening to withhold federal funds, Congress sent a message that the health care industry's problems had become too severe to allow for laxity. While the new health program was not mandatory, states had to be willing to forego federal assistance if they chose not to participate in the health planning program.

Whereas the federal guidelines under the CHP were vague, general standards for the construction and maintenance of facilities and equipment, and for triggering the CON review process were more explicit. Initially, a threshold of \$150,000 for capital projects, or a ten percent change in bed supply were established for triggering the CON review process.¹¹² States were free to strengthen these standards by lowering the thresholds, but were not allowed to raise them.

As was the case with the CHP, the composition of the various planning boards attracted much attention. Once again, Congress feared provider dominance on these committees. To address this issue, Congress stipulated that there be consumer majorities on all HSA and SHCC boards. "Providers" were defined as any medical care provider, or anyone receiving at least ten percent of their income from a provider.¹¹³ Provider dominance was one of the oft-cited weaknesses of the CHP program. Providers were still fearful of a loss of autonomy under the new health planning

¹¹²Budrys, p. 20.

¹¹³National Health Planning and Resources Development Act of 1974, sec. 1512 (b)(3)(A), p. 2232.

program, however.¹¹⁴ In fact, medical interest groups lobbied Congress quite heavily on substantive and structural issues, such as HSA governing board composition.¹¹⁵

Another departure from the CHP relates to funding. Under the CHP, area agencies were partially dependent upon private sources for their funding, often resulting in hospitals supporting the very bodies that were responsible for local health planning. Under PL 93-641, HSAs could still get private sector funding. However, the new law precluded them from receiving funds from individual or institutional providers.¹¹⁶ The Act established federal funding for HSAs at a minimum grant of \$175,000 and a maximum grant of \$3,750,000 per HSA, depending upon the population of the HSA.¹¹⁷ HSAs were to be as free as possible from undue provider influence, in terms of funding as well as membership.

P.L. 93-641 was intended to address many of the perceived deficiencies that had existed in prior health planning legislation. State and local health officials had made Congress aware of many of the problems that existed in the provision of

¹¹⁴Curran, p. 42.

¹¹⁵G. Gregory Raab, "National/State/Local Relationships in Health Planning: Interest Group Reaction and Lobbying," in Institute of Medicine, Health Planning in the United States: Selected Policy Issues, vol. 2, (Washington, D.C.: National Academy Press, 1981), p. 122.

¹¹⁶National Health Planning and Resources Development Act of 1974, sec. 1512 (5), p. 2235.

¹¹⁷National Health Planning and Resources Development Act of 1974, sec. 1516, p. 2241.

health care, and especially health facility services. Rather than let one level of agencies assume all of the burden, responsibility was shared among federal, state, and local health planning bodies. This division of responsibility in pursuit of a national health planning agenda marked yet another milestone in the development of American health and health facility planning as all three levels of government and the quasi-public HSAs collaborated and cooperated to form a national health planning program.

Conclusion

Public sector intervention in the provision of health care facilities and services underwent a number of phases in this century. Each phase represented a change in the way in which policy-makers and interested groups perceived the deficiencies within the hospital and health facility industry at a given time. Initially the problem was simply characterized as inadequate health facility resources. The subsequent legislative response was a major infusion of medical facility construction funds.

Some twenty years later lawmakers redefined the relevant issues. Health facility resources were still considered inadequate. However, the issue of health facilities resources was placed within the context of health planning generally, as consumers began to change their utilization patterns.

The locus of medical facility planning and construction assistance activity also shifted over time. Private sector

philanthropic organizations and voluntary hospital planning bodies defined early hospital planning and construction efforts. During the war years, the federal government assumed the leading role in hospital sector activity as large amounts of federal funds were allocated for medical facility construction. The Hill-Burton Act represented the first governmental attempt to provide an orderly hospital planning and construction system. Amendments to the Hill-Burton Act in the 1960's, and the federal Comprehensive Health Planning Act gave new credence to the notion of comprehensive health planning at the local level, although the CHP's implementation was hampered by such factors as vague federal guidelines, and minimal federal funding. Section 1122 and the National Health Planning and Resources Development Act of 1974 provided a health planning enforcement mechanism through certificate of need and concentrated health planning and regulatory authority at the state level.

The evolution of the certificate of need helped to reshape the public policy debate once again. People were no longer solely concerned with the quality and distribution of hospitals and health facilities. Health care costs had become a major factor by the late 1960's. In an effort to restrain these escalating expenditures, and to impose a sense of order and stability on the health care industry, Congress included a certificate of need provision, as part of a national health planning program. States developed their own certificate of need programs within federal guidelines.

It is beyond the scope of this study to examine CON programs in all of the states. Therefore the remainder of this paper shall be devoted to an examination of Virginia's CON program from its inception to the present.

CHAPTER 2
ENACTMENT OF VIRGINIA'S CERTIFICATE OF PUBLIC NEED LAW

The high cost of health care began to overshadow concern for the provision of health care during the late 1960's. With the implementation of Medicare and Medicaid, federal health expenditures rose dramatically from approximately \$40.5 billion in 1965 to \$71.5 billion in 1970.¹ Expenditures for these programs helped shift public discussion away from simply the provision of health care, toward health care cost containment. Concern over the high cost of health care was not limited to the federal government.

State governments also served as forums for public discourse relating to health care costs. Not only was there an increase in public expenditures, but also in the sums spent by individuals and private insurers. Private sector expenditures, including direct, out-of-pocket expenditures and health insurance benefits, rose from \$27.47 billion in 1965 to \$40.4 billion in 1970.² It was in this environment that the Virginia General Assembly confronted the issue of high medical costs in the Commonwealth.

Although not intended by Virginia lawmakers to deal

¹U.S. Department of Commerce, Bureau of the Census, Historical Statistics of the United States, Colonial Times to the Present pt. 1, Series B 221-235, (Washington, D.C.: U.S. Department of Commerce, 1975) p.73.

² Bureau of the Census, series B 236-247, p. 74.

exclusively with health care costs, or to be the sole instrument with which to combat high medical costs, certificate of need (CON) was one of a number of public policies designed to address problems within the health care industry. Utilizing the existing health planning administrative framework, certificate of need was incorporated into the health planning system, with authority concentrated in the Virginia Health Commissioner's office.

The Commission to Study Prepaid Health Care Plans
and Costs of Medical, Surgical, and Hospital Services

The operations of Virginia Blue Cross gained national attention in 1971. In January 1971 the U. S. Senate Judiciary Committee, Subcommittee on Antitrust and Monopoly held hearings to investigate alleged improprieties in the operation of the nation's Blue Cross plans. At the center of attention were questionable practices by officers of Virginia Blue Cross. Congressional investigators contended that there was considerable waste and mismanagement, which contributed to soaring administrative costs for the plan.

Some of the practices directly involved high-ranking Blue Cross officials, while other abuses were of a more general nature. In one instance, a rental car fleet contract bid that was \$30,000 higher than the low bid was accepted over the low bid. Blue Cross of Virginia also bought furniture from a company in which a Blue Cross board member had a major financial interest. The subcommittee also found that Blue Cross board

members charged private club membership dues to Blue Cross.³

Chaired by Senator Philip Hart (D-Michigan), the subcommittee members also sought to discern the effect that Blue Cross had on hospital costs. There appears to have been a bias during the hearings toward the enhancement of competition. Said Senator Hart at the outset of the hearings: "...the general thrust of these hearings is to see how competition can be put to work to lower the almost staggering costs, costs that went up almost fifteen percent last year."⁴ Thus the subcommittee was not only investigating alleged improprieties at Blue Cross, but also, the relationship between Blue Cross and rising hospital care costs. Indeed, Congress may have used the administrative scandal as a vehicle for exploring Blue Cross' effect on health care costs.

During the hearings, doubts were raised on the notion that Blue Cross played a significant role in constraining hospital costs. The fact that Blue Cross routinely paid whatever hospitals charged, and that the boards of directors of local Blue Cross plans were dominated by physicians and medical facility administrators undermined claims of cost containment potential. Also disclosed during the hearings was the fact that hospitalization costs had risen approximately thirty-eight

³U.S. Congress, Senate, Committee on the Judiciary, Subcommittee on Antitrust and Monopoly, The High Cost of Hospitalization, pt. 2, Blue Cross, 91st Cong., 2nd sess., 26 January 1971, pp.31-33.

⁴U.S. Congress, Senate 1971, p. 2.

percent over the five years prior to 1971.⁵ Senator Hart went so far as to suggest that "when the Blue Cross board is heavily loaded with hospital-oriented representatives...one wonders if those boards can go into a bargaining session with the aggressiveness that consumers would expect if indeed they were representing the consumer."⁶ Concern over Blue Cross practices was not limited to the national stage, however.

Revelations during the Senate Subcommittee hearings about improprieties in the operation of Virginia Blue Cross prompted Virginia lawmakers to more closely examine Virginia Blue Cross. On January 28, 1971, Governor Linwood Holton ordered a staff investigation of the charges made before Senator Hart's subcommittee. Virginia General Assembly members were anxious to take action. Strong sentiment existed in both houses for extending the regulatory jurisdiction of the State Corporation Commission to include Virginia Blue Cross, and Governor Holton also gave this idea consideration.⁷

In February, 1971, the General Assembly passed Senate Joint Resolution 20. This resolution created a commission "to study certain organizations such as Blue Cross-Blue Shield and the rates of insurance therefore."⁸ There is little doubt that the

⁵U.S. Congress, Senate 1971, p. 2.

⁶U.S. Congress, Senate 1971, p. 263.

⁷Hank Burchard and Helen Dewar, "Stricter Blue Cross Control Proposed", Washington Post, 29 January 1971, B-1.

⁸ Virginia Acts of Assembly (1971) Senate Joint Resolution 20, p. 557.

General Assembly was at least partly motivated by the activities of Senator Hart's subcommittee. "...Recent events have raised serious questions as to whether such plans [Blue Cross] operate on an efficient and economical basis..."⁹. The General Assembly was clearly sensitive to the notion that operational irregularities within insurance plans impacted upon medical costs, and that these costs were on the rise.

The General Assembly regarded the stabilization of the health care industry as an important task. To that end, the Commission to Study Prepaid Health Care Plans and Costs of Medical, Surgical and Hospital Services (hereafter referred to as "the Commission") was empowered by legislators to review not only administrative practices, but the means by which health care costs were established, as well.¹⁰ The members of the General Assembly seemed to be sending a signal to the health care industry that the price increases of recent years had become intolerable.

Commission membership consisted of three members from each house of the General Assembly, as well as three members appointed by the Governor, who could be state or local officeholders.¹¹

⁹Virginia Acts of Assembly (1971) Senate Joint Resolution 20, p. 557.

¹⁰Virginia Acts of Assembly (1971) Senate Joint Resolution 20, p. 558.

¹¹The following individuals served on the Commission: Senator Edward E. Willey (D-Richmond); Senator Adelard Brault (D-Fairfax); Senator Henry E. Howell, Jr. (D-Norfolk); Delegate Junie L. Bradshaw (D-Richmond); Delegate Donald Mc Glothlin, Sr. (D-Grundy); Delegate Richard J. Ryder (R-Annandale); E. Leo

The Insurance Commissioner was an ex officio member, and was responsible for providing support staff. A sum of \$10,000 was appropriated from the General Assembly contingency fund to cover expenses. SJR 20 directed the Commission to complete its investigation, and to present its findings and recommendations to the Governor and the General Assembly by December 1, 1971.¹²

Throughout 1971, the Commission held a series of meetings and hearings in an effort to obtain as many opinions and points of view as possible regarding perceived deficiencies within the Virginia health care industry. Present at these hearings were representatives of Medicare, Medicaid, Blue Cross-Blue Shield, private insurance companies, and health care providers.¹³ While Blue Cross was the focal point of attention, the Commission addressed a range of issues relating to the provision of health care services.

Most of the Commission's recommendations dealt with enhancing consumer participation and administrative responsiveness with respect to health care reimbursement practices. These recommendations included the establishment of voluntary hospital rate review boards, the introduction of health

Burton (Roanoke); Frank A. Schwalenberg (Newport News); Robert Carter (Richmond).

¹²Virginia Acts of Assembly (1971) Senate Joint Resolution 20, p. 558.

¹³Virginia General Assembly, Commission to Study Prepaid Health Care Plans and Costs of Medical, Surgical and Hospital Services Therefor, The Cost and Administration of Health Care Services in Virginia, Senate Document No. 14, in Senate Journal (Richmond, Virginia: Commonwealth of Virginia, 1972), p. 3.

maintenance organizations (HMOs), the submission of quarterly financial statements by health insurance plans to the State Corporation Commission, the stipulation that consumer majorities exist on health care plans' boards of directors, and "the establishment of certification of need prior to the establishment or extension of hospital facilities."¹⁴ Viewed in this context, it seems that lawmakers perceived CON as but one policy instrument to be implemented in a series of health policy initiatives intended to correct problems within the health care industry. The most significant of these problems was the high cost of medical services.

The Commission relied upon arguments similar to those espoused by CON proponents, summarized in chapter 1, in reaching its conclusions. The central factor influencing the Commission's recommendations seems to have been that "in many areas of Virginia there are hospital beds in excess of those needed," and that excess beds contributed to high costs.¹⁵ The city of Richmond had one of the highest ratios of hospital beds to population in the nation at that time. The Commission found that excess beds were often filled with patients not requiring hospitalization, thereby raising the cost of care for the public at large. Since excess beds existed, the Commission reasoned, administrators and doctors had no financial incentive to release

¹⁴Commission Report, p.3.

¹⁵Commission Report, p. 8.

patients at the earliest possible date.¹⁶ Although the existence of excess hospital beds was a source of concern to Commission members, they also seem to have been influenced by experience with CON elsewhere.

Certificate of need had been implemented in a number of states by 1971. In its report, the Commission observed that:

Other states have solved this problem [excess beds and high costs] by enacting legislation providing for certification of need prior to the establishment or expansion of hospital facilities It is critical that Virginia enact such legislation.¹⁷

This statement suggests that the Commission placed considerable weight on the experience of other states that had CON regulation.

Certificate of need was only one of a number of measures promoted by the Commission to address problems within the health care industry. Each recommendation addressed a particular facet of the industry. However, all of the issues and concomitant recommendations revolved around the themes of greater efficiency and cost control in the health care industry. By this time, the cost of health care had begun to overshadow concerns about the quantity and quality of health care resources. Although created in the aftermath of the Blue Cross scandal, the Commission addressed issues well beyond the administrative improprieties at Blue Cross.

¹⁶Commission Report, p. 5.

¹⁷Commission Report, p. 6.

Enactment of the Virginia Medical Care Facilities
Certificate of Public Need Statute

The debate in Virginia surrounding the high cost of health care did not take place in a vacuum. The federal Hill-Burton and Regional Medical Plan programs were still in existence. In addition, Virginia had voluntarily implemented health planning at the state and regional levels as part of the federal Comprehensive Health Plan. All of these programs were designed to ensure that adequate, accessible health facilities were available to the public. While medical facility resource planning was gaining prominence under these programs, they were not concerned ostensibly with cost containment.

Of course, one federal program that was concerned with cost containment was the federal Economic Stabilization Program. Price controls were established by the federal Cost of Living Council for a wide range of goods and services throughout the economy, including health care. A national Committee on the Health Services Industry was appointed by President Nixon to formulate price control guidelines that would not stifle innovation.¹⁸

¹⁸C. Jackson Grayson, Chairman of the Cost of Living Council, Washington, D. C., letter to Governor Linwood Holton, Richmond, Virginia, 17 January 1971, Executive Papers, Virginia State Archives, Richmond. The Economic Stabilization Program was implemented pursuant to Title II of the Defense Production Act (Statutes at Large, 1970, 91st Congress, 2nd sess., vol. 84, pt. 1, pp. 799-800), which authorized the President to sign Executive Order No. 11615, Providing for Stabilization of Prices, Rents, Wages, and Salaries, U. S. Code Congressional and Administrative News, 92nd Congress, 1st session, 1971, vol. 2, pp. 2575-2577.

In spite of the federal programs in existence, Virginia lawmakers seized the opportunity to implement their own cure for the high health care costs that plagued Virginians. To that end, Senator Adelard Brault (D-Fairfax Co.) and Senator Edward Willey (D-Richmond) introduced CON legislation in the Virginia Senate during the 1972 session. The CON bill passed the Senate by a vote of 24-12. Upon reaching the House of Delegates, the General Laws Committee voted to carry the bill over to the 1973 session.¹⁹

Support for CON in Virginia was widespread. Organizations in favor of a CON program included the Virginia Medical Society, Virginia Hospital Society, Virginia Nursing Home Society, Virginia Nurses Society, and Virginia Blue Cross-Blue Shield. However the Virginia Comprehensive Health Planning Council, the state's highest health planning council, expected opposition from some private physicians.²⁰ The State Comprehensive Health Planning Council had itself voted unanimously to endorse CON legislation as early as January 1972.²¹

Having passed the Senate during the previous session with

¹⁹Senate Journal (1972) vol. 1 (Richmond, VA: Commonwealth of Virginia, 1972), p. 485.

²⁰Virginia Comprehensive Health Planning Council, meeting, Minutes, 6 December 1972 (Richmond, Virginia), p. 5. Executive papers of Governor Linwood Holton, Virginia State Archives, Richmond, Virginia.

²¹Virginia Comprehensive Health Planning Council, meeting, Minutes, 12 January 1972, (Richmond, Virginia), p. 6. Executive papers of Governor Linwood Holton, Virginia State Archives, Richmond, Virginia.

relative ease, the certificate of need bill encountered more strident opposition in the House. Opponents of the bill viewed CON as an unreasonable extension of state authority. Delegate Edwin H. Ragsdale (D-Richmond) felt that certificate of need created a monopoly for existing hospitals. Sharing this sentiment, Delegate George F. Allen, Jr. (D-Richmond) argued that there was not a problem of excess capacity, and he felt that new development should be encouraged. While Delegate Samuel Glasscock (D-Nansemond) conceded that the bill might restrict free enterprise, CON was still a reasonable approach "because empty beds drive up medical costs."²²

When put to a floor vote in the House, the CON measure was defeated by a vote of 49-49. However, the bill was not to be defeated. Exerting his considerable influence as president pro tempore of the Senate, Senator Willey helped resurrect the moribund CON bill by directly confronting a number of delegates after the vote was taken. One of those delegates to change his mind was Delegate Allen, who later commented that he would have voted in favor of the bill initially "if I had just known it was the Senator's [Willey's] bill."²³ In the end, the measure passed the House by a vote of 50-44, and the Senate agreed to the House amendments, having already passed the measure by a margin of 23-13. Although CON in other states tended to pit urban areas that

²²Claude Burrows, "Deadlock Defeats Hospital Bill," Richmond Times-Dispatch, 16 February 1973, A-8.

²³"Senator Willey Aids House Passage of Hospital Bill", Richmond Times-Dispatch, 17 February 1973, B-1.

generally opposed CON against rural areas which favored CON, the voting on this bill in both houses did not reflect such a pattern.²⁴ Legislators from rural and urban regions in both houses were rather evenly divided on the bill.

Virginia's Original Certificate of Public Need Statute

The enactment of the Medical Facilities Certificate of Public Need (COPN) law provided the Commonwealth with an additional policy instrument to facilitate health planning and constrain health care costs.²⁵ Whereas the other health planning mechanisms that existed in Virginia as of 1973 were of federal origin, this program was a creature of the Commonwealth. While the General Assembly could have created an entirely new administrative apparatus, it did not. Instead, authority was vested in existing agencies created pursuant to the federal Comprehensive Health Plan, thereby signalling a desire to incorporate COPN into the existing health planning framework.

Administrative authority under the COPN law was quite

²⁴"Urban" and "Rural" designations are based on 1970 U.S. Census Bureau data as applied to Virginia senatorial and delegate districts. The record of the initial House vote may be obtained from Journal of the House (1973) vol. 1, p. 809-810. The second vote in the House may be obtained from Journal of the House (1973) vol. 1, pp. 826-827. The roll call vote record for the Senate vote may be obtained from Journal of the Senate, (1973) vol. 1, p. 485.

²⁵For the purposes of this and subsequent chapters the acronym COPN shall refer to the Virginia certificate of public need program specifically, while CON shall refer to the certificate of need as it applies to the general concept.

centralized. This centralization of authority was in keeping with the general thrust of Virginia government reorganization efforts that were underway during the early 1970's.²⁶ Virtually all decision-making authority was vested in the office of the Commissioner of Health. Statewide and areawide health planning bodies were given little more than advisory status. The Commissioner was authorized to prescribe rules and regulations, and to require any reports or investigations deemed necessary by him to administer the program. It was the Commissioner's responsibility to designate a statewide body to administer the program at the state level. The Commissioner was also directed to consult with the State Comprehensive Health Planning Council and the Advisory Hospital Council. However these bodies could only perform advisory and consultative functions.²⁷

In contrast to the broad powers conferred upon the Health Commissioner, the five areawide planning councils received only the briefest mention in the enabling statute. The areawide councils were directed to provide "advice or assistance" to the Statewide Comprehensive Health Planning Council, which, in turn,

²⁶Thomas R. Morris and John T. Whelan, "Gubernatorial Management of State Government in Virginia," in Virginia Government and Politics, Thomas R. Morris and Larry Sabato, eds. (Charlottesville, VA: Virginia Chamber of Commerce and the University of Virginia, 1984), p. 130. See for this piece for a more complete discussion of the move to consolidate gubernatorial authority in Virginia.

²⁷Virginia Acts of Assembly, (1973) vol. 1, ch. 419, sec. 32-211.6 (8) (a).

was to render advisory recommendations to the Commissioner.²⁸ Responsibility for the determination of COPN applications rested with the Commissioner of Health.

The scope of the initial statute was quite broad. Institutions which were within the purview of the COPN program included general hospitals, sanitarium and sanatoria, intermediate and extended care facilities, nursing homes, health maintenance organizations, and mental health and mental retardation facilities. However, physicians' offices and emergency first aid stations were specifically exempted from review.²⁹

Not every project undertaken by a health facility was subject to review. Only those projects that could legitimately be classified as capital expenditures were within the scope of the COPN program. Furthermore, a project had to have resulted in a capital expenditure in excess of \$100,000, or a change in the facility's bed capacity, or a significant change in the clinical services offered by a facility, in order to warrant a COPN review.³⁰ Taken in total, the statute's scope appears to have been sufficiently broad to encompass a wide range of medical facilities and services.

To guide the Commissioner in reaching decisions on COPN

²⁸Virginia Acts of Assembly, (1973) vol. 1, ch.419, sec. 32-211.7.

²⁹Virginia Acts of Assembly, (1973) vol. 1, ch. 419, sec. 32-211.5 (6).

³⁰Virginia Acts of Assembly, (1973) vol.1, chap. 419, sec. 32-211.5 (7).

applications, the General Assembly enumerated seven decision-making criteria in the statute. The Commissioner was directed to take into consideration the recommendation of the State Comprehensive Health Planning Council regarding a COPN application, although he was not legally bound by this recommendation. The Commissioner was to determine that the proposed project would contribute to the "orderly development and proper distribution of adequate and effective health services in the area to be served."³¹ In order to help the Commissioner determine the needs of the area to be served, the Commissioner was directed to take into account the "size, population, and growth of the area to be served by the proposed project."³²

The final four decision-making criteria were concerned primarily with the integration of a proposed project with existing health care resources. The number and type of existing or planned facilities similar to the proposed project, and the availability of existing or planned resources which may serve as alternatives or substitutes to the proposal were also to be factored into the Commissioner's decision.³³

While there was considerable attention paid to existing health resources, the Commissioner had to determine the

³¹Virginia Acts of Assembly, (1973) vol.1, ch. 419, sec. 32-211.6 (b) 1-2.

³²Virginia Acts of Assembly, (1973) vol.1, ch.419, sec. 32-211.6 (b) 3.

³³Virginia Acts of Assembly, (1973) vol. 1, ch. 419, sec. 32-211.6 (b) 4-5.

availability of qualified manpower to staff a prospective project when considering a COPN application.³⁴ After all, there was no sense approving a project if qualified personnel to staff it were unavailable. Whereas the preceding criteria dealt with the proposed project's impact on the area to be served, the final criteria were more concerned with the project's impact at the statewide level. Specifically, the Commissioner was to ensure the "compatibility of the proposed project with the comprehensive State plan including the State Hospital Construction program."³⁵ Health planning seems to have been of particular importance to the General Assembly. The statute placed special emphasis on the goal of integrating proposed projects with the existing health care environment. However the areawide agencies were given little opportunity for input into the planning process.

Responsibility for the administration of the COPN program rested with the Health Commissioner. Anyone wishing to initiate a health facility project was required to submit an application to the Health Commissioner. Determining what information would be necessary for the completion of the application form itself was left to the Commissioner's discretion. It was then the Commissioner's responsibility to see that copies of each application were forwarded to the State Comprehensive Health Planning Council (State CHP Council). The statute provided that

³⁴Virginia Acts of Assembly, (1973) vol. 1, ch. 419, sec. 32-211.6 (b) 7.

³⁵Virginia Acts of Assembly, (1973) vol.1, ch. 419, sec. 32-211.6 (b) 6.

the State CHP Council had forty-five days during which to review the application, and make its recommendation to the Commissioner. In doing so, the CHP Council was permitted to solicit "advice and assistance" from the area-wide health planning council in whose area the project was to be located. These recommendations were not binding on the Council or the Commissioner. Once the Commissioner received the CHP Council's recommendation, he was required to reach a decision regarding the application within forty-five days of receiving the CHP Council's recommendation. However, no more than ninety days were to elapse from the date the application was initially submitted until a final decision was rendered.³⁶

The centralization of administrative authority that was referred to earlier seems to be evident here also. The Health Commissioner was responsible for establishing administrative procedures not enunciated in the statute. Although the statute gave the State CHP Council the task of reviewing COPN applications, the Council had no authority to enforce its conclusions. Area-wide health planning agencies were to assist the CHP Council, but could only render advisory assistance. So as not to be unduly burdensome to applicants, a time frame of ninety days was established for the completion of the entire review process. As a result, applicants would have a definite timetable around which to formulate their own plans.

³⁶Virginia Acts of Assembly, (1973) vol. 1, ch. 419, sec. 23-211.7.

Further accommodations were afforded applicants to ensure a fair hearing, and adequate opportunity for judicial review, if necessary. Hearing procedures were to be governed by the Virginia General Administrative Agencies Act, and the Commissioner was to preside over the hearings. An applicant who was denied an application could appeal the Commissioner's decision to the State Board of Health.³⁷ If, however, an applicant was dissatisfied with the State Board of Health's ruling, there was yet another avenue of recourse.

An applicant dissatisfied with the decisions of the Health Commissioner and the State Board of Health was entitled to seek judicial relief. In order to be eligible for appeal, an applicant had to file for an appeal with the Circuit Court in the City of Richmond, or in a circuit court whose jurisdiction encompassed the area where the project was to be located, within thirty days after receipt of the Board of Health's decision. It was then the Board of Health's responsibility to forward all appropriate papers and records to the court having jurisdiction.³⁸ Upon examination of the appropriate documents and materials, courts were free to affirm, overturn or modify the Board's decision. Should a court find that sufficient need existed to warrant the granting of a certificate, the Health Commissioner was then obligated to grant a certificate. If any

³⁷Virginia Acts of Assembly, (1973) vol.1, ch.419, sec. 32-211.8

³⁸Virginia Acts of Assembly, (1973) vol.1, ch. 419, sec. 32-211.9.

party to the appeal wished to do so, a further appeal to the Virginia Supreme Court was provided for in the statute. The Supreme Court was the court of last resort, however.³⁹

Procedural fairness seems to have been a primary component of the original COPN statute. To the extent that certain administrative provisions were mandated by the Virginia General Agencies Act, the authors of this statute had little choice but to provide for administrative hearings. The COPN statute went much further, however, providing ample opportunities for judicial, as well as administrative relief.

Of course, the certificate itself was not an ambiguous document, allowing for open-ended interpretations. Indeed, the COPN statute established very definite parameters to govern the form and the issuance of individual certificates. Each certificate was to be valid for the specific project for which it was requested. Once the Health Commissioner granted a COPN, it was valid for a period lasting no longer than two years, at which time the applicant could request a renewal of the certificate.⁴⁰ Even though there were ample provisions to ensure that review proceedings were fair, and that certain administrative procedures were adhered to, the authors of this legislation took a less than benevolent view of those who failed to comply with the statute. Hence the statute also contained provisions for sanctions against

³⁹Virginia Acts of Assembly, (1973) vol. 1, ch. 419, sec. 32-211.9.

⁴⁰Virginia Acts of Assembly, (1973) vol.1, ch. 419, sec. 32-211. 11.

those who violated the law. Any legal entity which chose to undertake a project without first obtaining a COPN was guilty of a misdemeanor, and subject to a fine ranging from \$50 to \$1,000.⁴¹ Upon petition by the Health Commissioner, Board of Health, or the Attorney General, the court having jurisdiction over the area where the project was to be undertaken was given the authority to enjoin "any project which is constructed, undertaken, or commenced without the required certificate of public need as referred to herein."⁴²

Although the COPN statute was drafted ostensibly to control health facility expansion, the final section of the Act had very little to do with this purpose. Instead of discussing health facility expansion, this section addresses the issue of unjustifiable termination of, or exclusion from, employment of qualified personnel in a licensed health facility. Failure to provide adequate justification that the action in question was related to institutional rules and regulations, or the quality of patient care, was considered unacceptable under the statute. Therefore, institutions found to be in violation of this provision were subject to license suspension or revocation, pending appeal.⁴³ That such a provision was included in a measure designed to regulate health facility expansion may

⁴¹Virginia Acts of Assembly, (1973) vol. 1, ch. 419, sec.32-211.13.

⁴²Virginia Acts of Assembly, (1973) ch. 419, sec. 32-211. 12.

⁴³Virginia Acts of Assembly, (1973) ch. 419, sec. 32-211. 16.

possibly be attributed to efforts occurring nationally during this period to prohibit employment discrimination.

Amendments to the Statute

The original COPN statute has undergone numerous changes since its enactment. Many of the amendments to the statute were undoubtedly the product of federal requirements stemming from the federal CON statute, passed in 1974. Over time, the regulatory scope and administrative structure has been altered, as has the character of the decision-making process. Changes that have occurred with respect the decision-making process have generally streamlined the process while providing greater opportunities for input from the public than had existed under the original statute.

Final authority has remained at the state level. Although the Health Commissioner retained decision-making authority, other entities were given more prominent roles. For instance, the General Assembly required that areawide health planning agency recommendations be considered by the Commissioner when rendering a COPN application decision.⁴⁴ In the initial statute, the Commissioner's consideration of these recommendations was optional. In 1982, the General Assembly transferred responsibility for the promulgation of COPN rules and regulations

⁴⁴Virginia Acts of Assembly, (1975) vol. 1, ch. 220, sec. 32-211.6-8.

from the Health Commissioner to the State Board of Health.⁴⁵

Beginning in 1977, the General Assembly incorporated changes in the COPN program that were mandated by the federal National Health Planning and Resource Development Act (P. L. 93-641). Although retaining their functions, the designation of the areawide health planning agencies was changed to Health Systems Agencies, and the geographic areas that they represented were henceforth referred to as Health Systems Areas, and the Statewide Health Coordinating Council replaced the State Comprehensive Health Planning Council as the executive branch body responsible the statewide health and medical facilities plans.⁴⁶ It was also the SHCC's responsibility to review and make recommendations to the Commissioner regarding individual COPN applications. However the General Assembly rescinded this vestige of responsibility in 1984.⁴⁷ A year later, the Virginia Department of Health was designated as the State Health Planning and Development Agency (SHPDA), with responsibility for administering the COPN program.⁴⁸ The General Assembly made two attempts to strengthen statewide health planning capabilities by enhancing the tools that were at the Commissioner's disposal. In the 1977

⁴⁵Virginia Acts of Assembly, (1982) vol. 1, ch. 388, sec. 32-102.2.

⁴⁶Virginia Acts of Assembly, (1977) vol.1, ch. 575, sec. 32-211.5 (a).

⁴⁷Virginia Acts of Assembly, (1984) ch. 740, sec. 32-102.6.

⁴⁸Virginia Acts of Assembly, (1978) vol.1, ch. 454, sec. 32-211.21.

amendment to the COPN statute, the SHCC was given the task of formulating the State Health Plan (SHP), and the more specific State Medical Facilities Plan. Also, the standard review period for reaching decisions on COPN applications was extended from 90 to 120 days.⁴⁹ The number of criteria that the Commissioner used as a guide in determining the suitability of proposed projects was expanded from seven to twenty factors.⁵⁰ These changes seem to have been designed to integrate local needs and statewide concerns. For instance, the relationship of a project to local support and ancillary services, as well as the project's relationship to training programs and facilities for health care professionals in the area, were to be taken into consideration by the Commissioner.

Amendments to the original COPN statute also altered the scope of the COPN program. The types of facilities subject to COPN review were expanded in 1977 and 1982.⁵¹ Health Maintenance Organizations (HMOs) and non-profit nursing homes were also exempted in 1982.⁵² And in 1985, COPN requirements were lifted

⁴⁹Virginia Acts of Assembly, (1977) vol. 1, ch. 575, sec. 32-211.6 (6).

⁵⁰Virginia Acts of Assembly, (1982) vol. 1, ch. 388, sec. 32.1-102.3 (B).

⁵¹Virginia Acts of Assembly, (1977) vol.1, ch. 575, sec. 32-211.5-9, 12, 17. Also, Virginia Acts of Assembly, (1982) vol. 1, ch. 388, sec. 32- 102.1.

⁵²Virginia Acts of Assembly, (1982) vol. 2, ch. 659, sec. 32.1-96.1.

from home health agencies.⁵³ The capital expenditure thresholds for triggering the COPN review process were raised in 1977, 1982.⁵⁴ Thus while some amendments expanded the types of projects subject to COPN review, other amendments raised the thresholds and exempted certain types of projects, essentially restricting the program's coverage.

Conclusion

Certificate of need in Virginia was a policy borne of a perceived crisis. Skyrocketing health care costs and an excess of hospital beds, accentuated by questionable administrative practices at Virginia Blue Cross-Blue Shield helped provide the catalyst for change in the health care arena. Of course, public policies relating to the provision of health care were already in effect. The federal Hill-Burton program had been providing hospital construction funds for twenty-five years, and the Regional Medical Plan and the Comprehensive Health Planning Act established a health planning framework at the regional and statewide levels of implementation.

It was within this environment that certificate of need in Virginia evolved. Rather than create wholly new, independent

⁵³Virginia Acts of Assembly, (1985) vol. 1, ch. 513, sec. 32.1-102.1 (11).

⁵⁴Virginia Acts of Assembly, (1977) vol. 1, ch. 575, sec. 32-211.5(5)., Virginia Acts of Assembly, (1982) vol. 1, ch. 388, sec. 32.1-102.1 (6)(a).

planning bodies, the authors of this legislation chose to delegate responsibility for its implementation to the Health Commissioner, and to the state- and areawide health planning councils created pursuant to the Comprehensive Health Planning Act. COPN was thereby incorporated into the existing health planning structure.

Administratively, attention was focused at the state level. In fact, most of the authority was vested in the Health Commissioner's office through relatively broad delegations of authority and responsibility. This concentration of authority may well have been part of a larger movement occurring in Virginia government at the time which stressed the consolidation of authority at the cabinet level of government. Meanwhile, the areawide planning councils and the State Health Planning Council occupied largely advisory roles. Nonetheless, regional as well as statewide needs were to be taken into account when rendering a decision on a COPN application. If the Commissioner's decision regarding a particular COPN application resulted in a denial, there were ample provisions for appeal. These procedures were clearly enumerated in the statute, in contrast to the broad goals and delegations of authority that were to guide the program.

Several themes are evident in this legislation. First, there is the emphasis on the utilization of health planning in the furtherance of other goals, such as cost containment. By doing so, the authors of this legislation lent credence to the stated goal of enhancing health planning capabilities in the

Commonwealth. Secondly, the concentration of authority at the state level suggests that statewide health planning goals were to take precedence over area needs, since the areawide agencies were to act only in an advisory capacity. Applicants were to be treated fairly, and violators of the statute's provisions were subject to rather small fines, although there was the potential for license revocation.

In the fifteen years since its passage, the statute has been amended eight times. The statute that exists today has changed considerably from the statute as it was originally drafted. These alterations are reflected in a number of policies and procedures that differ from those in the original statute. The nature and implications of these changes for the implementation of the COPN program shall be discussed subsequently.

CHAPTER 3

THE VIRGINIA CERTIFICATE OF PUBLIC NEED PROCESS

With the passage of the Medical Care Facilities Certificate of Public Need statute in 1973, the Commonwealth of Virginia entered a new phase of health care policy. Certificate of Public Need (COPN) represented the Commonwealth's attempt to rationalize the health facility sector of the health care industry by constraining health facility development, except where it was deemed to be "needed." To that end, Virginia established a regional and statewide health planning system to gather information concerning state and regional health facility needs. These data were used at the state level to determine, within a regulatory environment, the efficacy of a proposed project. COPN provided Virginia health officials with a vehicle for controlling medical facility resource allocation.

Regulation is an inherently political process.¹ By creating the COPN program, Virginia policy-makers transformed what had been largely private decisions regarding health facility projects into often very political decisions. Decisions as to the efficacy of health facility projects were no longer primarily private concerns. Instead, final authority regarding the worthiness of projects was vested in state officials (most notably the Health Commissioner) who were required to adhere to

¹Meier, p.8.

legal and regulatory guidelines, and were often subject to political pressure. Also, the promulgation of rules and regulations provided opportunities for public input into the COPN process.

The evolution of the COPN process over the last sixteen years has not been a tranquil period. As noted in the previous chapter, the original statute has been amended numerous times, and there have been many non-legislative changes adopted by state Health Department officials. Not long after Virginia enacted its COPN statute, the federal government enacted a national health planning statute (P.L. 93-641), which included a provision that each state create its own certificate of need program. P.L. 93-641 provided federal funds to states for the establishment of CON programs, which were subject to broad federal guidelines. Through this federal health planning program, the federal government also influenced Virginia's COPN program, if only in a broad oversight capacity.

Virginia's COPN program encourages public participation. Over the last sixteen years, the COPN process has become less restrictive with respect to the groups or individuals who may play a role in the process. Virginia politics has not always been characterized by openness, however. The public participation that legislators and health department officials incorporated into the COPN process coincided with a broader movement in Virginia politics during the early 1970's to open the political process to greater levels of scrutiny and participation than had

existed previously.² Health care providers, third party payers, business groups and governmental agencies are just some examples of the participants in the COPN process. The participation by these and other parties has helped politicize the process, and there are particular features of the process that are especially susceptible to political forces. Alford has suggested that the rational objectives of CON are mitigated by the political activity common to the regulatory process.³ The notion that health care should be responsive to the public's needs,⁴ contributes further to the politicization of the COPN process.

The Certificate of Public Need Process

The COPN process that exists today is quite different from the process created in the original statute. Amendments to the statute, as well as subsequent regulatory changes adopted by Health Department officials have altered the complexion of the COPN process. These changes allowed the program to adapt to the evolving health care environment.

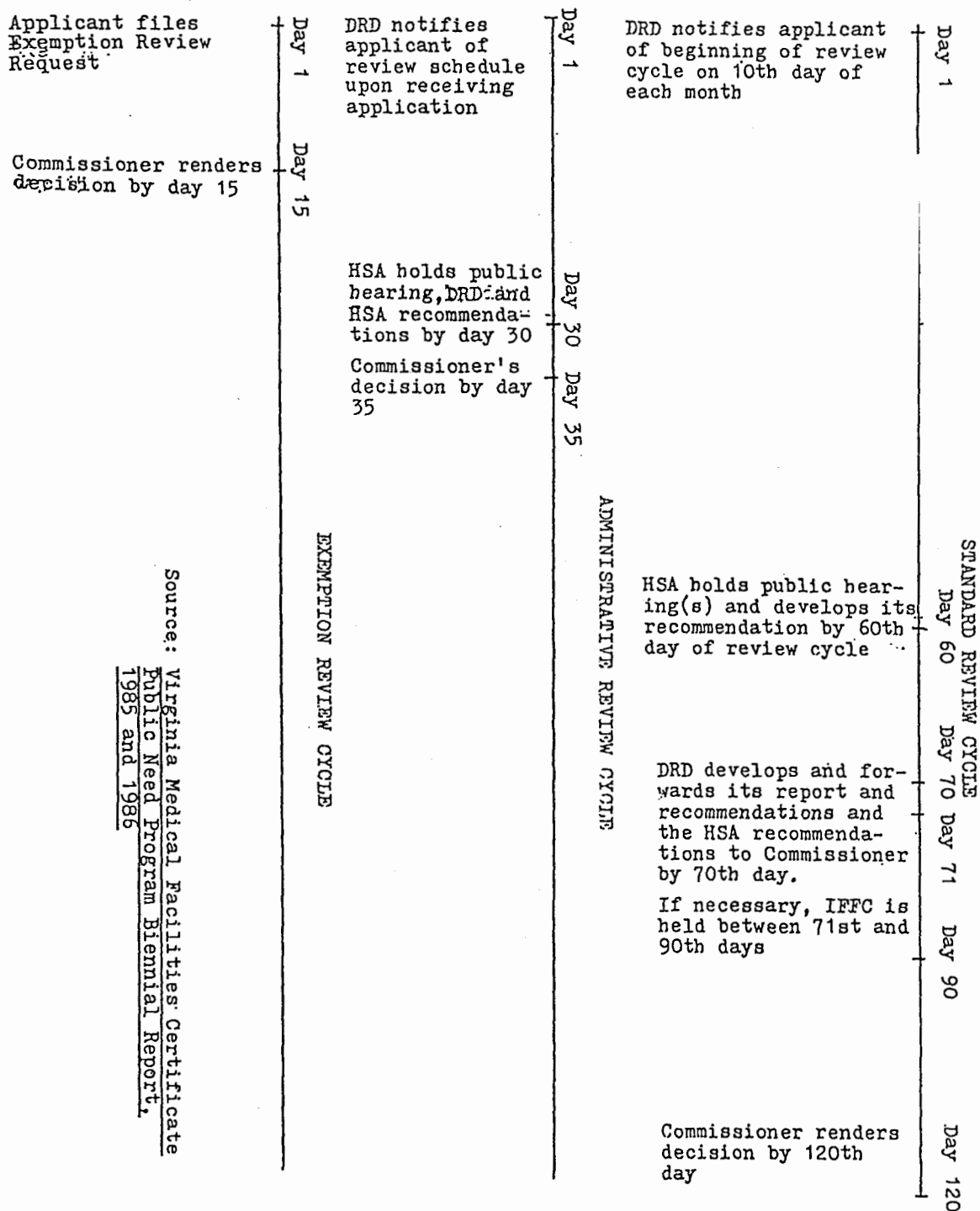
²Thomas R. Morris, "From 'Old Virginny' to the 'New Dominion': Two Decades of Public Policymaking in Virginia," in A Virginia Profile: 1960-2000, Assessing Current Trends and Problems, John V. Moeser, ed. (Pallisades Park, NJ: Commonwealth Books, 1981), p. 76.

³Robert R. Alford, Health Care Politics (Chicago: University of Chicago Press, 1975), p. 204.

⁴Virginia Department of Health, Division of Resources Development, Certificate of Public Need Biennial Report, 1983-1984, (Richmond, Virginia: Virginia Department of Health, 1984), p.1.

When discussing the COPN process the most important thing to recognize is that there is not a single COPN review process. As it currently exists, the COPN program consists of three review processes, and an appeal process. The Standard Review process is designed to handle COPN reviews for most of the projects that meet the criteria for reviewability. An abbreviated Administrative Review process facilitates the review of projects, such as parking garages, which meet some, but not all of the criteria for a Standard Review. Then there is an Exemption Review process which provides COPN applicants with the opportunity to demonstrate that their project should not have to undergo a review. Figure 3.1 provides a diagrammatic overview of the major elements of each review process and, the time frames in which each review process occurs. Figure 3.1 also illustrates some of the procedural differences between each process. There is also an appeal process, which provides avenues of remedial recourse for those parties dissatisfied with the outcome of a project review. The appeal process includes provisions for administrative, as well as judicial relief.

Each of the review processes operates within its own time frame. Due to the greater amount of time between steps in the process, 120 days are required to complete a Standard Review. Administrative and Exemption Reviews are simpler processes, requiring thirty-five and fifteen days, respectively, for the

Certificate of Public Need Review Cycles

Source: Virginia Medical Facilities Certificate
Public Need Program Biennial Report,
1985 and 1986

completion of these review cycles.⁵ These time frames permit the expeditious handling of less significant projects, while providing considerably more time to review larger, costlier projects that would probably have a greater impact on the cost and provision of health care. While it is unnecessary to delineate every step of each review process, highlighting important stages of each review process can be helpful in understanding the process, and may also provide a basis for comparison.

The first step in each of the review processes occurs when a prospective applicant files a Letter of Intent with the Division of Resources Development(DRD), the state agency responsible for administering the program. Those seeking an exemption from the COPN process under the Exemption Review procedure must submit an Exemption Review Request form to the DRD. A Letter of Intent must identify the owner of the facility in question, the nature and scope of the proposed project, the project's location and costs.⁶ The information required on the Exemption Review Request is much more detailed. Applicants must identify not only the owners of the facility, but also, the type of ownership (proprietary, non-profit, public, etc.), and the operator of the

⁵Division of Resources Development, Certificate of Public Need, Annual Report 1985-1986, (Richmond, Virginia: Virginia Department of Health), p. 7.

⁶Virginia Department of Health, Division of Resources Development, "Description of Certificate of Public Need Procedures," Presentation to the Commission on Medical Care Facilities Certificate of Public Need, February 16, 1987 (Richmond: Division of Resources Development) pp. 1, 6.

facility. The applicant has to provide a brief description of the project, including its capital and financing costs, and the proposed method of financing the project. A statement estimating the project's impact on the facility's rates, and a projection of revenues and expenditures for the first two years of operation is also required. The final element of the Exemption Review Request is a schedule for completion of the project.⁷ It should be noted here that both the Standard Review and the Administrative Review processes afford applicants the opportunity to consult with Health Systems Agency (HSA) or DRD officials prior to the submission of the application concerning community health facility needs, and the opportunity to provide general assistance in completing the applications, which are available upon request from the Health Commissioner.

Once an applicant files the Letter of Intent or Exemption Review Request with the Health Commissioner, the application is completed by the applicant and submitted to the DRD for a completeness review. The DRD has fifteen days to make certain that all pertinent information has been included on the application.⁸ When the application has been deemed complete, and it has been filed with the DRD and the appropriate HSA, the

⁷"Description of Certificate of Public Need Review Procedures," p. 10.

⁸Virginia Department of Health, Office of Health Planning and Resources Development, Rules and Regulations of the Board of Health, Commonwealth of Virginia, Virginia Medical Facilities Certificate of Public Need, (Richmond, Virginia: Department of Health, January 22, 1986) secs. 6.1 and 7.1, respectively.

formal review process can then begin.

Standard Review

The longest, most complex process is the Standard Review process (see Figures 3.1 and 3.2). Lasting 120 days, the Standard Review provides ample opportunity for review at the state level, as well as the solicitation of public comment on individual applications. After the DRD has received and approved the application, the applicant receives notification that the review is about to commence. The tenth day of each month is the beginning of the Standard Review cycle, and constitutes the first day of the 120 day process.⁹

All medical care facility projects that do not qualify for Administrative Review are subject to a Standard Review, unless they are declared exempt through an Exemption Review. Facilities that are subject to review include general hospitals, nursing homes, extended care and intermediate care facilities, specialized out-patient clinics, mental health and mental retardation facilities. Projects that are subject to Standard Review include capital expenditures of at least \$700,000 that also result in an increase in bed capacity and the introduction of new clinical health services. Equipment purchases costing at

⁹Virginia Department of Health, Division of Resources Development
Virginia Medical Care Facilities Certificate of Public Need
Program, Biennial Report, 1985 and 1986, (Virginia Department of
Health: Richmond, Virginia, 1987), p.11.

DRD notifies applicant
of beginning of review
cycle on 10th day of
each month

Day 1

HSA holds public hear-
ing(s) and develops its
recommendation by 60th
day of review cycle

Day 60

DRD develops and for-
wards its report and
recommendations and
the HSA recommenda-
tions to Commissioner
by 70th day.

Day 70

If necessary, IFFC is
held between 71st and
90th days

Day 71

Day 90

Commissioner renders
decision by 120th
day

Day 120

Virginia Certificate of Public Need

Figure 3.

least \$400,000 are also subject to Standard Review.¹⁰ These expenditure thresholds have increased substantially over time, as noted in chapter 2.

The HSAs play a major role during the first sixty days of the Standard Review process. It is during this time period that the HSA must hold at least one, but not more than two hearings on an application, allowing applicants the opportunity to respond to issues or questions that individuals or medical facility spokesman may raise during the hearing.¹¹ In addition to notifying the applicant of the review schedule, the HSA must notify other health care providers in the area who may be affected by the project, as well as identifiable interest groups. Notice of a hearing must be published in an area newspaper nine days prior to the hearing.¹² The HSA has sixty days in which to conduct the hearing(s), review the application, and make its recommendation to the Health Commissioner.¹³ These initial activities constitute the HSAs' role in the process. However, the Commissioner does take into consideration the HSA review and recommendation when rendering a decision.

Public input into the early stages of the process appears

¹⁰Certificate of Public Need Biennial Report 1985-1986, pp. 6-7.

¹¹Certificate of Public Need Rules and Regulations, sec. 7.6 (A).

¹²Certificate of Public Need Rules and Regulations, sec. 7.6. (B).

¹³Certificate of Public Need Rules and Regulations, sec. 7.6(A).

to be confined to the public hearings. It is during these public hearings that conflicts often arise, to be resolved by the antagonists through bargaining and negotiation.¹⁴ These conflicts may involve competing applicants with similar project requests, or the conflict may be between an applicant and members of the HSA governing board or staff.

While the HSA conducts its review, the DRD simultaneously conducts its own review. The DRD completes its staff report by the seventieth day of the review cycle. An important change in the Standard Review process came in 1984, when the Statewide Health Coordinating Council (SHCC), which was originally authorized to review COPN applications was removed from the review cycle through an amendment in the COPN statute.¹⁵ Even though the removal of the SHCC had no effect on the overall length of the review cycle, it did seem to streamline the process from an administrative standpoint.

When the DRD finishes its review, it forwards both the HSA report and recommendations, and the DRD report and recommendations to the Commissioner. If, by the seventieth day there is opposition to a project, an Informal Fact-Finding Conference (IFFC) is held by the DRD Director. The DRD notifies the applicant and any other interested parties of the date of the

¹⁴Drew Altman, Richard Greene, and Harvey M. Sapolsky, Health Planning and Regulation: the Decision Making Process (Washington, D. C. : AUPHA Press, 1981), p. 150.

¹⁵Virginia Acts of Assembly, (1984) vol. 2, ch. 740, sec. 32-102.6.

hearing. This date had actually been predetermined in the initial communication from the HSA, which allowed time for an IFFC in the initial review timetable. In order to participate in an IFFC, a party must show that: a) significant relevant information was not presented at the public hearing, or, b) significant changes in factors relating to the application have occurred since the public hearing, or, c) there was a serious mistake in fact or law in the DRD's staff report, or the HSA's staff report.¹⁶

These conferences are conducted by the DRD Director. The HSA and Interested Parties present their positions on the project, and the applicant is given the opportunity to respond to comments and criticisms. Based on the record of this hearing, the DRD Director makes a recommendation to the Health Commissioner regarding the COPN application in question. This recommendation takes into account the HSA and the DRD staff reports, as well as the informal fact-finding conference record.¹⁷ Since the IFFC must be conducted between the seventy-first and ninetieth days of the review cycle, the Commissioner has at least thirty days in which to arrive at a decision before the 120-day review period expires. Thus the IFFC provides yet another opportunity for public input into the Standard Review process by providing all parties to the original public hearing

¹⁶"Description of Certificate of Public Need Review Procedures," pp. 2-3.

¹⁷"Description of Certificate of Public Need Review Procedures," p. 3.

the opportunity to participate in the IFFC. However the presence of a definite timetable within which the IFFC must occur would seem to curb any tendency to prolong the process unnecessarily.

The Standard Review process provides ample time and opportunity for all of those who wish to comment on a COPN application to do so. Marmor and Marone have suggested that time constraints, together with conflict, combine to make the review process inefficient.¹⁸ While the Standard Review cycle facilitates public input into the review process, this input may result in delays if an IFFC should be necessary. However, such delay is not necessarily to be condemned. Delay is inherent in the regulatory process as regulators try to be responsive to the actions of those involved.¹⁹ In the final analysis, regulatory delay may represent a trade-off for procedural fairness.²⁰

Administrative Review

An alternative review process exists for those projects that meet some of the COPN review criteria, but do not meet all of the criteria for a Standard Review. For those projects that do not

¹⁸Theodore R. Marmor and James A. Marone, "Representing Consumer Interests: Imbalances Markets, Health Planning and the HSAs," Milbank Memorial Fund Quarterly/Health and Society (58) 1 (Winter 1980), p. 160.

¹⁹Bruce M. Owen and Ronald Braetigan, The Regulation Game (Cambridge, MA: Ballinger Co., 1978), p. 20.

²⁰ Meier, p. 279.

involve a major service, facility change, or capital expenditure, the Administrative Review process exists to expedite the issuance of COPNs (see Figures 3.1 and 3.3).

In order to be considered under the Administrative Review process, certain criteria must be met. These criteria have been adjusted over time to reflect changes in the health care sector as well as inflationary trends. Projects that are eligible for Administrative Review include any capital expenditure of at least \$700,000, but not more than \$3 million, that does not result in a change in bed capacity or the addition of a new clinical health service. COPNs may also be issued under Administrative Review if the project involves a capital expenditure of less than \$700,000, but does result in the addition of a new clinical health service, or if the project involves a change in bed capacity, or the replacement or relocation of at least ten percent of the existing bed capacity, or ten beds, whichever is less.²¹

The primary advantage of the Administrative Review over the Standard Review is that the Administrative Review is less time consuming. Whereas the Standard Review occurs within a 120-day time period, the Administrative Review lasts no more than thirty-five days. Less time elapses between the various stages of the Administrative Review as compared to the Standard Review. As with the Standard Review, applicants must request application forms from the Health Commissioner, and applicants may request a pre-consultation conference with representatives of the

²¹Certificate of Public Need Rules and Regulations, sec. 6.1.

DRD notifies
applicant of
review schedule
upon receiving
application

Day 1

HSA holds public
hearing, DRD and
HSA recommenda-
tions by day 30
Commissioner's
decision by
day 30

Day 30 Day 35

Virginia Certificate of Public Need
ADMINISTRATIVE REVIEW CYCLE

Figure 3.3

appropriate HSA.²²

Once the applicant has submitted copies of the application form to the DRD and the appropriate HSA, the Administrative Review can commence. Within thirty days of receipt of the completed application, the HSA must hold a public hearing, such as is required in the Standard Review process. Should the HSA fail to hold such a hearing within this time limit, the project in question shall receive an automatic recommendation for approval from the HSA.²³ The DRD also contacts the applicant once the application has been received in order to establish a review schedule, which includes a tentative date for an IFFC. Assuming that there is no need for an IFFC, both the HSA and the DRD recommendations must be transmitted to the Health Commissioner by the thirtieth day of the review cycle.²⁴ The Health Commissioner then has five days in which to render a decision.

If an IFFC is necessary, the decision-making timetable is automatically extended. The justifications for holding an IFFC are the same under the Administrative Review process as under the Standard Review process. The IFFC is usually held in Richmond, within seven days of the decision by the DRD that such a conference is warranted. The Health Commissioner then has at

²²Certificate of Public Need Rules and Regulations, sec. 6.2.

²³Certificate of Public Need Rules and Regulations, sec. 6.4.

²⁴Biennial Report, 1985-1986, p. 10.

least two weeks to arrive at a decision, pending the conclusion of the IFFC.²⁵

There are many similarities between the Standard Review process and the Administrative Review process. In fact, the critical difference between the two processes seems to be that the timetable for an Administrative Review is considerably shorter than for a Standard Review, and thus does not allow as much time for the consideration of a project by the Health Department. It also does not give opponents or advocates of a project as much time to marshal support or opposition to a project that is being reviewed under this process. Both processes are characterized by a great deal of communication between the applicant, the HSA, the DRD, and various Interested Parties. All of this often contributes to the need for review extensions and the devotion of Health Department resources to resolve disputes.²⁶

It seems only natural that the Administrative Review period would be considerably shorter than the Standard Review period, since the projects covered by the Administrative Review are not as significant financially. The creation of this abbreviated review schedule for projects that do not involve significant alterations in the provision of care allows Health Department officials to control health facility activities that may still have an impact on overall facility costs, even though they do not

²⁵Biennial Report, 1985-1986, p.10.

²⁶Biennial Report, 1983-1984, p. 30.

involve a significant capital outlay.

Decision-Making Criteria

By the time a COPN application finally reaches the Health Commissioner's desk, a great deal of information regarding the proposed project is available to the Commissioner. Factors that the Commissioner must consider when rendering a decision are specified in the COPN statute and in the Certificate of Public Need Rules and Regulations. This list of factors has changed over time in response to changes in the health care environment, and the concerns of lawmakers and health officials. Since agency heads are often the focal point of group intervention, it is important that legislative goals and grants of authority delegate as much authority as possible to these individuals.²⁷ By providing a list of decision-making criteria, the General Assembly seems to have been cognizant of the importance of specific criteria.

Initially, there were just seven factors that the Commissioner had to consider. These factors stressed the compatibility of the project with statewide health planning goals (identified in the State Health Plan and the State Medical Facilities Plan). In fact, the Commissioner is legally bound to consider the State Health Plan (SHP) and the State Medical Facilities Plan (SMFP). It is here that all of the need

²⁷Meier, pp. 16-18.

projection methodologies and inventories of existing health care facility resources are contained. Also to be considered in the initial list of criteria were the availability of less costly and more efficient alternatives to the proposed project, and the proposed project's relationship to the facility's long-range plans.²⁸ These factors seem to have been designed to facilitate the incorporation of the COPN program into an orderly, rational health planning scheme.

In the fifteen years since the enactment of the COPN statute, thirteen additional factors have been added to the list of considerations that the Commissioner must take into account when reviewing COPN applications. Where the seven original factors stressed state and regional planning goals, more recent additions to the list focus on the efficacy of the project, and on certain specialized segments of health care, such as health maintenance organizations, and research-oriented projects. The eighteenth factor on the list is an acknowledgement of changes that have occurred in the financing of health care, since it encourages competitive forces, quality assurance, and cost-effectiveness.²⁹ The emphasis on competition is especially significant, since competition in the health care marketplace was not as prominent in 1973 as it is today. In light of these factors it should be noted that each project is evaluated on its

²⁸Virginia Acts of Assembly, (1973) ch. 419, sec. 32-211.6 (b).

²⁹Virginia Acts of Assembly, (1984) vol. 2, ch. 740, sec.32.1-102.3 (B).

own merits.³⁰ However, the Commissioner does have some flexibility in the application of these criteria (particularly the SHP and the SMFP). The Commissioner is permitted to deviate from the SHP and the SMFP, but he must provide written justification for such departures. The Health Commissioner is thus afforded some latitude in reconciling COPN applications with these health planning documents.

It would appear that the Health Commissioner's decision-making criteria have evolved in response to changes in the health care environment. This is especially true of those criteria that focus on specific segments of the health care industry, such as reimbursement practices and specific types of health care services. As the health care industry became more complex, these criteria seem to have been altered to accommodate changes that were occurring. However, throughout the life of the COPN program, the Health Commissioner has frequently borne the brunt of political pressure being exerted by competing applicants and HSAs who try to influence his decision on a COPN application.³¹ Indeed, since he has sole decision-making authority on COPN applications, the political pressure may, at times, be especially acute. However the effects of this activity may be mitigated by fairly unambiguous decision-making criteria.

³⁰Marilyn West, Director of the Division of Resource Development, interview by author, 21 September 1988, Virginia Department of Health, Richmond, Virginia.

³¹West interview.

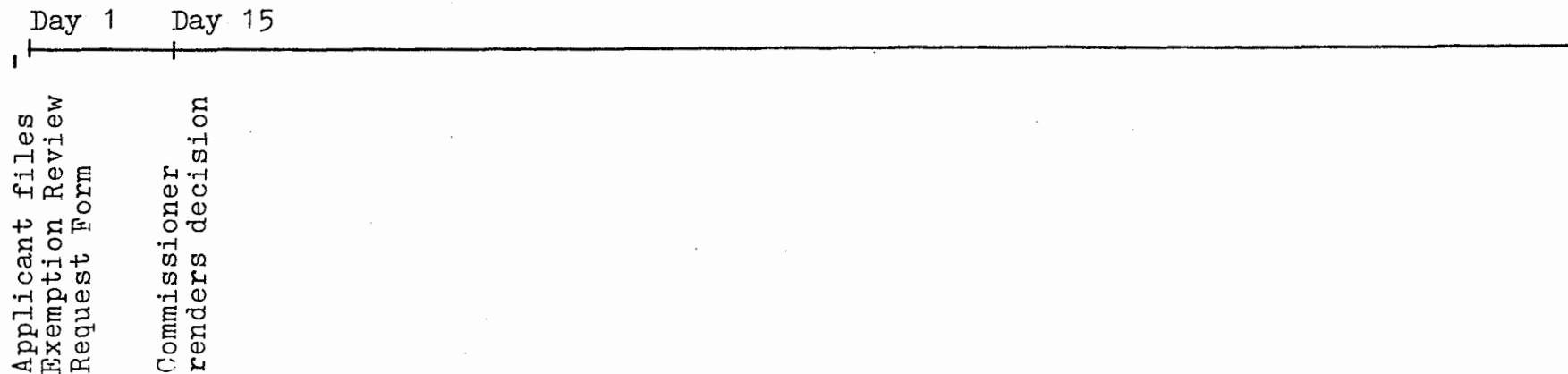
Exemption Review

In addition to the two review processes designed to handle most health facility projects, a third review mechanism - the Exemption Review - is also available to review health facility projects that may not meet the criteria for Standard Review or Administrative Review. The Exemption Review allows medical care facilities to circumvent the project review process if the project in question meets certain criteria, and does not meet all of the Standard or Administrative Review criteria.

Projects that satisfy any of the four Exemption Review criteria which are specified in the Certificate of Public Need Rules and Regulations are eligible for a COPN exemption. Clinical health services involving a capital expenditure less than \$700,000 and having operating costs in the first two years less than \$300,000 are exempt unless they involve specialized services, such as CT scanning. Also exempt from the review process are equipment expenditures less than \$700,000, unless this equipment results in the introduction of a new service. A capital expenditure less than \$1.5 million for construction that does not result in new health services is exempt from the COPN review process. Finally, any capital expenditure that is necessary to meet an emergency situation which threatens patients or staff is exempt if so certified by the Commissioner.³²

³²Certificate of Public Need Rules and Regulations, sec. 5.1 (A)-(D).

Figure 3.4
Virginia Certificate of Public Need
EXEMPTION REVIEW PROCESS



Source: Division of Resources Development,
Certificate of Public Need Annual Report,
1985-1986

Compared to the Standard and Administrative Reviews, the Exemption Review process is very simple (see Figure 3.4). In order to initiate an Exemption Review, an applicant need only file an exemption review request with the DRD and the appropriate HSA. This request form must specify the name and ownership of the facility, the nature of the project, its costs and its effect on the facility's charges for services, the proposed financing method, projected revenues, and a timetable for the project's completion.³³

No hearings are required for an Exemption Review, and the review is conducted entirely at the state level. The DRD reviews the exemption request to make certain that all relevant information is included, and then forwards the request to the Health Commissioner. The Commissioner must render a decision within fifteen days of the initial submission of the request. Although the DRD forwards a copy of the review request and the Commissioner's decision to the appropriate HSA, the HSA is not actually involved in the process.³⁴

The Exemption Review process is much more streamlined than the other two review processes. However, if an exemption request is denied, then the applicant must file a COPN application, and undergo one of the two project review processes. Unlike the other review processes, the Exemption Review process does not allow for public input regarding prospective projects. This fact

³³Certificate of Public Need Rules and Regulations, sec. 5.2.

³⁴Certificate of Public Need Annual Report, 1985-1986, p. 9.

undoubtedly helps facilitate the rapid completion of Exemption Reviews.

Actors in the Certificate of Public Need Process

Over the years, the number of participants in the COPN process has expanded. Today there are numerous potential actors in the COPN process (Figure 3.5). However the roles of state and regional officials have remained essentially unchanged. Each HSA is responsible for reviewing every COPN application submitted by an applicant within its geographic jurisdiction, or Health Systems Area. The HSA reviews the application for completeness, and makes a recommendation as to the appropriateness of the proposed project. At the state level, the Division of Resources Development, is responsible for processing and evaluating all COPN applications, conducting hearings, and providing administrative support to the Health Commissioner, the State Board of Health, and the Statewide Health Coordinating Council (SHCC). The SHCC develops the State Health Plan and the State Medical Facilities Plan.³⁵ The State Board of Health promulgates the rules and regulations that govern the day-to-day operation of the COPN program. Final decision-making authority on COPN applications rests with the Commissioner of Health.³⁶

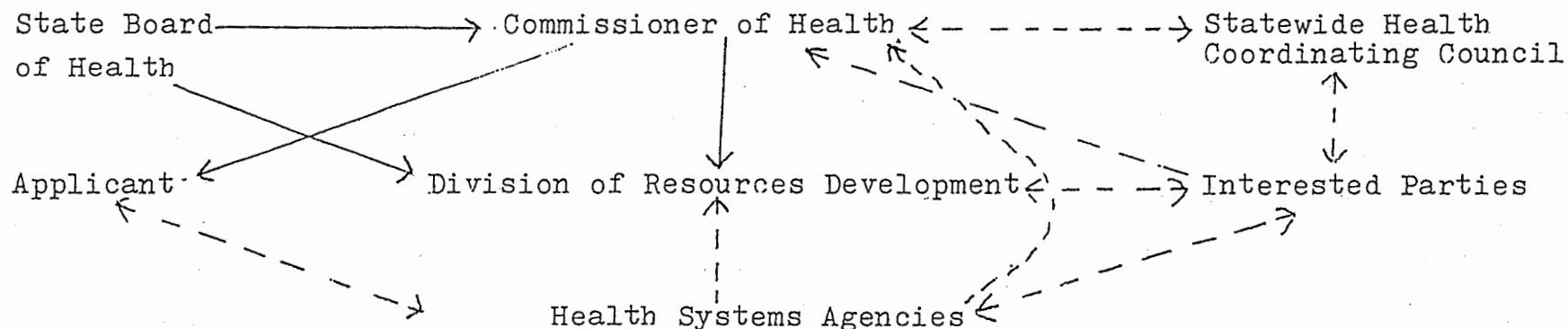
Throughout much of the Virginia COPN's existence the federal

³⁵Certificate of Public Need Biennial Report, 1985-1986, pp. 3-4.

³⁶Certificate of Public Need Biennial Report, 1985-1986, pp. 4-5.

Figure 3.5

ACTORS IN THE CERTIFICATE OF PUBLIC NEED PROCESS



Based on a description of the certificate of
public need process as described in Certificate
of Public Need, Biennial Report 1985-1986

Direct Authority _____

Advisory Relationship - - - -

government has overseen the program's implementation. As noted in the first chapter, Congress appropriated federal funds for the establishment and continuing operation of the HSAs, as well as assistance to the SHCC and the Department of Health. This funding was contingent upon the approval of the State Health Plan by the Secretary of Health, Education, and Welfare (later the Secretary of Health and Human Services).

The federal government's involvement has not been pervasive. Federal activities were intended primarily to ensure compliance with broad federal health planning guidelines and goals. The federal government did not control the daily operations of Virginia's COPN program.³⁷ Virginia had considerable autonomy in the administration and implementation of its COPN program.

Participation in the COPN program is not limited to government officials. Private sector groups and individuals have a voice in the program. The list of those parties who are permitted participate in the COPN program has grown over the years. The most obvious participant is the actual applicant, who may represent an existing facility, or a concern wishing to establish a new facility. Interested Parties Demonstrating Good Cause may present information to the effect that changes in the nature or circumstances surrounding a project have occurred since the application was originally submitted. Third party payers who provide coverage to at least five percent of the residents in the

³⁷West interview.

applicant's service area are eligible to participate in the informal, fact-finding conference.³⁸ Public hearings conducted by the HSA's on all COPN applications afford the general public the opportunity to comment on individual proposals. These opportunities are not limited to the decision-making and rule-making processes.

Certificate of Public Need Appeal Process

After the Health Commissioner has rendered a decision on a COPN application, it is possible to have the decision reconsidered. The original COPN statute provided for an appeal process, and this element of the program was subsequently incorporated into the Rules and Regulations. The appeal process allows for the administrative reconsideration and judicial review of decisions.

The initial stage of the appeal process is a formal, evidentiary hearing, conducted by the Health Commissioner within thirty days of receiving such a request. Parties who have standing to request such an appeal are the applicant, the HSA, persons demonstrating good cause, as defined previously, and third-party payers who provide insurance to at least five percent of the people within the facility's geographic service area.³⁹

³⁸Certificate of Public Need Biennial Report, 1985-1986, p. 7.

³⁹Certificate of Public Need Rules and Regulations, sec. 9.1.

This hearing essentially involves a reconsideration by the Health Commissioner of the various factors and points of view presented during the initial review process. The list of those parties who may request an appeal has grown considerably since 1973, when the statute granted only the applicant the right of appeal before the Board of Health.⁴⁰

If any parties to the evidentiary hearing are dissatisfied after a formal reconsideration of the decision, they may request an appeal to the circuit court in whose jurisdiction the project is located. Once the DRD has transmitted all pertinent records to the court, the court then either upholds, overturns or modifies the Commissioner's decision.⁴¹ Any party to the proceeding that is dissatisfied with the circuit court's ruling, may appeal to the Virginia Supreme Court.⁴² By expanding the list of parties who may request an appeal, Virginia seems to have enhanced the political nature of the COPN process in yet another way. The appeal process also increases the likelihood of delay in the project's completion, since an applicant would not be able to initiate a project until the project is no longer contested.

⁴⁰Virginia Acts of Assembly, (1973) ch. 419, sec. 32-211.9.

⁴¹Certificate of Public Need Rules and Regulations, sec. 9.2. (C).

⁴²Certificate of Public Need Rules and Regulations, sec. 9.2 (D).

Certificate of Public Need Conditions and Characteristics

There are certain elements that are common to all COPNs, regardless of the means by which they are granted. All COPNs are valid for the same period of time - one year.⁴³ If requested by the applicant, COPNs may be extended beyond this time period. Once a COPN has been granted, it is the Health Commissioner's responsibility to monitor projects to make certain that the original timetable and cost estimates are being met. If the Health Commissioner should find that: a) "substantial and continuing progress" has not been made, or, b) the capital expenditure limit for the project has been exceeded, or, c) the applicant "willfully or recklessly misrepresented intentions or facts" in order to obtain a COPN, then the Health Commissioner may revoke a COPN.⁴⁴ Other situations that would provide justification for the Commissioner to revoke a COPN include the applicant's failure to file periodic progress reports with the Health Department; making unapproved changes in a project; or, the applicant's failure to initiate a project within two years of the issuance of a COPN.⁴⁵ These measures represent the Commonwealth's effort to ensure the prompt completion of a

⁴³Virginia Acts of Assembly, (1984) ch. 740, sec.32.1-102.3 (B).

⁴⁴Virginia Acts of Assembly, (1984) vol. 2, ch. 740, sec. 32.1-102.4.

⁴⁵Certificate of Public Need Rules and Regulations, secs. 8.4 (A)-(F).

project, within the expenditure limits set forth in the COPN.

If an applicant violates the conditions of a COPN, or if a facility owner/operator fails to obtain a COPN prior to commencing a project, that individual or organization may be subject to sanction. Any project that is commenced without a COPN may be subject to the revocation of, or the refusal to grant a license for the facility in question. In addition, the Health Commissioner, the State Board of Health, or the Attorney General may petition the circuit court having jurisdiction to enjoin the completion of a project, or to enjoin the utilization of a completed project.⁴⁶ These provisions represent the "teeth" of the COPN program. While they do not provide for monetary penalties as the original statute did, the potential for injunctive penalties would still seem to be a credible punishment for violators, and may even serve as a deterrent against potential violators.

Regulatory Promulgation

A number of health care issues relating to COPN in Virginia have arisen over the last sixteen years. However the central themes of access, cost containment and quality control are still of paramount importance, as they were in 1973.⁴⁷ Even so, issues

⁴⁶Certificate of Public Need Rules and Regulations, secs. 10.1-10.2.

⁴⁷West interview.

emerge that require attention, and may necessitate regulatory changes in the COPN program. When such situations arise, there is an opportunity for input from a variety of public and private sector sources. Just as the review and appeal processes are characterized by bargaining and negotiation between various interests, so too, is the process of writing regulations often influenced by political conflict.⁴⁸

Public input into the regulatory promulgation process is permitted and even encouraged by Virginia officials. In fact, such participation is required by law. The Virginia Administrative Process Act governs the promulgation of regulations.⁴⁹ The SHCC has developed guidelines in accordance with the Act for facilitating public participation in the development of its regulations, which are generally located in the State Health Plan. These guidelines pertain to the identification and notification of Interested Parties, as well as the solicitation of input from those parties. For instance, Interested Parties may submit written comments concerning proposed regulations, or they may serve on ad hoc advisory panels that are established by the SHCC from time to time.⁵⁰

⁴⁸Drew Altman, "The Politics of Health Care Regulation: The Case of the National Health Planning and Resources Development Act," Journal of Health Politics, Policy, and Law (2) 4 (Winter 1978), p. 567.

⁴⁹Code of Virginia, (1950) Title 9, ch. 1.1, sec. 9-6.14: 7.1.

⁵⁰Statewide Health Coordinating Council, "Guidelines for Public Participation in the Development of Regulations," Adopted on 19 September 1984 by the Virginia Statewide Health Coordinating

Although the SHP contains much non-regulatory information, there are particular provisions within it that specify standards for review or methods for need determination for particular types of projects are considered regulatory material.⁵¹ When the SHCC desires to make changes in its regulations, there are a number of steps that it follows. Some of these steps are mandated by the Administrative Process Act, while the SHCC may also institute formal requirements on its own.

The initial step in the regulatory development process involves a determination by the SHCC that a change in the COPN regulations is necessary. The SHCC may arrive at this decision solely of its own accord, or it may receive suggestions from other parties, such as government agencies or health care providers.⁵² Once the SHCC determines that a change in its regulations is warranted, it notifies the public.⁵³

The designation and notification of Interested Parties occurs in the same manner for regulatory changes as it does for the IFFC. The SHCC also publishes a Notice of Intended Regulatory Action in a major Richmond newspaper, and in the Council (Richmond, Virginia), pp. 2-3.

⁵¹Statewide Health Coordinating Council, "Standards for Evaluating Certificate of Public Need Applications to Establish or Expand Nursing Home Services," Adopted 19 September 1984, by the Virginia Statewide Health Coordinating Council (Richmond, Virginia), p. 1.

⁵²John P. English, Health Planning Consultant, Division of Health Planning, Virginia Department of Health, interview by author, 25 August 1988, Richmond, Virginia.

⁵³English interview.

Virginia Register. This notice includes the title of the regulation in question, a brief description of the proposed change or new regulation, the identification of a SHCC contact person, and the deadline for notifying the SHCC of a desire to participate in the process. The SHCC maintains a list of parties who have been active in the regulatory process in the past, and at least once each biennium it publishes an open invitation to persons or parties who may wish to participate in the regulatory development process to so notify the SHCC of their desire to participate.⁵⁴

Once the SHCC has provided appropriate notification of its intent to make regulatory changes, it proceeds to develop the proposed new regulations or regulatory changes. It is also at this stage that the SHCC compiles a Regulatory Review Summary. This summary contains the proposed new regulations or regulatory changes, as well as a notice of a hearing date and a public comment period. After the hearing is held, and the public comment period has expired, the SHCC considers the results of the oral and written public comments that it has received and decides on the final form that the regulatory change should take.⁵⁵

Having decided on the final form that the regulation is to take, the SHCC publishes a Final Regulatory Review Summary. There are a number of components to this final summary. A

⁵⁴"Guidelines for Public Participation in the Development of Regulations," sec. 3.02.

⁵⁵English interview.

Summary of Comments, which includes the oral and written comments that the SHCC has received is incorporated into the Final Regulatory Review Summary.

Each Summary of Comments includes general comments on the overall proposal, as well as questions that were raised by the various interested parties during the hearing. Some of the persons who chose to comment on changes to the regulations governing CT and MRI scanners, and nursing homes include Governor Baliles, health facility administrators from around the state, as well as officials from Blue Cross-Blue Shield.⁵⁶ A SHCC response to each question raised is also included in the Summary of Comments. This format provides anyone who is interested with an overview of the exchanges that took place during the hearing. Such information may be useful to parties attempting to gauge the political climate at a given time. For instance, prospective COPN applicants and Health Department officials might be able to use these comments as a way to test the acceptability of a particular type of facility, service, or piece of equipment.

A statement of purpose for the proposed regulation, and an impact assessment statement are incorporated into the Final Regulatory Review Summary.⁵⁷ The impact assessment statement

⁵⁶"List of Persons That Commented on Proposed Standards for Evaluating Certificate of Public Need Applications to Expand CT or MRI Services," Final Regulatory Review Summary, pp. 1-2. Also memo from John P. English, Acting Director, Division of Health Planning, to the Virginia Statewide Health Coordinating Council, re Nursing Homes, 26 March 1987.

⁵⁷English interview.

projects the anticipated effect that the proposed regulation will have on the service or services in question. If approved, the regulation becomes effective no earlier than thirty days after the final regulations are published in the Virginia Register.

This signifies the conclusion of the regulatory promulgation process. As with the decision-making process, the promulgation of regulations governing review standards permits considerable public input into this aspect of the COPN program, and may permit certain groups or individuals to manipulate this aspect of the COPN program. However the influence of such groups may be mitigated by the presence of the SHCC which, acting as a committee, may be less susceptible to political pressure than the Health Commissioner.

Conclusion

Virginia's COPN program has a number of points of entry for public participation. The actual decision-making process, as well as the regulatory promulgation process offer opportunities for public access, and for political pressure to be brought to bear upon Health Department officials. The concentration of decision-making authority in the hands of the Health Commissioner make him especially susceptible to political pressure. Need criteria and regulations are also influenced by public input, since hearings are held prior to their implementation. Through these avenues, health care providers and other interested parties

have helped to shape the COPN program by influencing the daily decision-making process as well as the rule-making process that governs the COPN program.

CHAPTER 4

THE VIRGINIA CERTIFICATE OF PUBLIC NEED ENVIRONMENT

The health care environment is considerably more complex today than it was fifteen years ago when Virginia's COPN statute was enacted. Technological advances have revolutionized diagnostic and surgical medicine, and the concepts of health maintenance organizations, home health care, and ambulatory (outpatient) surgicenters are just a few examples of the changes that have taken place with respect to the provision of health care in the U.S.

Health care reimbursement practices have also changed during this period. Until fairly recently, third-party payers paid whatever providers charged for services rendered. In response to rapidly escalating medical bills however, public and private sector insurers have begun to introduce their own brands of cost control. One such effort is Medicare's prospective payment system, which pays providers according to negotiated fee ceilings for specific services.

National and state political developments have also impacted upon Virginia's COPN program. Throughout much of the 1970's regulation was viewed as a reasonable response to perceived deficiencies in the economy. With the ascension of the Reagan administration, national public policy assumed a decidedly pro-competitive posture. This philosophy appears to have been a significant factor in the ultimate demise of federal health

planning. Confusion emerged over the proper relationships between the federal, state, and local institutions that were developed under the federal health planning program (P.L. 93-641). Not long after the passage of P.L. 93-641, North Carolina challenged the constitutionality of the health planning program on the grounds that the statute infringed upon states' rights by requiring a CON program. Although the state's case was upheld by the North Carolina Supreme Court, the federal district court hearing the case ruled that the law's CON provision was not a violation of state sovereignty since states could elect to forego the federal funds that would be at stake. The court also found that the federal government had a legitimate interest in pursuing a national health program.¹ Intergovernmental tensions were further exacerbated by the fact that state and local government officials believed that the federal government was insensitive to their concerns.²

In Virginia, the notion of health planning and regulation through COPN has also undergone change. Lawmakers and health department officials altered the program in response to federal initiatives, as well as changes that were occurring in the health care environment. Health care providers, public and private

¹North Carolina ex rel Morrow v. Califano, 445 F. Supp. (E.D.N.C. 1977), 435 U.S. 962 (1978). For a more complete discussion of this case, see Roberta Roos, "Certificate of Need for Health Care Facilities: a Time for Reexamination," Pace Law Review, (7) 2 (winter 1987), pp. 491-530.

²Institute of Medicine, Health Planning in the United States: Selected Policy Issues, vol. 1 (Washington, D.C. : National Academy Press, Inc., 1981), pp. 38-40.

insurers, governmental agencies, and citizens' groups are examples of the types of groups that have entered the fray surrounding COPN.

Medical, political, and regulatory issues have been at the forefront of these discussions. Yet it is cost control, in light of massive public and private expenditures, that has been the dominant issue. Indeed, Virginia officials, including Governor Baliles, have regarded the continuing efficacy of COPN as a function of its effect on health care costs.

National Health Planning and Resources Development
Amendments of 1979

The first major development to impact upon Virginia's COPN actually was the result of federal government action. Even though federal regulations pertaining to the implementation of the P.L. 93-641 program were not finally issued until 1978, Congress had, by 1978, become dissatisfied with the progress that was being made toward the goal of a national health planning system.³

There were several issues that were of particular concern to members of the Senate Labor and Human Resources Committee, which held hearings on proposed amendments to P.L. 93-641. First there was the continuing problem of consumer representation on HSA boards. Various consumer groups began to bring suit on the issue of underrepresentation of population segments on HSA boards short-

³Budrys, p. 20.

ly after the national health planning program had been implemented. In *Texas ACORN v. Texas Area 5 Health Systems Agency, Inc.*, the plaintiffs argued that low-income groups were inadequately represented on HSA boards. The federal district court held that low-income groups must be proportionally represented. However the Circuit Court reversed the District Court opinion, but ordered HEW to develop HSA selection regulations.⁴

The Senate Labor and Human Resources Committee felt that consumers were still inadequately represented on HSA boards, even though P.L. 93-641 mandated that between fifty and sixty percent of a board's membership be comprised of consumers (see chapter 1 for the definitions of consumers and providers). While "mirroring the community", the Committee believed that consumers on the HSA boards should also reflect more fully specific population segments, such as low income groups.⁵ However, Marmor and Morone argue that there was no relationship between HSA representational structure and the HSAs' health planning duties.⁶

In addition to concerns about consumer representation, the

⁴Texas Association of Community Organizations for Reform Now v. Texas Area 5 HSA, U.C.A. No. S-76-102-CA (E.D. Texas, Sherman Div., 1 March 1977).

⁵West Publishing Co., National Health Planning and Resources Development Amendments of 1979, U.S. Code Congressional and Administrative News, 93d Congress, 1st sess. (1979) (St. Paul, MN: West Publishing Co.), pp. 1361-1368.

⁶James Morone and Theodore R. Marmor, "Representing Consumer Interests: The Case of American Health Planning," in Citizens and Health Care, Participation and Planning for Social Change, Barry Checkoway, ed. (New York: Pergamom Press, 1981), p. 27.

Committee also believe that consumers possessed insufficient information about the highly complex issues surrounding the provision of health care.⁷ As a result, Congress still considered consumers to be at a disadvantage relative to provider HSA board members. In an effort to address this inadequacy, the 1979 Amendments provided for the education of HSA members on health concepts and issues.⁸

Lastly, the Committee wanted to make the health planning program more responsive to changes that were taking place in the health care industry. Of particular concern was the notion that health planning should recognize and encourage the emergence of competitive forces whenever possible.⁹ To that end, specific mention is made in the 1979 Amendments of the need to encourage competition.¹⁰ For example, the 1979 Amendments call for the exclusion of health maintenance organizations (HMO) from CON review¹¹, since HMOs are considered to be organizations that encourage competition, and respond to classic market forces of supply and demand.

⁷West Publishing Co., National Health Planning and Resources Development Amendments of 1979, p. 1312.

⁸National Health Planning and Resources Development Amendments of 1979, Statutes at Large, vol. 93, sec. 149, p. 620 (1979).

⁹West Publishing Co., National Health Planning and Resources Development Amendments of 1979, p. 1358.

¹⁰National Health Planning and Resources Development Amendments of 1979, Statutes at Large, sec. 103, pp. 594-595 (1979).

¹¹National Health Planning and Resources Development Amendments of 1979, Statutes at Large, (1979), sec. 117 (b)(1), p. 615.

This provision is significant for a number of reasons. It was a tacit acknowledgement that economic regulation of health services is neither the norm nor the ideal, as far as Congress was concerned. Secondly, this declaration in favor of competition laid the conceptual foundation for the eventual dismantling of the national health planning program.

There were other important provisions of the 1979 Amendments. For instance, the minimum federal grant level for HSAs was raised from \$150,000 to \$250,000 in an attempt to lessen the burden on smaller, less populous HSAs.¹² Also, Congress added medical facility accessibility and quality control to the list of national health planning priorities.¹³ In a further attempt to reduce excess capacity in the interests of constraining costs, Congress included in the 1979 Amendments a program to encourage the voluntary discontinuance or conversion of unneeded services.¹⁴

The National Health Planning and Resources Development Amendments of 1979 represent some conflicting themes. On the one hand, it seems clear that Congress was generally supportive of the health planning program. The 1979 Amendments represented a congressional attempt to strengthen and improve the effectiveness of the HSAs. At the same time, the provision encouraging the

¹²West Publishing Co., National Health Planning and Resources Development Amendments of 1979, p. 1375.

¹³42 U.S.C., sec. 300m-1(c) (E) (14).

¹⁴National Health Planning and Resources Development Amendments of 1979, sec. 301, p. 636.

facilitation of competition suggests that Congress yearned for non-regulatory solutions to the problems of medical facility accessibility, quality control, and especially, high cost that still beset the health care industry.

Even with the changes mandated by the 1979 Amendments, it would not be long before the national health planning program would come under political attack at the national level. As noted earlier, the Reagan Administration entered office proclaiming an anti-regulatory, pro-competitive economic philosophy that included the health care industry. The enactment of the Omnibus Budget Reconciliation Act of 1981 exemplified this anti-regulatory approach by slashing health planning appropriations. Federal grants to HSAs fell from \$120 million to \$65 million.¹⁵

Then in 1982, the federal government dealt the national health planning program a devastating blow. In that year, Congress discontinued formal health planning appropriations.¹⁶ Also, each year thereafter, Congress attached a rider to the appropriations bill that prohibited the Secretary of Health and Human services from penalizing states that failed to comply with

¹⁵Omnibus Budget Reconciliation Act of 1981, Statutes at Large, (P. L. 97-35) vol. 95, Title 9, Subtitle E, sec. 1537, p. 570 (1981).

¹⁶42 U.S.C. (1982) sec. 300n-6.

P.L. 93-641.¹⁷ Congress maintained partial funding for the P.L. 93-641 program through the passage of continuing resolutions.¹⁸ The national health planning program eventually expired on September 30, 1986 when Congress failed to renew appropriations for the program.

With the demise of national health planning, states were left to decide for themselves the value of maintaining a CON program. Some states have chosen to modify their CON programs to more effectively address special concerns, while other states discontinued CON altogether. Since Virginia's COPN program predated P.L. 93-641, Virginia has maintained its program.

The sudden absence of the federal health planning program did impact upon Virginia's COPN program. The federal government had been funding Virginia's HSAs at a rate of 30 cents per capita, prior to its significant cutback in 1981. When the federal government discontinued its program, the Commonwealth and the HSAs were compelled to find alternative funding sources. The HSAs' initial reaction to the loss of federal funds was to reduce their staffing complements. Three Virginia HSAs, such as the Northern Virginia HSA, had financial reserves or nonfederal funding sources, such as private sector or local government

¹⁷James B. Simpson, "Full Circle: the Return of CON Regulation of Health Facilities to State Control," Indiana Law Journal, 19 (Fall 1986), p. 1056.

¹⁸Monroe Lerner, Ph.D., David S. Salkever, Ph.D., Stephen S. Mick, Ph.D., and Gregory V. de Lissovoy, Ph.D., Investigation of Certain Issues in Connection With the Virginia Certificate of Public Need Program, (Baltimore, MD: The Johns Hopkins University School of Public Health and Hygiene, 1987), ch. 2, p. 8.

contributions.¹⁹ However, the Southwest and Eastern HSAs were unable to continue their operations. Therefore, from the fall of 1986 to the present, the DRD staff has had to assume health planning responsibilities for those two regions.²⁰

Virginia has since increased its HSA funding from three cents per capita to nine cents per capita in an effort to compensate for the loss of federal funding.²¹ And as noted in chapters 2 and 3, Virginia lawmakers have altered the scope and threshold levels of the program over time. While the Virginia health planning program lost its federal financial support, the Commonwealth did have greater flexibility to develop its COPN program to meet Virginia's needs. The COPN review process is now shorter overall, and the program's scope is somewhat narrower than in the statute.²²

The cessation of federal health planning, and Virginia's efforts to adjust to this change are but one facet of the volatile environment in which COPN has existed in Virginia. The interplay among various private and public sector groups, and the changes that have taken place within the health care economy have all contributed to the development of COPN in Virginia.

¹⁹English interview.

²⁰Biennial Report 1985-1986, p.3.

²¹Virginia Acts of Assembly, (1985) vol. 1, ch. 513, sec. 32.1-102.1 (11).

²²West interview.

Group Positions Regarding Certificate of Public Need

Throughout COPN's fifteen year history, numerous groups have commented on the worthiness of COPN. To simplify the forthcoming discussion, and to allow for more meaningful comparisons among various groups, the groups to be discussed below shall be organized according to the following headings: providers (institutional and professional); third-party payers; government agencies; citizens' groups. These headings are consistent with relevant literature in the health policy field.

Before examining and comparing group positions, some rather general comments are in order. A group's perception of COPN may be motivated by economic self-interest, or economic or political ideology.²³ However this observation assumes that there is unanimity within a group. And as shall be seen, this is not necessarily the case. While a group may be outwardly homogeneous, it may be inwardly heterogeneous.²⁴ There may also be instances where a group's perceptions of COPN and a group's goals may be in conflict.²⁵ This tension may threaten the unity

²³Governor's Commission on Medical Care Facilities Certificate of Public Need, Report of the Governor's Commission on Medical Facility Certificate of Public Need to the Governor and General Assembly of Virginia, (Richmond, VA: Commonwealth of Virginia, 1987), p.13.

²⁴Alford, p. 192.

²⁵Monroe Lerner, Ph.D. and George Vlasak, Ph.D., "The Political Theory Aspects of CON in Virginia," presented at the Annual Convention of the American Public Health Association, New Orleans, LA, October 19, 1987, p.6.

of a group or weaken its resolve.

Providers

Health care providers are the most important and most powerful of the groups concerned with health care facility policy.²⁶ Within the health care community there are different types of providers. Primary care physicians and surgeons, and hospital and nursing home administrators are some of the more obvious examples of health care provider groups. Largely as a result of the highly complex, technical nature of many medical services, providers have been the dominant actors within the health care policy arena, although there may be divisions within each category stemming from differences in type of ownership, location, or services rendered.²⁷ That health care providers have a direct stake in health care policy developments because these individuals depend upon the provision of services for their income enhances the likelihood that they will be active in health planning activities.²⁸

²⁶Alford, p. 194.

²⁷Lerner and Vlasak, p.3.

²⁸Lawrence D. Brown, "Some Structural Issues in the Health Planning Program," in Institute of Medicine, Health Planning in the United States: Selected Policy Issues, vol. 2, (Washington, D.C.: National Academy Press, Inc., 1981), p. 15.

Institutional providers

Differences among health facility representatives regarding their organizations' opinions on COPN provide an example of such diversity. At first blush, one might easily assume that hospitals and nursing homes would be unified in their opinions regarding COPN. Such is not the case, however. Due largely to differences in reimbursement practices and the nature and scope of services rendered, hospitals in Virginia have generally opposed COPN while nursing homes have supported the program.

The principal group representing hospitals in Virginia is the Virginia Hospital Association (VHA). The VHA's views toward COPN have fluctuated considerably over the last fifteen years. COPN was initially supported and promoted by the VHA because it was seen as a useful cost containment mechanism in the face of cost-based reimbursement.²⁹ This reimbursement practice results in the payment of health providers after a service is rendered, based on to the fee charged by the provider. However, the VHA became "philosophically and ideologically opposed" to COPN in the late 1970's as the scope of the program was "deliberately" expanded with little regard for the initial legislation.³⁰

The VHA modified its position on COPN yet again in the early

²⁹Katharine M. Webb, Vice President for Government Relations, Virginia Hospital Association, statement, Governor's Commission on Medical Care Facilities Certificate of Public Need, hearing, Minutes, 9 March 1987, (Richmond, Virginia), p. 2

³⁰Webb, Governor's Commission on Medical Care Facilities Certificate of Public Need, hearing, Minutes, 9 March 1987, p. 2.

1980's. By this time, competition within the industry was on the rise, but the VHA saw COPN as a way to protect hospitals. Since November 1986, however, the VHA has opposed COPN on the grounds that the program favors physicians by allowing them to purchase some medical equipment without first obtaining a COPN.³¹ More recently, the VHA has assumed a decidedly pro-competitive posture. It is the VHA's position that "...competition can produce the optimal mix of price, quality, and variety for consumers."³²

Nursing homes in Virginia, on the other hand, have generally supported COPN. Whereas hospital leaders tend to regard COPN as having a stifling effect on competition within the industry, nursing home administrators feel that COPN is beneficial, and helps ensure that beds and facilities are located according to need.³³ The Virginia Health Care Association (VHCA), which represents 130 nursing homes in Virginia, has been active in the debate surrounding COPN. The VHCA believes that the elimination of COPN would have adverse consequences for quality control, accessibility concerns and Medicaid costs.³⁴

³¹Lerner, Salkever, Mick, and de Lissovoy, ch. 5, p. 8.

³²Katharine M. Webb, Vice President for Government Relations, Virginia Hospital Association, statement, Governor's Commission on Medical Care Facilities Certificate of Public Need, hearing, Minutes, 13 April 1987, (Richmond, Virginia), p. 10.

³³Peter Clendinin, Director, Virginia Health Care Association, statement, Governor's Commission on Medical Care Facilities Certificate of Public Need, hearing, Minutes, 13 April 1987 (Richmond, Virginia) p. 6.

³⁴Lerner, Salkever, Mick, and de Lissovoy, ch. 5, p. 13.

Non-profit nursing homes in Virginia also support COPN but, with some reservations. The Virginia Association of Non-Profit Homes for the Aging (VANHA) seems to have a less unified stance toward COPN than the VHCA. There is little unanimity among its members, except on the feeling that the COPN process is "inequitable and inefficient."³⁵ The VANHA is in favor of the simultaneous review of similar applications ("batching") and of vesting final decision-making authority for COPN applications in a commission rather than the Health Commissioner.³⁶ The VANHA believes that new construction is unnecessarily restrained by COPN, since institutions lending capital for such projects would require that marketing and feasibility studies be conducted in advance.³⁷

Medical professional societies

Because physicians are often dependent upon unrestrained access to hospitals in order to sustain their practices, they tend to favor maintaining as much control over health care resources as possible.³⁸ Both Virginia Medical Society and the

³⁵Nathan Bushnell, III, Chairman, Virginia Association of Non-Profit Homes for the Aging, statement, Governor's Commission on Medical Care Facilities Certificate of Public Need, hearing, Minutes, 11 May 1987, (Richmond, Virginia), p.1.

³⁶Report of the Governor's Commission on Medical Facilities Certificate of Public Need, p. 16.

³⁷Lerner, Salkever, Mick, and de Lissovoy, ch.5, p. 12.

³⁸Alford, p. 191.

Old Dominion Medical Society favor the discontinuation or dilution of COPN. Citing the highly volatile and complex nature of the health care industry, Virginia Medical Society (VMS) and the Old Dominion Medical Society (ODMS) feel that COPN is ill-equipped to operate effectively in such an environment.³⁹ These societies argue that COPN stifles creativity and technological innovation by making it difficult for new technologies and new providers to enter the market.⁴⁰ On the basis of these arguments, the VMS favors total repeal of COPN, while the ODMS would like to see medical services and equipment that have become standards of care exempted from COPN requirements.⁴¹

Third-Party Payers

This category is composed of private health insurance companies, Blue Cross/Blue Shield, Medicare and Medicaid. For the most part, organizations in this category favor COPN. There is a sense within the insurance industry that COPN acts as a restraint on wasteful, unnecessary spending by health facilities.⁴² Largely due to a shift toward a more price-sensitive health care market, Blue Cross/Blue Shield of Virginia

³⁹Lerner, Salkever, Mick, and de Lissovoy, ch. 5, p. 10.

⁴⁰C.M. Kinloch, M.D., Governor's Commission on Medical Facilities Certificate of Public Need, statement, hearing, Minutes, 11 May 1987, (Richmond, Virginia), p.3.

⁴¹Lerner, Salkever, Mick, and de Lissovoy, ch.5, p. 16.

⁴²Lerner, Salkever, Mick, and de Lissovoy, ch.5, p. 30.

does not believe that COPN has much impact overall on the insurance industry.⁴³

Third-party payer support of COPN is hardly universal. The Virginia Association of Health Maintenance Organizations favors the weakening or total repeal of COPN. This association's objections stem from the view that, contrary to the competitive philosophy underlying HMOs, COPN hinders competition among medical facilities by creating state-sanctioned franchises or cartels.⁴⁴ There is thus some diversity among third-party payer organizations with respect to their views on COPN. All of these organizations share a desire to constrain costs but, they differ according to the means by which they feel such a goal should be achieved.

Government Agencies

Another significant class of participants in the COPN debate is comprised of public agencies. Government's role in health care is unique in that it may act as a payer, provider, or planner/regulator of health care services. Government agencies concerned with health care in Virginia generally view COPN as a means of rationalizing and stabilizing the medical facility market.

⁴³Blue Cross-Blue Shield, statement, Governor's Commission on Medical Care Facilities Certificate of Public Need, hearing, Minutes, 11 May 1987, (Richmond, Virginia), p. 9.

⁴⁴Lerner and Vlasak, p.9.

Concerns about quality control, distribution of facilities and services, and cost containment are of paramount importance to those governmental agencies concerned with the provision of health care. The Statewide Health Coordinating Council believes that the health care industry cannot be self-regulating, and that COPN is sufficiently flexible to deal with an ever-changing health care market.⁴⁵ The State Board of Health sees COPN as being especially important for ensuring that remote or impoverished areas have adequate facilities and services.⁴⁶ The Health Services Cost Review Commission recognizes a need to balance competition and regulation and, the Commission sees COPN as an important planning tool.⁴⁷

Other public sector organizations in Virginia are less sanguine about COPN. The Board of Medical Assistance Services holds the position that, while providers are still not overly concerned about excess capacity and costs, COPN does little to reduce existing excess capacity. Yet the Board is apprehensive about the total repeal of COPN.⁴⁸ The Virginia Association of Health Systems Agencies believes that there is an "inevitable"

⁴⁵Lerner, Salkever, Mick, and de Lissovoy, ch.5, p. 20.

⁴⁶Lerner, Salkever, Mick, and de Lissovoy, ch.5, p. 23.

⁴⁷Virginia Health Services Cost Review Council, statement, Governor's Commission on Medical Care Facilities Certificate of Public Need, hearing, Minutes, 11 May 1987, (Richmond, Virginia), p. 12.

⁴⁸Robert Lambeth, Virginia Board of Medical Assistance Services, statement, Governor's Commission on Medical Care Facilities Certificate of Public Need, hearing, Minutes, 8 June 1987, (Richmond, Virginia), p.1.

tension between the regulator and the industry being regulated. VAHSA members also feel that COPN administration at the state level is ineffective and unenthusiastic.⁴⁹ Here too, there appears to be a marked difference of opinion within one of the major classes of groups interested in COPN. One gets the impression that these state agency groups view COPN as the best available response to the problems that beset the health care industry, but that they long for a more optimal solution.

Consumer Organizations

The last class of organizations that interact within the COPN arena is, in many ways, the most diffuse. Consumer organizations, such as Common Cause and the American Association of Retired Persons generally represent a wide range of concerns, such as consumers' rights issues and policy issues affecting retirees and the elderly. Health care issues do not tend to attract much attention from these groups. Indeed, Morone found that narrowly focused provider groups were more likely to be politically active in health planning than more diverse consumer organizations.⁵⁰ Schlozman and Tierney believe that

⁴⁹Dean Montgomery, Executive Director, Virginia Association of Health Systems Agencies, statement, Governor's Commission on Medical Care Facilities Certificate of Public Need, hearing, Minutes, 8 June 1987 (Richmond, Virginia), p. 6.

⁵⁰James A. Morone, "Models of Representation: Consumers and the HSAs", in Institute of Medicine, Health Planning in the United States: Selected Policy Issues, vol. 2 (Washington, D.C.: National Academy Press, 1981), p. 224.

organizations with narrow, technical political objectives tend to be more influential politically than those groups with broad goals.⁵¹ Whelan found that citizens' groups in Virginia tend to have a fragile organizational base, and that the consumer movement in Virginia has been in some disarray in recent years.⁵²

There are a number of factors that contribute to the lack of attention paid to health care issues by consumer organizations. Most significant among these factors is the prominence of third-party reimbursement, which tends to insulate consumers from the direct costs of their health care.⁵³ Because individual consumers represent such a wide array of needs, and have differing priorities it is probably difficult for an organization to represent very many of them.⁵⁴ Another possible explanation for the lack of consumer group involvement in health care issues is that many issues and concepts surrounding health care are so complex that only someone with training in a specific health field can analyze the highly technical information that is often associated with health care.⁵⁵

There does appear to be some public ambivalence toward

⁵¹Kay Lehman Schlozman and John T. Tierney, Organized Interests and American Democracy, (New York: Harper and Row, 1986), p. 396.

⁵²John T. Whelan, "Interest Groups in Virginia: a New Look for a 'Political Museum Piece'," presented at the 1986 Annual Meeting of the Southern Political Science Association, Atlanta, Georgia, 6-8 November 1986.

⁵³Morone, p. 224.

⁵⁴Lerner and Vlasak, p. 5.

⁵⁵Brown, p. 18.

health care. On the one hand, consumers want a full range of services that is readily available to them. On the other hand, this desire is tempered by concern about high costs.⁵⁶

Even in the face of such obstacles to group unity, a few consumer groups have been active in the discussion about COPN. Two of these groups are based in Richmond, and the third is a national citizens' group. The National Alliance of Senior Citizens favors a competitive, free-market to the health care industry, and is, therefore, opposed to COPN on principle.⁵⁷ The Richmond Chamber of Commerce is also ideologically committed to free-enterprise and those of its members who were knowledgeable about COPN opposed it.⁵⁸ It may seem odd that a group representing business leaders is categorized with consumer organizations. However business leaders purchase health insurance for their employees, and are thus quite interested in policies that may affect the cost of their employees' health care. In this way, businesses are themselves purchaser of health care. The Richmond Area Business Group on Health, on the other hand, has consistently supported COPN, but its support has begun to waver more recently as members are uncertain whether they will

⁵⁶Don Colburn, "Hospital Regulation Giving Way to Competition as a Means of Determining Growth of Hospitals and Services," Washington Post, 9 December 1986, HE-8.

⁵⁷Report of the Governor's Commission on Medical Care Facilities Certificate of Public Need, p. 17.

⁵⁸Report of the Governor's Commission on Medical Care Facilities Certificate of Public Need, p. 17.

benefit more from regulation, or from a free-market approach.⁵⁹ The views of these consumer groups tend to stress the potential economic impact of COPN over questions of access and quality, suggesting once again that it is the issue of cost control which has the most political salience for the public.

The foregoing discussion illustrates the diverse societal groups which, to varying degrees, affect or are affected by COPN. This is not to say that each group articulates its position with equal conviction relative to other groups. On the contrary, it stands to reason that institutional and professional providers would be the most vocal groups on this issue since their livelihood is at least partly dependent upon the availability of services and facilities for their patients.

Since third-party payers directly pay providers for much of the medical care rendered nationally and in Virginia, it is not difficult to understand this group's preoccupation with cost control. The positions of the government agencies noted above, while emphasizing cost control also stress the need for the rational distribution and control of health facilities by way of planning and regulation through COPN. Even agencies not entirely satisfied with COPN are reluctant to dismantle the program.

The reactions (or lack thereof) from consumer groups provide an interesting contrast to the other types of organizations that have been discussed. While it is true that we place great value on our health, there is also some truth to the notion that we do

⁵⁹Lerner, Salkever, Mick, and de Lissovoy, ch. 5, p. 19.

not generally concern ourselves with health care until we are in need of it. The other types of groups can afford to be more myopic with respect to health care issues because this is their primary area of concern. For most consumers, however, health care is but an intermittent concern as opposed to a number of concerns (family, education, occupation) that must be confronted daily. This fact helps to validate the notion that groups with narrow goals tend to be more effective than groups with broad goals.⁶⁰ Regardless of their positions on COPN, these groups and society at large have been influenced by changes occurring within the health care industry. It is to these changes that the next section shall be devoted.

Changes in the Health Care Industry

Since the enactment of the Virginia COPN statute in 1973, a number of changes have taken place in the health facility sector of the health care industry. These changes have altered the complexion of the industry and, have provided the impetus for the current debate among Virginia lawmakers over the continued efficacy of COPN in the current health care environment. Over the last fifteen years health facility costs have risen dramatically, while occupancy rates have tapered off, due in part to the emergence of outpatient care. National expenditures for medical facility care have risen from \$28 billion in 1970, to

⁶⁰Schlozman and Tierney, p. 396.

\$179 billion in 1986.⁶¹ Third-party payers have also taken a more active role than they had previously, often questioning the need for services as well as the fees charged for those services.

Changes have not been limited to the supply side of the care equation. The elderly population has increasingly required greater levels of sophisticated care, while the indigent population has strained hospital resources through a substantial uncompensated care burden. The total Medicaid bill in Virginia for FY 1989 is \$908 million, with the Commonwealth paying approximately 50 percent of these costs. For FY 1990, Virginia has appropriated \$520 million for Medicaid care. All of these factors have compelled many facilities to enter health "systems" or large, proprietary hospital chains in order to strengthen their financial positions. It is in this environment that COPN currently exists.

Health care costs

Rising health care costs have overshadowed the issues of access and quality control for some time. Medical facility care costs in Virginia have risen from an average of \$184.10 per day in 1979 to \$434.75 per day in 1987.⁶² The underlying theme that emerges from the debate over the reasons for the high cost of

⁶¹1988 U.S. Statistical Abstract, no. 131, p. 88.

⁶²Virginia Health Services Cost Review Council, Annual Report, 1984-85, and Annual Report, 1986-87, (Richmond, VA: Commonwealth of Virginia).

health care and, how best to control these costs ultimately turns on the issue of competition versus regulation.

Proponents of the position that competition will address the inequities and inefficiencies within the health care industry base their argument on the assumption that the marketplace is a better allocator of health care resources than the regulatory/planning arena. Free-market advocates maintain that the rise in health care costs emanates not from a lack of competition but, from a lack of price competition.⁶³ As a result, prices are artificially high, since hospitals are often not compelled to restructure because CON is said to protect existing providers from market forces.⁶⁴ Advocates of deregulation also point to econometric studies which indicate that CON has little or no effect on costs.⁶⁵

Advocates of CON and other forms of regulation argue that the health facility marketplace does not respond to the

⁶³James A. Bacon and James Schultz, "Gridlock," Virginia Business, (3) 6 (July 1988), p. 45.

⁶⁴James A. Bacon and James Schultz, "Competition or Compassion?," Virginia Business (3) 8 (August 1988), p. 8.

⁶⁵John Ashby, Jr., "The Impact of Hospital Regulatory Reforms on Per Capita Costs, Utilization, and Capital Investment," Inquiry, (21) 1 (Spring 1984), pp. 50-58. See also Salkever and Bice, Hospital Certificate of Need Controls: Impact on Investment, Cost and Use, (Washington, D.C.: American Enterprise Institute, 1978) and; Virginia General Assembly, Joint Legislative Audit and Review Commission, Certificate-of-Need In Virginia, (Richmond, Virginia, 1979).; Lerner, Monroe, Ph.D., Salkever, David, Ph.D., Mick, Stephen, S., Ph.D., and de Lissovoy, Gregory V. Investigation of Certain Issues in Connection With the Virginia Certificate of Public Need Program, (Baltimore, MD: The Johns Hopkins University School of Public Health and Hygiene, 1987).

traditional market forces of supply and demand. The prevalence of third-party reimbursement, and the highly technical nature of many medical services mitigate market forces.⁶⁶ According to Dr. Robert G. Petersdorf, dean of the University of California-San Diego School of Medicine, the "duplication of services is often motivated by nothing more than a drive for prestige and the preservation of the professional or administrative ego."⁶⁷ This comment illustrates some of the justification for CON regulation. However Louis Rossiter, professor of Medical Economics at the Medical College of Virginia, is not sure that "anyone's unequivocally shown the link between equipment and health care costs."⁶⁸

By the early 1980's it had been well established by insurers, scholars, and providers that the excess capacity and concomitant rise in health care costs were at least partly due to the retrospective, fee-for-service reimbursement practices that insulated consumers from high costs, and provided incentives to health care facilities to expand, since facilities were reimbursed whatever they were charged.⁶⁹ Under such a practice,

⁶⁶West Publishing Co., U. S. Congress, Senate Report on S 2994, U.S. Code Congressional and Administrative News, 93d Congress, 2nd sess., vol. 4, (1978) p. 7878.

⁶⁷Don Colburn, "Technology's High Price," The Washington Post, 26 December 1984, B-7.

⁶⁸James A. Bacon and James Schultz, "Competition Anxiety," Virginia Business, (June 1988), p. 38.

⁶⁹Elaine A. Anderson and Mark R. Ginsberg, "The Health Care Marketplace: Perspectives on a System in Transition," Policy Studies Review, (5) 3 (Fall 1986), p. 656.

hospitals were free to expand their facilities and services knowing that they could expect full payment for services rendered, without having to be concerned about efficiency of operation. There was little incentive for health facilities to economize.

Before long, third-party payers began to take matters into their own hands. The development of Medicare's prospective payment system, the expansion of HMOs, and the creation of preferred provider organizations (PPO) heralded a new, competitive approach to solving the problem of escalating health care costs. HMOs have actually been in existence since the early 1970's. However, they have become a prominent part of the health care landscape only since the early 1980's. HMOs are attractive to consumers because they hold down prices by charging plan members a single, flat, annual rate that covers all medical services rendered, provided the member utilizes providers affiliated with the HMO. HMOs may enter into contractual arrangements with individual providers, or they may establish a system of their own facilities and providers. In any event, the emphasis is on cost effectiveness, and on minimizing the utilization of hospital services as much as possible.⁷⁰

A second third-party initiative in the war on health care costs is known as the preferred provider organization (PPO). Under these plans, consumers are provided incentives by their insurer to utilize providers who are part of the plan. A

⁷⁰Anderson and Ginsberg, p. 658.

consumer may enter such a plan through an employer and, the plan pays nearly all of the costs that are incurred if the consumer visits a participating provider. Should a consumer go to a non-participating provider, the consumer is obligated to pay a certain percentage of the bill - perhaps twenty percent - and the plan pays the remainder of the bill. The ultimate goal of PPOs is to reduce the out-of-pocket expenditures for its membership.⁷¹ The reimbursement mechanisms just discussed are both private sector responses to high health care costs. The federal government has also taken some steps to hold down hospital care costs.

In 1983 the federal government enacted significant legislation designed to rein in the spiralling costs of its Medicare program by introducing a prospective payment system (PPS). This new wrinkle in the Medicare program is significant for two reasons. PPS is significant simply because it is associated with Medicare, which is the largest public sector source of medical insurance funds in the nation. In 1986 alone, Medicare accounted for \$77.7 billion in public health insurance expenditures.⁷² PPS is also significant because it represents a fundamental change in medical reimbursement philosophy. Previously, providers routinely submitted their charges to Medicare and collected their fees, often encountering little resistance from Medicare. Under this new system however,

⁷¹Anderson and Ginsberg, p. 658.

⁷²1988 U.S. Statistical Abstract, no. 130, p. 88.

Medicare negotiates an acceptable fee ceiling with providers for specific kinds of services, which are referred to as diagnosis-related groups (DRG). Providers whose bills exceed these limits are not reimbursed for that portion of the bill which exceeds the DRG ceiling.⁷³ This new reimbursement structure has prompted providers to become more cost-conscious and efficiency-oriented.

Delivery systems

Changes in health care reimbursement practices seem to have occurred at about the same time as the transformation in health care delivery was occurring. For much of this century, hospitals have been the dominant force in health facility care in the U.S. However there has been a relatively recent shift away from inpatient facility care, toward medical care that is provided in an outpatient or ambulatory setting.⁷⁴ Outpatient facilities are attractive to consumers because these facilities do not have the overhead that would be found at a hospital, and can, therefore offer many services at rates that are less expensive than those charged by hospitals.

This surge toward outpatient care has also provided hospitals with the opportunity to improve their standing in this new market. Not long after the movement toward outpatient care

⁷³Anderson and Ginsberg, pp. 656-657.

⁷⁴Joyce Riffer, "Can Surgicenters Stand Alone?," Hospitals 60 (20 July 1986), p. 44.

began in the early 1970's, hospitals themselves entered the market as a way to accommodate consumer and insurer demands for less expensive care, and also to react to what may have been perceived by hospital administrators as a threat to their institutions. In Virginia and elsewhere, for example, outpatient facilities are often owned by hospitals.⁷⁵ Hospital entry into the outpatient market gave these institutions flexibility in the face of declining occupancy.⁷⁶

As a reaction to the trend toward outpatient care, health facilities, especially hospitals, began to merge with one another under the banner of health "systems". Increasing competition among health facilities has prompted proprietary, for-profit institutions as well as non-profit facilities to consolidate their resources.⁷⁷ Such resource consolidation does help to reduce service duplication but, it also permits system member institutions to dominate local markets.⁷⁸ Some of the more prominent hospital systems in Virginia include Inova Health Systems (Fairfax), Sentara Health Systems (Hampton Roads), and Carillon Health System (Roanoke).⁷⁹

Concentrations of market power also have implications for the COPN program. The length of the process is a financial

⁷⁵Bacon and Schultz, "Gridlock," p.54.

⁷⁶Lerner, Salkever, Mick and de Lissovoy, ch. 8, p. 10.

⁷⁷Anderson and Ginsburg, p. 657.

⁷⁸Bacon and Schultz, "Gridlock," p. 46.

⁷⁹Bacon and Schultz, "Gridlock," p. 47.

hardship for many institutions because of the financial resources that facilities they may expend during the process. Large institutions do have an advantage over small institutions.⁸⁰ Large institutions, or those affiliated with health care systems tend to have greater resources, and are thus better able to endure the length of the process, even in a protracted appeal situation. Bacon and Schultz contend that institutions with large financial resources and a great deal of political clout are able to apply pressure, and manipulate the COPN system. Smaller institutions are at a disadvantage in such instances; especially where COPN applications are competing.⁸¹

Hospitals have also sought entry into another major health care market - that of extended care. As their occupancy rates have fallen in recent years, hospitals have looked longingly toward the market for extended, skilled nursing care beds, which has traditionally been the exclusive domain of nursing homes. The ability of hospitals to convert unused acute (general) bed space has been a source of some contention between hospitals and nursing homes.

On the one hand, hospitals want the flexibility to be able to convert general, acute care beds to skilled nursing care beds without having to undergo a COPN review. For their part, both proprietary and non-profit nursing home associations are willing to allow hospitals to convert bed space, so long as they are

⁸⁰West interview.

⁸¹Bacon and Schultz, "Gridlock," p. 52.

still required to undergo a COPN review before doing so.⁸²

Critics of COPN charge that, in instances such as this, COPN acts as a state-sponsored nursing home cartel.⁸³ Whichever position is taken, one thing is certain - the changing face of health care of medical facility care is affected by COPN.

Demographic influences

Two recurring themes that are evident in the current discussion surrounding COPN, and the provision of health care in Virginia generally, are the needs of the elderly and medically indigent segments of Virginia's population. The special needs and financial vulnerability of the elderly and the indigent mean that any drastic alteration of the health care industry should not be undertaken without first assessing the probable impact that such change might have on these groups. While the elderly and the indigent often require special kinds of care, or financial assistance, these needs place various demands on Virginia's health care system.

The questions of COPN's franchising effect and its implications for the distribution of health facilities pose difficult problems for Virginia lawmakers. While certainly not a new concern, the provision of health care for the indigent has

⁸²Lerner, Salkever, Mick, and de Lissovoy, ch. 5, pp. 12-14.

⁸³Karl Rhodes, "In the Pink," Virginia Business, (2) 2 (February 1987), pp.23-24.

become a major health priority under Governor Baliles. In 1986, \$576 million was either spent by the Commonwealth on indigent health care, or assumed as uncompensated care by health care facilities.⁸⁴ Not all of those who are medically indigent are impoverished, however. As insurance rates have risen, small-business employers and low-paid working people find it increasingly difficult to afford health insurance.⁸⁵ The Joint Subcommittee on Health Care For All Virginians reported that many of the working uninsured are employed in the retail, construction, and service industries, or for small businesses (those with fewer than 51 employees) because many of these employers do not offer health insurance, in spite of state mandated benefits.⁸⁶

Also contributing to the problems that the indigent have in obtaining health facility care is the population shift away from cities. With Virginia's affluent population gravitating toward the suburbs, hospitals find it increasingly difficult to operate in cities and rural areas where a greater proportion of indigent are likely to be found.⁸⁷ Through its capacity to influence the

⁸⁴Bacon and Schultz, "Competition or Compassion?," p. 8.

⁸⁵James A. Bacon and James Schultz, "Metastasis," Virginia Business (July 1988), p. 55.

⁸⁶Virginia General Assembly, Joint Subcommittee on Health Care for All Virginians, Interim Report of the Joint Subcommittee on Health Care For All Virginians to the Governor and the General Assembly of Virginia, Senate Document No. 18, (Richmond, VA: Commonwealth of Virginia, 1989), p. 12.

⁸⁷Bacon and Schultz, "Metastasis," p. 56.

location and services offered by facilities, COPN can have some influence on indigent health care. Health Department officials may use COPN to prevent a facility from moving out of an area where there may be a medically needy population to an area where there may be a greater number of paying patients.

Even though uncompensated indigent care is a strain on all hospitals, it is especially burdensome on small, non-profit hospitals. While all non-profit health facilities receive tax exemptions, many smaller facilities are in dire need of immediate reimbursement.⁸⁸ Since Medicaid negotiates per diem charges with institutional providers, facilities are constrained in the amount that they may charge Medicaid recipients. While individual hospitals do not write off uncompensated care, they usually absorb uncompensated care costs by shifting costs to services for which they can receive full reimbursement.⁸⁹ Uncompensated care thus poses a special problem for hospitals, since they must find alternative sources of revenue to compensate for uncompensated care.

A program has existed in Virginia for more than forty years that is designed to assist medical facilities that provide uncompensated care. In 1946 the Virginia General Assembly enacted the State-Local Hospitalization Program to provide funds

⁸⁸Bacon and Schultz, "Metastasis," p. 55.

⁸⁹Steve Fargis, Vice President for Operations, Virginia Hospital Association, 16 March 1989, telephone interview by author, Richmond, Virginia.

for the hospital care of the medically indigent.⁹⁰ This program involves a state-local partnership such that the state enters into voluntary agreements with localities wishing to receive state funding for indigent health care. The state appropriates funds to participating localities on a per capita basis, sufficient to cover 75 percent of the program cost, and participating localities contribute the remaining 25 percent. The state develops recommended eligibility standards as a guide for localities to follow, but each locality is actually responsible for establishing its own eligibility criteria.⁹¹ The Department of Social Services is responsible for administering the Hospitalization Program at the state level. The Department of Social Services has developed an income scale for determining medical indigency, as well as an income scale for determining the extent of coverage that each individual who is accepted into the program should receive. For instance, if a person's income exceeds the amount that is specified in the scale (\$850 per month), then that individual may only be eligible for partial coverage. If an individual's income exceeds the income scale ceiling by at least \$600 but not more than \$1200, coverage for that individual would not begin until after the third day of hospitalization. Individuals whose income exceeds the income scale ceiling by \$4000 or more are ineligible for coverage under

⁹⁰Virginia Acts of Assembly, (1946) ch. 197, pp. 336-338.

⁹¹Virginia Department of Social Services, Assistance Programs Manual, Revised, vol. 2, part 5, ch. A, (Richmond, VA: Commonwealth of Virginia, 1986), p. 3.

the program.⁹²

Those localities wishing to participate in the Hospitalization Program designate an authorizing agent who develops the locality's eligibility criteria, and determines the eligibility of individual applicants. The authorizing agent also determines the appeal process to be followed in those instances when an applicant is denied inclusion into the program.⁹³ It is up to localities to enter into contracts with area medical facilities, although these contracts are subject to state approval. Localities are also responsible for documenting each individual case, and submitting copies of this documentation to the state and the facility providing the care in each individual case.

Although the State-Local Hospitalization Program has operated in the manner described above since its inception, the General Assembly passed legislation in 1989 that will significantly alter the character of the program. Under the new law, the Department of Medical Assistance Services will assume administrative responsibility for the program, and localities will be required to participate.⁹⁴ The Director of Medical Assistance Services shall also be responsible establishing

⁹²Assistance Programs Manual, Revised, vol. 2, part 5, ch. B, p. 3.

⁹³Assistance Programs Manual, Revised, vol. 2, part 5, ch. A, p. 3.

⁹⁴Virginia Acts of Assembly, (1984), (HB 1854), secs. 32.1-333-334, (Uncertified Copy).

uniform eligibility standards, in addition to defining the scope of services to be covered under the program.⁹⁵ By mandating local government participation in the State-Local Hospitalization Program, the General Assembly is sending a clear signal that the problem of indigent health care requires participation not only by institutional providers and the state, but localities, as well.

Just as indigent health care issues are related to COPN, so too, is health care for the elderly. Indeed the elderly population's demands will continue to be an important factor influencing health care in Virginia, and COPN.⁹⁶ The elderly's demands for health care have implications for hospitals and nursing homes alike. With hospitals facing declining occupancy rates, many wish to convert unused beds to skilled nursing (long-term) beds. In order to undertake such conversions, hospitals must first secure a COPN. This would seem to be a significant factor contributing to the divergence of opinion between nursing homes and hospitals regarding the future of COPN in Virginia. Hospitals seeking to adapt their facilities in response to the growing need for nursing care beds probably view COPN as a needless constraint, while nursing homes need COPN to protect their status in the market.

It is evident from this discussion that COPN has become part of an increasingly complex health care environment. A

⁹⁵Virginia Acts of Assembly, (1989), secs. 32.1-335-336.

⁹⁶West interview.

fundamental shift in the philosophy behind reimbursement practices now places greater emphasis on prospective reimbursement than on fee-for-service reimbursement, thereby compelling health facilities to become more efficient and competitive. This philosophical shift occurred at approximately the same time that consumers and insurers began searching for less costly alternatives to hospital care, such as ambulatory surgical clinics. Renewed concern among Virginia government officials for the health care needs of the elderly and the indigent mandates that Health Department officials and lawmakers consider the ramifications of future health policy shifts on these vulnerable segments of the population.

Within the policy arena a number of public and private sector groups have interacted with one another to influence the direction of the COPN program. Along the way, these provider, payor, governmental and consumer organizations were surely influenced by changes taking place in Virginia's health care industry. The most conspicuous case in point is the 120-member Virginia Hospital Association, headquartered in Richmond, which had originally supported COPN but, because of increased competition within the industry and the shift toward prospective reimbursement, the VHA now opposes COPN.⁹⁷ All of these factors contributed to the creation of a state-level commission in 1986

⁹⁷Katharine M. Webb, Vice President for Government Relations, Virginia Hospital Association, statement, Governor's Commission on Medical Facilities Certificate of Public Need, hearing, Minutes, 13 April 1987 (Richmond, Virginia), p. 14.

to study and make recommendations regarding COPN.

The Governor's Commission on Medical Care Facilities
Certificate of Public Need

Much of the recent discussion among Virginia lawmakers is rooted in political developments that actually occurred in 1986. In that year two separate but related investigative efforts were initiated by Governor Baliles and the General Assembly. During the 1986 General Assembly session, legislators created the Task Force on Indigent Health Care, which was directed to undertake a comprehensive study of the problems and issues surrounding health care for the indigent.⁹⁷

A second study commission was created in 1986 by Governor Baliles. The Governor established the Commission on Medical Facilities Certificate of Public Need to undertake a comprehensive study of COPN, and to make recommendations as to whether the program was still serving a useful purpose. If the Commission's investigation determined that COPN was no longer effectively controlling medical facility costs, or ensuring quality and accessibility, then the Commission was to make recommendations to the Governor and the General Assembly

⁹⁷ Virginia Acts of Assembly, (1986) vol. 2, Senate Joint Resolution 32, pp. 2070-2071.

regarding the future of COPN.⁹⁸

In reaching his decision to form a COPN study commission, Governor Baliles appears to have been motivated by a recognition of the many changes in the health care environment that have occurred within the last decade, such as were noted in the previous section. Speaking before the Virginia Health Care Association in February 1987, Governor Baliles acknowledged the vulnerability of the medical facility industry to society's philosophical mood swings, such as the current emphasis on free-market solutions to economic problems. The Governor stated that "... if we attempt to apply yesterday's remedies to future problems - then we do a disservice to our people." Suggesting that COPN had outlived its usefulness Governor Baliles said, "I am increasingly concerned that Virginia's regulatory apparatus - called the certificate of need process - may be falling short of its desired ends."⁹⁹ The increased level of economic competition and changes in the delivery of medical facility care undoubtedly helped to influence the Governor's decision to investigate COPN.

However the Governor was not alone in sensing that the medical facility industry might be ready for some degree of deregulation. By this time, there was a general feeling within

⁹⁸Gerald L. Baliles, Governor of Virginia, Executive Order Thirty-One, 19 December 1986, in Report of the Governor's Commission on Medical Care Facilities Certificate of Public Need (Richmond, VA: Commonwealth of Virginia, 1987), pp. 1-2.

⁹⁹Gerald L. Baliles, Governor of Virginia, "The Remarks of the Honorable Gerald L. Baliles, Governor of Virginia, Virginia Health Care Association, Richmond, Virginia, 4 February 1987, p.

the health facility policy community in Virginia that the health care industry had changed considerably since COPN's inception, and that perhaps some degree of deregulation was appropriate in light of the prevailing deregulatory atmosphere at the time. However, this desire to deregulate the health facility industry was tempered by concerns over the effect that deregulation would have on inner-city hospitals that provide a great deal of uncompensated care to the medically indigent.¹⁰⁰ While state level policymakers were interested in giving health facilities as much freedom from regulation as possible, there was still a lingering fear that complete reliance on the marketplace would leave inner city facilities with a declining pool of paying patients. These concerns underscore the linkage between COPN and the indigent care issue and illustrate the common threads that bound the work of the two commissions together.

The COPN Commission's membership reflected a cross-section of legislators, health care providers, third-party insurers, state health department officials, and the general public.¹⁰¹

¹⁰⁰C. M. G. Buttery, M. D., Commissioner of Health, Virginia Department of Health, telephone interview with author, 28 March 1989, Richmond, Virginia.

¹⁰¹The Governor's Commission on Medical Care Facilities Certificate of Public Need consisted of the following individuals: Chairman, Maston T. Jacks, Esq., Deputy Secretary of Human Resources; Senator Stanley C. Walker (D-Lynchburg); Senator Elliot S. Schewel (D-Norfolk); Delegate J. Samuel Glasscock (D-Suffolk); Delegate Warren C. Stambaugh (D-Arlington); Delegate Mary Marshall (D-Arlington); C. M. G. Buttery, M. D., M. P. H., Commissioner of Health; Ray T. Sorrell, Director, Department of Medical Assistance Services; George T. Drumwright, Jr., Virginia State Board of Health; Ann Y. McGee, Director, Virginia Health Services Cost Review Council; Mrs. Samuel J. Ailor, Virginia Statewide Health

During the course of its investigation, the Commission established formal relations with health care provider and insurer groups, health regulatory and planning bodies, and other organizations "which have an interest in the orderly growth and development of the Commonwealth's health care system."¹⁰² With such a wide range of participants in the commission's work, it is clear that Governor intended to have the Commission engage in wide-ranging dialogue with those interests most concerned with medical facility care issues.

Throughout 1987 the Commission held twelve monthly hearings across the state in Salem, Abingdon, Harrisonburg, Norfolk and Richmond. To aid in its deliberations, the Commission contracted with The Johns Hopkins University School of Hygiene and Public Health to conduct a comprehensive study of COPN in Virginia. The team of researchers from Johns Hopkins conducted a detailed analysis of the COPN program with the goal of ascertaining the program's impact on the costs, quality, and accessibility of medical services. The Commission also directed the Johns Hopkins researchers to consider alternative means that Virginia might employ to pursue "the public interest in the area of medical services delivery today."¹⁰³

Coordinating Council; Richard S. Blanton, Cumberland, Virginia; The Reverend Carl T. Tinsley, Roanoke, Virginia; Rhoda Whiteacre Maddox, Winchester, Virginia; Delores Zachary Pretlow, Ed. D., Richmond, Virginia; Drew B. Williams, Richmond, Virginia.

¹⁰²Baliles, Executive Order Thirty-One, p.2.

¹⁰³Report of the Governor's Commission on Certificate of Public Need, p. 11.

With input from the Johns Hopkins study, as well as testimony gathered from the Commission's hearings, the Commission had a wealth of information from which to draw conclusions regarding COPN. In December the Commission published its findings, and submitted its report to the Governor and the General Assembly in time for the 1988 legislative session.

The Commission came to several conclusions regarding the effectiveness of COPN. The data pertaining to COPN's effect on health care costs were found to be inconclusive, but the Commission considered COPN to be an inappropriate cost containment mechanism for hospital care.¹⁰⁴ Likewise, the Commission did not find that COPN had much impact on the accessibility of hospital care, and that COPN's effect on the quality of hospital care was inconclusive.¹⁰⁵

The Commission reached rather different conclusions regarding COPN's relationship to the nursing home industry. The Commission deemed COPN necessary to prevent a rapid increase in long-term beds, which would then drive up Medicaid costs. Conversely, too few beds would limit consumer choice and inhibit competition.¹⁰⁶ In the face of such findings, the Commission recommended that the hospital industry be substantially

¹⁰⁴Report of the Governor's Commission on Certificate of Public Need, p. 20.

¹⁰⁵Report of the Governor's Commission on Medical Care Facilities Certificate of Public Need, pp. 22-23.

¹⁰⁶Report of the Governor's Commission on Medical Facilities Certificate of Public Need, p. 23.

deregulated while COPN should be retained for the nursing home industry.¹⁰⁷

During the course of its investigation, the Commission became aware of the relationship between its work and that of the Governor's Task Force on Indigent Health Care. These two investigative bodies determined that COPN and the problems facing the indigent impact upon one another in a number of ways. For instance, the provision of health care for the indigent places a considerable burden on providers in the form of uncompensated care. On the other hand, COPN affects the indigent population to the extent that it influences the location and mix of services provided by hospitals and other facilities.¹⁰⁸ As the financial costs of providing health care for the indigent population grows, so does Commonwealth's stake in ensuring the continued availability of health care for the medically indigent.

Certificate of Public Need Moratorium

The Governor's Commission on Medical Care Facilities

Certificate of Public Need published its findings just in time

¹⁰⁷Eva S. Teig, Secretary of Human Resources, and Maston T. Jacks, Deputy Secretary of Human Resources, letter to Governor Gerald L. Baliles and the General Assembly, 1 December 1987, Richmond, Virginia, in Report of the Governor's Commission on Certificate of Public Need.

¹⁰⁸Eva S. Teig, Secretary of Human Resources, and Maston T. Jacks, Deputy Secretary of Human Resources, letter to Governor Gerald L. Baliles and the General Assembly, Richmond, Virginia, 1 December 1987.

for the 1988 General Assembly session. As in 1973, opponents and supporters of COPN lined up for the confrontation early. One important difference between the debate over COPN that took place in 1973 and the one that occurred in 1988 concerns the role of the Office of the Governor.

In 1973, Governor Holton did not play a very active role in the development of the COPN statute. Governor Baliles, on the other hand, took a very active role in the effort to repeal COPN. Indeed, his participation in the activity surrounding COPN was characteristic of the manner in which he governed. By the end of the first General Assembly session during his term, Governor Baliles had established a reputation as a very active official, who worked hard behind the scenes to advocate his agenda.¹⁰⁹ His industriousness has helped him to establish an impressive record of legislative successes. Indeed, it is this style that the Governor employed during the 1987, 1988 and 1989 sessions in pursuit of his health care policy goals.

The renewed controversy over COPN stemmed, in part, from Virginia lawmakers' attempts to grapple with the state's Medicaid expenditures. Shortly before the start of the session, the Baliles Administration proposed that a bed tax be levied on Virginia hospitals and nursing homes. Hospitals were to be taxed at a rate of \$5 per bed per day, and nursing homes would have been subject to a tax of \$1 per bed per day. These revenues were

¹⁰⁹R. H. Melton, "Lawmakers, Governor Tally Achievements," The Washington Post, 2 March 1987, E-1.

then to be earmarked for the State's Medicaid budget.¹¹⁰

On December 30, 1987, the Secretary of Human Resources briefed hospital and nursing home representatives on the Governor's proposal.¹¹¹ Thus, by the time the 1988 General Assembly session began, the hospital and nursing home lobbies had mobilized their forces in opposition to the proposal. On the other side of the issue, Senator Dudley J. Emick, Jr. (D-Botetourt) argued that without the bed tax, the General Assembly would be compelled to raise taxes in order to fund Medicaid.¹¹² A rather acrimonious confrontation developed between Governor Baliles and the hospital industry over COPN and the Governor's bed-tax proposal. Governor Baliles accused the health care industry of being more concerned with profits than with providing care. The Governor tried to instill a sense of obligation on the hospital industry by differentiating between these institutions and manufacturing corporations. "Hospitals and nursing homes should adhere to a distinctly different and more rigorous standard [of moral obligation than most corporations]."¹¹³

The hospital lobbying efforts proved to be decisive. Having initiated an intensive letter-writing campaign, these groups were

¹¹⁰Michael Hardy, "Emick Sees Tax Rise Unless Assembly Acts on Medicaid", Richmond Times-Dispatch, 24 January 1988, p. A-6.

¹¹¹R. H. Melton, "Hospitals Outflank Baliles on Hospital Plan," The Washington Post, 31 December 1988, p. B-1.

¹¹²Hardy, A-6.

¹¹³Bill Wasson, "Baliles Aims to Force Bed-Tax Issue With Two Proposals," Richmond News Leader, 11 February 1988, p. 6.

able to mount such a potent political offensive that the Governor withdrew his proposal before it had been formally introduced in the General Assembly.¹¹⁴ This defeat was particularly irksome to the Governor, because he had wanted to have a free-flowing discussion of health care financing issues. Although this defeat of the Governor's bed-tax plan represented a setback to his health care agenda, it was not the final chapter of the unfolding saga.

Not long after he withdrew his bed tax proposal, Governor Baliles countered with yet another proposal for dealing with the Medicaid crisis. This time the Governor's proposal centered on COPN. Sponsored by Senator Emick, the proposal called for a one-year moratorium on granting new certificates of need while a legislative subcommittee considered alternative solutions to the Medicaid funding dilemma. After the defeat of his bed tax proposal, Governor Baliles seemed more determined that this second proposal should pass, commenting that he planned to "force the issue."¹¹⁵ The measure received early endorsements from Delegate Richard C. Cranwell (D-Roanoke Co.), House Finance Committee Chairman, and Delegate Samuel Glasscock (D-Suffolk), House Health, Welfare, and Institutions Committee chairman.¹¹⁶

In order to help ensure passage of the moratorium-and-study

¹¹⁴Hardy, A-6.

¹¹⁵Bonnie V. Winston, "Baliles Likely to Win Lull in Hospital Construction," Richmond News Leader 11 February 1988, A-11.

¹¹⁶Winston, A-11.

plan, the Governor included the measure as an amendment to the fiscal 1990 budget. By doing so, he circumvented normal procedures, since budgetary matters are generally not open to public hearings.¹¹⁷ Partly as a result of this maneuvering, and partly as a result of the nature of the moratorium itself, the moratorium proposal encountered resistance from within the General Assembly and the health facility community. Senator Emick, who introduced the Governor's proposal, was especially disenchanted with the Governor's move to include the moratorium in the budget. Senator Wiley F. Mitchell, Jr. (R-Alexandria) contended that the Governor was trying "to browbeat the hospitals into submission", and existing nursing homes would be "able to profit under the moratorium." For their part, hospital and nursing home representatives objected to provisions that would have prevented facilities from replacing defective equipment or from purchasing new high-tech equipment.¹¹⁸ While these questions surrounding the moratorium were difficult, they were not insurmountable.

By early March 1988, a compromise was in sight. The conference committee report on the budget included provisions in the moratorium plan that addressed the health facility lobby's concerns. Exempt from the moratorium were projects for the replacement or renovation of existing facilities or equipment;

¹¹⁷Betty Booker, "Hospitals, Regulators Reach Truce," Richmond Times-Dispatch, 6 March 1988, B-5.

¹¹⁸ Booker, B-1, 5.

projects necessary for compliance with federal research grants; projects needed to meet emergency situations; and non-clinical projects, such as parking lots.¹¹⁹ Having reached this compromise, Laurens Sartoris, president of the VHA indicated that the VHA would give its "full support" to the study.¹²⁰

While the moratorium essentially suspended the COPN program, the Division of Resources Development was deluged by a flood of applications submitted by health facilities in the hope of attaining approval prior to the initiation of the moratorium on July 1, 1988. The deadline for filing Standard Review applications was March 5, 1988, while the filing deadlines for Administrative and Exemption Review applications were May 24 and June 14, respectively.¹²¹

As one might suspect, health facility administrators rushed to file their applications before the moratorium went into effect. From March through June 1988, 193 hospital and nursing home applications were submitted to the DRD.¹²² By comparison, health facilities submitted 157 projects in all of 1986.¹²³ This

¹¹⁹Acts of Assembly (1988) Joint Conference Committee Report on House Bill No. 30, 11 March 1988, p. 123.

¹²⁰Wasson, p. 6.

¹²¹Marilyn H. West, Director, Division of Resources Development, Memorandum to Chief Executive Officers and Administrators of Virginia Medical Facilities Subject to Certificate of Public Need Requirements, 22 April 1988, Richmond, Virginia.

¹²²Sandra Evans, "Health Plans Beat Deadline," Washington Post, 8 July 1988, D-1,4.

¹²³Certificate of Public Need Biennial Report, 1985-1986, p. 14.

deluge of applications prompted some observers, such as Dean Montgomery, executive director of the Northern Virginia Health Systems Agency, to charge that the Department of Health would rush approval of applications in order to meet the July 1 deadline.¹²⁴ Of 193 applications submitted to the Health Department, 153 were approved, including 26 of 58 nursing home project requests.¹²⁵ Of course the COPN moratorium was but one facet of lawmakers' attempts to address the Medicaid funding issue. The General Assembly also created a joint subcommittee to study a wide range of health care issues, including COPN.

The Joint Subcommittee to Study Health Care For All Virginians

Introduced by Senator Stanley Walker (D-Norfolk), Senate Joint Resolution 99 (SJR 99) established the Joint Subcommittee to Study Health Care For All Virginians.¹²⁶ Of particular importance was the continued escalation of health care costs generally, and the burden that these costs place on the public and private sectors. The language of SJR 99 also directed the Subcommittee to consider the accessibility of health care, especially for the elderly and the medically indigent.

The Subcommittee consisted of seventeen individuals

¹²⁴Evans, D-1.

¹²⁵Evans, D-4.

¹²⁶Virginia Acts of Assembly, (1988) vol. 2, Senate Joint Resolution 99, pp. 258-261.

representing a broad spectrum of interests.¹²⁷ Four Senators, appointed by the Privileges and Elections Committee, and five Delegates appointed by the Speaker of the House represented the General Assembly. The Governor appointed six individuals to the Subcommittee representing physicians, hospitals and nursing homes, the commercial health insurance industry, and the Virginia Board of Medical Assistance Services. The joint resolution stipulated that the Subcommittee consider alternative policy mechanisms to alleviate the State's Medicaid woes, such as stronger rate setting and a fund to equalize the indigent care burden currently assumed by providers.¹²⁸ The joint resolution also instructed the Subcommittee to study "other related matters that the joint subcommittee may deem appropriate."¹²⁹ It was under this rather broad grant of responsibility that the Subcommittee also examined COPN during the course of its deliberations. The Subcommittee transmitted its findings and recommendations to the Governor and the General Assembly in time for the 1989 legislative session.

¹²⁷The following individuals served on the Subcommittee: Senator Stanley C. Walker, chairman; Delegate Ford C. Quillen, vice chairman; Senator Hunter B. Andrews; Senator Clarence A. Holland; Delegate Robert S. Ball, Sr.; Delegate George H. Heilig, Jr.; S. Wallace Stieffen; Samuel B. Hunter, M.D.; Robert G. Jackson II; Bette O. Kramer; Charles B. Walker; Gerald L. Good; Eva S. Teig, Secretary of Health and Human Resources; Stuart W. Connock; Elliot S. Schewel; Delegate J. Samuel Glasscock; J. Bland Burkhardt, Jr.

¹²⁸Virginia Acts of Assembly, (1988) Senate Joint Resolution 99, p. 259.

¹²⁹Virginia Acts of Assembly, (1988), Senate Joint Resolution 99, p. 3.

The Subcommittee held meetings throughout 1988. At the initial meeting in August, Delegate Robert B. Ball, Sr. (D-Henrico) urged the Subcommittee to totally deregulate the health care facility industry. Said he, "Eliminate the certificate of need and let free enterprise solve the problem of high medical costs." However, Delegate Samuel Glasscock (D-Suffolk) sounded a more cautionary note, suggesting, "Let's not vote on it yet, let's get all the facts."¹³⁰ In September, Deputy Secretary of Health and Human Resources, Maston T. Jacks presented the Governor's Commission study to the Subcommittee. In his summary of the report, Jacks noted its generally deregulatory tone.¹³¹ The Subcommittee did in fact ultimately advocate substantial deregulation of the health care industry.

Deregulation of the Virginia Health Care Industry

The Walker Subcommittee recommendations played a significant role in the 1989 General Assembly session. The Subcommittee did incorporate COPN into its examination of health care in Virginia. The SJR 99 combined its work with that of the House Joint Resolution Subcommittee which was studying Medicaid eligibility

¹³⁰Olivia Winslow, "Ball Offers Health Care Suggestion," Richmond Times-Dispatch, 4 August 1988, B-3.

¹³¹Olivia Winslow, "Cost Study Backs Less Regulation," Richmond Times-Dispatch, 21 September 1988, B-1.

requirements.¹³² The fundamental issue for the Commission to decide was whether or not COPN was still an appropriate regulatory mechanism in the current health care environment.¹³³

In its report to the Governor and the General Assembly, the Subcommittee adopted an essentially deregulatory posture. The report recommended that medical facilities, except for psychiatric and rehabilitative facilities be deregulated from COPN. The Subcommittee drew a distinction between most health care facilities and psychiatric and rehabilitative facilities because these facilities are reimbursed differently from most medical facilities. The Subcommittee also proposed the continuation of the nursing home bed moratorium, as well as the creation of an indigent care trust fund to alleviate the financial burden that many hospitals now face.¹³⁴

Reactions to the Subcommittee report were varied. The VHA advocated deregulation except for bed use conversions.¹³⁵ Hospitals had guarded enthusiasm for the Subcommittee's plan, although they felt that business should also be required to

¹³²Virginia General Assembly, Joint Subcommittee on Health Care for All Virginians. Interim Report of the Joint Subcommittee on Health Care For All Virginians to the Governor and the General Assembly of Virginia, Senate Document No. 18, (Richmond, VA: Commonwealth of Virginia, 1989), p. 2.

¹³³Joint Subcommittee on Health Care for All Virginians, Interim Report, p. 3.

¹³⁴Joint Subcommittee on Health Care for All Virginians, Interim Report, p. 10.

¹³⁵Joint Subcommittee on Health Care for All Virginians, Interim Report, p. 40.

contribute to the trust fund, since many do not provide health insurance for their employees.¹³⁶ The Hospital Corporation of America(HCA) adopted a neutral position on the COPN recommendations, but suggested that if alterations to the program were to be made, the HCA wanted COPN requirements for new facilities and bed relocations to remain intact.¹³⁷ The Humana hospital chain did not express an opinion on COPN, but did feel that it would be unfair to have tax-paying hospitals contribute to the indigent trust fund, since they already paid taxes that went toward Medicaid.¹³⁸

There were several groups that opposed deregulation. Free-standing dialysis centers believed that to deregulate hospitals while continuing to regulate non-hospital facilities would be discriminatory.¹³⁹ Blue Cross-Blue Shield of Virginia felt that deregulation would lead to higher health care costs.¹⁴⁰ The Virginia Association of Health Systems Agencies feared that deregulation would lead to higher health care costs because of continued expansionist incentives. These organizations were also

¹³⁶Bonnie V. Winston, "Health Care Pay Plan for Poor Proposed," The Virginia-Pilot and Ledger-Star, 17 December 1988, B-5.

¹³⁷Joint Subcommittee on Health Care for All Virginians, Interim Report, p.42.

¹³⁸Joint Subcommittee on Health Care for All Virginians, Interim Report, p. 41.

¹³⁹Joint Subcommittee on Health Care for All Virginians, Interim Report, p. 44.

¹⁴⁰Joint Subcommittee on Health Care for All Virginians, Interim Report, p. 42.

concerned that unregulated facility, equipment, and service expansion would lower quality, since a high volume of service per procedure helps to maintain quality.¹⁴¹

Even within its own ranks, the Subcommittee's recommendations did not receive unanimous support. Delegate Samuel Glasscock wrote a dissent in which he argued that facilities which provide large amounts of indigent care would be at a competitive disadvantage in an unregulated market, relative to those facilities which did not provide much indigent care. He was also fearful that, left to their own devices, hospitals would abandon needy, inner-city areas in search of paying patients.¹⁴² Subcommittee member J. Bland Burkhardt also dissented from the report. Most of his objections centered on the implementation of the indigent trust fund. However he favored deregulation for new beds and relocation of existing facilities, a continued nursing home bed moratorium, and allowing hospitals to convert beds to skilled nursing care beds to meet the growing demand.¹⁴³

At the outset of the session, Governor Baliles made plain his stand on the COPN and indigent health care issues. Delivering his State of the Commonwealth address to the General Assembly, Governor Baliles stated that:

¹⁴¹Joint Subcommittee on Health Care for All Virginians, Interim Report, pp. 43-44.

¹⁴²Joint Subcommittee on Health Care for All Virginians, Interim Report, p. 33.

¹⁴³Joint Subcommittee on Health Care for All Virginians, Interim Report, pp. 36-38.

Medical costs continue to skyrocket, placing new burdens on families, businesses, and governments. ...I urge you to review the Joint Subcommittee on Health Care's interim report, which proposes that a new public and private partnership be established to set up a trust fund for indigent health care. I agree.

... the subcommittee recommends that regulation of hospitals under the Certificate of Public Need program be ended ... and that the moratorium on nursing home expansions be continued until January 1, 1991. I concur with that as well.¹⁴⁴

The Governor's remarks suggest a deregulatory position on the COPN program, stressing medical costs and the impact that medical facility costs have had on Virginians trying to obtain health care. Cost control was clearly the predominant consideration, since health care costs would affect whatever measures would be devised to alleviate the indigent health care crisis.

During the course of the 1989 session, legislators dealt with several bills that pertained to COPN. Delegate Ford C. Quillan (D-Scott) introduced a bill on behalf of the Governor that would have deregulated the medical facility industry, except for psychiatric and rehabilitative facilities.¹⁴⁵ A carryover bill originally introduced by Senator Wiley F. Mitchell (R-Alexandria), that would have totally deregulated the health care industry, died in committee, and Senator Johnny S. Joannou (D-Portsmouth) introduced SB 373 to deregulate the industry for bed relocations, while continuing to regulate hospital size,

¹⁴⁴"Portions of the Governor's Speech to Legislators," Richmond Times-Dispatch, 12 January 1989, A-8.

¹⁴⁵Betty Booker, "Health Care Trust For Poor is Aim," Richmond Times-Dispatch, 25 January 1989, A-5.

location, and services. Delegate Glasscock also introduced a bill that would have continued to regulate hospital construction, expansion, and bed additions, while deregulating equipment and services (HB 1975).¹⁴⁶

In the end, legislators from these competing pro and anti-regulation factions were able to reach a compromise, however the path to that compromise was not a smooth one. In early February the House Health, Welfare, and Institutions Committee voted unanimously to send the Glasscock measure to the House floor while the Senate approved the Joannou proposal to deregulate the medical facility industry only for bed relocations.¹⁴⁷ The Governor's proposal to deregulate the medical facility industry was defeated in the House, Health, Welfare, and Institutions Committee. Having waged a protracted struggle over COPN that spanned three General Assembly sessions, the defeat of the Governor's proposal to deregulate the medical facility industry represented an uncharacteristically harsh defeat for a governor who tended to enjoy considerable success in enacting his legislative agenda. It may also have been a sign that the General Assembly was not yet ready to completely deregulate the health facility industry.

¹⁴⁶Commonwealth of Virginia, Cumulative Index of Senate and House Bills, Resolutions, and Joint Resolutions Introduced in the 1989 Session of the Virginia General Assembly, (Richmond, VA: Commonwealth of Virginia, 1989), p. 139.

¹⁴⁷Jeane Cummings and Michael Martz, "Move to Deregulate Loses Favor in Committee Discussion," Richmond News Leader, 3 February 1989, A-4.

There were two central issues that overshadowed the General Assembly's activities in this area. Members of the General Assembly were concerned that medical facilities would abandon inner-city areas in a deregulated market. Secondly, there was a feeling among legislators that the Health Care for All Virginians Subcommittee had not completed its work.¹⁴⁸ Without a final set of recommendations from the Subcommittee, many members may well have been reluctant to opt for a completely deregulatory solution to the medical care industry dilemma. In the face of such uncertainty, a compromise was inevitable.

That compromise came in the form of a bill introduced by Senator Stanley C. Walker (D-Norfolk), who also chaired the Subcommittee. He introduced SB 762, which deregulated medical facilities services and equipment while continuing to regulate new facility construction, expansion and bed relocation. The bill also included an expiration date for the COPN program on July 1, 1991, at which time the General Assembly will determine whether or not the program continues to serve the public's interests.¹⁴⁹

Lawmakers reached a compromise that appears to satisfy many of the concerns of parties on both sides of this issue. The stipulation that will continue COPN regulation for much of the industry should assuage the fears of those individuals who feared

¹⁴⁸Buttery interview.

¹⁴⁹R. H. Melton and Donald P. Baker, "Most in Virginia Assembly Going Home Happy," The Washington Post, 26 February 1989, D-1,8.

that total deregulation would lead to the curtailment of hospital services in needy inner-city areas. However this restraint on the industry may be short-lived. Should the General Assembly decide in 1991 that COPN no longer serves a useful purpose, then the medical care industry may well be free of this form of state regulation.

By simultaneously passing legislation to create an indigent care trust fund, the General Assembly has created a program that will help to mitigate the effects of deregulation on facilities that serve large numbers of indigent patients. For his part, Governor Baliles' efforts in the health facility policy area have yielded him a significant achievement at the expense of a modest setback. Even though he was unable to secure the immediate deregulation of the medical facility industry, the General Assembly's creation of an indigent care trust fund represents a significant achievement. Advocates of regulation have bought themselves a little more time to come up with alternative solutions to the health care cost and indigent health care issues. Although opponents of COPN may not have gotten the complete package that they had sought, the door toward a substantially deregulated health care industry has been left open.

Conclusion

Regardless of the General Assembly's eventual decision concerning COPN, it is clear that the environment in which the

program now operates is vastly different from the health care environment that existed fifteen years ago when lawmakers created COPN. Indeed, it is these very differences which have prompted Virginia lawmakers to once again examine COPN in the broad context of Virginia health care policy. Of particular concern to the Governor and the General Assembly are the State's burgeoning Medicaid bill, and the provision of health care for the medically indigent. Since the medically indigent are often dependent upon Medicaid, the Commonwealth has a vested financial interest, as well as a humanitarian concern, in alleviating their plight. Both of these concerns are affected by the rising costs of medical care generally, which precludes many individuals from obtaining adequate health care, and which serves to inflate Virginia's Medicaid budget. This increase in the state's Medicaid budget and the general rise in medical facility care costs have prompted lawmakers and the Governor to tie the fate of COPN directly to its ability to constrain medical facility care costs.

In fact it is the cost of health care that has overshadowed concerns about health care quality and accessibility. Even though state lawmakers have elevated the prominence of Medicaid, this development is as much a function of the program's cost as it is a function of lawmakers' concern for the plight of the medically indigent.

The changing face of health care delivery and medical technology have accentuated cost control concerns, as officials

have altered the program in an effort to address the challenges posed by these changes. Just as the health planning and regulatory community has striven to address new health care issues and concepts, public and private sector organizations have introduced measures of their own (such as prospective payment) as a means of enhancing the competitiveness of the health care industry.

Throughout COPN's history, a variety of public and private sector organizations have been active in the discussion concerning COPN. Whether motivated by economic, professional, or ideological factors, providers, insurers, government agencies, and consumers have all taken positions on COPN. This is not to say that there has always been unanimity within a group, or that a group's position has remained consistent with respect to the efficacy of COPN. Nonetheless, the interaction among these groups has contributed to the evolution of COPN in Virginia. These groups will doubtless assume an active role in the coming deliberations regarding certificate of public need in Virginia.

The pattern that emerges from the interaction of various groups on the COPN issue is consistent with more general observations regarding the interaction of groups in American politics. All groups do not fair equally well in American politics. Those groups with narrow goals and substantial resources tend to be more influential than groups with broad, diffuse goals.¹⁵⁰ Those groups that represent business or

¹⁵⁰Schlozman and Tierney, p. 400.

economic interests are more likely to be influential than citizens' groups.¹⁵¹ These observations help explain the dominance of medical provider groups on the Virginia political scene in comparison to the more broad-based, diffuse consumer groups.

¹⁵¹Ronald J. Hrebenar and Ruth K. Scott, Interest Group Politics in America, (Englewood Cliffs, NJ: Prentice-Hall, Inc., 1982), p. 197.

CONCLUSION

Health facility public policy is in the midst of a transitionary phase. This transition is driven by the three separate but related impulses of cost, access, and quality. With the federal government altering its role in this policy area, state and local governments must redefine individually the proper level and nature of intervention that they will pursue. Lawmakers are also currently redefining other salient health issues that require attention. While health care costs still dominate health care policy discussions, officials in Virginia have become increasingly concerned about the availability and affordability of health care for the elderly and medically indigent. Central to these concerns is the issue of government's proper role in the health care facility industry.

During the sixteen years that Certificate of Public Need has existed in Virginia, Health Department officials have relied on the three basic issues of quality, and especially, the accessibility and cost of medical facility services as justification for the program. Accessibility and quality of medical facility services have long been significant policy considerations. More recently, cost control has grown to overshadow these longer-standing concerns. It was not until the late 1960's and early 1970's that health care costs became a significant issue on the national political landscape. Mirroring

this phenomenon, Virginia lawmakers began to closely scrutinize health care costs in Virginia during the early 1970's.

To meet the new challenge posed by rapidly rising health care costs, lawmakers in Congress and the states revised health facility policy prescriptions. New York and several other states experimented with certificate of need controls during the early 1960's as a means of achieving achieving health planning objectives. By 1972 almost half of the states had established capital expenditure review programs. Relying heavily on the experiences of these states, the Virginia General Assembly created a certificate of need program in 1973. A year later, Congress enacted a federal health planning statute that all but required states to develop capital expenditure review programs. The passage of this federal statute signalled a clear shift away from simply the provision of medical facility resources toward the rational planning and utilization of medical facility resources.

As certificate of need gained prominence, some analysts, political leaders, and health care providers questioned the desirability of CON regulation in the health facility industry. In fact, Virginia's COPN statute was quite controversial when it was introduced. At issue was the proper role of government in the medical facility industry. Proponents of a free-market approach to medical facility care, such as the Richmond Metro Chamber of Commerce have taken the stance on ideological and economic grounds that the free market is a better allocator of

health care resources than regulation. By subjecting prospective capital expenditure decisions to CON review, the decision became highly politicized, as the review process has often been marked by negotiation between the applicant, competing applicants, and the state agency having final decision-making authority.¹ Other groups, such as the Virginia Health Care Association and Virginia Blue Cross have supported COPN as a reasonable response to the problems within the health care facility industry. The Virginia Hospital Association has altered its position on COPN several times in response to the perceived effect that COPN has had on its member institutions. Initially supportive of the program, the VHA currently opposes COPN on ideological and economic grounds.

Group interaction has played an important role in the development of COPN in Virginia. It is often the case in American politics that groups which are well-organized and well-financed, and have narrow concerns are more active politically than those groups which are not. Health care provider and payer groups in Virginia have been much more active in the COPN dialogue than citizens' groups. The Virginia Hospital Association and the Virginia Health Care Association have been two of the most active groups on the COPN issue. Groups have not only been active in the formulation of legislation pertaining to COPN, but also in the daily operation of the program. Interested

¹Roberta M. Roos, "Certificate of Need for Health Care Facilities: a Time for Reexamination," Pace Law Review (7) 2 (Winter 1987), p. 509.

parties participate in the decision-making process on COPN applications, as well as in the promulgation of the regulations that govern the program.

Over the period of fifty or sixty years that government has been active in this policy area, the locus of activity shifted from the private sector, to local and state governments, and then to the federal government. Tensions arose under the federal health planning program between the various levels of government and the quasi-public HSAs. The focal point of these disagreements concerned the proper role of each level of government and the HSAs.

More recently, states and localities have resumed the dominant role in health planning in the wake of the dismantling of the federal health planning program. The absence of a federal health planning program has provided Virginia and other states with the opportunity to redefine their health planning goals. In Virginia, this development has meant that lawmakers have been able to give the needs of the medically indigent a much more prominent position on the political agenda than had previously been the case.

The indigent health care issue has accentuated concern about medical facility care costs in Virginia. Virginia lawmakers have tied COPN's fate to its ability to constrain costs. That Virginia's Medicaid budget has grown considerably has heightened officials' concerns about health care costs, since these costs influence the state's Medicaid budget. It is the effect that

health care costs have on Virginia's Medicaid budget which has prompted lawmakers to partially deregulate the health facility industry while creating a trust fund to assist institutions that provide substantial amounts of indigent care.

The federal government impacts upon the health care facility industry in a number of ways. The federal government provides incentives to employers to provide employee health insurance. Broad Medicare and Medicaid eligibility requirements are established by the federal government as are standards for nursing home care.²

State and local governments continue to be active in the health facility industry. Virginia and thirty-eight other states maintain active health planning and CON programs. States and localities are also responsible for health care facility licensing and, health and safety inspections. There are rate regulation programs in Virginia and elsewhere. Under a rate regulation plan, facilities work together with regulators to reach an agreement on revenue limits while regulators attempt to distribute equitably the indigent care burden among facilities.³ Virginia also continues to maintain its State and Local Hospitalization Program as a way to help ensure health care for the medically indigent.

²John F. Hoadley, "Health Care in the U. S.: Access, Costs, Quality," PS (20) 2 (Spring 1987), p. 198.

³Carl J. Schramm, Steven C. Renn, and Brian Biles, "Controlling Hospital Cost Inflation: New Approaches to Rate Setting", Health Affairs (Fall 1986), p.30.

Reduced to its most fundamental elements, the question of government intervention in the medical facility industry really reverts back to the long-standing debate over the relative merits of regulation and the free market. This question is still as hotly contested today as it was fifteen or twenty years ago. Yet today, there is a new wrinkle in this issue. Since all levels of government are, to varying degrees, involved in the medical facility industry, the current dilemma centers on the character that such intervention should take.

Medical facility public policy in this country is clearly at a crossroads. Public and private sector leaders continue to search for solutions to the deficiencies in the health care industry. Sixteen years ago the Virginia General Assembly enacted a certificate of need program in the hope that it would address the problems of access, cost, and quality. Access and cost are still at the forefront of political discussions sixteen years later, as the General Assembly has decided to scale back Virginia's COPN program in an effort to allow competitive market forces to work to achieve the Commonwealth's health care policy objectives. The quality of medical facilities is not as prominent a factor in the COPN program as it was originally, however. As the Governor and the General Assembly have struggled to deal with these issues and the fate of COPN they have received input from a variety of groups representing various segments of the health care industry and society at large. These groups have

played an important role in the development of medical facility policy in Virginia.

Governor Baliles and the General Assembly have made the issue of access to affordable health care for all Virginians a high priority, however concern over the cost of this care still overshadows the issue of the accessibility of medical facility care for many Virginians. Lawmakers' decisions regarding the continued efficacy of COPN are also motivated by these two issues. As long as these concerns remain high political priorities in Virginia, the Commonwealth will continue to play an active role in this ever-changing industry.

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VITA

Stephen Webb is single and has been living in Richmond for the last three years. Mr. Webb is currently employed at the Boatwright Memorial Library, University of Richmond.