Certificate-of-Need Over Hospitals in Rhode Island: A Forty-Year Retrospective

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ABSTRACT

The health reform legislation debate of the past year has been heavily laced with rhetoric about our nation's historic and continuing failure to effectively contain health care costs. National health insurance proposals have surfaced periodically since the early 1930s. With the exception of Medicare and Medicaid, most have not survived the political gauntlet. Thirty-five years ago, the country seemed primed for change, but the political wisdom determined that system controls should be implemented before any movement was attempted in a direction akin to a national health insurance program. That reform legislation – the last true attempt at substantive systemic interaction – lasted for only nine years before it was repealed. The only vestiges remaining, the certificate-of-need programs that continue to exist in select states, operate without much apparent impact on costs. This Essay will look at the history of certificate-of-need in Rhode Island, showing how its shortcomings were identified from a very early stage, and why its impact on cost has

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been minimal at best. In so doing, this Essay will also attempt to explain why certificate-of-need remains an annual lightning rod for spirited legislative debate despite the fact (or perhaps because) it has been a greater force for preservation of the systemic status quo than would likely have been the case had no such law been enacted.

INTRODUCTION

One recurrent criticism of the effort to reform health care in 2009 has been the attention paid to expanding health insurance coverage in contrast with the scant relative attention paid to controlling health care costs. This criticism brings to mind the nearly reverse situation that characterized the last major attempt to achieve structural change to the health care system as a precursor to the adoption of a national health insurance program. Thirty-five years ago, the National Health Planning and Resources Development Act of 1974 ("NHPRDA")[1] was enacted shortly after Congress came as close as it has in history to passing a true national health insurance act.[2] The goal of the NHPRDA was to bring rationality to health care decision making by giving states monetary incentives to engage in planning, to implement capital expenditure controls through compliant certificate-of-need programs, to review federal grant-making and to initiate appropriateness review of existing health services.[3] The NHPRDA lasted less than ten years and left behind little trace other than certificate-of-need programs in half of the nation's states.[4] Originally instituted, at least in part, for reasons of cost containment, certificate-of-need programs provide little by way of

1. *See generally* Pub. L. No. 93-641, 88 Stat. 2225 (1974), *amended by* Health Planning and Resources Development Amendments of 1979, Pub. L. No. 96-79, 93 Stat. 592 (1979), *partially repealed by* Pub. L. No. 99-660 § 701, 100 Stat. 3743, 3799 (1986).

2. DAVID BLUMENTHAL & JAMES A. MORONE, THE HEART OF POWER: HEALTH AND POLITICS IN THE OVAL OFFICE 244-47 (2009).

3. *See* Pub. L. No. 93-641, 88 Stat. 2225 (1974).

4. *Id.*, *amended by* Health Planning and Resources Development Amendments of 1979, Pub. L. No. 96-79, 93 Stat. 592 (1979), *partially repealed by* Pub. L. No. 99-660, § 701, 100 Stat. 3743, 3799 (1986). Those of us who lived through the repeal did not understand it to be a partial repeal. Certainly as to certificate-of-need there was no longer any federal money to support it.

conclusive evidence of their power to constrain costs. Nonetheless, they continue to exist in states like Rhode Island. To understand the reasons for that continued existence, a review of the highlights of the Rhode Island program over the last forty years may be instructive.

In reviewing the history of a program that has undergone so many legislative amendments over the course of its existence[5] and that interconnects with, influences and is affected by so many other voluntary and mandatory planning and regulatory programs, the choice of highlights is personal and reflects my own views and not the views of any other individual.

I. CERTIFICATE OF NEED AS A REGULATORY CONCEPT

The franchising aspects of public utility regulation were first adopted under the rubric "certificate-of-need" in 1964 in the State of New York as a partial response to the perceived cost-accelerating overcapacity of facilities and equipment in the hospital sector.[6]

The underlying (and somewhat flawed) premise of the regulatory scheme was that the major component of price increases in the health care sector was attributable to the non-payroll cost increases in rent, depreciation, interest, equipment and supplies which accompanied the overcapacity referred to above, which over-supply generated a self-fulfilling demand for use. It was felt that only by the imposition of external controls, subjecting all significant investments to public scrutiny, would an alleviation of resource allocation inefficiency be assured.

The mechanism, as designed, required review of health-related capital expenditures in hospitals and other health care facilities to assure: (1) compliance with rational planning guidelines; (2) rational allocation of limited resources, with emphasis on satisfaction of a legitimate need as opposed to satisfaction of an induced demand; and (3) reduction of duplication and under-utilization. Controls were limited to the introduction of

5. Of the forty-two years of its existence in Rhode Island, the certificate-of-need law was amended in twenty-five of those years, often more than once in the course of a given year.

6. Gerard Romeo Goulet, Lessons for Health Planning: The Certificate-of-Need Experience in Rhode Island 4 (1975) (on file with author).

new equipment or construction, or the expansion and modernization of such, and the effect upon existing entities was in the nature of an economic protectionist device, the sole sanction, for the most part, being the drastic and infeasible one of revocation or denial of licensure.

Certificate-of-need-type regulations had been used in Europe, in Britain, Scandinavia and on the continent.[7] The European tendency was to look at the number of beds needed rather than at the number currently demanded, implying a mechanism for providing alternative ways of meeting demands.[8] The essence of American certificate-of-need legislation, in general, and of the Rhode Island legislation, in particular, was and remains to provide the statutory ability to refuse permission to build beds or provide services, without providing any counter-balancing authority to initiate action to either build more beds when they are needed or develop alternative patterns of care that would make more beds unnecessary.[9]

Certificate-of-need has had a long history in Rhode Island. Only the second state in the nation to have enacted a program of capital expenditure review (after New York), Rhode Island is unlike many other states in that its history is far less reflective of the Federal legislative promotion of capital expenditure review that occurred from 1972 through 1986. Even in its years of compliance with Federal requirements, the program has been fundamentally state-oriented.

A. The Brosco Commission

Resolution #39 of the January 1966 session of the General Assembly called for the creation of a "Commission to Investigate Hospital Room Rates and Study the Advisability of Placing Such Rates Under State Regulation."[10] Chaired by Anthony J. Brosco, a state legislator with political aspirations for higher office, it consisted of seven legislators, four representatives of the public and three *ex-officio* members, the Director of Health, the State Budget Officer and the Fiscal Assistant to the House Finance

7. Brian Abel-Smith, *Value for Money in Health Services*, 37 SOCIAL SECURITY BULLETIN 17, 22 (July 1974).
8. Goulet, *supra* note 6, at 107.
9. *See generally* R.I. GEN. LAWS § 23-15-4 (1956).
10. Goulet, *supra* note 6, at 40.

Committee,[11] and was served by a team of four consultants from Columbia, Duke and Harvard Universities.[12]

The report of the Commission, entitled "Hospital Costs in Rhode Island," was completed on April 14, 1967, and addressed, as its critical issue, the financial situation of the individual hospitals.[13] From the start, the focus of certificate-of-need in Rhode Island was on the hospital sector.[14] As the report indicated, there was a clamor for government to do something about rising hospital costs and charges.[15] In fact, the language in the report's introduction could have been written in the context of the current debate about Federal health reform.[16]

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11. The members of the Commission were: Representative Anthony J. Brosco, Chairman; Paul F. Murray, Attorney, Vice Chairman; Philip J. Campana, C.P.A.; Joseph E. Cannon, M.D., M.P.H., Director of Health; Representative Joseph A. Capineri; William J. DeNuccio (successor to Howard A. Kenyon), Fiscal Assistant to the House Finance Committee; Representative Raymond M. Durfee; Senator Francis J. LaChapelle; Senator Henry E. Laliberte; Representative Alfred R. Moan; John C. Murray, State Budget Officer; Senator Charles A. Perry, Jr.; William L. Reiff, President, Almacs, Inc.; and William K. Turner, Director, Newport Hospital. COMMISSION TO INVESTIGATE HOSPITAL ROOM RATES AND STUDY THE ADVISABILITY OF PLACING SUCH RATES UNDER STATE REGULATION, HOSPITAL COSTS IN RHODE ISLAND: A REPORT TO THE LEGISLATURE, S. Res. 39, January 1966 Sess., at iii (Apr. 1967).

12. *Id.* at iv. The consultants and their positions in 1967 were: Ray E. Trussell, M.D., M.P.H., Associate Dean (Public Health), Director, School of Public Health and Administrative Medicine, and DeLamar Professor of Administrative Medicine, Columbia University; Ray E. Brown, Director, Graduate Program in Hospital Administration, Duke University; Jerome Pollack, Associate Dean for Medical Care Planning, Harvard Medical School, Professor of Economics of Medical Care, Harvard University; and Charles Roswell, Adjunct Associate Professor of Administrative Medicine, Columbia University. *Id.*

13. *See generally id.*

14. "Resolved, [t]hat a Commission be and the same is hereby created consisting of fourteen (14) members . . . and whose purpose it shall be to investigate *hospital* room rates and study the advisability of placing such rates under state regulation." *Id.* at 1 (emphasis added).

15. *See id.*

16. *Id.* at 2. "The Commission was not created by accident. Rising tax supported appropriations for hospital care of the needy are a problem in Rhode Island as well as in other States and in Washington. Such increases cannot be voted through blindly year after year. There is a genuine and often expressed need in the Legislature and by the public for better understanding of the justification for such increases and for assurance that hospitals are making every effort to keep their costs and charges as low as possible consistent with a high quality of care of the sick. Equally pressing are the

After studying Blue Cross subscriber coverage, changes in hospital bed complement, comparisons of hospital costs and charges, hospital capital indebtedness and hospital working capital, the Commission concluded that the overall financial condition of hospitals was a "relatively weak one."[17]

The members analyzed the high cost of unoccupied beds and emphasized the fact that associated fixed charges were "loaded" on the charges to paying patients, Blue Cross and the government.[18] The Commission also emphasized the tendency toward greater and unnecessary utilization and was concerned about the potential impact of "reasonable cost" reimbursement, structured without incentives for efficient management, under Medicare, and particularly, for the state of Rhode Island, under Medicaid.[19] The prime concern of the Commission in this area was that costs attributable to community service, standby-expenses, bad debts and contractual write-offs would be loaded onto the private pay patients in the form of increased charges in order to maintain sufficient operating income.[20] This, it was feared, would further undermine accessibility to hospital-based services.

The Commission was interested in the relatively newly legislated comprehensive health planning programs, recognized

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reactions of people who have some hospitalization insurance, yet who find themselves confronted with out of pocket expenditures – often very large – at the time of an illness requiring hospital care." *Id.*

17. *Id.* at 29. Forty years later, the diagnosis as to the health of our hospitals has changed very little. "Unless systemic changes are made, most community hospitals will face continued financial trouble in the coming years. A few hospitals will face more difficulty in the next 2 years, and one community hospital is in dire financial trouble right now." GARY D. ALEXANDER & CHRISTOPHER F. KOLLER, CMTY. HOSP. TASK FORCE, REPORT OF THE CMTY HOSP. TASK FORCE 3 (June 3, 2008), *available at* http://www.ohic.ri.gov/documents/Committees/Final%20community%20hospital%20taskforce/CHTF%20Letter%20and%20Final%20Report.pdf. "In 2008, the financial 'health' of RI's hospitals deteriorated. Statewide profitability declined from 3.5% to 0.1%, and net worth fell 12%." BRUCE CRYAN, R.I. DEPT. OF HEALTH, THE HEALTH OF RHODE ISLAND'S HOSPITALS (2008): A FINANCIAL ANALYSIS 1 (July 2009), *available at* http://www.health.ri.gov/publications/reports/HealthOfHospitals.pdf.

18. COMMISSION TO INVESTIGATE HOSPITAL ROOM RATES AND STUDY THE ADVISABILITY OF PLACING SUCH RATES UNDER STATE REGULATION, HOSPITAL COSTS IN RHODE ISLAND: A REPORT TO THE LEGISLATURE, S. Res. 39, Jan. 1966 Sess., at 30 (Apr. 1967) (on file with author).

19. *Id.*

20. *Id.* at 33.

the need for promotion of alternatives to the use of expensive in-hospital care such as out-patient diagnostic services, nursing homes and home care, and spoke of the need to broaden ambulatory care and promote group practice prepayment organizations in order to reduce in-patient admissions.[21] It recognized the hospitals' collective history of voluntary efforts to control costs, including: (1) subscription to the Professional Activities Study (PAS), Medical Audit Program (MAP), and Hospital Administration Services (HAS); (2) establishment of utilization review committees long before Medicare made their use mandatory; (3) establishment of a fifteen day recertification of medical need program at least a year before Medicare made it mandatory; (4) group purchasing by hospitals; (5) uniform cost accounting and reporting for third party payors; (6) voluntary discontinuation of the obstetrical service at Roger Williams Hospital; and (7) pilot programs with Blue Cross for home care at Kent County Hospital and for extended patient care at Newport Hospital.[22] Notwithstanding these efforts, the Commission pointed out that 42% of Blue Cross subscribers under sixty-five were covered by indemnity-type policies covering from $8 to $20 per day in the face of an average per diem semi-private charge of $35.54.[23]

The Commission met for more than a year, listened to testimony of national and local experts, and submitted four recommendations to the legislature in April of 1967.[24] Of the four recommendations set forth in the Commission's report, the only one that was acted upon was the one that called for establishment by law of a Health Services Council, representative of the public, providers, and payers, to review proposals for hospital construction.[25]

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21. *Id.* at 35-36.
22. *Id.* at 36-38.
23. *Id.* at 32.
24. *See id.*
25. *Id.* at 48-49. "Recommendation One – A Rhode Island Health Services Council or Commission should be established by law to bring together the community and the government in a joint effort to fuse the basic public responsibility with the resources of the voluntary sector. This citizen council appropriately appointed as determined by the law should represent the public, consumer groups, professions, Blue Cross, health facilities and government. An appropriate precedent for such a Council exists in New York

Apart from citing the reference to New York State's pre-existing capital expenditure review program, the Commission report was silent on the costs, benefits or theoretical economic underpinnings of capital expenditure review as a form of economic regulation.[26] In fact, the first significant scholarly effort of note was not published until five years after the Rhode Island program had been enacted.[27]

The Commission report was submitted too late for legislative action by the 1967 legislature; however, the 1968 legislature amended the Hospital Licensure Act to provide for a capital expenditures review program with three of the five initial statutory review criteria focused on avoidance of duplication: (1) the availability of facilities or services which may serve as alternatives or substitutes for the construction; (2) the need for special equipment in view of existing utilization of comparable equipment, and (3) possible economies from operation of joint central services.[28] Effective January 1, 1969, a Health Services Council was to be appointed by representatives of government to conduct the reviews and advise the Director of Health.[29]

B. The Health Services Council

Appointment of the Health Services Council members was delayed by a change of administration and clarifications afforded by an additional amendment to the law,[30] such that the Council did not hold its first meeting until November 5, 1969.[31]

These earliest years of the certificate-of-need program were marked by tension among the leadership of the Health Department, the Hospital Association of Rhode Island ("HARI"), Blue Cross of Rhode Island and the State Budget Office. The Health Department was not enthralled with the role thrust upon

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State . . . . The Council should pass on all proposals for establishment, expansion or substantial modification of hospitals which should be made uniformly subject to approval of the Director of Health after receiving the advice of the Council." *Id.*

26. *See generally id.*

27. *See generally* Clark C. Havighurst, *Regulation of Health Facilities and Services by "Certificate of Need"*, 59 VA. L. REV. 1143 (1973).

28. 1968 R.I. Pub. Laws 1458-1460.

29. 1968 R.I. Pub. Laws 1460.

30. 1969 R.I. Pub. Laws 84-85.

31. Goulet, *supra* note 6, at 46.

it – one that expected it to deny capital development.[32] The agency had as a core philosophy facilitating the provision of additional health care services, and it was uncomfortable with its potential new power to deny providers the right to provide additional services. HARI, for its part, feared that the Department would take to this new role with a vengeance and that only HARI institutions – the hospitals - would be affected. Blue Cross of Rhode Island and the State Budget Office were skeptical that the Health Department would have the intestinal fortitude to make the hard decisions.[33]

The tone of the organizational meeting of the Council was one of extreme caution, as evidenced by the adoption of executive sessions, and the exclusion of the press.[34] The Council was confused about the nature of its jurisdiction and the members seemed somewhat ambivalent toward their potential roles as regulators.[35]

By April of 1969, rules and regulations had been largely developed by the Health Department staff with the assistance of a professional consultant and experts in specific areas of costs, charges, inspections, utilization, quality of care, planning and construction. Meetings were then held with representatives of the hospitals, the voluntary and pre-existing Health Planning Council and the Rhode Island Medical Society to arrive at a final draft of the regulations. In the regulations presented to the Health

32. Interview with Joseph E. Cannon, M.D., Former Dir. of Health, R.I. Dep't of Health; Interview with John T. Tierney, Former Deputy Dir. of Health, R.I. Dep't of Health.

33. Interview with Armand Leco, Former Vice President, Blue Cross of R.I.; Interview with John C. Murray, Former Budget Director, State of R.I. Budget Office.

34. Goulet, *supra* note 6, at 117.

35. The membership was further confused as to the extent of its authority by the stance of Dr. Cannon, who offered the honest opinion that the Department of Health had no power to control hospital costs but that by gathering information, making comparisons and dealing directly with hospitals on occasion, it could be shown that steps could be taken by the hospitals to at least warrant a regular pattern of rising costs. It was outlined to the members of the Council that over 70% of hospital costs were attributable to labor and that virtually little opportunity existed to turn back the number of wage increases of recent years. This pronouncement, although an accurate appraisal of the situation, left the membership with only the prevention of duplication as a primary mission through a straightforward entry control mechanism.

Services Council for final review, the expenditure limits requiring review were raised from the original $50,000, or 1% of the hospital's physical asset value, to $200,000, or 3%, thereby allowing substantial (for 1970) construction or equipment replacement (together with the attendant annualized personnel costs) to take place without prior review by the Council.[36] The remainder of the Council's meetings through June 19, 1970 was spent approving these regulations.

In essence, the regulations restated that construction projects of a substantial nature required approval of the licensing agency, to which the Health Services Council was the advisory body.[37] Approval was to be sought by the filing of an application consisting of two parts: (1) the letter of intent, upon which the licensing agency had to render a decision within sixty to ninety days; and (2) if the letter of intent was approved, the formal application, upon which the licensing agency had to render a decision within six months.[38] The applicant was afforded appellate rights through a public hearing presided over by the Health Department with further redress affordable through the Superior Court.[39]

However, in the opinion of the Department of Health, prior approval of hospital construction by the Health Services Council after demonstration of public need could not become operative until the regulations were formally adopted and promulgated.[40] As a result, no applications for construction could be reviewed prior to September 3, 1970, when the regulations became official, and none were presented prior to the Health Services Council's first meeting of 1971.

At the close of 1971, the first full year of the Council, little, if anything, had been accomplished by its members. The Council had met fourteen times, adjourning once without a quorum.[41] Four proposals for substantial construction had been received and

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36. Goulet, *supra* note 6, at 184.

37. *Id.* at 172-75 (referencing the 1969 version of R.I. GEN. LAWS § 23-16-12).

38. *Id.* at 184, 187.

39. *Id.* at 190-91 (referencing the 1969 version of R.I. GEN. LAWS § 23-16-9).

40. *See generally* R.I. GEN. LAWS § 42-35 (2010).

41. Goulet, *supra* note 6, at 52.

acted upon and two others antedating the effective date of the law had been reviewed without action.[42] Review time had been extremely limited with the letter of intent and formal application actions occurring at the same meeting for all approvals. As the chief of the division of planning and standards, which served as staff to the Council, noted in a February 4, 1972 report to the Council: "Judged by proposals acted upon, the effectiveness of the franchising provisions of the law have not been great, but staff have observed a marked deterrent effect on uncoordinated planning from the mere existence of the mechanism."[43] The Council's growing pains continued into 1972 and have been extensively detailed elsewhere.[44]

In its early years, the Council was delayed in developing its abilities by a number of factors, including: (1) uncommitted and inadequate staffing; (2) failure to establish clearly defined internal administrative procedures, criteria to govern review, or bylaws to govern the Council's structure and function; and (3) attempting to compete with the pre-existing, voluntary Health Planning Council rather than utilizing its talents.[45]

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42. *Id.*

43. *Id.* (citing Clark C. Havighurst, *Regulation in the Health Care System,* 48 HOSPITALS J.A.H.A. 65-71 (1974). The validity of this statement is not easily ascertained. The long and short range plans submitted by the hospitals for fiscal year 1973 proposed over $25,000,000 in capital expenditures for short term projects with little, if any, planning coordination noticeable. This concept of a deterrent effect was to be a recurrent theme in future justifications for the continued existence of the program.

44. *See id.* at 42-58.

45. *Id.* at 156-57. As an example, in one of its early reviews, prior to the advent of written reports, the Health Services Council, in its approval of the Pawtucket Memorial Hospital replacement of nonconforming beds, was subjected to criticism for its divergence from the Health Planning Council's advisory on the application.

The Health Planning Council had suggested elimination of Memorial's obstetrics department, in keeping with its commitment to consolidate obstetrics services for the Providence area into one facility. Conversion of the freed beds to medical/surgical would have reduced the hospital's need for expansion by twenty-six beds. The Health Services Council believed such a proposal to be in error in recognition of the Memorial Hospital's reputation for the broadest scope of community services in the state and its high occupancy rate in obstetrics, and (assuming it had the authority to do so) was not presented with sufficient evidence to mandate elimination of the hospital's entire obstetrics capability (the second largest in the state). Although the Council's credibility was substantially uplifted,

In any event, through 1973, the Health Services Council continued to take no active planning role, and due to its lack of standards, criteria, and internal rules of order, could not be effectively measured in terms either of its process or its outcome. The Department failed to allow for evaluation of the process on either a continuing or periodic basis and, apart from paying lip-service to the notion of a more concerted planning effort on the part of hospitals, was not able, in any quantitative manner, to measure the impact on either costs or utilization of the reviews by the Council.

The year 1974 marked a maturation in a number of respects. The Council began to issue written reports in recognition of the Council's inability to operate much longer on the basis of decisions

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particularly among residents of the Blackstone Valley community, approval of the Pawtucket Memorial proposal unleashed a fair amount of controversy within the state. The failure of the Department of Health to mandate closing of the hospital's obstetrics unit in accordance with the Health Planning Council's advisory on the matter or with its previous policy statement on the consolidation of obstetrics facilities, brought sharp attacks from the Health Planning Council itself, the Lying-In Hospital (now Women & Infants Hospital of Rhode Island and chief beneficiary of the obstetrics consolidation plan) and the Executive Director of Blue Cross, who chastised the Department of Health for its failure to act upon the issue of underutilized facilities. For its part, the Health Services Council essentially adopted a position of rationality in the control of costs and reallocation of resources, consistent with its view of the due process requirements inherent in the exercise of its statutory responsibility and implied that the process would, at its level, involve consideration of elements apart from a strict analysis of cost. However, none of its reasoning was documented.

Although the rationale for Health Services Council decision making was documented in its later reports, on those occasions when the recommendation to the Director of Health differed from the advisory of the Health Planning Council, there was no attempt made to explicitly set forth the relevant differences.

The staff to the Health Services Council should have recognized that the existence of the Health Planning Council in a radical or extremist role was of value to the effectiveness of the Health Services Council in its reallocation role. Had not the Health Planning Council been able to react negatively to politically sensitive proposals, it is difficult to believe the Health Services Council could have effected any type of compromise or amendment to the applications it reviewed.

The Health Services Council, had it been the only reviewing agency, would perhaps, in many situations, have been forced to bow to political pressures, whereas, it could reach practical decisions and effect reallocations as a counterpoint to the Health Planning Council's recommendations of outright denial.

handed down from executive sessions – decisions which did not delineate in great detail the exact nature of the investigations conducted or the exact nature of the rationale leading to approval or disapproval.[46] In terms of decisions rendered, the Council matured to a considerable extent in its evaluation of applicant evidence of need and in its analysis of the financial impact of projects. It was able to force the withdrawal of an application that proposed commercial financing when the option of a tax-free bond issue (at a considerably reduced interest rate) was available.[47] Another hospital was forced to resubmit its plans for laboratory expansion due to its failure to convincingly document a need for the expansion in the face of potential changes to the health delivery system in the area.[48] A third hospital was forced to abandon its expansion of a special care unit and scale down the scope of its kitchen renovation considerably.[49] The Council also embarked on a significant venture into planning and allocation of resources in its modification of the proposals of two other hospitals, through negotiations that culminated in each hospital providing separately licensed skilled nursing units.[50]

The year 1974, therefore, was marked by increased sophistication and intense activity on the part of the Health Services Council. In the course of only seven meetings, it approved eight capital expenditures projects for hospitals totaling $7,670,000, disapproved one project totaling $450,000, and forced withdrawal of a $1,500,000 project.[51] Review times exceeded seven months for the most part.[52]

The year 1974 also marked the entry of the Council into the arena of nursing home proposals, and marked a new era for the Council in terms of pressure and politics, as the Council attempted to embark on a relatively unfamiliar course in the regulation of the largely proprietary, affluent, and well-connected nursing home industry.[53] Cost containment results in this arena

46. *Id.* at 62, 65.
47. *Id.* at 66.
48. *Id.*
49. *Id.*
50. *Id.* at 66-67.
51. *Id.* at 65-67.
52. *Id.* at 65, 68.
53. *Id.* at 68.

would fall far short of the effort exerted. Because of generous grandfathering provisions,[54] the need for additional nursing home construction was not readily apparent. Accordingly, over the first year of its active review of nursing home proposals, the Council tightened its requirements in a series of steps designed to prevent new nursing home applications from being initiated and to provide more grounds on which to base disapprovals because of the Department's conviction that the need for nursing home beds statewide was nearly satisfied.[55] As a result, the initial nursing home proposals were subject to a much more detailed analysis than had been the case for hospital applications.

However, as a purely reactive agency, the Health Services Council could not enforce the closing of those facilities that had been allowed to continue in operation as a result of intense lobbying and the granting of fire code variances. As a result, the Council spent the next several years attempting to hold the line on additional nursing home construction. Indeed, the Council faced intense pressure from the construction industries and the legislature acting in the interests of contractors for promotion of employment, in the interests of present owners wishing to replace non-conforming facilities and in the interest of developers wishing to build entirely new facilities. Existing providers were unhappy, as were prospective providers. In this arena, the Council experienced the difficult balance between cost containment and stifling competition in a way that would never occur for hospital proposals.

At this point in time, the Council was beginning to look at the performance of the Rhode Island program in comparison with other programs across the country. As of January 1974 (before the passage of the NHPRDA), twenty-two states and the District of Columbia had enacted certificate-of-need legislation.[56] Seven

54. *Id.* at 70.

55. These actions took place on December 10, 1974, although the criteria so designated had been in use since July 1974. *See id.* at 204.

56. *See* ROBERT JAMES CIMASI, THE U.S. HEALTHCARE CERTIFICATE OF NEED SOURCEBOOK 22-23 (Beard Books 2005) (noting that the twenty-two states were: Arizona, California, Colorado, Connecticut, Florida, Kansas, Kentucky, Maryland, Massachusetts, Minnesota, Nevada, New Jersey, New York, North Dakota, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Virginia and Washington). North Carolina's law was repealed by a state Supreme Court decision declaring it to be

other states passed similar statutes within the following three years.[57] In addition, thirty-seven states had signed agreements to implement section 1122 of the 1972 Amendments to the Social Security Act, Public Law 92-603,[58] which had established a capital expenditure review requirement for health care facilities or HMOs participating in the Medicare, Medicaid or maternal and child health programs.[59]

Despite the widespread adoption of certificate-of-need-type laws and the espousal of the concept by the Federal government, they were controversial as was evidenced by the number of court cases in various states[60] and by the comparisons of such regulation to that of public utilities largely considered by experts in law and economics to have been of ambiguous value.[61]

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unconstitutional. *Id.*

57. *See id.* (listing the seven states as: Alaska, Arkansas, Hawaii, Illinois, Montana, Ohio and Texas).

58. *Id.* at 5-6.

59. Those states that had not signed 1122 agreements were: Arizona, California, Connecticut, Illinois, Kansas, Massachusetts, Ohio, Rhode Island, South Dakota, Tennessee, Texas, Vermont and West Virginia. Only West Virginia did not have either type of regulatory mechanism at that time.

60. *See* In Matter of Certification-of-Need for Aston Park Hosp., Inc., 193 S.E.2d 729 (N.C. 1973); Attoma v. State Dep't of Social Welfare, 270 N.Y.S.2d 167 (N.Y. App. Div. 1966); Woodland Park Hosp., Inc. v. Comprehensive Health Planning Auth., 504 P.2d 753 (Or. Ct. App. 1972) (the issues addressed include: (1) regulation of construction involving private funds only; (2) the danger of creating monopolies by restricting competition; (3) the imposition of regulation on construction without the accompanying regulation of hospital rates; (4) the validity of the criteria used in judging need; and (5) the adequacy of the hearing procedures).

61. *See generally* Richard A. Posner, *Taxation by Regulation*, 2 THE BELL J. OF ECON. AND MANAGEMENT SCI. 22 (1971); George Stigler, *The Theory of Economic Regulation*, 2 THE BELL J. OF ECON. AND MANAGEMENT SCI. 3 (1971). Due to costs of administration and the invariable protection offered to previously existing providers, certificate-of-need laws were (and continue to be) accused of having an opposite effect from that of lowering or restraining costs. They have been alleged to:

> (1) raise costs, eroding thereby the potential profitability of monopoly pricing;
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> (2) contribute to misallocation by virtue of cross subsidization schemes to preserve comprehensiveness of services;
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> (3) protect producers through guaranteed markets;
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> (4) delay or prevent technological innovation; and
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> (5) induce inefficiency.

In this context, collective determination of the bed supply becomes a form of

There was certainly reason to look upon the development of such laws with suspicion, particularly since hospitals themselves had been instrumental in securing their passage in many states. The argument proposed most often in support of the adoption of such laws revolved around the notion of "cream-skimming" - the theory that new competition deprives existing providers of essential revenues, thereby disrupting their internal subsidization capabilities and jeopardizing their ability to provide useful services at prices below costs. This argument depends on the assumption that the comprehensiveness of health services offered by an institution is an inherently desirable aspect and that hospitals depend on internal subsidies to support indigent care. [62]

The arguments for and against public utility regulation of the health industry, and particularly certificate-of-need, had been addressed by many authors by 1973,[63] and they made an impression on Council staff. At this juncture, staff began to look at the impact on costs of the certificate-of-need program. Only 1.3% of Rhode Island's total health expenditures for 1972 were allocated to construction in comparison with the U.S. average of 4.7%. However, it was impossible to demonstrate any direct impact upon costs as a result of the impact of certificate-of-need. The inherent problem remained that capital construction expenses were minor in comparison to those for labor and supplies. An emphasis on hospital programs and hospital expenses, nearly two-thirds of which were attributable to labor, had to be incorporated as an adjunct to the capital expenditure restrictions if certificate-of-need was to have any chance of having an impact on hospital

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output restriction and the allocation of geographical or activity-related areas of responsibility becomes an example of monopolistic market division. Havighurst, *supra* note 27, at 1149. Although such cartel-like practices may be allowed in industries replete with third party payment and non-profit firms, self-interest can undermine any potential for rational reallocation.

62. Havighurst, *supra* note 27, at 1164.

63. *See id.* at 1143-1232. *See also* Roger G. Noll, Public Utility Regulation of Hospitals: On Snatching Catastrophe From the Jaws of Crisis, Presented at the Program in Hospital and Health Care Administration, Univ. of Minn., (Oct. 3, 1973); Anne R. Somers, *"State Regulation of Hospitals and Health Care: "The New Jersey Story,"* Blue Cross Reports Research Series 11, July 1973; Anne R. Somers, HOSPITAL REGULATION: THE DILEMMA OF PUBLIC POLICY (Princeton Univ. Press 1969); The International Health Advisory Council and Booz, Allen and Hamilton, Inc., MANAGEMENT MEMORANDUM ON HOSPITAL FRANCHISING (Booz, Allen and Hamilton, Inc. 1973).

costs. This was underscored by the experience with room charges, which were the impetus, however unreasonable, for the investigations of the Brosco Commission. According to HARI, the per-day average for semi-private rooms at the fourteen voluntary short-term hospitals more than doubled from $35.54 in December 1966 to $82.25 by October 1974.[64] Also, in the period from 1966 to 1973, inpatient routine and ancillary per diem cost increased from $44.91 to $108.12.[65] So, at least in the period leading up to NHPRDA, cost containment did not seem to be a hallmark of Rhode Island's certificate-of-need program.

A strength of the Council, however, was in the area of education of hospitals through policy statements similar to that issued on December 3, 1974, concerning the financing of capital expenditures.[66] The requirement that hospitals explore the relative merits of several alternative types of financing helped to preclude dependence on high interest borrowings from area banks in favor of issuance of tax exempt revenue bonds, at a savings to the reimbursement system and, ultimately, to the community.[67] The requirements of complete amortization schedules, demonstrations of cash flows during the period of capital financing and the depreciable life of the proposed asset, and use of present worth analysis in determining purchase-lease advantages, demanded an unprecedented sophistication on the part of hospital financial managers.[68] In addition, the number of projects that underwent some modification as a result of the Council's recommendations demonstrated a transition from passive to active review. Although the changes may have had little impact on the rise in costs, the Council sought to effect reallocations in the health system through approvals of configurations more in keeping with eventual shifts in the health delivery system. Herein lay its future.

The legislative politics of certificate-of-need were also made clear for the first time when on May 10, 1974, section 12 of chapter 16 of the General Laws was amended by insertion of the following language:

64. Goulet, *supra* note 6, at 131.
65. *Id.*
66. *Id.* at 199-201.
67. *Id.* at 200.
68. *Id.*

> When an application is made for a certificate-of-need to construct or to expand an osteopathic facility the need for such facility shall be determined on the need and availability in the community for osteopathic services and facilities.[69]

The amendment was passed at a time when disapproval of the formal application of the Cranston General Hospital for an increased capacity of twenty-six beds was imminent. It effectively checked the Council and the Department from rendering a disapproval since the osteopathic need per se had not previously been at issue. The Council agreed that the amendment rendered the application before it incomplete and that a new application and review complying with the requirements of Rhode Island General Laws section 23-16-12, as amended,[70] was in order. As a result, the Director of Health, noting that the action taken was not to be deemed a disapproval of the application but a step taken in the best interest of the parties, denied the application without prejudice to the right of the hospital to submit a new application.[71] This statutory amendment revealed a fatal flaw of the certificate-of-need legislation in that any special interest group, be it osteopathic, community, municipality or religious organization, could undermine any attempt at a rationalization of the health system by appealing to the legislature for either special consideration or an exclusion.

By 1975, this flaw manifested itself in the form of additional bills before the General Assembly relating to the Health Services Council, which sought to abolish or delimit its functions or to clarify its jurisdiction.[72] The fact that delimiting bills had been introduced was considered to be adequate testimony that the Health Services Council had begun to have an impact. Interestingly, opposition to the delimiting bills came largely from

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69. 1974 R.I. Pub. Laws 1348.

70. Goulet, *supra* note 6, at 61-62 (referencing the 1974 amendment to R.I. GEN. LAWS § 23-16-12).

71. *Id.* at 62.

72. 75-H 5835, introduced on March 21, 1975, proposed to abolish the Health Services Council and 75-H 5836, also introduced on March 21, 1975, proposed to repeal the responsibilities of the Health Services Council as they related to nursing or personal care homes while 75-H 6339, introduced on April 10, 1975, proposed to clarify the functions of the Health Services Council with respect to construction of nursing and personal care facilities.

the regulated, notably from HARI and the trade association of the for-profit nursing homes.

II. LEGISLATING COMPLIANCE WITH NHPRDA

The history of the early certificate-of-need program in Rhode Island from 1969 through 1974 has been detailed previously.[73] As of the end of 1974, the Rhode Island certificate-of-need program covered hospitals, nursing homes and health maintenance organizations. Osteopathic hospitals, for their part, had received the first legislative exception.

On January 4, 1975, the President of the United States signed into law Public Law 93-641, "The National Health Planning and Resources Development Act of 1974."[74] From the perspective of state government, the Act generated a significant amount of controversy because it effectively reduced state control over health resources and the health system in virtually every state, through the division of the country into 202 health systems areas, the establishment of non-governmental health system agencies within such areas, and the allocation of substantial authority to the health systems agencies and to consumer dominated Statewide Health Coordinating Councils.[75] As a result of section1536[76] of

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73. *See generally* Havighurst, *supra* note 27.

74. Pub. L. No. 93-641, 88 Stat. 2225 (1974), *amended by* Health Planning and Resources Development Amendments of 1979, Pub. L. No. 96-79, 93 Stat. 592 (1979), *partially repealed by* Pub. L. No. 99-660 § 701, 100 Stat. 3743, 3799 (1986); see James F. Blumstein & Frank A. Sloan, *Health Planning and Regulation Through Certificate of Need: An Overview*, 1978 UTAH L. REV. 8 (1978) for an analysis of the Act.

75. Among the significant functions formerly performed through the state executive branch were the following:

> By the health systems agencies – review and approval of each proposed use within the health systems area of Federal funds appropriated under the Public Health Service Act, the Community Mental Health Centers Act, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 for grants, contracts, loans or loan guarantees for the development, expansion or support of health resources.
>
> By the Statewide Health Coordinating Council – annual review and approval or disapproval of any state plan and of any application submitted to the Secretary as a condition to the receipt of any funds under allotments made to states under the aforementioned acts.

76. Pub. L. No. 93-641, 88 Stat. 2225.

(a) Any state which –

the Act, the so-called "Pell Amendment,"[77] however, Rhode Island, uniquely defined by virtue of its lack of county or municipal health departments and by its pre-existing substantially compliant health planning system, was neither required to establish a health service area nor to designate a health systems agency separate from the State agency. In addition, the Governor of the State had sole appointment power over the Statewide Health Coordinating Council.

This unique situation, though applauded by Rhode Island government officials and envied by governors of states across the nation, was not necessarily greeted with enthusiasm by local voluntary planning bodies and consumer activists. To them, the "Pell Amendment" represented a piece of special interest legislation which strengthened the already significant control of Rhode Island state government over the health care system and undercut the substantial direct consumer emphasis mandated in virtually every other state.[78]

Recognizing that the effects of the "Pell Amendment" in Rhode Island were not fully supported by significant other parties, including the Federal Department of HEW, and further

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(1) has no county or municipal public health institution or department, and

(2) has, prior to the date of enactment of this title, maintained a health planning system which substantially complies with the purposes of this title, and the Virgin Islands, Guam, the Trust Territories in the Pacific Islands, and American Samoa shall each be considered in accordance with subsection (b) to be a State for purposes of this title.

(b) In the case of an entity which under subsection (a) is to be considered a State for purposes of this title –

(1) no health service area shall be established within it,

(2) no health systems agency shall be designated for it,

(3) the State Agency designated for it under section 1521 may, in addition to the functions prescribed by section 1523, perform the functions prescribed by section 1513 and shall be eligible to receive grants authorized by sections 1516 and 1640, and

(4) the chief executive officer shall appoint the Statewide Health Coordinating Council prescribed by section 1524 in accordance with the regulation of the Secretary.

77. Named after Senator Claiborne Pell of Rhode Island who proposed the amendment.

78. Only Hawaii and the District of Columbia were similarly designated.

recognizing that the state agency was compelled to have in place an administrative program to effectuate the purposes of the Act within stipulated time frames in order to guarantee eventual designation under the Act and the continued flow of federal health care dollars into the state, the agency set out to secure passage of a compliant certificate-of-need law,[79] the only aspect of the mandatory state administrative program which could not be accomplished by means other than statutory enactment.

The Rhode Island law, as it was constituted in 1975, covered hospitals, nursing homes, and certain types of prepaid group practices, but it had to be amended to include the full range of health facilities likely to be included by the Federal government in its implementing regulations. It was the further understanding of the state agency that a compliant program had to be implemented not later than the expiration of the first regular legislative session of the state, which commenced after January 4, 1975.

It was at this juncture that the next stage of Rhode Island's certificate-of-need history began – the great debate among the health department, HARI and Blue Cross over the next iteration of the certificate-of-need program for Rhode Island – a debate that would consume the legislative sessions from 1975 through 1978 – culminating in a certificate-of-need law that would pass initial muster against the template set forth in the NHPRDA.

In attempting to secure passage of the legislation, the major point of emphasis throughout the process was the fact that, consistent with the carrot-stick approach adopted by the Federal government in many other areas, failure to adopt a compliant law by the federally mandated deadline could result in the loss of up to $2.5 million annually by the State of Rhode Island and, more importantly, failure to qualify for the waiver provisions afforded by the earlier referenced "Pell Amendment." It appeared that the

79. 42 U.S.C. 1320a-1 (1974) provides that the state agency shall administer a State certificate of need program which applies to new institutional health services proposed to be offered or developed within the State and which is satisfactory to the Secretary. Such program shall provide for review and determination of need prior to the time such services, facilities and organizations are offered or developed or substantial expenditures are undertaken in preparation for such offering or development and provide that only those services, facilities, and organizations found to be needed shall be offered or developed in the State.

potential loss of Federal funds and state control would be an unbeatable selling point in combination. The next four legislative sessions would prove, however, that it was somewhat more complicated an endeavor than originally contemplated.

Accordingly, the years 1975 through 1978 were marked primarily by the Health Department's efforts to secure passage of such a law, to correct some of the problems noted during the early years of the state's experience with its own certificate-of-need law, and to satisfy, to the extent possible, conflicting interests of numerous other parties.

A. 1975

Part of the Department's strategy in introducing a bill at all in 1975 was to begin to get the General Assembly to consider broadening the certificate-of-need legislation. In the absence of the federal regulations, the state really had very little guidance in terms of the necessary substance of the bill, and attempted to counter the lack of information with sufficiently vague language to allow for eventual conformance through the agency's regulations, a much easier task than that involved in shepherding extremely detailed and complicated legislation through the General Assembly.

The bill, 75-H-6230, bore a great resemblance to the type of tinkering legislation in which the Department, on the advice of its legal counsel, appeared to specialize prior to 1976.[80] It merely attempted, through the modification of a couple of passages in the existing statute, to broaden its scope of coverage from one pertaining to hospitals and pre-paid group practices to one encompassing all types of health care facilities.[81] The bill also attempted to expand coverage from exclusive concern with substantial construction and acquisition of high cost equipment to encompass initiation, expansion and modification of health care services and programs.[82]

The proposed extension of jurisdiction to all health services facilities essentially served as a protectionist device since it sought to impose control over the laboratories, surgicenters and other

80. *See generally* 75-H 6230, Jan. 1975 Sess. (R.I. 1975).
81. *See generally id.*
82. *See generally id.*

similar centers accused of "cream-skimming" by the hospitals. On the other hand, there was a hope that the scope of such control could eventually add a new dimension of rationality to the system if the regulators were able to operate without the hindrance of vested interests. The potential would finally exist for movement away from average cost reimbursement to a more rational service-determined cost to allow hospitals to compete with the more cost effective mechanisms if they so chose. By changing the regulatory focus to invite hospitals to terminate losing services rather than impose unilateral barriers to entry, to preclude inclusion of plant assets used for rendering non-remunerated services from being figured in the rate base (as Blue Cross, the Health Planning Council and the Health Services Council were attempting to do in their review of underutilized facilities) and to insist that hospitals adopt accounting procedures designed to reveal the true costs of serving various classes of customers, it was hoped the public could be much better served. Expansion of jurisdiction to include all health-related facilities would guarantee that the statewide planning system would be all-inclusive and, together with Blue Cross postulating a "maxicap" for the hospitals for 1975-1976 of approximately 9% coupled with a reduction in utilization of up to 4%, promised to be an effective model for cost containment. Such at least was the plan.

Introduced as an administration bill late in the session, 75-H-6230 was apparently doomed from its inception, perhaps fortunately so, since its passage would not have obviated the need to introduce additional amendments in succeeding sessions merely to resolve the procedural deficiencies evident in comparison with the eventual federal regulations. As it turns out, the bill was never reported out of committee. Instead, a special interest bill, 75-H-5906, introduced on behalf of a single small hospital that was adversely affected by the sliding budget-related thresholds triggering review in the agency's implementing regulation, was enacted with the support of HARI, which feared the Department's proposed extension of authority into programs. Thus, all hospitals, regardless of budget, were placed on even keel with respect to the imposition of controls by the state on new construction or equipment - there would be no review of construction or equipment acquisition of less than $100,000 in cost and, at least as of the end of the 1975 legislative session, no

extension of control to other health care facilities.

B. 1976

The message accompanying the Health Department's 1976 proposal[83] again argued that legislation had to be passed in the 1976 session and that failure to do so could result in the potential for loss of funds and state control.[84] HARI, which was supportive of some extension of the Department of Health's jurisdiction, strenuously expressed its opposition to the Health Department proposal.

The March 29, 1976 testimony of HARI, which was distributed to all members of the General Assembly, not only argued that the Department bill was premature but, in particular, expressed concern about the "enormous extension of the regulatory and control powers of the Department" and away from the boards and professional staffs of voluntary agencies and providers.[85] HARI did acknowledge its support for extension of certificate-of-need authority to free-standing clinics, centers for diagnostic or therapeutic radiology, hemodialysis, computer assisted tomography and surgery, but limited its support to capital expenditure review alone. This testimony was one of the first articulations of HARI's position that hospitals were disadvantaged by certificate-of-need controls that did not extend to hospital competitors.

In response, on May 10, 1976, the Department circulated its first direct statement on the cost containment potential of certificate-of-need as it had existed prior to that time to the members of the General Assembly.[86] The substance of the memorandum was a comparison of: (1) the operating budgets of the voluntary hospitals over the period 1966 through 1976; (2) the total of approved capital expenditures for hospitals for the period

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83. 76-H 7797, Jan. 1976 Sess. (R.I. 1976).

84. Letter from Joseph E. Cannon, Former Dir. of the R.I. Dep't of Health, to Clifford J. Cawley, Jr., Chairman, Judiciary Comm., H.R. (Apr. 2, 1976) (on file with author).

85. *Health Care Facility Licensing and Health Resources Approval Act of R.I.: Hearing on 76-H 7797* (1976) (testimony of Hosp. Ass'n of R.I.) (on file with author).

86. R.I. DEP'T HEALTH, FACT SHEET: THE NEED FOR HEALTH RESOURCE REGULATION, 76-H 7797, 1976 Sess. (1976) (on file with author).

1971 through 1976; (3) the associated annualized costs of those capital expenditures; and (4) the associated annualized costs of hospital programs approved through the voluntary health planning process.[87]

The memorandum concluded that only $1.5 million or .65% of the $222.5 million authorized for fiscal year 1976 hospital operating budgets was attributable to authorized expenditures subject to the capital expenditure regulatory review of the Department of Health and actually implemented as of 1976.[88] The memorandum also showed that review of new programs had a far greater cost containment potential since the aggregate impact on costs of programs approved through the voluntary planning process in the period from 1973 to 1976 represented nearly 10% of the 1976 annual operating budgets of the hospitals.[89]

Thus, this simplistic analysis attempted to underscore the need for program review as an important adjunct to capital expenditure review if cost containment was to ever be achieved. However, HARI's arguments on prematurity, overregulation of the hospital industry and greater need for controls over other providers than over hospital programmatic expenditures seemed to be prevailing.

In an effort to salvage something from the session, the legislative members of the Health Services Council, John McFarland and Bruce Daniel, amended a resolution that was sitting in the House Committee on Health, Education and Welfare to create a special legislative commission.[90] Its purpose was to study all health care delivery service regulations and statutes, recommend any changes deemed necessary and to report to the General Assembly by March 1, 1977.[91] Thus, the 1976 legislative session ended with no substantive modification to the state's certificate-of-need law.

87. *Id.*
88. *Id.*
89. *Id.*
90. R.I. Acts & Resolves 180.
91. *Id.* at 180-81.

C. 1977

By 1977, HARI and the Health Department were back on the same team, but serious tension developed between the Department of Health and HARI on the one hand, and Blue Cross of Rhode Island and the State Budget Office, on the other. This was dramatically underscored by the fight within the General Assembly over two sentences in the Department's new legislation, 77-H-6120.[92] Those two sentences read as follows:

> Reasonable costs associated with offering or developing new institutional health services or new health care equipment approved under this chapter shall be deemed to constitute new costs for purposes of reimbursement. Nothing in the preceding sentence, however, shall be construed to mandate the reimbursement of all previously existing or other proposed new costs of a health care facility.[93]

The third-party purchasers opposed inclusion of those sentences in the legislation because they insisted that the final say on funding new programs that went through the certificate-of-need process had to rest with the budget negotiators at the budget table and not with the Health Department.[94]

Interestingly the same two sentences had not been opposed the prior year when they had been included in 76-H-7797,[95] which died in committee because of HARI's opposition to programmatic review but not because of the two sentences.

At the time of the 1977 legislative testimony on the issue of these two sentences, the hospitals and third party payors were nearing completion of the three-year prospective budgeting and reimbursement experiment that they had embarked upon with the Medicare program, and were contemplating a revised two-year

92. 77-H 6120, Apr. 1977 Sess. (R.I. 1977).

93. *Id.* (quoting proposed amendment to R.I. GEN. LAWS § 23-17-4(c)(15)(g)).

94. *Health Care Certificate-of-Need Act of R.I.: Hearing on 77-H 6120A Before the S. HEW Comm.* (1977) (testimony of Hosp. Ass'n of R.I.) (on file with author).

95. 76-H 7797, Jan. 1976 Sess. (R.I. 1976).

extension. While the program had achieved cost containment objectives, the hospitals felt strongly that too much had been cut at the budget table from the service changes, innovations and capital projects areas of the budgets because such costs (not having yet been incurred) were easier to reduce than the tougher but necessary cost-cutting decisions to be made in the existing budgets of the hospitals.[96]

Also reiterated in the 1977 testimony was a repeat of HARI's 1976 articulation of the hospitals' long standing support of certificate-of-need and the planning process in Rhode Island.[97] Ultimately, Blue Cross and the State Budget Office prevailed in their arguments and the legislation was vetoed by the Governor.

D. 1978

Finally, in June 1978, the state enacted a certificate-of-need law that it believed could comply with the requirements of the NHPRDA.[98] Within months of the law's passage, however, there was internal friction within the Department.

Discord was apparent as early as December 1978, when the

96. *Health Care Certificate-of-Need Act of R.I.: Hearing on 77-H 6120A Before the S. HEW Comm.* (1977) (testimony of Hosp. Ass'n of R.I.) (on file with author).

97. *Id.*

98. *See generally* 1978 R.I. Pub. Laws ch. 269. The 1978 law covered hospitals, skilled nursing and intermediate care facilities, home health agencies, clinical laboratories, rehabilitation centers, kidney disease treatment centers, health maintenance organizations, free standing emergency care facilities, surgicenters, and organized ambulatory care facilities unless such organized ambulatory care facilities were owned and operated by professional service corporations. *Id.* The only other exemption was for private practitioners (except for new health care equipment exceeding $150,000 in capital costs). *Id.*

These entities were required to secure state approval for establishment of new health care facilities; new capital expenditures exceeding $150,000; increases in licensed bed capacity; new and substantial health services as defined in regulations, and capital expenditures for new health care equipment exceeding $150,000.

Offering or developing the foregoing services without review by Health Services Council and approval by the Department of Health would subject the facility to licensure sanctions or reimbursement denials by Medicaid or Blue Cross. Going forward after disapproval would place the facility in jeopardy of losing future federal or state grant funds. Approvals by the Department of Health could be subject to conditions but only conditions incorporated in regulations promulgated by the Department.

Deputy Director of the Department, in a memo expressing fear that the state agency would be forced to apply controls equally against facilities it wished to promote and facilities it wished to retard and arguing against extension of certificate of need to non-hospital facilities, described certificate-of-need as a mechanism for cost containment among other alleged attributes.[99] This elicited a response from the certificate-of-need staff that demonstrated the staff's lack of delusion on this score. In summary, the argument went as follows: In the area of cost containment, certificate-of-need had some cost avoidance effects to the extent that additional inpatient beds were not built and that financing mechanisms taking advantage of equity and/or tax exempt bonding came into play. However, staff noted the high approval rate of the process, the fact that, in Rhode Island, there was virtually no concrete evidence of abandonment of plans by hospitals because of the existence of the process (the so-called "deterrence effect"), and that capital investment in equipment and beds seemed to be replacing new construction. Accordingly, staff felt that the hidden costs of certificate-of-need, reflected in the preservation of hospitals, which should perhaps have been eliminated had new competing hospitals been allowed into the system during the ten years since passage of certificate-of-need, probably outweighed the cost savings.[100]

The staff memorandum noted that certificate-of-need had been but one recommendation of the Brosco Commission to resolve the financial difficulties of hospitals, but that the state's prospective reimbursement experiment probably had had more to do with any alleviation that had taken place, citing the 1976 evidence that certificate-of-need had meant little in terms of impact on hospital budgets.[101]

In arguing for maintaining control over all health care facilities, the staff memorandum concluded that certificate-of-need had protected hospitals and the hospitals hoped that extension of certificate-of-need to health care facilities other than hospitals

99. Memorandum from John Tierney to Gerry Goulet (Dec. 18, 1978) (on file with author).

100. Memorandum from Gerry Goulet to John Tierney (Dec. 25, 1978) (on file with author).

101. R.I. DEP'T HEALTH, FACT SHEET: THE NEED FOR HEALTH RESOURCE REGULATION, 76-H 7797, 1976 Sess. (1976) (on file with author).

would continue to protect the markets of hospitals. It suggested that it was up to the agency to assure that such was not the case. Repeal of certificate-of-need over certain types of health care facilities might be one solution, it posited, but preservation of flexibility in the certificate-of-need decision making process was most certainly another.[102]

The arguments expressed in the dueling memos were those of the planners against those of the regulators. The planners saw certificate-of-need as a planning tool targeted against certain providers to contain costs, improve accessibility, assure quality and rationalize the system. The regulators were much more realistic about the cost containment limitations of an exclusively reactive process, but believed they could make reasoned distinctions in evaluating capital projects and new programs of hospitals and nursing homes compared to capital projects and new programs of other types of health care facilities. The planners were concerned that the extension of certificate-of-need to non-hospital ambulatory care facilities would result in denials of such proposals even if the Department wished to favor them. This concern stemmed from the planners' not unreasonable belief that regulators would be required to sacrifice distinctions presented by individual cases in order assure to equal procedural treatment of applicants. The upshot of the memorandum exchange was that certain categories of non-hospital organized ambulatory care facilities were delayed from inclusion within the certificate-of-need law's coverage in the first set of regulations promulgated in 1979.[103]

The law underwent another set of changes in 1980, in order to conform its provisions to the latest procedural changes in the Federal regulations,[104] to eliminate clinical laboratories[105] and to delay organized ambulatory care facilities from inclusion until mid-1981. This resulted in the promulgation of the 1981

102. Memorandum from John Tierney to Gerry Goulet (Dec. 18, 1978) (on file with author).

103. R.I. DEP'T OF HEALTH, RULES AND REGS. FOR DETERMINATION OF NEED FOR NEW HEALTH CARE EQUIP. AND NEW INSTITUTIONAL HEALTH SERVS. (1979) (on file with author).

104. 1980 R.I. Pub. Laws 288-306.

105. 1980 R.I. Pub. Laws 322.

amendment to the state regulations.[106]

In 1981, the Department's continuing debate over the scope of the certificate-of- need law,[107] with the regulators now teaming up with the planners, culminated in a legislative proposal to repeal certificate-of-need over various types of facilities, an action that was strenuously and successfully opposed by South County Hospital and HARI. Thus, by the end of 1981, the dream of covering all health care facilities and of rationalizing the system through the certificate-of-need process had already begun to give way to more modest goals.

E. 1982: The Big Year

The year 1982 was, in many ways, a watershed year for the certificate-of-need program. Certificate-of-need made its way into a scholarly journal; the Department reviewed its most significant hospital capital project to that time; and, at least in part, as a result of the latter, the General Assembly initiated the process of fashioning legislation to more closely align the capital review and hospital budgeting and reimbursement processes.

In June 1982, three of the Department's senior staff wrote what appears to have been the first published defense of Rhode Island's certificate-of-need program.[108] Citing the extensive, mostly negative, literature that had been authored in previous years regarding the effectiveness of certificate-of-need, particularly its apparent lack of success in controlling health care costs,[109] the authors shifted gears and argued that the Rhode Island program was having a positive effect in three areas that were rarely measured in the literature: deterrence, guidance and institutional planning.[110]

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106. R.I. DEP'T OF HEALTH, RULES AND REGS. FOR DETERMINATION OF NEED FOR NEW HEALTH CARE EQUIP. AND NEW INSTITUTIONAL HEALTH SERVS. (1981) (amending the 1979 version) (on file with author).

107. Memorandum from Gerard R. Goulet to Health Services Council re: Proposed Repeal of Certificate-of-Need over free standing emergency rooms, ambulatory care facilities and home health agencies (Feb. 27, 1981) (on file with author).

108. John T. Tierney, William J. Waters & William H. Rosenberg, *Certificate-of-Need—No Panacea but Not Without Merit,* 3 J. OF PUB. HEALTH POL'Y 178, 178 (1982).

109. *Id.*

110. *Id.*

The deterrence argument was familiar. Institutions were unlikely to spend the time, energy and money to navigate the complicated certificate-of-need process for a frivolous or obviously misdirected project. While this argument had largely been anecdotal in previous iterations, the authors attempted to validate the premise by citing research comparing hospital bed supply and physician supply in the state from 1956-1980. Their underlying theory was that, in the absence of certificate-of-need, one would have expected the hospital bed supply to expand commensurate with the expanding supply of practicing physicians.[111] Instead, beds per physician declined from 2.1 in 1958 to 1.5 in 1980.[112] Thus, the authors concluded that had certificate-of-need over hospitals not existed, Rhode Island would have had 300 more hospital beds in 1980.[113]

A second line of argument was that, while overall hospital investment did not appear to be reduced by certificate-of-need, the program may have had a positive impact on the types of investments hospitals were making.[114] Citing the program's promotion of: (1) "the utilization of tax-exempt bonds where appropriate," (2) "the pursuit of community fund drives as a source of financing capital expenditures," and (3) "the employment of debt/equity ratio limitations" as evidence, the authors suggested that hospital adoption of any or all of the above in Rhode Island was more likely to have been attributable to certificate-of-need than to any other influence.[115] They also pointed to the relatively slow dispersion of CAT scanners in Rhode Island in comparison with the experience in other states as evidence of the influence of certificate-of-need in restraining the introduction of new technology.[116]

For their third argument, the authors asserted that

111. *Id.* at 179.
112. *Id.*
113. *Id.* Of course, the exact same effect could have been achieved had the state simply adopted a moratorium on licensing new hospital beds similar to the moratorium on licensing new nursing home beds that the nursing home industry succeeded in getting enacted in 1996. *See* R.I. GEN. LAWS § 23-17-44 (2008). In the thirteen years since that law was first enacted, certificate-of-need has been more theoretical than real for nursing homes.
114. Tierney, *supra* note 108, at 179.
115. *Id.* at 180.
116. *Id.*

"certificate-of-needs tend to promote better institutional planning."[117] While there was little evidence that the quality of the annual long and short range plans of the individual hospitals were any better than they had been before certificate-of-need, the authors cited significant inter-institutional planning involving nine of the state's hospitals over the prior ten years.[118] Presumably, it was to be inferred that, in the absence of institutional planning, inter-institutional planning could not possibly exist. Each of these effects is difficult, if not impossible, to measure, but if they did exist, they provided some explanation why the program should continue to exist despite its lack of denials. The authors closed with an argument for a capital expenditure limit – recommending that financial boundaries be established to limit the dollars and, by extension, the number of certificate-of-need proposals that could be approved in a given timeframe through application of a replicable priority setting process.[119]

As this Essay was going to print, Women & Infants Hospital was presenting the Department of Health with the largest capital expenditure proposal in the history of certificate-of-need to that point in time. On January 1, 1982, the Hospital had submitted an application to relocate and construct a replacement facility on the campus of the Rhode Island Hospital – a proposal to which Roger Williams Hospital objected.[120] Six years before, in the context of an earlier certificate-of-need approval to renovate its then existing physical plant, the Health Services Council had expressed its opinion that Women & Infants Hospital should affiliate with a general hospital and should not invest further in its existing facility.[121]

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117. *Id.*
118. *Id.*
119. *Id.* at 181.
120. A major focus of the application was whether the hospital should renovate at its existing location and affiliate with Roger Williams Hospital or whether it should relocate to the Rhode Island Hospital campus and affiliate with that institution.
121. "As a final consideration, it is a finding of the Committee that completion of this final phase of renovation constitutes the conclusion of capital development proposals at the existing physical plant of the Women & Infants Hospital. Accordingly, any proposal to undertake additional capital programs within the existing physical plant beyond that already initiated or herein authorized, other [sic] that for relief of a documented emergency

During the 1982 review, the Department of Health asked the State Auditor General to conduct a comparison of the two options for relocation/affiliation.[122] After review of the application, the Health Services Council favored the move to the Rhode Island Hospital campus, but found Women & Infants' proposed method of financing to be too expensive.[123] It therefore recommended denial of the application without prejudice to the presentation of a modification to the proposed method of financing.[124] The Director of Health adopted the Council's recommendation on December 23, 1982.[125] Within a three-month timeframe, the Hospital requested reconsideration, was denied, and requested an adjudicative public hearing.[126] This was continued pending action on the Hospital's concurrent request for remand to the Health Department on the basis of new, "'significant relevant information not previously considered by the [state agency].'"[127] On March 29, 1983, "the adjudication officer remanded the application to the state agency 'for consideration of the new information set forth in [the Remand Order].'"[128] This new information was considered at four separate

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situation, will be viewed by the Health Services Council as unwarranted from the community perspective considering the scarcity of capital resources and the limited useful life attendant upon any future [development]." RHODE ISLAND HEALTH SERVS. COUNCIL, REPORT ON WOMAN & INFANTS HOSP. PROPOSAL (Jan. 12, 1977) (on file with author).

122. *See generally* R.I. DEP'T OF HEALTH, AMENDED RECOMMENDATION OF THE HEALTH SERVS. COUNCIL ON THE WOMEN & INFANTS HOSP. PROPOSAL FOR AFFILIATION AND RELOCATION (1983) (on file with author).

123. *Id.*

124. *Id.*

125. *Id.*

126. *Id.*

127. *Id.* at 2.

128. *Id.* at 3. The relevant portions of the remand points are set forth as follows:

> (1) WIH has, together with those other hospitals in Rhode Island having obstetric services, begun to assume a leadership role in the integrated planning of perinatal care services throughout Rhode Island. The intent of the hospitals' efforts, spearheaded by WIH, is to establish appropriate roles and responsibilities among the region's hospitals in the context of a regional perinatal system. At the hospitals' meeting on February 22, 1983, ... WIH was identified as the tertiary perinatal center for the State of Rhode Island. Also at the meeting, consensus was reached that a regional approach to perinatal referrals within the State of Rhode Island should be developed immediately. The Chairman of the Perinatal Committee of

the Medical Society volunteered to draft a referral plan. That task is in process, and additional meetings of the participating hospitals are planned. WIH's efforts in furtherance of regional perinatal planning underscore the Hospital's previously stated commitment to the regional planning process and to the quality of care and cost benefits attendant thereto. WIH requests specific state authorization to continue with its planning efforts.

(2) WIH will not, at this time, seek the 3 bassinet increase in its Neonatal Intensive Care Unit capacity it had requested in its CON application.

(3) WIH has resolved . . . to establish a modern "alternative birthing center" within its proposed facility design and/or proximate to the WIH. Implementation will commence at the earliest possible time based on the results of a study now in process, provided that adequate third-party reimbursement can be assured.

(4) The Hospital has recently reaffirmed its commitment to early maternity discharge and follow-up home health care. It is hoped that these two programs, coupled with the implementation of an alternative birthing center, will reduce the demand on the Hospital's obstetrics service and thereby enable the Hospital to reduce its obstetrical bed complement by as many as five beds. On this basis, the Hospital hereby proposes to reduce the obstetrical bed component of its proposed facility by five beds, thereby emphasizing its support of regional obstetrical services, statewide bed reduction efforts, and cost containment goals.

(5) Insofar as is otherwise financially prudent and feasible, given the "Murray Plan" constraints (including those regarding future capital budgeting by the applicant), WIH will . . . set aside one-half million dollars of existing endowment plus 50% of any monies raised net of expenses in excess of five million dollars ($5,000,000) through its capital funds drive, the future income of which is to be utilized for the provision of primary prevention services to low income residents of WIH's proposed service area.

(6) Through additional refinements to its project plans, the Hospital is seeking, and hereby commits, to reallocate space and reduce square footage to achieve a reduction in the size of its proposed project equivalent to 10,000 gross square feet -- at an average cost of $125 per square foot -- or $1.25 million (average cost as identified in the Lammers and Gershon Study). The project cost, estimated in June, 1982 as $34 million is now, as a result of project inflation during an estimated eight month construction delay, increased to $36,909,999. The reduction of $1.25 million from this cost will result in a total project construction cost of $35.7 million, provided, however, that if an alternative birthing center is incorporated into the proposed facility, the cost of that facility would have to be adjusted accordingly.

(7) WIH is now committed to additional annual operating savings at its new facility of $250,000, or a total of $750,000, such saving to be accomplished through further reductions in FTE's and other

services, and to become effective in accordance with and pursuant to the financial plan agreed upon with the third-party payors. The savings are a product of recently completed discussions with Blue Cross concerning the so-called "Murray Plan."

(8) Blue Cross/Blue Shield of Rhode Island, the primary payor for WIH's patient population, has endorsed the "Murray Plan" for financing of the proposed project, specifically stating that the plan is financially feasible. Blue Cross' recent endorsement of the Model as a viable financing mechanism for this project paves the way for an effective "bond life" cost savings, when compared to conventional financing, of approximately $53.5 million for the project -- representing a reduction in financing costs from more than $83 million to approximately $29.5 million.

(9) WIH has resolved . . . to join with Rhode Island Hospital (hereinafter "RIH") to study and seek to refine future capital development plans for the RIH campus as they relate to activities involving maternal and child health care. This commitment to joint planning on the RIH campus serves as an additional illustration of WIH'S efforts to minimize potentially unnecessary and costly duplications on the RIH campus and to maximize the integration of WIH and RIH perinatal services.

(10) In an attempt to create the single, unified organizational structure proposed by the Health Services Council in its report, the Hospital commits to the following program planning as part of its affiliation structure at the RIH campus. This joint planning will result in present and future program integrations to reduce program duplication now and in the future. This approach encompasses the following:

(A) The Trustee Affiliation Committee (TAC) of Women & Infants Hospital (WIH) and Rhode Island Hospital (RIH) shall be a signatory on all joint WIH-RIH certificate of need (CON) applications. Each WIH-CON application shall be accompanied by a written recommendation from the TAC as to approval or disapproval of the application.

(B) The board of trustees of each hospital shall be a signatory on joint WIH-RIH submissions of short and long range plans (SLPs) to the Department henceforth. All WIH submissions of SLPs to the Department shall be accompanied by a written recommendation from the TAC as to approval or disapproval of each of the short and long range plans (Proposed Institutional Programs-PIPs). Said recommendation shall explicitly identify any plan (PIP) of which the TAC does not approve.

(C) The TAC shall review and make written recommendations as to approval or disapproval of the annual capital budgets and new program budgets of WIH.

(D) In accordance with their Trustee Affiliation Agreement, Women & Infants Hospital and Rhode Island Hospital plan to have single clinical chiefs for the departments of OB/GYN,

meetings over the course of the succeeding six weeks, at the last of which the Hospital requested the Health Services Council to accept the eleven points of the remand petition as an amendment to the application.[129] The Council did so on May 17, 1983, and its action was adopted by the Director of Health on May 20, 1983.[130]

In its initial consideration of the Hospital's application, the Health Services Council had been troubled by a number of issues, including: (1) a failure of other hospitals providing obstetrics care to designate Women & Infants as the only tertiary facility in the state; (2) failure of the Hospital to pay sufficient attention to shortening the length of stay for obstetrics patients; (3) failure of the Hospital to consider alternative birthing centers; (4) insufficient integration with Rhode Island Hospital to achieve meaningful economies; (5) failure of the Hospital to emphasize prevention; (6) lack of a master plan for development of the Rhode Island Hospital campus; (7) excessive obstetrics and neonatal intensive care space; (8) lack of compatibility with recommendations of the Auditor General; and (9) excessive

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> Medicine, Psychiatry and Surgery. In addition, the WIH/RIH Trustee Affiliation Agreement provides for joint planning in those departments that do not have a single chief. Those departments---namely, Pediatrics, Radiology, Pathology and Anesthesia -- reflect unique and distinctly separate foci and resource needs in the two hospitals due to Women & Infants Hospital's primarily perinatal focus. The TAC shall, nevertheless, make provision for these departments to conduct joint program planning through the auspices of a standing subcommittee of the affiliation Review Committee.
>
> (11) WIH agrees, beginning in the fourth year of occupancy of its proposed facility, to conduct a feasibility study with respect to the establishment of a new and separate corporate entity for the purpose of planning future capital development on the RIH campus. The study shall address, among other things, an examination and analysis of the operating and administrative experience of the project as well as current financial, legal and other related aspects of the project. The results of such study shall be disseminated to the Department. *Id.* at A-1 to A-8.
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> Of course, points nine through eleven were effectively rendered moot when in 1997 Woman & Infants Hospital joined Care New England, the rival health system to Lifespan, with which Rhode Island Hospital had affiliated in 1994.

129. *Id.* at 4.

130. *Id.* at 5.

interest cost associated with the proposed method of financing.[131]

The move to the Rhode Island Hospital campus was eventually favored over the proposal to remain in place and affiliate with Roger Williams Hospital for several reasons: (1) the life-cycle cost of a new facility under the "Murray" financing plan was only slightly more than renovating and updating Women & Infants' existing facility; (2) the latter proposal would only have a useful life of ten to fifteen years in comparison to thirty years for a new facility; (3) Rhode Island Hospital had services and facilities which would require development by any other hospital with which Women & Infants might contemplate affiliating; (4) on a practical level, Women & Infants had insufficient access to capital to fund its own renovation, and potential affiliation partners other than Rhode Island Hospital were only able to raise capital for their own needs.[132] Finally, architectural consultants engaged by the Department of Health found the Women & Infants' existing facility to be functionally obsolete and deserving of abandonment.[133]

Although the path to this conclusion was particularly tortuous because of both the need to modify the application, rather than merely fashion conditions, and the effort to over-document the record in order to stave off further court proceedings, the Women & Infants 1983 decision was a precursor to the detailed conditional approval process that was ushered in some twenty years later with yet another Women & Infants application and that continues to date. While some saw the failure to deny the application outright as a missed savings opportunity, adoption of the modified financing plan was in itself associated with significant savings over virtually any other practical alternative considered.

The original proposal would have increased Blue Cross premium rates by 1.67%.[134] A minimum renovation would have increased Blue Cross premium rates by .29%.[135] The modified proposal would increase Blue Cross premium rates by .75%, an incremental increase of only .46% above a minimum

131. *See generally id.*
132. *See generally id.*
133. *See generally id.*
134. *See generally id.*
135. *See generally id.*

renovation.[136] This review underscored the minimal cost containment impact of capital expenditure review that had been first discussed in 1976.[137] This had been a massive capital expenditure program by Rhode Island certificate-of-need standards. Yet, its cost impact at its worst was barely 1.5% in Blue Cross premiums or $15 on every $1,000.[138] Such a modest cost to replace an entire hospital provides some indication of the relative insignificance of new capital cost control to the overall cost of health care services in general, and of hospital services in particular. Nevertheless, the scope of this proposal was no small factor in launching the next major phase of the certificate-of-need process: that associated with the "CONCAP" years.[139]

In the 1982 session, the General Assembly enacted a Joint Resolution Creating a Special Legislative Commission to Study Health Care Capital Expenditures.[140] Chaired by the chairman of the House Committee on Health, Education and Welfare, Representative Anthony J. Carcieri, the Commission sought to integrate the certificate-of-need process with that of the prospective reimbursement process – a goal that had actually been articulated by HARI representatives in 1979.[141] But, the genesis of the concept actually stemmed from an April 29, 1977 letter from Fred Burdett, Chief of Medical Care Standards, the division within state government that was responsible for the certificate-of-need process, to Paul Carvisiglia, Executive Director of the voluntary Health Planning Council.[142]

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136. *See generally id.*

137. *See generally id.*

138. *See generally id.*

139. The CONCAP was the maximum annual aggregate increase in interest and depreciation costs determined by negotiation among the state budget office, Blue Cross of Rhode Island and HARI. All certificate-of-need approvals for a given year had to fit within this negotiated ceiling.

140. 1982 R.I. Acts & Resolves 359.

141. *See generally* R.I. DEP'T OF HEALTH, AMENDED RECOMMENDATION OF THE HEALTH SERVS. COUNCIL ON THE WOMEN & INFANTS HOSP. PROPOSAL FOR AFFILIATION AND RELOCATION (1983) (on file with author).

142. Letter from Fred Burdett, Chief, Medical Care Standards, R.I. Dep't of Health, to Paul Carvisiglia, Exec. Dir., R.I. Health Planning Council, Inc. (Apr. 29, 1977) (on file with author). The letter advised Mr. Carvisiglia that the Health Services Council ("HSC") had adopted a policy three days earlier that stipulated that actions taken by the HSC after May 1, 1977, would take into account the aggregate of proposals before the Council in order to determine the availability of resources. *Id.* The mechanism was to "involve

While the Commission was meeting, the General Assembly was not standing still. In 1982, clinical laboratories were inadvertently reintroduced as covered entities,[143] but neighborhood health centers were eliminated from coverage by the certificate-of-need program.[144] In 1983, facilities providing hospice care were added.[145]

In 1984, neighborhood health centers were restored in one piece of legislation,[146] but more importantly, the Health Care System Affordability Act of 1984 was enacted.[147] In addition to again eliminating clinical laboratories from the scope of certificate-of-need, this amendment provided for short-lived coverage of program expansions,[148] introduced the concept of the cost impact analysis and of affordability, reduced the number of annual application filings from two to one, and established the "CONCAP" priority setting process.[149] The law also linked the

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the establishment of an appropriate level of annual investment in capital assets and the ranking of all proposals identified as implementation Category I in the long and short range plans submitted by hospitals in terms of their priority within the capital resource constraints established." *Id.*

Noting that this was merely a verbal affirmation of an effort the HSC had advocated for a considerable period, Mr. Burdett also represented that he had been asked by the HSC to "convene a meeting of interested and affected agencies in order to discuss the feasibility of approximating an annual level of capital investment or alternatively of establishing a maximum percentage increment for capital expenditures within the framework of an overall maximum percentage increment in total hospital expenditures." *Id.*

This concept is virtually indistinguishable from the "CONCAP" that was to emerge from the Carcieri Commission's deliberations from 1982 through early January 1984.

143. 1982 R.I. Pub. Laws 958.

144. *Id.* at 1862, 1864.

145. 1983 R.I. Pub. Laws 339, 340.

146. 1984 R.I. Pub. Laws 744, 746.

147. Health Care System Affordability Act of 1984, ch. 4, 1984 R.I. Pub. Laws 7. The intent of the legislation was set forth in the preamble. "Now, therefore, the general assembly, in furtherance of the public interest, requires that health care program coordination among health care planning, certificate of need review and provider reimbursement systems be improved and that said three programs include consideration of affordability by the people of the state." *Id.*

148. *Id.* at 9 (amending R.I. GEN. LAWS § 23-15-2(j) by adding subsection (6): "Major expansion of an existing program which increases operating expenditures in a health care facility by one hundred fifty thousand dollars ($150,000) or more within one (1) year.").

149. Health Care System Affordability Act of 1984, ch. 4, 1984 R.I. Pub. Laws 12, amending R.I. GEN. LAWS § 23-15-4 by adding Section (e) thereto,

certificate-of-need and reimbursement processes in a manner nearly diametrically opposed to that which had been advanced in the General Assembly battle of 1977.[150]

To further assure alignment of these processes, certain health services council appointments were specifically assigned to representatives of Blue Cross, Medicaid, the state budget office

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the relevant language of which provided:

> . . . [T]he health services council shall evaluate each proposal for which a determination of need has been established in relation to other such proposals, comparing proposals with each other, whether similar or not establishing priorities among the proposals for which need has been determined and taking into consideration the criteria and standards relating to relative need and affordability as set forth . . . herein.

R.I. GEN. LAWS § 23-15-6 was also extensively amended by adding sections (f), (g), (h) and (i) thereto. *See* Health Care System Affordability Act of 1984, ch. 4, 1984 R.I. Pub. Laws 13. These sections imposed an obligation on the state budget office and Blue Cross of Rhode Island to file cost impact analyses with the health services council that would address increases in operating expenses, per diem rates, health care insurance premiums and public expenditures as well as acceptability of interest rates and minimum equity contributions/maximum debt. *See* Health Care System Affordability Act of 1984, at 13.

The CONCAP itself was the "maximum aggregate increase in interest and depreciation costs associated with implementation of needed proposals which can be afforded." *See id.* at 16. The performance of the state's economy was to be one guideline in establishing the CONCAP and other hospital operating expenses were to be another guideline. *Id.* at 16-17. It was a number on which the State, Blue Cross and the hospitals, through HARI, had to reach agreement (through mediation and arbitration, if necessary) by not later than 270 days after initiation of the application process. *Id.* at 16. If the parties failed to do so, no hospital project submitted in the review cycle could be approved. *Id.*

The health services council's determination of affordability required it to consider the condition of the state's economy, the statements of parties affected by the proposals, and, in particular, for hospital proposals, whether approval of a hospital proposal with a low priority ranking would cause the maximum increase is interest and depreciation costs to be exceeded. *Id.* at 16-17. The council's determination remained independent in that it was free to deem a hospital proposal with a low rank unaffordable notwithstanding the fact that the CONCAP limit may not have been exceeded.

150. *Id.* at 13 (amending R.I. GEN. LAWS § 23-15-4 (h) by adding the following language: "Government agencies and hospital and medical service corporations organized under the laws of the state shall during budget negotiations hold health care facilities and health care providers accountable to operating efficiencies claimed or projected in proposals which receive the approval of the state agency in accordance with this chapter.").

and the hospitals.[151]

Cost containment was the backdrop of the Health Care System Affordability Act of 1984,[152] and the value of certificate-of-need on the basis of cost containment or other claims played itself out in various publications both before and after the 1984 law's enactment.

III. COST CONTAINMENT OR NOT?

The memorandum circulated to the General Assembly in May of 1976 had been the only serious attempt to discuss the actual cost containment experience of the pre-existing program during the four years of legislative debate that accompanied the attempt to enact a NHPRDA-compliant certificate-of-need law. The statistics in that analysis supported the Department's position that the capital expenditures avoided had been minimal in comparison with the operating costs of the collective hospitals, and that cost containment was unlikely to be achieved through control of capital expenditures alone.[153] By 1977, program review seemed to be a permanent feature of each legislative package, and cost containment appears to have been simply taken for granted as a side effect of a complete program that would cover both new capital expenditures and new programs that promised to substantially increase operating expenses.

As if to lend further credence to that argument, four years later, in 1980, agency staff attempted to replicate the methodology employed in a 1979 study of the Massachusetts certificate-of-need program that concluded that the benefits of that program were outweighed by its costs.[154] The Massachusetts study had measured costs for: (1) application preparation, (2) application fees, (3) costs of state government, (4) costs of health systems agencies, and (5) inflation.[155] Against these costs, the

151. 1984 R.I. Pub. Laws 17.

152. *See* Health Care System Affordability Act of 1984, ch. 4, 1984 R.I. Pub. Laws 13.

153. R.I. DEP'T HEALTH, FACT SHEET: THE NEED FOR HEALTH RESOURCE REGULATION, 76-H 7797, 1976 Sess. (1976) (on file with author).

154. *See generally* HARBRIDGE HOUSE, INC., AN INQUIRY INTO THE COSTS AND BENEFITS OF THE MASSACHUSETTS DETERMINATION OF NEED PROGRAM (1979).

155. *See id.*

Massachusetts study offset savings in capital costs from projects denied and concluded that costs outstripped benefits.[156]

Rhode Island's agency staff found these measures to have been too limiting, adding to them four additional categories: (1) projects withdrawn, (2) project modifications, (3) operating cost avoidance, and (4) interest cost savings.[157] In contrast with the Massachusetts study, the Rhode Island analysis calculated the measurable benefits of Rhode Island's program for its first eight years to have outweighed its costs by nearly (over atwenty year period) $250 million when operating cost savings were considered.[158] Restricting the measure of savings to only capital cost savings reduced that figure to $27 million, but it remained positive.[159] Thus, by expanding the criteria beyond simple project denials, the Department felt that it had identified a truer measure of the cost avoidance value of the program.[160]

This was expanded upon in an early 1982 response to a request for information from the American Health Planning Association.[161] Three positive effects of certificate-of-need were identified in that letter. The first was the Department's evidence of a deterrent effect based on its analysis that the supply of physicians was a good predictor of the supply of hospital beds between 1954 and 1971 (R = .89).[162] Analysis of the post-certificate-of-need period (1971 – 1980) "show[ed] a weak, but negative, relationship (R = -.33)."[163] According to the Department's analysis, "[h]ad the trend of 1954–1971 continued through the [1970s,] there would have been 300-600 more hospital beds in Rhode Island."[164]

The second argument for some measure of effectiveness of certificate-of-need was derived from the Department's analysis of

156. *Id.*
157. *See* R.I. DEP'T OF HEALTH, DIVISION OF MEDICAL CARE STANDARDS, COSTS AND BENEFITS OF CERTIFICATE OF NEED IN RHODE ISLAND 3 (1980) (on file with author).
158. *See id.* at 3-5.
159. *See id.* at 5.
160. *See id.* at 3-5.
161. Letter from John T. Tierney, Deputy Director of R.I. Dep't of Health, to Harry P. Cain II, Ph.D., Executive Dir. American Health Planning Ass'n (Feb. 4, 1982) (on file with author).
162. *Id.*
163. *Id.*
164. *Id.*

the program's performance in conducting hospital reviews from May 20, 1971, to February 1, 1982.[165] During that time period, the program "reviewed 79 hospital proposals having over $175 million in capital costs and over $30 million in associated annual operating costs."[166] As a result of project denials, withdrawals or modifications, the Department claimed $30 million in capital cost savings and over $12 million in related operating cost savings.[167]

Finally, in a real leap of faith, the Department identified long- and short-range plan estimates for hospitals in 1981 through 1983 of nearly $77 million.[168] Since annual total capital expenditures for hospitals had averaged $15-$20 million in the years prior to 1981, the Department suggested that, in the absence of certificate-of-need, hospital capital expenditures could nearly double.[169]

Less than four months later, a couple of these points were incorporated in the Department's first published defense of the certificate-of-need program, but that defense actually emphasized cost containment less and subjective benefits more.[170]

It was not until 1986 that an outside criticism of the cost containment failures of the Rhode Island program was published.[171] In this report, the author criticized the Department's analyses of the early 1980's,[172] the conclusions of which had been largely based on early experiences characterized by short review times and comparably favorable review flexibility (e.g. no application format, no filing time frame, relatively small delay related inflation costs). The author then used newer data from 1980 to 1985 to demonstrate that, with few exceptions, hospital proposals were approved[173] while the very result the planners had feared in 1978 had occurred – non-hospital health

165. *Id.*
166. *Id.*
167. *Id.*
168. *Id.*
169. *Id.*
170. *See generally* Tierney, *supra* note 108.
171. *See generally,* Joseph M. Chazan, M.D., *Certificate of Need: A Concept Whose Time Has Passed*, 69 RHODE ISLAND MED. J. 273 (June 1986).
172. *Id.* at 273-74.
173. *Id.* Of fifty-one hospital proposals reviewed from 1980 to 1985, forty-eight were approved with capital costs of $122 million and only three were denied with capital costs barely exceeding $3 million. *Id.* at 273.

care facilities were subject to a significant denial rate.[174] The author also elaborated upon something that had never been discussed in the earlier studies – the overstated nature of apparent cost modifications and reductions attributed to the program.[175] The author concluded that alternatives to hospital care (e.g. outpatient surgical centers, dialysis centers, and emergency rooms) should not be regulated and that even hospital proposals that are not reimbursed on a charge or cost basis should be unregulated since they are routinely approved anyway.[176]

It took nearly one year, but the Department of Health responded to the 1986 publication with one of its own in the same journal.[177] The analysis largely reiterated the subjective benefits the Department had advanced in its 1982 publication, but in a more detailed manner. The authors again referred to the deterrent effect and argued that certificate-of-need had prevented the unnecessary duplication of expensive capital expenditures.[178] The authors specifically highlighted in their analysis "that roughly 33 per cent [sic] of the capital costs of CON applications acted upon during the period 1971-1986 were not accepted, withdrawn, modified, or denied."[179] They also used as corroboration that Rhode Island had a relatively modest hospital bed supply of 3.7 acute-care community-hospital beds per 1000 population versus 4.4 for the United States.[180] However, in the case of the former, it was a partial truth and, in the case of the latter, it was irrelevant. The 33% figure was derived by combining hospital and all other health care facility proposals.[181]

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174. *Id.* at 275. Of sixty-three non-hospital proposals reviewed over the same time frame, eighteen were denied or withdrawn, with thirteen of the eighteen representing proposals by proprietary facilities to establish alternatives to institutional care. *Id.*

175. *Id.* at 274. ("The reviewers, in order to satisfy the federal government's need to document savings, demonstrate that they are in fact 'reducing' the project and 'saving' dollars. Thus, applicants who expect proposals to be revised downward during the review process inflate their original proposals to enable the state agency to claim savings.").

176. *Id.* at 274-75.

177. *See generally* H. Denman Scott, M.D., M.P.H., et al., *Certificate of Need: A State Perspective,* 70 RHODE ISLAND MED. J. 341 (Aug. 1987).

178. *See id.* at 342.

179. *Id.*

180. *Id.*

181. *Id.*

The actual figure for hospitals was much more modest. Hospital projects totaling only 1% of the capital costs of all hospital projects submitted during the fifteen-year period were not accepted, 9% were withdrawn, 3.5% were denied, and 6% were modified.[182] As such, only 20% of the capital costs of hospital projects were affected, totaling only $68.1 million in capital costs over a fifteen-year period.[183] For non-hospital projects, the results were startlingly more negative. Twenty percent of the capital dollars submitted by non-hospitals were not accepted.[184] Nearly 19% were withdrawn and another 13% were denied.[185] The only category that fared better for non-hospital projects was that of modifications – representing only 5% of the capital costs submitted.[186] Thus, the authors' data supported Dr. Chazan's criticism of the year before.[187] Nearly 60% of the non-hospital capital projects were affected by certificate-of-need, but only 20% of hospital projects were so affected.[188] As to the supply of beds per 1000 population, that had actually been lower and below national averages during the last pre-certificate-of-need year of 1967 when a population of 949,723 was supported by 3117 hospital beds for a ratio of 3.28 beds per 1000 population.[189] Apparently aware of the disingenuous nature of their arguments, the authors obliquely alluded to the protectionist aspects of certificate-of-need in advancing, as a positive, the argument that certificate-of-need minimized or prevented market-generated failures, closures and dislocations, and thereby facilitated a "stable and fairly predictable environment" for the management of health facilities.[190]

In fairness, the authors did point to downsides of the program.[191] They alluded to the potential for bureaucratic delays and of stifling innovation.[192] They noted the risk that certificate-

182. *Id.*
183. *Id.*
184. *Id.*
185. *Id.*
186. *Id.*
187. *See* Chazan, *supra* note 171, at 273-74.
188. Scott, et al., *supra* note 177, at 342.
189. *Id.*
190. *See id.* at 343.
191. *See id.*
192. *See id.*

of-need would respond "too conservatively to new ideas."[193] The authors even noted that well-established providers could use the process to block the entrance of legitimate competitors into the market, maintain the "status quo," and thereby protect inefficient, outdated and weak providers.[194]

While recognizing the very same pitfalls that seemed to be suggested by Dr. Chazan's earlier criticism, the authors continued to view the 1985 legislative changes as positive, including the passage of the CONCAP legislation, the addition of the request for proposals (RFP) feature and pro-innovation criterion to the certificate-of-need process, and the increase in the capital expenditure thresholds.[195]

The authors then argued for further adaptive changes to assure that certificate-of-need would serve the public interest rather than the providers that were to be the subject of its regulations.[196] They proposed the concept of review of advanced medical technology services regardless of cost, exemption of non-clinical programs from review, and accelerated review of non-controversial proposals (all of which came to be enacted by 1991) and recommended two changes which were never implemented – subjecting non-hospital proposals to the CONCAP and setting the CONCAP for a three to five year period.[197] (Either of these steps may have extended the life of CONCAP in Rhode Island). In closing, the authors argued that certificate-of-need was required to aid in health care cost control, notwithstanding the fact that health care spending had been accelerating since 1980 and that even had there been a complete moratorium on approval of the capital expenditures that had been submitted for review by hospitals from 1971-1986, the impact on annual operating costs would have paled by comparison with the increases associated with the maintenance of the operating systems for Rhode Island's hospitals taken in the aggregate.[198] While the Department emphasized aspects other than cost containment in its defense of the program, the thrust of its argument continued to be that

193. *Id.*
194. *Id.*
195. *See id.* at 343-44.
196. *See id.*
197. *See id.* at 344.
198. *See id.*

certificate-of-need had more than incidental effects on cost in these early years of the CONCAP phase. The Department's retort invited one final rebuttal in December of 1987.[199]

In particular, the Department's citation of the 1984 CONCAP law as major innovation to the process was subjected to pointed criticism.[200] The CONCAP, by combining all programs into one dollar package, forces the choice between equally good, but unrelated, programs comparing apples with oranges. In a given year, worthwhile projects may exceed or fall short of the CAP, thus potentially excluding worthy projects or including less needed ones.

All of these analyses were complicated by the concurrent existence of the prospective rating agreement among Rhode Island's hospitals acting through the Hospital Association of Rhode Island, Blue Cross of Rhode Island and the State Budget Office. An experiment begun in 1976 involving the Medicare program, prospective rating continued without Medicare after 1978, and was widely regarded as the primary factor in restraining hospital costs in Rhode Island through the early 1990s. In fact, the prospective rating program was so highly regarded that one of its major elements, the MAXICAP, was adapted through the CONCAP as a modification to the state's certificate-of-need program.

The CONCAP decade probably represented the sole period during the history of CON where some evidence of non-incidental cost containment seemed to emerge from the data. As noted earlier, the CONCAP limit was determined in annual negotiations among hospitals, Blue Cross, and the State Medicaid program.[201] If the parties were unable to reach agreement, the CONCAP was determined by an outside arbitrator.[202] The 1985 CONCAP did not really provide a test of the new law because of the relatively small number of projects and capital dollars proposed by hospitals.[203] In 1986, however, the parties were unable to negotiate the CONCAP amount and an out-of-state arbitrator

199. Joseph A. Chazan, *More on Certificate of Need,* 70 RHODE ISLAND MED. J. 531, 531-32 (1987).
200. *Id.* at 532.
201. *See supra* note 149 and accompanying text.
202. *See id.*
203. *See id.*

determined the final CONCAP threshold, supporting the third parties' position of $1.7 million, roughly one-half the amount that had been spent historically. Although all "needed" projects were ultimately approved, in part by contributing more equity and reducing interest expense, HARI was deeply troubled by the absolute cost containment potential of the CONCAP process and, in turn, published a white paper setting forth its arguments in March 1987. While reiterating its long standing support for a statewide voluntary health planning program and for continuation of certificate-of-need review, HARI, nevertheless, provided an overview of hospital capital spending in Rhode Island to disprove the assumption underlying the passage of CONCAP legislation – that hospital capital spending in Rhode Island had been excessive. HARI also set forth the major problems it saw with the CONCAP program as it was enacted and provided recommendations for change to the CON program that it believed would obviate the need for continuation of the CONCAP.

HARI felt that it had lost influence within the state planning process and that its members had become subject to a project ranking process that was, if not irrational, at least not replicable in the scientific sense. It had fought against the idea of an annual CONCAP during the proceedings of the Carcieri Commission and although the Commission continued to study the issue and the Department of Health seemed supportive of a multiyear CONCAP, the influence of Representative Carcieri, a Health Services Council member, within the General Assembly stymied efforts to make any significant changes to the CONCAP process. This 1987 report was the first volley in the almost constant attacks by HARI on the CONCAP process during the period of its existence. These attacks recurred notwithstanding the fact that over the next several years, the CONCAP was successfully negotiated each year and low-ranked hospital projects managed to secure approval by shaving debt or reducing project costs. The HARI concerns were not without effect as the CONCAP process underwent further tinkering as a result of legislative amendments in 1987,[204] 1988[205] and 1991.[206] One could argue that costs had

204. 1987 R.I. Pub. Laws 759 (shortening the time frame within which CONCAP agreements must be reached from 270 days to 150 days after initiation of health services council review).

205. 1988 R.I. Pub. Laws 470 (providing an exemption from CONCAP

been contained during this period, but the containment was largely symbolic, for many of the reasons articulated by the Department staff in 1976.[207] In fact, there was only one other failure of the parties to agree to a CONCAP after 1986 and that occurred in 1992. This time the hospitals succeeded in arbitration. But the hospitals kept the pressure on and the CONCAP provisions were finally repealed in 1994.

Whether significant cost containment was actually achieved during the CONCAP years is largely irrelevant. The perception of the hospitals was that their capital expenditures were being unfairly and discriminatorily targeted. While the real impact on costs was relatively modest, the fact that proposed new costs of hospitals were subject to a more rigorous review than either existing costs of hospitals or proposed new costs of non-hospitals mobilized the hospitals to protest, and the CONCAP repeal that resulted from the protest became corroborating circumstantial evidence that CON had constrained costs sufficiently to make the regulated parties object.

IV. NON-CONCAP EVENTS POST 1984

CONCAP was not the only development in the period from 1984 on. In 1985, even before the CONCAP law's first major test, another set of amendments enabled the Department to achieve a balance it had felt it lacked by introducing a criterion to favor innovative projects and by giving the Department the authority to achieve a degree of proactivity through an RFP process. The Department attempted to combine the two shortly thereafter through the issuance of an RFP for the provision of MRI services.[208] To the Department's surprise, it found itself awarding the certificate-of-need grant to a non-profit entity of which all the

provisions if the annualized expense for depreciation and interest associated with all hospital capital projects included in a cycle is "four tenths of one percent (.4%) or less of the aggregate total operating expense" of hospitals during the preceding fiscal year).

206. *See generally* 1991 R.I. Pub. Laws 1030 (shortening and repositioning of CONCAP negotiating process relative to start of certificate-of-need review cycle).

207. R.I. DEP'T HEALTH, FACT SHEET: THE NEED FOR HEALTH RESOURCE REGULATION, 76-H 7797, 1976 Sess. (1976) (on file with author).

208. *See generally* R.I. DEP'T OF HEALTH, REQUESTS FOR PROPOSALS FOR THE MAGNETIC RESONANCE IMAGING SERVICES (1986) (on file with author).

hospitals were members, which controlled the dissemination of MRI services for a number of years and limited it to services provided through the hospital network (RIMRIN).

In 1986, the various monetary thresholds were increased over a three-year period, ending in 1988, to $600,000 for capital expenditures, $250,000 for new services and $400,000 for health care equipment. More importantly, the twenty-one month experiment with coverage of expanded programs was terminated as of June 27, 1986.

By 1987, the history of federal funding of capital expenditure review had ended with the repeal of NHPRDA,[209] and the state was now modifying the law to accommodate its own interests rather than those of the Federal government. As an illustration, the legislative amendment of 1991 represented a significant overhaul of the process. In addition to eliminating coverage of outpatient rehabilitation, and increasing review thresholds, the law exempted non-clinical expenditures, research, and bond issues from review, introduced review of new or expanded tertiary services regardless of capital or operating costs, as well as accelerated review for one-for-one equipment replacement.[210] It also reduced the review period from 210 days to 120 days.[211] This legislative enactment sought to focus the Department's attention on more important projects and, in fact, new or expanded tertiary services became an ever-increasing focus of the Department over the next decade and a half, to the extent that now it is one of the cornerstones of the existing program.

The year 1996 was another watershed year. A New Director of Health had arrived the preceding year from Colorado[212] – a state that had shed its certificate-of-need program after the repeal of NHPRDA without appreciable adverse effect on health care costs.[213] The Department mounted a serious effort to repeal

209. *See supra* note 4 and accompanying text.

210. *See* 1991 R.I. Pub. Laws ch. 290.

211. *Id.*

212. *See* Rhode Island Cancer Council, Inc., Members, http://www.ricancercouncil.org/about/members/Nolan.php (last visited Mar. 5, 2010).

213. *See* Vivian Ho, *Does Certificate of Need Affect Cardiac Outcomes and Costs*, THE JAMES BAKER III INST. FOR PUB. POLICY AT RICE UNIV. at 24 (July 2007), *available at* http://www.bakerinstitute.org/publications/CardiacCON1.pdf.

certificate-of-need.[214] The effort was so serious that HARI went so far as to amend the health department bill on the off chance that some such bill would pass.[215] HARI's amendment proposed to phase the certificate-of-need program out over the succeeding four-year period[216] rather than in one fell swoop upon passage as the Health Department had proposed. As it turned out, the repeal bills did not secure passage. Instead, two other bills were enacted. In the first, home health agencies were dropped from coverage despite the strenuous objections of the non-profit home health agencies which found the certificate-of-need process as it was being implemented not stringent enough, never mind a candidate for repeal.[217]

The year 1996 saw further streamlining of the certificate-of-need law with the elimination of coverage of HMOs, free-standing emergency rooms, outpatient hospice and organized ambulatory care facilities of all types, complete exemption for one-for-one equipment replacement, and further streamlining of the exemption process for non-clinical and research projects.[218] Although the law was subject to additional changes throughout the next decade, they were all in the nature of changes on the margin, rather than substantive changes of substantial import.[219]

The Governor did propose repeal of certificate-of-need again in 2003, but the hospitals did not support repeal and the effort failed again. On the heels of that failure, the Department determined that certificate-of-need was likely to survive as a

214. *See generally* 96-S-3032, Jan. 1996 Sess. (R.I. 1996) (on file with author).

215. *See generally id.*

216. *See generally id.*

217. *See generally* 1996 R.I. Pub. Laws 1674-89.

218. *See generally* 1996 R.I. Pub. Laws 2110-29.

219. *See* 2006 R.I. Pub. Laws 1892-1910 (addition of health insurance commission as affected party, elevate cost impact statements to level of consideration in determining need, restore pre-NHPRDA concept of letter of intent; change application fees; institute change for state use of experts); 2006 R.I. Pub. Laws 1975-80, 2372-77 (addition of safe patient handling as a consideration in determining need); 2004 R.I. Pub. Laws 1476-79, 1775-79 (addition of community impact, relationship to capital development plan, expansion of Health Services Council from 22 to 24 members); 1999 R.I. Pub. Laws 921-26 (a technical change to the definition of "capital assets for new health care equipment" that leveled the playing field for health care facilities and individual practitioners).

program indefinitely. Accordingly, it embarked on a two-pronged effort to achieve policy gains through the certificate-of-need process without the need for legislative change. Its first move was to enforce conditions imposed on previously issued certificate-of-need approvals. Over the period of the early 2000s, the rarity of a hospital project denial had become obvious. Whether hospitals were actually deterred from proposing projects or services for system-wide or institutional needs, or they were constrained from proposing all but absolutely necessary projects or services by the constraints of the reimbursement systems, or whether the Department's imposition of conditions eased Health Services Council member consciences in instances where the need was not readily apparent, is not easily ascertainable. Whatever the cause, the occasional denial of hospital projects that occurred during the early years of the program had now been replaced by, if anything, lengthy delays and more extensive conditions. Historically, however, those conditions, once imposed, were never routinely revisited despite the obvious opportunity to do so annually at the time of license renewal. In fact, until 2004, the only revisiting of conditions occurred when hospitals voluntarily submitted change orders or when they submitted new applications. Beginning in 2005, however, the Department made a concerted effort to correspond with holders of certificate-of-need approvals of the preceding few years and to demand compliance reports. The effort revealed that many hospitals had failed to implement or had violated conditions (whether inadvertently or consciously), which had led to a marked increase in the number of change order submissions – the purpose of which was either to seek modification of one or more previously imposed conditions or to seek deletion of conditions that had not and could not be effectuated.

The second major development at this time was the imposition of conditions that achieved Departmental public policy objectives without regard to the relevance of those conditions to the projects for which approvals were being rendered. A case in point is illustrated by the November 2005 "Report of the Committee of the Health Services Council on the Application of Women & Infants Hospital of Rhode Island for a Certificate-of-Need to Construct a Five-Story Addition and Increase the

Licensed Bed Capacity,"[220] which was adopted by the Director of Health as his decision on November 2, 2005.[221] The significance of this approval was in the breadth of its conditions. In addition to the normal regulatory conditions that apply to all approvals and the customary project specific conditions relating to capital cost limitation, minimum equity participation, incremental operating cost limitation, data accessibility, non-discriminatory service provision, and compliance with licensing regulations, the Council recommended a series of wide-ranging additional conditions and made mandatory an annual progress report on implementation of not only the project but of each condition of approval.[222]

One of the additional conditions required Women & Infants to agree to work with the Department of Human Services, RIte Care payors, and physicians in health centers, in private practice and in hospital settings to develop and implement a pilot program as an early intervention site for post-natal care of children born in the hospital's neonatal intensive care unit.[223] The hospital was required to provide expertise through that program to assure that community-based health services, including primary care, were prepared to provide care for fragile infants in their communities.[224] The hospital was further required to evaluate the program to determine whether it reduced medical expenses and improved outcomes and to make changes as appropriate to enable the program to attain those ends.[225] Given that the application had simply proposed to replace the hospital's neonatal intensive care unit, this extension of the hospital's obligation to after-care in the community was an extraordinary step for a regulatory process that had been largely reactive throughout its

220. *See* R.I. DEP'T OF HEALTH, HEALTH SERVS. COUNCIL, REPORT ON THE APPLICATION OF WOMEN & INFANTS HOSP. OF R.I. FOR A CERTIFICATE-OF-NEED TO CONSTRUCT A FIVE-STORY ADDITION AND INCREASE THE LICENSED BED CAPACITY (2005) (on file with author) [hereinafter REPORT ON WOMEN & INFANTS].

221. Letter from David R. Gifford, Director of R.I. Dep't of Health, to Constance A. Howes, President, Women & Infants Hosp. of R.I. (Nov. 2, 2005) (on file with author).

222. *See* REPORT ON WOMEN & INFANTS, *supra* note 220.

223. *Id.*

224. *Id.*

225. *Id.*

history.

The hospital was also required to address two Department-identified problems: (1) prenatal care for women at risk for premature births, and (2) unnecessary emergency room utilization.[226] The connection between the first issue and the hospital's request for additional NICU beds (i.e., with better prenatal care, the need for NICU beds would presumably be lessened) is relatively straightforward. However, the connection between the hospital's request and the difficult problem of emergency room utilization is less readily apparent. Nevertheless, the Department viewed it as a priority issue in the public policy arena and enlisted Women & Infants, as a successful applicant, to assist in the effort to attack the problem.

Thus, the hospital was required to target communities with documented high rates of pre-term births and expand its outreach, education and early prenatal care in these communities. It was also required to evaluate expanded clinic hours, review protocols for triage of patients from the emergency room to the clinics during those expanded hours, improve after-hours telephone access to clinic patients and study the feasibility of pre-payment for certain clinic patients.[227]

This robust extension of the conditional approval process beyond the four corners of the application was taken to another level less than three years later in the context of the Director of Health's April 2008 decision on Kent County Memorial Hospital's application to establish a pilot primary angioplasty program.[228] Here again, the Health Services Council, as had become its custom, had imposed two conditions that were beyond those it normally imposed on applicants – implementation of a definitive agreement with an academic medical center with cardiac surgery expertise and provision of quarterly volume and outcome information – but both were directly related to the Kent application.[229] While the Director of Health accepted the report of

226. *See generally id.*
227. *See generally id.*
228. *See* R.I. DEP'T OF HEALTH, HEALTH SERVS. COUNCIL, REPORT ON THE APPLICATION OF KENT COUNTY MEM'L HOSP. FOR A CERTIFICATE-OF-NEED TO ESTABLISH A PILOT PRIMARY ANGIOPLASTY PROGRAM (Mar. 2008) (on file with author) [hereinafter REPORT ON KENT COUNTY].
229. *See id.*

the Health Services Council and its conditions, he also added fourteen conditions.[230]

230. *See id.*; *see also* Letter from David R. Gifford, Director of R.I. Dep't of Health, to Mark E. Crevier, President and Chief Exec. Officer, Kent County Mem'l Hosp. (Apr. 2, 2008) (on file with author). The additional conditions were the following:

> . . . 9. that, prior to implementation of the proposal, the applicant will equip the EMS units serving Washington and Kent Counties (that will serve Kent Hospital for primary PCI) to obtain and transmit 12-lead EKG results to Kent Hospital's emergency department, as well as maintain this capability;
>
> 10. that, prior to implementation of the proposal, the applicant will purchase a lifepack 12 with blood pressure and pulse oximetry monitoring for the Block Island Community Health Center;
>
> 11. that, prior to implementation of the proposal, the applicant will develop standardized rapid screening and transfer protocol for persons with STEMI with South County Hospital, Westerly Hospital and execute a Memorandum of Understanding (MOU), acceptable to the Department, with each of these hospitals and provide a copy of each such MOU to the Department;
>
> 12. that, prior to the implementation of the proposal, the applicant will conduct initial training for EMS personnel in Washington and Kent counties in the use and transmission of 12-lead EKG consistent with Rhode Island Prehospital Care Protocols and Standing Orders, and, subsequent to implementation, will conduct ongoing training thereafter;
>
> 13. that the applicant will work with area EMS services to develop procedures based on transporting patients directly to PCI-capable facilities as consistent with the AHA mission Lifeline and described in the Rhode Island Prehospital Care Protocols and Standing Orders;
>
> 14. that the applicant will monitor and report to the Department, on a monthly basis for the first year of operation, door-to-balloon time for all patients with STEMI and stratified for those arriving by EMS, self-referral and transfer from another institution as well as cases that present to the emergency room while the catheterization lab is in use. Data should show number and percentage of patients achieving door-to-balloon time in time increments (e.g. <60, 61-90, 91-120, 120-150, >150 or some other increments agreed by the Department);
>
> 15. that the applicant provide primary PCI consistently on a 24/7 basis; consistently means selecting PCI as the treatment approach for all clinically indicated STEMI patients requiring reperfusion therapy;
>
> 16. that the applicant report data to a recognized national registry acceptable to the Director of Health and provide annual reports from the registry showing both the applicant's data and risk-adjusted comparative data from the database;

Of these, conditions nine and ten were particularly noteworthy. During the review process, which extended significantly beyond the normal 150 days, deficiencies in the capabilities of community EMS departments were uncovered.[231] In prior years, such deficiencies would typically have been reported to the affected communities with the expectation that those communities, through their normal policy and budgeting processes, would have addressed them. In this instance, however, Kent Hospital was charged with the responsibility to purchase, equip, and maintain twelve lead EKG units for all twenty-three EMS agencies serving Washington and Kent counties.[232] Kent

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17. that the applicant shall perform at least 36 primary angioplasties per year and each physician at least 11 primary angioplasties per year (and demonstrate that each physician perform at least 75 total angioplasties per year) or at least the minimum number as may be developed in the regulations;

18. that, prior to the implementation, the applicant develop a plan to provide reports and findings of diagnostic cardiac catheterization and primary angioplasty procedures in electronic form to Rhode Island hospitals performing open heart surgery or angioplasty, referral hospital in Kent and Washington counties and, where feasible, to primary care physicians, when such reports and findings are requested by a facility or a provider in connection with a patient's care;

19. that the applicant implement the proposal, as approved;

20. that, prior to implementation, the applicant submit to the Department within sixty (60) calendar days of approval a written plan with timetables designed to demonstrate compliance with the conditions set forth herein;

21. that the applicant shall notify the Department within seven (7) calendar days of learning it is out of the compliance with any of the conditions of approval; and

22. that failure of the applicant to comply with these conditions of approval and any other requirements, including regulatory, as may be imposed and/or developed by the Department related to the subject matter of this application and the conditions referred to herein may result in withdrawal of approval in whole or in part and/or the suspension and/or termination of the primary angioplasty program at Kent Hospital.

Letter from David R. Gifford, Director of R.I. Dep't of Health, to Mark E. Crevier, President and Chief Exec. Officer, Kent County Mem'l Hosp. (April 2, 2008) (on file with author).

231. *See generally* REPORT ON KENT COUNTY, *supra* note 228.

232. Letter from David R. Gifford, Director of R.I. Dep't of Health, to Mark E. Crevier, President and Chief Exec. Officer, Kent County Mem'l Hosp. (Apr.

was also required to purchase a specific piece of equipment for the Block Island Community Health Center – a service provider that was outside of the primary or secondary service area of the hospital.[233]

This, therefore, represents the latest step in the effort to move certificate-of-need from a reactive cost containment vehicle to one that attempts to employ the regulatory process as a tool for implementing public policy priorities. Furthermore, those public policy priorities appear to be ad hoc and determined by the nature of the application presented rather than products of a comprehensive planning process. Nevertheless, in the absence of the latter, a more rigorous conditional approval process may represent one of the most effective tools that has been employed to date by public health authorities to achieve public health goals. So for the Department, certificate-of-need has a fresh vitality: one that is premised not so much on cost containment as it is on using a historically reactive process in a proactive manner to achieve public health priorities that would otherwise likely remain unsatisfied.

CONCLUSION

In the final analysis, the cost containment record of certificate-of-need in Rhode Island has been extremely difficult to substantiate if only because certificate-of-need is but one of many factors impinging on hospital costs. Review of cost impact statements filed by the third party payors in recent years suggests that the incremental costs associated with even the largest capital and equipment projects are extremely small in comparison to the collective operating costs of the hospitals. The Health Department recognized this fact as early as 1976, defended the program for a variety of reasons other than cost containment, and attempted on several occasions over the last thirty years to repeal the law. Each time, however, the hospitals argued strenuously against repeal. Supportive of the concept of certificate-of-need from its inception, the hospitals have collectively remained steadfast in their support of the continuation of certificate-of-need, if only to prevent the unlikely prospect of a new hospital's establishment in

2, 2008) (on file with author).

233. *Id.*

an already overcrowded market. Because of the constant legislative changes in entities covered, activities subject to review and in the process itself, the Health Department has had to adapt continuously over the years. Arguably, within the last five years, it has discovered the combination of interventions that transform a reactive process into one that can actually advance public health agendas. The Department has done so by fashioning conditions that go considerably beyond the scope of the projects and programs that are the subjects of the approvals to which they are attached. More importantly, the Department is actively enforcing its conditions on an annual basis and monitoring hospitals to assure that they actually implement those conditions. In response, the hospitals have done little more than continue to seek a level playing field, having determined that a regulatory program that modestly stymies all existing hospitals periodically is preferable to the prospect of a new hospital competitor or open competition where access to capital becomes the sole determinant of continued investment in plant and equipment.

The result is that we have the hospital system we have. There are two fewer voluntary hospitals than there were in 1969, but neither was forced out by certificate-of- need. Whether our hospital system would be significantly differently configured now, had certificate-of-need not been enacted to begin with or had it been repealed at an earlier time, is open to speculation. No doubt any attempt by a new hospital to enter the state would have resulted in a legislative intervention of some kind. However, for as much as the insurers complain about hospital costs and the hospitals complain about inadequate reimbursement, Rhode Island reached a state of equilibrium in the early 1990s that has been preserved by a combination of certificate-of-need barriers to entry and tightly negotiated reimbursement agreements. Whether national health reform efforts will upset that state of equilibrium is the next question. Meanwhile, the dance goes on.

On November 7, 2009, in a special session of the General Assembly, chapter 197 of the Public Laws of Rhode Island, 2009, was enacted.[234] The law calls for the extension of certificate-of-need coverage to multi-practice physician ambulatory surgery centers and multi-practice podiatry ambulatory surgery centers

234. 2009 R.I. Pub. Laws. ch. 197.

and specifies in law for the first time specific services to be included within the list of tertiary and specialty care services.[235] These services are not, however, cutting edge technologies. Full body magnetic resonance imaging and computerized axial tomography are services that had been included in the Department of Health listing of tertiary and specialty care services in the past, but had been removed from that listing once they had become so widely dispersed throughout the state that the justification for their special classification was no longer in evidence. They had become lightning rods for the small community hospitals in recent years as unregulated physician surgery centers and non-hospital MRI and CAT scanning service centers were opening and operating in the vicinity of the hospitals without regulation. These interlopers were continually accused of "skimming the cream" from nearby hospitals, without having to discharge the free care and other obligations of those hospitals.

For both casual and seasoned observers of the certificate-of-need revolving door, this is a curious piece of legislation. Coming as it did forty years after the initial passage of certificate-of-need legislation in Rhode Island and more than twenty-five years after the last significant providers of services were added by the General Assembly, it represents a return to the protectionist environment in which Rhode Island's law was born. Ultimately, this latest enactment underscores the primary reason for the survival of certificate-of-need in the face of the Health Department's historical vacillation between ambivalence and antipathy. As noted herein, in the early years, when the Health Department attempted to apply its programmatic tools equally across all types of service providers, the non-hospital providers disproportionately experienced denials and short- term cost-containment effects in comparison with the hospital providers. Even at this late date, when it would seem that all of the MRIs and CAT scanners that are ever going to be introduced in Rhode Island have already been introduced, the hospitals are willing to reintroduce regulation of hospital provision of these services in exchange for the opportunity to secure regulation of non-hospital provision of these services. This suggests that the arguments advanced in the early 1970s by the economists against public

235. *See id.*

utility regulation seem ripe for resurrection. Whether the Department of Health's heightened emphasis on conditional approvals will be sufficient to offset the defensive use of the certificate-of-need process by the regulated sector for its own ends remains to be seen.