
Review of the State Health Planning and Development Agency

A Report to the
Governor
and the
Legislature of
the State of
Hawaii

Report No. 92-5
January 1992

THE AUDITOR
STATE OF HAWAII

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Submitted by

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Foreword

In Section 48 of the 1991 General Appropriations Act, the Hawaii Legislature requested the State Auditor to conduct a review of the State Health Planning and Development Agency. Legislators have been concerned about the effectiveness of the agency and its certificate of need program.

This review of the State Health Planning and Development Agency examines whether the agency is fulfilling its principal mission of containing increases in health care costs. We assessed the extent to which various agency functions support its mission and the effectiveness of the certificate of need program in containing costs.

We wish to acknowledge the cooperation extended to us by staff of the agency and members of its advisory committees. We also extend our appreciation to the members of Hawaii's health care community who assisted us in this review.

Marion M. Higa
Acting Auditor
State of Hawaii

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Chapter 1

Introduction

Health care costs have increased steadily in the past decade. Since 1980, health care spending across the nation increased by 163 percent, up from \$230 billion in 1980 to \$606 billion in 1990.¹ Today, more than 12 cents out of every dollar earned is used to buy health care services.² Hawaii's total health expenditures reached an estimated \$2.6 billion in 1988, the latest year for which figures are available. This total is equivalent to spending 11 cents out of every dollar of state income on health care services.³

A principal function of Hawaii's State Health Planning and Development Agency (SHPDA) is to control increases in health care costs. The effectiveness of the agency and its certificate of need program (which regulates certain proposed health services) has been questioned. The Legislature, in Section 48 of the 1991 General Appropriations Act, requested the Auditor to conduct a management and fiscal review of the agency. The request asked for an assessment of SHPDA and the impact of the certificate of need program on costs and the availability of public and private health services.

Background on SHPDA

Congress passed the National Health Planning and Resources Development Act of 1974 (PL93-641) to ensure the development of a national health policy and effective state and local health planning and resources. The law focused on equal access to quality health care at reasonable cost. States receiving federal monies under this law had to establish health planning agencies and regulate health care providers through an approval process, also termed a "certificate of need" process. Almost all states, including Hawaii, established state health planning agencies.

Hawaii established its SHPDA in 1975 under Act 159 of 1975 (Chapter 323D, Hawaii Revised Statutes). Amendments to the law in 1976 introduced a health planning approach that incorporated extensive community participation. It established a certificate of need process that decided whether health care facilities could expand or modify their services, buildings, or equipment when capital expenditures were in excess of \$100,000.

Seeing the federal law as costly, without benefit, and even detrimental to the rational allocation of resources, the Reagan administration requested that it be phased out, and it was repealed in 1987.⁴ Since

then, 11 states have eliminated their certificate of need programs and most of the remaining states have significantly modified their certificate of need process.⁵

Hawaii's law has remained much the same since 1975. SHPDA has continued to stress "equal access to quality health services." A significant change came in 1984 when the Legislature made a principal function of the agency the responsibility for controlling increases in health care costs.

At the time of our review in 1991, SHPDA had a permanent fulltime staff of ten, including the administrator. Staff were divided into a Data Analysis and Research Section, a Plan Development Branch, a Regulatory Branch, and a Subarea Coordination Section (to coordinate activities of the community subarea councils). In the 1991 General Appropriations Act, the Legislature appropriated \$700,218 to the agency for FY1991-92 and added three positions—planner, clerk typist, and a person to monitor approved certificates of need.

Objectives of the Review

1. Assess whether SHPDA is fulfilling its primary mission of cost containment.
2. In particular, examine the effectiveness of the certificate of need program as an instrument for cost containment and the efficiency and fairness with which it is managed.
3. Describe and evaluate alternative regulatory strategies that could be undertaken by the State and make recommendations if appropriate.

Scope and Methodology

We reviewed SHPDA's functions and its certificate of need program to assess the extent to which they help control increases in health care costs. We interviewed the SHPDA administrator, key staff, and members of the advisory committees and also observed meetings of the advisory committees. We interviewed members of insurer, provider, and physician organizations, including the Hawaii Medical Services Association, Hawaii Healthcare Association, the Hawaii Medical Association, and the Hawaii Federation of Physicians and Dentists.

We analyzed the pertinent statutes and rules for consistency, clarity, precision, and fairness, and we examined SHPDA's management of the certificate of need application process for compliance with the

statutes and rules. We reviewed all of the certificate of need applications submitted to the agency between January 1988 through December 1990. We also reviewed SHPDA's budget and expenditures for the last biennium.

To assess health planning efforts in the State, we interviewed officials at the Department of Health and consulted with the Office of State Planning and the executive director of the Governor's Blue Ribbon Panel on Health Care. We also requested information from other states about their certificate of need programs.

Our work was performed from May through November 1991 in accordance with generally accepted government auditing standards.

Chapter 2

Impact of SHPDA on Controlling Health Care Costs

A principal function of the State Health Planning and Development Agency (SHPDA) is to control increases in health care costs. In this chapter, we assess the extent to which the agency has succeeded in this mission.

Summary of Findings

1. Increases in health care costs are due to many factors beyond SHPDA's purview. There is no convincing evidence that the certificate of need program has controlled costs, although the program may deter large capital expenditures.
2. Chapter 323D, Hawaii Revised Statutes, assigns disparate, contradictory functions to SHPDA.

Mission of the Certificate of Need Program

In 1984, the Legislature gave SHPDA a principal mission of controlling increases in health care costs and designated the certificate of need program to carry it out. The program regulates investments in new medical facilities and equipment, changes in the number of hospital beds, and expansions in certain medical services. The assumption was that costs would be controlled by (1) delaying implementation of new technology, (2) encouraging cost conscious renovations, and (3) preventing duplication of services and reducing excess capacity.

The program requires SHPDA's approval for expenditures which exceed certain financial thresholds for various categories of services, for changes in beds or services covered by 55 categories of service as defined in the agency's rules, for some changes in location or ownership, and for physicians in private practice if they propose a health care service which exceeds the expenditure minimum or involves one of the 55 service categories. Health maintenance organizations, which were exempt until 1987, are now included in the scope of regulation.

Little Evidence on Program's Impact on Health Care Costs

We found no convincing evidence that the program has restrained health care costs in Hawaii. Many factors outside the agency's purview continue to fuel these costs. Neither proponents nor opponents of the program have data to support either side of the question. Data from other states is not conclusive as to the effect of similar programs. Perhaps most important, SHPDA itself has not instituted the means to gauge its effectiveness.

Many factors increase health costs

The elements which contribute to increases in health care costs are numerous and complex. In addition to investments in facilities and new technology—factors subject to regulation under the certificate of need process—increasing costs are attributed to malpractice awards, the high cost of care, an aging population, inflation, increases in physicians' net incomes, a shortage of hospital workers, and consumers' expectations. Private insurance and Medicaid and Medicare programs have also added to increased costs.

New technology is one of the major causes of cost increases and may occur in hospitals, physicians' offices, and nursing homes. It includes the cost of equipment as well as the cost of operating and maintaining it. The latter may exceed the original amortized cost.

National debates about the causes of health care cost inflation continue. Some proponents of regulation see the health care economy as distorted by Medicaid and Medicare programs and by patients who do not shop comparatively when seeking care. Opponents contend that continued regulation may actually increase costs because it shields providers from competition. They suggest that the cost of certificate of need applications are passed on to consumers anyway and that the regulatory process tends to favor large providers over the small. Some studies have suggested that restricting technology raises serious ethical issues about access to care.

In Hawaii, efforts that may control costs include doctors reviewing their peers' medical charges and hospitals' sharing of their equipment and buying in bulk. Prepaid health plans and employer-provided group health insurance may help to hold down costs. And preventive efforts of various kinds may also be effective in cost control.

Local opinion divided

In Hawaii, neither proponents nor opponents of the certificate of need program has convincing evidence that the program has significantly affected costs.

Several supporters within the health industry suggest that the program has prevented mainland and foreign providers from entering Hawaii's market and driving established nonprofit agencies out of business. Others suggest the program has prevented, or at least delayed, the proliferation of such expensive technologies as magnetic resonance imaging units (MRIs), which cost \$2 to 3 million each and have yearly operating expenses of \$1 million or more.¹ However, supporters lack data to back up their claims.

Opponents argue that the program may cost the State, the public, and private providers time and money with little or no measurable benefit. They say that limits on new equipment—such as the number of MRIs—and delays in their acquisition prevent people from obtaining important state of the art health care. Here again, data is not available to support this claim.

Evidence from other states inconclusive

After repeal of the federal law in 1987, many states eliminated their certificate of need programs and most of the remaining states significantly modified or streamlined theirs.² These changes were made for different reasons and therefore their impact on costs is uncertain.

States that eliminated the program

States that eliminated the certificate of need program cite several reasons for their action: the increasing burden of litigation from applicants who were disapproved, the high costs of the program as against limited results, the pressures placed on legislatures by those opposed to the program, and the attractiveness of voluntary cost control efforts such as moratoriums on services.

Some experts predicted that the elimination of certificate of need programs would result in a rash of new building and an expansion in services. The American Hospital Association found that some states have experienced higher hospital costs³ but that other states (such as New Mexico and South Dakota) have reported no serious effects. The evidence, however, is inconclusive, because nine states reporting no growth did institute other cost containment measures such as moratoria on new building and services.⁴

States that continued the program

The District of Columbia and 39 states have continued their regulatory programs.⁵ Most have taken a moderate approach—streamlining programs and deregulating services and providers (particularly those perceived as not contributing to long-term health cost increases). They have raised their thresholds to exempt from regulation all but the

Program has few means to gauge its impact

most costly projects. Nineteen states have capital thresholds of \$1 million or more, 10 states have equipment thresholds of \$1 million or more, and 6 states have service thresholds of \$1 million or more.⁶

In several areas, SHPDA has not instituted the means to measure, assess, and monitor its progress.

Limited measures of effectiveness

SHPDA does not have adequate measures of effectiveness to indicate whether the cost-saving objective of the certificate of need program is being met. Like other state agencies, SHPDA is required to develop measures to gauge how well it meets program objectives and to report these to the Department of Budget and Finance. We found that of the 14 most recent agency measures, only 2 addressed the certificate of need program: (1) the percent of the previous year's certificates monitored and (2) the number of excess beds denied or discouraged as a percent of the total proposed.

These two measures give a limited picture of costs and the program's ability to deal with them. The first measure involves the agency's periodic review of certificate holders to see if they have adhered to the terms of their certificate. The second indicates whether the program is indeed restricting the number of unneeded beds. For the agency to assess whether the program in fact restrains costs will require much more data and a far more comprehensive analysis.

Insufficient cost data

Our review of all 95 applications submitted from January 1988 through December 1990 showed that many did not contain a complete discussion of the proposal's effect on health care costs as requested by the agency. SHPDA rules say that applicants must address 12 criteria, 3 of which focus on cost:

1. The probable impact of the proposal on the overall costs of health services to the community,
2. The probable impact of the proposal on the costs of and charges for providing health services by the applicant, and
3. The availability of less costly and more effective alternatives for providing service.

In 78 applications deemed complete by the agency, an average of 38 percent did not report required information, such as per unit charges for proposed services, per unit costs to the applicant, proposed costs

and charges compared to similar services in the community, and the potential for existing rates to change.

Moreover, the discussions often did not adequately explain the proposal's effect on costs. Without providing evidence, applicants merely asserted that there would be minimal impact on costs or a reduction in costs.

SHPDA is aware of the need for better reporting. In its revised *Certificate of Need Manual*, the agency included a checklist that applicants could use to check the completeness of their proposals.

Poor monitoring of approved certificates

We found that the agency did not routinely monitor applications after approving them. By law, the agency must periodically review the progress of approved projects and may withdraw an approval if the project does not adhere to requirements. The agency may also require periodic reports from certificate holders.

Systematic monitoring of certificate holders could capture data on expenditures and charges and also information on the timeliness of completing a project. The agency could then determine if there were significant differences between what was proposed and what actually occurred. Eventually the data could indicate whether restraints imposed by SHPDA on capital expenditures were effective.

With its current approach, the agency is unable to determine whether the program's objectives are being met. Although it has taken steps to hire someone for this purpose, at the time of our review the agency was not in compliance with statutory requirements for reviewing the projects it had approved.

Important costs not reported

In addition to not collecting data relevant to the program's effect on health care costs, SHPDA is not analyzing the data it collects. For example, from 1983 to 1988 the agency reported an annual reduction in expenditures from those initially proposed by applicants, but it did not report these reductions in 1989 or 1990. Further, since 1983 the agency has not reported permanent reductions in expenditures.⁷ Permanent reductions measure the effectiveness of the certificate of need program in restraining unnecessary capital investment in the health care system. They represent expenditures which have been disapproved by the agency as opposed to those for which applicants will reapply.

Without analyzing the restrictions imposed by the certificate of need program (such as permanent reductions) the agency is unable to accurately assess whether its program in fact restrains increases in health care costs. Although the agency is not required to report these figures, it should analyze all available data to determine the program's effectiveness.

Current Mission Exceeds Agency's Capacity

SHPDA's mission to control increases in health care costs implies that it has the capacity to affect a range of factors contributing to the economy of health care. But the ability of the certificate of need program to contain health care costs is limited.

As noted earlier, many factors drive up health care costs. They include capital investments, malpractice awards, increases in physicians' net incomes, an aging population, inflation, a shortage of hospital workers, the low reimbursement rates of Medicare and Medicaid making necessary a cost shifting onto private insurers, and consumer expectations for quality care and access. Many of these are beyond the program's control.

Program could control large capital investments

The program, however, has the potential to control the proliferation of new and expensive medical technologies. It is suited to regulating the investment of capital in the health care system.

Recent literature suggests that the use of high technology significantly contributes to overall increases in health care costs. According to some economists, newer technologies do not replace the old; instead, the use of both increases.⁸ Increases in the number of diagnostic imaging units, such as magnetic resonance imagers and computerized tomography scanners, appear to increase demand for their use without reducing the cost for their use.⁹ Machines such as these cost from \$400,000 (lowest cost for computerized tomography scanners) to over \$4,000,000 (highest cost for positron emission tomography scanners), so their impact is considerable.¹⁰

By regulating the use of certain new high technology equipment, a certificate of need program could control the flow of capital into the health care system. It could also control the use of expensive scanners and have some effect on insurance rates.

Program could eliminate review of lower-cost items

SHPDA could regulate capital investment more effectively and decrease its workload substantially if it eliminated its review of lower cost facilities and services. Its current thresholds are \$400,000 for

used medical equipment, \$1 million for new and replacement medical equipment, and \$4 million for capital expenditures.

Less than a third of the applications submitted between 1988 and 1990 accounted for 95 percent of the total capital investments. This same third equaled 92 percent of the total projected operating costs proposed in the applications. The remaining two-thirds of the applications were for projects with capital investments of under \$1,000,000. The majority of these applications were proposing capital investments of under \$400,000.

The numerous service categories which currently require a certificate of need are extending the agency's resources without appreciably expanding its impact on health care costs. The agency could more effectively use its resources if the program's scope were limited to large capital expenditures and high technology. For example, service categories that may not merit regulation include family planning clinics and some mental health clinics.

Statute Assigns Disparate Responsibilities to SHPDA

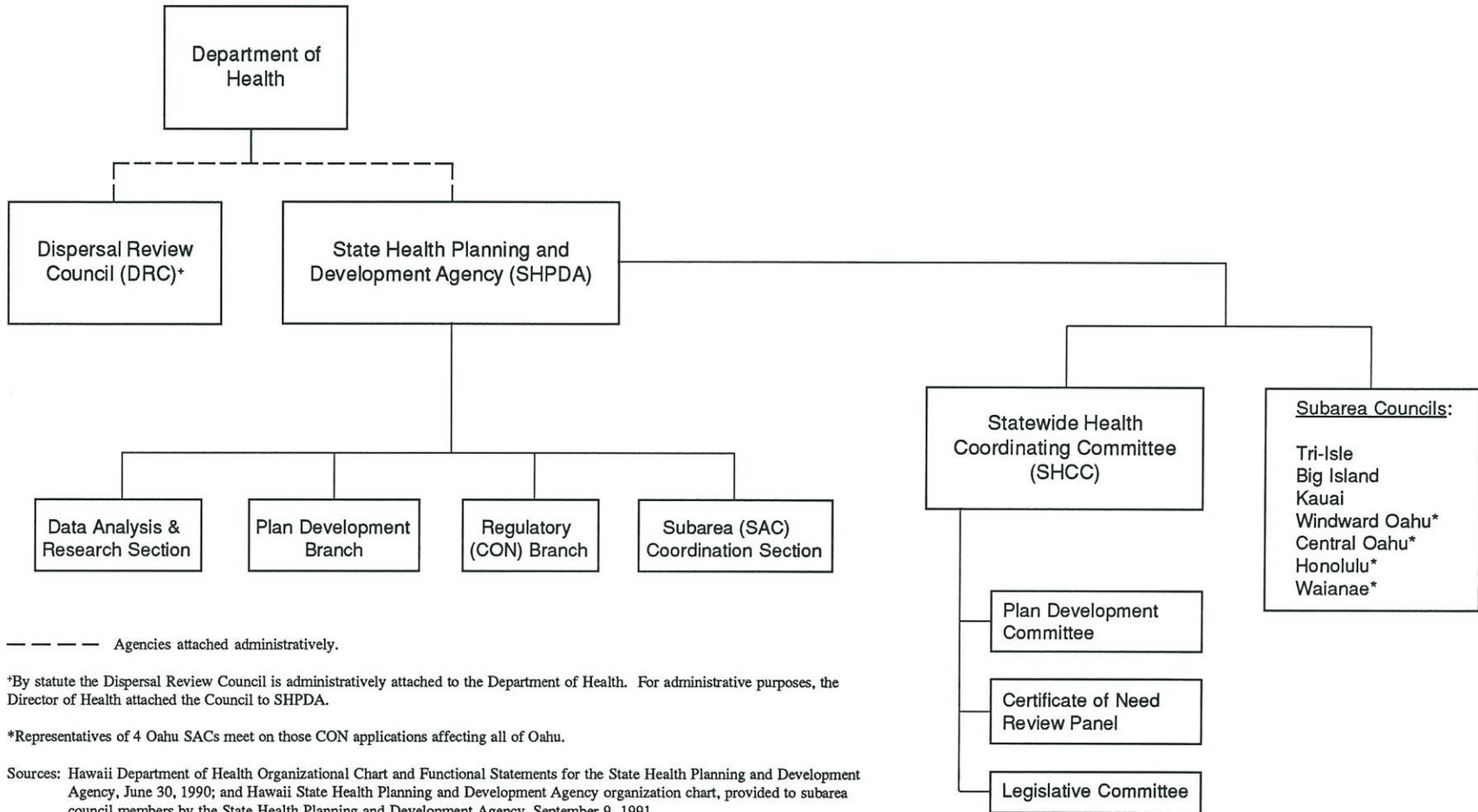
SHPDA's original mandate in 1975 was to ensure equal access to quality health services through the development of health delivery systems. When the Legislature amended the statute in 1984 to make cost containment a principal function of the agency, it did not delete the original functions. Today, SHPDA continues to state that its purpose is to ensure equal access to quality health care at reasonable cost.

"Access," "quality health care," and "reasonable cost" are broad and far-reaching purposes which even singly would be difficult to achieve. Moreover, they are often incompatible and work at cross purposes. Guaranteeing access to health care for everyone *and* ensuring high quality health care—especially when it requires sophisticated technology—is likely to be expensive. Restricting costs may mean reducing quality and accessibility. A 1985 evaluation of SHPDA by the Department of Health concluded that elements in SHPDA's purpose were somewhat contradictory.¹¹

Agency focuses on planning

The SHPDA administrator sees the agency's primary mission as statewide health planning. As a consequence, substantial staff resources are devoted to an effort that has little relationship to regulating costs. The agency staffs an extensive system for health planning that includes seven "subarea" councils (SACs), the Statewide Health Coordinating Council (SHCC), and the SHCC subcommittee on planning (see Figure 2.1). The advisory committees are comprised

Figure 2.1
Organization Chart for the State Health Planning and Development Agency



of approximately 130 members who represent consumers, providers of health care services, insurers, and labor unions.

A current focus of the agency is a special task force to conduct a needs assessment for the island of Hawaii. Immediate goals are to (1) assess the current status of health care on the island, (2) identify current and future health care needs and gaps in service, (3) define alternatives for meeting these needs, and (4) establish priorities and specific recommended solutions. Members were appointed by the SHPDA administrator and include representatives of state and county government, providers, insurers, and consumers.

Dispersal Review Council is another responsibility

In addition to health planning and the certificate of need program, SHPDA is responsible for staffing the Dispersal Review Council. The council was created by the Legislature in 1988 to ensure that group living facilities for persons who are developmentally disabled, elderly, handicapped, or mentally ill are dispersed throughout the state. The council is attached administratively to the Department of Health, and the Director of Health has administratively attached the council to SHPDA.

According to the department's Administrative Services Office, the council has had no expenditures since March 1991. The first chairperson resigned in January 1991 and his successor in August 1991. No successor has been appointed.

SHPDA has made certificate of need decisions based upon the council's requirement to distribute group care homes throughout the community. Recently, these decisions have been questioned in legal suits seeking rulings that the statute establishing the council is in violation of the Federal Fair Housing Act.¹²

Conclusions

Reforms in the health care system are invariably interconnected. A reform of one element in efforts to control costs may adversely impact another element, and perhaps reduce access to care. So reforms must be proposed carefully. Rising health care costs continue to be a topic of national and local debate and various proposals to hold down costs have been offered. In testimony to the U.S. House of Representatives Ways and Means Committee, the Comptroller General proposed comprehensive changes, saying that "piecemeal reforms are unlikely to reduce the growth of national health spending substantially."¹³

In Hawaii, the Director of Health issued a "Seamless System Report" proposing a comprehensive approach. Furthermore, the Governor has

established the Blue Ribbon Panel on Health Care to study health care costs and finances. The panel has not yet issued its reports and findings which may also include proposals for health care cost control.¹⁴ Changes to SHPDA and any other changes in the health care system should fit in with the overall policies and plans for the health care system. These are not yet set out. Until the directions are clear, major adjustments to SHPDA and its cost containment program may be premature.

SHPDA was assigned a primary objective of controlling increases in health care costs. At this time, it can mount no convincing argument that it has succeeded. Evidence from other states on the usefulness of regulation is also not sufficient. In only one area does regulation have potential, and that is in controlling the introduction of new and expensive technology.

We believe that the agency's function should be limited to one where it is likely to have the most impact—regulating large capital expenditures and high cost technology. Its other broad planning functions should be removed, in large part because they take away from what could be a useful function.

To determine over the long run whether SHPDA can be effective in cost control, the agency needs to improve the collection, reporting, and analysis of useful data. It needs to develop measures of effectiveness which will enable it to assess the program's effect on health care costs. If SHPDA's function is limited to regulation, its current staff and budget should be more than adequate.

Recommendations

1. The Legislature should consider limiting the function of the State Health Planning and Development agency to regulating large capital investments in health care facilities and medical technology.
2. SHPDA should review the scope of the certificate of need program, determine the appropriateness of its numerous service categories, and recommend more meaningful thresholds for those it decides to retain.
3. SHPDA should develop better measures to indicate the program's effect on containing costs in capital investments for new facilities and services. In addition, it should report its methodology and the results of its analyses to the Legislature each year.
4. SHPDA should require complete reporting by applicants on a project's effect on health care costs and it should monitor the projects it approves.

Chapter 3

Management of the Certificate of Need Program

In this chapter we discuss the State Health Planning and Development Agency's (SHPDA) management of the certificate of need program and ways in which it can be improved.

Summary of Findings

1. To prevent further delays, the agency needs a better system for managing the processing of standard review applications.
2. The advisory committees' review of applications is unnecessarily burdensome, involving large numbers of people and extensive work by staff.
3. The agency needs better research methods and better data for making decisions on applications.

Review Process

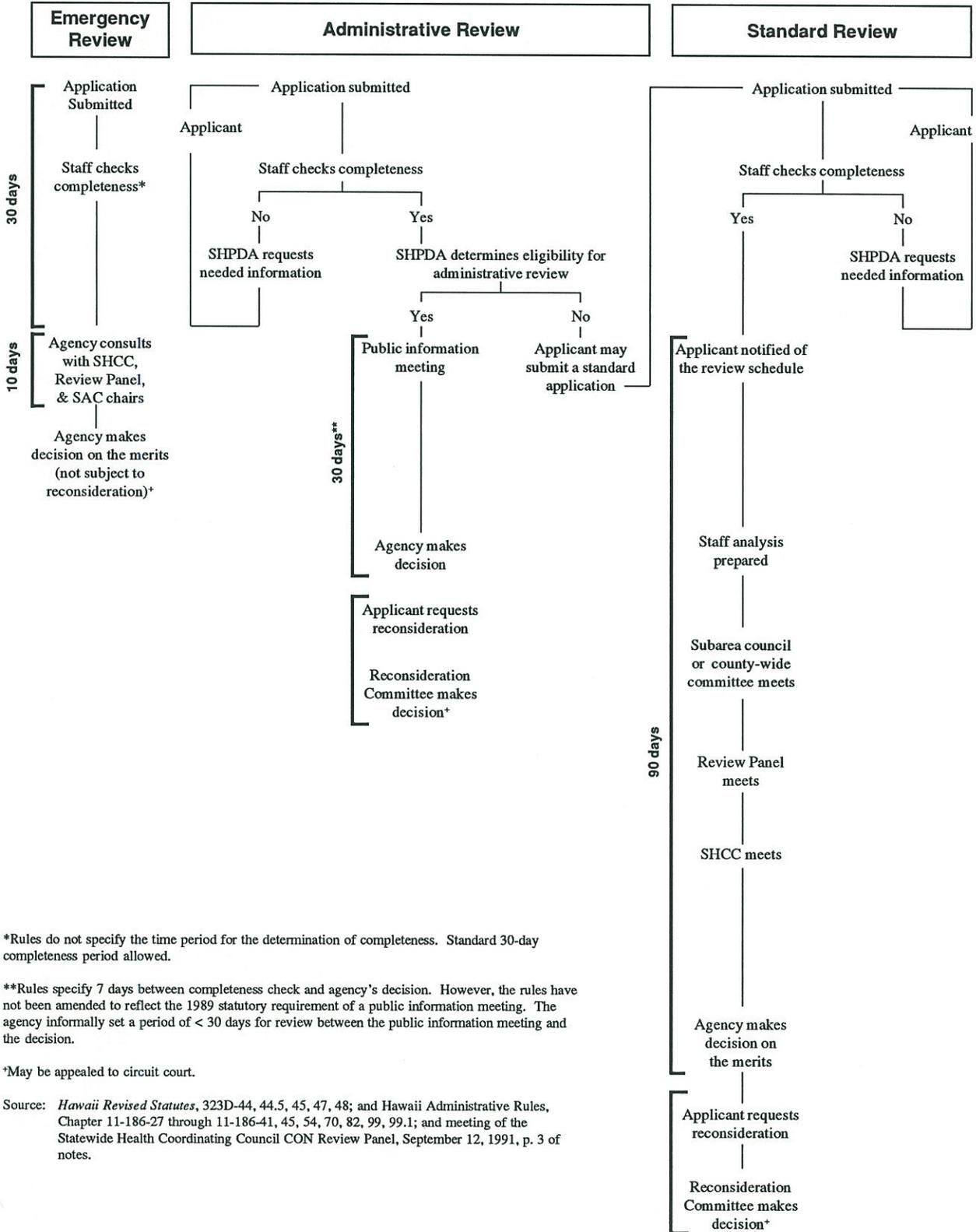
The agency has three types of review—emergency, administrative, and standard—as delineated in Figure 3.1. Applicants may apply for emergency review if they address some actual, substantial injury to the public health or some clear and present danger. Most applications undergo either administrative or standard reviews. An administrative review is done for proposals with expenditures of under \$1 million or those which will not have a significant impact on the health care system. Proposals that do not qualify for an emergency or administrative review must undergo standard review.

Steps in the process

The agency first checks the application for completeness. For administrative and standard reviews, the agency must notify each applicant within 30 days whether the application is complete. If the application is not complete, the applicant has 60 days to respond.

Once an application is deemed complete, agency review begins. In an administrative review, applications are heard at a single public information meeting and the agency tries to issue a decision within 30 days. In a standard review, hearings are held before each of three advisory committees and a decision must be issued within 90 days of the date of the notification of completeness or the date of the public notice of the agency's review, whichever is later.

Figure 3.1
SHPDA Certificate of Need, Types of Application Review



*Rules do not specify the time period for the determination of completeness. Standard 30-day completeness period allowed.

**Rules specify 7 days between completeness check and agency's decision. However, the rules have not been amended to reflect the 1989 statutory requirement of a public information meeting. The agency informally set a period of < 30 days for review between the public information meeting and the decision.

*May be appealed to circuit court.

Source: *Hawaii Revised Statutes*, 323D-44, 44.5, 45, 47, 48; and Hawaii Administrative Rules, Chapter 11-186-27 through 11-186-41, 45, 54, 70, 82, 99, 99.1; and meeting of the Statewide Health Coordinating Council CON Review Panel, September 12, 1991, p. 3 of notes.

During the 90-day period for a standard review, staff writes an analysis of the application. This report becomes part of the application file and is presented at each of the advisory committee meetings. The three advisory committees involved in the process are (1) the appropriate subarea review council (SAC) or Oahu countywide committee, (2) the certificate of need review panel which is a subcommittee of the State Health Coordinating Council (SHCC), and (3) the SHCC itself. Each advisory committee separately reviews each standard application at a public meeting. The applicant usually makes a presentation, answers questions, and addresses concerns. The SAC reviews the application first and sends its recommendation to the certificate of need review panel. The review panel sends its recommendations to the SHCC, which then makes a recommendation to the agency.

Extensions

In both standard and administrative reviews, applicants may request a 15-day extension to provide additional information. Under the standard review, the agency and the applicant may agree in writing to extend this period. The agency may also extend the standard review period for 60 days if it notifies the applicant in writing within the 90-day period.

Standard Review Applications Are Frequently Delayed

The processing of applications is subject to delays that can adversely affect those who apply for review. A cause of the problem is that the agency has not developed an effective tracking system to support the applications process.

The standard review process can be lengthy. On the average, the agency takes twice as long as the rules require to notify applicants that the forms are complete. The administrative rules require the agency to notify applicants within 30 days that the applications are complete. Except for extensions, total processing time is supposed to be 120 days for those applications deemed complete. We found that these applications were delayed an average of 41 days. This delay amounts to a 34 percent increase in processing time. Both the agency and the applicant shoulder the cost of delays.

The agency does not use a tracking system to monitor the status of applications being reviewed. Its approach is to compile a summary describing the status of active applications and the actions pending. The summary, however, is not updated at regular intervals and therefore does not effectively follow the flow of paper.

We also found that when two or more drafts of an application were submitted, the agency was not consistent about which draft it stamped with a filing date. The filing date starts the clock on the agency's review deadlines and is required by the rules. Of the 95 applicants we reviewed, 44 had two or more drafts submitted for initial comment by the agency. Without a consistent way of recording the "in" date, the agency cannot adequately analyze and improve the timeliness of review procedures.

Given the complexity of the process and the substantial amount of data needed by the agency, the 30-day limit for completeness review may not be sufficient. The deadline—established by a 1980 revision to the administrative rules—may need reconsideration.

Committee Review System is Burdensome

The current method of review involves large numbers of people, extensive paperwork, and much duplication of effort. Agency staff must provide services and materials to three separate advisory committees.

For a standard review, applicants must present essentially the same information at three public meetings, thereby increasing their costs. Committee members who belong to more than one advisory body must attend two, three, sometimes more meetings. Several committees also have difficulty obtaining quorums. Noting these obstacles, members of the advisory committees have recommended simplifying the process.

In the review process, agency staff first sends a summary, or copy, of the application to each of 14 or so members of the subarea council in whose district the proposed project will be established, along with a copy of the staff report and the criteria for review. The council votes after the applicant's presentation.

Next, each of the 11 members of the review panel receives essentially the same information—the application, staff report, criteria, and other pertinent information. The applicant again makes a presentation, after which the panel votes on the application.

Finally, SHPDA staff sends each of 21 members of the Statewide Health Coordinating Council an agenda, minutes from the subarea council meeting, a summary of the application, criteria, and sometimes the staff report or summary. The applicant makes a third presentation, after which the coordinating council votes.

In reviewing some difficult cases, each committee may meet more than once. Once, when a committee lost its quorum, the applicant had to return for a fourth presentation.

The committee system is a holdover from the federal law which has been repealed. The concerns of community groups are important but the process need not be so repetitive. Joint meetings may be held by the subarea council and the review panel, or by the coordinating council and the review panel. We suggest a single joint hearing by the Statewide Health Coordinating Council and the local subarea council at the subarea district in order to streamline the process while ensuring community input.

Better Data is Needed for Making Decision

SHPDA's *Health Services and Facilities Plan* is the agency's main planning document. It delineates the services and facilities needed to meet the State's health care needs. By law, each application approved by the agency must be consistent with the plan. Data in the current plan, however, is outdated for many services, and the discussion of costs in several areas is not adequate for evaluating applications.

In a 1985 evaluation, the Department of Health recommended that, to keep current, SHPDA should update the plan annually instead of every three years.¹ Nine of the plan's twelve chapters were adopted in 1986. The three remaining chapters (on radiology) were added in 1989. The plan is partially based on needs assessments last conducted by the subarea councils in 1979. The agency is planning to update the needs assessments by June 1992.

Need to strengthen research capacity

To carry out the certificate of need program and support its commitment to cost containment, the agency needs to obtain better information. The information would provide a context for testing data presented in certificate of need applications and for monitoring those that are approved.

The agency has not assigned staff to perform cost studies and analyses. It did not fill a position for a Resource Allocation Systems Analyst, and the authorization to fill the position expired in June 1991. The agency did not have a health economist or research analyst who could help develop its *Health Services and Facilities Plan*, which is used as a basis for decisions on applications. In the current plan, discussions of costs are often just a few paragraphs long and limited to describing charges to patients. They do not fully analyze the potential impact of services on Hawaii's insurers, taxpayers, or the overall health economy. To adequately carry out its regulatory

program, the agency must have information that is up-to-date, relevant, and in sufficient depth.

We note that the law charges SHPDA with preparing reports and making recommendations on Hawaii's health care costs and efforts to reduce or control them. Except for one chapter on cost control prepared for a 1988 Department of Health report on AIDS, the agency has not issued any substantive reports on these matters in the last three years. No agency staff has been performing studies and analysis on containing health care costs.

Conflict of Interest

The statutes allow agency decisions on applications to be appealed. These appeals are handled by the reconsideration committee comprised of the SHPDA administrator and the chairpersons of the statewide council, the review panel, the plan development committee, and the appropriate subarea council. The SHPDA administrator chairs the reconsideration committee. Concern has been expressed by some applicants and the SHPDA administrator about conflict of interest when the administrator decides on the application and is also the person who reviews appeals of that decision. The administrator has suggested that the statute and rules be amended to have the chair of SHCC chair the reconsideration committee.²

Recommendations

1. The State Health Planning and Development Agency should develop better management controls over the certificate of need process by improving its record keeping and developing a better application tracking system.
2. SHPDA should streamline the certificate of need process by reducing the number of reviews by advisory committees.
3. SHPDA should develop the capacity to carry out needed research in support of the certificate of need program.
4. The statute and rules should be amended to permit the chair of the State Health Coordinating Council to also chair the Certificate of Need Reconsideration Committee.

Notes

Chapter 1

1. Shelda Harden, "Confronting the Health Care Crisis," *State Legislatures*, vol. 17, no. 6, June 1991, p.35.
2. Testimony on U.S. health care spending submitted by Charles A. Bowsher, Comptroller, United States Government Accounting Office, to the House of Representatives Committee on Ways and Means, April 17, 1991.
3. Bank of Hawaii, "Health Care Services," *1989 Hawaii Annual Economic Report*, 1989.
4. U.S. Congress, "Legislative History P.L. 99-660," *United States Code Congressional and Administrative News*, 99th Cong., 2nd sess., November 17, 1986, p. 6410.
5. American Hospital Association, *State Issues Forum Monograph Series: Certificate of Need (CON)*, Issue VI, July, 1991, p.2 and 4; and George Washington University, "Certificate of Need: Taking a New Look at an Old Program," *State Health Notes*, No. 114, June, 1991, p.1.

Chapter 2

1. Andrew Pollack, "Medical Technology 'Arms Race' Adds Billions to the Nation's Bills," *New York Times*, vol. CXL, no. 48,858, April 1991, p. B8.
2. American Hospital Association, *State Issues Forum Monograph Series: Certificate of Need (CON)*, Issue VI, July, 1991, p. 1-2.
3. Ibid.
4. Virginia Secretary of Health and Human Resources, *Final Report on the Virginia Medical Care Facilities Certificate of Public Need Program*, November 15, 1990, p. 34-38.
5. American Hospital Association, p. 2.
6. Tennessee Health Facilities Commission, *Health Care at the Crossroads: A Survey of Certificate of Need Programs in the United States as Compared to Tennessee*, January 1990, pp. 9-10.

7. State Health Planning and Development Agency, *Annual Report FY1983-84 and 1984-85*, p. 13; *Annual Report FY1985-86*, p. 15; *Annual Report FY1987 and 1988*, p. 15 and 18; *Annual Report FY1988-89 and FY1989-90*, pp. 31 and 38.
8. D. P. Doessel, "Technology and health expenditures: a demand approach applied to a process innovation," *Applied Economics*, volume 22, number 10, October 1990, pp. 1277-1289.
9. Edwin Chen, "Doctoring, Dollars, and Sense," *Los Angeles Times*, February 28, 1990, p. A-18.
10. Andrew Pollack, "Medical Technology 'Arms Race' Adds Billions to the Nation's Bills," *New York Times*, April 29, 1991, p. A1.
11. Hawaii Department of Health, *Evaluation of the Effectiveness of the State Health Planning and Development Agency*, December 1985, p. 12.
12. *Research Center of Hawaii v. State Health Planning and Development Agency*, minute order issued by Judge Klein, First Circuit Court, April 1990.
13. Charles A. Bowsher, Comptroller General of the United States, "U.S. Health Care Spending: Trends, Contributing Factors, and Proposals for Reform," testimony before the Committee on Ways and Means, U. S. House of Representatives, April 17, 1991, GAO report no. GAOT-HRD-91-16, p. 1.
14. Hawaii State Department of Health, "Toward a Seamless System of Universal Access, the Hawaii Experience," report to the National Academy for State Health Policy, Annual State Health Policy Conference in Denver, Colorado, by Dr. John C. Lewin, Director of Health, August 5, 1991; and Minutes of the Governor's Blue Ribbon Panel, Honolulu, August 6, 1991.

Chapter 3

1. Hawaii State Department of Health, "Evaluation of Effectiveness of the State Health Planning and Development Agency, December 1985," p. 19.
2. Interviews with Mrs. Kina'u Kamali'i, Administrator, State Health Planning and Development Agency, July 12, 1991 and September 24, 1991.

Responses of the Affected Agencies

Comments on Agency Responses

We transmitted a draft of this review to the State Health Planning and Development Agency and to the Department of Health on January 9, 1992. A copy of the transmittal letter to the agency is included as Attachment 1. A similar letter was sent to the Department of Health. The response from the agency is included as Attachment 2 and that from the department is included as Attachment 3.

The agency disagrees strongly with our recommendation to limit its function to regulating large capital investments in medical facilities and technology. It says that its mission is to promote accessibility for all the people of the state to quality health care at reasonable cost. It agrees with our recommendations to review the scope of the certificate of need program, develop better measures on the program's effect on costs, and to report on its progress to the Legislature. It also agrees to require complete reporting by applicants and to monitor the projects it approves. In addition, it agrees to improve its record keeping, develop a better tracking system for applicants, and to carry out needed research. However, it does not agree that the number of reviews by advisory committees should be reduced. It says that the agency's mission requires broad community-based participation.

The Department of Health responded that it appreciated the many constructive comments and recommendations in the report but left comments on specific issues for SHPDA to answer.

We are pleased that the affected agencies agreed with so many of our recommendations and look forward to their implementation. With respect to those recommendations with which the agencies did not agree or had reservations about, we hope that some constructive action will nevertheless result.

ATTACHMENT 1

STATE OF HAWAII
OFFICE OF THE AUDITOR
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Honolulu, Hawaii 96813



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January 9, 1992

C O P Y

Ms. Kina'u Boyd Kamali'i
Administrator
State Health Planning and Development Agency
335 Merchant Street, Room 214E
Honolulu, Hawaii 96813

Dear Ms. Kamali'i:

Enclosed are three copies, numbered 6 through 8, of our draft report, *Review of the State Health Planning and Development Agency*. We ask that you telephone us by Monday, January 13, 1992, on whether you intend to comment on our recommendations. If you wish your comments to be included in the report, please submit them no later than Tuesday, January 21, 1992.

Copies of the report have been transmitted to Dr. John C. Lewin, Director of Health. The Governor and presiding officers of the two houses of the Legislature have also been provided copies of this draft report.

Since this report is not in final form and changes may be made to it, access to the report should be restricted to those assisting you in preparing your response. Public release of the report will be made solely by our office and only after the report is published in its final form.

Sincerely,

Marion M. Higa
Acting Auditor

Enclosures



STATE HEALTH PLANNING
AND DEVELOPMENT AGENCY

Mailing Address: P. O. Box 3378, Honolulu, HI 96801 Phone: ~~548-4050~~ = 587-0788

JOHN WAIHEE
GOVERNOR OF HAWAII
KINA'U BOYD KAMALI'I
ADMINISTRATOR

January 21, 1992

Ms. Marion M. Higa, Acting Auditor
Office of the Auditor
465 S. King Street, Room 500
Honolulu, Hawai'i 96813

RECEIVED
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OFF. OF THE AUDITOR
STATE OF HAWAII

Dear Ms. Higa:

Thank you for this opportunity of responding to the draft of a report to the Governor and the Legislature of the State of Hawai'i titled Review of the State Health Planning and Development Agency (SHPDA). We would also like to express our appreciation for the time and courtesy your staff gave us during the research phase of this report.

Although we concur with many of the findings and recommendations contained in this report, we also have a number of concerns. To better highlight our concensus or disagreement with this review, we have structured our responses to this report in two parts:

- I. General comments regarding the limitations of scope and focus of this report;
- II. Specific comments to each chapter of the report and, as part of the chapter-by-chapter response, specific comments to the recommendations made.

I. GENERAL COMMENTS. We are deeply concerned that this report is too limited in its scope and focus. Although the proviso which authorized this audit did specify reporting on the cost containment effectiveness of the Certificate of Need process, it also requested an overall review of "whether the program is fulfilling the purpose for which it was enacted."

We do not believe that this report has fully addressed the intended scope of the audit mandate.

Rather, this report and the majority of its recommendations reflect a too-narrow assessment of the cost containment component of the Certificate of Need (CON) process, a process which is itself only a part of the Agency's work. Although the cost containment function of the CON merits examination, the virtual sole emphasis of the report on this aspect of SHPDA's functions may lead the reader to unknowingly conclude that the CON and cost containment are all that deserves attention when evaluating the Agency or, worse, that the CON and cost containment are the only duties of the Agency.

As established by Hawaii Revised Statutes, HRS, Chapter 323D-1:

"...The purpose of this chapter is to establish a state health planning program to promote accessibility for all the people of the state to quality health care services at reasonable cost..."

A full review of SHPDA, then, requires an assessment of three major health program elements -- (1) accessibility, (2) quality care, and (3) reasonable cost -- and of the efforts by the Agency to assure a balance among these elements through planning and extensive community involvement.

Without an understanding of the public policy dynamic among these elements, this report makes the fundamentally-flawed conclusion (page 11) that these elements are "...incompatible and work at cross purposes..." Like too many other reports on health cost containment, then, the unstated methodology of this review is a presumption of market analysis as a basis for evaluation.

A large body of literature has developed over the last few years, however, to persuasively argue that the customer:client:patient relationship to goods:services:quality care is not consistent with a market theory. Market forces of supply and demand can and do control the cost of pencils, but not of health care.

Simply, those in need of health care neither shop around for the best price nor do they defer care because of cost.

To separate cost as an element, then, and to argue as this report does (page 14) "...that the agency's function should be limited to one where it is likely to have the most impact -- regulating large capital expenditures and high cost technology..." would represent a basic public policy change.

We strongly disagree with this recommendation.

The proposed limitation of the Agency's function would, in effect, endorse the rationing of health care through an implicit curtailing of construction and technology based solely on cost.

The rationing of health facilities and services is among the most controversial of public policy decisions. As an example, ceiling reviews on high cost technology may more accurately mean a choice between life-prolonging diagnostic services for our oldest citizens or pre-natal diagnostic services for our youngest.

When health cost is viewed within the perspective of accessibility and quality care *for all of the people of the state*, then the wisdom of the planning function and community participation may be best understood. Only through careful planning and community involvement can the consolidation of services and the avoidance of the costly duplication of technologies occur. Then costs are maintained at reasonable levels which do not require rationing, but instead promote accessibility to quality care.

The implications of this disagreement echo throughout this report, and will be addressed as appropriate. It is also important to note, however, that there are additional recommendations regarding the functions of the Agency which would enhance the mission and work of the Agency, and these features are also addressed as appropriate.

II. COMMENTS BY CHAPTER.

CHAPTER 1: Introduction

Chapter 1 presents the "Introduction" to this report. Again, we wish to strongly emphasize the conflicting descriptions of cost containment (page 2) as "...a principal function..." of the agency and the assertion later on that same page that such containment is the agency's "...primary mission..."

We agree that cost containment is a principal function of the Agency's CON process. However, cost containment is not the primary mission of the Agency or of the CON. Rather, all functions of the Agency are subservient to the statutory mission of "...promot[ing] accessibility for all the people of the state to quality health care services at reasonable cost..."

To ignore this distinction is to underestimate, as this report does, the importance and inter-relationships among the planning, data, and community participation functions of the Agency in fulfilling its mission.

CHAPTER 2: Impact of SHPDA on Controlling Health Care Costs

Chapter 2 compounds the error of assessing the cost containment function within the CON process as being the primary mission of that process (page 5). Again, cost containment is only one of the features involved in the CON review. Further, the Agency is concerned with the unspoken assumption -- which recurs throughout the report -- that the denial of a CON, rather than the conditions of approval, has greater sway in cost outcomes.

While we agree that denial is the most measureable cost outcome, with the apparent savings of whatever the proposed cost of equipment or services may have been in the submitted application. SHPDA urges reviewers to view the CON as also useful in promoting desired health care outcomes which may not be so easily quantified. For example, recent practice in review and approval has been to require a percentage of services or facility useage to Medicaid patients.

This type of conditional review was also utilized in the Magnetic Resonance Imaging (MRI) review of CON applications to allow for a phasing-in of equipment once threshold limits of procedures had been attained. In this way, the time and cost of applying for a CON was significantly reduced by not exercising the power of denial.

Assessments of the cost increases or savings occasioned by the granting of a CON are elusive. A difficulty in making this judgment quantifiable are the accounting practices of hospitals. Typically, the costs and incomes from a new service or a new facility are not accounted for in a separate category.

Agency Response to Recommendations of Chapter 2.

1. "The legislature should consider limiting the function of the State Health Planning and Development Agency to regulating large capital investments in health care facilities and medical technologies."

As stated earlier, the Agency strongly disagrees with this recommendation.

This recommendation assumes that cost containment should be the primary mission of the Agency and that the CON is the sole vehicle for this containment. Moreover, this recommendation assumes that the effectiveness of the CON in promoting such cost containment is either limited to or most effective solely in the area of large capital investments.

No substantiation or reasoning for this assumption is set forth in the report. Rather, it is only by inference from the subsequent recommendations in this chapter and again in Chapter 3 that an outline of rationale seems apparent. Rather than guess the logic, however, we will respond to the component recommendations as presented.

What we must raise at this point, however, is the concern that allowing too many lower cost equipment and services to proliferate would, in our view, greatly contribute to higher costs and encourage unnecessary utilization.

What has been omitted in this assessment is the role of comprehensive planning and the function of "The Health Services and Facilities Plan" to set criteria for need and use. Since 1974, SHPDA has formally provided a coordinated process involving all governmental levels, providers, and consumers, to set policies, standards and recommendations for the implementation of services and facilities. These policies, standards, and recommendations are developed independent of the CON process -- and are used to guide decision-making.

Again, this planning rests on an analysis of each service to include availability, accessibility, quality, cost, and overall need. By providing a standardized reference of use and need, highly technical services and procedures are made more comprehensible to the general public, and promotes greater community participation in decision-making.

Too often, at too high a cost, the community might be forced into an attitude of let-the-experts-decide. Decisions about the quality, cost, and need for services and facilities are community decisions.

2. "SHPDA should review the scope of the certificate of need program, determine the appropriateness of its numerous service categories, and recommend more meaningful thresholds for those it decides to retain."

The Agency agrees with this recommendation.

We anticipate amendments to existing rules which reduce the number of service categories by mid-1992. At this time, we will also examine current thresholds and pursue changes if needed.

3. SHPDA should develop better measures to indicate the program's effect on containing costs in capital investments for new facilities and services. In addition, it should report its methodology and the results of its analyses to the Legislature each year.

The Agency agrees with this recommendation.

However, we believe that it is more important to address the annual and on-going operating costs associated with new capital investments, rather than a one-time capital cost.

To develop these measures, the Agency will immediately begin to (a) initiate a national survey of sister agencies regarding their measurement systems; (b) convene a technical committee of relevant experts to assist in the development of a cost analysis system; and (3) based on the technical committee's guidance, determine if a contract for services to retain a consultant in the development of such a system is needed.

We anticipate that this process of system development would require a year or more to complete. A report on progress and possible methodology could be submitted to the 1993 Legislature, with a request for additional funding, if needed.

4. SHPDA should require complete reporting by applicants on a project's effect on health care costs and it should monitor the projects it approves.

The Agency agrees with this recommendation.

We acknowledge that the monitoring of applicants is a weakness. In fact, in 1990, the Agency developed the forms and a procedure for monitoring, but recognized that we could not implement the needed monitoring without additional staff. That recognition prompted a biennium budget request which was approved for a position and funds to support monitoring.

SHPDA initiated the paperwork to establish this position in June, 1991. On January 7, 1992, we received formal notification that the position was administratively established. We have now requested permission to fill the position, and expect to complete hiring and begin monitoring by March of this year.

CHAPTER 3: Management of the Certificate of Need Program

Overall this chapter sets forth -- and the Agency concurs -- that the CON process can be streamlined. However, the specifics of how or where this stream-lining may occur needs further review.

For example, under the rules, the Agency has 30 days in which to inform an applicant as to whether the application is complete or not. Frequently, we are able to make that determination in less time. The applicant is then able to re-submit and to set the clock again. However, because of difficulties in the tracking system for CONs, there can be a misimpression of which specific application is being reviewed and the length of time required to complete.

The Agency is not responsible for the incompleteness of an application, but does strive to inform applicants of deficiencies or omissions in as expeditious a fashion as possible. However, the finding that "...the agency takes twice as long as the rules require to notify applicants that the forms are complete....," we believe reflects the time required by applicants to furnish needed information, rather than the time required for staff review.

This pattern is explicit in the longer review cycles also allowed under rules. Thus, the Agency established a 150-day review cycle for the five MRI applications received in 1990. The complexity and volume of information and informed review required for these applications could not be assured in the shorter 90-day review cycle.

Also raised as a concern in this chapter was the need to strengthen the Agency's research capacity. We concur.

However, as noted (page 19) in this report, the Agency "...did not fill a position for a Resource Allocation Systems Analyst, and the authorization to fill this position expired in June, 1991..." The Agency was simply unable to fill this position -- first, because it was temporary (as indicated by the expiration), and second, because the salary was not competitive. The Agency was then unsuccessful in its efforts to request a permanent position at a higher salary.

Other comments related to this chapter are better addressed in responses to specific recommendations.

Agency Responses to Recommendations in Chapter 3.

- 1. "The State Health Planning and Development Agency should develop better management controls over the certificate of need process by improving its record keeping and developing a better application tracking system.*

The Agency agrees with this recommendation, and will institute a tracking system by the end of this fiscal year.

2. *"SHPDA should streamline the certificate of need process by reducing the number of reviews by advisory committees."*

We do not agree with this recommendation.

This chapter and its reflection in this recommendation is that the broad public participation in CON review and decision-making is burdensome. As expressed by the state Legislature in creating SHPDA (Act 152, SLH 1976) "health planning for the State is a complex area, and requires the input of persons of various interests and representing various geographical areas." The Legislature went on to stress that the purpose of SHPDA and its citizen committees was "to ensure the pragmatic health planning of the State by providing a permanent vehicle for citizen input into the health planning process, so that the total health services plans of the State will be based on informed decision making..."

The Agency continues to believe that a good health planning process and the fulfillment of the Agency's mission requires the broad community-based system established in current law. We also recognize that this system can seem burdensome to an applicant. However, the state law holds -- and we agree -- that there is a proper balance between the applicant's need for an expeditious review and the community's need for meaningful participation.

We note that this report is in factual error (page 19) when it says that "...the committee system is a holdover from the federal law which has been repealed..." Federal law mandated citizen participation, but it was state law which described the system of Subarea Health Planning Councils.

The report also suggests that streamlining could occur by holding a single, joint hearing by the Statewide Council and the relevant Subarea Council. We believe that this option would be impractical in most instances. For example, a combined meeting between the State Health Coordinating Council (SHCC) and a Neighbor Island Subarea Council would result in a committee size of 35 individuals -- in our opinion, too large a number to allow full participation. In addition, an average of 19 members from the SHCC would need to travel to another island -- creating a significant cost in travel expenses and volunteer time.

In 1984, the Legislature acted to streamline this review process by amending the law to provide that SHCC's smaller sub-committee, called the Review Panel, was empowered to conduct the detailed review and to make its recommendation for ratification to the full SHCC. This part of the process has not functioned as anticipated.

Rather than shortening the time needed for SHCC review, applicants have chosen to make full, duplicate presentations and SHCC members who do not participate in the Review Panel often ask for full information.

Thus, while the Agency is hesitant to view community participation as burdensome, additional consideration should be given to whether the Review Panel is functioning as intended, or whether it has become another, duplicative part of the SHCC review.

3. *"SHPDA should develop the capacity to carry out needed research in support of the certificate of need program."*

The Agency agrees with this recommendation.

This improved capacity will require additional positions and funding. It is the intent of the Agency, consistent with legislative budgetary practices, to seek this enhanced staffing in the next biennium budget cycle.

4. *"The statute and the rules should be amended to permit the chair of the State Health Coordinating Council to also chair the Certificate of Need Reconsideration Committee."*

The Agency agrees with this recommendation.

Last year, the Agency sought this statutory amendment through House Bill 1707, which was passed by the Legislature. However, the governor vetoed this measure because of technical deficiencies. We anticipate that another measure will be introduced this session, and will effectuate this needed change.

This concludes our response to the draft of the legislative audit of SHPDA. Again, we wish to acknowledge those involved in the preparation of this report, and to express our mahalo a nui loa for the opportunity to respond in detail.

As SHPDA Administrator, I bear full responsibility for the opinions expressed in this response. However, I would be remiss if I did not acknowledge the invaluable contributions of my staff, especially Mr. Patrick Boland, for their assistance.

Me ke aloha,



(Mrs.) Kina'u Boyd Kamali'i
Administrator
State Health Planning and Development Agency



JOHN WAIHEE
GOVERNOR OF HAWAII

JOHN C. LEWIN, M.D.
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH

P. O. BOX 3378
HONOLULU, HAWAII 96801

January 22, 1992

In reply, please refer to:
File:

OPPPD

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RECEIVED
JAN 22 12 00 PM '92
OFFICE OF THE AUDITOR
STATE OF HAWAII

Dear Mrs. Higa:

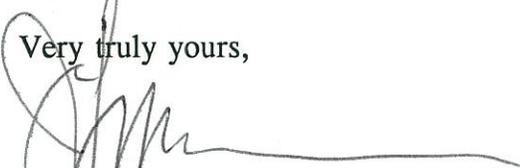
Thank you for the opportunity to review the Auditors Report on the State Health Planning and Development Agency (SHPDA). In general, we appreciate the many constructive comments and recommendations. We will leave the comments on specific issues for SHPDA to answer.

However, we would like to emphasize that the future role of SHPDA, and the Certificate of Need (CON) program, is important to the Hawaii. Many of the other states which repealed their CON and health planning agencies are currently reviewing this decision with the intent to reinstate these programs.

The SHPDA in Hawaii could become even more important as we continue our health care reform efforts which will include the design of new cost control mechanisms.

Again, thank you for the opportunity to comment on this important subject, and we are looking forward to continuing the debate on the health care cost containment process most appropriate for our State.

Very truly yours,


JOHN C. LEWIN, M.D.
Director of Health