Maple Grove Hospital Public Interest Reviews

Senate Health and Family Security Committee
April 12, 2005

Scott Leitz, Director
Office of Health Policy, Statistics, and Informatics

Scott Leitz

MINNESOTA MDH DEPARTMENT OF HEALTH

Background

- Since 1984, Minnesota law has prohibited the construction of new hospitals or expansion of bed capacity at existing hospitals without specific authorization from the Legislature
  - Currently, there are 18 exceptions listed in the statute
- A 2004 law established a new process for review of proposals for exceptions to the hospital moratorium

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Hospital Public Interest Review Process

- Under the new law, a hospital seeking to increase its number of licensed beds or an organization seeking to obtain a hospital license must submit a plan to MDH for review
- The Commissioner of Health issues a finding as to whether a plan is in the public interest
- The decision of whether to grant an exception to the hospital moratorium is still made by the Legislature

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5 Factors to Be Considered in MDH Public Interest Review:

- Whether the new hospital or hospital beds are needed to provide timely access to care or access to new or improved services
- The financial impact of the new hospital or hospital beds on existing acute-care hospitals that have emergency departments in the region
- How the new hospital or hospital beds will affect the ability of existing hospitals in the region to maintain existing staff
- The extent to which the new hospital or hospital beds will provide services to nonpaying or low-income patients relative to the level of services provided to these groups by existing hospitals in the region
- The views of affected parties

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Proposals to Build a Hospital in Maple Grove: Received November 2004

- North Memorial
- Fairview
- Allina/Park Nicollet/Children's ("Maple Grove Tri-Care Partnership")
- In accordance with the statute, MDH reviewed each plan separately and issued a separate finding for each plan

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MDH Approach to Review of Maple Grove Proposals

- ★ Common to all 3 proposals:
  - Public input
  - Analyzing historical and projected data on demographics and hospital use
    - Statewide
    - Specific to Maple Grove area
  - Reviewing previously published research on relevant topics
- ★ Specific to each proposal:
  - Evaluation in light of each of the statutory factors
  - Analysis of impact on other hospitals in the region, including impact on uncompensated care

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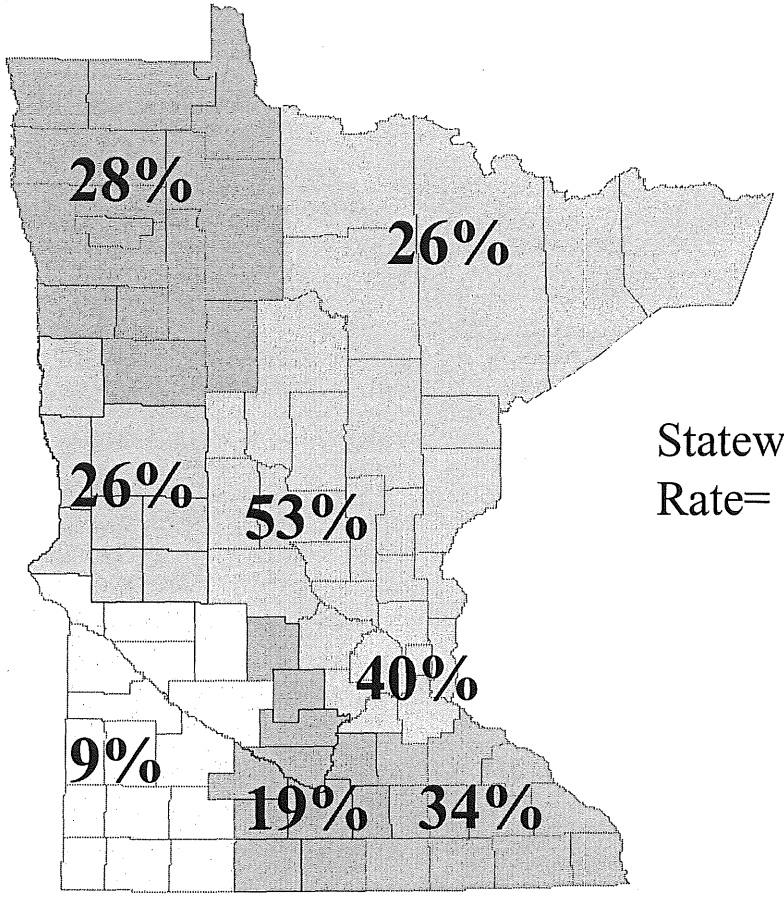
Projected Growth in Inpatient Days by Region, 2000 to 2020



Statewide Growth Rate= 37%

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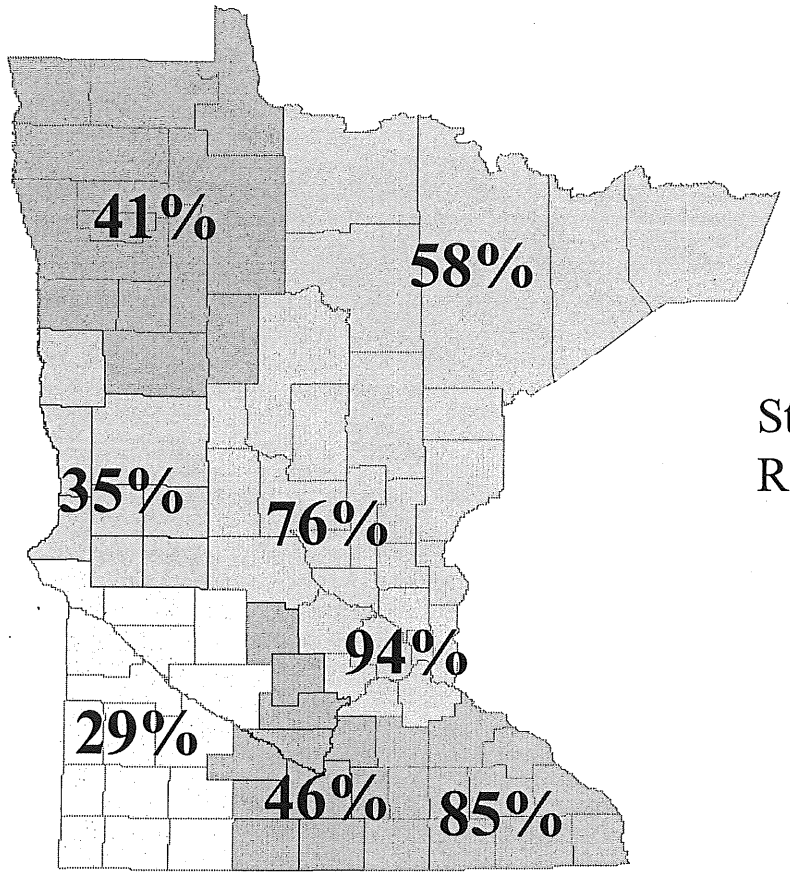
Projected Occupancy Rates as % of 2003 Available Beds, by Region, 2020



Statewide Occupancy Rate= 75%

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Future Occupancy Rates: Additional Factors to Consider

- Occupancy rates vary widely across the state – projected occupancy in Twin Cities metro area is much higher than statewide
- Due to fluctuations in demand, measuring occupancy rates over a full-year period likely understates the degree to which the hospital system may be operating at or near capacity constraints at certain times

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Maple Grove Area: Demographic Trends and Use of Hospital Services

- The Maple Grove area is experiencing rapid population growth – expected to grow 3 to 4 times faster than the state as a whole over the next decade
- MDH analysis focused on 11 hospitals that currently serve most patients from the Maple Grove area
  - Projection of occupancy rates at existing hospitals if no new hospital is built
    - Incorporates population growth and aging, and a range of assumptions about future hospital utilization rates
  - Because these 11 hospitals account for about one-third of annual hospital admissions in Minnesota, the results of this analysis have implications beyond Maple Grove

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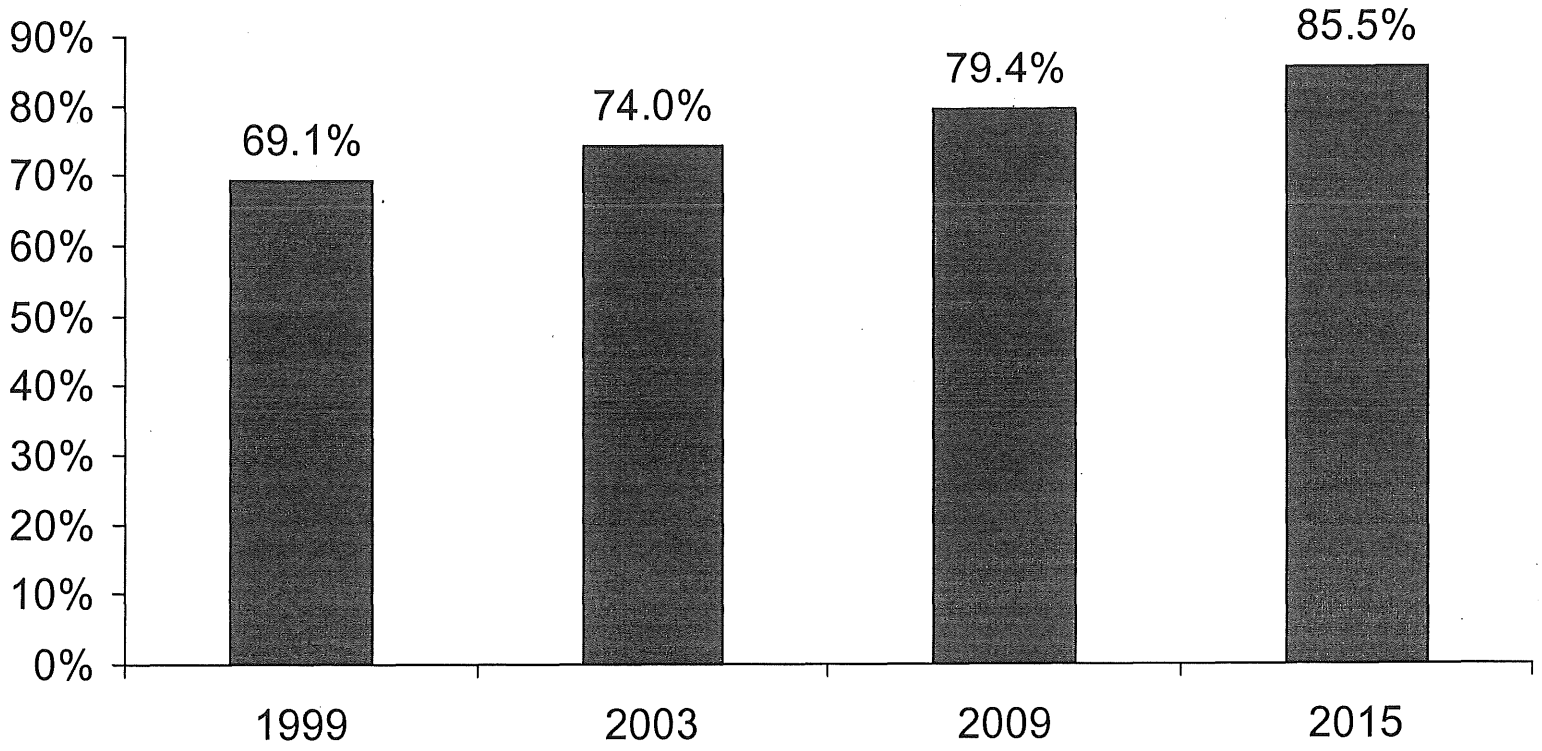
Occupancy Rates at Existing Hospitals Serving the Maple Grove Community



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Projected Occupancy Rates at Maple Grove Area Hospitals

- **By 2009:**
  - The group of 11 hospitals serving Maple Grove area resident is projected to have an occupancy rate of 79.4%
  - 6 hospitals in this group are expected to have occupancy above 75%
- **By 2015:**
  - Occupancy rate at the group of hospitals currently serving Maple Grove area residents is projected to be 85.5%
  - 10 hospitals in this group are expected to have occupancy above 75%
  - 4 hospitals in this group are expected to have occupancy above 90%

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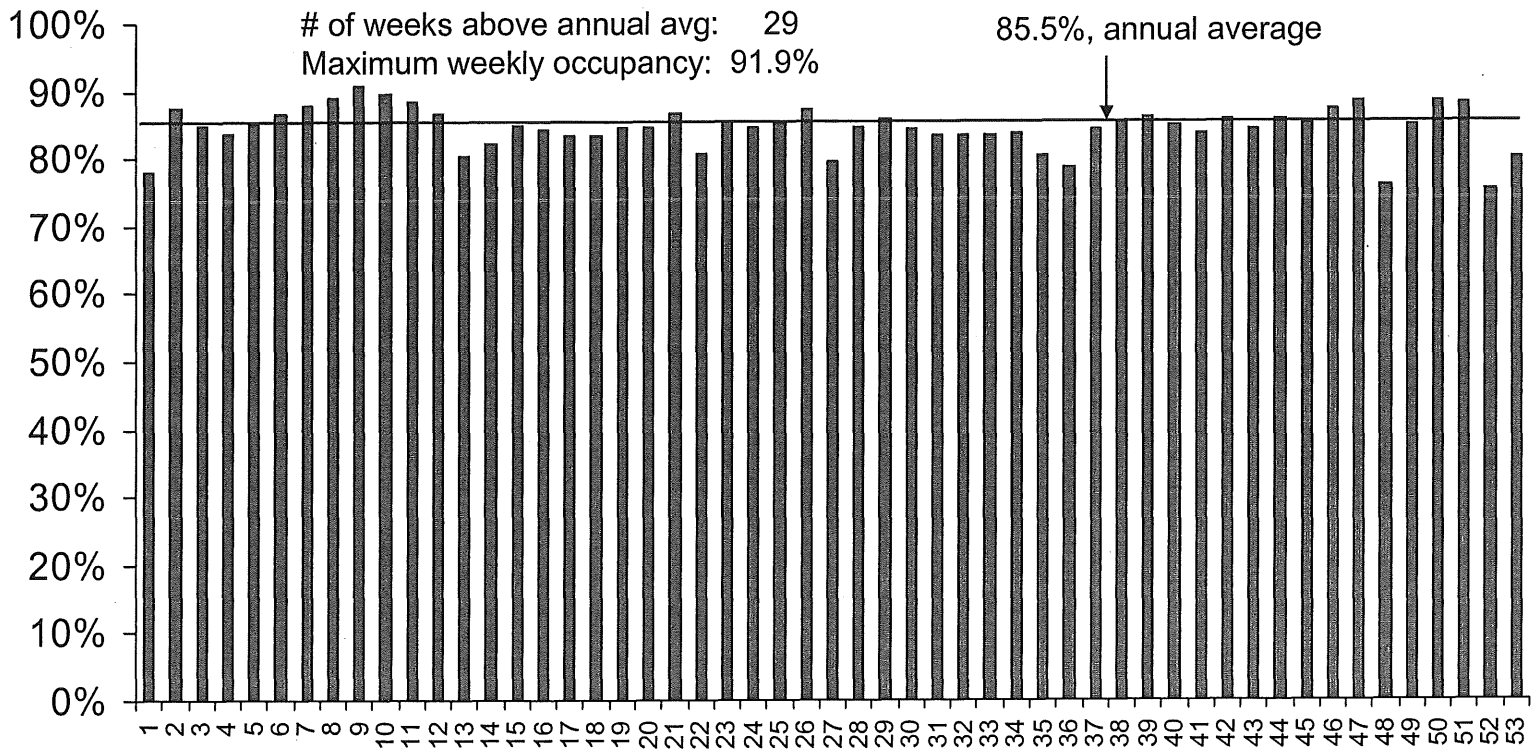
2015 Weekly Projected Occupancy Rates for Hospitals Serving Residents of the Maple Grove Area



Occupancy rates calculated based on 2003 available beds.

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Factor 1: Whether the new hospital or hospital beds are needed to provide timely access to care or access to new or improved services

- MDH analysis shows that there will be increasing strains on capacity at existing facilities serving Maple Grove
- In addition, each report address to varying degrees the specific services identified by the community and MDH as likely necessary services:
  - Inpatient mental health
  - Obstetrics
  - Emergency services
- Relationship between time/distance to emergency services and impact on health outcomes; other factors, such as having a well-functioning EMS system, are also important

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Factor 2: The financial impact of the new hospital or hospital beds on existing acute-care hospitals that have emergency departments in the region

- Compared to projections in the absence of a new hospital, some facilities are likely to experience a loss of volume
  - Impact varies depending on current market share
  - In general, those with largest market share have largest impact
- In nearly all cases, however, volume of services is projected to rise at area hospitals compared to 2003
- In other words: for most facilities, growth in demand will still occur, but will be slower than it would have otherwise been

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Factor 3: How the new hospital or hospital beds will affect the ability of existing hospitals in the region to maintain existing staff

- Concerns about shortages of particular types of staff (e.g., nurses)
  - In the Twin Cities, labor shortage seems to have eased compared to a few years ago, but vacancy rates for nurses are still above the statewide average
- Proposed Maple Grove facility is small relative to the overall market so new facility probably won't have a substantial impact
  - May have some impact on labor issues, but other factors such as rising overall demand for hospital services may be even more important
- For individual employees, there will be tradeoffs in employment decisions (e.g., shorter commute vs. less seniority)

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Factor 4: The extent to which the new hospital or hospital beds will provide services to nonpaying or low-income patients relative to the level of services provided to these groups by existing hospitals in the region

- Applicants propose to implement current charity care policies at proposed Maple Grove hospital
- Concerns about impact on safety net hospitals' ability to continue to provide care to low-income or nonpaying populations:
  - MDH analysis looks at sources of health insurance coverage in the areas served by specific hospitals, estimated with and without the impact of the proposed Maple Grove hospital
  - Estimated effect is in the direction expected, but size of impact is small

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Factor 5: The views of affected parties

- Public meeting in Maple Grove on January 11, 2005
  - Community views summarized in each report
- MDH received several written comments in support of each application
  - Included in each report
- North Memorial concerns about impact of Fairview and Tri-Care proposals
  - North Memorial concerns included in each report
  - Fairview and Tri-Care rebuttals also included in their respective reports

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Other Factors Considered

- Hospital competition and consolidation
- Bed types and services provided
- Potential health care system costs

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Summary: Key MDH Findings

- All three reports from MDH to the legislature find that it is in the public interest to build a hospital in Maple Grove:
  - The Maple Grove area can support a hospital
  - Rapid population growth and aging will increase demand for hospital services
  - Hospitals currently serving residents of the area are projected to experience increasing strains on capacity
    - This issue affects all Minnesotans, not just residents of the Maple Grove area (1/3 of statewide discharges)
- We also recommend that the legislature should consider requiring the addition of inpatient behavioral health services as a condition of granting an exception to the hospital moratorium

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Senate Counsel, Research, and Fiscal Analysis

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Senate

State of Minnesota

S.F. No. 1840 - Moratorium Exception For a New Maple Grove Hospital

Author: Senator Warren Limmer

Prepared by: David Giel, Senate Research (296-7178)

Date: April 11, 2005

S.F. No. 1840 authorizes an exception to the hospital moratorium for the construction of a new hospital in Maple Grove by an existing hospital that relocates or redistributes beds from its current site. The number of beds is unspecified.

DG:rdr

Senator Limmer introduced--

S.F. No. 1840: Referred to the Committee on Finance.

A bill for an act

relating to health; providing an exception to the hospital construction moratorium; amending Minnesota Statutes 2004, section 144.551, subdivision 1.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2004, section 144.551, subdivision 1, is amended to read:

Subdivision 1. [RESTRICTED CONSTRUCTION OR MODIFICATION.] (a) The following construction or modification may not be commenced:

(1) any erection, building, alteration, reconstruction, modernization, improvement, extension, lease, or other acquisition by or on behalf of a hospital that increases the bed capacity of a hospital, relocates hospital beds from one physical facility, complex, or site to another, or otherwise results in an increase or redistribution of hospital beds within the state; and

(2) the establishment of a new hospital.

(b) This section does not apply to:

(1) construction or relocation within a county by a hospital, clinic, or other health care facility that is a national referral center engaged in substantial programs of patient care, medical research, and medical education meeting state and national needs that receives more than 40 percent of its patients from outside the state of Minnesota;

(2) a project for construction or modification for which a health care facility held an approved certificate of need on May 1, 1984, regardless of the date of expiration of the certificate;

(3) a project for which a certificate of need was denied before July 1, 1990, if a timely appeal results in an order reversing the denial;

(4) a project exempted from certificate of need requirements by Laws 1981, chapter 200, section 2;

(5) a project involving consolidation of pediatric specialty hospital services within the Minneapolis-St. Paul metropolitan area that would not result in a net increase in the number of pediatric specialty hospital beds among the hospitals being consolidated;

(6) a project involving the temporary relocation of pediatric-orthopedic hospital beds to an existing licensed hospital that will allow for the reconstruction of a new philanthropic, pediatric-orthopedic hospital on an existing site and that will not result in a net increase in the number of hospital beds. Upon completion of the reconstruction, the licenses of both hospitals must be reinstated at the capacity that existed on each site before the relocation;

(7) the relocation or redistribution of hospital beds within a hospital building or identifiable complex of buildings provided the relocation or redistribution does not result in: (i) an increase in the overall bed capacity at that site; (ii) relocation of hospital beds from one physical site or complex to another; or (iii) redistribution of hospital beds within the state or a region of the state;

(8) relocation or redistribution of hospital beds within a hospital corporate system that involves the transfer of beds from a closed facility site or complex to an existing site or complex provided that: (i) no more than 50 percent of the capacity of the closed facility is transferred; (ii) the capacity of the site or complex to which the beds are transferred does not increase by more than 50 percent; (iii) the

beds are not transferred outside of a federal health systems agency boundary in place on July 1, 1983; and (iv) the relocation or redistribution does not involve the construction of a new hospital building;

(9) a construction project involving up to 35 new beds in a psychiatric hospital in Rice County that primarily serves adolescents and that receives more than 70 percent of its patients from outside the state of Minnesota;

(10) a project to replace a hospital or hospitals with a combined licensed capacity of 130 beds or less if: (i) the new hospital site is located within five miles of the current site; and (ii) the total licensed capacity of the replacement hospital, either at the time of construction of the initial building or as the result of future expansion, will not exceed 70 licensed hospital beds, or the combined licensed capacity of the hospitals, whichever is less;

(11) the relocation of licensed hospital beds from an existing state facility operated by the commissioner of human services to a new or existing facility, building, or complex operated by the commissioner of human services; from one regional treatment center site to another; or from one building or site to a new or existing building or site on the same campus;

(12) the construction or relocation of hospital beds operated by a hospital having a statutory obligation to provide hospital and medical services for the indigent that does not result in a net increase in the number of hospital beds;

(13) a construction project involving the addition of up to 31 new beds in an existing nonfederal hospital in Beltrami County;

(14) a construction project involving the addition of up to eight new beds in an existing nonfederal hospital in Otter Tail County with 100 licensed acute care beds;

(15) a construction project involving the addition of 20 new hospital beds used for rehabilitation services in an existing hospital in Carver County serving the southwest

suburban metropolitan area. Beds constructed under this clause shall not be eligible for reimbursement under medical assistance, general assistance medical care, or MinnesotaCare;

(16) a project for the construction or relocation of up to 20 hospital beds for the operation of up to two psychiatric facilities or units for children provided that the operation of the facilities or units have received the approval of the commissioner of human services;

(17) a project involving the addition of 14 new hospital beds to be used for rehabilitation services in an existing hospital in Itasca County; ~~or~~

(18) a project to add 20 licensed beds in existing space at a hospital in Hennepin County that closed 20 rehabilitation beds in 2002, provided that the beds are used only for rehabilitation in the hospital's current rehabilitation building. If the beds are used for another purpose or moved to another location, the hospital's licensed capacity is reduced by 20 beds; or

(19) a project for the construction of a new hospital in the city of Maple Grove with a licensed capacity of up to .. beds by an existing hospital that relocates or redistributes the beds from its current site.

Minnesota Hospital Public Interest Review:

Fairview Health Services Proposal for a New Inpatient Facility in Maple Grove, Minnesota

Minnesota Department of Health

March 2005

MINNESOTA MDH DEPARTMENT OF HEALTH

Office of Health Policy, Statistics and Informatics
Health Economics Program
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MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, maintaining and improving the health of all Minnesotans

March 11, 2005

The Honorable Jim Abeler
Chair, Health Care Cost Containment Division
Minnesota House of Representatives
509 State Office Building
100 Rev. Dr. Martin Luther King Jr. Blvd.
Saint Paul, Minnesota 55155

The Honorable Linda Berglin
Chair, Health and Human Services
Budget Division
Minnesota Senate
Room 309, State Capitol
75 Rev. Dr. Martin Luther King Jr. Blvd
Saint Paul, Minnesota 55155-1606

The Honorable Fran Bradley
Chair, Health Policy and Finance
Committee
Minnesota House of Representatives
563 State Office Building
100 Rev. Dr. Martin Luther King Jr. Blvd.
Saint Paul, Minnesota 55155

The Honorable Becky Lourey
Chair, Health and Family Security
Committee
Minnesota Senate
Room G-24, State Capitol
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Saint Paul, Minnesota 55155-1606

To the Honorable Chairs:

Minnesota Statutes 144.552 requires any hospital seeking to increase its number of licensed beds or an organization seeking to obtain a hospital license to submit a plan to the Commissioner of Health. The Commissioner is required to review each plan submitted under Minnesota Statutes 144.552 and issue a finding on whether the plan is in the public interest. The law requires that the Commissioner provide a copy of the finding on whether the plan is in the public interest to the chairs of the House and Senate committees having jurisdiction over health and human services policy and finance.

In November 2004, the MDH received three proposals from entities planning to seek a license to build a new hospital in Maple Grove, Minnesota. North Memorial Health Care and Fairview Health Services each submitted a proposal, and the third proposal was submitted by a partnership between Allina Hospitals and Clinics, Park Nicollet Health Services, and Children's Hospitals and Clinics (the "Maple Grove Tri-Care Partnership"). Consistent with the requirements of Minnesota Statutes 144.552, we have reviewed each of the three plans that we received. Because the law does not specifically contemplate situations in which more than one proposal may be submitted for the same geographic area, we reviewed each of the plans individually. A separate report and findings for each of the plans submitted to MDH for public interest review is enclosed.

All three of the reports find that it is in the public interest to construct a new hospital in Maple Grove. From a local perspective, the Department concurs that the community can support a hospital of the size and scope proposed, and that a new facility would provide more convenient access to services for residents in the community. From a statewide perspective, the Department finds that existing inpatient hospital capacity is likely to experience increasing strains over the next decade, and that construction of some new capacity may be necessary to relieve those strains. Because hospitals that currently serve the Maple Grove area collectively account for about one third of total hospital admissions in Minnesota, this issue is a statewide concern. The three proposals address this issue to varying degrees. Also to varying degrees, all three proposals specifically address issues of statewide concern such as a shortage of inpatient behavioral health services. In considering whether to grant an exception to the hospital moratorium, the legislature may wish to give strong consideration to whether certain services, such as inpatient behavioral health services, should be included as a requirement under any moratorium exception granted.

While the Department finds that it is in the public interest to construct a new hospital in Maple Grove, we believe that it is unlikely that the construction of three new inpatient facilities in Maple Grove would be in the public interest. As noted above, the legislation establishing the public interest review process did not contemplate a situation in which there would be simultaneous proposals to expand hospital capacity in the same geographic area. A direct comparison of the three proposals and recommendation as to which proposal is best is beyond the scope of the Department's authority under the law.

I look forward to working with into the future on issues of hospital capacity in Minnesota.

Sincerely,

Dianne M. Mandernach

Dianne M. Mandernach
Commissioner
P.O. Box 64882
St. Paul, Minnesota 55164-0882

Minnesota Hospital Public Interest Review:

Fairview Health Services Proposal for a New Inpatient Facility in Maple Grove, Minnesota

Minnesota Department of Health

March 2005

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As required by Minnesota Statute 3.197: This report cost approximately $75,000 to prepare including staff time, printing and mailing expenses

Table of Contents

1. Background

Since 1984, Minnesota law has prohibited the construction of new hospitals or expansion of bed capacity of existing hospitals without specific authorization from the Legislature (Minnesota Statutes 144.551). As originally enacted, the law included a few specific exceptions to the moratorium on new hospital capacity; other exceptions have been added over time, and there are currently 18 exceptions to the moratorium that are listed in the statute. Many of these exceptions apply to specific facilities, but some define an exception that applies more broadly (for example, an exception that allows for the relocation of a hospital within five miles of its original site under some circumstances).

The moratorium on licensure of new hospital beds replaced a Certificate of Need (CON) program that provided for case-by-case review and approval of proposals by hospitals and other types of health care providers to undertake large projects such as construction and remodeling or purchases of expensive medical equipment. The CON program was in effect from 1971 until it was replaced by the hospital moratorium in 1984. The CON program was criticized for failing to adequately control growth, but at the same time there was substantial concern among policymakers about allowing the CON program to expire without placing some other type of control on investment in new capacity.

At the time the hospital moratorium was enacted, policymakers were concerned about excess capacity in the state's hospital system, its impact on the financial health of the hospital industry, and its possible impact on overall health care costs. According to a 1986 Minnesota Senate Research Report on the hospital moratorium, "Declining occupancy has resulted in thousands of empty hospital beds across the state, in financial difficulty for some hospitals, and in efforts by hospitals to expand into other types of care. In spite of the excess hospital capacity in the state, hospitals continued to build and expand until a moratorium was imposed...."[1] The moratorium was seen as a more effective means of limiting the expansion of hospital capacity than the Certificate of Need program it replaced. One drawback of the moratorium, however, has been that there is no systematic way of evaluating proposals for exceptions to the moratorium in terms of the need for new capacity or the potential impact of a proposal on existing hospitals.

[1] "Hospital and Nursing Home System Growth: Moratoria, Certificate of Need, and Other Alternatives," Minnesota Senate Research Report, by Dave Giel and Michael Scandrett, January 1986.

2. Hospital Public Interest Review Process

In 2004, the Legislature established a new process for reviewing proposals for exceptions to the hospital moratorium (Minnesota Statutes 144.552). This "public interest review" process requires that hospitals planning to seek an exception to the moratorium law submit a plan to the Minnesota Department of Health (MDH). Under the law, MDH is required to review each plan and issue a finding on whether the plan is in the public interest. Specific factors that MDH is required to consider in the review include:

- Whether the new hospital or hospital beds are needed to provide timely access to care or access to new or improved services;
- The financial impact of the new hospital or hospital beds on existing acute-care hospitals that have emergency departments in the region;
- How the new hospital or hospital beds will affect the ability of existing hospitals in the region to maintain existing staff;
- The extent to which the new hospital or hospital beds will provide services to nonpaying or low-income patients relative to the level of services provided to these groups by existing hospitals in the region; and
- The views of affected parties.

Finally, the law requires that the public interest review be completed within 90 days, but allows for a review time of up to six months in extenuating circumstances. Authority to approve any exception to the hospital moratorium continues to rest with the Legislature.

In November 2004, MDH received three separate filings for public interest review of a proposal to build a new hospital in Maple Grove, Minnesota. North Memorial Health Care and Fairview Health Services each submitted proposals, and a joint proposal from Allina Hospitals and Clinics, Park Nicollet Health Services, and Children's Hospitals and Clinics (collectively, the "Maple Grove Tri-Care Partnership") was also submitted. The law that established the public interest review process does not specifically contemplate situations in which more than one proposal for an exception may be submitted for the same geographic area. With regard to the three applications for public interest review that MDH has received for the Maple Grove area, we have reviewed each plan separately according to the criteria established in the law. It is important to note that each of the three proposed projects also involves the construction of large new outpatient facilities that will provide a broad range of services such as primary and specialty care, ambulatory surgery, and diagnostic imaging, with construction beginning as early as 2005; however, Minnesota law does not restrict the ability to construct outpatient facilities in the same way as it does for inpatient facilities, and those portions of the proposed projects are therefore outside of the scope of MDH's public interest review.

Our review of each proposal included several different components. Some of these components, such as soliciting public input, reviewing historical and projected data on population demographics and hospital use, and reviewing previously published research on relevant topics, were overlapping among the three proposals. Other aspects of our review, such as estimating the potential impact of the proposed facility on other hospitals in the region and evaluating each proposal in light of the specific criteria listed in the law, were conducted separately for each proposal.

The remainder of this report is organized as follows:

- Section 3 provides a summary of the comments from the public and other affected parties that we received related to the need for a hospital in Maple Grove;
- Section 4 presents information on trends in the use of hospital services and how the use of hospital services is projected to change as a result of future demographic changes, from a statewide and regional perspective and also for the local hospital market serving residents of the Maple Grove area;
- Section 5 evaluates Fairview's plan to build a hospital in Maple Grove in light of the criteria for review that are specified in Minnesota Statutes 144.552;
- Section 6 concludes the report with a summary of the analysis and findings, along with other factors that policymakers may wish to consider in evaluating this proposal for an exception to the hospital moratorium.

3. Public Input

We used three strategies to collect input on the views of affected parties. First, we sent a letter to all hospital administrators in Minnesota notifying them of the plans that had been filed and soliciting their input if they wished to provide any. Second, we published a notice in the December 6, 2004 State Register as a general notice to interested parties that we had received three plans and providing an opportunity to comment on the proposals. Third, we held a public meeting in Maple Grove on January 11, 2005 to solicit input from the community on the need for a hospital in Maple Grove and the impact that a hospital in Maple Grove might have on other hospitals in the region. In addition, we posted an electronic copy of each of the filings that we received on MDH's website, in order to provide convenient access to the proposals to anyone who might wish to comment. Copies of written comments that we received about this proposal for an exception to the hospital moratorium are included in Appendix 1.

The public meeting that MDH held in Maple Grove on January 11 was intended to provide a forum for public input to MDH on the general need for a hospital in Maple Grove. An estimated 300 people attended the meeting, and 42 citizens provided comments. Many of the comments shared similar themes, which are summarized below:

- Concerns about health and safety:
    - Citizens are concerned about the distance to the nearest hospital (11 miles to North Memorial in Robbinsdale) and by the amount of time that it takes to travel there due to frequent traffic congestion.
    - Citizens and health care professionals alike believe that the Maple Grove area needs to have more timely access to emergency and trauma services. According to one person, the closest emergency care is "20 to 30 minutes away on a good day" and there is a need for more timely access.
    - Some health care professionals expressed specific public safety concerns about the lack of access to emergency care. They reported that the distance to the nearest emergency room deters some people from seeking emergency care that they really need (or causes them to delay seeking care), and they reported that urgent care centers currently located in Maple Grove are increasingly being used by people who are too sick to be treated there because of the lack of convenient access to a hospital emergency room.
- Shortages of specific services:
    - Several people commented on the need for additional mental health and chemical dependency services, due to a shortage of inpatient beds available to treat these conditions.

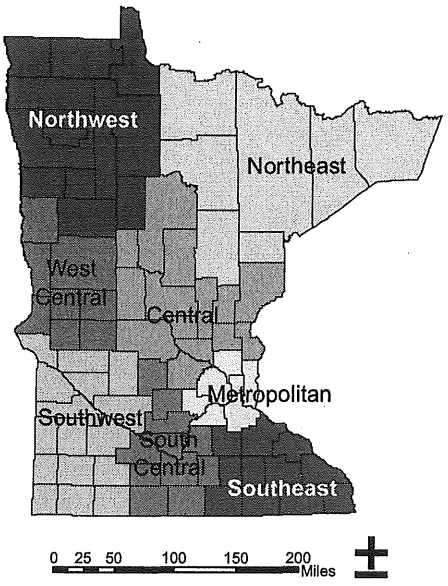
- Convenient access to services:
  - Community residents expressed a desire for more convenient access to health care services, particularly obstetric care, pediatric care (including specialty pediatric services), and cancer treatment.
  - Although many of the comments that focused on convenient access to services related to services that are likely to be provided in an outpatient setting, several people expressed a desire that any hospital that is built in Maple Grove should be a "full service" hospital providing a complete range of care without the need for patients to be transferred to other hospitals to receive more complex services.
- Collaboration between health care providers and the community:
  - Several people provided comments that emphasized the need for any organization that builds a hospital in Maple Grove to work collaboratively with the community (schools, churches, etc.) to identify and address community needs.
- Impact on other hospitals in the region:
  - Several community residents, some of whom are employed by North Memorial, expressed concerns about a potential adverse impact on North Memorial if one of the other two proposals were to be approved, about North Memorial's ability to survive as an independent institution, and about potential further consolidation of the hospital market into a market controlled by one or two large hospital systems.

4. Trends in the Use of Inpatient Hospital Services and Projected Impact of Future Demographic Change

State and Regional Trends

As noted above, one of the reasons for the original enactment of the hospital moratorium was that there was perceived to be a significant amount of excess capacity in Minnesota's hospital system. Since the moratorium was enacted, occupancy rates for Minnesota's hospital system as a whole have continued to be relatively low in comparison to licensed capacity. For example, in 2003 the system as a whole had an occupancy rate of about 42 percent of licensed beds; however, there is substantial variation in occupancy rates among different regions of the state – in 2003, occupancy rates ranged from a low of 28 percent in the South Central region to a high of 48 percent in the Twin Cities Metropolitan region (see map for region definitions).

Regional Definitions



In some ways, however, analyzing occupancy rates based on licensed beds can be misleading because many hospitals (particularly in the Twin Cities Metropolitan and Southeast regions) have large numbers of beds that are licensed but are unused. In some cases, these licensed beds may not even be able to be used within a facility's current physical capacity (i.e., a facility would have to undertake a major construction project in order to make use of these licensed beds). As a result, counting all of these licensed hospital beds when calculating occupancy rates is likely to overstate

the true capacity of Minnesota's hospital system. When occupancy rates are calculated based on "available beds",[2] the statewide hospital occupancy rate was 59 percent in 2003, ranging from a low of 28 percent in the Southwest region to a high of 71 percent in the Twin Cities Metropolitan region.

Because of advances in technology (e.g., the ability to do many procedures on an outpatient basis that formerly would have required a hospital stay), changes in standards of care, changes in health insurance payment systems, and other factors, use of inpatient hospital services in Minnesota (both admissions and total number of inpatient days) declined through the mid-1990s despite population growth. As shown in Table 1, even though Minnesota's population grew by about 20 percent from 1987 to 2003, the number of hospital admissions grew more slowly over the same period (14 percent) and the number of inpatient hospital days actually declined by 16 percent.

Table 1

Historical Trends in Use of Inpatient Hospital Services

	Percent change in:		
	Inpatient Admissions	Inpatient Days	Minnesota Population
1987 to 1994	-6.5%	-20.2%	8.9%
1994 to 1998	7.9%	-1.6%	4.4%
1998 to 2003	13.4%	7.1%	5.2%
1987 to 2003	14.4%	-15.9%	19.6%

Source: MDH, Hospital Cost Containment Information System, 1987 to 2003. 1987 was the first year of data collection.

There are several factors that are likely to influence future use of hospital services. Population growth will continue to play an important role, and aging will begin to be a more important factor as the baby boom generation reaches the age at which use of hospital services begins to increase sharply. In addition, technological advance will continue to be a very important determinant of future use of hospital services, with some new technologies likely increasing the use of inpatient services and others decreasing the use of services. Changes in the prevalence of disease (for example, due to rising rates of overweight and obesity) are also likely to play a role.

According to MDH estimates, population growth and the changing age distribution of the population are expected to result in an overall 36 percent increase in inpatient hospital days statewide between 2000 and 2020. As shown in Figure 1, this estimated increase varies by region: growth in the Central and Metropolitan regions is expected to be strongest, with growth in inpatient days of 53 percent and 40 percent, respectively. As a result, if the number of available beds were unchanged, occupancy rates would rise as well. The highest projected occupancy rates in

[2] The definition of "available beds" is the number of acute care beds that are immediately available for use or could be brought on line within a short period of time.

2020 are for the Metropolitan region (94 percent), Southeast region (85 percent) and Central region (76 percent), compared to a statewide average of 77 percent (see Figure 2). If occupancy rate calculations are performed using the number of hospital beds licensed in 2003 instead of available beds, the estimated future occupancy rates are much lower – 63 percent in the Metropolitan region, 53 percent in the Southeast region, 64 percent in the Central region, and 55 percent statewide.

Figure 1

Projected Growth in Inpatient Days by Region, 2000 to 2020

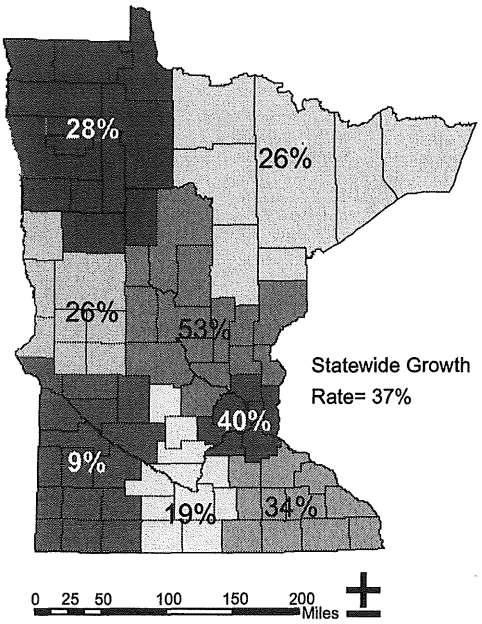
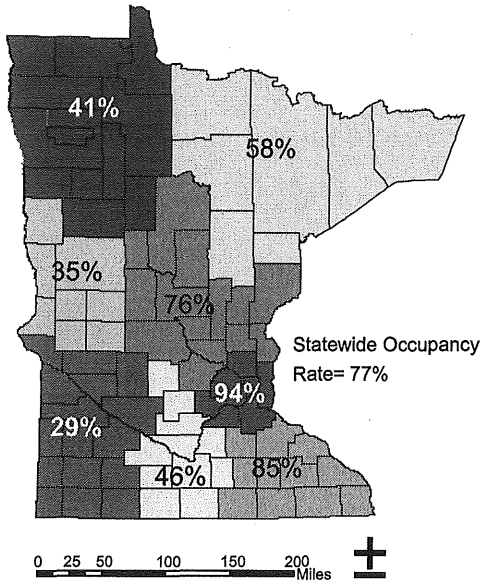


Figure 2

Projected Occupancy Rates as % of 2003 Available Beds by Region, 2020



In other words, there is clearly no shortage of licensed hospital beds in the state as a whole, nor is a shortage likely to materialize in the next fifteen years. However, the fact that the aggregate number of licensed beds in the state appears to be sufficient over this time period does not necessarily mean that there is no need for new physical hospital capacity, particularly in certain areas of the state experiencing rapid growth. There are several reasons why this may be the case:

- First, as noted earlier, occupancy rates vary widely across the state. Based on the number of currently available beds, occupancy rates projected for 2020 in the Metropolitan region (94 percent) and Southeast region (85 percent) are very high. The degree to which hospitals in these regions may be able to expand the number of available beds to meet future demand without undertaking major construction projects to increase physical capacity is uncertain. (This issue is discussed more specifically with regard to the Maple Grove area below.)

- In addition, average occupancy rates measured over a full-year period do not capture variations in occupancy rates that occur during the year. This consideration is important because even though a hospital's annual occupancy rate may not seem high enough to create concerns about whether capacity is sufficient, there are likely a number of times during the year when the hospital's occupancy rate is substantially higher than the average experienced over the entire year. As a result, using occupancy rates that measure capacity use over a full-year period may understate the degree to which the hospital system may be operating at or near capacity constraints at certain times.

It should also be noted that hospitals' ability to make full use of their licensed beds within existing facilities is limited by the relatively recent shift in the hospital market (both in Minnesota and nationally) toward private instead of semi-private hospital rooms. Consumer preferences have played an important role in many hospitals' business decisions to convert semi-private to private rooms, as well as concerns about patient safety and compliance with patient privacy laws.[3]

While Minnesota's hospitals likely have the ability to expand the number of available beds to some degree at existing facilities to meet projected future demand, it may also be the case that future demand in high-growth areas cannot be met without some major construction projects, either the construction of new hospitals or the expansion of existing facilities. If it is likely that some type of major construction project will be necessary to meet future needs, then the question before legislators as they consider granting an exception to the hospital moratorium becomes more a question not of whether new hospital capacity is needed, but where the new capacity should be located.

Trends in the Maple Grove Area

The Maple Grove area is experiencing rapid population growth. Although each of the proposals for an exception to the hospital moratorium in Maple Grove defines the area somewhat differently, population growth is projected to be much faster than the statewide average regardless of the specific geographic definition chosen. The Maple Grove area is expected to grow approximately 3 to 4 times faster than the projected statewide growth rates of 4.7 percent from 2003 to 2009 and 5.0 percent from 2009 to 2015.

The plans submitted to MDH by the hospitals seeking an exception to the moratorium identify several hospitals that currently serve significant numbers of residents of the Maple Grove area. Figure 3 shows the locations of each of the eleven hospitals that currently serve most residents of the Maple Grove area. Key utilization and financial indicators for these hospitals in 2003 (the most recent year of data that is available) are listed in Table 2. Recent trends in admissions, the total number of inpatient days, and occupancy rates are described in Table 3. For these eleven hospitals as a group, the occupancy rate as a percentage of available beds increased from 69 percent in 1999 to 74 percent in 2003.

[3] Michael Romano, "Going Solo: Private-Rooms-Only Provision for New Hospital Construction Stirs Controversy," Modern Healthcare, November 29, 2004.

Figure 3

Hospitals Serving the Maple Grove Area

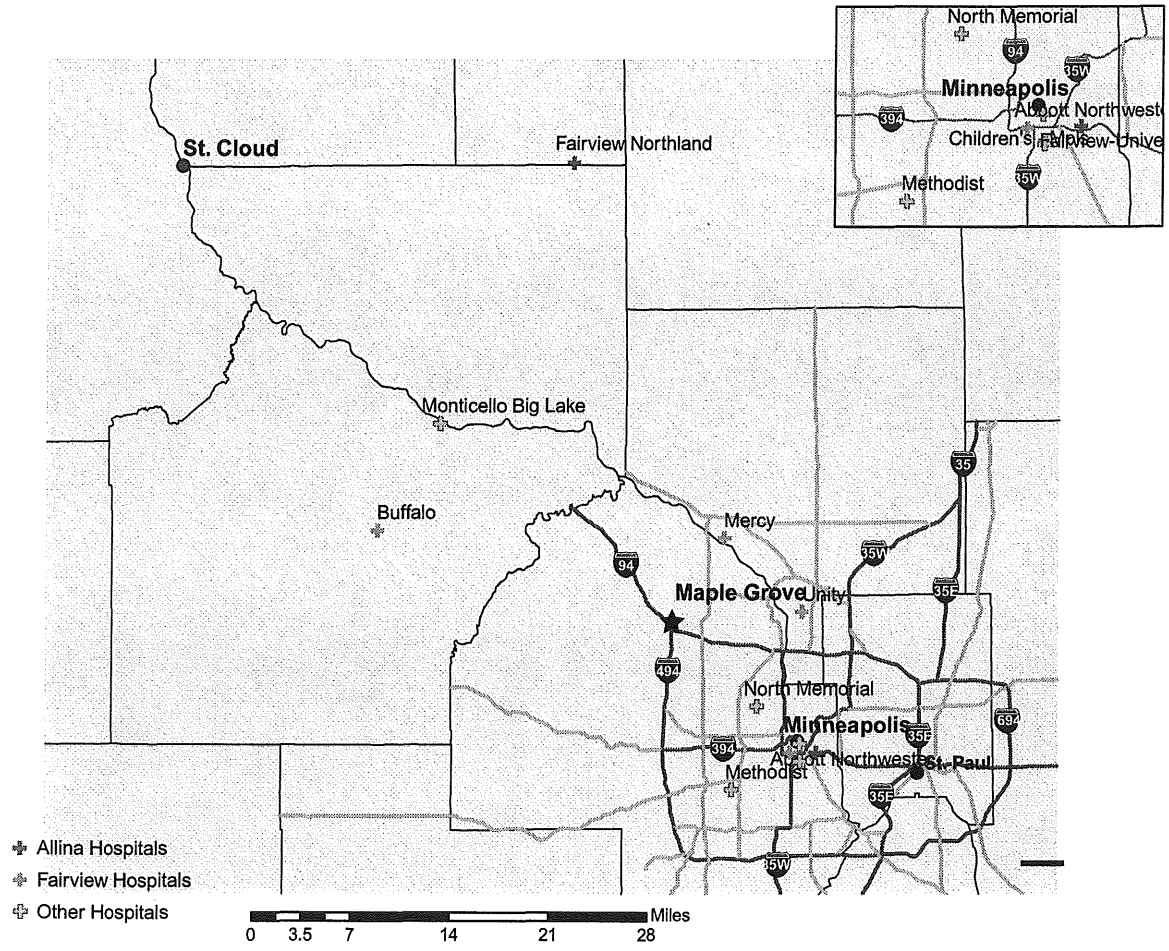


Table 2

Hospitals Serving Maple Grove Area Patients: Capacity and Financial Indicators for 2003

	Distance from Maple Grove	Licensed Beds	Available Beds	Occupancy Rate (as % of Available Beds)	Net Income ($ millions)	Net Income as % of Revenue	Uncompensated Care* ($ millions)	Uncompensated Care as % of Operating Expenses
Abbott Northwestern Hospital	20 miles	926	627	75.5%	$44.1	7.5%	$6.0	1.1%
Buffalo Hospital	32 miles	65	34	59.7%	$2.9	8.8%	$0.7	2.4%
Children's Hospitals and Clinics, Minneapolis	19 miles	153	153	84.6%	$12.1	5.9%	$1.8	0.9%
Fairview Northland Regional Hospital	35 miles	41	41	51.4%	($2.2)	-3.6%	$1.5	2.3%
Fairview-University Medical Center	20 miles	1,700	729	69.6%	$39.5	5.7%	$3.8	0.6%
Hennepin County Medical Center	19 miles	910	422	71.3%	($7.2)	-1.8%	$21.8	5.3%
Mercy Hospital	11 miles	271	212	78.6%	$15.3	6.8%	$3.4	1.6%
Methodist Hospital Park Nicollet Health Services	17 miles	426	370	71.3%	$17.5	5.3%	$2.3	0.7%
Monticello-Big Lake Hospital	22 miles	39	18	57.1%	$1.2	5.4%	$1.0	3.9%
North Memorial Medical Center	11 miles	518	432	74.0%	$23.6	7.8%	$3.3	1.0%
Unity Hospital	14 miles	275	211	66.1%	$1.7	1.1%	$3.0	2.0%
Statewide average				59.4%		5.3%		1.6%

*Uncompensated care is adjusted by a ratio of hospital costs to charges.
Source: MDH, Health Care Cost Information System.
Distance from Maple Grove is measured as the driving distance from the Maple Grove Community Center, according to MapQuest.

Table 3

Trends for Maple Grove Area Hospitals

	1999	2000	2001	2002	2003
Total available beds			3,260	3,158	3,249
Inpatient admissions	176,550	180,772	185,029	190,882	190,475
Inpatient days	822,799	849,862	854,346	857,519	858,746
Occupancy rate*	69.1%	71.4%	71.8%	74.4%	72.4%

*calculated based on available beds. For 1999 and 2000, calculation is based on 2001 available beds (data were not collected in 1999 and 2000).
Source: MDH, Health Care Cost Information System.

Projections for Hospitals Currently Serving the Maple Grove Area

Each of the three plans that were submitted to MDH for a public interest review contained an analysis of the ability of the Maple Grove area to sustain a hospital. While the question of whether the community can support a hospital is important, it is a different question from whether there is a need for a new hospital in the community. The legislation that established the public interest review process directs MDH to evaluate proposals for exceptions to the hospital moratorium based on the question of the need for the proposed facility, not whether the community can support a new facility.

As the starting point for MDH's analysis of the Maple Grove area, we analyzed the need for a new hospital from the perspective of the hospital system as a whole. Our analysis began with an estimate of what will happen to occupancy rates at hospitals that currently serve the majority of patients living in the Maple Grove area in the absence of a new hospital being built in Maple Grove. These "baseline" estimates incorporate projected changes in population and demographics in the market areas served by these hospitals. The baseline estimates also incorporate a range of assumptions about future hospital use rates, due to the inherent uncertainty in projecting changes in use of services due to factors like technological change.[4] This set of estimates formed the starting point for our analysis, and was the same for each of the three plans submitted to MDH for public interest review.

The overall results from this baseline analysis are presented in Table 4. As shown in the table, the occupancy rate for the eleven hospitals included in this analysis was 74 percent of available beds in 2003.[5] The occupancy rate is projected to increase to 79.4 percent in 2009, and 85.5 percent in 2015 (assuming no increase in available beds). It is important to note that this increasing strain on hospital capacity affects more than just residents of the Maple Grove area. Because the eleven

[4] More detail on the methodology we used to create the baseline estimates is included in Appendix 2. This discussion of the results of our analysis does not identify individual hospitals because the data we used to perform the analysis were collected under MDH's authority provided by Minnesota Statutes 62J.301, and Minnesota Statutes 62J.321 Subd. 5(e) prohibits the release of analysis that names any institution without a 21-day period for review and comment.

[5] This figure differs from Table 3 because it uses a different data source.

hospitals included in our analysis account for about one-third of total hospital admissions in Minnesota, the issue of rising occupancy rates is an issue that will likely have a much broader impact.

Table 4

Projections for Hospitals Serving Maple Grove Residents

	2003 Actual	2009 Projected	2015 Projected
Number of discharges	193,402	207,828 Range: 187,045 to 228,610	224,267 Range: 201,840 to 246,304
Number of inpatient days	877,448	943,712 Range: 849,341 to 1,038,084	1,016,040 Range: 914,436 to 1,115,288
Occupancy rate: 2003 available beds	74.0%	79.4% Range: 71.5% to 87.4%	85.5% Range: 77.0% to 93.9%
Occupancy rate: as % of maximum physical capacity		69.6% Range: 62.7% to 76.6	75.0% Range: 67.5% to 82.3%

Source: MDH Health Economics Program. Data sources include Minnesota hospital discharge database, Health Care Cost Information System (HCCIS), and population projections from Claritas, Inc.

As part of the public interest review process, we also conducted an informal survey of hospitals that currently serve patients living in the Maple Grove area to find out whether those hospitals have the physical capacity to expand the number of available beds at their current locations to meet expected growth in demand. We asked these hospitals about the maximum number of beds that they could operate on a permanent basis without undergoing major construction.[6] While there may be issues with the quality of this self-reported data, based on the results of that informal survey, if each of the eleven hospitals increased its number of available beds to the maximum level that would be feasible with its current physical capacity, the projected occupancy rates for 2009 and 2015 are 69.6 percent and 75.0 percent, respectively. One important thing to note about this analysis, however, is that the hospitals that currently serve the largest numbers of Maple Grove area residents did not report much ability to expand the number of available beds without a major construction project; the only hospital that reported having the ability to make a large number of additional beds available without a major construction project is one of the hospitals that is most distant from Maple Grove, and currently serves a small share of the Maple Grove market.

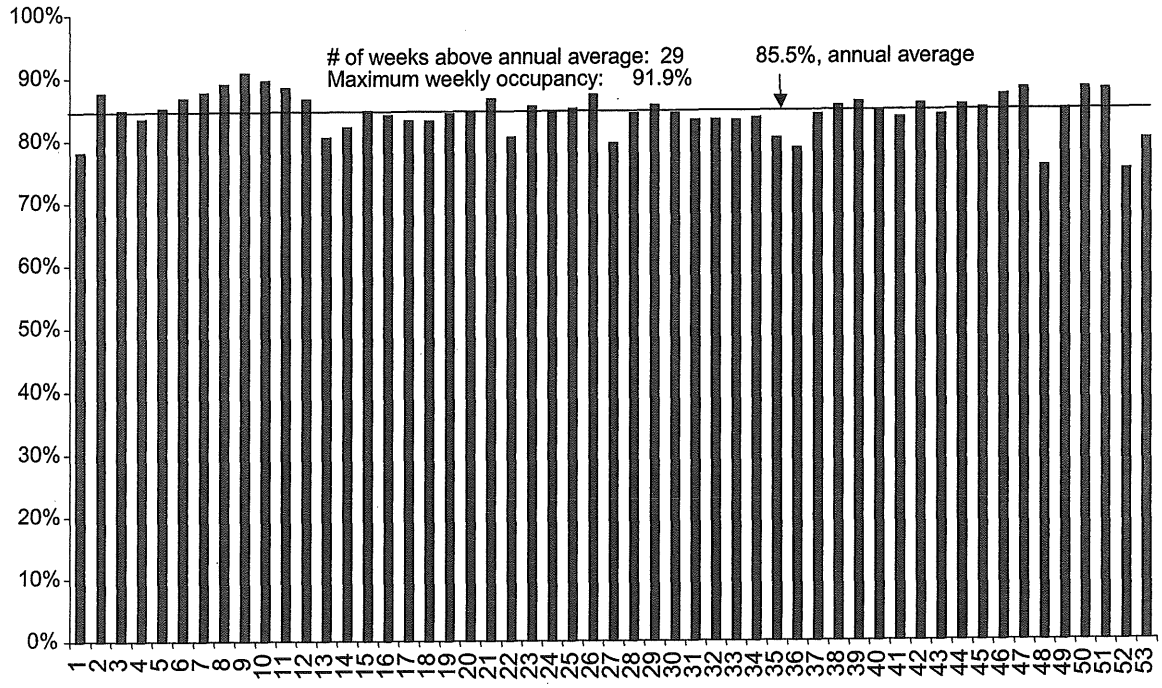
At certain times during the year the occupancy rate for the group of eleven hospitals currently serving most Maple Grove residents is expected to be substantially higher than the average occupancy rate over the entire year. In 2009, the highest projected weekly occupancy rate for the eleven hospitals as a group is 85.4 percent; in 2015, the peak weekly occupancy rate is projected to

[6] We asked the hospitals to answer this question within the context of their current business plan – for example, if their business plan calls for all private rooms and they would not consider converting rooms to semi-private rooms in order to serve a larger number of patients, then they would report their maximum physical capacity based on a configuration of all private rooms.

be 91.9 percent for the group of hospitals currently serving residents of the Maple Grove area. Figure 4 provides an illustration of the variation in projected occupancy rates at different times of the year for the group of eleven existing hospitals that serve residents of the Maple Grove area.

Figure 4

2015 Weekly Projected Occupancy Rates for Hospitals Serving Residents of the Maple Grove Area



Occupancy rates calculated based on available beds.

One key question that arises from this analysis is at what point should a hospital's (or group of hospitals') occupancy rate be considered "too high"? Unlike some other industries, which strive to operate at or near full capacity, hospitals are different. Because the level of demand at any given time is somewhat unpredictable, hospitals generally attempt to operate at a level below full capacity in order to be able to meet unexpected surges in the need for services. In addition, operating at a level too close to full capacity can lead to costly inefficiencies, such as delays in the ability to admit new patients or transfer patients between units.

One approach to answering the question of the "right" occupancy rate would be to define a specific benchmark level above which the occupancy rate is considered too high. Alternatively, one could define a specific number of hospital beds that is needed given an area's population. Both of these approaches have been used extensively in the past, particularly under Certificate of Need regulatory structures. However, more recent analysis of this question has pointed out that the question of

what an appropriate occupancy rate should be requires a much more complex approach than identifying a single number that applies to all hospitals, but instead depends on both hospital size and the number and size of distinct units within the hospital.[7] There is no agreed-upon standard for occupancy rates or threshold for when an occupancy rate should be considered too high in either hospital industry trade publications or peer-reviewed academic research publications. Industry experts that we spoke to indicated that 70 to 80 percent occupancy is an appropriate range, and that costly inefficiencies may occur at occupancy levels above 85 percent.

Analysis of Specific Proposals

After projecting what occupancy rates at hospitals serving patients from the Maple Grove area would be in the absence of a new hospital, the next step in our analysis was to estimate the impact of a new facility in Maple Grove on admissions, inpatient days, and occupancy rates at these hospitals. Since each of the three proposals to build a hospital in Maple Grove is unique, this analysis was performed separately for each proposal and the results are presented below in the discussion of the specific proposal as it relates to each of the criteria specified in the law.

Importantly, the analysis of each proposal is specific to the service area that was defined by the applicant as the proposed primary service area. The three proposed service areas range in size from 10 to 22 zip codes. For a variety of reasons, such as variation in existing physician affiliations and referral patterns, we believe it is possible that the proposed Maple Grove hospital's service area (the geographic area from which it draws most of its patients) may vary depending on which, if any, of the three proposals is approved by the Legislature. The "true" service area for any new hospital can only be observed after the fact; as a result, it is likely that all of the applicants' proposed service areas are different from what the service area for a hospital built in Maple Grove would eventually be. In this case, there is an especially high degree of uncertainty about the proposed hospital's service area due to the likelihood that as many as three large new ambulatory care centers may be built in the community, which we would expect to have an impact on patterns of hospital referrals. For these reasons, MDH did not attempt to independently define a service area for the proposed Maple Grove hospital.

We used a similar approach to analyze the impact on hospitals currently serving patients from the Maple Grove area in terms of the potential financial impact on these hospitals, including the potential impact on their ability to provide services to nonpaying or low-income patients. These results are also included below in the discussion of how the proposal relates to each of the evaluation criteria in the law.

[7] See, for example, Linda V. Green, "How Many Hospital Beds?" Inquiry v. 39, Winter 2002/2003.

5. Review of Fairview's Proposal for an Exception to the Hospital Moratorium

This section describes Fairview's proposal for an exception to the hospital moratorium in order to build a new hospital in Maple Grove. Following a brief description of the proposed project, we evaluate Fairview's proposal in light of each of the five factors specified in the statute that established the public interest review process.

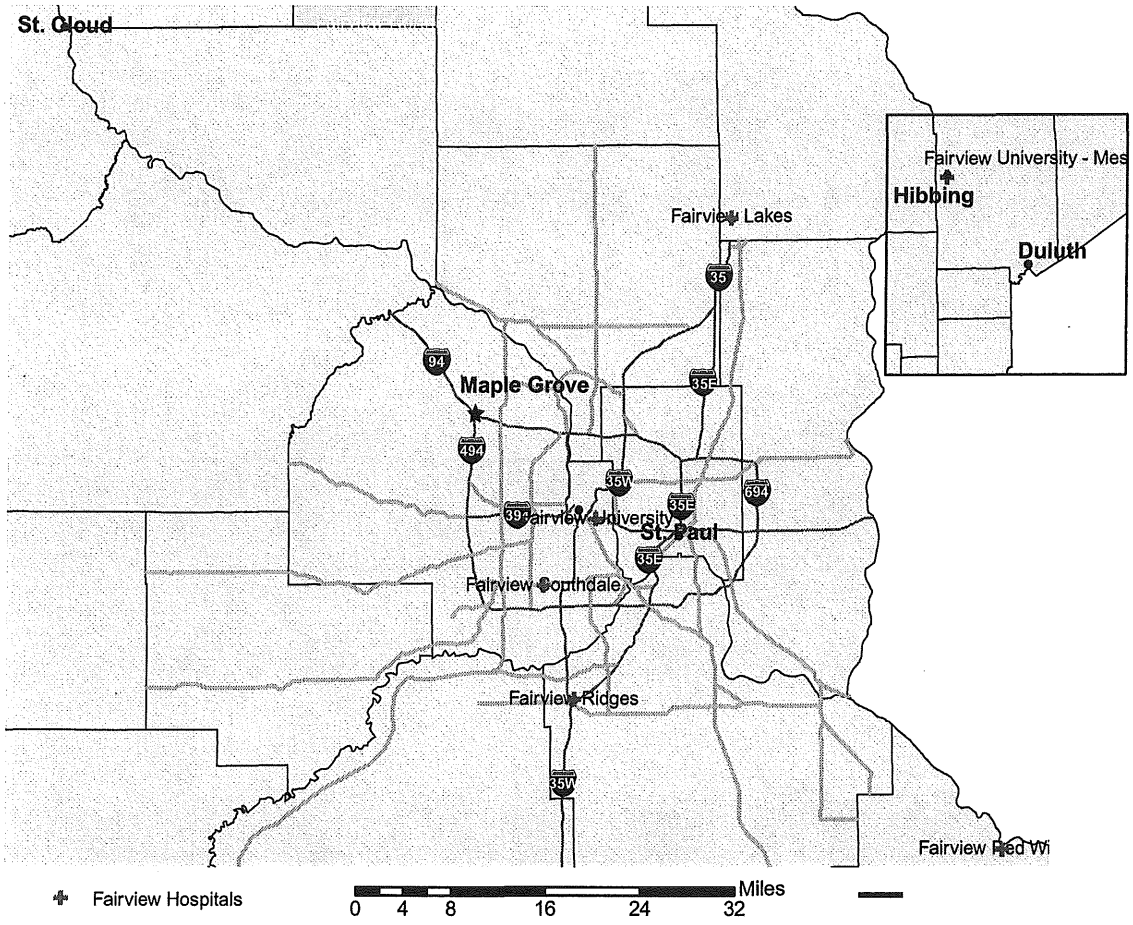
Background and Project Description

Fairview Health Services is a non-profit integrated health network that operates 7 hospitals and 31 primary care clinics. In partnership with the University of Minnesota Physicians, Fairview has 60 specialty care locations. Fairview also intends to partner with the University of Minnesota Physicians to provide care at its proposed Maple Grove campus. Fairview provides care through a number of other partnerships, such as Fairview Physician Associates, the Institute of Athletic Medicine, and Behavioral Healthcare Providers. Through the clinics that it owns and through partnerships with other health care providers, Fairview currently provides primary care and specialty services in and around the Maple Grove community.

Fairview's seven hospitals are located in Burnsville, Edina, Hibbing, Minneapolis, Princeton, Red Wing and Wyoming, Minnesota. Together, these facilities accounted for approximately 13 percent of total acute care hospital admissions statewide and generated $87 million in net income in 2003. Figure 5 shows the locations of Fairview's current hospitals.

Figure 5

Hospitals Owned by Fairview



Fairview proposes the construction of a health care campus in Maple Grove that would include both an ambulatory care center and an acute care hospital. Phase 1 of the project, scheduled to be completed as early as 2006, would include a 126,000 square foot ambulatory care center providing primary and specialty care, mental health and chemical dependency services, imaging, cardiology, and laboratory services, a women's center, a cancer center, and other services. As noted earlier, Minnesota law does not restrict the ability of a health care provider to construct outpatient facilities, and the ambulatory care center portion of Fairview's proposed Maple Grove campus is outside of the scope of the public interest review process established under Minnesota Statutes 144.552.

In Phase 2 of the project, Fairview proposes to construct a hospital with 72 to100 acute care beds, as well as a level III trauma center,[8] which would open no later than 2009. Future phases of the project would expand the hospital incrementally to a total of 284 acute care inpatient beds. Fairview's request for an exception to the hospital moratorium would transfer 284 licensed beds to the new Maple Grove hospital from Fairview-University Medical Center (FUMC); these bed licenses are not currently in use at FUMC. The proposed distribution of beds by type of service is shown in Table 5.

Table 5

Fairview's Proposed Breakdown of Inpatient Beds by Service Category

	2009 (100 beds)	2015 (240 beds)	2020 (284 beds)
Medical	37	94	107
Surgical	24	56	68
Obstetrical	14	30	34
Pediatric	6	16	18
Mental Health Services	12	28	38
Neonatal (Level 2 Nursery)	7	16	19
Total	**100**	**240**	**284**

Source: Fairview submission to MDH dated November 9, 2004.

Fairview estimates the costs for the construction of the ambulatory care center at $47 million, with an additional $64.8 million to $90.0 million for construction of the 72- to 100-bed hospital. For the completion of all phases of the project including expansion of the hospital to 284 beds, Fairview has estimated the total cost at $299 million.

The proposed location of the Fairview Maple Grove campus is a 26.7-acre site that is bounded by the proposed Highway 610 corridor to the north and Fernbrook Avenue to the east. According to Fairview's submissions, construction of the proposed hospital is contingent on an East-West connector in Maple Grove. The extension of Highway 610 is not required but would benefit the ease of access to Fairview's proposed hospital.

Primary Service Area

Fairview expects the primary service area (PSA) of its proposed Maple Grove hospital to be the area within an approximate 10-mile radius of the proposed site. The service area defined by Fairview includes 10 zip codes and covers portions of Hennepin, Sherburne, Wright, and Anoka counties. Communities in the proposed service area include Albertville, Anoka, Dayton, Elk River, Maple Grove, Osseo, Plymouth, Rogers, and St. Michael.

[8] See Appendix 3 for a description of the differences between Level I, II, III and IV emergency services as defined by the American College of Surgeons.

The population in Fairview's proposed service area is projected increase by 20.8 percent between 2003 and 2009, and by an additional 20.5 percent between 2009 and 2015; these growth rates are substantially higher than the projected statewide population growth of 4.7 percent between 2003 and 2009 and 5.0 percent from 2009 to 2015.[9] In addition to rapid population growth in the proposed service area, the most rapid projected population growth is among the population aged 55 years or older; while this is also true for the state as a whole, growth among this population is expected to be much faster in the service area defined by Fairview compared to statewide growth (41.8 percent from 2003 to 2009 compared to 13.5 percent statewide). This combination of rapid population growth and an aging population is expected to increase the demand for hospital services by residents of this area. Based on MDH's analysis, the number of hospitalizations of residents of this area is expected to increase by 26.3 percent from 2003 to 2009, and by an additional 26.5 percent from 2009 to 2015.

Factor 1: Whether the new hospital or hospital beds are needed to provide timely access to care or access to new or improved services

In order to assess the impact of all three proposals for a Maple Grove hospital that MDH received in terms of whether the hospital is needed to provide timely access to care, we analyzed the impact of each of the proposals on future occupancy rates at existing hospitals that serve residents of the Maple Grove area. We also looked at how the proposals addressed specific service areas such as mental health, obstetrics, and emergency services that were identified by community members as areas of need for additional services.

Capacity of existing facilities

Residents of the Maple Grove primary service area were hospitalized in many hospitals throughout the state during 2003, but eleven metro area hospitals provided the bulk of inpatient acute care to residents during that year. These facilities are also dependent, to varying degrees, upon this area for an ongoing proportion of their inpatient volume. The eleven hospitals are North Memorial, Mercy, Methodist, Abbott Northwestern, Buffalo, Monticello-Big Lake, Hennepin County, Fairview-University, Minneapolis Children's, Unity, and Fairview Northland.

As noted earlier, MDH analysis projects that in the absence of any new hospital capacity being built, occupancy rates at the group of 11 hospitals that currently serve most residents of Maple Grove and the surrounding communities are projected to increase from 74.0 percent in 2003 to 79.4 percent and 85.5 percent in 2009 and 2015, respectively. In 2009, six of the eleven hospitals are projected to have occupancy rates above 75 percent; by 2015, ten of the eleven will have occupancy rates above 75 percent and four will exceed 90 percent. As discussed earlier, the usefulness of annual occupancy rates as a measure of the degree to which existing capacity is strained is limited, but it can still be useful as a rough guide.

[9] Population projections for 2009 are from Claritas, Inc.; projections for 2015 were developed by MDH assuming the same annual growth rate from 2009 to 2015 as projected by Claritas for 2004 to 2009.

If Fairview's proposal for an exception to the hospital moratorium is approved, the addition of new hospital capacity is expected to reduce occupancy rates at existing area hospitals below the rates that are projected if no new hospital is built. Because Fairview's proposal involves expanding the size of the hospital over time, the effect of the new hospital on existing hospitals would also increase over time. In our analysis of Fairview's proposal, we assumed that the Maple Grove hospital would have 90 beds in 2009 and 240 beds in 2015.[10] Under this scenario, the projected occupancy rate for the group of eleven existing area hospitals would be 77.5 percent in 2009 (compared to 79.4 percent if no hospital were built), and 80.3 percent in 2015 (compared to 85.5 percent if no hospital were built). In other words, the impact of Fairview's proposed Maple Grove hospital would be to reduce occupancy rates at existing hospitals serving the Maple Grove area by 1.9 percentage points in 2009 and 5.2 percentage points in 2015.

Some hospitals that currently serve Maple Grove area residents would experience a larger impact than others as a result of the Fairview proposal. Hospitals that currently serve the largest share of patients from the service area that Fairview anticipates for the Maple Grove hospital would likely experience the largest impact. At the eleven existing hospitals, the impact of Fairview's proposal on occupancy rates ranges from a decline of 0.3 percentage points to 8.2 percentage points in 2009 compared to the projection with no new hospital; for 2015, the decline in occupancy rates ranges from 0.9 percentage points to 21.8 percentage points compared to no new hospital being built.

Although it is not possible to state definitively what occupancy level is "right" for a hospital or the hospital system as a whole, it seems reasonable to conclude that hospitals in the Maple Grove area will experience increasing strains on capacity in the absence of any new capacity being added to serve patients from this area over the next ten years. As noted earlier, if no new capacity is added, MDH projections show that in 2015 ten of the eleven existing area hospitals will have occupancy rates above 75 percent, and four would have occupancy rates above 90 percent. Under Fairview's proposal, we estimate that these strains on capacity would be reduced somewhat: only 8 of the eleven hospitals would have occupancy rates above 75 percent in 2015, and only 2 would have occupancy rates above 90 percent.

As noted earlier, it is also important to recognize the considerable diversity of size and service capability among these eleven hospitals. For example, the tertiary care facilities operate many specialty units, such as cardiac, cardiovascular, stroke, orthopedic, and research services that often require specially equipped beds. Some of these beds may not be open to other patients. In another example, the American College of Obstetrics and Gynecology recommends a target occupancy level of 75% for maternity units given the emergent nature of the care provided. Given the current trend toward specialty units, an overall occupancy levels may be more a reflection of the mix of services available than generally available capacity to be filled.

[10] Additional assumptions and the methodology we used for our analysis are described in more detail in Appendix 2.

Distance and Time to Existing Facilities

In the plan submitted by Fairview to MDH, Fairview describes the concern of Maple Grove residents over timely access to health care services, a concern that was also echoed at the MDH-sponsored public meeting in Maple Grove. According to Fairview, the community expressed an "interest to meet and improve upon the metro standard for ambulance travel times to hospital care of 15 minutes." Currently, most residents of Maple Grove and nearby communities obtain inpatient care from hospitals that are at a distance of between 11 and 32 miles, which translates into travel time under normal weather and road conditions of 20 to 30 minutes. The nearest level I trauma centers are North Memorial Health Care and Hennepin County Medical Center, about 11 miles and 19 miles from Maple Grove, respectively. However, travel times vary significantly depending on the time of day, weather conditions and traffic congestion.

In addition, a recurring theme expressed by numerous Maple Grove residents at the MDH public hearing January 11, 2005 was a concern about family and children's safety, given the driving distance to the nearest Level I trauma center at North Memorial, traffic congestion, and the number of traffic lights encountered en route. North Memorial Medical Center and Hennepin County Medical Center are the only American College of Surgeons verified Level I Trauma Centers in Hennepin County. Driving times can vary substantially depending upon the route taken, time of day, weather and traffic conditions. Helicopter transport with advanced life support is available in the area for the most critical medical emergencies.

Based on information provided by Fairview in its application, drive times from the proposed Fairview Maple Grove hospital campus to existing acute care hospitals that serve residents of the Maple Grove area range from 20 to 45 minutes or more depending on the time of day and weather conditions. Only two hospitals (Mercy and North Memorial) are within a 20-minute drive from the proposed Fairview site in normal, non-congested, non-rush hour traffic. Within the Hennepin County portion of the service area, North Ambulance provides EMS transportation, both ground and air. In some cases, EMS transport times may be extended if an emergency department is diverting ambulances to other facilities. EMS diversions may occur if emergency department beds or other beds are full at a hospital, a staff shortage exists, or on-call specialist physicians are unavailable.

Although a reduction in travel time will mean quicker access to hospital care for Maple Grove area residents, it is unclear to what degree having more timely access will improve health outcomes. At the public meeting in Maple Grove, we heard anecdotal stories of people who delay seeking emergency treatment due to the distance from a hospital emergency room, or people who inappropriately use urgent care clinics when they really need to go to a hospital emergency room. As part of the public interest review process, MDH conducted a review of published research on the impact that distance and/or travel time to a hospital have on health outcomes. There is not a large amount of published research on this topic, but some researchers have found evidence that increased distance to the nearest hospital is associated with higher mortality from emergent

conditions such as heart attacks and unintentional injuries.[11] However, other factors not related to distance or time, such as short Emergency Medical Service (EMS) response times and sophisticated on-scene medical interventions can also improve survival and, in some time-sensitive conditions such as heart attack, stroke, and certain traumas, sustain longer advanced life support transport distances and times. So, while distance to a hospital ER may be a factor for consideration, a well-functioning and timely EMS system also plays a critical role in ensuring patient outcomes.

Access to Specific Services: Mental Health, Obstetrics, and Emergency Services

At the public meeting on January 11, 2005, residents of the Maple Grove area expressed concerns about access to three specific types of hospital services: mental health, obstetrics, and emergency services. Several community residents stated that there was a shortage of inpatient mental health services; for obstetrics and emergency/trauma services, convenience and a desire for more timely access were the main concerns.

With regard to inpatient mental health services, MDH analysis shows that about 93 percent of all hospitalizations of residents of the Maple Grove area (as defined by Fairview) occur at one of the eleven hospitals that we identified as serving a significant number of Maple Grove area residents. For psychiatry and chemical dependency services, however, when residents of the Maple Grove area are hospitalized they are much more likely to be hospitalized at a facility other than one of the eleven hospitals that serve most of this market (18.9 percent and 10.6 percent of the time for psychiatric and chemical dependency services, respectively). In other words, residents of the Maple Grove area who need to be hospitalized for psychiatric care or chemical dependency are much more likely to leave their local hospital market to receive care than residents who are hospitalized for other reasons. This is consistent with a statewide pattern that individuals who are hospitalized for psychiatric or chemical dependency services are less likely to be hospitalized in their local area than they would be for other services.[12] Fairview's proposal for a Maple Grove hospital includes 12 behavioral health services beds initially, growing to as many as 38 beds in 2020 if the hospital is expanded to the full proposed 284 beds.

An additional area of concern for Maple Grove area residents was timely access to obstetric services. Because the population in this area is younger on average than the state as a whole, obstetric admissions represent a higher share of total inpatient admissions from the Maple Grove area than for the state as a whole. In 2003, about 22 percent of hospital admissions from the service area defined by Fairview were for obstetric services, compared to 16 percent statewide. The Maple Grove hospital proposed by Fairview would include 14 obstetric beds initially, growing to as many as 34 beds in 2020 if the hospital is expanded to the full proposed 284 beds.

[11] Thomas C. Buchmueller, Mireille Jacobson, and Cheryl Wold, "How Far to the Hospital? The Effect of Hospital Closures on Access to Care," National Bureau of Economic Research Working Paper No. 10700, August 2004.

[12] Minnesota Department of Health, Health Economics Program, "Minnesota Mental Health and Chemical Dependency Treatment Utilization Trends: 1998 – 2002," Issue Brief 2004-07, November 2004.

Finally, Maple Grove area residents have expressed concerns about timely access to emergency and trauma services. As noted above, there is not much clear evidence about how closer access to an emergency room will affect health outcomes. It should be noted, however, that the emergency services proposed by Fairview would meet the American College of Surgeons criteria for designation as a level III trauma center, which means that the hospital would provide "prompt assessment, resuscitation, emergency surgery, and stabilization" and that more complicated cases would be transferred to other hospitals.

In summary, Fairview's proposed Maple Grove hospital does include the mental health, obstetric, and emergency services mentioned as being of most concern to community residents. The proposed hospital would not offer new or improved services that are not already available at other hospitals nearby.

Factor 2: The financial impact of the new hospital or hospital beds on existing acute-care hospitals that have emergency departments in the region

For a number of reasons, there is a high degree of uncertainty involved in predicting the financial impact of any of the three proposals to build a Maple Grove hospital on existing hospitals that currently serve residents of the Maple Grove area. The potential for three large new ambulatory care centers in Maple Grove providing a wide range of specialty care services would almost certainly have a significant impact on which hospitals residents of the Maple Grove area are referred to by their physicians for inpatient services. The combination of this change (which may occur even if the Legislature does not approve any exceptions to the hospital moratorium) with the addition of a new hospital makes it especially difficult to predict the impact on existing hospitals.

In addition, although MDH has access to hospital discharge data that allowed us to analyze and project hospital discharges, inpatient days, and occupancy rates, we do not have any data that allows us to translate the impact of a new hospital on the volume of services provided into an estimate of the specific financial impact of a new hospital on existing hospitals in the region. If a hospital loses patients that it would have served in the absence of the new hospital being built, it not only loses potential revenue but also avoids costs (such as staffing and supplies) that it would have otherwise incurred. Because we do not have information available to us that allows us to calculate the net financial impact of the proposed hospital on other existing hospitals in the region, in this section we focus instead on changes in the volume of business and occupancy rates.

Applicant's Analysis

Fairview's analysis of the financial impact of its proposed Maple Grove hospital on existing hospitals that currently serve the Maple Grove area finds little adverse impact. This analysis is based on the assumption that population growth will increase the demand for hospital services at all facilities in the area, resulting in the ability to "easily backfill" capacity.

MDH Analysis

There are two ways of looking at the financial impact of a new hospital on existing hospitals: first, in relation to a hospital's current business; and second, in relation to what would have occurred in the absence of the new hospital. The impact of Fairview's proposal on existing hospitals in the Maple Grove area varies by hospital, with hospitals that currently serve a large share of the Maple Grove market likely to experience the biggest impact. This is illustrated by the projections described above that compare projected occupancy rates at each of the eleven hospitals to the occupancy rates that would be projected in the absence of a new hospital. However, when comparing the impact of Fairview's proposal in relation to the current patient volume and occupancy rates at existing hospitals, the results of our analysis are largely consistent with Fairview's assertion that growth in overall demand for services will offset the impact of increased competition for patients from the Maple Grove area. Assuming that Fairview's proposal for a Maple Grove hospital were approved, ten of the eleven existing hospitals that currently serve patients from the Maple Grove area are projected to experience increases in the total number of inpatient days in 2009 and 2015 compared to 2003; in many cases, however, the increase in volume is much slower than it would have been in the absence of a new hospital. One hospital would experience a projected 1.5 percent decline in inpatient days in 2015 compared to 2003.

Additional Factors for Consideration

There are three additional factors that may be important in analyzing the potential financial impact of Fairview's proposal on existing hospitals that serve patients from the Maple Grove area:

- First, the impact is likely to vary by type of service. Because profitability varies by type of service, this is an important consideration. We did not attempt to specifically estimate the impact on existing hospitals by type of service.

- Second, there is a high degree of uncertainty about how physician referral patterns may change as a result of the new hospital and the multiple new ambulatory care centers that are currently being proposed. Even if the proposed Fairview hospital does not directly provide highly specialized services (such as open heart surgery), its association with the Fairview hospital system could have an impact on referrals to non-system affiliated hospitals. Our analysis does not incorporate this possible change, but instead uses the information that we have on current travel patterns of patients from the Maple Grove area. However, it is important to note that the change is a possibility that could have an impact.

- The third area relates to patient preference. A common theme heard in our public meeting in Maple Grove was the desire of the community for nearby hospital services. An MDH literature review showed that patients prefer hospitals closer to home when alternative choices are available. Consumer preferences for nearby hospital services may act as a mitigating factor to any potential shift of highly specialized services away from North Memorial toward system-affiliated hospitals that are more distant from Maple Grove than North Memorial.

In summary, for the 11 primary hospitals providing care to residents in the applicants proposed service area, our analysis finds that the inpatient volumes, even with the construction of a new facility as described in the Fairview application, would continue to increase above 2003 levels (with one exception). However, the increase would generally be at levels that are below what otherwise would have occurred without the construction of a new facility in Maple Grove, with some facilities experiencing larger effects than others Other factors that are important to consider include the fact that the effect of a new hospital will likely vary by service type; that there is a possibility that physician referral patterns may be altered as a result of the new hospital construction; and the impact that patient preference will have on those referral patterns.

Factor 3: How the new hospital or hospital beds will affect the ability of existing hospitals in the region to maintain existing staff

Fairview estimates that its proposed Maple Grove hospital will require between 420 and 550 full-time equivalent staff positions with an average annual labor expense of $25 to $32 million. Fairview anticipates that many of its 341 current employees who live in or near Maple Grove will choose to work at the new hospital.

While MDH is unable to predict the specific workforce shifts that may occur from surrounding facilities, there are several factors that may directly or indirectly influence potential job-seeking behavior by persons considering employment in any new facility in Maple Grove. First, for employees living in Maple Grove or the Northwest corridor, the opportunity to work closer to home to reduce commuting time and costs may prove to be an important consideration. Second, for employees working in unionized hospitals with significant earned seniority, potential loss of that seniority may mitigate their willingness to move to a different employer, although the exact effects are unknown.

In recent years, shortages of particular types of medical staff (especially nurses) have resulted in competition among hospitals to attract and retain staff, both in Minnesota and nationally. One reason why there is concern about the impact of a new hospital on the ability of existing hospitals in the region to maintain their staff is that if competition among hospitals for staff intensifies, this would drive up wages at all area hospitals (and therefore contribute to rising health care costs).

According to the Minnesota Department of Employment and Economic Development, the job vacancy rate for nurses in the seven-county Twin Cities metropolitan area was 3 percent in the fourth quarter of 2004. Although the job vacancy rate for nurses in the Twin Cities has declined over the past four years (in the fourth quarter of 2000, the job vacancy rate for nurses was 8 percent), it is still higher than the overall job vacancy rate in the Twin Cities (2 percent in the fourth quarter of 2004).[13] Although the nursing shortage in the Twin Cities appears to have eased somewhat compared to 2000, many factors will likely contribute to continuing shortages into the

[13] Minnesota Department of Employment and Economic Development, Job Vacancy Surveys for fourth quarter 2000 and fourth quarter 2004.

future. These factors include rising demand for health care services due to population growth, the aging of the population, and technological advance; in addition, Minnesota's nursing workforce is older than average – as these workers begin to retire, shortages will occur if they are not replaced by newly trained professionals.[14]

In comparison to the existing 11 hospitals serving residents of the Maple Grove area, the size of Fairview's proposed facility is not large. In 2003, the existing hospitals as a group had 3,249 available beds; Fairview's proposal would add 72 to 100 beds initially, with the possibility of up to 284 beds. In other words, while the Fairview's proposal would add to the local demand for hospital staff, it is unlikely to have a large impact on the labor market because the proposal is small relative to the existing market; the other factors contributing to labor shortages that are described above may well have a larger impact on staffing shortages than the new hospital capacity proposed by Fairview.

Factor 4: The extent to which the new hospital or hospital beds will provide services to nonpaying or low-income patients relative to the level of services provided to these groups by existing hospitals in the region

In 2003, Fairview hospitals provided $10.7 million in uncompensated care, which represented 0.9% of their operating expenses (compared to a statewide average of 1.6 percent). In addition to hospital uncompensated care, Fairview's proposal describes a number of community-based initiatives that provide services to uninsured or underserved populations. In its proposal, Fairview states that it will provide charity care and community benefits to residents of the Maple Grove area that are similar to those provided in other communities served by Fairview.

In addition to concerns about the level of UC that will likely be provided by the new hospital, a related concern is whether the new hospital will change the payer mix of existing hospitals in the region that provide relatively large amounts of UC. For example, if a large number of privately insured patients are attracted to the new hospital, this could adversely affect the ability of existing facilities that provide large amounts of UC to continue to serve nonpaying patients. Compared with the state as a whole, the service area proposed by Fairview for the Maple Grove hospital has a higher share of residents with private group insurance and a lower share of residents with public coverage, as shown in Table 6. The uninsurance rate for Fairview's proposed Maple Grove service area is not statistically different from the state average (although it is directionally lower than the statewide average, the difference is within the survey's margin of error). In spite of what may be a somewhat lower rate of uninsurance in the community, based on comments from people who attended the January 11, 2005 public meeting, there may be significant pockets of unmet need in the area.

[14] Minnesota Department of Health, Health Economics Program, "Labor Availability and Health Care Costs: Report to the Minnesota Legislature," October 2002.

Table 6

Sources of Health Insurance Coverage, 2001

	Fairview's proposed Maple Grove service area*	Minnesota
Private	**87.8%**	74.6%
Group	**84.4%**	69.6%
Individual	3.4%	4.9%
Public	**9.4%**	20.1%
Uninsured	2.9%	5.4%

*As defined by Fairview, includes 10 zip codes
Source: MDH Health Economics Program analysis of 2001 Minnesota Health Access Survey
Numbers in bold indicate a statistically significant difference (95% level) from statewide rate.

In order to analyze the potential impact of the proposed Fairview Maple Grove hospital on the payer mix of other existing hospitals, we used data from the 2001 Minnesota Health Access Survey[15] to estimate sources of health insurance coverage in Fairview's proposed Maple Grove service area. We combined these estimates with information on hospital discharges and travel patterns to estimate 1) the insurance coverage distribution for populations served by hospitals that currently provide significant amounts of UC to patients living in this area, and 2) how this distribution would change if Fairview's proposed Maple Grove hospital were built. The distribution of coverage in the area served by an existing hospital could change, for example, if the proposed Maple Grove hospital were to draw patients from zip codes with higher than average rates of private insurance coverage. According to our analysis, the payer mix of existing hospitals that provide large amounts of UC would not be changed significantly by Fairview's proposed Maple Grove hospital. For example, we estimate that the share of the population in North Memorial's service area that is enrolled in public programs would increase by less than one percentage point by 2015, and the proportion enrolled in private insurance would decrease by about 1.5 percentage points; the proportion who are uninsured is estimated to rise by about 0.5 percentage points. Our findings for other hospitals providing high levels of uncompensated care were similar.

Factor 5: The views of affected parties

As described above, the process that we used to solicit the views of affected parties included a letter to all hospital administrators in Minnesota, a notice in the State Register, and a public meeting held in Maple Grove. The views of citizens of the Maple Grove area, as expressed at the public meeting on January 11, 2005, pertain mainly to the need for a hospital and for specific services and are reflected in the discussion of Fairview's proposal with regard to the first four statutory review criteria. In addition, we received several written comments in support of Fairview's proposal; copies of these are included in Appendix 1.

[15] Although this survey was updated in 2004, we used 2001 data because it has a much larger sample size and produces better estimates of health insurance coverage for small geographic areas.

North Memorial Health Care (NMHC) is the only entity that has expressed concerns about Fairview's proposal to build a hospital in Maple Grove. Depending on which geographic area is chosen for analysis, NMHC has either the highest or second-highest market share of any hospital serving the Maple Grove area. According to NMHC, about 30 percent of its admissions are from this area, and so there is significant potential for NMHC to be affected by Fairview's proposal to build a hospital built in Maple Grove. NMHC has expressed several specific concerns about the Fairview proposal:

- NMHC believes that "current occupancy rates are appropriate and that there is no current need to increase hospital bed capacity." (NMHC's proposal for a Maple Grove hospital would transfer currently staffed beds from NMHC's Robbinsdale campus.)

- NMHC states that approval of Fairview's proposal could result in "destructive competition that could so financially damage a hospital that, in the end, it would result in a profound anticompetitive effect that would leave health care consumers and purchasers with fewer options."

- NMHC argues that approval of Fairview's proposal would create "an anti-competitive hospital environment that could make it virtually impossible for any independent provider not aligned with a large system to successfully compete in this market." Further, NMHC argues that Fairview's proposal would result in an undesirable increase in hospital market concentration in the Twin Cities area.

- NMHC states that the service area chosen by Fairview was "chosen in a calculated effort to diminish the apparent impact on North Memorial" and that the actual impact of the proposal on NMHC would be large.

- NMHC states that it will not experience admissions growth at its Robbinsdale facility that will help to offset the impact of the proposed Fairview Maple Grove hospital. According to NMHC, "North Memorial is located in an urban area that is not predicted to grow, except in the Maple Grove area and beyond....Each of [the] population areas around the current North Memorial Robbinsdale urban location is projected to decline in population, unlike the Maple Grove area, which is predicted to grow 9% over the next five years." Population projections from the Metropolitan Council indicate that most of the communities surrounding NMHC are in fact expected to grow, although at a slower rate than many more suburban communities; between 2000 and 2010, Brooklyn Park is expected to grow by 10.6 percent, Columbia Heights by 8.0 percent, and Robbinsdale by 6.2 percent.

- NMHC expresses concerns that a system-affiliated hospital built in Maple Grove, such as that proposed by Fairview, would act as a "feeder" of more complex cases to other hospitals in the system.

- NMHC argues that independent, non-system hospitals have administrative and other advantages over larger systems.

- NMHC is also concerned about the potential impact of Fairview's proposed Maple Grove hospital on NMHC's ability to retain its existing staff, since a large percentage of NMHC staff live in the Maple Grove area.

- Finally, NMHC argues that Fairview's proposed Maple Grove hospital would disproportionately attract privately insured patients away from NMHC in Robbinsdale, resulting in a higher percentage of NMHC patients being low-income or uninsured, and less resources (profits from privately insured patients) to subsidize their care.

Fairview Health Services has responded to these stated concerns as follows:

- With regard to the value of health systems, Fairview states:
    - That it believes the creation of health systems "could create greater value to the communities and patients they serve"
    - That the organizational design and consolidation of clinical and organizational talent allow health systems to provide high-quality care at lower cost
    - That both Fairview Ridges and Fairview Southdale hospitals are among the least expensive providers based on expenses per adjusted admission in the metro area and that Fairview-University Medical Center's higher expenses are due to the clinically complex and challenging patient population.

- With regard to NMHC's assertion that Fairview's proposal for a Maple Grove hospital would have a serious and negative impact on NMHC's ability to provide care, continue its charitable care program and maintain selected services such as its level I trauma service, Fairview contends that NMHC's concerns are "overstated" and that "recent Twin Cities experience does not bear out North Memorial's speculation." Fairview argues that the new Woodwinds Health Campus (2000) did not result in declines in inpatient discharges at the nearest hospitals and that those hospitals have actually continued to grow, even though their market shares may have changed.

- With regard to NMHC's concern that a Fairview hospital may result in decreased competition, Fairview argues that:
    - "There is healthy competition in the Twin Cities and the Herfindahl Index demonstrates that."
    - With regard to the local Maple Grove area, because of NMHC's dominance in that service area, granting NMHC the license to acute care beds "would limit choice, not increase it."
    - "A Fairview hospital would introduce a new competitor to that part of the metro region."

- With regard to NMHC's contention that there is no current need to increase hospital bed capacity, Fairview argues that "a move of acute care beds from the Robbinsdale campus to a Maple Grove campus will not solve the bed demand resulting from anticipated population growth and aging" of the Maple Grove area. Fairview states that the inpatient demand from

the current service area of NMHC will continue to grow and that given this growth, NMHC will need to return to the Legislature in the future to request a moratorium exception for new licensed beds on one or both campuses.

- With regard to NMHC's criticism of the criteria used by Fairview to define the Maple Grove service area, Fairview argues that differences in the service area would be expected given historic differences in patient populations served.

- Fairview states that because its proposed hospital would provide only level III emergency services, the nearby level I trauma program at NMHC will continue to be required and used.

- Finally, Fairview states that NMHC's association of the Public Interest Review Process with the "Ambulance Law" (144E.11) is not applicable because in the case of the Moratorium Law, the "Legislature has elected to retain control of the application for exception process because of the complexity and economic consequences associated with a decision."

6. Discussion and Recommendations

The 2004 Legislature established a new step in the process for seeking an exception to Minnesota's hospital moratorium, putting in place a Public Interest review by the Minnesota Department of Health. The proposals to build new inpatient capacity in the Maple Grove area present the first opportunity to apply the new law.

The public interest review law requires a hospital seeking to increase its number of licensed beds or an organization seeking to obtain a hospital license to submit a plan to the MDH. The commissioner is required to review the plan and issue a finding on whether the plan is in the public interest. As mentioned earlier in this report, there are a number of statutory factors the MDH must consider during its review, in addition to other factors the MDH believes are relevant to the review.

The public interest review statute does not define "public interest" nor does it define for which "public" the analysis should be conducted. There could be a variety of different "publics": the citizens of the proposed service area, the citizens of communities not in the proposed service area that could be affected by the proposal, or the citizens of Minnesota. In addition, the statute does not provide direction to MDH on the analysis of situations where more than one hospital is intending to seek an exception to the hospital moratorium for the same or similar geographic area. We received three separate requests for reviews at approximately the same time in November 2004: Fairview Health Services, North Memorial Health Care, and the Maple Grove Tri-Care Partnership. The MDH reviewed all three proposals simultaneously under the public interest review law relative to the statutory factors in Minn. Stat. 144.552, and is issuing separate findings on each plan. The finding in this report is specific to the Fairview proposal.

The previous section of the report examined the proposal of Fairview in light of the five specific factors MDH must consider as part of the public interest review process. This final section of the report highlights several issues that the Legislature may wish to consider in its deliberations on proposals brought before it for new inpatient capacity in the Maple Grove area. These issues are outlined below.

Ability to Support versus Need for a Hospital

During the review process for the Maple Grove hospital proposals, MDH has heard from the community, as well as from those who are interested in seeking an exception to the hospital moratorium to build new inpatient capacity in Maple Grove, that the community can support a new hospital. Based on analysis of population growth in the service areas defined by the three applicants, the likely use of services in the community, and the clearly-stated community desire for inpatient hospital capacity in the community, the Department concurs that the community could support a hospital of the size and scope in the proposals. That is, if a new inpatient facility as described in any of the three applications were constructed, it is unlikely that the hospital would fail due to insufficient usage.

However, it is also important to distinguish between support and need. Specifically, while the ability of a community to support a hospital is an important consideration, the hospital public interest review law requires the MDH to conduct an examination of need. That is, whether a given community can support a hospital is a separate question than whether a new hospital in a given community is necessary to ensure the health outcomes of the residents of the community. Analysis of need must also take into account the capacity of existing facilities that currently serve residents of the community, the likely health care needs of the residents of the community, and any other factors that might influence the availability of services for members of a given community.

In our projections of hospital occupancy, we estimate that, absent any new facility being constructed, the overall occupancy rate of hospitals currently serving the Maple Grove area will grow from 74.0% in 2003 to approximately 79.4% by 2009 and 85.5% by 2015. As mentioned earlier in this report, these estimates of occupancy rates will also vary by facility, depending on patient flows and the expected growth in areas served by these various hospitals. There is no single "right" rate of occupancy. To some degree, the rate of occupancy at which facilities can and should operate depends on the mix of services being provided at that facility. However, based on the projected occupancy figures, it is reasonable to conclude that hospitals serving the Maple Grove market will face increasing capacity strains within the next several years. It is also important to note that the 11 facilities that currently serve Maple Grove also account for approximately one-third of statewide admissions, so the likely increased strain on capacity has an impact on geographic areas beyond Maple Grove as well.

As the Legislature considers proposals to build a new inpatient facility in Maple Grove, it may wish to consider whether the estimated growth in occupancy rates at existing facilities is sufficient to merit the construction of a new facility. Should the legislature determine that some new inpatient capacity is needed to address rising occupancy rates at area hospitals, then the question for policymakers to consider is not whether new capacity should be added, but rather how and where this new capacity should be added: by expansion of existing facilities to the extent that is feasible, or through the construction of a new facility.

Hospital Competition and Consolidation

Another issue for consideration is the degree to which the addition of a new hospital in Maple Grove will add to or decrease hospital competition. This is an important issue because, on balance, peer-reviewed studies show that increases in hospital concentration lead to higher hospital prices.[16] The Twin Cities hospital market already operates with a certain degree of "systemness." That is, several hospital systems have a relatively large share of the inpatient market in the metro area: Allina-affiliated hospitals have approximately 30% of the market, Fairview hospitals approximately 20%, and HealthEast hospitals around 10%.

[16] See, for example, David Dranove and Richard Lindrooth, "Hospital Consolidation and Costs: Another Look at the Evidence," Journal of Health Economics, Volume 22, Issue 6, November 2003.

There are two ways to think about the issue of hospital competition and concentration for the Twin Cities market: metro-wide and local. A hospital constructed in Maple Grove by an existing hospital system, such as Fairview, Allina, or Children's, would likely increase the level of Twin Cities-wide concentration. However, it's important to note that all of the proposed hospitals for Maple Grove are relatively modest in size and may be unlikely to substantially increase the level of Twin Cities-wide hospital market concentration. In addition, it's difficult in advance to know the exact impact that a new facility in Maple Grove owned by an existing system will have on market concentration overall, since the exact effect depends on patient flow patterns that can only be observed after the fact.

On the other hand, a new hospital constructed in Maple Grove by an existing facility with substantial existing market share in the immediate local area, such as North Memorial Health Care, may increase local concentration levels. This increase in local concentration may be mitigated, at least to some degree, by the fact that North Memorial's proposal does not result in an increase in overall bed capacity. The degree to which prices are increased due to increases in either local or Twin Cities-wide concentration depends on whether prices are set at a local level for services or whether they are set system- and Twin Cities-wide.

Bed Types and Services Provided

Another consideration for the Legislature in considering granting an exception is the mix of bed types and services provided in any new hospital constructed in Maple Grove. For example, the expected rapid increase in the population of childbearing age in the Maple Grove area is likely to increase the need for obstetric services.[17] In addition, because differentials exist in payment rates by type of service, hospital beds used for different services generate different levels of profitability. For instance, beds for cardiac care are generally profitable, while those used for behavioral health are generally less profitable. Over time this can lead to a situation where Minnesota may have sufficient capacity or over-capacity for profitable services, and an undersupply of beds for services that are less profitable. Evidence suggests that Minnesota may have sufficient supply of certain types of beds and services, but may lack adequate inpatient behavioral health capacity.[18]

In general, all three proposals respond to the likely need into the near future for obstetric services in the Maple Grove area. Two of the three proposals (Fairview and North Memorial) propose to include some level of additional inpatient behavioral health capacity in their initial inpatient construction (12 and 4 beds, respectively), while the third (Tri-Care) does not specifically plan the construction of new inpatient capacity, although it states its intent to "construct a viable model for inpatient services."

[17] The population aged 18 to 44 is in the Maple Grove area is projected to grow between 18.3% and 33.9%, depending on the service area defined, compared to 1.7% statewide.

[18] See "The Shortage of Psychiatrists and of Inpatient Psychiatric Bed Capacity," Minnesota Psychiatric Society Task Force Report, September 2002 and "Minnesota Mental Health and Chemical Dependency Treatment Trends: 1998-2002," Minnesota Department of Health, Health Economics Program, Issue Brief 2004-07, November 2004.

In considering the proposals to build new inpatient capacity in Maple Grove, the legislature may wish to give strong consideration to whether certain services, such as behavioral health inpatient capacity, should specifically be included as a requirement under any moratorium exception granted. For instance, the legislature could require that a certain percentage of beds of any exception granted be used for behavioral health services.

Potential Health Care System Costs

Although not included as a specific statutory criterion under the public interest review law, health care cost is also a policy issue important to the consideration of inpatient hospital construction and expansion. As a matter of policy, states have generally taken some interest in monitoring or in some way constraining the expansion of inpatient hospital facilities. For instance, hospital CON laws still operate, in some form, in 37 states.[19] States have generally shown an interest in inpatient hospital capacity, as it relates to health care cost, for two reasons. First, hospitals are expensive to construct and operate, and those costs are built into the health care system and subsequently into health insurance premiums. Second, some argue that duplication of services increases health care costs under the argument that, in health care, supply of services is likely to induce demand for those services. Laws, such as Minnesota's construction moratorium law, that restrict the construction of new inpatient facilities unless approved in advance, can have the effect of reducing potential duplication of services.

While we did not attempt to estimate the specific impact that the addition of a new inpatient facility in Maple Grove would have on health care costs, it is likely that the construction of any new facility will add at least some additional cost to Minnesota's health care system, although the proposed construction costs of all three proposed projects are relatively modest in comparison to overall state hospital spending. The extent to which the construction of a new hospital is duplicative of existing services and is therefore likely to induce excess demand depends in large part upon whether the existing facilities serving the Maple Grove area have sufficient capacity to serve the population into the future or whether those facilities are sufficiently strained to merit additional capacity. That is, if existing capacity is insufficient to provide services to the Maple Grove community into the future, then policy issues related to construction cost and the potential of induced demand may be less of a concern.

Summary and Recommendations

Reviews related to the construction of a new inpatient facility in the Maple Grove area are the first under the new public interest review process passed by the 2004 Legislature. The law requires that the MDH issue a finding as to whether the proposal is in the public interest.

[19] U. S. General Accounting Office. "Specialty Hospitals: Geographic Location, Services Provided, and Financial Performance," October 2003.

As mentioned earlier in this section, the legislation does not define "public" for the purposes of "public interest" and therefore the "public" can be defined in a variety of ways. One potential "public" could be the persons living in the Maple Grove area. With regard to the ability of the community to support a hospital, MDH believes that the community can support a hospital and should one be constructed in the Maple Grove area, it is unlikely that the hospital would fail due to lack of use. In addition, the construction of a new facility as proposed would provide more convenient access to services for residents in the community. Therefore, we believe it would likely be in the public interest of members of the Maple Grove community if a new hospital were to be constructed.

In examining whether Fairview's proposal is in the public interest for Minnesota as a whole, the analysis is more complicated because it must also take into consideration issues such as system capacity, potential cost impact, and the statutory factors, such as the effect of the new inpatient construction on existing facilities, examined in section 5 of this report.

As shown earlier, we project that occupancy rates for hospitals serving the Maple Grove community will increase over the course of the next ten years, and will be at levels that are relatively high by 2015. Based on this analysis, we conclude that hospitals serving the Maple Grove market will face increasing capacity constraints in the next 10 years. In addition, because the hospitals that serve Maple Grove also account for approximately one-third of the state's overall admissions, the strain on these facilities also has an impact on geographic areas beyond the Maple Grove area. MDH concludes that allowing construction of new inpatient capacity of the size and scope proposed by Fairview would relieve, at least to some degree, these expected capacity strains.

In conclusion, after examining the proposal submitted by Fairview in relation to the factors specifically required by Minn. Stat. 144. 552 and other relevant factors, the Minnesota Department of Health has the following findings and recommendations:

- Fairview's proposal to build a new inpatient facility in Maple Grove, Minnesota is in the public interest; and
- The legislature should consider requiring that a certain percentage of hospital beds of any exception granted for the Maple Grove area be dedicated for behavioral health services.

Appendix 1

Copies of Comments on the Proposal

CITY OF
Hibbing

Rick Wolff
Mayor

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401 E. 21st Street ★ Hibbing, Minnesota 55746

November 3, 2004

Minnesota Department of Health
Attn: Commissioner Dianne Mandernach
P.O. Box 64882
St Paul, MN 55164-0882

Dear Commissioner Mandernach:

I am writing this letter in support of Fairview Health Services' efforts to build a new hospital in Maple Grove, Minnesota. Fairview has a hospital in Hibbing where I currently serve as Mayor. We consider the hospital to be a treasured community asset. They have stepped to the plate on numerous occasions to assist us as well other entities in the community needing support. They have been and continue to be an outstanding corporate citizen of Hibbing.

Since 1998, Fairview University Medical Center – Mesabi has provided high quality health care for Hibbing and our surrounding area. They have taken the initiative to establish, promote and conduct wellness programs in our community. I have had an opportunity to attend some of their individualized training sessions and have found them to be very thought provoking and helpful.

Also, I have attended their community report meeting just recently. They encourage community input and support when developing their programs. The ongoing community dialogue they have established makes their facility a leader in developing community based initiatives and decisions regarding future health care needs and issues.

I believe Fairview could only be a positive addition to Maple Grove. If I can provide additional information or assistance, please contact me at
(218) 262-3486 ext. 127.

Sincerely,

Mayor Rick Wolff

City of Edina

November 3, 2004

Dianne Mandernach, Commissioner
Minnesota Department of Health
P.O. Box 64882
St. Paul, MN 55164-0882

Dear Commissioner Mandernach:

I strongly support Fairview Health Services' efforts to build a new hospital in Maple Grove, Minnesota. Fairview has a hospital in Edina, where I am Mayor elect, and has been a tremendous corporate and community citizen for our city.

Since 1965, Fairview Southdale has provided high-quality, community-based health care in our area. They have demonstrated leadership through community initiatives that promote the health and well being of our community.

I believe Fairview would make a positive addition to the Maple Grove community, as it has to my community. If I can provide any additional information, please contact me at 612-874-8550.

Sincerely,

James B. Hovland
Mayor Elect
City of Edina

JBH/d

City Hall
4801 WEST 50TH STREET
EDINA, MINNESOTA, 55424-1394

www.cityofedina.com

952-927-8861
FAX 952-826-0390
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Twin Cities Campus

Academic Health Center
Office of the Senior Vice President for Health Sciences

Mayo Mail Code 501
420 Delaware Street S.E.
Minneapolis, MN 55455-0374
612-626-3700
Fax: 612-626-2111
Offices located at:
410 ChRC
426 Church Street S.E.
Minneapolis, MN 55455-0374

November 3, 2004

Dianne Mandernach
Commissioner
Minnesota Department of Health
P.O. Box 64882
St. Paul, MN 55164-0882

Dear Commissioner Mandernach,

I write to endorse a hospital created from the partnership of University of Minnesota Physicians and Fairview, linked to the breakthrough medicine of the Academic Health Center.

As one of our fastest growing communities, a local hospital is important to the health of Maple Grove's citizens. University of Minnesota Physicians and Fairview are committed to creating a world-class community hospital. This hospital will closely link to Minnesota's premier Academic Health Center at the University of Minnesota. As head of that Academic Health Center, I can assure you that this partnership brings access to the education and training of nearly two-thirds of Minnesota's health care professionals.

I hope you will recognize and recommend this need for acute care beds in Maple Grove.

Sincerely,

Frank B. Cerra, MD
Senior Vice President for Health Sciences

City of RED WING

November 5, 2004

Dianne Mandernach, Commissioner
Minnesota Department of Health
P.O. Box 64882
St. Paul, MN 55164-0882

Dear Commissioner Mandernach:

I strongly support Fairview Health Services' efforts to build a new hospital in Maple Grove, Minnesota. Fairview has a hospital in Red Wing and has been a tremendous corporate and community citizen for our city.

Since 1997, Fairview Red Wing Health Services has provided high-quality, community-based health care in our area. They have demonstrated leadership through community initiatives that promote the health and well-being of our community.

I believe Fairview would make a positive addition to the Maple Grove community, as it has to my community. If I can provide any additional information, please contact me at 651.385.3615.

Sincerely,

Vern Steffenhagen, Mayor
City of Red Wing, Minnesota

Donna Dummer, Mayor Elect
City of Red Wing, Minnesota

315 West 4th Street
Red Wing, MN 55066
Website: www. red-wing.org
Phone: 651.385.3600
Fax: 651.388.9608

Executive Offices
Suite 401 South
2550 University Avenue West
St. Paul, MN 55114
651-603-5330 Phone
651-603-5360 Fax

UNIVERSITY *of* MINNESOTA PHYSICIANS

SPECIALIZING IN BREAKTHROUGHS

November 5, 2004

Dianne Mandernach
Commissioner
Minnesota Department of Health
P.O. Box 64882
St. Paul, MN 55164-0882

Dear Commissioner Mandernach:

As Chief Executive Officer of University of Minnesota Physicians, I am writing to confirm that our organization is committed to partnering with the Fairview Health System in a community-based hospital proposed for Maple Grove. The close relationship between our two organizations and the Academic Health Center will bring breakthrough medicine into this community.

UMPhysicians is committed to working in partnership with Fairview and the local community to bring high quality medical specialty care to the Maple Grove area as a first step in enhanced health care at the local area for the residents of this area of the state

I hope you will recommend this need for acute care beds in Maple Grove.

Sincerely,

Roby C. Thompson, M.D.
Professor of Orthopaedic Surgery
Associate Dean for Clinical Affairs
University of Minnesota Medical School
CEO, University of Minnesota Physicians

City of
Maple Grove
12800 Arbor Lakes Parkway, P.O. Box 1180, Maple Grove, MN 55311-6180 763-494-6000

November 5, 2004

Dianne Mandernach
Commissioner of Health
85 E. 7th Place
St. Paul, MN 55101

Dear Commissioner Mandernach:

As Mayor of Maple Grove, I am pleased Fairview has submitted a review process paper to the Minnesota Department of Health for the potential development of a hospital in Maple Grove.

As you are probably aware, Maple Grove and the surrounding suburbs are among the fastest growing communities in Minnesota. We are excited to have a hospital in our community. With a 37.4 percent growth in population between 1990 and 2000 for Maple Grove and eight neighboring suburbs, the need for a hospital to serve the northwest metropolitan area is obvious.

Clearly, with the snarl of congested traffic patterns in the northwest metro area, putting a hospital and its emergency services in the heart of our community would certainly be instrumental in saving lives. The area also is in need of more OB/Gyn services. There are a tremendous number of young families in our region. We also are concerned about the behavioral needs of our citizens, especially teenagers.

We are pleased Fairview, with its current presence in this area, is interested in adding more community-based care in Maple Grove. We look forward to having a first-rate health care hospital linked to leading, nationally recognized medical centers.

Thank you for your time and attention on this matter. If I can be of any further assistance, please don't hesitate to call me at 763-560-5700.

Sincerely,

Mark Steffenson
Mayor

MDH 110904.BH cc: Doug Stang

City of Princeton

705 SECOND STREET NORTH
PRINCETON, MINNESOTA 55371
E-MAIL: city@princetonmn.org
www.princetonmn.org

Red Folley
Scott Satz
HP, I&CM

November 9, 2004

Dianne Mandernach
Commissioner
Minnesota Department of Health
P.O. Box 64882
St. Paul, MN 55164-0882

Dear Commissioner Mandernach:

I strongly support Fairview Health Services' efforts to build a new hospital in Maple Grove, Minnesota. Fairview has a hospital in Princeton, where I am mayor, and has been a tremendous corporate and community citizen for our city.

For many years, Fairview Northland Regional Health Care has provided high-quality, community-based health care in our area. They have demonstrated leadership through community initiatives that promote the health and well being of our community.

I believe Fairview would make a positive addition to the Maple Grove community, as it has to my community. If I can provide any additional information, please contact me at 763-389-2040.

Sincerely,

Brian Humphrey
Mayor, City of Princeton

Rec 11-16-04
Sent 11-16-04
Due 11-24-04

FAIRVIEW
Fairview Ridges Hospital

December 31, 2004

201 Nicollet Boulevard
Burnsville, MN 55337-5799
Tel 952-892-2000
Fax 952-892-2107

Scott Leitz
Minnesota Department of Health
Director, Health Economics Program
PO Box 64882
St. Paul, MN 55164-0882

Dear Mr. Leitz:

Thank you for offering me the opportunity to comment on developing a hospital in the Maple Grove area.

I strongly support Fairview's proposal to develop this hospital. The Maple Grove service area needs community-based inpatient health care. The hospital will draw patients from the immediate area, where Fairview already has a market share. I don't believe local, rural hospitals, such as Monticello/Big Lake or Buffalo, will be affected by this hospital.

Fairview does not intend to increase the number of hospital beds in the state, rather to transfer existing beds from Fairview-University to the new Maple Grove site, which sets its proposal apart. Fairview already has a presence in this market. In addition to hospital patients who already come from this service area, Fairview has relationships with local school districts to provide behavioral health and athletic training services. It is also affiliated with primary and specialty care physicians currently serving the Maple Grove community.

Fairview is best positioned to bring comprehensive, regional health care services linked to the University of Minnesota Physicians to this area of our state. As members of the Minnesota Valley Care System will attest, Fairview is a health care provider who partners with the local community to meeting residents' needs. The services offered at Fairview Ridges Hospital are based on what our community sought in its health care provider of choice. The ongoing involvement of community members through our board of trustees keeps us in synch with those needs and desires.

Sincerely,

Sara Criger
President
Fairview Ridges Hospital
Minnesota Valley Care System

FAIRVIEW
Fairview-University Medical Center

January 3, 2005

University Campus
420 Delaware Street Southeast
Minneapolis, MN 55455
Tel 612-273-3000

Riverside Campus
2450 Riverside Avenue
Minneapolis, MN 55454
Tel 612-672-6000

Dianne Mandernach
Commissioner of Health
85 East 7th Place
St. Paul, MN 55101

Dear Commissioner Mandernach:

Thank you for the opportunity to comment on the proposed hospital for Maple Grove, Minnesota. I am the CEO of the Fairview-University Medical Center. I have been affiliated with the Fairview system for over 25 years, first as an OB/Gyn physician and now in my current administrative role. One of the reasons I have been an active member of the Fairview team is because of Fairview's value to be a community based health care system. Fairview first and foremost wants to serve the community in which they reside. I saw this first hand as a physician in Edina. Fairview and the Edina community worked arm and arm in service to this community.

In my current position, I have the opportunity to experience the comparable partnership between the Cedar Riverside and the broader Minneapolis community and Fairview University Medical Center .

I strongly believe if Fairview is given the chance to build a health care campus in Maple Grove, Fairview will continue its tradition of being a health care system that is there to meet community need.

Fairview currently has been in the Maple Grove community for numerous years through the school system. Fairview provides behavioral care and athletic training for the Osseo/Maple Grove school district.

Fairview is best positioned to bring comprehensive, regional health care services linked to the University of Minnesota Physicians to this area of our state. Linked to the Fairview University Children's Hospital and the University of Minnesota Medical School, Fairview is in the unique position of offering its extensive community based care that is affiliated with the premier referral hospital in the state – from flu shots to robotic surgery.

Thank you for allowing me to comment on behalf of Fairview-University Medical Center. We would be privileged to serve the people of Maple Grove.

Sincerely,

Gordon L. Alexander, Jr., MD

Gordon L. Alexander, Jr., MD
President
Fairview-University Medical Center

FAIRVIEW
Fairview Northland Regional Health Care

Fairview Northland Regional Hospital
911 Northland Drive
Princeton, MN 55371
Tel 1-763-389-1313

Fairview Northland Clinics Elk River
290 Main Street
Elk River, MN 55330
Tel 763-241-0373
Fax 763-241-5835

Fairview Northland Clinics Milaca
150 Northwest 10th Street
Milaca, MN 56353
Tel 320-983-7400
Fax 320-983-2766

Fairview Northland Clinics Princeton
919 Northland Drive
Princeton, MN 55371
Tel 763-389-3344
Fax 763-389-6545

Fairview Northland Clinics Zimmerman
25945 Gateway Drive
Zimmerman, MN 55398
Tel 763-856-6900
Fax 763-856-6906

January 3, 2005

Mr. Scott Leitz
Director, Health Economics Program
Minnesota Department of Health
P.O. Box 64882
St. Paul, MN 55164-0882

Dear Mr. Leitz:

Thank you for offering me the opportunity to comment on developing a hospital in the Maple Grove area.

I strongly support Fairview's proposal to develop this hospital. The Maple Grove service area needs community-based inpatient health care. The hospital will draw patients from the immediate area, where Fairview already has a market share. I don't believe local hospitals, such as Monticello/Big Lake or Buffalo, will be affected by this hospital.

Fairview does not intend to increase the number of hospital beds in the state, rather to transfer existing beds from Fairview-University to the new Maple Grove site, which sets its proposal apart. Fairview already has a presence in this market. In addition to hospital patients who already come from this service area, Fairview has relationships with local school districts to provide behavioral health and athletic training services. It is also affiliated with primary and specialty care physicians currently serving the Maple Grove community.

Fairview is best positioned to bring comprehensive, regional health care services linked to the University of Minnesota Physicians to this area of our state. As members of Princeton, Milaca, Zimmerman and Elk River communities will attest, Fairview is a health care provider who partners with the local community to meeting residents' needs. The services offered at Fairview Northland Regional Health Care are based on what our communities sought in their health care provider of choice. The ongoing involvement of community members through our board of trustees keeps us in synch with those needs and desires.

Sincerely,

Michael J. Youso
President

FAIRVIEW
Fairview Lakes Regional Health Care

January 4, 2005

Fairview Lakes Regional Medical Center
5200 Fairview Boulevard
Wyoming, MN 55092- 8013
Tel 651-982-7000
Fax 651-982-7999

Mr. Scott Leitz, Director
Health Economics Program
Minnesota Department of Health
P.O. Box 64882
St. Paul, MN 55164-0882

Dear Mr. Leitz:

I appreciate the opportunity to comment on the proposal for a hospital in the Maple Grove area.

I believe Fairview is best positioned to bring hospital services to this rapidly growing community. As members of the Fairview Lakes communities will attest, Fairview is a health care provider who partners with its local community to meet citizen's needs. The services we offer at Fairview Lakes Regional Medical Center are based on what our communities articulated as service requirements for our rapidly growing area. Fairview Lakes continues that community involvement six years after building our new medical center through our community based board of trustees and our community outreach programs that keeps us well aware of changing health care needs and desires.

I support Fairview's proposal to develop the hospital in Maple Grove. The Maple Grove service area strongly demonstrates a need for community based inpatient health care. Fairview has demonstrated over and over again from the Lakes market to the Fairview Ridges market and many more, its ability to develop and establish community based hospital services. The hospital will draw new patients from the immediate area where Fairview already has a market share and established services. When appropriately placed which I believe a Maple Grove hospital is, the establishment of a new facility does not affect other hospitals. This occurs for two reasons; 1) the population presence in a given community to support a hospital in its own right and 2) the tendency for that same community in the absence of a hospital facility to show a very scattered distribution of where it receives hospital services.

Fairview has proposed to establish a hospital in Maple Grove within the State guidelines and the hospital moratorium law by not increasing the number of hospital beds in the State. Fairview's relationship with the Maple Grove community combined with its unique relationship with the University of Minnesota Physicians allows Fairview to bring comprehensive regional health care services to this community. I strongly support Fairview's proposal to provide services to the Maple Grove area.

Thank you for the opportunity to comment on this important endeavor.

Sincerely,

Daniel K. Anderson
President

...MDH/2006/MapleGrove...

FAIRVIEW
Fairview Red Wing Health Services

Fairview Red Wing Medical Center
701 Fairview Boulevard
P.O.Box 95
Red Wing, MN 55066-0095

Tel 651-267-5000
Toll Free 866-297-9215

January 4, 2005

Scott Leitz, Director
Health Economics Program
Minnesota Department of Health
P.O. Box 64882
St. Paul, MN 55164-0882

Dear Mr. Leitz:

I appreciate the opportunity to offer comment on the proposal to develop a hospital in the Maple Grove, Minnesota, area.

I offer a unique perspective and my support for Fairview Health Services' proposal to build a hospital in Maple Grove. I am currently the President and Chief Executive Officer of Fairview Red Wing Health Services in Red Wing, Minnesota. Prior to this role, I served as the President of Chisago Health Services in Chisago City and its successor organization, Fairview Lakes Regional Health Care, now headquartered in Wyoming, Minnesota. I have had the privilege of personally observing the impact Fairview has had on the communities in which I have had the privilege of serving as a health care administrator.

In both Wyoming and Red Wing, Fairview's focus has been to create a healthcare system which benefits the community by making significant capital and clinical investment. In both instances, Fairview has delivered. Other examples of Fairview's community leadership are evident in Princeton, Burnsville, and Edina. Fairview's community-based mission clearly places it as an excellent choice for the Maple Grove project.

As you know, the Maple Grove service area is the most rapidly developing area in the Metro. The location of an inpatient facility will only strengthen care delivery both in Maple Grove and across the metro region. My experience, and also data from other community-based hospitals, demonstrates that patients using the new Maple Grove facility will come from the immediate community with minimal, if any, impact on other hospitals such as Monticello or Buffalo.

Fairview's proposal will not require the approval of additional hospital beds in the state. Rather, its proposal is to transfer existing beds from Fairview University to the new Maple Grove campus. Clearly, this sets Fairview's proposal apart from other competitive proposals for Maple Grove. Fairview is a natural partner as it has a presence in this market currently and also has a positive working relationship with the local school districts, providing behavioral health and athletic training services. Fairview also enjoys affiliated primary and specialty care relationships in the Maple Grove area.

Key to any development of a hospital is the ability to work closely with the medical staff. Fairview's relationship with the University of Minnesota Physicians provides assurance of Fairview's ability to deliver on this important variable.

As noted above, without question, members of the two communities in which I have had the privilege to serve as a Fairview administrator will attest that Fairview is a healthcare provider who partners with the local community to meet residents' needs in the community. Input from the community is critical and drives the services offered by Fairview. Over time, the ongoing involvement by a community-based Board of Directors provides excellent checks and balances to meeting community-based needs.

Again, I thank you for the opportunity endorse Fairview's proposal to build a hospital facility in the Maple Grove community. Please feel free to contact me should you have any questions.

Sincerely,

Scott Wordelman
President and CEO

SW/vl

Scott Leitz - Maple Grove Medical Facility

From: "DOUG MCLAUGHLIN" <DMCLAUG3@fairview.org>
To: <Scott.Leitz@state.mn.us>
Date: 1/12/2005 9:15 AM
Subject: Maple Grove Medical Facility

Scott,

I was at the community center in Maple Grove last night but did not speak.

I am a Fairview employee.

My comments are as follow:

1. Choice; two individuals spoke last night about choice and I could not agree more. As a Fairview employee I would like to use a Fairview facility. However, since North Memorial monopolizes this area I receive all my health care for me and my family at North Memorial. This is not a choice, there is no competition as there should be.

2. Public uses North Memorial most for Maple Grove residents, see #1. Again bring in a quality provider and let the people have a real choice. This argument is bogus.

3. Trauma based facility. I think you would agree that Maple Grove and it's surround area is alittle different than North Minneapolis. I do believe that which ever facility is built needs to have an ER, but I question the need for a level 1 Trauma center. I lived in the area for over 12 years and can count on one hand the number of violent person on person events. Largest reason for ER would be traffic related.

4. Adverse effect; I think it would be very difficult for any Health Services organization, Fairview, North Memorial or Allina to justify a new Hospital in Maple Grove would negatively have a long term impact. With the projected population growth for this area and the time to build a 70 to 100 bed hospital, this does not include the clinics, of about five years Unity/Mercy, North Memorial will increase their volumes regardless. It's frustrating to think that the northwest metro area would have only one provider (North Memorial). Yea I'm already sick of hearing about North Memorial.

5. Bottom line the area is ready and has a need for one and only one facility. Let's bring in competition, something North Memorial has never had, and that will ensure the quality.

6. Traffic problems. One lady spoke last night about the traffic on Fernbrook and County 30. By looking at the proposed sites for the three organizations I believe anyone can see that Allina probably has the best site, Fairview second (don't tell my boss I said that) after the 610 is completed. Both Allina and Fairview will be a major intersections.

No matter what happens you and the State Legislature really need to get this done ASAP. All health organization don't make a great deal of money. It would be unfair for the two losers to keep spending hundreds of thousands of dollars on a project that will never happen.

Thanks for your time.....

you are hereby notified that any review, retransmission, dissemination, distribution, or copying of this message is strictly prohibited. If you have received this communication in error, please destroy and delete this message from any computer and contact us immediately by return e-mail.
<<<<P.H.I.>>>>

Appendix 2
Methodology

This appendix provides additional details on MDH's analysis of the application for public interest review. It describes the methods and data that we used to:

- Project future utilization and occupancy rates at hospitals currently serving residents of the Maple Grove area in the absence of a new hospital being built in Maple Grove;
- Estimate the impact of the proposed Maple Grove hospital on existing hospitals that serve residents of the Maple Grove area; and
- Analyze the potential shift in payer mix at existing hospitals as a result of the proposed Maple Grove hospital.

Projecting Hospital Use and Occupancy in the Absence of a New Hospital

This analysis focused on eleven hospitals that were identified as (a) holding a significant market share of the discharges from the Maple Grove area (as defined by the applicant); (b) having a high dependency on patients from the Maple Grove area (even if the hospital does not have a large share of the total market, it may be very dependent on the Maple Grove area as a source of admissions), or (c) being a major safety-net hospital provider in the region. The hospitals included in this analysis were Abbott Northwestern Hospital, Buffalo Hospital, Children's Hospital in Minneapolis, Fairview Northland Regional Hospital, Fairview-University Medical Center, Hennepin County Medical Center, Mercy Hospital, Methodist Hospital Park Nicollet Health Services, Monticello-Big Lake Hospital, North Memorial Medical Center, and Unity Hospital.

We used Minnesota hospital inpatient discharge data from calendar year 2003, excluding discharges of normal newborns. This data includes information on the patient's zip code and age. First, we calculated occupancy rates for each of the eleven hospitals and for the eleven hospitals as a group in 2003.

Next, we projected inpatient volumes and occupancy rates to 2009 and 2015. In order to take account of population growth and demographic change that may be occurring in a particular hospital's service area, we looked specifically at the zip codes from which most of the hospital's patients originate. We chose to define this area as the geographic area (group of zip codes) from which the top 75 percent of the hospital's discharges of Minnesota residents originated in 2003. For each of the eleven hospitals, we calculated hospital-specific and age-specific hospitalization rates for the population living in the geographic area as defined above. We used projections of future

[19] Population estimates by zip code and age were obtained from Claritas, Inc. for 2000, 2004 and 2009. We estimated 2003 population by assuming a constant average annual growth rate from 2000 to 2004. We projected forward to 2015 by applying the same average annual growth rate estimated by Claritas from 2004 to 2009.

population (by age group) in the same geographic area to project future hospital volumes.[19] The geographic areas that comprised the remaining 25 percent of the hospital's discharges of Minnesota residents were treated as a group for the purpose of projecting future use of hospital services, and we assumed that the number of discharges of non-Minnesota residents would grow at the same rate as discharges of residents of the state.

The major assumptions that we made in this analysis are as follows:

- We assumed that hospitalization rates by age group would be the same as they were in 2003. To take account of potential future changes in hospitalization rates, we also created projections assuming a range of future use rates – either a 10% increase or 10% decrease in hospitalization rates for each age group. Factors that could cause future hospitalization rates to increase include rising levels of disease (for example, conditions associated with obesity) or technological change; on the other hand, technological change can also be a major driver of reductions in hospitalization rates. (Changes in overall hospital utilization due to the projected aging of the population are accounted for already by the fact that the analysis is done separately for each age group.)

- We assumed that the average length of stay would also be unchanged compared to 2003. Although the average length of a hospital stay declined in Minnesota from 5.1 days in 1993 to 4.3 days in 2003, the average length of stay has been stable over the past five years.

- We assumed that average annual population growth for the geographic areas defined for each hospital would be the same for 2009 to 2015 as projected by Claritas, Inc. for 2004 to 2009. To the degree that this method might overstate or understate actual population growth during this period, our estimates of future hospital use would also be overstated or understated.

- Finally, we assumed that the group of zip codes from which each hospital receives its core business (the geographic area accounting for 75% of discharges) would remain the same over time.

Finally, because calculating occupancy rates over an entire year does not adequately capture variations in occupancy rates that occur at different times of the year, we projected seasonal occupancy rates for 2009 and 2015 by assuming that the distribution of inpatient days across the year would be the same as it was for 2003. In order to account for hospital days that occurred in 2003 but are missing from our data set because the patient was not discharged until 2004, we used hospital days from patients who were admitted in 2002 but not discharged until 2003 as a proxy.

Estimating the Impact of the Proposed Hospital on Existing Hospitals That Serve Residents of the Maple Grove Area

In order to calculate the impact of the proposed hospital on existing hospitals that serve residents of the Maple Grove area, we estimated the potential impact on discharges, inpatient days, and occupancy rates at each of the eleven hospitals. First, based on the applicants' submissions,[20] we calculated the total number of bed days that the new Maple Grove facility is designed to accommodate, incorporating information from the applicants on both the size of the facility and the expected occupancy rate. We calculated the impact on existing hospitals by assuming that the new facility would in fact provide the volume of inpatient services consistent with the proposed size and occupancy rate anticipated by the proposal. We also assumed that all of the patients served by the Maple Grove Hospital would come from within the applicant's defined service area. Our estimate of the impact of the facility is therefore a conservative estimate, representing an upper bound on the volume of inpatient services that would be shifted away from existing hospitals.

To estimate the impact on individual hospitals, we assumed that the hospital's market share of the services provided to Maple Grove area residents at hospitals other than the proposed new facility would be the same as its current market share among the group of eleven existing hospitals. Essentially, this assumes that people who do not receive services at the proposed Maple Grove hospital will maintain the same travel patterns that currently exist. As noted in the main text of the report, however, there is a high level of uncertainty about how travel patterns may change. There are two main factors contributing to this uncertainty: first, the possibility of as many as three large new ambulatory care centers in the community, which would likely have an impact on physician referral patterns; and second, the possibility that a system-affiliated hospital in Maple Grove could affect the pattern of referrals to other hospitals for services not provided directly at the proposed Maple Grove hospital. For each hospital, we estimated the impact of the proposed Maple Grove hospital on existing hospitals as the difference between a) projected volumes in the absence of a new hospital and b) projected volumes incorporating the loss of volume from the addition of a new facility in Maple Grove.

Analyzing Potential Payer Mix Shift

To estimate the potential effect of the proposed Maple Grove hospital on payer mix for existing hospitals, we calculated the distribution of insurance coverage at the zip-code or zip-code-group level for the core service areas of several hospitals. For this analysis, we limited the list of hospitals to those that are either 1) most likely to be affected by the proposed Maple Grove hospital, or 2) major providers of uncompensated care in the region. We used data from the 2001 Minnesota Health Access Survey, which was a health insurance survey of over 27,000 Minnesota households,

[20] For the Tri-Care proposal, we assume an 80-bed hospital for 2009 that will increase to 120 beds in 2015. Fairview Health Services' design anticipates also an 80-bed hospital in 2009, which it projects to expand to 240 beds in 2015. Because NMHC has indicated that they are only seeking legislative approval for the transfer of 80 beds at this time, this analysis assumes 80 beds in both 2009 and 2015. (NMHC has indicated that it may request another exception from the hospital moratorium in order to expand its proposed Maple Grove hospital in the future.)

to estimate insurance coverage for zip codes, or for groups of zip codes where there was insufficient data to estimate it at the zip code level. We aggregated these estimates of insurance status by zip code to the geographic area from which the top 75 percent of a hospital's discharges originated in 2003, as defined above in the projection of future demand for hospital services.

Next, we weighted our estimates of the sources of insurance coverage in the geographic area according to the proportion of the hospital's discharges from each zip code or group of zip codes.. This provided an approximation of the distribution of insurance coverage in the geographic area from which the hospital draws most of its patients. We repeated this analysis for 2009 and 2015 for 1) the projections of inpatient volumes in the absence of a new hospital and 2) the projections with the proposed new hospital.

Appendix 3
American College of Surgeons Classification of Trauma Centers

American College of Surgeons Committee on Trauma Classification System of Trauma Center Level

ACS Levels and Descriptions

Level I

Provides comprehensive trauma care, serves as a regional resource, and provides leadership in education, research, and system planning.

A level I center is required to have immediate availability of trauma surgeons, anesthesiologists, physician specialists, nurses, and resuscitation equipment. American College of Surgeons' volume performance criteria further stipulate that level I centers treat 1200 admissions a year or 240 major trauma patients per year or an average of 35 major trauma patients per surgeon

Level II

Provides comprehensive trauma care either as a supplement to a level I trauma center in a large urban area or as the lead hospital in a less population-dense area.

Level II centers must meet essentially the same criteria as level I but volume performance standards are not required and may depend on the geographic area served. Centers are not expected to provide leadership in teaching and research.

Level III

Provides prompt assessment, resuscitation, emergency surgery, and stabilization with transfer to a level I or II as indicated.

Level III facilities typically serve communities that do not have immediate access to a level I or II trauma center.

Level IV & V

Provides advanced trauma life support prior to patient transfer in remote areas in which no higher level of care is available.

The key role of the level IV center is to resuscitate and stabilize patients and arrange for their transfer to the closest, most appropriate trauma center level facility.

Level V trauma centers are not formally recognized by the American College of Surgeons, but they are used by some states to further categorize hospitals providing life support prior to transfer.

Source: MacKenzie EJ et. al. National Inventory of Hospital Trauma Centers. JAMA 2003 Mar 26; 289(12):1516.

To obtain additional copies of this report, please contact:

Minnesota Department of Health
Minnesota Health Information Clearinghouse
P.O. Box 64975
St. Paul, Minnesota 55164-0975
(651) 282-6314; (800) 657-3793
TDD (651) 215-8980

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UNIVERSITY OF MINNESOTA

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Testimony of Frank B. Cerra, M.D.
Senior Vice President for Health Sciences
McKnight Presidential Leadership Chair
University of Minnesota
April, 2005
To the Senate Health and Human Services Budget Division, and the Health and Family Security Committee

I'd like to thank you for this opportunity to provide testimony on the need for new health facilities to serve the community of Maple Grove and the surrounding area.

We have a unique partnership with Fairview Health Services, initiated in 1997 when they purchased the University of Minnesota Hospitals and Clinics. This partnership has become a national model for a public-private partnership that effectively supports the education and research mission of an Academic Health Center while competing in the health marketplace.

I'd like to also make the point that the health professional schools of the University of Minnesota are dependent on each and every health system, hospital, and clinic in the State of Minnesota for the success of our education and training programs.

- We have major affiliations with Veterans Administration Medical Center, Hennepin County Medical Center, and Regions Hospital, and strong relationships with such major health systems as Park Nicollet, North Memorial, and Allina.
- We also have affiliation agreements with more than 400 communities, clinics, and health facilities throughout the state of Minnesota.
- We are dependent on these relationships for the teachers and facilities needed to educate and train the next generation of health professionals who serve the health needs of those communities.

The Regent's approved practice plan at the Medical School, University of Minnesota Physicians, is core to the mission of the Medical School. Simply stated, our clinical faculty can not teach if they do not practice, and furthermore without practice students can not learn. Their primary teachers are the faculty who practice at UMPhysicians. UMPhysicians provides core financial support to the operations of the Medical School and competes with all other practices in the state within the same health marketplace. And, with declining state support, the importance of that revenue to the Medical School has increased.

When Fairview purchased UMHC in 1997, it created a special relationship with Fairview around the University's Hospital. UMPhysicians is a primary partner in the success of Fairview's University Medical Center. We see this development in Maple Grove as an important part of this partnership, as a clinical training site for students and residents and for the provision of specialty and subspecialty services in that community.

Finally, we were pleased to learn from studies performed in Maple Grove that the people who live there value the presence of the University in their community.

"Draft" Criteria for the Evaluation of New Proposals for "An Exception to the Hospital Construction Moratorium" Hot Topics in Health Care April 4, 2005

The threshold questions are:

(1) What information about the health care market and the existing distribution and supply of providers should we have to determine the need for a new Hospital?
(2) How soon does the community need the Hospital?
(3) Should the beds be new or transferred from an existing facility?
(4) What should the process be for making a decision?

Criteria for evaluation of new proposals:

- Commitment to Uncompensated Care including;
  - Discounts for uninsured patients
  - Coordination with Community Health Centers and other providers of care to low income uninsured
  - Coordination with other hospitals providing uncompensated care and serving public program participants

- Provision of a full continuum of Behavioral Health services including mental health services for children and adolescents and alternatives to inpatient care.

- How does the organization rank on existing measures of patient safety and quality of care?

- Has the organization invested in electronic medical records and other information technology? Future plans?

- What will be the impact on workforce development? Relationship with the University of Minnesota?

- Should the facility provide Trauma Level 3 or Level 2 emergency room services? How will they partner with Hennepin County Medical Center and other Trauma Centers?

- What will be their "Center of Excellence"?

- How will the facility partner or coordinate with other providers to reduce the duplication of "high cost" services and technology?

- What effect will the facility have on the viability of existing providers, including physicians, in the same market? In the Twin Cities? In Minnesota?

- Will the new facility increase competition? Add to the pressure to consolidate?

- Can we hold the "winning" proposal accountable for what they commit to do?

Comparison of Proposals for an Exception to Hospital Construction Moratorium

Unless indicated otherwise, all information in this document is based on MDH reports to the Legislature on proposals for a new inpatient facility in Maple Grove, or from information provided to MDH in filings for public interest review under Minnesota Statutes 144.552. **Many of the factors listed in this table were not included in the Department's October 2004 guidance about information to be submitted by applicants filing for public interest review.**

	Tri-Care	North Memorial Health Care	Fairview
1. Commitment to Uncompensated Care: Discounts for Uninsured Patients	In 2003, Allina, Park Nicollet, and Children's hospitals provided a combined $25.8 million in uncompensated care, which represented 1.2 percent of operating expenses (compared with a statewide average of 1.6 percent). Tri-Care's application states: "The Maple Grove Hospital will provide the same levels of charity care to residents in its service area as other hospitals in the region provide to their residents." Members of the Tri-Care partnership propose to provide uncompensated care relative to their level of equity ownership in the proposed partnership.	In 2003,NMHC provided $3.3 million in uncompensated care, which represented 1.0 percent of operating expenses (compared with a statewide average of 1.6 percent). NMHC has stated that it would institute the same charity care policy that is in place at its Robbinsdale facility at the proposed Maple Grove hospital. The information provided by NMHC does not include details on its current charity care policy.	In 2003, Fairview hospitals provided $10.7 million in uncompensated care, which represented 0.9% of their operating expenses (compared to a statewide average of 1.6%). Fairview has stated that it will provide charity care and community benefits to residents of the Maple Grove area that are similar to those provided in other communities served by Fairview. Fairview's Community Care Program and other Charity Care Plans provide discounts (up to 100%) based on several factors including income level and family size.
2. Commitment to Uncompensated Care: Coordination with Community Health Centers and other providers of care to low income uninsured	In addition to hospital uncompensated care, the applicants will support the Healthy Communities Initiative that is facilitated by the Park Nicollet Foundation. "It includes the Northwest Hennepin Family Collaborative, Osseo School	No information provided.	In addition to hospital uncompensated care, Fairview's proposal describes several community-based initiatives that provide services to uninsured and underserved populations, including "various community-based social service programs such as subsidized

	Tri-Care	North Memorial Health Care	Fairview
	District 279, St. Mary's Carondolet Caring Clinics, and the Plymouth, Maple Grove and Brooklyn Center Park Nicollet Clinics. Our partnership responds to the health care needs of children and families who are underserved and/or underinsured. Services provided through this partnership include: same day access, immunizations, and mental health with a focus on health disparities."		clinics, health screenings, interpreter services, social service and support counseling for patients and families, transportation to and from the hospitals, and the donation of space for use by community groups."
3. Commitment to Uncompensated Care: coordination with other hospitals providing uncompensated care and serving public program participants	Tri-Care application states, "We are currently in discussions with Children's Hospitals and Clinics and Hennepin County Medical Center to assure the full array of community needs are met."	No information provided.	No information provided.
4. Provision of a full continuum of behavioral health services including mental health services for children and adolescents and alternatives to inpatient care.	The Tri-Care proposal does not specifically include inpatient mental health services, but notes that "community demand for behavioral health services is high" and indicates a plan in Phase I to provide outpatient and observation services as they "construct a viable model for inpatient services." Proposal does not specifically address mental health services for children and adolescents.	NMHC proposal includes 4 psychiatric beds as part of its initial 80-bed phase. Proposal does not include chemical dependency services. Proposal does not specifically address mental health services for children and adolescents.	Fairview's proposal includes 12 behavioral health services beds initially (out of a total of 100 beds), growing to as many as 38 beds in 2020 if the hospital is expanded to the full proposed 284 beds. Proposal indicates that inpatient mental health services will serve adult, pediatric, and adolescent populations. As at other Fairview hospitals, Fairview expects to partner with the non-profit Behavioral Healthcare Providers to provide behavioral

	Tri-Care	North orial Health Care	Fairvie
			health care services. Ambulatory care center is proposed to include mental health and chemical dependency services.
5. How does the organization rank on existing measures of patient safety and quality of care?	The Tri-Care applicants provided a 3-page list of quality-related awards, including the first annual Patient Safety Award from the Minnesota Alliance for Patient Safety (Park Nicollet), awards related to diabetes care, disease management, heart disease care, and others. See attachments for additional information on quality and patient safety indicators: hospital quality indicators data from Centers for Medicare and Medicaid Services (CMS), and January 2005 MDH report "Adverse Events in Minnesota Hospitals."	According to NMHC, "North Memorial Medical Center was the first hospital in Minnesota to receive national certification as a Primary Stroke Center by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)…North Memorial was named one of the nation's Top 100 Cardiovascular Hospitals by Solucient in 2002 and 2003." See attachments for additional information on quality and patient safety indicators: hospital quality indicators data from Centers for Medicare and Medicaid Services (CMS), and January 2005 MDH report "Adverse Events in Minnesota Hospitals."	Fairview states that it "has received numerous awards over the last five years for our exemplary programs and clinical quality, including being named in the 2004 100 Best Hospitals in seven specialty areas by US News and World Report, being selected by the Robert Wood Johnson Foundation as one of six Palliative Leadership Centers (centers teaching other hospitals to care for dying patients) and selection of the Newborn Intensive Care Unit as one of the top four in the United States." See attachments for additional information on quality and patient safety indicators: hospital quality indicators data from Centers for Medicare and Medicaid Services (CMS), and January 2005 MDH report "Adverse Events in Minnesota Hospitals."
6. Has the organization invested in electronic medical records and other information technology? Future	Park Nicollet quality awards include a "2003 Gold Award for Innovation in Clinical Quality" for its development of an integrated clinical information	No information provided.	No information provided.

	Tri-Care	North Memorial Health Care	Fairview
plans?	system.		
7. What will be the impact on workforce development? Relationship with the University of Minnesota?	The Tri-Care partners believe that the Maple Grove hospital will shift staffing resources from existing facilities/providers in the region to an area that is more appropriately positioned to meet the demands of the community. In addition, they expect that their proposed hospital will participate in teaching programs offered through the University of Minnesota to train needed health care professionals.	NMHC's proposal involves the transfer of fully staffed beds from Robbinsdale to Maple Grove. Because the net result of the NMHC proposal is no change in inpatient hospital capacity, NMHC's proposal likely would have no impact on the ability of other hospitals in the region to maintain their existing staff. No information was provided on NMHC's relationship with the University of Minnesota.	Fairview's application describes extensive efforts to recruit, develop and maintain staff at existing Fairview facilities. Partnership with the University of Minnesota Physicians: "The University of Minnesota Physicians have provided services to Maple Grove residents for many years. This campus will be the first effort by both Fairview and the University of Minnesota Physicians to capture the distinctive talents and capabilities of the academic medical community and combine it with Fairview's extensive understanding of community health services. The University of Minnesota Physicians plan to expand their services and bring additional services to the community that will extend the technology and world class clinical services of the University to Maple Grove and surrounding area residents."
8. Will the facility provide Trauma Level 3 or Level 2 emergency room services? How will they partner with Hennepin County Medical Center and	Level II trauma center proposed, which means that the hospital would provide "comprehensive trauma care either as a supplement to a level I trauma center in a large urban area or as the lead hospital is a less	Level III trauma center proposed, which means that the hospital would provide "prompt assessment, resuscitation, emergency surgery, and stabilization with transfer to a level I or II as indicated" according to American College of Surgeons	Level III trauma center proposed, which means that the hospital would provide "prompt assessment, resuscitation, emergency surgery, and stabilization with transfer to a level I or II as indicated" according to American College of Surgeons

	Tri-Care	North orial Health Care	Fairvie
other Trauma Centers?	population-dense area" according to American College of Surgeons criteria. The closest Level I trauma center to Maple Grove is North Memorial.	criteria. The closest Level I trauma center to Maple Grove is North Memorial.	criteria. The closest Level I trauma center to Maple Grove is North Memorial.
9. What will be their "Center of Excellence"?	The hospital proposed by Tri-Care is primarily intended to be a community hospital and not a highly specialized inpatient facility. The Tri-Care partners stated: "We do not believe it is necessary to duplicate the highly complex specialty services already available in the Twin Cities."	The hospital proposed by NMHC is primarily intended to be a community hospital and not a highly specialized inpatient facility. The most complicated medical cases will likely be referred to other hospitals in the Twin Cities.	The hospital proposed by Fairview is primarily intended to be a community hospital and not a highly specialized inpatient facility. The most complicated medical cases will likely be referred to other hospitals in the Twin Cities.
10. How will the facility partner or coordinate with other providers to reduce the duplication of "high cost" services and technology?	See #9 above.	No information provided.	No information provided.
11. What effect will the facility have on the viability of existing providers, including physicians, in the same market? In the Twin Cities? In Minnesota?	MDH found that Tri-Care's proposal would have a modest impact on existing hospitals that serve patients from the Maple Grove area. Most hospitals currently serving patients from this area would continue to experience growth in demand for inpatient services, although at a slower rate than would have been the case if no hospital were built	MDH found that NMHC's proposal would have a modest impact on existing hospitals that serve patients from the Maple Grove area. Of the eleven hospitals that currently serve most patients from this area, all would continue to experience growth in demand for inpatient services, although at a slower rate than would have been the case if no hospital were built in Maple Grove.	MDH found that Fairview's proposal would have a modest impact on existing hospitals that serve patients from the Maple Grove area. Most hospitals currently serving patients from this area would continue to experience growth in demand for inpatient services, although at a slower rate than would have been the case if no hospital were built in Maple Grove.

	Tri-Care	North Memorial Health Care	Fairview
	in Maple Grove.		
12. Will the new facility increase competition? Add to the pressure to consolidate?	MDH found that Tri-Care's proposal would likely result in a modest increase in the level of market concentration in the Twin Cities.	MDH found that while it would likely result in a modestly lower level of market concentration in the Twin Cities as a whole, NMHC's proposed hospital in Maple Grove would likely result in a modest increase in the degree of market concentration in the local area (northwest Hennepin County).	MDH found that Fairview's proposal would likely result in a modest increase in the level of market concentration in the Twin Cities. Fairview states that "A Fairview hospital would introduce a new competitor to that part of the metro region."
13. Can we hold the "winning" proposal accountable for what they commit to do?	No information provided on accountability.	No information provided on accountability.	No information provided on accountability.

TABLE 1
OVERALL STATE-WIDE REPORT

Reported adverse health events: **ALL EVENTS** (July 1, 2003- October 6, 2004)

	CATEGORY OF EVENTS						
	SURGICAL	**PRODUCTS OR DEVICES**	**PATIENT PROTECTION**	**CARE MANAGEMENT**	**ENVIRONMENTAL**	**CRIMINAL**	**TOTAL**
ALL HOSPITALS	52 Events	4 Events	2 Events	31 Events	9 Events	1 Event	99 Events
SEVERITY DETAILS	Serious Disability: 0 Death: 2 Neither: 50	Serious Disability: 0 Death: 4	Serious Disability: 2 Death: 0	Serious Disability: 2 Death: 5 Neither: 24	Serious Disability: 0 Death: 9	Serious Disability: 0 Death: 0 Neither: 1	Serious Disability: 4 Death: 20 Neither: 75

TABLE 3: HOSPITAL-SPECIFIC DATA

TABLE 3.16

NORTH MEMORIAL MEDICAL CENTER

Address: 3300 Oakdale Avenue North Robbinsdale, MN 55422
Website: www.northmemorial.com
Phone number: 763-520-5183
Number of beds: 518

HOW TO READ THESE TABLES

These tables show the number of events reported at each hospital. They include the reported number for each of the 27 event types, organized under six categories. Categories and event types are not shown if no events were reported.

	REPORTED ADVERSE HEALTH EVENTS (JULY 1, 2003-OCTOBER 6, 2004)	
	NUMBER	**BACKGROUND**
CATEGORY AND TYPE		
Surgical Events		**23,637 surgeries were performed at this facility during this time period**
Surgery performed on wrong body part	3	Deaths: 0; Serious Disability: 0; Neither: 3
Care Management		**There were 202,022 patient days at this facility during this time period**
A medication error	1	Deaths: 1; Serious Disability: 0; Neither: 0
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	3	Deaths: 0; Serious Disability: 0; Neither: 3
TOTAL EVENTS FOR THIS FACILITY	7	Deaths: 1; Serious Disability: 0; Neither: 6

TABLE 3: HOSPITAL-SPECIFIC DATA

TABLE 3.1

ABBOTT NORTHWESTERN HOSPITAL

Address: 800 East 28th Street Minneapolis, MN 55407
Website: www.allina.com/patientsafety
Phone number: 612-775-9762
Number of beds: 926

HOW TO READ THESE TABLES

These tables show the number of events reported at each hospital. They include the reported number for each of the 27 event types, organized under six categories. Categories and event types are not shown if no events were reported.

	REPORTED ADVERSE HEALTH EVENTS (JULY 1, 2003–OCTOBER 6, 2004)	
	NUMBER	BACKGROUND
CATEGORY AND TYPE		
Surgical Events		**36,537 surgeries were performed at this facility during this time period**
Surgery performed on wrong patient	1	Deaths: 0; Serious Disability: 0; Neither: 1
Wrong surgical procedure performed	2	Deaths: 0; Serious Disability: 0; Neither: 2
Retention of a foreign object in a patient after surgery or other procedure	3	Deaths: 0; Serious Disability: 0; Neither: 3
Patient Protection Events		**There were 288,326 patient days at this facility during this time period**
Patient suicide or attempted suicide resulting in serious disability	1	Deaths: 0; Serious Disability: 1; Neither: 0
Care Management		**There were 288,326 patient days at this facility during this time period**
Hypoglycemia	1	Deaths: 1; Serious Disability: 0; Neither: 0
Environmental Events		**There were 288,326 patient days at this facility during this time period**
A fall while being cared for in a facility	1	Deaths: 1; Serious Disability: 0; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	9	Deaths: 2; Serious Disability: 1; Neither: 6

TABLE 3: HOSPITAL-SPECIFIC DATA

TABLE 3.22

ST. FRANCIS REGIONAL MEDICAL CENTER

Address: 1455 St. Francis Avenue Shakopee, MN 55379
Website: www.allina.com/patientsafety
Phone number: 612-775-9762
Number of beds: 70

HOW TO READ THESE TABLES

These tables show the number of events reported at each hospital. They include the reported number for each of the 27 event types, organized under six categories. Categories and event types are not shown if no events were reported.

	REPORTED ADVERSE HEALTH EVENTS (JULY 1, 2003-OCTOBER 6, 2004)	
	NUMBER	**BACKGROUND**
CATEGORY AND TYPE		
Surgical Events		**5,440 surgeries were performed at this facility during this time period**
Surgery performed on wrong body part	1	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	1	Deaths: 0; Serious Disability: 0; Neither: 1

TABLE 3: HOSPITAL-SPECIFIC DATA

TABLE 3.4

FAIRVIEW LAKES REGIONAL MEDICAL CENTER

Address: 5200 Fairview Boulevard Wyoming, MN 55092-8013
Website: www.fairview.org
Phone number: 651-982-7835
Number of beds: 70

HOW TO READ THESE TABLES

These tables show the number of events reported at each hospital. They include the reported number for each of the 27 event types, organized under six categories. Categories and event types are not shown if no events were reported.

	REPORTED ADVERSE HEALTH EVENTS (JULY 1, 2003–OCTOBER 6, 2004)	
	NUMBER	**BACKGROUND**
CATEGORY AND TYPE		
Surgical Events		**4,687 surgeries were performed at this facility during this time period**
Retention of a foreign object in a patient after surgery or other procedure	1	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	1	Deaths: 0; Serious Disability: 0; Neither: 1

TABLE 3: HOSPITAL-SPECIFIC DATA

TABLE 3.5

FAIRVIEW NORTHLAND REGIONAL HOSPITAL

Address: 911 Northland Drive Princeton, MN 55371
Website: www.fairview.org
Phone number: 763-389-6305
Number of beds: 41

HOW TO READ THESE TABLES

These tables show the number of events reported at each hospital. They include the reported number for each of the 27 event types, organized under six categories. Categories and event types are not shown if no events were reported.

	REPORTED ADVERSE HEALTH EVENTS (JULY 1, 2003-OCTOBER 6, 2004)	
	NUMBER	**BACKGROUND**
CATEGORY AND TYPE		
Product or Device Events		**There were 27,614 patient days at this facility during this time period**
The use or malfunction of a device in patient care	1	Deaths: 1; Serious Disability: 0; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	1	Deaths: 1; Serious Disability: 0; Neither: 0

TABLE 3: HOSPITAL-SPECIFIC DATA

TABLE 3.6

FAIRVIEW RED WING MEDICAL CENTER

Address: 701 Fairview Blvd. Red Wing, MN 55066
Website: www.fairview.org
Phone number: 651-267-5757
Number of beds: 57

HOW TO READ THESE TABLES

These tables show the number of events reported at each hospital. They include the reported number for each of the 27 event types, organized under six categories. Categories and event types are not shown if no events were reported.

	REPORTED ADVERSE HEALTH EVENTS (JULY 1, 2003–OCTOBER 6, 2004)	
	NUMBER	BACKGROUND
CATEGORY AND TYPE		
Surgical Events		**3,840 surgeries were performed at this facility during this time period**
Wrong surgical procedure performed	1	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	1	Deaths: 0; Serious Disability: 0; Neither: 1

TABLE 3: HOSPITAL-SPECIFIC DATA

TABLE 3.7

FAIRVIEW RIDGES HOSPITAL

Address: 201 East Nicollet Boulevard Burnsville, MN 55337
Website: www.fairview.org
Phone number: 952-892-2262
Number of beds: 150

HOW TO READ THESE TABLES

These tables show the number of events reported at each hospital. They include the reported number for each of the 27 event types, organized under six categories. Categories and event types are not shown if no events were reported.

	REPORTED ADVERSE HEALTH EVENTS (JULY 1, 2003–OCTOBER 6, 2004)	
	NUMBER	**BACKGROUND**
CATEGORY AND TYPE		
Surgical Events		**12,611 surgeries were performed at this facility during this time period**
Wrong surgical procedure performed	1	Deaths: 0; Serious Disability: 0; Neither: 1
Retention of a foreign object in a patient after surgery or other procedure	1	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	2	Deaths: 0; Serious Disability: 0; Neither: 2

TABLE 3: HOSPITAL-SPECIFIC DATA

TABLE 3.8

FAIRVIEW SOUTHDALE HOSPITAL

Address: 6401 France Avenue South Edina, MN 55435
Website: www.fairview.org
Phone number: 952-924-5161
Number of beds: 390

HOW TO READ THESE TABLES

These tables show the number of events reported at each hospital. They include the reported number for each of the 27 event types, organized under six categories. Categories and event types are not shown if no events were reported.

	REPORTED ADVERSE HEALTH EVENTS (JULY 1, 2003–OCTOBER 6, 2004)	
CATEGORY AND TYPE	NUMBER	BACKGROUND
Surgical Events		**23,744 surgeries were performed at this facility during this time period**
Surgery performed on wrong body part	1	Deaths: 0; Serious Disability: 0; Neither: 1
Product or Device Events		**There were 131,466 patient days at this facility during this time period**
The use or malfunction of a device in patient care	1	Deaths: 1; Serious Disability: 0; Neither: 0
Environmental Events		**There were 131,466 patient days at this facility during this time period**
A fall while being cared for in a facility	2	Deaths: 2; Serious Disability: 0; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	4	Deaths: 3; Serious Disability: 0; Neither: 1

TABLE 3: HOSPITAL-SPECIFIC DATA

TABLE 3.9

FAIRVIEW-UNIVERSITY MEDICAL CENTER

Address: 2450 Riverside Avenue Minneapolis, MN 55454
Website: www.fairview.org
Phone number: 612-672-6396
Number of beds: 1700

HOW TO READ THESE TABLES

These tables show the number of events reported at each hospital. They include the reported number for each of the 27 event types, organized under six categories. Categories and event types are not shown if no events were reported.

	REPORTED ADVERSE HEALTH EVENTS (JULY 1, 2003–OCTOBER 6, 2004)	
	NUMBER	BACKGROUND
CATEGORY AND TYPE		
Surgical Events		**26,310 surgeries were performed at this facility during this time period**
Retention of a foreign object in a patient after surgery or other procedure	6	Deaths: 0; Serious Disability: 0; Neither: 6
Product or Device Events		**There were 362,802 patient days at this facility during this time period**
The use or malfunction of a device in patient care	1	Deaths: 1; Serious Disability: 0; Neither: 0
Care Management		**There were 362,802 patient days at this facility during this time period**
A medication error	1	Deaths: 0; Serious Disability: 1; Neither: 0
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	5	Deaths: 0; Serious Disability: 0; Neither: 5
TOTAL EVENTS FOR THIS FACILITY	13	Deaths: 1; Serious Disability: 1; Neither: 11

TABLE 3: HOSPITAL-SPECIFIC DATA

TABLE 3.14

METHODIST HOSPITAL PARK NICOLLET HEALTH SERVICES

Address: 6500 Excelsior Blvd. St Louis, MN 55426
Website: www.parknicollet.com/methodist/patients-visitors/patient_safety.cfm
Phone number: 952-993-5114
Number of beds: 426

HOW TO READ THESE TABLES

These tables show the number of events reported at each hospital. They include the reported number for each of the 27 event types, organized under six categories. Categories and event types are not shown if no events were reported.

	REPORTED ADVERSE HEALTH EVENTS (JULY 1, 2003-OCTOBER 6, 2004)	
	NUMBER	**BACKGROUND**
CATEGORY AND TYPE		
Surgical Events		**25,860 surgeries were performed at this facility during this time period**
Retention of a foreign object in a patient after surgery or other procedure	6	Deaths: 0; Serious Disability: 0; Neither: 6
TOTAL EVENTS FOR THIS FACILITY	6	Deaths: 0; Serious Disability: 0; Neither: 6

TABLE 3: HOSPITAL-SPECIFIC DATA

TABLE 3.28

UNITED HOSPITAL

Address: 333 North Smith Avenue St. Paul, MN 55102
Website: www.allina.com/patientsafety
Phone number: 612-775-9762
Number of beds: 556

HOW TO READ THESE TABLES

These tables show the number of events reported at each hospital. They include the reported number for each of the 27 event types, organized under six categories. Categories and event types are not shown if no events were reported.

	REPORTED ADVERSE HEALTH EVENTS (JULY 1, 2003–OCTOBER 6, 2004)	
	NUMBER	**BACKGROUND**
CATEGORY AND TYPE		
Surgical Events		**19,978 surgeries were performed at this facility during this time period**
Surgery performed on wrong body part	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
Care Management		**There were 198,887 patient days at this facility during this time period**
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**2**	Deaths: 0; Serious Disability: 0; Neither: 2

TABLE 3: HOSPITAL-SPECIFIC DATA

TABLE 3.29

UNITY HOSPITAL

Address: 550 Osborne Road N.E. Fridley, MN 55432-2718
Website: www.allina.com/patientsafety
Phone number: 612-775-9762
Number of beds: 275

HOW TO READ THESE TABLES

These tables show the number of events reported at each hospital. They include the reported number for each of the 27 event types, organized under six categories. Categories and event types are not shown if no events were reported.

	REPORTED ADVERSE HEALTH EVENTS (JULY 1, 2003-OCTOBER 6, 2004)	
	NUMBER	BACKGROUND
CATEGORY AND TYPE		
Surgical Events		**11,046 surgeries were performed at this facility during this time period**
Surgery performed on wrong body part	2	Deaths: 0; Serious Disability: 0; Neither: 2
Retention of a foreign object in a patient after surgery or other procedure	1	Deaths: 0; Serious Disability: 0; Neither: 1
Environmental Events		**There were 98,412 patient days at this facility during this time period**
A fall while being cared for in a facility	1	Deaths: 1; Serious Disability: 0; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	4	Deaths: 1; Serious Disability: 0; Neither: 3

It's The Prices, Stupid: Why The United States Is So Different From Other Countries

Higher health spending but lower use of health services adds up to much higher prices in the United States than in any other OECD country.

by Gerard F. Anderson, Uwe E. Reinhardt, Peter S. Hussey, and Varduhi Petrosyan

PROLOGUE: In Fall 1986 *Health Affairs* published the first of nearly two decades' worth of reports summarizing the state of health care spending in industrialized countries that are members of the Organization for Economic Cooperation and Development (OECD). In that first report, featuring 1984 data, the United States led the way in per capita health care spending at $1,637, nearly double the OECD mean of $871 (in purchasing power parities based on the U.S. dollar). In the latest offering, featuring data from 2000, the situation is much the same, although the absolute numbers are much higher (U.S. per capita spending of $4,631, compared with an OECD median of $1,983).

Over the years the OECD has refined its methodology to improve the comparability of data from vastly different health care systems. The analysis published in *Health Affairs* has greatly expanded from those early reports to examine underlying trends in spending differentials and to examine what the different countries get for their health care dollar in terms of population health indicators. In the current report, the authors look in depth at factors contributing to higher health care prices in the United States, which they contend are responsible for much of the difference between the U.S. spending levels and those of the other countries.

Lead author Gerard Anderson has been on the faculty of the Johns Hopkins University since 1983. He is a professor in the Department of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health, and serves as that department's associate chair. He holds a doctorate in public policy analysis from the University of Pennsylvania. Uwe Reinhardt is the James Madison Professor of Political Economy at the Woodrow Wilson School, Princeton University. He holds a doctorate in economics from Yale. Peter Hussey is a doctoral candidate in the Department of Health Policy and Management. He serves as a consultant to the OECD Social Policy Division/Health Policy Unit. Research assistant Varduhi Petrosyan is also a doctoral candidate at Hopkins. She will become an assistant professor at American University of Armenia in May 2003.

ABSTRACT: This paper uses the latest data from the Organization for Economic Cooperation and Development (OECD) to compare the health systems of the thirty member countries in 2000. Total health spending—the distribution of public and private health spending in the OECD countries—is presented and discussed. U.S. public spending as a percentage of GDP (5.8 percent) is virtually identical to public spending in the United Kingdom, Italy, and Japan (5.9 percent each) and not much smaller than in Canada (6.5 percent). The paper also compares pharmaceutical spending, health system capacity, and use of medical services. The data show that the United States spends more on health care than any other country. However, on most measures of health services use, the United States is below the OECD median. These facts suggest that the difference in spending is caused mostly by higher prices for health care goods and services in the United States.

EVERY YEAR the Organization for Economic Cooperation and Development (OECD) publishes data that allow for comparisons of health systems across thirty industrialized countries. Over the years *Health Affairs* has published papers on a wide range of topics using these data.[1] This paper, the latest installment in an annual series, uses the most recent OECD data to present a series of snapshots of the health systems in the thirty OECD countries in 2000. Together these snapshots show that the United States spends more on health care than any of the other OECD countries spend, without providing more services than the other countries do. This suggests that the difference in spending is mostly attributable to higher prices of goods and services. This same story is told in earlier, more in-depth studies by other researchers, including Mark Pauly, Victor Fuchs and James Hahn, and Pete Welch and colleagues.[2] Our paper updates these earlier studies with more recent data and more countries.[3] The story is particularly relevant given the recent increases in U.S. health care prices.

The Overall Spending Picture

Exhibit 1 presents selected data on total national health spending per capita in 2000, its average annual growth rate during 1990–2000, private health spending as a percentage of total health spending in 2000, and the change in the percentage of private health spending during 1990–2000. It also includes data on gross domestic product (GDP) per capita, a rough indicator of a country's ability to pay for health care, and on the fraction of the population over age sixty-five, an important factor influencing the demand for health care services. All of the data on per capita spending and GDP have been translated into U.S. dollar equivalents, with exchange rates based on purchasing power parities (PPPs) of the national currencies. The annual growth rates, on the other hand, are calculated from data expressed in the 1995 constant-value units of each country's own currency, adjusted for general inflation using each nation's GDP price deflators.

■ **Total health spending per capita.** U.S. per capita health spending was $4,631 in 2000, an increase of 6.3 percent over 1999 (Exhibit 1).[4] The U.S. level was 44 percent higher than Switzerland's, the country with the next-highest expenditure per

EXHIBIT 1
Health Spending In OECD Countries, 1990–2000

		Total health spending, 2000		Average annual growth rate, 1990–2000		Private health spending, 2000		
	GDP per capita, 2000 (US$ PPP)	Per capita (US$ PPP)	As percent of GDP	GDP per capita	Health spending per capita	As percent of total health spending	Change in percentage points, 1990–2000	Percent of population over age 65, 2000
Australia	$26,497	$2,211	8.3%	2.4%	3.1%	27.6%	–5.3	12.3%
Austria	26,864	2,162	8.0	1.8	3.1	30.3	3.8	15.5
Belgium	26,049	2,269	8.7	1.8	3.5	28.8	–[a]	17.0
Canada	27,963	2,535	9.1	1.7	1.8	28.0	2.6	12.6
Czech Republic	14,236	1,031	7.2	0.1	3.9	8.6	4.8	13.8
Denmark	29,050	2,420	8.3	1.9	1.7	17.9	0.6	15.0
Finland	25,078	1,664	6.6	1.8	0.1	24.9	5.8	14.9
France	24,847	2,349	9.5	1.4	2.3	24.0	0.6	16.0
Germany	25,936	2,748	10.6	1.2[b]	2.1[b]	24.9	2.2[b]	16.4
Greece	16,950	1,399	8.3	1.9	2.8	44.5	7.2	17.6
Hungary	12,423	841	6.8	2.7[c]	2.0[c]	24.3	13.4[c]	14.6
Iceland	29,323	2,608	8.9	1.6	2.9	15.6	2.2	11.7
Ireland	29,066	1,953	6.7	6.4	6.6	24.2	–4.7	11.3
Italy	25,206	2,032	8.1	1.4	1.4	26.3	5.6	18.1
Japan	25,937	2,012	7.8	1.1	3.9	23.3	0.9	17.2
Korea	15,045	893	5.9	5.1	7.4	55.6	–7.8	7.1
Luxembourg	46,960	2,701[d]	6.0[d]	4.5	4.1[e]	7.1[d]	0.2[e]	14.4
Mexico	9,136	490	5.4	1.6	3.7	53.6	–5.6	4.7
Netherlands	27,675	2,246	8.1	2.3	2.4	32.5	–0.4	13.7
New Zealand	20,262	1,623	8.0	1.5	2.9	22.0	4.4	11.7
Norway	30,195	2,362	7.8	2.8	2.8	14.8	–2.4	15.4
Poland	9.580	576[d]	6.2[d]	3.5	5.3[e]	28.9[d]	20.6[e]	12.1
Portugal	17,638	1,441	8.2	2.4	5.3	28.7	–5.8	15.6
Slovakia	11,650	690	5.9	4.0[f]	–[a]	10.4	10.4	11.4
Spain	20,297	1,556	7.7	2.4	3.9	30.1	8.8	17.0
Sweden	24,845	1,847[f]	7.9[f]	1.4	–0.04[g]	16.2[f]	6.1[g]	17.4
Switzerland	30,098	3,222	10.7	0.2	2.5	44.4	13.8	16.0
Turkey	6,439	320[f]	4.8[f]	1.8	6.1[g]	28.1[f]	–10.9[g]	5.8
United Kingdom	24,323	1,763	7.3	1.9	3.8	19.0	2.6	15.8
United States	35,657	4,631	13.0	2.3	3.2	55.7	–4.7	12.3
OECD median	25,142	1,983	8.0	1.9	3.1	25.6	2.2	14.8

SOURCE: Organization for Economic Cooperation and Development, *OECD Health Data 2002* (Paris: OECD, 2002).
NOTES: For median calculation, see Note 5 in text. PPP is purchasing power parity (U.S. dollars).
[a] Data not available.
[b] 1992–2000.
[c] 1991–2000.
[d] 1999.
[e] 1990–1999.
[f] 1998.
[g] 1990–1998.

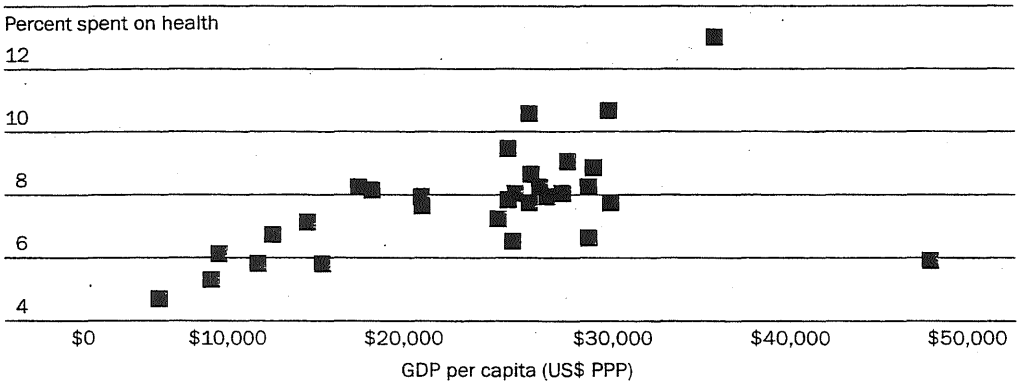
capita; 83 percent higher than neighboring Canada; and 134 percent higher than the OECD median of $1,983.[5] Although the United States can claim some success during the mid-1990s in its attempt to control health spending with managed care, over the entire 1990–2000 period the spending gap between the United States and the OECD median actually widened slightly.

Analysis suggests some convergence of health spending levels among the thirty OECD countries during the 1990s. Countries with higher spending levels in 1990 tended to have lower growth rates of real health spending per capita between 1990 and 2000 than did countries with lower initial levels of health spending.[6] The United States was an exception to this pattern. It reported the highest health spending level in 1990, but its growth rate in per capita health spending was slightly above the OECD median.

■ **Health systems' share of GDP.** Measured in terms of share of GDP, the United States spent 13.0 percent on health care in 2000, Switzerland 10.7 percent, and Canada 9.1 percent. The OECD median was 8.0 percent. Ability to pay—measured here by per capita GDP—has repeatedly been shown to be a powerful predictor of the percentage of GDP allocated to health care.[7] This is evident in Exhibit 2. In 2000 about 27 percent of the observed cross-national variation in the percentage can be explained by GDP per capita with a simple bivariate regression of the former on the latter variable. If Luxembourg is eliminated from the regression equation as an outlier, the explained variation increases to 56 percent.[8] In spite of this high level of association, Exhibit 2 shows considerable cross-national variation in the health sector's share on GDP at given levels of per capita GDP, especially in the range between $25,000 and $30,000.

■ **Public versus private health spending.** Private spending in the OECD data falls into the broad categories of (1) out-of-pocket spending for deductibles, coinsurance, and services not covered by health insurance; and (2) premiums paid by families and individuals for private health insurance. As shown in Exhibit 1, the share of total health spending that is privately financed varies considerably across

EXHIBIT 2
Percentage Of Gross Domestic Product (GDP) Spent On Health Care, In Relation To GDP Per Capita, In Thirty OECD Countries, 2000



SOURCE: Organization for Economic Cooperation and Development, *OECD Health Data 2002* (Paris: OECD, 2002).
NOTES: PPP is purchasing power parity (U.S. dollars). GDP is gross domestic product. Data for Luxembourg and Poland are for 1999; data for Sweden and Turkey are for 1998. Individual countries are not shown because of space constraints. Graph points were plotted from columns 1 and 3 of Exhibit 1; individual countries' values can be identified by looking at that exhibit.

the OECD countries. The median country finances 26 percent of its health care from private sources. The range is as high as 56 percent in the United States and Korea to as low as 7 percent in Luxembourg and 9 percent in the Czech Republic. As a percentage of GDP, the OECD countries spent 0.4–7.2 percent of GDP on privately financed health care in 2000, with an OECD median of 2.0 percent. The United States was the highest at 7.2 percent. U.S. private spending per capita on health care was $2,580, more than five times the OECD median of $451.

In most OECD countries the privately financed share of total health spending increased during the 1990s (Exhibit 1). The private share tended to increase more rapidly in countries with lower shares of private health spending in 1990. The explanation for the increase varied from country to country. For example, the level of cost sharing increased in Sweden, while private insurance coverage increased in Switzerland.[9] Countries with the largest share of private financing in 1990—the United States, Mexico, and Korea—had a decreasing private share of financing during the 1990s (Exhibit 1).

Although the percentage of the health care dollar financed from public sources in the United States is low compared with other OECD countries, the absolute amount is relatively similar to other OECD countries. Public sources in the United States accounted for spending of 5.8 percent of GDP in 2000, very close to the OECD median of 5.9 percent. In fact, on this measure of public spending, the United States is virtually identical to the United Kingdom, Italy, and Japan (5.9 percent each) and not much smaller than neighboring Canada (6.5 percent). Finally, U.S. public sources spent $2,051 per person in 2000; this places the United States among the top four countries listed in Exhibit 1, just behind Luxembourg ($2,510), Iceland (2,202), and Germany ($2,063). On that measure, the United States ranks far above the OECD median of $1,502, Japan's $1,542, and the United Kingdom's $1,429.

Furthermore, as Steffie Woolhandler and David Himmelstein pointed out recently in *Health Affairs*, the OECD data (and the U.S. national health accounts on which the OECD database draws) actually understate the role of the public sector in health care. These researchers measured the public sector's share of total health spending not by who ultimately paid the providers of health care, but by the fraction of health spending that originated in households in the form of taxes. On that measure, close to 60 percent of total U.S. health spending in 1999—7.7 percent of GDP—was financed through taxes.[10]

■ **Spending on pharmaceuticals.** Spending per capita on pharmaceuticals—a subject of interest to policymakers throughout the OECD countries—varied from $93 in Mexico to $556 in the United States in 2000 (Exhibit 3). In spite of having the highest per capita spending, the United States is closer to other countries on pharmaceutical spending than spending for other health services and goods.

Average annual growth in real per capita spending on pharmaceuticals during 1990–2000 increased at an annual compound rate of 4.5 percent in the median

EXHIBIT 3
Spending On Pharmaceuticals In Selected OECD Countries, 1990–2000

	As percent of GDP, 2000	Spending per capita, 2000 (US$ PPP)	Average annual growth in per capita spending, 1990–2000
Australia	1.0%[a]	$252[a]	6.9%[b]
Belgium	1.4[c]	352[c]	4.1[d]
Canada	1.4	385	4.8
Czech Republic	1.0	260	5.8
Denmark	0.8	223	3.9
Finland	1.0	259	5.2
France	1.9	473	4.2
Germany	1.4	375	1.2[e]
Greece	1.5	258	5.2
Hungary	1.8[c]	193[c]	−0.1[f]
Iceland	1.3[g]	382[g]	2.3[h]
Ireland	0.6	187	4.9
Italy	1.8	459	2.1
Japan	1.2[g]	313[g]	0.6[h]
Korea	0.8[g]	110[g]	−0.4[h]
Luxembourg	0.7[g]	317[g]	1.3[h]
Mexico	1.1[g]	93[g]	–[i]
Netherlands	1.0	264	4.5
New Zealand	1.1[c]	210[c]	2.9[d]
Norway	0.7[c]	217[c]	7.4[d]
Portugal	2.0[a]	334[a]	5.7[b]
Spain	1.4[c]	264[c]	4.8[d]
Sweden	1.0[c]	244[c]	6.8[d]
Switzerland	1.1	346	3.0
United Kingdom	1.1[c]	253[c]	6.0[d]
United States	1.6	556	6.0
OECD median	1.2	262	4.5

SOURCE: Organization for Economic Cooperation and Development, *OECD Health Data 2002* (Paris: OECD, 2002).
NOTES: For median calculation, see Note 5 in text. PPP is purchasing power parity (U.S. dollars). GDP is gross domestic product. Data for Austria, Poland, Slovakia, and Turkey were not available.
[a] 1998.
[b] 1990–1998.
[c] 1997.
[d] 1990–1997.
[e] 1992–2000.
[f] 1991–1997.
[g] 1999.
[h] 1990–1999.
[i] Data not available.

OECD country (Exhibit 3). Only Australia, Norway, and Sweden registered higher rates than the United States during the 1990s.

Capacity And Utilization

Exhibits 4 and 5 present selected data on the supply side of the health systems in the OECD. There is considerable variation in the composition of the supply side and in reported utilization rates. A limitation of these data, of course, is that they mask important differences in the specialty composition of the physician supply

EXHIBIT 4
Health Care Workforce In OECD Countries, 1990 And 2000

	Nurses per 1,000 population, 2000	Nurses per acute care bed, 2000	Physicians per 1,000 population		Physician visits per capita, 2000
			1990	2000	
Australia	8.1[a]	1.4[b]	2.3[c]	2.5[d]	6.4
Austria	9.2	0.8	2.2	3.1	6.7
Belgium	–[e]	–[e]	3.3	3.9	7.9
Canada	7.6	–[e]	2.1	2.1	6.4[b]
Czech Republic	8.4	0.5	2.8	3.1	12.6
Denmark	7.3[b]	1.2[a]	3.1	3.4	6.1
Finland	14.7	–[e]	2.4	3.1	4.3
France	6.5	0.5[b]	3.1	3.3	–[e]
Germany	9.3	0.6	3.1[f]	3.6	–[e]
Greece	3.9[b]	0.9[b]	3.4	4.4[b]	2.5[d]
Hungary	4.9	0.3[b]	2.9	3.2[b]	21.9
Iceland	14.2[b]	–[e]	2.8	3.4[b]	5.2[a]
Ireland	9.2	1.3	1.6	2.3[b]	–[e]
Italy	4.5[b]	0.8[d]	4.7	6.0	6.1
Japan	7.8[d]	–[e]	1.7	1.9	–[e]
Korea	1.4	–[e]	0.8	1.3	8.8[b]
Luxembourg	7.1	0.6[d]	2.0	3.1	2.8[d]
Mexico	1.1	–[e]	1.1	1.8	2.5
Netherlands	13.0	–[e]	2.5	3.2	5.9
New Zealand	9.7	–[e]	1.9	2.2	–[e]
Norway	10.3	1.5	2.6[c]	2.9	–[e]
Poland	4.9	–[e]	2.1	2.2	5.4
Portugal	3.7	1.0[d]	2.8	3.2	3.4[d]
Slovakia	7.3	0.6	–[e]	–[e]	–[e]
Spain	3.7	0.8[a]	2.3	3.3	7.8[d]
Sweden	8.4[b]	–[e]	2.9	2.9[b]	2.8
Switzerland	–[e]	–[e]	3.0	3.5	–[e]
Turkey	1.1	0.3[b]	0.9	1.3	2.5
United Kingdom[g]	8.1	1.2[b]	1.4	1.8	5.4[d]
United States	8.3[b]	1.3	2.4	2.8[b]	5.8[h]
OECD median	7.6	0.8	2.4	3.1	5.9

SOURCE: Organization for Economic Cooperation and Development, *OECD Health Data 2002* (Paris: OECD, 2002).
NOTE: For median calculation, see Note 5 in text.
[a] 1997.
[b] 1999.
[c] 1991.
[d] 1998.
[e] Data not available.
[f] 1992 (from 1992 onward, data refer to Germany after reunification).
[g] Some of the data were provided by the United Kingdom Department of Health.
[h] 1996.

"Countries with higher GDP per capita are not more likely to have more physicians per capita than are countries with low GDP."

and in the content of crude utilization rates, such as "physician visits," "hospital admissions," and "acute care hospital days."

■ **Supply of physicians.** The general picture that emerges from Exhibit 4 is that the number of physicians per 1,000 population (physican density) increased in most of the OECD countries during the 1990s. As the exhibit also shows, however, there are some exceptions to these general trends. In both Canada and Sweden physician growth was limited to population growth during the 1990s. In the United States medical school enrollment has been essentially constant since 1980. The observed increase in the number of physicians has mostly come from physicians who immigrated to the United States following medical education in other countries.[11]

Richard Cooper and colleagues have argued that a common driver of physician density in all industrialized countries has been economic growth, represented by GDP per capita. The authors observe that within OECD countries, GDP and the number of physicians per capita are highly correlated.[12] However, countries with higher GDP per capita are not more likely to have more physicians per capita than are countries with low GDP per capita.[13] This suggests the importance of factors unrelated to GDP in determining physician supply differences. Several commentators have observed that a causal link between GDP and physician supply may be overly simplistic.[14]

■ **Supply of nurses.** While many OECD countries perceive a nurse shortage, the actual number of nurses varies considerably across the OECD countries (Exhibit 4).[15] The number of nurses per 1,000 population (nurse density) ranged from 1.1 in Turkey and Mexico to 14.7 in Finland, and the number of nurses per acute care hospital bed ranged from 0.3 in Turkey to 1.5 in Norway. The United States ranks higher than the OECD median on both measures, although several of the European countries report a higher nurse density than does the United States.

Some researchers have contended that as a population ages, the demand for nurses will grow rapidly.[16] The OECD data show that there is no significant correlation between the percentage of population age sixty-five and older and the number of practicing nurses per 1,000 population.[17] However, there is a significant positive correlation between the growth rate of the percentage of population age sixty-five and older and the growth rate of the number of practicing nurses per capita between 1990 and 2000.[18]

■ **Hospitals.** Most of the OECD nations greatly reduced the number of acute care hospital beds, the average length of acute care hospital stay, and the number of acute care hospital days per capita during the 1990s (Exhibit 5). Turkey and Korea, however, increased their systems' bed capacity, and the United Kingdom increased its average length of hospital stay slightly.

EXH 5
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Australia
Austria
Belgium
Canada

Czech Republic
Denmark
Finland
France

Germany
Greece
Hungary
Iceland

Ireland
Italy
Korea
Luxembourg

Netherlands
New Zealand
Nor
Po

Slova
Spain
Sweden
Switzerland

Turkey
United Kingdom
United States

OECD median

SOURCE: Organ
NOTES: For med
[a]1991.
[b]1999.
[c]1997.
[d]1996.
[e]1992 (from 19
[f]1998.
[g]1993.
[h]Data not avail
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EXHIBIT 5
Health Services Capacity And Use In Selected OECD Countries, 1990 And 2000

	Acute care beds per 1,000 population		Admissions per 1,000 population		Average length of hospital stay (days)		Acute care hospital days per capita	
	1990	2000	1990	2000	1990	2000	1990	2000
Australia	4.4[a]	3.8[b]	168[a]	155	6.5[a]	6.2[b]	1.2	1.0
Austria	7.1	6.2	215	283	9.3	6.3	2.0	1.8
Belgium	4.9	4.6[c]	169	180[d]	8.7	8.8[c]	1.5	1.3[c]
Canada	4.0	3.3[b]	120	99[b]	8.6	7.1[b]	1.4	1.0[b]
Czech Republic	8.5	6.6	180	196	12.0	8.7	2.2	1.7
Denmark	4.1	3.3[b]	190	194[b]	6.4	5.2[b]	1.2	1.0[b]
Finland	4.3	2.4	163	203	7.0	4.4	1.1	0.9
France	5.2	4.2	209	204[b]	7.0	5.5[b]	1.5	1.1[b]
Germany	7.3[e]	6.4	183[e]	205	12.9[e]	9.6	2.3[e]	1.9
Greece	4.0	4.0[b]	123	133[c]	7.5	6.3[f]	0.9[g]	1.0[f]
Hungary	7.1	6.4	191	225	9.9	7.9	1.9	1.8
Iceland	4.3	–[h]	176	–[h]	7.0	–[h]	1.2	–[h]
Ireland	3.2	2.9	147	144	6.7	6.4	1.0	0.9
Italy	6.2	4.5[b]	150	176[f]	9.5[a]	7.2[f]	1.6	1.3[f]
Korea	2.7	5.2	–[h]	–[h]	12.0	11.0	–[h]	–[h]
Luxembourg	6.9	5.7	184	213[f]	11.0	–[h]	2.0	–[h]
Netherlands	4.3	3.5	103	93	11.2	9.0	1.2	0.8
New Zealand	8.0	–[h]	–[h]	–[h]	–[h]	4.9[f]	–[h]	0.3[f]
Norway	3.8	3.1	148	154	7.8	6.0	1.1	0.9
Portugal	3.6	3.3[f]	106	119[f]	8.4	7.3[f]	0.9	0.9[f]
Slovakia	–[h]	5.9	–[h]	177	–[h]	8.6	–[h]	1.5
Spain	3.3	3.0[c]	96	113[c]	9.6	7.6[c]	0.9	0.9[c]
Sweden	4.1	2.4	166	159[d]	6.5	5.0	1.1	–[h]
Switzerland	6.5	4.1	139	136	13.4	9.3	1.9	1.3
Turkey	2.0	2.2	54	73	6.0	5.4	0.3	0.4
United Kingdom[i]	–[h]	3.3	–[h]	151	5.7	6.2	0.9	0.9
United States	3.7	3.0	125	118	7.3	5.9[b]	0.9	0.7
OECD median	4.3	3.8	163	154	8.4	6.4	1.2	1.0

SOURCE: Organization for Economic Cooperation and Development, *OECD Health Data 2002* (Paris: OECD, 2002).
NOTES: For median calculation, see Note 5 in text. Data for Japan, Mexico, and Poland were not available.
[a] 1991.
[b] 1999.
[c] 1997.
[d] 1996.
[e] 1992 (from 1992 onward, data refer to Germany after reunification).
[f] 1998.
[g] 1993.
[h] Data not available.
[i] Some of the data were provided by the United Kingdom Department of Health.

The German and Swiss health systems appear particularly well endowed with physicians and acute care hospital beds compared with the United States. The two countries rank much higher than the United States does on hospital admissions per capita, average length-of-stay, and acute care beds per capita. The average cost per hospital admission and per patient day in these countries must be considerably lower than the comparable U.S. number, however, because both countries spend considerably less per capita and as a percentage of GDP on hospi-

tal care than the United States does. The average U.S. expenditure per hospital day was $1,850 in 1999—three times the OECD median.[19]

Explanations for differences. There are several plausible explanations for this difference. First, the inputs used for providing hospital care in the United States—health care workers' salaries, medical equipment, and pharmaceutical and other supplies—are more expensive than in other countries. Available OECD data show that health care workers' salaries are higher in the United States than in other countries.[20] Second, the average U.S. hospital stay could be more service-intensive than it is elsewhere. While this may be true, it should be noted that the average length-of-stay and number of admissions per capita in the United States are only slightly below the OECD median. Third, the U.S. health system could be less efficient in some ways than are those of other countries. The highly fragmented and complex U.S. payment system, for example, requires more administrative personnel in hospitals than would be needed in countries with simpler payment systems.[21] Several comparisons of hospital care in the United States with care in other countries, most commonly Canada, have shown that all of these possibilities may be true: U.S. hospital services are more expensive, patients are treated more intensively, and hospitals may be less efficient.[22]

U.S.-Canada comparisons. Some in the United States believe that Canada is rationing health care by placing tight constraints on capacity and waiting lists. That impression is reinforced annually by the annual waiting list survey of Canada's Fraser Institute.[23] Exhibit 5 shows that hospital admissions per capita, indeed, were lower in Canada than in the United States in 2000. Remarkably, however, Canada actually had a higher acute care bed density than did the United States and also reported a greater number of acute care hospital days per capita. The explanation for this seeming paradox could be the much longer average length of hospital stay in Canada. In both 1990 and 1999 the Canadian length-of-stay exceeded the comparable U.S. numbers by about 20 percent. To the extent that bed capacity is a binding constraint in Canada, further reductions in average lengths-of-stay could help to relax that constraint.

Medical technology. Hospital beds and health professionals are, of course, not the only binding constraints on a health system's capacity. Just as constraining, and possibly more so, can be the availablity of advanced medical technology. As shown in Exhibit 6, Canada has far fewer computed tomography (CT) and magnetic resonance imaging (MRI) scanners per capita than the United States does. Indeed, Canada's endowment with this type of equipment lies considerably below the OECD median, although Canada's is the fifth most expensive health system in the OECD.[24] As is further shown in Exhibit 6, Canada's health system also delivers far fewer highly sophisticated procedures than does the U.S. system. For example, the U.S. system delivers four times as many coronary angioplasties per capita and about twice the number of kidney dialyses. These data, of course, do not provide insight on the medical necessity of these procedures.

EXHIBIT 6
Use Of Sophisticated Medical Technologies In Selected OECD Countries, 1999 And 2000

	MRI units per million population, 2000	CT scanners per million population, 2000	Coronary angioplasties per 100,000 population, 1999	Patients undergoing dialysis per 100,000 population, 2000
Australia	4.7	–[a]	102.7	33.2
Austria	10.8	25.8	–[a]	37.1
Belgium	3.2[b]	–[a]	201.4[c]	–[a]
Canada	2.5	8.2[b]	80.8	45.7[d]
Czech Republic	1.7	9.6	–[a]	–[a]
Denmark	6.6	11.4	82.0	36.3[d]
Finland	11.0	13.5	–[a]	22.9
France	2.8[d]	9.6[d]	–[a]	–[a]
Germany	6.2[b]	17.1[b]	165.7[b]	64.0
Greece	1.5[d]	7.8[d]	–[a]	66.6
Hungary	1.5	5.4	27.4	–[a]
Iceland	10.7	21.3	167.0	13.9
Ireland	–[a]	–[a]	80.4	–[a]
Italy	6.7[d]	19.6[d]	67.2	–[a]
Japan	23.2[d]	84.4[d]	–[a]	162.4
Korea	5.4	28.2	–[a]	–[a]
Luxembourg	4.6	25.1	–[a]	60.1[d]
Mexico	0.3	2.0	1.8	32.5
New Zealand	2.6[c]	8.9	65.5	–[a]
Poland	0.4[b]	0.4[b]	–[a]	128.9
Portugal	2.8[b]	12.3[b]	41.7	–[a]
Slovakia	1.1	8.3	–[a]	39.8
Spain	4.9	12.2	–[a]	43.7[b]
Sweden	7.9[d]	14.2[d]	–[a]	–[a]
Switzerland	13.0[d]	18.5[d]	–[a]	–[a]
Turkey	–[a]	7.2[d]	–[a]	23.4[d]
United Kingdom	3.9	6.5[e]	51.0[f]	27.0[d]
United States	8.1[d]	13.6[d]	388.1	86.5[c]
OECD median	4.7	12.2	–[g]	39.8

SOURCE: Organization for Economic Cooperation and Development, *OECD Health Data 2002* (Paris: OECD, 2002).
NOTES: For median calculation, see Note 5 in text. Data for the Netherlands and Norway were not available. MRI is magnetic resonance imaging. CT is computed tomography.
[a] Data not available.
[b] 1997.
[c] 1998.
[d] 1999.
[e] 2001 data for England were provided by the United Kingdom Department of Health.
[f] 2000 data for England were provided by the United Kingdom Department of Health.
[g] Data were not available for enough countries to present the median.

Quite remarkable, and inviting further research, is the extraordinarily high endowment of Japan's health system with CT and MRI scanners and its relatively high use of dialysis. These numbers are all the more remarkable because Japan's health system is among the least expensive in the OECD.

Health Spending Versus Health Care Provision

To explore further how the observed differences in the percentage of GDP going to health care might affect volume, quality, and spending, it is important to distinguish between two distinct categories of resources that may go in opposite directions: (1) the allocation of real resources (human labor and other physical inputs); and (2) the allocation of financial claims on the country's GDP to the owners of these real resources.[25] The relationship between these two distinct resource flows manifests itself in the money prices paid for health services. Several important insights follow from this relationship.

First, the relationship between the financial resources that individuals pay to the providers of health care and the real resources these providers contribute to the process of health care may not be nearly as tight as some observers have proposed. Some health care providers have argued that every proposed cut in health care spending is a direct threat to the well-being of patients. As one of us (Reinhardt) has argued, spending on health care can also have a direct effect on the incomes of providers.[26] The question is whether increased spending results in more real resources devoted to patient care or higher incomes to providers.

Second, the distinction between financial and real resource flows in health care raises the fundamental question of what is meant by the "cost" of a country's health system.[27] Because labor and other productive inputs are allocated to health care rather than to the next most valuable productive enterprise, there is an "opportunity cost" associated with devoting more resources to health care. Alternatively, the "cost" of the health care system could be measured by health spending (that is, the percentage of GDP spent on health). If one ranked countries by the costliness of their health systems on each of these two cost measures, the two rankings might be very different. Consider, for example, that Country A might devote a larger fraction of its GDP to health care providers than does Country B but uses fewer real resources in its health system than does nation B. In other words, Country A spends more per capita on health care than Country B, and yet economists might rate Country A's health system less costly than Country B's because fewer actual resources are devoted to health care.

■ **Previous research.** To explore this possibility at the empirical level, Mark Pauly sought to estimate the opportunity costs of the human labor represented by physicians, nurses, and other medical workers in a set of OECD countries for the year 1988.[28] Although the United States spent a far greater share of its GDP on health care than did the other OECD countries in 1988, Pauly found that in terms of the opportunity cost of real resource use, the U.S. health system ranked somewhere in the middle of the OECD cohort.

Victor Fuchs and James Hahn came to a similar conclusion.[29] They noted that expenditures on physician services in 1985 in U.S. dollar equivalents were $347 per capita in the United States but only $202 in Canada. Yet another comparison, by Pete Welch and colleagues, provides additional evidence of higher prices with

"Simple comparisons suggest that Americans are receiving fewer real resources than are people in the median OECD country."

lower utilization in the United States.[30] It must be emphasized, of course, that the data used by these researchers are many years in the past, which makes the case for replicating the analysis with more recent data. We also now have the advantage of having data on more countries.

■ **Recent data.** As shown in Exhibits 4 and 5, in 2000 the United States had fewer physicians per 1,000 population, physician visits per capita, acute care beds per capita, hospital admissions per 1,000 population, and acute care days per capita than the median OECD country. These simple comparisons suggest that Americans are receiving fewer real resources than are people in the median OECD country. There are, however, other explanations. A more comprehensive approach would be to compare the actual progression of treatment for a set of tracer conditions in various countries.

A study by the McKinsey Global Institute followed that more in-depth approach. The research team, which was advised by a number of prominent health economists, based its analysis on four tracer diseases: diabetes, cholelithiasis (gall stones), breast cancer, and lung cancer.[31] Using PPP-adjusted U.S. dollars as the common yardstick, the McKinsey researchers found that in the study year of 1990 Americans spent about $1,000 (66 percent) more per capita on health care than Germans did. The researchers estimated that Americans paid 40 percent more per capita than Germans did but received 15 percent fewer real health care resources. A similar comparison revealed that the U.S. system used about 30 percent more inputs per capita than was used in the British system and spent about 75 percent more per capita on higher prices.[32]

■ **Prices and total health spending.** The preceding analysis suggests the crucial role of prices as drivers of cross-national differences in health spending. As noted earlier, the prices paid for health care represent the generalized claims on its GDP that a country cedes to the providers of real health care resources. The magnitudes of these money transfers depend upon a whole host of factors, among them the relative bargaining power of the providers and those who pay them.

Even if, within each country, the markets for health care and the related markets for the labor and other inputs used in health care were perfectly competitive in the textbook sense, the money prices of identical health care goods or services or inputs would likely still vary among countries. It is so because neither the goods and services nor all of the inputs that produce them are perfectly mobile across countries. Unlike markets for electronics or financial securities, which are truly global, the markets for the health workforce (especially physicians) are still largely national and even local within countries. Furthermore, of course, most of the markets related to health care within localities do not satisfy the rigorous con-

ditions of the textbook model of competition.[33] In health care, for example, one finds varying degrees of monopoly power on the sell side of the market and varying degrees of monopsony power on the buy side.

■ **How the buy and sell sides operate.** Monopoly power allows sellers to raise prices above those they would obtain in perfectly competitive markets. In the jargon of economics, they are thus able to earn "rents," defined as the excess of the prices actually received by sellers above the minimum prices the sellers would have to be paid to sell into the market. Countries differ in the degree to which they try to whittle away at the rent earned on the supply side through the creation of market power on the buy (monopsony) side of the market. A single-payer system would be called a "pure monopsony."

In the U.S. health system, for example, money flows from households to the providers of health care through a vast network of relatively uncoordinated pipes and capillaries of various sizes. Although the huge federal Medicare program and the federal-state Medicaid programs do possess some monopsonistic purchasing power, and large private insurers may enjoy some degree of monopsony power as well in some localities, the highly fragmented buy side of the U.S. health system is relatively weak by international standards. It is one factor, among others, that could explain the relatively high prices paid for health care and for health professionals in the United States.

In comparison, the government-controlled health systems of Canada, Europe, and Japan allocate considerably more market power to the buy side. In each of the Canadian provinces, for example, the health insurance plans operated by the provincial governments constitute pure monopsonies: They purchase (pay for) all of the health services that are covered by the provincial health plan and used by the province's residents.

Even a pure monopsonist, of course, is ultimately constrained by market forces on the supply side—that is, by the reservation (minimally acceptable) prices of the providers of health care below which they will not supply their goods or services. But within that limit, monopsonistic buyers enjoy enough market clout to drive down the prices paid for health care and health care inputs fairly close to those reservation prices. It can explain, for example, why Fuchs and Hahn found that "U.S. fees for procedures are more than three times as high as Canadian fees [and] the difference in fees for evaluation and management services is about 80 percent."[34]

■ **Impact on quantity and quality.** Just what impact variations in the distribution of market power between the buy and the sell sides of health systems have on the quantity and quality of health care, and on overall economic welfare, is an exceedingly challenging question on which even economists are unlikely to agree. In the simple textbook model used to analyze monopsony, a firm is assumed to procure inputs in a market in which it has monopsony power and sell its output in a perfectly price-competitive market. It can then be shown that the firm will hire too few

inputs and produce too few units of output, relative to the welfare-maximizing levels that would obtain in the absence of monopsony.[35] If this theory is applied to health care, it must be amended to allow for the ease with which providers can alter not only the quantity of services offered, but also their quality. As Pauly writes in his previously cited study: "Monopsony actually reduces total welfare, since it reduces quantity or quality, so it actually is a negative-sum game—but the primary effect is to control medical spending by controlling providers' incomes.[36]

Monopsony power, however, does not necessarily trigger this negative welfare effect. If its exercise were confined strictly to capturing economic rents that would otherwise be earned by providers, then economic theory would not predict an inevitable reduction in the quantity or quality of health care. The effect might be merely to redistribute income from the providers of health care to the rest of society. Even then, however, it is possible that a monopsonistic payer might push this process too far and eventually trigger reductions in either the quantity or quality of health care, or both. Using monopsonistic payer systems in health care to procure just the mix of quantity and quality that is actually desired by the insured citizenry is a daunting task and not always achieved sucessfully in practice.

To complicate matters further, there is the problem of defining precisely what is meant by the elusive term "quality" in the context of health policy. If the use of monopsony power enables a country to make health care more readily accessible to all members of society—or at least to more than would otherwise be possible—then the citizens of that country might well give their health system a higher overall quality rating, even if the exercise of monopsony power reduced somewhat the clinical quality and the amenities that accompany clinical treatment. That possibility could explain, for example, why in cross-national surveys on the satisfaction of citizens with their health system, Canada and the European nations have consistently earned higher marks than has the U.S. system.[37] Another reason could well be that the monopsony power allocated by these systems to the payer side reduces the prices paid to providers for health care, thereby transfering wealth from these providers to the rest of society.

IN 2000 THE UNITED STATES spent considerably more on health care than any other country, whether measured per capita or as a percentage of GDP. At the same time, most measures of aggregate utilization such as physician visits per capita and hospital days per capita were below the OECD median. Since spending is a product of both the goods and services used and their prices, this implies that much higher prices are paid in the United States than in other countries. But U.S. policymakers need to reflect on what Americans are getting for their greater health spending. They could conclude: It's the prices, stupid.

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NOTES

1. See S. Woolhandler and D.U. Himmelstein, "Paying for National Health Insurance—And Not Getting It," *Health Affairs* (July/Aug 2002): 88–98; and U.E. Reinhardt, P.S. Hussey, and G.F. Anderson, "Cross-National Comparisons of Health Systems Using OECD Data, 1999," *Health Affairs* (May/June 2002): 169–181.
2. See M.V. Pauly, "U.S. Health Care Costs: The Untold True Story," *Health Affairs* (Fall 1993): 152–159; V.R. Fuchs and J.S. Hahn, "How Does Canada Do It?" *New England Journal of Medicine* (27 September 1990): 884–890; and W.P. Welch et al., "A Detailed Comparison of Physician Services for the Elderly in the United States and Canada," *Journal of the American Medical Association* 275, no. 18 (1996): 1410–1416.
3. On the quality of the OECD data, see Reinhardt et al., "Cross-National Comparisons," 177–179.
4. Ibid., Exhibit 1.
5. The OECD median was calculated only if figures were available for fifteen of the thirty countries. In some cases, missing data points were replaced by values within three years; the calculation of the median included these substituted values. PPPs are used to adjust for differences in cost of living across countries by comparing prices for a fixed market basket of goods. The basket of goods used here is broad-based, not health-based. Inflation is adjusted for by using the U.S. Consumer Price Index (CPI). All values were converted into 2000 U.S. dollars.
6. The coefficient of correlation between health care spending per capita in 1990 (PPP) and mean annual growth in health spending per capita (national currency unit at 1995 GDP price) between 1990 and 2000 is −0.56 ($p < .002$). The correlation coefficient is −0.67 ($p < .0001$) when the United States is excluded.
7. U.G. Gerdtham and B. Jönsson, "International Comparisons of Health Expenditure," in *Handbook of Health Economics*, ed. A.J. Culyer and J.P. Newhouse (New York: Elsevier Science B.V., 2000), 11–53.
8. The coefficient of correlation between the per capita GDP and percentage of GDP allocated to health care in 2000 is 0.52 ($p < .003$). The correlation coefficient is 0.75 ($p < .0001$) when Luxembourg is excluded. Because of its role as an international center of finance and commerce, Luxembourg has an extraordinarily high GDP per capita. On the other hand, its health spending is controlled by a social insurance system. The relationship shown was between the per capita GDP and percentage of GDP allocated to health care in 2000, not health spending per capita as reported in other articles. (See, for example, Reinhardt et al., "Cross-National Comparisons." The correlation coefficient between the per capita GDP and per capita health spending was as high as 0.86 ($p < .0001$) in 2000.
9. P. Zweifel, "Switzerland," *Journal of Health Politics, Policy and Law* 25, no. 5 (2000): 937–944; F. Diderichsen, "Sweden," *Journal of Health Politics, Policy and Law* 25, no. 5 (2000): 931–935; and R.G. Evans, "Canada," *Journal of Health Politics, Policy and Law* 25, no. 5 (2000): 889–897.
10. Woolhandler and Himmelstein, "Paying for National Health Insurance."
11. Health Resources and Services Administration, *Graduate Medical Education and Public Policy: A Primer* (Washington: U.S. Department of Health and Human Services, 2000).
12. R.A. Cooper et al., "Economic and Demographic Trends Signal an Impending Physician Shortage," *Health Affairs* (Jan/Feb 2002): 140–154.
13. The correlation coefficient between GDP per capita and the number of active physicians per 1,000 population in OECD countries in 2000 was 0.28 ($p = .14$). Richard Cooper and colleagues hypothesize a ten-year lag between GDP and physician supply; the correlation coefficient between GDP per capita in 1990 and the number of active physicians per 1,000 population in 2000 was 0.31 ($p = .10$).
14. K. Grumbach, "The Ramifications of Specialty-Dominated Medicine," *Health Affairs* (Jan/Feb 2002): 155–157; and F. Mullan, "Some Thoughts on the White-Follows-Green Law," *Health Affairs* (Jan/Feb 2002): 158–159.
15. See R. Steinbrook, "Nursing in the Crossfire," *New England Journal of Medicine* (30 May 2002): 1757–1766; P.I. Buerhaus, D.O. Staiger, and D.I. Auerbach, "Implications of an Aging Registered Nurse Workforce," *Journal of the American Medical Association* 283, no. 22 (2000): 2948–2954); and L.H. Aiken et al., "Nurses' Reports on Hospital Care in Five Countries," *Health Affairs* (May/June 2001): 43–53.
16. See R. Steinbrook, "Nursing in the Crossfire," *New England Journal of Medicine* (30 May 2002): 1757–1766.
17. The correlation is not significant even when countries with less than 7 percent elderly population are excluded (Korea, Mexico, and Turkey). These three countries have very low percentages of population over age sixty-five (5–7 percent) compared with other OECD countries (the median is 14.8 percent).
18. The coefficient of correlation between the two growth rates is 0.58 ($p < .002$).
19. Reinhardt et al., "Cross-National Comparisons."

20. Ibid.
21. See McKinsey Global Institute, *Health Care Productivity* (Los Angeles: McKinsey and Company, 1996); and U.E. Reinhardt, "The Interaction of the Private and Public Sectors in the United States Health System" (Unpublished paper, Princeton, N.J., August 2002).
22. Canada-U.S. comparisons include J.P. Newhouse, G.M. Anderson, and L.L. Roos, "Hospital Spending in the United States and Canada: A Comparison," *Health Affairs* (Winter 1988): 6–16; J.V. Tu et al., "Use of Cardiac Procedures and Outcomes in Elderly Patients with Myocardial Infarction in the United States and Canada," *New England Journal of Medicine* (22 May 1997): 1500–1505; and C.M. Bell et al., "Shopping Around for Hospital Services: A Comparison of the United States and Canada," *Journal of the American Medical Association* 279, no. 13 (1998): 1015–1017.
23. M. Walker and G. Wilson, *Waiting Your Turn: Hospital Waiting Lists in Canada*, 11th ed., September 2001, www.fraserinstitute.ca/shared/readmore.asp?sNav=pb&id=206 (15 September 2002).
24. Part of Canada's expense is, of course, driven by its proximity to the even more expensive U.S. market, which functions as an implicit benchmark for Canada's markets of health professionals.
25. A country's GDP represents the market value of all goods and services produced within the country's boundaries and traded in the marketplace. What if the providers of health care spend the money they receive on goods and services produced in other countries? These other countries would thereby earn a claim on the GDP of the providers' country.
26. U.E. Reinhardt, "Resource Allocation in Health Care: The Allocation of Lifestyles to Providers," *Milbank Quarterly* 65, no. 2 (1987): 153–176.
27. Pauly, "U.S. Health Care Costs."
28. Ibid.
29. Fuchs and Hahn, "How Does Canada Do It?"
30. Welch et al., "A Detailed Comparison."
31. McKinsey Global Institute, *Health Care Productivity*, Exhibit 5.
32. Ibid.
33. T.H. Rice, *The Economics of Health Reconsidered* (Chicago: Health Administration Press, 1998).
34. Fuchs and Hahn, "How Does Canada Do It?"
35. M.L. Katz and H.S. Rosen, *Microeconomics* (Homewood, Ill.: Irwin, 1991), 524–527.
36. Pauly, "U.S. Health Care Costs," 155.
37. R.J. Blendon et al., "Who Has the Best Health System? A Second Look," *Health Affairs* (Winter 1995): 220–230; and R.J. Blendon, M. Kim, and J.M. Benson, "The Public versus the World Health Organization on Health System Performance," *Health Affairs* (May/June 2001): 10–24.

Increased Spending On Health Care: How Much Can The United States Afford?

It remains to be seen whether U.S. consumers will accept the growing percentage of income growth devoted to health care that is forecasted over the next several decades.

by Michael E. Chernew, Richard A. Hirth, and David M. Cutler

PROLOGUE: The question of affordability, be it at the micro level of the individual household or the macro level of state and federal governments, is often a subject of consuming interest because resources are far more scarce than demands for their use. During a period when health care spending continues to soar even in a sour economy, this question becomes all the more important. And, of course, the views of any particular stakeholders are overwhelmingly influenced by their role in the system. In this paper three economists bring new thinking to the subject of affordability and come up with an answer that may well surprise some readers. Economists Michael Chernew, Richard Hirth, and David Cutler step back from all of the expressed concern over escalating costs and examine how these increases relate to overall spending. Using the Medicare Technical Advisory Panel's definition of *affordability* and making a couple of critical assumptions, they plot a trajectory for increased health spending out to 2075. They conclude that although we may not want to spend more on health care, we can afford to do so without reducing overall non–health care spending. Readers may disagree about their assumptions but may appreciate a fresh look at the health care "guns versus butter" debate.

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ABSTRACT: Perceptions of whether health care cost growth is affordable contribute greatly to pressures for health system reform. In this paper we develop a framework for thinking about affordability, concluding that a one-percentage-point gap between real per capita growth in health care costs and growth in GDP would be affordable through 2075. A two-percentage-point gap would only be affordable through 2039. In either case, the share of income growth devoted to health care would exceed historical norms. The value of care, which determines willingness to pay, and distributional issues are more important than our ability as a society to pay for care.

THE RISING SHARE of U.S. gross domestic product (GDP) devoted to health care has been well documented and often lamented. Growth in health care spending appears to have recently accelerated after a slowdown in the mid- and late 1990s. In fact, for most of the post–World War II period, inflation-adjusted health care costs rose at a much faster rate than did GDP. To illustrate, between 1945 and 1998 the growth rate in real per capita national health care spending averaged 4.1 percent, compared with a 1.5 percent increase in GDP. Moreover, for every ten-year period between 1945 and 1998, spending on health care grew at a rate faster than that of income. Although some increase in health spending would be expected solely from the aging of the U.S. population, evidence suggests that historically, changing demographics have accounted for only a small fraction of the gap between the growth of real health care spending and GDP.[1]

■ **The CMS's new methodology.** Recently, the Office of the Actuary, Centers for Medicare and Medicaid Services (CMS), altered its methodology for forecasting long-term health care cost growth upward to assume that over the long run, inflation- and demographic-adjusted per capita health care costs would grow one percentage point faster than inflation-adjusted per capita GDP.[2] This new assumption implies that after the projected change in population demographics is accounted for, health care spending will consume 38 percent of GDP by 2075, a figure some might find alarming and unaffordable. In fact, the previous CMS forecasting methodology assumed no gap between health care cost growth and GDP growth in the long run, in part because it was perceived that such a gap could not be sustained by the economy and would therefore not occur.

■ **Reform and affordability.** Perceptions of whether such health care cost growth is affordable contribute greatly to pressures to reform the health care system. They influence pressure on providers to accept reductions in reimbursements and to alter practice styles. Yet to date there has been little discussion or analysis about what rate of health care spending growth is affordable or even about how the concept of *affordability* might be defined.

Health care costs and cost growth have primarily been discussed via cross-sectional comparisons with other countries at a point in time or via comparisons of the percentage change in health care spending relative to that of real (inflation-adjusted) national income. We believe that these traditional methods are not

well suited to yielding insights about how much we, as a nation, can afford to spend on health care and how much we are willing to spend. Therefore, in this study we present a framework for thinking about affordability and ultimately suggest that under the current CMS assumption about long-term health care cost growth, health care costs will be affordable through 2075.

■ **Value of health care.** The central message of this work is that discussions of health care financing must address the value of health care services. Strict thresholds of affordability imply that we could not consume certain services regardless of their value. Our belief is that within a reasonable range of projected health care spending growth, we can afford to spend more for health care if we place sufficient value on those services relative to forgone non–health care consumption.

Several subtleties of the argument should be mentioned at the onset. First, we take a broad perspective when discussing affordability, focusing on affordability at the level of the economy as a whole. We do not discuss the extent to which rising private health care costs are ultimately paid by employees, as the evidence suggests, or by employers.[3] We also do not discuss in detail mechanisms for funding future spending growth.

Similarly, the distributional consequences of health care cost inflation are important and deserve greater attention than we devote to them here. Any statement about the ability of the economy to sustain any given rate of health care spending growth is not meant to imply that all consumers can afford such growth. Distributional issues will certainly be a central aspect of the political economy surrounding how society responds to rising health care costs. Yet these issues are more closely related to whether we are willing as a society to sustain rising health care costs and how care should be financed or subsidized, as opposed to whether we are able to sustain rising health care costs.

Finally, even if the economy is able to "afford" a given rate of spending growth, that rate may not be desirable. Certainly there exists wasteful spending in the health care system (that is, spending that does not result in health improvements or justify the associated reduction in consumption of non–health care goods and services such as housing, entertainment, and education). Although we may be able to afford wasteful spending, we should nevertheless strive to eliminate it. Increases in the efficiency of the health care system are valuable regardless of our ability to afford current or future levels of spending.

Framework

The concept of *affordability* is vague. Literally, a product is affordable if one is able to bear the cost. Yet how do we determine if the cost is bearable? Certainly, if the price of health care services were greater than one's economic resources, then they would not be affordable. However, insurance may be affordable, even if health care services would otherwise not be, because the cost of the premium is proportional to the probability of illness.

How should we think of affordability of insurance in the case when health care costs do not exceed income? One approach would be to pick a minimum level of nonhealth spending. By definition we could "afford" the difference between national income and that minimum spending amount. What should the minimum level be? We could define the minimum based on the level of nonhealth spending observed at some point in the past. For example, in 1960 we spent much less on non–health care commodities than we do now. Would it be affordable to devote the same amount of spending to non–health care products as we did in 1960 and devote the rest to health care? Whether we would want to do this depends on the effectiveness of care and the relative desirability of non–health care goods and services, but it might not be unreasonable to say we could afford to if we wanted to.

A second, more conservative approach asks what share of the increase in income over time can we afford to spend on health care. If we spent 100 percent of the inflation-adjusted increase in income each year on health care, we would still have the same amount to spend on non–health care products as we do now. If in any given year we spent less than 100 percent of our increase in income on health care, so that nonhealth spending increased, the minimum amount of nonhealth spending would be assumed to rise in future years. Using this definition, there would never be a downward trend in nonhealth spending.

Regardless of which approach one takes, the absolute amount of money the United States could afford to spend on health care (or health insurance) would obviously rise with income (and wealth). Moreover, the percentage of income that could be devoted to health care, without reducing spending on other products, would also rise with income because the increase in income allows spending on all products to rise even if most of the increase is devoted to health care. This implies that as our society gets richer, we can spend a greater absolute amount, and a greater share of income, on health care.

A recent Medicare Technical Review panel employed the second approach to defining affordability—that there would never be a downward trend in nonhealth spending—and we adopt this definition. Reasonable people may prefer alternate definitions, and we believe that a discussion of different concepts would be useful. Yet in the meantime, we believe that this is a conservative definition because it defines minimum nonhealth spending based on observed consumption patterns as opposed to some theoretical minimum acceptable consumption.

Some may argue that we have become accustomed to, and demand, rising nonhealth spending, and therefore we should not consider spending 100 percent of our increase in income each year on health care. We recognize that devoting 100 percent of increased income to health care would be outside of historical norms, and we discuss this below. Yet we believe that greater nonhealth spending is an issue of desirability, not affordability. By definition, we can bear the level of nonhealth spending we currently enjoy. Many societies exist with a lot less.

Methods

We simulate the impact of different rates of health care cost growth on non–health care spending, computing the rate of change and the fraction of aggregate income growth devoted to non–health care goods and services. We assume that real GDP per capita grows according to the Medicare trustees' assumptions (1.2 percent per year).

Health care spending growth reflects overall GDP growth, the excess rates of health care spending growth above overall GDP growth, plus an adjustment for changing demographics based on data from the CMS.[6] Spending on goods and services outside of the health sector is the difference between GDP and health care spending. We then compute the average rate of growth in nonhealth spending and the share of income growth devoted to health care spending, following the methods of George Kowalczyk and colleagues.[7]

As a sensitivity analysis, we assume that investment spending grows at the same rate as GDP in order to support rising GDP. We assume an investment share of 18 percent of GDP. This is at the high end of the historical share of GDP devoted to investment. With this assumption, health care spending growth will be less affordable because increases in health care spending would have to come from the noninvestment portion of GDP.

Results

We start by examining trends in the growth of health care and non–health care spending from 1960 to 1999 (Exhibit 1). Despite rapidly growing real (inflation-adjusted) health care expenditures, both in absolute terms and as a percentage of GDP, income growth has been sufficient to allow substantial growth in non–health care spending as well.

This is a message that can easily be lost when examining time trends in the percentage of GDP devoted to health care. Such a measure masks the overall increase

EXHIBIT 1
U.S. Health Care And Non-Health Care Spending, With All Values Adjusted To 1996 U.S. Dollars, Selected Years 1960–1999

	1960	1970	1980	1990	1999
(1) Health care spending as percent of GDP[a]	5.1%	7.0%	8.8%	12.0%	13.1%
(2) Per capita GDP[a]	$12,764	$17,022	$21,271	$26,388	$31,962
(3) Per capita health care spending[a]	646	1,197	1,870	3,165	4,192
(4) Per capita spending on all items other than health care[b]	12,118	15,825	19,401	23,223	27,770

SOURCES: See below.

NOTE: GDP is gross domestic product.

[a] Authors' tabulations based on data from U.S. Bureau of the Census, *Statistical Abstract of the United States, 2001,* Table 640; and Centers for Medicare and Medicaid Services, www.cms.hhs.gov/STATISTICS/NHE/historical/nhegdp01.zip.

[b] Authors' tabulations based on Rows (2) and (3). Row (2)–Row (3) may not equal Row (4) because of rounding.

53% 25% 24% 21%

in GDP over time. In fact, in each decade a relatively small share of the increase in inflation-adjusted income was devoted to health care (Exhibit 2). For example, in the 1980s (the decade that saw the highest share of income growth spent on health care), real health care spending per capita rose by nearly 70 percent, but this growth consumed only about one-quarter of the increase in real income per capita. That is, the substantial growth in health spending during the 1980s did not prevent three-quarters of real income growth from being spent on goods other than health care.

■ **Spending growth and GDP.** The reason health expenditures could rise so much faster than GDP while still consuming only a relatively small fraction of real income growth is that health care has consumed a relatively small share of GDP throughout the postwar period. Because of the relatively low base share, rapid increases relative to GDP do not necessitate a drop in non–health care spending, provided that overall real income is rising by at least a moderate rate. Yet as the share of GDP devoted to health care rises, greater sacrifices will have to be made if the rate of growth in inflation-adjusted health care spending exceeds inflation-adjusted GDP growth.

■ **Two spending-growth scenarios.** Exhibit 3 illustrates the impact of different rates of health care spending growth on nonhealth spending and on the share of income growth devoted to health care. The first set of results assumes that real per capita national health care spending rises one percentage point faster than real per capita GDP, before accounting for demographic changes. The second set assumes that the differential is two percentage points, again before adjusting for demographic changes.

One-percentage-point gap. Under the one-percentage-point-gap assumption, which matches what the technical review panel recommended and what was adopted by the Medicare trustees as the base scenario, spending on non–health care goods and services continues to rise throughout the seventy-five-year period. Even between 2050 and 2075, about 35 percent of the forecasted increase in per capita GDP remains available for increased spending on non–health care products. By 2075 health care represents 38 percent of GDP.

By our definition, the one-percentage-point gap between health care spending

EXHIBIT 2
Percentage Real Change In Health Spending And Percentage Increase In Real Income Devoted To Health Care, 1960–1999

	1960–1970	1970–1980	1980–1990	1990–1999 (est.)
Percent real increase in per capita health care expenditures	85.2%	56.3%	69.2%	32.5%
Percent of real increase in per capita income devoted to health care	12.9	15.8	25.3	18.4

SOURCE: Authors' tabulations based on Exhibit 1.

EXHIBIT 3
Percentage Real Change In Health Spending And Percentage Increase In Real Income Devoted To Health Care, 1999–2075

Differential between real per capita GDP growth and health care spending growth	1999–2010	2010–2050	2050–2075	1999–2075
One percentage point				
Average annual percent increase in inflation-adjusted non-health care spending per capita	1.0%	0.8%	0.6%	0.8%
Percent of real increase in per capita income devoted to health care	30.9	45.5	66.3	54.8
Two percentage points				
Average annual percent increase in inflation-adjusted non-health care spending per capita	0.8	0.2	−2.1	−0.7
Percent of real increase in per capita income devoted to health care	44.9	87.8	165.6	124.2

SOURCE: Authors' tabulations.
NOTE: GDP is gross domestic product.

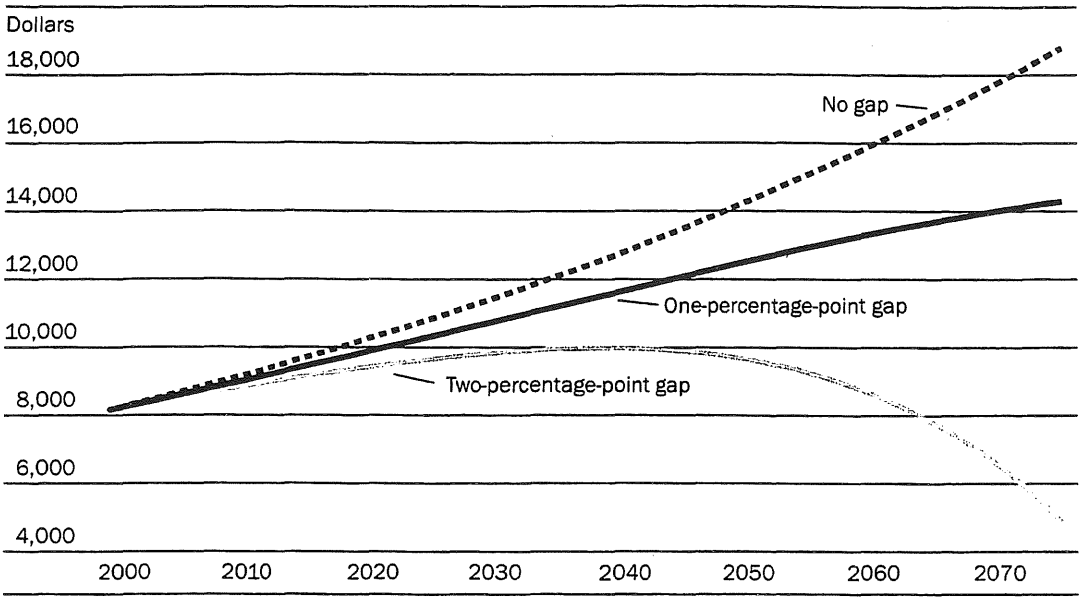
and GDP would be affordable. Yet it should also be noted that even under this assumption, the share of income growth devoted to health care is quite high by historical norms. The highest percentage devoted to health care in any of the past four decades (25.3 percent in the 1980s) is lower than the projected percentage in the 1999–2010 period (30.9 percent).

Further, the projected percentage of income growth consumed by health spending continues to rise after 2010. This suggests that should health care costs continue to grow even at this seemingly conservative rate, it would represent a major break with historical norms in terms of the share of income growth devoted to health care. If we as a society are unwilling to accept having a large and growing fraction of income growth go to the health sector, even the seemingly conservative scenario could set the table for another perceived health care cost crisis and motivate policy action to control spending below forecasted levels.

Two-percentage-point gap. The two-percentage-point assumption, which is closer to the historical gap between health care spending growth and GDP growth, reveals a greater burden on the economy. Through 2039 spending on non–health care goods and services continues to grow, but at a much slower rate (Exhibit 4). About two-thirds of the increase in per capita income between 2010 and 2040 is devoted to health care.

The period between 2040 and 2075 exhibits a drop in spending on non–health care goods and services (which would not be affordable according to the definition adopted by the technical review panel). Under this scenario, per capita nonhealth spending drops to 1999 levels around 2062. By 2075 the rise in health care spending has reduced nonhealth spending to about 60 percent of current levels, which suggests that a two-percentage-point differential would not be sustainable by the second half of this century.

EXHIBIT 4
Spending On Nonhealth Goods And Services, In 1999 Dollars, Assuming Different Gaps Between Real Per Capita GDP And Health Care Cost Growth, 1999–2075



SOURCE: Authors' tabulations.
NOTE: GDP is gross domestic product.

Discussion

Health care spending appears once again to be on an upward trajectory. The resulting concern has generated considerable debate. Our analysis suggests that the economy could sustain a differential of one percentage point between growth of real per capita health care costs and growth of GDP well into the future. However, we believe that it is important to distinguish between spending that we cannot afford to pay for and spending that we are unwilling to pay for—a difference between unsustainable and unwilling to sustain. The former approach emphasizes a need to curb spending, whereas the latter phrasing emphasizes the extent to which the extra spending can be justified by extra value received relative to the value of non–health care services that could otherwise be consumed.

■ **Limitations of the analysis.** The analysis that leads us to these conclusions has several limitations because of its aggregate nature. First, it is not based on a complete, detailed model of the economy. We make several simplifying assumptions such as assuming that the rate of GDP growth is not influenced by the rate of health care cost growth. A macroeconomic analysis using a more detailed economic model, conducted by the INFORUM group at the University of Maryland, indicates that there are two important issues to consider when examining the results from simplified models such as ours: financing and productivity.[8]

Financing and productivity. The sustainability of health care cost growth depends on the mechanism of financing the cost growth. The INFORUM model suggests that financing policies do exist that would allow the economy to sustain growth rates in health care spending of one percentage point above GDP through 2075.[9]

"Our challenge is to develop systems to reduce the amount and share of spending that exceeds our willingness to pay."

These financing policies may entail raising taxes to support growing public spending on health care through programs such as Medicare and Medicaid.

The sustainability of health care cost growth also depends on the productivity of workers in the health care sector. Productivity in the health care sector has been notoriously hard to measure because of difficulty in measuring health care prices.[10] The INFORUM model confirmed that reasonable assumptions regarding productivity could allow the economy to cope with health care spending growth of one percentage point above GDP.[11]

Personal consumption missing. Second, our measure of affordability is based on trends in spending on all nonhealth goods and services. Some of that spending will reflect investment and government spending. A more detailed approach, which would require greater assumptions about investment and other government spending, would base affordability on the impact of growing health spending on personal consumption expenditures. Mark Freeland and colleagues, using slightly different scenarios in which the spending differential above GDP was phased in, estimate that a one-percentage-point gap between real per capita GDP and health care spending growth would translate into about a 52 percent share of personal consumption spending, but personal consumption spending would continue to grow throughout the seventy-five-year study window.[12] This is consistent with our sensitivity analysis, which held investment to 18 percent of GDP.[13] Yet because investment and government spending may adjust in response to the growth in health care spending, we prefer the more aggregate measures.

Distributional impacts. Third, although the rise in health care costs may be affordable at the national level, it is important to recognize the distributional consequences of rising health care costs. What is affordable on average may not be affordable to all segments of society. Rising health care costs may contribute to falling rates of health insurance coverage and reductions in access to care.[14] The appropriate response requires discussion about the ramifications of the lack of coverage and the merits of subsidizing insurance or care for various segments of the population. Discussion of society's willingness to pay must recognize that, in part, this will reflect the willingness of some people to pay for care used by others.

■ **Value we can afford.** Despite these issues, our fundamental message is that medical services and new medical technologies create value that people desire. Our analysis suggests that at least for the foreseeable future, we can afford to purchase these services. In fact, in many cases, we should feel fortunate to have the opportunity to purchase these services.

However, simply because we can afford to pay more for health care services does not imply that we should reduce efforts to reduce wasteful practices in the

health care sector. Information technologies and management strategies will continue to play an important role in promoting more cost-effective and -efficient care. However, even as we strive to eliminate waste, some will remain. For example, a substantial part of health care cost growth is attributable to new technologies, and we should recognize that when new technologies are approved for coverage, unnecessary and cost-ineffective care inherently comes with valued care. We must accept a portion of that as part of the cost of the new technology and ask: Even with some level of unnecessary or even inappropriate use, does the value of the new technology justify its coverage?

IT REMAINS TO BE SEEN whether U.S. consumers will accept the growing percentage of real income growth devoted to health care that is forecasted even under conservative assumptions, or demand policy action to check the increases. One way in which our willingness to pay for new technologies, and hence cost growth, is now measured is by the threshold applied in cost-effectiveness analysis. Thresholds used to define cost-effective care (care we are willing to pay for), if enforced, essentially define the societal value of health. A recent review of the "value of life" literature suggests that traditional thresholds used to define cost-effective care ($50,000–$100,000 per quality-adjusted life year, or QALY) greatly underestimate the value of health.[15] Discomfort with these thresholds, although they are admittedly seldom enforced, may suggest that as a society we are willing to sustain high and rising health care spending. Our challenge for the next several decades is to develop systems to reduce the amount and share of spending that is wasteful and that exceeds our willingness to pay.

The authors thank Mark Freeland, Steven Heffler, Greg Won, Sean Keehan, and Paul Feldstein for helpful comments.

NOTES

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4. G.I. Kowalczyk, M.S. Freeland, and K. Levit, "Using Marginal Analysis to Evaluate Spending Trends," *Health Care Financing Review* 10, no. 2 (1988): 123–129.
5. Technical Review Panel, *Review of the Assumptions and Methods.*
6. The demographic adjustment is 0.43 percentage points per year.
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10. J.E. Triplett, *Measuring the Prices of Medical Treatments* (Washington: Brookings Institution, 1999); and D.M. Cutler and E.R. Berndt, *Medical Care Productivity and Output* (Chicago: University of Chicago Press, 2002).
11. Technical Review Panel, *Review of the Assumptions and Methods.*
12. M. Freeland et al., "Issues on the Sustainability of Long-Term Health Spending Projections" (Paper prepared for the meetings of the Allied Social Sciences Association on Long-Term Cost Projections, Atlanta, Georgia, 4–6 January 2002).
13. We label that 18 percent as investment, but it could be any goods or services that must grow at the rate of GDP. Health care spending growth under the one-percentage-point-gap scenario remains affordable throughout the seventy-five-year window, although the nonhealth percentage increase in the non–health care, noninvestment GDP over the entire period drops from 0.8 percent to 0.6 percent, and the share of noninvestment GDP growth devoted to health care between 2050 and 2075 is about 81 percent, compared with 67 percent of total GDP growth devoted to health care. Under the two-percentage-point-gap scenario, health care spending would become unaffordable by 2030 instead of 2039, and nonhealth, noninvestment GDP would reach 1999 levels around 2051 instead of 2062.
14. R. Kronick and T. Gilmer, "Explaining the Decline in Health Insurance Coverage, 1979–1995," *Health Affairs* (Mar/Apr 1999): 30–47.
15. R.A. Hirth et al., "Willingness to Pay for a Quality-Adjusted Life Year: In Search of a Standard," *Medical Decision Making* (July–September 2000): 332–334.

Quality Measures for Hospital Affiliated ...e Allina Hospitals and Clinics*

Heart Attack Care Quality Measures - Higher Percentages Are Better

Quality Measure	Abbott Northwestern Hospital Inc	Buffalo Hospital	Cambridge Medical Center	Hutchinson Area Health Care	Mercy Hospital	New Ulm Medical Center	Owatonna Hospital	Phillips Eye Institute	Unity Hospital	United Hospital
Percent of Heart Attack Patients Given ACE Inhibitor for LVSD if appropriate	92% of 72 patients	0 patients	100% of 1 patients[1]	100% of 1 patients[1]	96% of 50 patients	0 patients	50% of 4 patients[1]	Not available[4]	100% of 4 patients[1]	93% of 41 patients
Percent of Heart Attack Patients Given Adult Smoking Cessation Advice/Counseling if appropriate	96% of 75 patients	0 patients	0 patients	0 patients	96% of 54 patients	0 patients	100% of 1 patients[1]	Not available[3]	0 patients	92% of 52 patients
Percent of Heart Attack Patients Given Aspirin at Arrival if appropriate	98% of 121 patients	64% of 11 patients[1]	71% of 14 patients[1]	80% of 10 patients[1]	98% of 162 patients	100% of 12 patients[1]	92% of 25 patients	Not available[4]	96% of 68 patients	99% of 164 patients
Percent of Heart Attack Patients Given Aspirin at Discharge if appropriate	99% of 418 patients	100% of 5 patients[1]	88% of 8 patients[1]	100% of 2 patients[1]	99% of 253 patients	100% of 3 patients[1]	94% of 17 patients[1]	Not available[4]	95% of 22 patients[1]	98% of 274 patients
Percent of Heart Attack Patients Given Beta Blocker at Arrival if appropriate	90% of 61 patients	88% of 8 patients[1]	90% of 10 patients[1]	73% of 11 patients[1]	92% of 119 patients	83% of 12 patients[1]	91% of 22 patients[1]	Not available[4]	87% of 46 patients	90% of 118 patients
Percent of Heart Attack Patients Given Beta Blocker at Discharge if appropriate	97% of 383 patients	100% of 5 patients[1]	80% of 5 patients[1]	100% of 2 patients[1]	98% of 246 patients	100% of 3 patients[1]	88% of 17 patients[1]	Not available[4]	95% of 22 patients[1]	93% of 249 patients
Percent of Patients Given PTCA Received Within 90 Minutes Of Arrival	Not available[3]	Not available[4]	Not available[4]	Not available[4]	Not available[4]	Not available[4]	Not available[4]	Not available[3]	Not available[4]	Not available[4]
Percent of Patients Given Thrombolytic Agent Received Within 30 Minutes	Not available[3]	Not available[4]	Not available[4]	Not available[4]	Not available[4]	Not available[4]	Not available[4]	Not available[3]	Not available[4]	Not available[4]

Source: Adapted from the Hospital Compare website hosted by the United States Department of Health and Human Services (www.hospitalcompare.hhs.gov/).This information comes from the quality data submitted by hospitals to the QIO Clinical Data Warehouse for inpatient discharges during the time period January - June 2004.

*Data not available for Sibley Medical Center

1: The number of cases is too small (n<25) for purposes of reliably predicting hospital's performance.

2: Measure reflects the hospital's indication that its submission was based on a sample of its relevant discharges.

3: This hospital is not currently reporting this measure.

4: No data is available from the hospital for this measure for the reporting period.

Heart Failure Care Quality Measures - Higher Percentages Are Better

Quality Measure	Abbott Northwestern Hospital Inc	Buffalo Hospital	Cambridge Medical Center	Hutchinson Area Health Care	Mercy Hospital	New Ulm Medical Center	Owatonna Hospital	Phillips Eye Institute	Unity Hospital	United Hospital
Percent of Heart Failure Patients Given ACE Inhibitor for LVSD if appropriate	78% of 153 patients	100% of 6 patients[1]	92% of 13 patients[1]	100% of 5 patients[1]	85% of 84 patients	100% of 3 patients[1]	88% of 8 patients[1]	Not available[4]	74% of 54 patients	72% of 128 patients
Percent of Heart Failure Patients Given Adult Smoking Cessation Advice/Counseling if appropriate	73% of 15 patients[1]	100% of 1 patients[1]	100% of 3 patients[1]	100% of 1 patients[1]	100% of 20 patients[1]	0 patients	0% of 1 patients[1]	Not available[3]	94% of 17 patients[1]	90% of 30 patients
Percent of Heart Failure Patients Given Assessment of Left Ventricular Function if appropriate	95% of 397 patients	89% of 35 patients	83% of 52 patients	72% of 32 patients	92% of 269 patients	100% of 27 patients	79% of 38 patients	Not available[4]	91% of 180 patients	87% of 304 patients
Percent of Heart Failure Patients Given Discharge Instructions if appropriate	78% of 143 patients	50% of 14 patients[1]	89% of 18 patients[1]	75% of 12 patients[1]	91% of 128 patients	55% of 11 patients[1]	92% of 12 patients[1]	Not available[3]	89% of 65 patients	79% of 121 patients

Source: Adapted from the Hospital Compare website hosted by the United States Department of Health and Human Services (www.hospitalcompare.hhs.gov/).This information comes from the quality data submitted by hospitals to the QIO Clinical Data Warehouse for inpatient discharges during the time period January - June 2004.

*Data not available for Sibley Medical Center

1: The number of cases is too small (n<25) for purposes of reliably predicting hospital's performance.

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3: This hospital is not currently reporting this measure.

4: No data is available from the hospital for this measure for the reporting period.

Pneumonia Care Quality Measures - Higher Percentages Are Better

Quality Measure	Abbott Northwestern Hospital Inc	Buffalo Hospital	Cambridge Medical Center	Hutchinson Area Health Care	Mercy Hospital	New Ulm Medical Center	Owatonna Hospital	Phillips Eye Institute	Unity Hospital	United Hospital
Percent of Pneumonia Patients Given Adult Smoking Cessation Advice/Counseling if appropriate	67% of 12 patients[1]	67% of 6 patients[1]	100% of 4 patients[1]	67% of 3 patients[1]	78% of 9 patients[1]	0 patients	0% of 1 patients[1]	Not available[3]	50% of 14 patients[1]	94% of 16 patients[1]
Percent of Pneumonia Patients Given Blood Cultures Performed Before First Antibiotic Received if appropriate	82% of 57 patients	74% of 19 patients[1]	81% of 21 patients[1]	87% of 15 patients[1]	85% of 39 patients	77% of 13 patients[1]	73% of 11 patients[1]	Not available[3]	91% of 64 patients	65% of 57 patients
Percent of Pneumonia Patients Given Initial Antibiotic Timing if appropriate	73% of 207 patients	69% of 78 patients	78% of 78 patients	88% of 56 patients	69% of 111 patients	85% of 41 patients	79% of 56 patients	Not available[4]	66% of 149 patients	72% of 140 patients
Percent of Pneumonia Patients Given Oxygenation Assessment if appropriate	100% of 211 patients	99% of 79 patients	100% of 78 patients	100% of 58 patients	99% of 115 patients	98% of 42 patients	95% of 57 patients	Not available[4]	99% of 152 patients	99% of 143 patients
Percent of Pneumonia Patients Given Pneumococcal Vaccination if appropriate	47% of 133 patients	0% of 42 patients	64% of 33 patients	82% of 28 patients	60% of 55 patients	84% of 25 patients	62% of 34 patients	Not available[4]	50% of 90 patients	28% of 87 patients

Source: Adapted from the Hospital Compare website hosted by the United States Department of Health and Human Services (www.hospitalcompare.hhs.gov/).This information comes from the quality data submitted by hospitals to the QIO Clinical Data Warehouse for inpatient discharges during the time period January - June 2004.

*Data not available for Sibley Medical Center

1: The number of cases is too small (n<25) for purposes of reliably predicting hospital's performance.

2: Measure reflects the hospital's indication that its submission was based on a sample of its relevant discharges.

3: This hospital is not currently reporting this measure.

4: No data is available from the hospital for this measure for the reporting period.

Quality Measures for North Memorial Health Care

Heart Failure Care Quality Measures - Higher Percentages Are Better

Quality Measure	North Memorial Health Care
Percent of Heart Attack Patients Given ACE Inhibitor for LVSD if appropriate	88% of 85 patients
Percent of Heart Attack Patients Given Adult Smoking Cessation Advice/Counseling if appropriate	94% of 31 patients
Percent of Heart Attack Patients Given Aspirin at Arrival if appropriate	100% of 264 patients
Percent of Heart Attack Patients Given Aspirin at Discharge if appropriate	96% of 260 patients
Percent of Heart Attack Patients Given Beta Blocker at Arrival if appropriate	95% of 231 patients
Percent of Heart Attack Patients Given Beta Blocker at Discharge if appropriate	96% of 264 patients
Percent of Patients Given PTCA Received Within 90 Minutes Of Arrival	Not available[4]
Percent of Patients Given Thrombolytic Agent Received Within 30 Minutes Of Arrival	Not available[4]

Source: Adapted from the Hospital Compare website hosted by the United States Department of Health and Human Services (www.hospitalcompare.hhs.gov/).This information comes from the quality data submitted by hospitals to the QIO Clinical Data Warehouse for inpatient discharges during the time period January - June 2004.

1: The number of cases is too small (n<25) for purposes of reliably predicting hospital's performance.

2: Measure reflects the hospital's indication that its submission was based on a sample of its relevant discharges.

3: This hospital is not currently reporting this measure.

4: No data is available from the hospital for this measure for the reporting period.

Heart Failure Care Quality Measures - Higher Percentages Are Better

Quality Measure	North Memorial Health Care
Percent of Heart Failure Patients Given ACE Inhibitor for LVSD if appropriate	85% of 111 patients
Percent of Heart Failure Patients Given Adult Smoking Cessation Advice/Counseling if appropriate	91% of 23 patients[1]
Percent of Heart Failure Patients Given Assessment of Left Ventricular Function if appropriate	95% of 296 patients
Percent of Heart Failure Patients Given Discharge Instructions if appropriate	50% of 124 patients

Source: Adapted from the Hospital Compare website hosted by the United States Department of Health and Human Services (www.hospitalcompare.hhs.gov/).This information comes from the quality data submitted by hospitals to the QIO Clinical Data Warehouse for inpatient discharges during the time period January - June 2004.

1: The number of cases is too small (n<25) for purposes of reliably predicting hospital's performance.

2: Measure reflects the hospital's indication that its submission was based on a sample of its relevant discharges.

3: This hospital is not currently reporting this measure.

4: No data is available from the hospital for this measure for the reporting period.

Pneumonia Care Quality Measures - Higher Percentages Are Better

Quality Measure	North Memorial Health Care
Percent of Pneumonia Patients Given Adult Smoking Cessation Advice/Counseling if appropriate	84% of 25 patients
Percent of Pneumonia Patients Given Blood Cultures Performed Before First Antibiotic Received if appropriate	77% of 66 patients
Percent of Pneumonia Patients Given Initial Antibiotic Timing if appropriate	87% of 302 patients
Percent of Pneumonia Patients Given Oxygenation Assessment if appropriate	100% of 303 patients
Percent of Pneumonia Patients Given Pneumococcal Vaccination if appropriate	46% of 164 patients

Source: Adapted from the Hospital Compare website hosted by the United States Department of Health and Human Services (www.hospitalcompare.hhs.gov/).This information comes from the quality data submitted by hospitals to the QIO Clinical Data Warehouse for inpatient discharges during the time period January - June 2004.

1: The number of cases is too small (n<25) for purposes of reliably predicting hospital's performance.

2: Measure reflects the hospital's indication that its submission was based on a sample of its relevant discharges.

3: This hospital is not currently reporting this measure.

4: No data is available from the hospital for this measure for the reporting period.

Quality Measures for Hospital Affiliated with Fairview Health Services

Heart Attack Care Quality Measures - Higher Percentages Are Better

Quality Measures	Fairview Lakes Regional Health Care	Fairview Northland Regional Hospital	Fairview Red Wing Hospital	Fairview Ridges Hospital	Fairview Southdale Hospital	Fairview University Medical Center	University Medical Center-Mesabi
Percent of Heart Attack Patients Given ACE Inhibitor for LVSD if appropriate	100% of 3 patients[1,2]	60% of 5 patients[1,2]	100% of 2 patients[1]	100% of 4 patients[1,2]	100% of 56 patients[2]	88% of 17 patients[1,2]	33% of 3 patients[1]
Percent of Heart Attack Patients Given Adult Smoking Cessation Advice/Counseling if appropriate	100% of 1 patients[1,2]	0% of 1 patients[1,2]	0 patients	50% of 2 patients[1,2]	100% of 38 patients[2]	71% of 7 patients[1,2]	0% of 1 patients[1]
Percent of Heart Attack Patients Given Aspirin at Arrival if appropriate	100% of 31 patients[2]	95% of 19 patients[1,2]	90% of 10 patients[1]	91% of 34 patients[2]	98% of 167 patients[2]	97% of 36 patients[2]	96% of 25 patients
Percent of Heart Attack Patients Given Aspirin at Discharge if appropriate	93% of 14 patients[1,2]	90% of 10 patients[1,2]	70% of 10 patients[1]	75% of 16 patients[1,2]	99% of 258 patients[2]	96% of 54 patients[2]	86% of 7 patients[1]
Percent of Heart Attack Patients Given Beta Blocker at Arrival if appropriate	100% of 33 patients[2]	89% of 19 patients[1,2]	86% of 7 patients[1]	78% of 32 patients[2]	95% of 159 patients[2]	88% of 32 patients[2]	92% of 25 patients
Percent of Heart Attack Patients Given Beta Blocker at Discharge if appropriate	100% of 17 patients[1,2]	100% of 11 patients[1,2]	80% of 10 patients[1]	79% of 14 patients[1,2]	97% of 254 patients[2]	85% of 52 patients[2]	67% of 9 patients[1]
Percent of Patients Given PTCA Received Within 90 Minutes Of Arrival	0 patients [2]	0 patients [2]	Not available[5]	0 patients [2]	81% of 21 patients[1,2]	25% of 4 patients[1,2]	Not available[4]
Percent of Patients Given Thrombolytic Agent Received Within 30 Minutes Of Arrival	0 patients [2]	0 patients [2]	Not available[5]	0 patients [2]	0 patients [2]	0 patients [2]	Not available[4]

Source: Adapted from the Hospital Compare website hosted by the United States Department of Health and Human Services (www.hospitalcompare.hhs.gov/).This information comes from the quality data submitted by hospitals to the QIO Clinical Data Warehouse for inpatient discharges during the time period January - June 2004.

1: The number of cases is too small (n<25) for purposes of reliably predicting hospital's performance.

2: Measure reflects the hospital's indication that its submission was based on a sample of its relevant discharges.

3: This hospital is not currently reporting this measure.

4: No data is available from the hospital for this measure for the reporting period.

Heart Failure Care Quality Measures - Higher Percentages Are Better

Quality Measures	Fairview Lakes Regional Health Care	Fairview Northland Regional Hospital	Fairview Red Wing Hospital	Fairview Ridges Hospital	Fairview Southdale Hospital	Fairview University Medical Center	University Medical Center-Mesabi
Percent of Heart Failure Patients Given ACE Inhibitor for LVSD if appropriate	95% of 19 patients[1,2]	50% of 10 patients[1,2]	91% of 11 patients[1]	55% of 29 patients[2]	89% of 91 patients[2]	80% of 95 patients[2]	73% of 30 patients
Percent of Heart Failure Patients Given Adult Smoking Cessation Advice/Counseling if appropriate	100% of 3 patients[1,2]	50% of 2 patients[1,2]	0 patients	0% of 2 patients[1,2]	80% of 10 patients[1,2]	23% of 13 patients[1,2]	50% of 12 patients[1]
Percent of Heart Failure Patients Given Assessment of Left Ventricular Function if appropriate	100% of 53 patients[2]	59% of 32 patients[2]	82% of 33 patients	86% of 74 patients[2]	93% of 248 patients[2]	89% of 170 patients[2]	85% of 74 patients
Percent of Heart Failure Patients Given Discharge Instructions if appropriate	100% of 16 patients[1,2]	54% of 13 patients[1,2]	50% of 10 patients[1]	57% of 28 patients[2]	82% of 103 patients[2]	35% of 79 patients[2]	21% of 28 patients

Source: Adapted from the Hospital Compare website hosted by the United States Department of Health and Human Services (www.hospitalcompare.hhs.gov/).This information comes from the quality data submitted by hospitals to the QIO Clinical Data Warehouse for inpatient discharges during the time period January - June 2004.

1: The number of cases is too small (n<25) for purposes of reliably predicting hospital's performance.

2: Measure reflects the hospital's indication that its submission was based on a sample of its relevant discharges.

3: This hospital is not currently reporting this measure.

4: No data is available from the hospital for this measure for the reporting period.

Pneumonia Care Quality Measures - Higher Percentages Are Better

Quality Measure	Fairview Lakes Regional Health Care	Fairview Northland Regional Hospital	Fairview Red Wing Hospital	Fairview Ridges Hospital	Fairview Southdale Hospital	Fairview University Medical Center	University Medical Center-Mesabi
Percent of Pneumonia Patients Given Adult Smoking Cessation Advice/Counseling if appropriate	100% of 7 patients[1,2]	56% of 9 patients[1,2]	88% of 8 patients[1]	89% of 9 patients[1,2]	56% of 18 patients[1,2]	25% of 12 patients[1,2]	50% of 10 patients[1]
Percent of Pneumonia Patients Given Blood Cultures Performed Before First Antibiotic Received if appropriate	86% of 42 patients[2]	72% of 25 patients[2]	83% of 24 patients[1]	84% of 32 patients[2]	91% of 81 patients[2]	84% of 49 patients[2]	96% of 24 patients[1]
Percent of Pneumonia Patients Given Initial Antibiotic Timing if appropriate	76% of 97 patients[2]	62% of 82 patients[2]	80% of 85 patients	73% of 127 patients[2]	83% of 206 patients[2]	44% of 179 patients[2]	96% of 70 patients
Percent of Pneumonia Patients Given Oxygenation Assessment if appropriate	100% of 99 patients[2]	98% of 84 patients[2]	100% of 85 patients	100% of 130 patients[2]	100% of 208 patients[2]	95% of 184 patients[2]	99% of 75 patients
Percent of Pneumonia Patients Given Pneumococcal Vaccination if appropriate	82% of 51 patients[2]	11% of 37 patients[2]	88% of 52 patients	27% of 64 patients[2]	3% of 142 patients[2]	56% of 57 patients[2]	28% of 43 patients

Source: Adapted from the Hospital Compare website hosted by the United States Department of Health and Human Services (www.hospitalcompare.hhs.gov/).This information comes from the quality data submitted by hospitals to the QIO Clinical Data Warehouse for inpatient discharges during the time period January - June 2004.

1: The number of cases is too small (n<25) for purposes of reliably predicting hospital's performance.

2: Measure reflects the hospital's indication that its submission was based on a sample of its relevant discharges.

3: This hospital is not currently reporting this measure.

4: No data is available from [illegible] hospital for this measure for the reporting period.

Quality Measures for Methodist Hospital Park Nicollet Health Services

Heart Attack Care Quality Measures - Higher Percentages Are Better

Quality Measure	Methodist Hospital Park Nicollet Health Services
Percent of Heart Attack Patients Given ACE Inhibitor for LVSD if appropriate	100% of 29 patients[2]
Percent of Heart Attack Patients Given Adult Smoking Cessation Advice/Counseling if appropriate	85% of 27 patients[2]
Percent of Heart Attack Patients Given Aspirin at Arrival if appropriate	99% of 157 patients[2]
Percent of Heart Attack Patients Given Aspirin at Discharge if appropriate	98% of 195 patients[2]
Percent of Heart Attack Patients Given Beta Blocker at Arrival if appropriate	99% of 144 patients[2]
Percent of Heart Attack Patients Given Beta Blocker at Discharge if appropriate	99% of 191 patients[2]
Percent of Patients Given PTCA Received Within 90 Minutes Of Arrival	73% of 22 patients[1,2]
Percent of Patients Given Thrombolytic Agent Received Within 30 Minutes Of Arrival	0 patients [2]

Source: Adapted from the Hospital Compare website hosted by the United States Department of Health and Human Services (www.hospitalcompare.hhs.gov/).This information comes from the quality data submitted by hospitals to the QIO Clinical Data Warehouse for inpatient discharges during the time period January - June 2004.

1: The number of cases is too small (n<25) for purposes of reliably predicting hospital's performance.

2: Measure reflects the hospital's indication that its submission was based on a sample of its relevant discharges.

3: This hospital is not currently reporting this measure.

4: No data is available from the hospital for this measure for the reporting period.

Heart Failure Care Quality Measures - Higher Percentages Are Better

Quality Measure	Methodist Hospital Park Nicollet Health Services
Percent of Heart Failure Patients Given ACE Inhibitor for LVSD if appropriate	76% of 79 patients[2]
Percent of Heart Failure Patients Given Adult Smoking Cessation Advice/Counseling if appropriate	77% of 13 patients[1,2]
Percent of Heart Failure Patients Given Assessment of Left Ventricular Function if appropriate	98% of 244 patients[2]
Percent of Heart Failure Patients Given Discharge Instructions if appropriate*	18% of 93 patients[2]

Source: Adapted from the Hospital Compare website hosted by the United States Department of Health and Human Services (www.hospitalcompare.hhs.gov/).This information comes from the quality data submitted by hospitals to the QIO Clinical Data Warehouse for inpatient discharges during the time period January - June 2004.

1: The number of cases is too small (n<25) for purposes of reliably predicting hospital's performance.

2: Measure reflects the hospital's indication that its submission was based on a sample of its relevant discharges.

3: This hospital is not currently reporting this measure.

4: No data is available from the hospital for this measure for the reporting period.

Pneumonia Care Quality Measures - Higher Percentages Are Better

Quality Measure	Methodist Hospital Park Nicollet Health Services
Percent of Pneumonia Patients Given Adult Smoking Cessation Advice/Counseling if appropriate	41% of 27 patients[2]
Percent of Pneumonia Patients Given Blood Cultures Performed Before First Antibiotic Received if appropriate	79% of 108 patients[2]
Percent of Pneumonia Patients Given Initial Antibiotic Timing if appropriate	73% of 362 patients[2]
Percent of Pneumonia Patients Given Oxygenation Assessment if appropriate	100% of 367 patients[2]
Percent of Pneumonia Patients Given Pneumococcal Vaccination if appropriate	57% of 244 patients[2]

Source: Adapted from the Hospital Compare website hosted by the United States Department of Health and Human Services (www.hospitalcompare.hhs.gov/).This information comes from the quality data submitted by hospitals to the QIO Clinical Data Warehouse for inpatient discharges during the time period January - June 2004.

1: The number of cases is too small (n<25) for purposes of reliably predicting hospital's performance.

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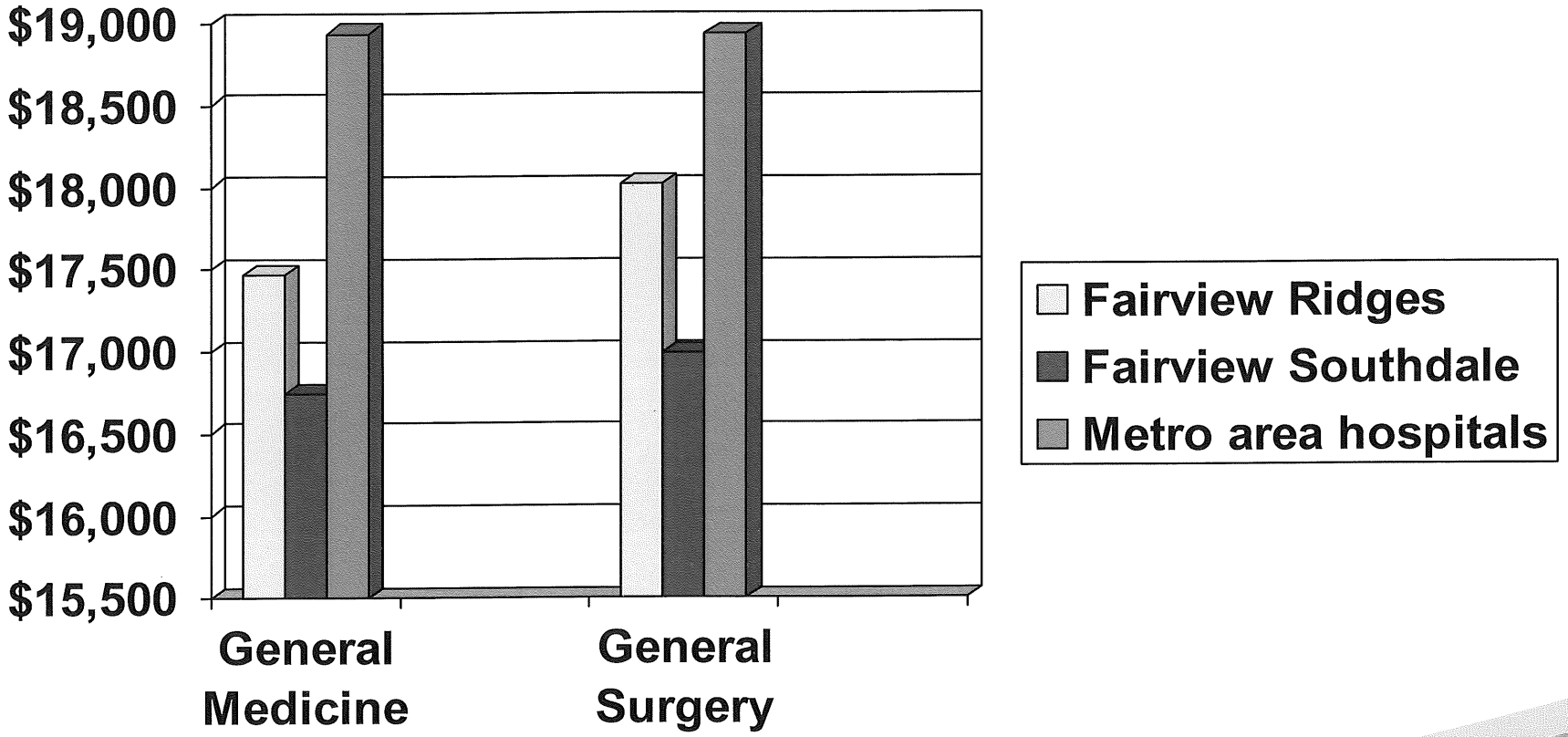
3: This hospital is not currently reporting this measure.

4: No data is available from the hospital for this measure for the reporting period.

Fairview is a leader in providing high-quality, low-cost inpatient care in the Twin Cities



FAIRVIEW

Statement of Agreement: Fairview and Attorney General Mike Hatch

Shared goal: provide needed, high-quality health care to our patients, regardless of income.

- Central to our mission is extending free or discounted care to those who qualify.
- We don't want to pursue those who can't pay; but we must pursue those who can pay.

The Collections Standards Agreement provides for:

- Third party review before Fairview files a lawsuit to collect medical debt.
- Third party review before Fairview garnishes wages or bank accounts. Fairview will not use pre-judgment garnishments.
- Certain other collection procedures, audits and policies.
- Binding arbitration for hospital accounts over $1,000.
- Two-year term of agreement

Independent of the Collections Standards Agreement, Fairview modified its existing Charity Care Policy to increase the maximum threshold from 400 percent of the federal poverty guidelines to 450 percent of federal poverty guidelines. The discount at this maximum level was increased from 30 percent to 40 percent.

INSTITUTE® FOR ATHLETIC MEDICINE

A service of Fairview and North Memorial

Orthopedic and Sports Rehabilitation

Physical therapy, athletic training and chiropractic services

Apple Valley
Bandana Square
Bloomington
Brooklyn Park
Burnsville
Eagan
Eden Prairie
Edina
Elk River
Highland Park
Lino Lakes
Maple Grove
Maplewood
Minneapolis
Minnetonka
N.E. Minneapolis
Osseo
Plymouth
Robbinsdale
Roseville
WestHealth
Woodbury

The Institute for Athletic Medicine offers complete, state-of-the-art orthopedic and sports physical therapy and rehabilitation services for people of all ages and skill levels. Our physical therapists and certified athletic trainers are committed to caring for people with musculoskeletal injuries.

We get you back in the game of life

Injury can take your time away from children, community activities, recreation and work – the activities of life. At the Institute for Athletic Medicine, our goal is to return you to health by helping you recover from or prevent injury or chronic musculoskeletal problems.

Our physical therapists, athletic trainers and chiropractors understand the unique physical demands of athletics as well as the effects of overuse, poor physical condition, surgery and aging. We work closely with you and your physician to design a treatment plan to get you back in the game of life.

Comprehensive services include:

- orthopedic and sports physical therapy treatment
- specialized sports- and movement-specific treatment programs
- services to prevent injury at home, work or play
- special obstetric/gynecologic physical therapy services for women

Specialized services

(Available at some locations)

- chiropractic care
- MedX, computerized medical back rehabilitation technology
- industrial rehabilitation

Sports- and movement-specific programs

Our staff has developed clinical expertise unavailable elsewhere, providing you with the highest quality care.

- ***Back In Balance Program***

  Physical therapists who understand the complexities of the back work with you individually to evaluate and treat low-back problems using MedX computerized rehabilitation equipment. Therapists help you learn to care for your back and minimize your risk of future back problems through core muscle strengthening and physical activity.

- ***Golf Program***

  Suited for the dedicated golfer, the Golf Program works to get you back in the swing. Physical therapists complete a biomechanical assessment and video analysis of your golf swing, test your golf-specific muscle strength and movement and design an exercise program to enhance your strength and flexibility while minimizing injury.

Institute for
Athletic Medicine
775 Prairie Center Dr.
Suite 250
Eden Prairie, MN 55344
612-672-7278
www.athletic-medicine.org

(continued on back)

- ***Next Step Program***

  Next Step is a 5-week, 10-session sports rehabilitation program that bridges the gap between in-clinic sports injury rehabilitation and your return to high-intensity sport activities. Physical therapists and certified athletic trainers work one-on-one and in group settings to help you improve strength, endurance, agility, coordination, speed and confidence necessary to competitive play.

- ***Running Program***

  Physical therapists and athletic trainers work with you to design an individualized program to help you improve running mechanics and maximize your performance. Take advantage of a video analysis of your running gait as well as strength, endurance and flexibility testing and shoe recommendations.

- ***Thrower's Injury Program***

  With an understanding of the unique mechanical requirements of throwing, physical therapists develop a return-to-throwing program to improve strength, mobility and throwing mechanics to prevent further injury. Therapists analyze video to evaluate your throwing or pitching motion, pinpointing causes of injury.

- ***For Women Only***

  Changes in a woman's body brought about by pregnancy, aging or illness often result in discomfort, loss of mobility and lifestyle changes. Because women have unique medical needs during childbearing years and beyond, *For Women Only* offers exercise programs for the prenatal and postpartum woman, and physical therapy for low-back pain during pregnancy, incontinence/pelvic floor weakness and osteoporosis.

A convenient clinic near you

The Institute for Athletic Medicine has 23 convenient neighborhood clinics in the metro area offering extended hours.

For more information

For more information about our programs and clinic locations, call the Institute for Athletic Medicine's information line, **612-672-7278.**

To schedule an appointment

Call our centralized appointment number, **612-672-7100**. We accept self-referrals and a wide range of health plans. Check with your insurance carrier about coverage.

For treatment of a sports injury

For advice on treating a sports injury or to schedule a personal evaluation, call the 24-hour Athletic Medicine Hotline, **952-920-8850.**

The Institute for Athletic Medicine is a service of Fairview Health Services and North Memorial Health Care.

FAIRVIEW

Fairview Health Services Fact Sheet

Maple Grove Hospital Survey

Fairview Health Services surveyed residents in Northwestern Hennepin County to determine their views on a variety of subjects relating to the proposed Maple Grove hospital.

Key findings

Timing

- Nearly 85 percent (84.8%) of residents surveyed believe it is important that a new Maple Grove hospital be under construction in the next 12 months.
- Nearly 84 percent (83.5%) of residents believe it is important that the Minnesota Legislature approve a new Maple Grove hospital this year.

Fairview is the only provider competing for a Maple Grove hospital that:

- **Already owns land for a Maple Grove hospital**
- **Has the various local permissions needed to proceed**
- **Has been planning to build in Maple Grove for five years**
- **Can have a hospital under construction in the next 12 months if approved this legislative session**

Services

- Nearly 87 percent (86.5%) of residents believe it is important that the new Maple Grove hospital provide access to the services offered by University of Minnesota Physicians.
- Nearly 88 percent (87.8%) of residents believe it is important that the new Maple Grove hospital offer the best access to the latest medical advances of the University of Minnesota.

Fairview Maple Grove is a partnership of Fairview Health Services, University of Minnesota Physicians, and Fairview-University Children's Hospital. As the only partnership with the world-class doctors at the University of Minnesota Medical School, Fairview Maple Grove will provide residents of Northwestern Hennepin County with direct access to specialty care and the latest medical breakthroughs.

- More than 80 percent (80.3%) of residents believe it is important that the new Maple Grove hospital offer affiliated senior assisted living services.

  Fairview owns Ebenezer, one of Minnesota's most respected providers of compassionate, community-centered care for older adults and others in need. Fairview can bring to Maple Grove the expertise of Ebenezer to provide older adults access to a full range of coordinated programs and services, including senior housing, assisted living, memory care, transitional and long-term care, adult and intergenerational programs, and a variety of community-based services.

- Nearly 79 percent (78.5%) of residents believe it is important that the new Maple Grove hospital offer mental health, behavioral health, and chemical dependency services.

  Fairview's proposal is the only one with a significant commitment to establishing a mental health, behavioral health, and chemical dependency unit in Maple Grove.

Competition

- More than 88 percent (88.3%) of residents believe it is important that the new Maple Grove hospital offer new health care options.

  Fairview Maple Grove would add a new choice to the health care scene in Northern Hennepin County, which would:
  - **broaden the array of services available**
  - **help hold down costs for consumers**
  - **bring the innovation of Fairview University Medical Center to local residents**

Survey facts

- The survey was conducted March 23 and 24, 2005 by the Tarrance Group, an independent polling firm based in Alexandria, Virginia.
- The survey was conducted through telephone interviews of 400 randomly selected registered likely voters in Minnesota Senate District 32 in Northwestern Hennepin County. Senate District 32 includes the cities of Maple Grove, Osseo, Corcoran, Dayton, Rogers, Hassan, and Hanover.
- The survey has a confidence level of 95% and a margin of error of 4.9%.
- The survey was designed to meet the high statistical standards of media-sponsored polls.

FAIRVIEW

Fairview Maple Grove Health Care Campus

	Fairview Health Services	North Memorial Medical Center	Tri-Care Partnership
Collaborative partners	• University of Minnesota Physicians • Fairview-University Children's Hospital • Ebenezer Senior Care	None	• Park Nicollet • Children's Hospital • Allina Health Systems
Opening date for hospital	2007	2008	2008
Beds – 2007/2008 2013 and beyond	120 Beds Total Beds 284	80 Beds Total Beds 260	60 to 100 Beds Total Beds 250
Moratorium request	Transfer Licensed Non-operating	Transfer Current Operating	New Licensed Beds
Number and type of hospital beds 2008-2009	OB 24 beds Psych 20 beds Other 76 beds	OB 7 beds Psych 4 beds Other 78 beds	OB 12-16 beds Psych 0 beds Other 56-80 beds
Number and type of hospital beds 2013 and beyond	OB 34 beds Psych 28 beds Other 212 beds	Not Defined in Application Other 260 beds	Not Defined in Application Other 250 beds
Cost of project Initial - 2006	$47M for Ambulatory Center	$117 M for Medical Office Building and Ambulatory Center	Not provided in application
Phase II - 2008	$64.8M to $90M for Hospital Facility	$58M for Hospital Facility	$72M for Hospital Facility
Bond ratings (S&P)	A	A	New organization - Unknown
Site size and ownership	26.7 acres Owned by Fairview Purchased 2002	30 acres Not owned by applicant Requires new bridge for access	84 acres Not owned by applicant

FAIRVIEW
Fairview Health Services

2450 Riverside Avenue
Minneapolis, MN 55454-1395
Tel 612-672-6300

Fairview's number one strategy for future success is clinical excellence. Fairview has adopted the six aims recommended by the Institute of Medicine and pledge to provide care that is safe, timely, effective, efficient, equitable and patient-centered. Indicators reflecting the organization's performance against this pledge are tracked in the Fairview Greenbook and shared broadly. Executive incentive compensations is partially linked to clinical performance improvement.

Fairview is committed to collaborating with other organizations to improve care. Fairview plays a major role in efforts related to quality and safety within Minnesota and nationally. David R. Page, CEO and other senior leaders actively participate in efforts including the Institute for Clinical Systems Improvement (ICSI), the Minnesota Community Measurement Project, Safest in America (a community-wide collaborative on safety), the Minnesota Alliance for Patient Safety (MAPS – a multi-stakeholder consortium focused on safety), and the Minnesota Hospital Association Committee on Safety. Fairview is a member of the National Patient Safety Foundation (NPSF). Mr. Page is a founding board member of NPSF. Mr. Page was the first individual recognized by MAPS for individual leadership in Patient Safety.

Fairview is committed to greater accountability and transparency in health care. Fairview is one of 270 hospitals nation-wide participating in the Center for Medicare and Medicaid Service (CMS) Incentive Demonstration Project. Two Fairview hospitals rank in the top 10% nationally in cardiac care (I.e. Acute Myocardial Infarction and congestive heart failure). Some of our other hospitals do not rank in the top 2 deciles in coronary care. We are committed to being open about the quality care we deliver and doing everything in our power to improve.

Hospital Quality Incentive Demonstration Project
October 2003 – September 2004

	AMI (Acute Myocardial Infarction)	CABG (Coronary Artery Bypass Graft)	HF (Heart Failure)	Pneumonia	Hip & Knee
FUMC	5	8	7	9	2
Southdale	-	2	-	8	2
Lakes	1	-	1	2	N/A
Northland	10	-	9	10	9
Ridges	8	-	7	6	1

*** # Indicates the decile the hospital falls into in relation to the other hospitals in the project.
E.g. #1 means the top 10%, #2 means the top 20%

Minnesota Hospital Public Interest Review:

North Memorial Health Care Proposal for a New Inpatient Facility in Maple Grove, Minnesota

Minnesota Department of Health

March 2005

MINNESOTA MDH DEPARTMENT OF HEALTH

Office of Health Policy, Statistics and Informatics
Health Economics Program
PO Box 64882
St. Paul, Minnesota 55164-0882
(651) 282-6367
www.health.state.mn.us

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, maintaining and improving the health of all Minnesotans

March 11, 2005

The Honorable Jim Abeler
Chair, Health Care Cost Containment Division
Minnesota House of Representatives
509 State Office Building
100 Rev. Dr. Martin Luther King Jr. Blvd.
Saint Paul, Minnesota 55155

The Honorable Linda Berglin
Chair, Health and Human Services
Budget Division
Minnesota Senate
Room 309, State Capitol
75 Rev. Dr. Martin Luther King Jr. Blvd
Saint Paul, Minnesota 55155-1606

The Honorable Fran Bradley
Chair, Health Policy and Finance
Committee
Minnesota House of Representatives
563 State Office Building
100 Rev. Dr. Martin Luther King Jr. Blvd.
Saint Paul, Minnesota 55155

The Honorable Becky Lourey
Chair, Health and Family Security
Committee
Minnesota Senate
Room G-24, State Capitol
75 Rev. Dr. Martin Luther King Jr. Blvd
Saint Paul, Minnesota 55155-1606

To the Honorable Chairs:

Minnesota Statutes 144.552 requires any hospital seeking to increase its number of licensed beds or an organization seeking to obtain a hospital license to submit a plan to the Commissioner of Health. The Commissioner is required to review each plan submitted under Minnesota Statutes 144.552 and issue a finding on whether the plan is in the public interest. The law requires that the Commissioner provide a copy of the finding on whether the plan is in the public interest to the chairs of the House and Senate committees having jurisdiction over health and human services policy and finance.

In November 2004, the MDH received three proposals from entities planning to seek a license to build a new hospital in Maple Grove, Minnesota. North Memorial Health Care and Fairview Health Services each submitted a proposal, and the third proposal was submitted by a partnership between Allina Hospitals and Clinics, Park Nicollet Health Services, and Children's Hospitals and Clinics (the "Maple Grove Tri-Care Partnership"). Consistent with the requirements of Minnesota Statutes 144.552, we have reviewed each of the three plans that we received. Because the law does not specifically contemplate situations in which more than one proposal may be submitted for the same geographic area, we reviewed each of the plans individually. A separate report and findings for each of the plans submitted to MDH for public interest review is enclosed.

All three of the reports find that it is in the public interest to construct a new hospital in Maple Grove. From a local perspective, the Department concurs that the community can support a hospital of the size and scope proposed, and that a new facility would provide more convenient access to services for residents in the community. From a statewide perspective, the Department finds that existing inpatient hospital capacity is likely to experience increasing strains over the next decade, and that construction of some new capacity may be necessary to relieve those strains. Because hospitals that currently serve the Maple Grove area collectively account for about one third of total hospital admissions in Minnesota, this issue is a statewide concern. The three proposals address this issue to varying degrees. Also to varying degrees, all three proposals specifically address issues of statewide concern such as a shortage of inpatient behavioral health services. In considering whether to grant an exception to the hospital moratorium, the legislature may wish to give strong consideration to whether certain services, such as inpatient behavioral health services, should be included as a requirement under any moratorium exception granted.

While the Department finds that it is in the public interest to construct a new hospital in Maple Grove, we believe that it is unlikely that the construction of three new inpatient facilities in Maple Grove would be in the public interest. As noted above, the legislation establishing the public interest review process did not contemplate a situation in which there would be simultaneous proposals to expand hospital capacity in the same geographic area. A direct comparison of the three proposals and recommendation as to which proposal is best is beyond the scope of the Department's authority under the law.

I look forward to working with into the future on issues of hospital capacity in Minnesota.

Sincerely,

Dianne M. Mandernach

Dianne M. Mandernach
Commissioner
P.O. Box 64882
St. Paul, Minnesota 55164-0882

Minnesota Hospital Public Interest Review:

North Memorial Health Care Proposal for a New Inpatient Facility in Maple Grove, Minnesota

March 2005

MINNESOTA MDH DEPARTMENT OF HEALTH

Office of Health Policy, Statistics and Informatics
Health Economics Program
PO Box 64882
St. Paul, Minnesota 55164-0882
(651) 282-6367
www.health.state.mn.us

As required by Minnesota Statute 3.197: This report cost approximately $75,000 to prepare including staff time, printing and mailing expenses

Table of Contents

1. Background

Since 1984, Minnesota law has prohibited the construction of new hospitals or expansion of bed capacity of existing hospitals without specific authorization from the Legislature (Minnesota Statutes 144.551). As originally enacted, the law included a few specific exceptions to the moratorium on new hospital capacity; other exceptions have been added over time, and there are currently 18 exceptions to the moratorium that are listed in the statute. Many of these exceptions apply to specific facilities, but some define an exception that applies more broadly (for example, an exception that allows for the relocation of a hospital within five miles of its original site under some circumstances).

The moratorium on licensure of new hospital beds replaced a Certificate of Need (CON) program that provided for case-by-case review and approval of proposals by hospitals and other types of health care providers to undertake large projects such as construction and remodeling or purchases of expensive medical equipment. The CON program was in effect from 1971 until it was replaced by the hospital moratorium in 1984. The CON program was criticized for failing to adequately control growth, but at the same time there was substantial concern among policymakers about allowing the CON program to expire without placing some other type of control on investment in new capacity.

At the time the hospital moratorium was enacted, policymakers were concerned about excess capacity in the state's hospital system, its impact on the financial health of the hospital industry, and its possible impact on overall health care costs. According to a 1986 Minnesota Senate Research Report on the hospital moratorium, "Declining occupancy has resulted in thousands of empty hospital beds across the state, in financial difficulty for some hospitals, and in efforts by hospitals to expand into other types of care. In spite of the excess hospital capacity in the state, hospitals continued to build and expand until a moratorium was imposed...."[1] The moratorium was seen as a more effective means of limiting the expansion of hospital capacity than the Certificate of Need program it replaced. One drawback of the moratorium, however, has been that there is no systematic way of evaluating proposals for exceptions to the moratorium in terms of the need for new capacity or the potential impact of a proposal on existing hospitals.

[1] "Hospital and Nursing Home System Growth: Moratoria, Certificate of Need, and Other Alternatives," Minnesota Senate Research Report, by Dave Giel and Michael Scandrett, January 1986.

2. Hospital Public Interest Review Process

In 2004, the Legislature established a new process for reviewing proposals for exceptions to the hospital moratorium (Minnesota Statutes 144.552). This "public interest review" process requires that hospitals planning to seek an exception to the moratorium law submit a plan to the Minnesota Department of Health (MDH). Under the law, MDH is required to review each plan and issue a finding on whether the plan is in the public interest. Specific factors that MDH is required to consider in the review include:

- Whether the new hospital or hospital beds are needed to provide timely access to care or access to new or improved services;
- The financial impact of the new hospital or hospital beds on existing acute-care hospitals that have emergency departments in the region;
- How the new hospital or hospital beds will affect the ability of existing hospitals in the region to maintain existing staff;
- The extent to which the new hospital or hospital beds will provide services to nonpaying or low-income patients relative to the level of services provided to these groups by existing hospitals in the region; and
- The views of affected parties.

Finally, the law requires that the public interest review be completed within 90 days, but allows for a review time of up to six months in extenuating circumstances. Authority to approve any exception to the hospital moratorium continues to rest with the Legislature.

In November 2004, MDH received three separate filings for public interest review of a proposal to build a new hospital in Maple Grove, Minnesota. North Memorial Health Care and Fairview Health Services each submitted proposals, and a joint proposal from Allina Hospitals and Clinics, Park Nicollet Health Services, and Children's Hospitals and Clinics (collectively, the "Maple Grove North Memorial Partnership") was also submitted. The law that established the public interest review process does not specifically contemplate situations in which more than one proposal for an exception may be submitted for the same geographic area. With regard to the three applications for public interest review that MDH has received for the Maple Grove area, we have reviewed each plan separately according to the criteria established in the law. It is important to note that each of the three proposed projects also involves the construction of large new outpatient facilities that will provide a broad range of services such as primary and specialty care, ambulatory surgery, and diagnostic imaging, with construction beginning as early as 2005; however, Minnesota law does not restrict the ability to construct outpatient facilities in the same way as it does for inpatient facilities, and those portions of the proposed projects are therefore outside of the scope of MDH's public interest review.

Our review of each proposal included several different components. Some of these components, such as soliciting public input, reviewing historical and projected data on population demographics and hospital use, and reviewing previously published research on relevant topics, were overlapping among the three proposals. Other aspects of our review, such as estimating the potential impact of the proposed facility on other hospitals in the region and evaluating each proposal in light of the specific criteria listed in the law, were conducted separately for each proposal.

The remainder of this report is organized as follows:

- Section 3 provides a summary of the comments from the public and other affected parties that we received related to the need for a hospital in Maple Grove;
- Section 4 presents information on trends in the use of hospital services and how the use of hospital services is projected to change as a result of future demographic changes, from a statewide and regional perspective and also for the local hospital market serving residents of the Maple Grove area;
- Section 5 evaluates North Memorial's plan to build a hospital in Maple Grove in light of the criteria for review that are specified in Minnesota Statutes 144.552;
- Section 6 concludes the report with a summary of the analysis and findings, along with other factors that policymakers may wish to consider in evaluating this proposal for an exception to the hospital moratorium.

3. Public Input

We used three strategies to collect input on the views of affected parties. First, we sent a letter to all hospital administrators in Minnesota notifying them of the plans that had been filed and soliciting their input if they wished to provide any. Second, we published a notice in the December 6, 2004 State Register as a general notice to interested parties that we had received three plans and providing an opportunity to comment on the proposals. Third, we held a public meeting in Maple Grove on January 11, 2005 to solicit input from the community on the need for a hospital in Maple Grove and the impact that a hospital in Maple Grove might have on other hospitals in the region. In addition, we posted an electronic copy of each of the filings that we received on MDH's website, in order to provide convenient access to the proposals to anyone who might wish to comment. Copies of written comments that we received about this proposal for an exception to the hospital moratorium are included in Appendix 1.

The public meeting that MDH held in Maple Grove on January 11 was intended to provide a forum for public input to MDH on the general need for a hospital in Maple Grove. An estimated 300 people attended the meeting, and 42 citizens provided comments. Many of the comments shared similar themes, which are summarized below:

- Concerns about health and safety:
    - Citizens are concerned about the distance to the nearest hospital (11 miles to North Memorial in Robbinsdale) and by the amount of time that it takes to travel there due to frequent traffic congestion.
    - Citizens and health care professionals alike believe that the Maple Grove area needs to have more timely access to emergency and trauma services. According to one person, the closest emergency care is "20 to 30 minutes away on a good day" and there is a need for more timely access.
    - Some health care professionals expressed specific public safety concerns about the lack of access to emergency care. They reported that the distance to the nearest emergency room deters some people from seeking emergency care that they really need (or causes them to delay seeking care), and they reported that urgent care centers currently located in Maple Grove are increasingly being used by people who are too sick to be treated there because of the lack of convenient access to a hospital emergency room.
- Shortages of specific services:
    - Several people commented on the need for additional mental health and chemical dependency services, due to a shortage of inpatient beds available to treat these conditions.

- Convenient access to services:
  - Community residents expressed a desire for more convenient access to health care services, particularly obstetric care, pediatric care (including specialty pediatric services), and cancer treatment.
  - Although many of the comments that focused on convenient access to services related to services that are likely to be provided in an outpatient setting, several people expressed a desire that any hospital that is built in Maple Grove should be a "full service" hospital providing a complete range of care without the need for patients to be transferred to other hospitals to receive more complex services.
- Collaboration between health care providers and the community:
  - Several people provided comments that emphasized the need for any organization that builds a hospital in Maple Grove to work collaboratively with the community (schools, churches, etc.) to identify and address community needs.
- Impact on other hospitals in the region:
  - Several community residents, some of whom are employed by North Memorial, expressed concerns about a potential adverse impact on North Memorial if one of the other two proposals were to be approved, about North Memorial's ability to survive as an independent institution, and about potential further consolidation of the hospital market into a market controlled by one or two large hospital systems.

4. Trends in the Use of Inpatient Hospital Services and Projected Impact of Future Demographic Change

State and Regional Trends

As noted above, one of the reasons for the original enactment of the hospital moratorium was that there was perceived to be a significant amount of excess capacity in Minnesota's hospital system. Since the moratorium was enacted, occupancy rates for Minnesota's hospital system as a whole have continued to be relatively low in comparison to licensed capacity. For example, in 2003 the system as a whole had an occupancy rate of about 42 percent of licensed beds; however, there is substantial variation in occupancy rates among different regions of the state – in 2003, occupancy rates ranged from a low of 28 percent in the South Central region to a high of 48 percent in the Twin Cities Metropolitan region (see map for region definitions).

Regional Definitions

In some ways, however, analyzing occupancy rates based on licensed beds can be misleading because many hospitals (particularly in the Twin Cities Metropolitan and Southeast regions) have large numbers of beds that are licensed but are unused. In some cases, these licensed beds may not even be able to be used within a facility's current physical capacity (i.e., a facility would have to undertake a major construction project in order to make use of these licensed beds). As a result, counting all of these licensed hospital beds when calculating occupancy rates is likely to overstate

the true capacity of Minnesota's hospital system. When occupancy rates are calculated based on "available beds",[2] the statewide hospital occupancy rate was 59 percent in 2003, ranging from a low of 28 percent in the Southwest region to a high of 71 percent in the Twin Cities Metropolitan region.

Because of advances in technology (e.g., the ability to do many procedures on an outpatient basis that formerly would have required a hospital stay), changes in standards of care, changes in health insurance payment systems, and other factors, use of inpatient hospital services in Minnesota (both admissions and total number of inpatient days) declined through the mid-1990s despite population growth. As shown in Table 1, even though Minnesota's population grew by about 20 percent from 1987 to 2003, the number of hospital admissions grew more slowly over the same period (14 percent) and the number of inpatient hospital days actually declined by 16 percent.

Table 1

Historical Trends in Use of Inpatient Hospital Services

	Percent change in:		
	Inpatient Admissions	Inpatient Days	Minnesota Population
1987 to 1994	-6.5%	-20.2%	8.9%
1994 to 1998	7.9%	-1.6%	4.4%
1998 to 2003	13.4%	7.1%	5.2%
1987 to 2003	14.4%	-15.9%	19.6%

Source: MDH, Hospital Cost Containment Information System, 1987 to 2003. 1987 was the first year of data collection.

There are several factors that are likely to influence future use of hospital services. Population growth will continue to play an important role, and aging will begin to be a more important factor as the baby boom generation reaches the age at which use of hospital services begins to increase sharply. In addition, technological advance will continue to be a very important determinant of future use of hospital services, with some new technologies likely increasing the use of inpatient services and others decreasing the use of services. Changes in the prevalence of disease (for example, due to rising rates of overweight and obesity) are also likely to play a role.

According to MDH estimates, population growth and the changing age distribution of the population are expected to result in an overall 36 percent increase in inpatient hospital days statewide between 2000 and 2020. As shown in Figure 1, this estimated increase varies by region: growth in the Central and Metropolitan regions is expected to be strongest, with growth in inpatient days of 53 percent and 40 percent, respectively. As a result, if the number of available beds were unchanged, occupancy rates would rise as well. The highest projected occupancy rates in

[2] The definition of "available beds" is the number of acute care beds that are immediately available for use or could be brought on line within a short period of time.

2020 are for the Metropolitan region (94 percent), Southeast region (85 percent) and Central region (76 percent), compared to a statewide average of 77 percent (see Figure 2). If occupancy rate calculations are performed using the number of hospital beds licensed in 2003 instead of available beds, the estimated future occupancy rates are much lower – 63 percent in the Metropolitan region, 53 percent in the Southeast region, 64 percent in the Central region, and 55 percent statewide.

Figure 1

Projected Growth in Inpatient Days by Region, 2000 to 2020

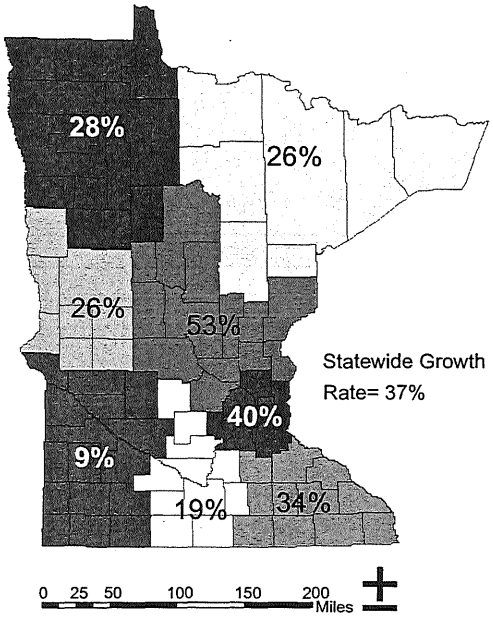
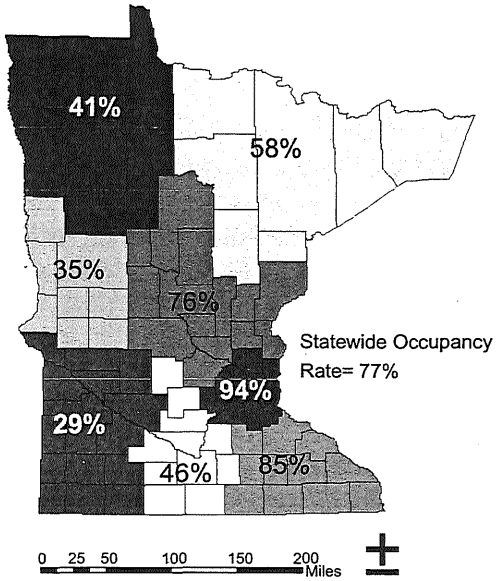


Figure 2

Projected Occupancy Rates as % of 2003 Available Beds by Region, 2020



In other words, there is clearly no shortage of licensed hospital beds in the state as a whole, nor is a shortage likely to materialize in the next fifteen years. However, the fact that the aggregate number of licensed beds in the state appears to be sufficient over this time period does not necessarily mean that there is no need for new physical hospital capacity, particularly in certain areas of the state experiencing rapid growth. There are several reasons why this may be the case:

- First, as noted earlier, occupancy rates vary widely across the state. Based on the number of currently available beds, occupancy rates projected for 2020 in the Metropolitan region (94 percent) and Southeast region (85 percent) are very high. The degree to which hospitals in these regions may be able to expand the number of available beds to meet future demand without undertaking major construction projects to increase physical capacity is uncertain. (This issue is discussed more specifically with regard to the Maple Grove area below.)

- In addition, average occupancy rates measured over a full-year period do not capture variations in occupancy rates that occur during the year. This consideration is important because even though a hospital's annual occupancy rate may not seem high enough to create concerns about whether capacity is sufficient, there are likely a number of times during the year when the hospital's occupancy rate is substantially higher than the average experienced over the entire year. As a result, using occupancy rates that measure capacity use over a full-year period may understate the degree to which the hospital system may be operating at or near capacity constraints at certain times.

It should also be noted that hospitals' ability to make full use of their licensed beds within existing facilities is limited by the relatively recent shift in the hospital market (both in Minnesota and nationally) toward private instead of semi-private hospital rooms. Consumer preferences have played an important role in many hospitals' business decisions to convert semi-private to private rooms, as well as concerns about patient safety and compliance with patient privacy laws.[3]

While Minnesota's hospitals likely have the ability to expand the number of available beds to some degree at existing facilities to meet projected future demand, it may also be the case that future demand in high-growth areas cannot be met without some major construction projects, either the construction of new hospitals or the expansion of existing facilities. If it is likely that some type of major construction project will be necessary to meet future needs, then the question before legislators as they consider granting an exception to the hospital moratorium becomes more a question not of whether new hospital capacity is needed, but where the new capacity should be located.

Trends in the Maple Grove Area

The Maple Grove area is experiencing rapid population growth. Although each of the proposals for an exception to the hospital moratorium in Maple Grove defines the area somewhat differently, population growth is projected to be much faster than the statewide average regardless of the specific geographic definition chosen. The Maple Grove area is expected to grow approximately 3 to 4 times faster than the projected statewide growth rates of 4.7 percent from 2003 to 2009 and 5.0 percent from 2009 to 2015.

The plans submitted to MDH by the hospitals seeking an exception to the moratorium identify several hospitals that currently serve significant numbers of residents of the Maple Grove area. Figure 3 shows the locations of each of the eleven hospitals that currently serve most residents of the Maple Grove area. Key utilization and financial indicators for these hospitals in 2003 (the most recent year of data that is available) are listed in Table 2. Recent trends in admissions, the total number of inpatient days, and occupancy rates are described in Table 3. For these eleven hospitals as a group, the occupancy rate as a percentage of available beds increased from 69 percent in 1999 to 74 percent in 2003.

[3] Michael Romano, "Going Solo: Private-Rooms-Only Provision for New Hospital Construction Stirs Controversy," Modern Healthcare, November 29, 2004.

Figure 3

Hospitals Serving the Maple Grove Area

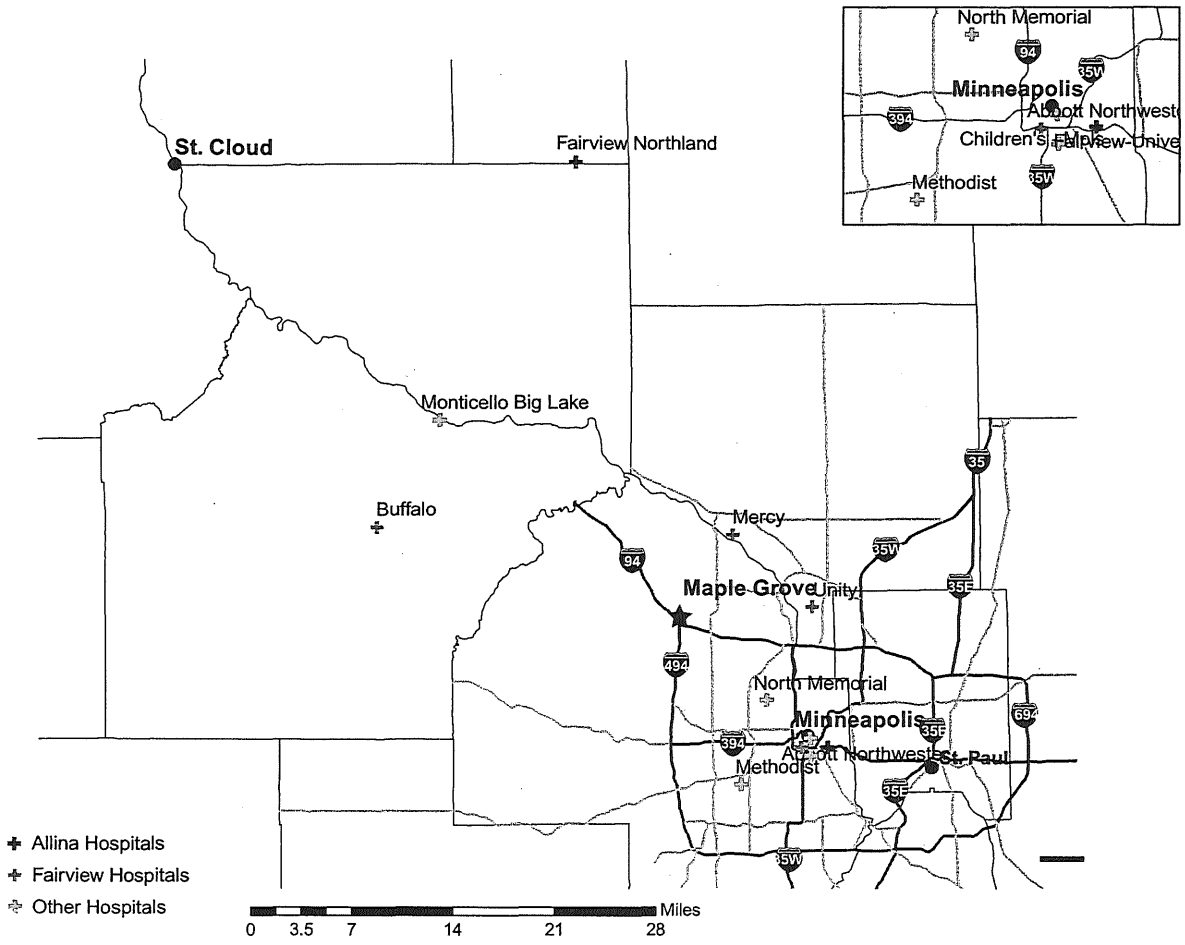


Table 2

Hospitals Serving Maple Grove Area Patients: Capacity and Financial Indicators for 2003

	Distance from Maple Grove	Licensed Beds	Available Beds	Occupancy Rate (as % of Available Beds)	Net Income ($ millions)	Net Income as % of Revenue	Uncompensated Care* ($ millions)	Uncompensated Care as % of Operating Expenses
Abbott Northwestern Hospital	20 miles	926	627	75.5%	$44.1	7.5%	$6.0	1.1%
Buffalo Hospital	32 miles	65	34	59.7%	$2.9	8.8%	$0.7	2.4%
Children's Hospitals and Clinics, Minneapolis	19 miles	153	153	84.6%	$12.1	5.9%	$1.8	0.9%
Fairview Northland Regional Hospital	35 miles	41	41	51.4%	($2.2)	-3.6%	$1.5	2.3%
Fairview-University Medical Center	20 miles	1,700	729	69.6%	$39.5	5.7%	$3.8	0.6%
Hennepin County Medical Center	19 miles	910	422	71.3%	($7.2)	-1.8%	$21.8	5.3%
Mercy Hospital	11 miles	271	212	78.6%	$15.3	6.8%	$3.4	1.6%
Methodist Hospital Park Nicollet Health Services	17 miles	426	370	71.3%	$17.5	5.3%	$2.3	0.7%
Monticello-Big Lake Hospital	22 miles	39	18	57.1%	$1.2	5.4%	$1.0	3.9%
North Memorial Medical Center	11 miles	518	432	74.0%	$23.6	7.8%	$3.3	1.0%
Unity Hospital	14 miles	275	211	66.1%	$1.7	1.1%	$3.0	2.0%
Statewide average				59.4%		5.3%		1.6%

*Uncompensated care is adjusted by a ratio of hospital costs to charges.
Source: MDH, Health Care Cost Information System.
Distance from Maple Grove is measured as the driving distance from the Maple Grove Community Center, according to MapQuest.

Table 3

Trends for Maple Grove Area Hospitals

	1999	2000	2001	2002	2003
Total available beds			3,260	3,158	3,249
Inpatient admissions	176,550	180,772	185,029	190,882	190,475
Inpatient days	822,799	849,862	854,346	857,519	858,746
Occupancy rate*	69.1%	71.4%	71.8%	74.4%	72.4%

*calculated based on available beds. For 1999 and 2000, calculation is based on 2001 available beds (data were not collected in 1999 and 2000).
Source: MDH, Health Care Cost Information System.

Projections for Hospitals Currently Serving the Maple Grove Area

Each of the three plans that were submitted to MDH for a public interest review contained an analysis of the ability of the Maple Grove area to sustain a hospital. While the question of whether the community can support a hospital is important, it is a different question from whether there is a need for a new hospital in the community. The legislation that established the public interest review process directs MDH to evaluate proposals for exceptions to the hospital moratorium based on the question of the need for the proposed facility, not whether the community can support a new facility.

As the starting point for MDH's analysis of the Maple Grove area, we analyzed the need for a new hospital from the perspective of the hospital system as a whole. Our analysis began with an estimate of what will happen to occupancy rates at hospitals that currently serve the majority of patients living in the Maple Grove area in the absence of a new hospital being built in Maple Grove. These "baseline" estimates incorporate projected changes in population and demographics in the market areas served by these hospitals. The baseline estimates also incorporate a range of assumptions about future hospital use rates, due to the inherent uncertainty in projecting changes in use of services due to factors like technological change.[4] This set of estimates formed the starting point for our analysis, and was the same for each of the three plans submitted to MDH for public interest review.

The overall results from this baseline analysis are presented in Table 4. As shown in the table, the occupancy rate for the eleven hospitals included in this analysis was 74 percent of available beds in 2003.[5] The occupancy rate is projected to increase to 79.4 percent in 2009, and 85.5 percent in 2015 (assuming no increase in available beds). It is important to note that this increasing strain on hospital capacity affects more than just residents of the Maple Grove area. Because the eleven

[4] More detail on the methodology we used to create the baseline estimates is included in Appendix 2. This discussion of the results of our analysis does not identify individual hospitals because the data we used to perform the analysis were collected under MDH's authority provided by Minnesota Statutes 62J.301, and Minnesota Statutes 62J.321 Subd. 5(e) prohibits the release of analysis that names any institution without a 21-day period for review and comment.

[5] This figure differs from Table 3 because it uses a different data source.

hospitals included in our analysis account for about one-third of total hospital admissions in Minnesota, the issue of rising occupancy rates is an issue that will likely have a much broader impact.

Table 4

Projections for Hospitals Serving Maple Grove Residents

	2003 Actual	2009 Projected	2015 Projected
Number of discharges	193,402	207,828 Range: 187,045 to 228,610	224,267 Range: 201,840 to 246,304
Number of inpatient days	877,448	943,712 Range: 849,341 to 1,038,084	1,016,040 Range: 914,436 to 1,115,288
Occupancy rate: 2003 available beds	74.0%	79.4% Range: 71.5% to 87.4%	85.5% Range: 77.0% to 93.9%
Occupancy rate: as % of maximum physical capacity		69.6% Range: 62.7% to 76.6	75.0% Range: 67.5% to 82.3%

Source: MDH Health Economics Program. Data sources include Minnesota hospital discharge database, Health Care Cost Information System (HCCIS), and population projections from Claritas, Inc.

As part of the public interest review process, we also conducted an informal survey of hospitals that currently serve patients living in the Maple Grove area to find out whether those hospitals have the physical capacity to expand the number of available beds at their current locations to meet expected growth in demand. We asked these hospitals about the maximum number of beds that they could operate on a permanent basis without undergoing major construction.[6] While there may be issues with the quality of this self-reported data, based on the results of that informal survey, if each of the eleven hospitals increased its number of available beds to the maximum level that would be feasible with its current physical capacity, the projected occupancy rates for 2009 and 2015 are 69.6 percent and 75.0 percent, respectively. One important thing to note about this analysis, however, is that the hospitals that currently serve the largest numbers of Maple Grove area residents did not report much ability to expand the number of available beds without a major construction project; the only hospital that reported having the ability to make a large number of additional beds available without a major construction project is one of the hospitals that is most distant from Maple Grove, and currently serves a small share of the Maple Grove market.

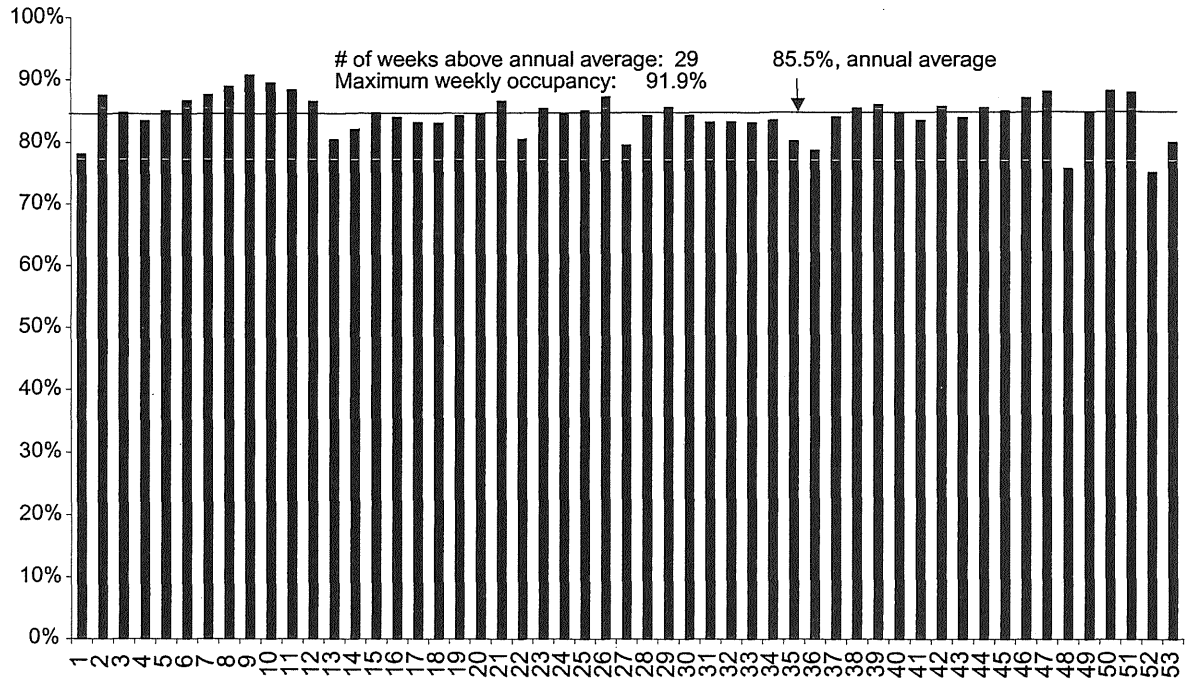
At certain times during the year the occupancy rate for the group of eleven hospitals currently serving most Maple Grove residents is expected to be substantially higher than the average occupancy rate over the entire year. In 2009, the highest projected weekly occupancy rate for the eleven hospitals as a group is 85.4 percent; in 2015, the peak weekly occupancy rate is projected to

6 We asked the hospitals to answer this question within the context of their current business plan – for example, if their business plan calls for all private rooms and they would not consider converting rooms to semi-private rooms in order to serve a larger number of patients, then they would report their maximum physical capacity based on a configuration of all private rooms.

be 91.9 percent for the group of hospitals currently serving residents of the Maple Grove area. Figure 4 provides an illustration of the variation in projected occupancy rates at different times of the year for the group of eleven existing hospitals that serve residents of the Maple Grove area.

Figure 4

2015 Weekly Projected Occupancy Rates for Hospitals Serving Residents of the Maple Grove Area



Occupancy rates calculated based on available beds.

One key question that arises from this analysis is at what point should a hospital's (or group of hospitals') occupancy rate be considered "too high"? Unlike some other industries, which strive to operate at or near full capacity, hospitals are different. Because the level of demand at any given time is somewhat unpredictable, hospitals generally attempt to operate at a level below full capacity in order to be able to meet unexpected surges in the need for services. In addition, operating at a level too close to full capacity can lead to costly inefficiencies, such as delays in the ability to admit new patients or transfer patients between units.

One approach to answering the question of the "right" occupancy rate would be to define a specific benchmark level above which the occupancy rate is considered too high. Alternatively, one could define a specific number of hospital beds that is needed given an area's population. Both of these approaches have been used extensively in the past, particularly under Certificate of Need regulatory structures. However, more recent analysis of this question has pointed out that the question of

what an appropriate occupancy rate should be requires a much more complex approach than identifying a single number that applies to all hospitals, but instead depends on both hospital size and the number and size of distinct units within the hospital.[7] There is no agreed-upon standard for occupancy rates or threshold for when an occupancy rate should be considered too high in either hospital industry trade publications or peer-reviewed academic research publications. Industry experts that we spoke to indicated that 70 to 80 percent occupancy is an appropriate range, and that costly inefficiencies may occur at occupancy levels above 85 percent.

Analysis of Specific Proposals

After projecting what occupancy rates at hospitals serving patients from the Maple Grove area would be in the absence of a new hospital, the next step in our analysis was to estimate the impact of a new facility in Maple Grove on admissions, inpatient days, and occupancy rates at these hospitals. Since each of the three proposals to build a hospital in Maple Grove is unique, this analysis was performed separately for each proposal and the results are presented below in the discussion of the specific proposal as it relates to each of the criteria specified in the law.

Importantly, the analysis of each proposal is specific to the service area that was defined by the applicant as the proposed primary service area. The three proposed service areas range in size from 10 to 22 zip codes. For a variety of reasons, such as variation in existing physician affiliations and referral patterns, we believe it is possible that the proposed Maple Grove hospital's service area (the geographic area from which it draws most of its patients) may vary depending on which, if any, of the three proposals is approved by the Legislature. The "true" service area for any new hospital can only be observed after the fact; as a result, it is likely that all of the applicants' proposed service areas are different from what the service area for a hospital built in Maple Grove would eventually be. In this case, there is an especially high degree of uncertainty about the proposed hospital's service area due to the likelihood that as many as three large new ambulatory care centers may be built in the community, which we would expect to have an impact on patterns of hospital referrals. For these reasons, MDH did not attempt to independently define a service area for the proposed Maple Grove hospital.

We used a similar approach to analyze the impact on hospitals currently serving patients from the Maple Grove area in terms of the potential financial impact on these hospitals, including the potential impact on their ability to provide services to nonpaying or low-income patients. These results are also included below in the discussion of how the proposal relates to each of the evaluation criteria in the law.

[7] See, for example, Linda V. Green, "How Many Hospital Beds?" Inquiry v. 39, Winter 2002/2003.

5. Review of North Memorial Health Care's Proposal for an Exception to the Hospital Moratorium

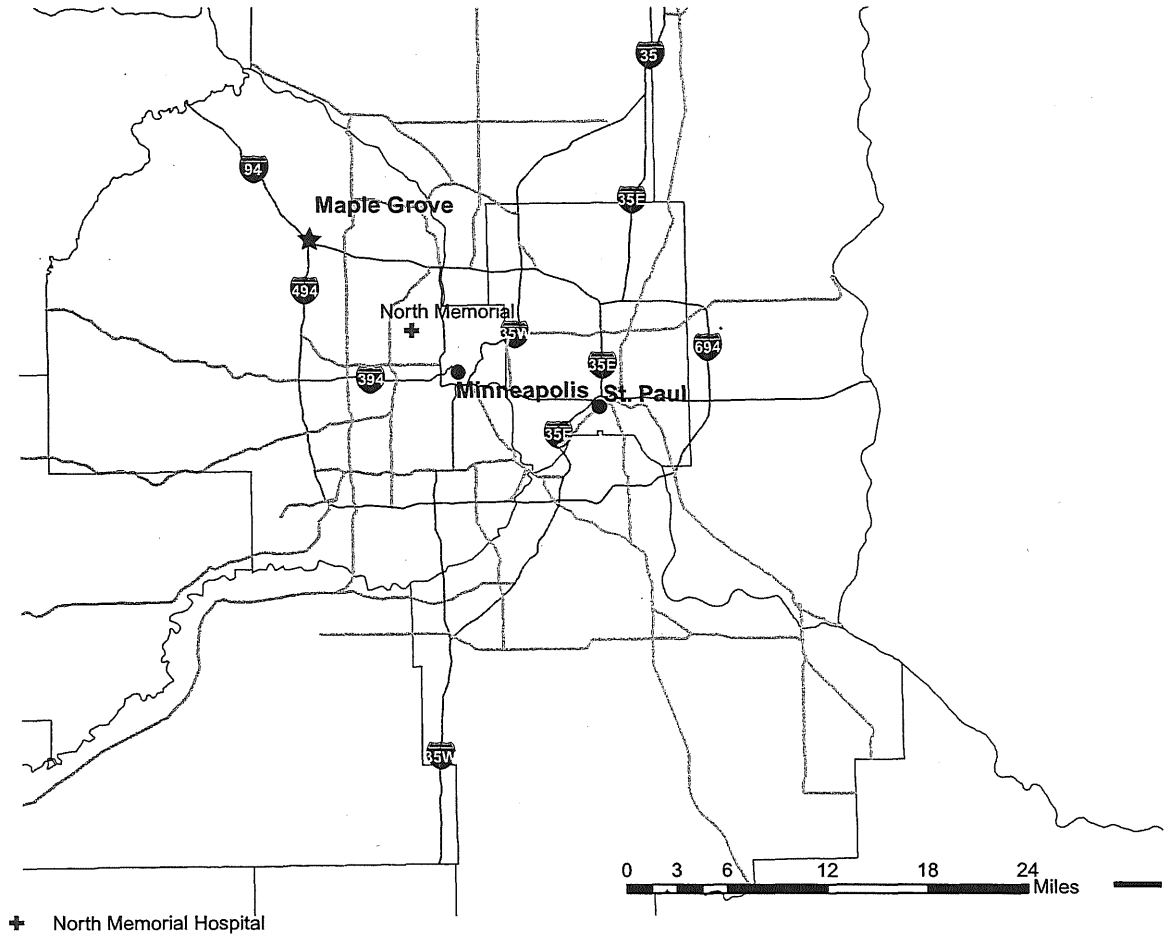
This section describes North Memorial Health Care's (NMHC's) proposal for an exception to the hospital moratorium in order to build a new hospital in Maple Grove. Following a brief description of the proposed project, we evaluate NMHC's proposal in light of each of the five factors specified in the statute that established the public interest review process.

Background and Project Description

NMHC is an independent non-profit hospital located in Robbinsdale. Currently, NMHC is licensed for 518 beds, of which 438 are considered "available beds" (beds that are immediately available for use or could be brought online within a short period of time). NMHC is one of three hospitals in Minnesota that have been designated as Level I trauma centers by the American College of Surgeons. Figure 5 shows the location of NMHC in comparison to Maple Grove.

Figure 5

North Memorial Health Care



In the spring of 2005, NMHC will open a new 80-bed heart and stroke center at its Robbinsdale facility. At the same time, NMHC will close other beds for remodeling and conversion to private rooms. The net result of these changes is expected to be no change in the number of available beds. If NMHC's proposal for a Maple Grove hospital is approved, NMHC proposes to transfer 80 staffed beds from its Robbinsdale campus, resulting in no net increase in the number of available beds.

NMHC proposes the phased construction of a health care campus in Maple Grove, which would include an acute care hospital with Level III emergency services[8] primary and specialty physician clinics, outpatient surgical suites, and urgent care facilities. As noted earlier, Minnesota law does not restrict the ability of a health care provider to construct outpatient facilities, and the outpatient

[8] See Appendix 3 for a description of the differences between Level I, II, III and IV emergency services as defined by the American College of Surgeons.

portion of NMHC's proposed Maple Grove campus is outside of the scope of the public interest review process established under Minnesota Statutes 144.552. In order to proceed with the inpatient hospital portion of the project, NMHC is seeking an exception to the hospital construction moratorium.

The proposed exception would allow the transfer of 80 licensed beds, currently assigned to NMHC's Robbinsdale facility, to a newly constructed acute care hospital in Maple Grove. The estimated cost of the proposed health care campus is $117 million—$59 million for the medical office building and ambulatory center (Phase I of the project, planned to open in 2006) and $58 million for the 80-bed acute care hospital (Phase II, proposed to open in 2008 pending legislative approval). NMHC has also proposed the expansion of the 80-bed hospital to as many as 260 beds by 2013 (Phase III) if the need for an expansion is sufficiently demonstrated. NMHC has stated that it would seek all necessary legislative approval for an increase in the hospital's licensed beds at that time.

According to the information in the plan submitted by NMHC to the Minnesota Department of Health, NMHC's proposed 80-bed acute care hospital would offer the following services:

- Inpatient services:
    - Cardiology
    - General medical/surgical
    - Obstetrics/gynecology
    - Level II nursery
    - Oncology
    - Orthopedics
    - Pediatrics
    - Psychiatry
    - Special care units
- Inpatient surgical suites
- Level III trauma center
    - Linked to North Memorial Health Care's Level I trauma center
    - Air and ground ambulance service
    - Emergency services
    - Expanded ambulance garage (NMHC already has ambulances in Maple Grove)
    - Heliport

- Cardiopulmonary services
    - Catheterization/electrophysiology labs
    - Stress testing
    - Echocardiography
    - Holter monitoring
    - Electrocardiogram
    - Respiratory therapy
    - Pulmonary diagnostics
    - Cardiac rehabilitation
- Neurology services
    - Evoke potential
    - Electroencephalography
    - Stroke clinic
- Oncology services
    - Outpatient clinic
    - Chemotherapy/infusion therapy
    - Possible radiation therapy
- Medical imaging
    - General radiology
    - Bone densitometry
    - Fluoroscopy
    - Nuclear medicine
    - Mammography
    - Computed tomography (CT)
    - Magnetic resonance imaging (MRI)
    - Interventional radiology
    - Positron emission tomography (PET) - possible
- Dialysis services
- Inpatient laboratory
- Pharmacy
- Rehabilitation services
    - Physical therapy
    - Occupational therapy
    - Speech pathology
- Community education

NMHC's proposed breakdown of inpatient beds by service category is shown in Table 5.

Table 5

NMHC's Proposed Breakdown of Inpatient Beds by Service Category

Cardiology	9
Ear, nose, throat	1
General medicine	21
General surgery	9
Gynecology	2
Neurology	5
Newborns	6
Obstetrics	7
Oncology	4
Orthopedics	8
Psychiatry	4
Urology	3
Total	79

Source: NMHC submission to MDH dated December 2, 2004.

NMHC's proposed health care campus would be built on 30 acres of a proposed 157-acre development at the intersection of I-94 and the proposed extension of Highway 610. Currently, there are no ramps that connect the site to I-94, and current plans do not call for the extension of Highway 610 for at least several years. However, there are many advocates of beginning the extension of Highway 610 earlier than is currently planned, if funding can be obtained.

Primary Service Area

NMHC expects the primary service area (PSA) of its proposed Maple Grove hospital to span 20 zip codes and cover portions of Hennepin, Sherburne, Wright, and Anoka counties. Communities in the proposed PSA include Albertville, Maple Grove, Champlin, Dayton, Elk River, Medina, Hamel, Corcoran, Hanover, Loretto, Osseo, Rockford, Rogers, St. Michael, New Hope, Plymouth, Brooklyn Park, Crystal, and Fridley.

The population in NMHC's proposed service area is projected to increase by 13.3 percent between 2003 and 2009, and by an additional 13.3 percent from 2009 to 2015; these growth rates are substantially higher than the projected statewide population growth of 4.7 percent between 2003 and 2009 and 5.0 percent between 2009 and 2015.[9] In addition to rapid population growth in the proposed service area, the most rapid projected population growth is among the population aged 55 years or older; while this is also true for the state as a whole, growth among this population is

[9] Population projections for 2009 are from Claritas, Inc.; projections for 2015 were developed by MDH assuming the same annual growth rate from 2009 to 2015 as projected by Claritas for 2004 to 2009.

expected to be much faster in the service area defined by NMHC compared to statewide growth (28.1 percent from 2003 to 2009 compared to 13.5 percent statewide). This combination of rapid population growth and an aging population is expected to increase the demand for hospital services by residents of this area. Based on MDH's analysis, the number of hospitalizations of residents of this area is expected to increase by 17.1 percent from 2003 to 2009, and by an additional 17.4 percent from 2009 to 2015.

Factor 1: Whether the new hospital or hospital beds are needed to provide timely access to care or access to new or improved services

In order to assess the impact of all three proposals for a Maple Grove hospital that MDH received in terms of whether the hospital is needed to provide timely access to care, we analyzed the impact of each of the proposals on future occupancy rates at existing hospitals that serve residents of the Maple Grove area. We also looked at how the proposals addressed specific service areas such as mental health, obstetrics, and emergency services that were identified by community members as areas of need for additional services.

Capacity of Existing Facilities

Residents of the Maple Grove area were hospitalized in many hospitals throughout the state during 2003, but eleven metro area hospitals provided the bulk of inpatient acute care to residents during that year. These facilities are also dependent, to varying degrees, upon this area for an ongoing proportion of their inpatient volume. The eleven hospitals are North Memorial, Mercy, Methodist, Abbott Northwestern, Buffalo, Monticello-Big Lake, Hennepin County, Fairview-University, Minneapolis Children's, Unity, and Fairview Northland.

As noted earlier, MDH analysis projects that in the absence of any new hospital capacity being built, occupancy rates at the group of 11 hospitals that currently serve most residents of Maple Grove and the surrounding communities are projected to increase from 74.0 percent in 2003 to 79.4 percent and 85.5 percent in 2009 and 2015, respectively. In 2009, six of the eleven hospitals are projected to have occupancy rates above 75 percent; by 2015, ten of the eleven will have occupancy rates above 75 percent and four will exceed 90 percent. As discussed earlier, the usefulness of annual occupancy rates as a measure of the degree to which existing capacity is strained is limited, but it can still be useful as a rough guide.

If NMHC's proposal for an exception to the moratorium is approved, NMHC plans to convert semi-private rooms at its Robbinsdale facility to private rooms and to transfer 80 beds to the proposed Maple Grove facility, with no net increase in the number of available beds in the hospital system. Because the total number of available beds will not increase, the occupancy rate for existing Maple Grove area hospitals is not projected to change significantly under this proposal. Because NMHC would be transferring bed capacity at its Robbinsdale campus, the occupancy rate calculated for the group of eleven existing hospitals would rise slightly due to the reduction in total available capacity at existing hospitals. For the eleven existing hospitals as a group, the projected occupancy rate would rise to 79.7 percent in 2009 and 86.0 percent in 2015.

Some hospitals that currently serve Maple Grove area residents would experience larger impact than others as a result of the NMHC proposal. Hospitals that currently serve the largest shares of patients from the service area that NMHC anticipates for the Maple Grove hospital would likely experience the largest impact. At hospitals other than NMHC that currently serve large numbers of Maple Grove area patients, the impact of NMHC's proposal on occupancy rates ranges from a decline of 0.5 percentage points to 2.9 percentage points in 2009 compared to the projection with no new hospital; for 2015, the decline in occupancy rates ranges from 0.5 percentage points to 2.9 percentage points compared to no new hospital being built.

Distance and Time to Existing Facilities

Because it does not add new available beds to the hospital system, one of the main impacts of NMHC's proposal would be to improve the timeliness of access to inpatient hospital services for residents of the Maple Grove area. As noted earlier, concerns about distance and travel time to a hospital are key issues that were mentioned many times at the public meeting in Maple Grove on January 11, 2005.

In addition, a recurring theme expressed by numerous Maple Grove residents at the MDH public hearing January 11, 2005 was a concern about family and children's safety, given the driving distance to the nearest Level I trauma center at North Memorial, traffic congestion, and the number of traffic lights encountered en route. North Memorial Medical Center and Hennepin County Medical Center are the only American College of Surgeons verified Level I Trauma Centers in Hennepin County. Driving times can vary substantially depending upon the route taken, time of day, weather and traffic conditions. Helicopter transport with advanced life support is available in the area for the most critical medical emergencies.

According to information submitted by NMHC in its application, from the intersection of Highway 30 and Interstate 94, travel time to NMHC is shorter than to any other hospital regardless of the time of day. Depending on the time of day, however, the travel time to NMHC ranged from 14 to 39 minutes; in comparison, travel times to Mercy Hospital and Methodist Hospital ranged from 20 to 44 minutes and 20 to 52 minutes, respectively. According to data from North Memorial Ambulance Service, the average ambulance transport time (averaged across all points of origin in the proposed service area) to NMHC in 2003 was 16 minutes, with a range of 8 to 34 minutes. In some cases, EMS transport times may be extended if an emergency department is diverting ambulances to other facilities. EMS diversions may occur if emergency department beds or other beds are full at a hospital, a staff shortage exists, or on-call specialist physicians are unavailable.

Although a reduction in travel time will mean quicker access to hospital care for Maple Grove area residents, it is unclear to what degree having more timely access will improve health outcomes. At the public meeting in Maple Grove, we heard anecdotal stories of people who delay seeking emergency treatment due to the distance from a hospital emergency room, or people who inappropriately use urgent care clinics when they really need to go to a hospital emergency room. As part of the public interest review process, MDH conducted a review of published research on

the impact that distance and/or travel time to a hospital have on health outcomes. There is not a large amount of published research on this topic, but some researchers have found evidence that increased distance to the nearest hospital is associated with higher mortality from emergent conditions such as heart attacks and unintentional injuries.[10] However, other factors not related to distance or time, such as short Emergency Medical Service (EMS) response times and sophisticated on-scene medical interventions can also improve survival and, in some time-sensitive conditions such as heart attack, stroke, and certain traumas, sustain longer advanced life support transport distances and times. So, while distance to a hospital ER may be a factor for consideration, a well-functioning and timely EMS system also plays a critical role in ensuring patient outcomes.

Access to Specific Services: Mental Health, Obstetrics, and Emergency Services

At the public meeting on January 11, 2005, residents of the Maple Grove area expressed concerns about access to three specific types of hospital services: mental health, obstetrics, and emergency services. Several community residents stated that there was a shortage of inpatient mental health services; for obstetrics and emergency/trauma services, convenience and a desire for more timely access were the main concerns.

With regard to inpatient mental health services, MDH analysis shows that about 93.5 percent of all hospitalizations of residents of the Maple Grove area (as defined by NMHC) occur at one of the eleven hospitals that we identified as serving a significant number of Maple Grove area residents. For psychiatry and chemical dependency services, however, when residents of the Maple Grove area are hospitalized they are much more likely to be hospitalized at a facility other than one of the eleven hospitals that serve most of this market (13.6 percent and 10.1 percent of the time for psychiatric and chemical dependency services, respectively). In other words, residents of the Maple Grove area who need to be hospitalized for psychiatric care or chemical dependency are much more likely to leave their local hospital market to receive care than residents who are hospitalized for other reasons. This is consistent with a statewide pattern that individuals who are hospitalized for psychiatric or chemical dependency services are less likely to be hospitalized in their local area than they would be for other services.[11] NMHC's proposal for a Maple Grove hospital includes 4 psychiatric beds.

An additional area of concern for Maple Grove area residents was timely access to obstetric services. Because the population in this area is younger on average than the state as a whole, obstetric admissions represent a higher share of total inpatient admissions from the Maple Grove area than for the state as a whole. In 2003, about 21 percent of hospital admissions from the service area defined by NMHC were for obstetric services, compared to 16 percent statewide. The Maple Grove hospital proposed by NMHC would include 7 obstetric beds.

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[10] Thomas C. Buchmueller, Mireille Jacobson, and Cheryl Wold, "How Far to the Hospital? The Effect of Hospital Closures on Access to Care," National Bureau of Economic Research Working Paper No. 10700, August 2004.

[11] Minnesota Department of Health, Health Economics Program, "Minnesota Mental Health and Chemical Dependency Treatment Utilization Trends: 1998 – 2002," Issue Brief 2004-07, November 2004.

Finally, Maple Grove area residents have expressed concerns about timely access to emergency and trauma services. As noted above, there is not much clear evidence about how closer access to an emergency room will affect health outcomes. It should be noted, however, that the emergency services proposed by NMHC would meet the American College of Surgeons criteria for designation as a level III trauma center, which means that the hospital would provide "prompt assessment, resuscitation, emergency surgery, and stabilization" and that more complicated cases would be transferred to other hospitals.

In summary, NMHC's proposed Maple Grove hospital does include the mental health, obstetric, and emergency services mentioned as being of most concern to community residents. The proposed hospital would not offer new or improved services that are not already available at other hospitals nearby.

Factor 2: The financial impact of the new hospital or hospital beds on existing acute-care hospitals that have emergency departments in the region

For a number of reasons, there is a high degree of uncertainty involved in predicting the financial impact of any of the three proposals to build a Maple Grove hospital on existing hospitals that currently serve residents of the Maple Grove area. The potential for three large new ambulatory care centers in Maple Grove providing a wide range of specialty care services would almost certainly have a significant impact on which hospitals residents of the Maple Grove area are referred to by their physicians for inpatient services. The combination of this change (which may occur even if the Legislature does not approve any exceptions to the hospital moratorium) with the addition of a new hospital makes it especially difficult to predict the impact on existing hospitals.

In addition, although MDH has access to hospital discharge data that allowed us to analyze and project hospital discharges, inpatient days, and occupancy rates, we do not have any data that allows us to translate the impact of a new hospital on the volume of services provided into an estimate of the specific financial impact of a new hospital on existing hospitals in the region. If a hospital loses patients that it would have served in the absence of the new hospital being built, it not only loses revenue but also avoids costs (such as staffing and supplies) that it would have otherwise incurred. Because we do not have information available to us that allows us to calculate the net financial impact of the proposed hospital on other existing hospitals in the region, in this section we focus instead on changes in the volume of business and occupancy rates.

In the service area defined by NMHC for the proposed Maple Grove hospital, the largest market share is currently held by NMHC's Robbinsdale facility. In 2003, more than 30 percent of the discharges from this area were from NMHC, and patients from this service area represented more than 30 percent of NMHC's total discharges. Other hospitals identified in the plan that NMHC submitted for review as having a substantial share of the market in this service area are Mercy Hospital, Methodist Park Nicollet Health Services, Unity Hospital, Abbott Northwestern Hospital, and Fairview-University Medical Center. As noted earlier, NMHC's proposed Maple Grove facility

does not add new capacity to the hospital system. However, the construction of a new hospital in Maple Grove by NMHC would likely result in some shift of patients away from the other ten hospitals that currently serve patients from the Maple Grove area.

There are two ways of looking at the financial impact of a new hospital on existing hospitals: first, in relation to a hospital's current business; and second, in relation to what would have occurred in the absence of the new hospital. The impact of NMHC's proposal on existing hospitals in the Maple Grove area varies by hospital, with hospitals that currently serve a large share of the Maple Grove market likely to experience the biggest impact. This is illustrated by the projections described above that compare projected occupancy rates at each of the eleven hospitals to the occupancy rates that would be projected in the absence of a new hospital. However, when comparing the impact of NMHC's proposal in relation to the current patient volume and occupancy rates at existing hospitals, all eleven of the existing hospitals that currently serve patients from the Maple Grove area are projected to experience increases in the total number of inpatient days in 2009 and 2015 compared to 2003. In many cases, however, the increase in volume is slower than it would have been in the absence of a new hospital.

At the eleven existing area hospitals as a group, the total number of patient days is projected to decline by 2 percent in 2009 and 2015 compared to the baseline projection without a new hospital. At individual hospitals other than NMHC, the percentage decrease in inpatient days ranges from 0.7 percent to 3.2 percent. Similarly, the projected occupancy rates for the eleven existing hospitals as a group would rise from 79.4 percent to 79.7 percent in 2009, and from 85.5 percent to 86.0 percent in 2015 (because of the decline in available capacity planned by NMHC at its Robbinsdale campus). For individual hospitals in this group other than NMHC, the projected change in occupancy rates ranges from a decline of 0.5 to 2.9 percentage points.

There are two additional factors that may be important in analyzing the potential financial impact of NMHC's proposal on existing hospitals that serve patients from the Maple Grove area:

First, the impact is likely to vary by type of service. Because profitability varies by type of service, this is an important consideration. We did not attempt to specifically estimate the impact on existing hospitals by type of service.

Second, there is a high degree of uncertainty about how physician referral patterns may change as a result of the new hospital and the multiple new ambulatory care centers that are currently being proposed. Even if the proposed NMHC hospital does not directly provide highly specialized services (such as open heart surgery), its association with NMHC could have an impact on referrals to other hospitals. Our analysis does not incorporate this possible change, but instead uses the information that we have on current travel patterns of patients from the Maple Grove area. However, it is important to note that the change is a possibility that could have an impact.

Factor 3: How the new hospital or hospital beds will affect the ability of existing hospitals in the region to maintain existing staff

According to NMHC, more than 1,700 (or 25 percent) of its employees live in the proposed Maple Grove hospital's service area; 1,000 NMHC employees live within a five-mile radius of the proposed site. If NMHC's proposal for an exception to the moratorium is approved, NMHC plans to reduce the number of beds at its Robbinsdale facility and transfer staff to its new Maple Grove facility. Because the net result of the NMHC proposal is no change in inpatient hospital capacity, NMHC's proposal likely would have no impact on the ability of other hospitals in the region to maintain their existing staff.

Factor 4: The extent to which the new hospital or hospital beds will provide services to nonpaying or low-income patients relative to the level of services provided to these groups by existing hospitals in the region

In 2003, NMHC was one of the top 10 providers of uncompensated care (or UC, which includes both charity care and bad debt) in Minnesota, but spent less on UC as a percentage of operating expenses than the statewide average (North Memorial Health Care's UC represented 1.0 percent of operating expenses compared with a statewide average of 1.6 percent). In its plan submitted to MDH for review, NMHC makes a commitment to implement the charity care policies in place at its Robbinsdale facility at the proposed Maple Grove facility.

In addition to concerns about the level of UC that will likely be provided by the new hospital, a related concern is whether the new hospital will change the payer mix of existing hospitals in the region that provide relatively large amounts of UC. For example, if a large number of privately insured patients are attracted to the new hospital, this could adversely affect the ability of existing facilities that provide large amounts of UC to continue to serve nonpaying patients. Compared with the state as a whole and with the current service area of NMHC's Robbinsdale facility, the service area proposed by NMHC for the Maple Grove hospital has a higher share of residents with private group insurance and a lower share of residents with public coverage, as shown in Table 6. The uninsurance rates for both NMHC's current service area and the proposed Maple Grove service area are not statistically different from each other, or from the state average (although the rates are directionally lower than the statewide average, the difference is within the survey's margin of error). In spite of what may be a somewhat lower level of uninsurance in the community, based on comments from people who attended the January 11, 2005 public meeting, there may be significant pockets of unmet need in the area.

Table 6

Sources of Health Insurance Coverage, 2001

	NMHC service area*	NMHC proposed Maple Grove service area**	Minnesota
Private	76.0%	**82.1%**	74.6%
Group	72.6%	**78.4%** *	69.6%
Individual	**3.4%**	3.6%	4.9%
Public	19.2%	**12.8%** *	20.1%
Uninsured	4.8%	5.2%	5.4%

*Defined by MDH as the zip codes accounting for 75% of NMHC's admissions
**As defined by NMHC, includes 20 zip codes
Source: MDH, Health Economics Program analysis of 2001 Minnesota Health Access Survey.
Numbers in bold indicate a statistically significant difference (95% level) from statewide rate.
Numbers with an asterisk indicate a statistically significant difference (95% level) from the rate for NMHC's current service area.

With the exception of Hennepin County Medical Center, NMHC is more reliant on public payers (Medicare and state programs) as a source of revenue than other hospitals that serve Minneapolis and the northern suburbs. In its plan submitted to MDH for review, NMHC argues that in order to continue to provide UC and a high level of services to patients insured by public programs, it needs to maintain a strong base of patients with private insurance. NMHC argues further that an NMHC Maple Grove hospital will enable it to strengthen or maintain its market position among patients with private insurance, thereby providing cross-subsidies to make up for shortfalls in public program payments and to fund UC.

In order to analyze the potential impact of the proposed NMHC Maple Grove hospital on the payer mix of other existing hospitals, we used data from the 2001 Minnesota Health Access Survey[12] to estimate sources of health insurance coverage in the area currently served by NMHC and the proposed Maple Grove service area. We combined these estimates with information on hospital discharges and travel patterns to estimate 1) the insurance coverage distribution for populations served by that hospitals currently provide significant amounts of UC to patients living in this area, and 2) how this distribution would change if NMHC's proposed Maple Grove hospital were built. The distribution of coverage in the area served by an existing hospital could change, for example, if the proposed Maple Grove hospital were to draw patients from zip codes with higher than average rates of private insurance coverage. According to our analysis, the payer mix of existing hospitals that provide large amounts of UC would not be changed significantly by NMHC's proposed Maple Grove hospital.

12 Although this survey was updated in 2004, we used 2001 data because it has a much larger sample size and produces better estimates of health insurance coverage for small geographic areas.

Factor 5: The views of affected parties

As described above, the process that we used to solicit the views of affected parties included a letter to all hospital administrators in Minnesota, a notice in the State Register, and a public meeting held in Maple Grove. The views of citizens of the Maple Grove area, as expressed at the public meeting on January 11, 2005, pertain mainly to the need for a hospital and for specific services and are reflected in the discussion of NMHC's proposal with regard to the first four statutory review criteria. In addition, we received several written comments in support of NMHC's proposal; copies of these are included in Appendix 1. MDH did not receive input from any affected parties who believed that NMHC's proposal would be either not in the public interest or harmful to them specifically.

6. Discussion and Recommendations

The 2004 Legislature established a new step in the process for seeking an exception to Minnesota's hospital moratorium, putting in place a Public Interest review by the Minnesota Department of Health. The proposals to build new inpatient capacity in the Maple Grove area present the first opportunity to apply the new law.

The public interest review law requires a hospital seeking to increase its number of licensed beds or an organization seeking to obtain a hospital license to submit a plan to the MDH. The commissioner is required to review the plan and issue a finding on whether the plan is in the public interest. As mentioned earlier in this report, there are a number of statutory factors the MDH must consider during its review, in addition to other factors the MDH believes are relevant to the review.

The public interest review statute does not define "public interest" nor does it define for which "public" the analysis should be conducted. There could be a variety of different "publics": the citizens of the proposed service area, the citizens of communities not in the proposed service area that could be affected by the proposal, or the citizens of Minnesota. In addition, the statute does not provide direction to MDH on the analysis of situations where more than one hospital is intending to seek an exception to the hospital moratorium for the same or similar geographic area. We received three separate requests for reviews at approximately the same time in November 2004: Fairview Health Services, North Memorial Health Care, and the Maple Grove Tri-Care Partnership. The MDH reviewed all three proposals simultaneously under the public interest review law relative to the statutory factors in Minn. Stat. 144.552, and is issuing separate findings on each plan. The finding in this report is specific to the North Memorial Health Care's (NMHC) proposal.

The previous section of the report examined the proposal of NMHC in light of the five specific factors MDH must consider as part of the public interest review process. This final section of the report highlights several issues that the Legislature may wish to consider in its deliberations on proposals brought before it for new inpatient capacity in the Maple Grove area. These issues are outlined below.

Ability to Support versus Need for a Hospital

During the review process for the Maple Grove hospital proposals, MDH has heard from the community, as well as from those who are interested in seeking an exception to the hospital moratorium to build new inpatient capacity in Maple Grove, that the community can support a new hospital. Based on analysis of population growth in the service areas defined by the three applicants, the likely use of services in the community, and the clearly-stated community desire for inpatient hospital capacity in the community, the Department concurs that the community could support a hospital of the size and scope in the proposals. That is, if a new inpatient facility as described in any of the three applications were constructed, it is unlikely that the hospital would fail due to insufficient usage.

However, it is also important to distinguish between support and need. Specifically, while the ability of a community to support a hospital is an important consideration, the hospital public interest review law requires the MDH to conduct an examination of need. That is, whether a given community can support a hospital is a separate question than whether a new hospital in a given community is necessary to ensure the health outcomes of the residents of the community. Analysis of need must also take into account the capacity of existing facilities that currently serve residents of the community, the likely health care needs of the residents of the community, and any other factors that might influence the availability of services for members of a given community.

In our projections of hospital occupancy, we estimate that, absent any new facility being constructed, the overall occupancy rate of hospitals currently serving the Maple Grove area will grow from 74.0% in 2003 to approximately 79.4% by 2009 and 85.5% by 2015. As mentioned earlier in this report, these estimates of occupancy rates will also vary by facility, depending on patient flows and the expected growth in areas served by these various hospitals. There is no single "right" rate of occupancy. To some degree, the rate of occupancy at which facilities can and should operate depends on the mix of services being provided at that facility. However, based on the projected occupancy figures, it is reasonable to conclude that hospitals serving the Maple Grove market will face increasing capacity strains within the next several years. It is also important to note that the 11 facilities that currently serve Maple Grove also account for approximately one-third of statewide admissions, so the likely increased strain on capacity has an impact on geographic areas beyond Maple Grove as well.

As the Legislature considers proposals to build a new inpatient facility in Maple Grove, it may wish to consider whether the estimated growth in occupancy rates at existing facilities is sufficient to merit the construction of a new facility. Should the legislature determine that some new inpatient capacity is needed to address rising occupancy rates at area hospitals, then the question for policymakers to consider is not whether new capacity should be added, but rather how and where this new capacity should be added: by expansion of existing facilities to the extent that is feasible, or through the construction of a new facility.

Hospital Competition and Consolidation

Another issue for consideration is the degree to which the addition of a new hospital in Maple Grove will add to or decrease hospital competition. This is an important issue because, on balance, peer-reviewed studies show that increases in hospital concentration lead to higher hospital prices.[13] The Twin Cities hospital market already operates with a certain degree of "systemness." That is, several hospital systems have a relatively large share of the inpatient market in the metro area: Allina-affiliated hospitals have approximately 30% of the market, Fairview hospitals approximately 20%, and HealthEast hospitals around 10%.

[13] See, for example, David Dranove and Richard Lindrooth, "Hospital Consolidation and Costs: Another Look at the Evidence," Journal of Health Economics, Volume 22, Issue 6, November 2003.

There are two ways to think about the issue of hospital competition and concentration for the Twin Cities market: metro-wide and local. A hospital constructed in Maple Grove by an existing hospital system, such as Fairview, Allina, or Children's, would likely increase the level of Twin Cities-wide concentration. However, it's important to note that all of the proposed hospitals for Maple Grove are relatively modest in size and may be unlikely to substantially increase the level of Twin Cities-wide hospital market concentration. In addition, it's difficult in advance to know the exact impact that a new facility in Maple Grove owned by an existing system will have on market concentration overall, since the exact effect depends on patient flow patterns that can only be observed after the fact.

On the other hand, a new hospital constructed in Maple Grove by an existing facility with substantial existing market share in the immediate local area, such as North Memorial Health Care, may increase local concentration levels. This increase in local concentration may be mitigated, at least to some degree, by the fact that North Memorial's proposal does not result in an increase in overall bed capacity. The degree to which prices are increased due to increases in either local or Twin Cities-wide concentration depends on whether prices are set at a local level for services or whether they are set system- and Twin Cities-wide.

Bed Types and Services Provided

Another consideration for the Legislature in considering granting an exception is the mix of bed types and services provided in any new hospital constructed in Maple Grove. For example, the expected rapid increase in the population of childbearing age in the Maple Grove area is likely to increase the need for obstetric services.[14] In addition, because differentials exist in payment rates by type of service, hospital beds used for different services generate different levels of profitability. For instance, beds for cardiac care are generally profitable, while those used for behavioral health are generally less profitable. Over time this can lead to a situation where Minnesota may have sufficient capacity or over-capacity for profitable services, and an undersupply of beds for services that are less profitable. Evidence suggests that Minnesota may have sufficient supply of certain types of beds and services, but may lack adequate inpatient behavioral health capacity.[15]

In general, all three proposals respond to the likely need into the near future for obstetric services in the Maple Grove area. Two of the three proposals (Fairview and North Memorial) propose to include some level of additional inpatient behavioral health capacity in their initial inpatient construction (12 and 4 beds, respectively), while the third (Tri-Care) does not specifically plan the construction of new inpatient capacity, although it states its intent to "construct a viable model for inpatient services."

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[14] The population aged 18 to 44 is in the Maple Grove area is projected to grow between 18.3% and 33.9%, depending on the service area defined, compared to 1.7% statewide.

[15] See "The Shortage of Psychiatrists and of Inpatient Psychiatric Bed Capacity," Minnesota Psychiatric Society Task Force Report, September 2002 and "Minnesota Mental Health and Chemical Dependency Treatment Trends: 1998-2002," Minnesota Department of Health, Health Economics Program, Issue Brief 2004-07, November 2004.

In considering the proposals to build new inpatient capacity in Maple Grove, the legislature may wish to give strong consideration to whether certain services, such as behavioral health inpatient capacity, should specifically be included as a requirement under any moratorium exception granted. For instance, the legislature could require that a certain percentage of beds of any exception granted be used for behavioral health services.

Potential Health Care System Costs

Although not included as a specific statutory criterion under the public interest review law, health care cost is also a policy issue important to the consideration of inpatient hospital construction and expansion. As a matter of policy, states have generally taken some interest in monitoring or in some way constraining the expansion of inpatient hospital facilities. For instance, hospital CON laws still operate, in some form, in 37 states.[16] States have generally shown an interest in inpatient hospital capacity, as it relates to health care cost, for two reasons. First, hospitals are expensive to construct and operate, and those costs are built into the health care system and subsequently into health insurance premiums. Second, some argue that duplication of services increases health care costs under the argument that, in health care, supply of services is likely to induce demand for those services. Laws, such as Minnesota's construction moratorium law, that restrict the construction of new inpatient facilities unless approved in advance, can have the effect of reducing potential duplication of services.

While we did not attempt to estimate the specific impact that the addition of a new inpatient facility in Maple Grove would have on health care costs, it is likely that the construction of any new facility will add at least some additional cost to Minnesota's health care system, although the proposed construction costs of all three proposed projects are relatively modest in comparison to overall state hospital spending. The extent to which the construction of a new hospital is duplicative of existing services and is therefore likely to induce excess demand depends in large part upon whether the existing facilities serving the Maple Grove area have sufficient capacity to serve the population into the future or whether those facilities are sufficiently strained to merit additional capacity. That is, if existing capacity is insufficient to provide services to the Maple Grove community into the future, then policy issues related to construction cost and the potential of induced demand may be less of a concern.

Summary and Recommendations

Reviews related to the construction of a new inpatient facility in the Maple Grove area are the first under the new public interest review process passed by the 2004 Legislature. The law requires that the MDH issue a finding as to whether the proposal is in the public interest.

As mentioned earlier in this section, the legislation does not define "public" for the purposes of "public interest" and therefore the "public" can be defined in a variety of ways. One potential "public" could be the persons living in the Maple Grove area. With regard to the ability of the

[16] U. S. General Accounting Office. "Specialty Hospitals: Geographic Location, Services Provided, and Financial Performance," October 2003.

community to support a hospital, MDH believes that the community can support a hospital and should one be constructed in the Maple Grove area, it is unlikely that the hospital would fail due to lack of use. In addition, the construction of a new facility as proposed would provide more convenient access to services for residents in the community. Therefore, we believe it would likely be in the public interest of members of the Maple Grove community if a new hospital were to be constructed.

In examining whether NMHC's proposal is in the public interest for Minnesota as a whole, the analysis is more complicated because it must also take into consideration issues such as system capacity, potential cost impact, and the statutory factors examined in section 5 of this report. After examining the proposal submitted by NMHC in relation to the factors specifically required by Minn. Stat. 144. 552 and other relevant factors, the Minnesota Department of Health has the following findings and recommendations specific to NMHC's proposal:

- NMHC's proposal to build a new inpatient facility in Maple Grove, Minnesota is in the public interest; and
- The legislature should consider requiring that a certain percentage of hospital beds of any exception granted for the Maple Grove area be dedicated for behavioral health services.

Appendix 1

Copies of Comments on the Proposal

City of
Maple Grove
12800 Arbor Lakes Parkway, P.O. Box 1180, Maple Grove, MN 55311-6180 763-494-6000

November 5, 2004

Dianne Mandernach
Commissioner of Health
85 E. 7th Place
St. Paul, MN 55101

Dear Commissioner Mandernach:

As Mayor of Maple Grove, I am pleased North Memorial has submitted a review process paper to the Minnesota Department of Health for the potential development of a hospital in Maple Grove.

As you are probably aware, Maple Grove and the surrounding suburbs are among the fastest growing communities in Minnesota. We are excited to have a hospital in our community. With a 37.4 percent growth in population between 1990 and 2000 for Maple Grove and eight neighboring suburbs, the need for a hospital to serve the northwest metropolitan area is obvious.

Clearly, with the snarl of congested traffic patterns in the northwest metro area, putting a hospital and its emergency services in the heart of our community would certainly be instrumental in saving lives. The area also is in need of more OB/Gyn services. There are a tremendous number of young families in our region. We also are concerned about the behavioral needs of our citizens, especially teenagers.

We are pleased North Memorial, with its current presence in this area, is interested in adding more community-based care in Maple Grove. We look forward to having a first-rate health care hospital linked to leading, nationally recognized medical centers.

Thank you for your time and attention on this matter. If I can be of any further assistance, please don't hesitate to call me at 763-560-5700.

Sincerely,

Mark Steffenson
Mayor

MIKE OPAT
COMMISSIONER

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BOARD OF HENNEPIN COUNTY COMMISSIONERS
A-2400 GOVERNMENT CENTER
MINNEAPOLIS, MINNESOTA 55487-0240

November 29, 2004

To Whom It May Concern:

I understand North Memorial Health Care has a comprehensive plan for bringing expanded health care services to the Maple Grove community. As an elected official that represents a number of Northwest suburbs, I strongly encourage you to embrace North Memorial's proposal.

I am very familiar with the outstanding care North Memorial provides and the organization's commitment to our area. When we launched the Northwest Corridor Partnership to transform County Road 81, North Memorial was our first private partner. I know North Memorial is committed to this region for the long-term.

North Memorial has already made significant investments in the Maple Grove area and is a recognized leader in cardiology, ENT, general medicine, gynecology, neonatology, neurology, obstetrical and newborn care, oncology, orthopedics and urology.

As you know, North Memorial's paramedics, emergency physicians and emergency transport personnel have trained and worked with northwest communities' first responders for decades, and their trauma and emergency medicine programs are regional leaders. These services are needed in Maple Grove, and North Memorial is uniquely qualified to provide them. I strongly support their plans for a Maple Grove outpatient health care center and their vision for a hospital on this campus.

Research suggests thousands of area residents already consider North Memorial their "home-town" hospital. I urge your support for North Memorial's plans for expanded health care in Maple Grove. Please contact me if you have questions or would like further information.

Sincerely,

Mike Opat
Hennepin County Board of Commissioners

HealthPartners®

November, 2004

To Whom It May Concern:

For over seven years, HealthPartners has enjoyed a positive and successful relationship with North Memorial Medical Center. The decision to make North Memorial a significant partner in our west-metro strategy was based on their high standards and proven track record in the community they serve. It was also based on selecting a partner that demonstrated the same commitment to patient care and desire to continuously look for ways to improve care.

North Memorial is a health care organization that is well respected by physicians. Over 20 years ago, North worked collaboratively with primary care physicians to help establish clinics to serve the northwest region; they encouraged physicians to practice in the area. They are committed to improving care and their actions demonstrate that commitment, with a current marketshare of greater than 50 percent.

It is a well known fact, for several decades, that their Level I Trauma services and emergency transport system have provided peace of mind to the west and northwest regions. In addition, North is the trusted partner for Minneapolis Children's providing top level newborn intensive care services. North offers its partners value by delivering a full range of the best inpatient and outpatient specialty services, including general medical, surgery, cardiology, obstetrics, orthopedics, neurology, and emergency services.

When we began our evaluation process to select a west-metro hospital partner, we looked for qualities that reflect a hospital's long term commitment to a community, the provision and mix of a full-range of specialty services and high ratings with respect to patient satisfaction. North delivered on our selection criteria, and continues to do so.

North has demonstrated its desire to serve all patients in an exceptional manner. Our recent patient satisfaction survey results show that patients rank them at a 95% or greater level in all areas. Examples of areas assessed included: overall satisfaction with hospital care, willingness to recommend the hospital to others, the attention received from nurses and being treated with respect and dignity.

We trust North Memorial as a proven partner in providing the kind of care and service that we expect for the benefit of our patients, our members and the community.

Sincerely,

Mary Brainerd

Mary Brainerd
President & Chief Executive Officer
HealthPartners

Minnesota
Neonatal
Physicians, P.A.

Ronald E. Hoekstra, MD
David E. Brasel, MD
Andre J. Nelson, MD
Robert J. Couser, MD
Bonnie G. Landrum, MD
T. Bruce Ferrara, MD
Nathaniel R. Payne, MD
Virginia A. Hustead, MD
Roy C. Maynard, MD
Diane J. Camp, MD
Ellen M. Bendel-Stenzel, MD
Jeanne D. Mrozek, MD
John J. Fangman, MD, PhD (Ret.)

Diane Mandernach
Commissioner
Minn. Dept of Health

12/16/04

Dear Commissioner Mandernach,

I am a physician with Minnesota Neonatal Physicians, an independent thirteen-member group of specialists who provides physician services for ill and premature infants in virtually all of the west metro area hospitals. It is with great enthusiasm that my group endorses the proposal by North Memorial Health Care to develop a hospital in the Maple Grove area. We have worked with North Memorial in providing neonatal care to patients in this area for over 20 years. Patients from this area have benefited greatly by the commitment and expertise North Memorial has provided, and the satisfaction of families with these services has been excellent. In an era of consolidation and expansion of huge health care conglomerates, North Memorial has provided a competitive alternative for patients and payers in this market in a manner that has been beneficial to the communities it serves. The stability of its administration and the clearness of its vision distinguish North Memorial from other entities. Its focus has been to provide top quality services for the families in its geographic service area, which includes Maple Grove. My group looks forward to developing an expansion of services for newborn babies and their families in partnership with North Memorial Healthcare.

Sincerely,

Bruce Ferrara MD
President,
Minnesota Neonatal Physicians

DEC 20 2004

2545 Chicago Ave. S. Suite 517, Minneapolis, MN 55404 • Phone (612) 871-7203 • 24-Hour Care Line 1-888-455-BABY • Email neo@mnneo.org • www.mnneo.org

Ridgeview MEDICAL CENTER

500 South Maple Street • Waconia, MN 55387-1791
952/442-2191 800/967-4620

December 21, 2004

Scott Leitz, Director
Health Economics Program
Minnesota Department of Health
85 East 7th Place, Suite 300
St. Paul, MN 55101

Re: Hospital Bed Moratorium Law as it relates to a proposed hospital in Maple Grove, Minnesota

Dear Mr. Leitz:

As President of Ridgeview Medical Center, Waconia, Minnesota, I'm pleased to provide input into the proposal to build a new hospital in Maple Grove, Minnesota.

This letter is not directed at the specific needs for additional hospital beds within this marketplace. I'm assuming that the Minnesota Department of Health, as well as the prospective applicants, have done their due diligence in regards to the need for a hospital in this marketplace and its affect on area facilities that would provide similar services.

My comments are related to which applicant is best suited to be awarded an exemption from the state's hospital bed moratorium law to construct a hospital within this community. Although all three health systems have provided excellent care and have the financial where-with-all to build and operate an acute care hospital, one of these health systems has compelling differences that should weigh heavily in their favor. Of the three applicants for this exemption, North Memorial Health Care has two factors that tip the scales in its favor. The first significant advantage is that North Memorial Health Care currently serves the majority of patients from this marketplace. Patients obviously have the confidence and knowledge of North Memorial that they actively seek this organization out for their healthcare services.

Secondly, North Memorial Health Care is a single hospital health system. They do not manage or have ownership interest in any other acute care facility in the state of Minnesota. The other two applicants have considerable acute care hospital holdings not only in Minnesota, but also surrounding this marketplace. To award an exemption to construct hospital beds to either the Fairview Health System or Park Nicollet/Allina would continue the current consolidation of health care services within the seven county

metro area and Minnesota as a whole. This would reduce competition without any demonstrable difference in quality or cost.

Assuming that a demonstrated need for acute care hospital beds is determined, I would then encourage the Department of Health to strongly consider North Memorial Health Care as the desired entity to build an acute care hospital in Maple Grove, Minnesota. Should you have any questions or concerns regarding this letter, please don't hesitate to contact my office directly.

Sincerely,

Robert Stevens
President

Cc: Mike Werner, Chairman, Ridgeview Medical Center Board of Directors

From: "Susan Kreatz" <Susan.Kreatz@northmemorial.com>
To: <Scott.Leitz@state.mn.us>
Date: 12/30/2004 11:39:37 AM
Subject: Maple Grove Hospital

I am a resident of Maple Grove and would like to share my public opinion as to why North Memorial Medical Center should be the hospital of choice for the Maple Grove and surrounding areas. It is only fair to say that I also am an employee of North Memorial, but would like to share my thoughts as to why I feel North Memorial is unique and by far should be the hospital of choice.

I moved to the Twin Cities in 1978, and have worked in at least 5 other hospital organizations. What makes North Memorial so special, for one, is that we have remained independent. From the time I first started at North Memorial and walked through it's doors, I felt something that I have not experienced with any of the other organizations. North Memorial treats their employee's with importance and is built around the relationships we develop not only with each other, but especially those with our patients and families. Many of the patients we have cared for, come back and will return to the unit they were on, just to see the staff once again. Many have even developed lasting friendships with the staff.

I am not only speaking from a nurse perspective but also from my own personal experience that impacted my family significantly. I have been on the other side with my daughter who was extremely ill with cancer and ultimately died as a result of the cancer. If I had not had the relationships I developed at North Memorial, I cannot imagine how much harder this experience would have been, since none of my family lived here. My fellow employees at North became my family support system. I continue to see this each and every day, by how we relate and treat each other. thus in turn our patients and families.

Out of the three hospitals that have applied, we are the only one to have a Level 1 Trauma Center, with a pediatric focus. We are committed to the people in our community to provide the safest and highest level of care possible that result in positive outcomes for our patients.

We also have many specialized programs that serve our populations as well. (The Hubert Humphrey Cancer Center, Our Stroke Program, first in the Twin Cities to be accredited by JCAHO, and the New Women's Heart Center, just to list a few).

North Memorial wants to continue to serve the Maple Grove Area as we have for so many years with our clinics and ambulance service by bringing our doors close to you. Our care delivery system is one that centers around our patients and families. That is what is most important to us as an organization,

the remarkable care we give to our patients, to achieve the best possible patient outcomes.

Thank-you,

A family recipeint of care with my daughter as a mother as well as a nurse.

Susan R.B. Kreatz, BS, RN, Nurse Manager

From: "Carol Skaja-Jacobsen" <Carol.Skaja-Jacobsen@northmemorial.com>
To: <Scott.Leitz@state.mn.us>
Date: 1/5/2005 1:48:42 PM
Subject: Hospital in Maple Grove

I feel that Maple Grove definitely needs a hospital in their area. Maple Grove and all of the cities North and West of them has grown substantially in the last 10 years. I think North Memorial would be ideal in that area since they are a Trauma I Center, now a Stroke Center, they created the first women's heart care clinic by Pamela Paulson, M.D., along with all their other specialties and excellent doctors, and the majority of people that I know from this area (Champlin) are North Memorial patients. I had all of my children at North Memorial even though there is another hospital closer to our home. Many of our neighbors choose North Memorial over other hospitals in the area. They have a great reputation from around the state for their trauma service. I hope North Memorial is the hospital to be built in that area.

Carol Skaja-Jacobsen
Champlin, MN

From: "Todd Butler" <Todd.Butler@northmemorial.com>
To: <Scott.Leitz@state.mn.us>
Date: 1/10/2005 2:08:30 PM
Subject: North Memorial Maple Grove Hospital Support

To Whom It May Concern,

My name is Todd Butler and my home is located in Hassan Township, just northwest of Maple Grove. I would like to express my strong support for the proposed plan for a North Memorial Health Care Maple Grove Hospital.

I have been employed as a nurse anesthetist for just over 5 years by North Memorial. I rotated through multiple hospitals in the Twin Cities area as part of my nurse anesthesia education including Fairview, Allina, and Park Nicollet facilities and chose North Memorial as an employer because of the independent, community feel of the facility, not the corporate healthcare outpost feel of the others. I also choose and trust North Memorial for my health care needs and, with my wife and I expecting a baby very soon, plan on delivering our first born child there.

I, of course, have been thinking a lot about our new child and the changes that he or she will bring to our lives. One of those things that has weighed heavily (probably because of my profession) on my mind is the distance from our home to a hospital. Currently, it takes about 25-35 minutes for us to reach North Memorial or any other hospital. If a North Memorial hospital were to be built in Maple Grove, our travel time to that hospital would be more than cut in half to about 5-10 minutes. If my child, my wife, or I need urgent or emergent care, I would be pleased to drive or be taken a very short distance to excellent emergent care. When I go to work, I would be pleased to commute only 5-10 minutes to my community facility that I have strong ownership in. And, if we choose to have another child, I would be very happy to deliver that child in my own community, at my own community hospital, hopefully a North Memorial community hospital.

These are just a few reasons why I think a North Memorial Maple Grove Hospital makes good sense. Thank you.

Sincerely,

Todd Butler, CRNA, MS
24055 Northridge Avenue
Rogers, MN 55374

Minneapolis
City of Lakes

City Council

Don Samuels
Council Member, Third Ward

350 South 5th Street - Room 307
Minneapolis MN 55415-1383

Office 612 673-2203
Fax 612 673-3940
TTY 612 673-2157

January 14, 2005

Commissioner Dianne Mandernach
Minnesota Department of Health
Golden Rule Building
85 East 7th Place
P.O. Box 64882
Saint Paul, MN 55164-0882

Dear Commissioner Mandernach:

I am writing as a public official interested in the decision the Minnesota Department of Health will be making regarding a hospital in Maple Grove, Minnesota. As a Minneapolis City Council Member, and a community leader in the north Minneapolis area, I am very familiar with North Memorial Medical Center, one of the organizations submitting a proposal to build a hospital in Maple Grove.

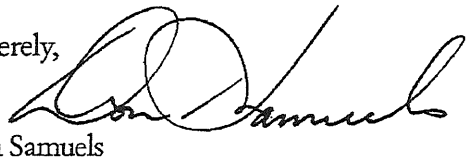
I believe one of the considerations in your evaluation should be the quality of care from the hospital, but also the quality of the hospital as a community partner. North Memorial has been a strong and steady community partner for Minneapolis as well as a provider of excellent care. For example, their education department works with North High School to expose high school students to health care careers, and Carol Kelsey, North's education director services on the Career Center advisory board.

They are also a long-time sponsor of Healthy Neighbors, a program focused on neighborhood revitalization on the north side of Minneapolis and the Jordan neighborhood.

I respect that your department has a difficult task in reviewing proposals to build in Maple Grove. I do urge you to consider these facts in making your decisions: 1) North Memorial was the first hospital to focus on the northeast side of Minneapolis, and has earned a strong following and one-third of the market share in the Maple Grove area; 2) North has a proven track record as a good community partner and they would be a good partner in the northwest corridor communities, and 3) giving North Memorial the opportunity to grow in the suburban areas would help keep them strong in the urban area. The larger hospital systems have other branch hospitals where they can extend their reach. North Memorial is an independent, one-location hospital, and they need to have access to patient growth areas to keep them strong. Please consider North Memorial as the best partner for a new hospital in Minnesota.

Thank you for your acknowledgement that this decision needs to be made with Minneapolis and Robbinsdale in mind— not just Maple Grove.

Sincerely,



Don Samuels
Minneapolis City Council

Scott Leitz - Comments on Maple Grove Hospital

From: "Maureen Vanek" <Maureen.Vanek@northmemorial.com>
To: <Scott.Leitz@state.mn.us>
Date: 1/18/2005 1:30 PM
Subject: Comments on Maple Grove Hospital

Scott Leitz, Director
Health Economics Program
Minnesota Department of Health
85 E. 7th Place, Suite 300
St. Paul, MN 55101

Dear Mr. Leitz:

I am writing to you to comment on the proposed hospital in Maple Grove. I am currently a resident of Maple Grove, having lived there for 7 ½ years. As a resident I truly believe a hospital in our community is important. On our cul-de-sac alone, 10 of the 11 households are inhabited by baby boomers. And of course as we age we will be in need of more and more medical services.

I am also and employee of North Memorial Medical Center and in the capacity as Manager of Volunteer Services and Lifeline programs I would like to comment on the impact of the new hospital on these programs.

North Memorial has strong community support in Maple Grove and surrounding communities. The majority of our volunteers come from the communities going northwest in an arc from North Memorial through Brooklyn Park, Champlin, Rogers, St. Michael, Corcoran, Maple Grove, down to Plymouth. We currently have over 1100 volunteers and a hospital in Maple Grove, other than North Memorial would hugely impact our volunteer corps and our ability to recruit from those areas. Having had the support of these communities has strengthened and grown our program over the past 48 years. In the Hospice program alone, three-fourths of their volunteers come from the communities north and west of North Memorial.

I also manage the Lifeline program. Lifeline is a personal response system used by people who are alone in their homes, have chronic health problems, and are elderly or disabled. We are the primary provider of Lifeline services in the impacted area and we provide a quality service to our clients and their families. We currently serve about 980 clients with 159 of them living in Brooklyn Park, Brooklyn Center, Plymouth and Maple Grove, Elk River, etc... Out of 47 Lifeline volunteers, most of whom install the Lifeline equipment, 44 come from the communities north and west of North Memorial. Our Lifeline program could be severely impacted by another hospital providing service in this market.

Thank you for your consideration of my comments. I would be happy to provide any additional related information you might require. My work number is 763-520-2144.

Maureen Vanek
Work: Manager
Volunteer Services/Lifeline
North Memorial Medical Center
Home: 16515 84th Place No
Maple Grove, MN 55311

North Memorial Clinic
Occupational Health

February 8, 2005

Mr. Scott Leitz
Health Policy, Information and Compliance Monitoring Division
Golden Rule Building
85 East Seventh Place
Suite 300
St. Paul, MN 55101

Dear Mr. Leitz:

Today Pat Cooksey, North Memorial Health Care's Vice President for Business Development and Strategic Planning, asked if I would contact your office to inform you of additional community connections in the Maple Grove area which North Memorial enjoys. I am happy to do so.

North Memorial Health Care has long supported an occupational health product serving local municipalities and community employers. The history of "NorthWorks" (now North Memorial Clinic – Occupational Health) goes back more than 15 years. In its infancy the program was based out of the Emergency Department of North Memorial Medical Center, and eventually became a free-standing, off-site program involving occupational medicine, occupational health nursing services, occupational and physical therapy, and occupational drug testing.

We have some large and loyal customers in the Maple Grove region. First, there is the City of Maple Grove itself. We serve as the medical director for their fire and police departments. We work closely with Ann Marie Shandley of their Human Resources Department. Other nearby municipalities that we also serve include Osseo and Rogers (police and fire departments). In fact, we provide services to 27 different municipalities from Minnetonka to Annandale to Roseville.

Our largest client in the Maple Grove region is Boston Scientific. We do the great majority of their worker's compensation injury care and also serve as the local medical consultant for their medical surveillance programs (for workers handling hazardous materials) and for their health and safety programs in general. Today we have 21 different examination protocols for Boston Scientific employees reflecting the size and diversity of that work force. A few of the examination types include hearing surveillance, pre-placement evaluations, Department of Transportation driver evaluations, examinations for employees who wear respiratory protection, and examinations for workers exposed to hazardous materials. Recently we helped implement an extensive examination program for employees exposed to paclitaxel, a cytotoxic compound. Paclitaxel is coated on the surface of Boston Scientific's market-leading drug-eluting cardiovascular stent (Taxus).

Caterpillar Paving in Brooklyn Park is also an important and long-standing customer of ours. We provide them with worker's compensation injury services, pre-placement examinations, on-site occupational health nursing services, and support for their medical surveillance programs. Other large local employers in that region which use us exclusively include Alcoa KAMA, Alcoa Reynolds, Banta Catalog, REO Plastics, Tennant (they have a Maple Grove and Golden Valley manufacturing site), Upsher Smith, and United Parcel Service (recently they built a very large distribution center in Maple Grove). All totaled, in 2004 we had standing agreements to provide occupational health services to 161 companies with business addresses in Maple Grove, Rogers, Brooklyn Park, Loretto, Osseo, Dayton, Rockford, and Elk River.

Robbinsdale Town Center Suite 200 • 4080 West Broadway • Robbinsdale, MN 55422 • Phone: (763) 520-5551 • Fax: (763) 520-1734
8301 Golden Valley Road Suite 150 • Golden Valley, MN 55427 • Phone: (763) 520-3898 • Fax (763) 520-3899

Two weeks ago we sat down with three health and safety professionals representing Hennepin County. They will likely become a customer in the near term future. They showed a great deal of enthusiasm for a possible Maple Grove base for our occupational health services. While we are quite fortunate to have many loyal customers who are willing to send their employees over a considerable distance to reach us, proximity and convenience is still very important to most community employers. I anticipate there will be a very high level of interest among community employers in the Maple Grove region if we are able to provide our quality service from that location.

Mr. Leitz, thank you for your time and attention. It was my goal to provide you with additional credible information demonstrating North Memorial's connection to the Northwest Suburban community. Please don't hesitate to contact us if you have further questions.

Sincerely,

Gary B. Johnson, MD, MPH, FACOEM
Medical Director
North Memorial Clinic – Occupational Health

cc: Pat Cooksey
Vice President
Business Development and Strategic Planning
North Memorial Health Care

City of Robbinsdale

4100 Lakeview Avenue North
Robbinsdale, Minnesota 55422-2280
Phone: (763) 537-4534
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www.robbinsdalemn.com

February 14, 2005

Commissioner Dianne Mandernach
Minnesota Department of Health
85 East 7th Place
Suite 400
St. Paul, MN 55101

Dear Commissioner Mandernach:

I would like to take this opportunity to share my perspective regarding the report your department is preparing relating to a future hospital in the Maple Grove area. I serve as Mayor of Robbinsdale, which is the home of North Memorial Medical Center, and I'm well acquainted with North Memorial and its staff.

I would support North Memorial as the organization to build a hospital in Maple Grove because:

- North Memorial is a good neighbor as proven by their participation in the Robbinsdale community, with sponsorship of events and providing numerous volunteers in our community.

- North Memorial Medical Center is the only Level I Trauma Center facility proposing a hospital. As such, they have the experience and depth of trained staff to respond to any level of trauma or injury. Our residents have benefited many times from the care and healing of this trauma staff.

- North Memorial has proposed a very rational approach for moving beds from Robbinsdale to Maple Grove. They are moving the beds to where the patients are moving. Yet, they are also still investing in our Robbinsdale area, with new outpatient services in our neighborhood and by continuing to improve the current hospital.

- As a single, independent hospital, North Memorial needs access to growing communities, such as Maple Grove, in order to stay strong. I'm concerned that if larger hospital systems are the only ones allowed access to new markets that North Memorial's long-term stability could be harmed, which has a direct negative impact on Robbinsdale.

In summary, I would urge you to endorse North Memorial's plan for a hospital in Maple Grove. North has proven itself to be an excellent community partner in Robbinsdale and I know they would continue this tradition of excellence and citizenship in Maple Grove.

Sincerely,

Mike Holtz
Mayor of Robbinsdale

MH:mm

February 21, 2005

Commissioner Dianne Mandernach
Department of Health
85th East Seventh Place, Suite 400
St. Paul, MN 55101

Dear Commissioner Mandernach:

I would like to take this opportunity to share my perspective regarding the report your department is preparing relating to the future hospital in the Maple Grove area. I represent the Crystal community and I am well acquainted with North Memorial Medical Center.

I support North Memorial's goal to build a hospital in Maple Grove because North Memorial has always been a great friend and neighbor in our community. They have not only sponsored events and provided volunteers they have demonstrated partnerships with the city of Crystal and our local school district (Robbinsdale Area School). When I served as a member of the Robbinsdale School Board, they provided the usual school education programs and helped to finance the cost of our annual district-wide arts calendar.

One of the partnerships is with West Metro Fire Department which serves both Crystal and New Hope. The fire department no longer responds to emergency health calls because it is now done by North Memorial Medical Center's ambulance service. Since NMMC is close and their ambulances are parked in our community, we benefit in two ways:

1. Less strain on the fire department resources along with actual monetary savings
2. Top-notch medical care strategically located to citizens at a time when a citizen needs it most.

North Memorial Medical Center has grown its facility in Robbinsdale during a time when many businesses have taken flight. Their presence in our community provides not only great medical care at all levels, but also provides important jobs that add to the prosperity of our community. They continue to need access to growing communities in order to stay strong and I am convinced they will serve the community of Maple Grove as well as they have served our communities.

I would urge you to endorse North Memorial's plan for a hospital in Maple Grove. NMMC has proven itself to be an excellent neighbor and community partner for the city of Crystal. I know they will continue this tradition of excellence with the city of Maple Grove.

Respectfully,

ReNae J. Bowman
Mayor of Crystal
763/531-2074

City of Brooklyn Center

A Millennium Community

February 21, 2005

Commissioner Dianne Mandernach
Department of Health
85th East Seventh Place, Suite 400
St. Paul, Minnesota 55101

Dear Commissioner Mandernach,

I would like to add my thoughts regarding the report your department is preparing relating to a future hospital in the city of Maple Grove. I am the Mayor of the city of Brooklyn Center and appreciate having North Memorial Medical Center and it's excellent staff as the major medical facility used by our community.

I would support North Memorial as the hospital to build its new facility in Maple Grove because:

North Memorial Medical Center is the only Level I Trauma Center facility proposing a hospital. My family and I have personal experience in the excellence of the trained staff and facilities needed in the event of a major medical emergency. They have cared for us many times in the almost 40 years we have been in this area.

North Memorial has proposed moving beds from Robbinsdale to Maple Grove, moving beds where the need is. They are currently in the process of adding a new heart center and emergency department in Robbinsdale. Not taking away the quality of care expected by the people using their facilities, but adding and improving on site.

Maple Grove will benefit in many ways with North Memorial as a independent hospital in their community, and North Memorial will continue to grow and become the medical facility the citizens can count on, as we do here in Brooklyn Center.

I would urge you to endorse North Memorial's plan for a hospital. Bring a new Hospital and it's excellent staff and state of the art equipment to the people of Maple Grove and surrounding area.

I hope my personal endorsement of North Memorial will add to your positive thoughts to bring a quality facility to Maple Grove.

Sincerely,

Myrna Kragness

Myrna Kragness
Mayor of Brooklyn Center MN

6301 Shingle Creek Parkway
Brooklyn Center, MN 55430-2199
City Hall & TDD Number (763) 569-3300
FAX (763) 569-3494

Recreation and Community Center Phone & TDD Number
(763) 569-3400
FAX (763) 569-3434

Commissioner Dianne Mandernach
Department of Health
85th East Seventh Place, Suite 400
St. Paul , Minnesota 55101

Dear Commissioner Mandernach:

I would like to take this opportunity to share my opinion regarding the report your Department is preparing relating to a future hospital in the Maple Grove area (North West Metro). I represent the New Hope community, which is a part of the North West Metro Area that is currently served by The North Memorial Medical Center. As the Mayor of New Hope and as a resident of North Memorial's service area I am knowledgeable of the excellent care this hospital provides for New Hope's residents as well as the entire area.

I support North Memorial to be the prefer hospital for this needed expansion.

1) North Memorial is the only Hospital that is a Level 1 Trauma Center of all those Applying for consideration. Their Staff is well trained, and able to handle all Emergencies. North Memorial should be given extra consideration for this level of experience.
2) North Memorial is currently serving this community and receives about 20% of its current patient base from the immediate Maple Grove, Rogers, Elk River area the very residents the expansion is to serve. If this portion of North Memorials base is allowed to be served by a different medical facility it could have a very negative effect on North's ability to serve the entire North West Metro Area and my City's residents.
3) North Memorial purposed a very well planned expansion allowing for the improved care of the entire North West Metro area, for the continued great care at it's Robbinsdale Base and the new treatment facility/hospital in Maple Grove.
4) North Memorial Supports my community emergency medical response and transport and their air lift fleet covers a large area of MN. . Again weakening North Memorial by not allowing them access to maintain their current clientele and this controlled expansion will surely hurt North Memorial's ability to maintain itself as a true health care leader and a valuable community member/ contributor.

In summary, I strongly urge you and your staff to endorse North Memorial as the Hospital of choice for the planned Maple Grove expansion as well as their plan to make it happen

Sincerely,

Martin E. Opem Sr.
Mayor of New Hope

CITY OF NEW HOPE

4401 Xylon Avenue North • New Hope, Minnesota 55428-4898 • www. ci.new-hope.mn.us
City Hall: 763-531-5100 • Police (non-emergency): 763-531-5170 • Public Works: 763-592-6777 • TDD: 763-531-5109
City Hall Fax: 763-531-5136 • Police Fax: 763-531-5174 • Public Works Fax: 763-592-6776

February 21, 2005

Commissioner Dianne Mandernach
Department of Health
85th East Seventh Place, Suite 400
St. Paul, MN 55101

Dear Commissioner Mandernach:

I would like to take this opportunity to share my perspective regarding the report your department is preparing relating to the future hospital in the Maple Grove area. I represent the Crystal community and I am well acquainted with North Memorial Medical Center.

I support North Memorial's goal to build a hospital in Maple Grove because North Memorial has always been a great friend and neighbor in our community. They have not only sponsored events and provided volunteers they have demonstrated partnerships with the city of Crystal and our local school district (Robbinsdale Area School). When I served as a member of the Robbinsdale School Board, they provided the usual school education programs and helped to finance the cost of our annual district-wide arts calendar.

One of the partnerships is with West Metro Fire Department which serves both Crystal and New Hope. The fire department no longer responds to emergency health calls because it is now done by North Memorial Medical Center's ambulance service. Since NMMC is close and their ambulances are parked in our community, we benefit in two ways:

1. Less strain on the fire department resources along with actual monetary savings
2. Top-notch medical care strategically located to citizens at a time when a citizen needs it most.

North Memorial Medical Center has grown its facility in Robbinsdale during a time when many businesses have taken flight. Their presence in our community provides not only great medical care at all levels, but also provides important jobs that add to the prosperity of our community. They continue to need access to growing communities in order to stay strong and I am convinced they will serve the community of Maple Grove as well as they have served our communities.

I would urge you to endorse North Memorial's plan for a hospital in Maple Grove. NMMC has proven itself to be an excellent neighbor and community partner for the city of Crystal. I know they will continue this tradition of excellence with the city of Maple Grove.

Respectfully,

ReNae J. Bowman
Mayor of Crystal

North Memorial Community Foundation

March 4, 2005

Dianne Mandernach
Commissioner of Health
85 E 7th Place
St Paul, MN 55101

To Whom It May Concern:

We would like to take this opportunity to share our strong endorsement for North Memorial Medical Center and its plans to create a community hospital in Maple Grove. As community board members for the North Memorial Community Foundation, we are intimately involved with the hospital and its programs and staff. We can personally attest to the integrity and quality of this organization.

Here are the reasons we believe that North Memorial's plan deserves your support as well:

- North Memorial has already made a major commitment to the Maple Grove and northwest communities—we have served these communities for more than 20 years. We provide the ambulance service for that area and will be locating a new ambulance base on our outpatient campus, set to open in 2006. **Our medical experts provide critical training to fire, police, and other first responders**—this is a valuable contribution to the community that is uniquely provided by North Memorial staff—**at no cost.**
- North Memorial is used by more Maple Grove area residents than any other hospital—**one-third of the community uses North Memorial for their hospital care.** Our plan offers patients the best continuity of care.
- North Memorial has proposed a very reasonable plan for the hospital. ***We are moving the beds to where the patients are moving.*** We believe this is the kind of rational, efficient approach to health care planning the legislature intended when it passed the hospital moratorium law.
- Competition in health care keeps costs down and quality up. A recent evaluation of the competing hospital proposals by a University of Minnesota health economist states, **"...patient welfare is best served when hospitals vigorously compete. Hospital prices are lower and the quality of care is higher."** We believe that giving the large hospital systems a hospital in Maple Grove does not improve health care in Minnesota.

In summary, we urge you to support North Memorial's plan for a hospital in Maple Grove. North has proven itself to be an excellent community health care partner in the communities it serves and we want the chance to continue this tradition of excellence in Maple Grove.

Sincerely,

Joseph G Boston, Executive Director
North Memorial Community Foundation

Owen V Kane, Chairman of the Board
North Memorial Community Foundation

NORTH MEMORIAL COMMUNITY FOUNDATION
BOARD of DIRECTORS
2005

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Minneapolis MN 55412
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(W) 567-7000; after 7pm: 220-2564
(CAR) 209-9454 (FAX) 593-2649

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Appendix 2
Methodology

This appendix provides additional details on MDH's analysis of the application for public interest review. It describes the methods and data that we used to:

- Project future utilization and occupancy rates at hospitals currently serving residents of the Maple Grove area in the absence of a new hospital being built in Maple Grove;
- Estimate the impact of the proposed Maple Grove hospital on existing hospitals that serve residents of the Maple Grove area; and
- Analyze the potential shift in payer mix at existing hospitals as a result of the proposed Maple Grove hospital.

Projecting Hospital Use and Occupancy in the Absence of a New Hospital

This analysis focused on eleven hospitals that were identified as (a) holding a significant market share of the discharges from the Maple Grove area (as defined by the applicant); (b) having a high dependency on patients from the Maple Grove area (even if the hospital does not have a large share of the total market, it may be very dependent on the Maple Grove area as a source of admissions), or (c) being a major safety-net hospital provider in the region. The hospitals included in this analysis were Abbott Northwestern Hospital, Buffalo Hospital, Children's Hospital in Minneapolis, Fairview Northland Regional Hospital, Fairview-University Medical Center, Hennepin County Medical Center, Mercy Hospital, Methodist Hospital Park Nicollet Health Services, Monticello-Big Lake Hospital, North Memorial Medical Center, and Unity Hospital.

We used Minnesota hospital inpatient discharge data from calendar year 2003, excluding discharges of normal newborns. This data includes information on the patient's zip code and age. First, we calculated occupancy rates for each of the eleven hospitals and for the eleven hospitals as a group in 2003.

Next, we projected inpatient volumes and occupancy rates to 2009 and 2015. In order to take account of population growth and demographic change that may be occurring in a particular hospital's service area, we looked specifically at the zip codes from which most of the hospital's patients originate. We chose to define this area as the geographic area (group of zip codes) from which the top 75 percent of the hospital's discharges of Minnesota residents originated in 2003. For each of the eleven hospitals, we calculated hospital-specific and age-specific hospitalization rates for the population living in the geographic area as defined above. We used projections of future

population (by age group) in the same geographic area to project future hospital volumes.[17] The geographic areas that comprised the remaining 25 percent of the hospital's discharges of Minnesota residents were treated as a group for the purpose of projecting future use of hospital services, and we assumed that the number of discharges of non-Minnesota residents would grow at the same rate as discharges of residents of the state.

The major assumptions that we made in this analysis are as follows:

- We assumed that hospitalization rates by age group would be the same as they were in 2003. To take account of potential future changes in hospitalization rates, we also created projections assuming a range of future use rates – either a 10% increase or 10% decrease in hospitalization rates for each age group. Factors that could cause future hospitalization rates to increase include rising levels of disease (for example, conditions associated with obesity) or technological change; on the other hand, technological change can also be a major driver of reductions in hospitalization rates. (Changes in overall hospital utilization due to the projected aging of the population are accounted for already by the fact that the analysis is done separately for each age group.)

- We assumed that the average length of stay would also be unchanged compared to 2003. Although the average length of a hospital stay declined in Minnesota from 5.1 days in 1993 to 4.3 days in 2003, the average length of stay has been stable over the past five years.

- We assumed that average annual population growth for the geographic areas defined for each hospital would be the same for 2009 to 2015 as projected by Claritas, Inc. for 2004 to 2009. To the degree that this method might overstate or understate actual population growth during this period, our estimates of future hospital use would also be overstated or understated.

- Finally, we assumed that the group of zip codes from which each hospital receives its core business (the geographic area accounting for 75% of discharges) would remain the same over time.

Finally, because calculating occupancy rates over an entire year does not adequately capture variations in occupancy rates that occur at different times of the year, we projected seasonal occupancy rates for 2009 and 2015 by assuming that the distribution of inpatient days across the year would be the same as it was for 2003. In order to account for hospital days that occurred in 2003 but are missing from our data set because the patient was not discharged until 2004, we used hospital days from patients who were admitted in 2002 but not discharged until 2003 as a proxy.

[17] Population estimates by zip code and age were obtained from Claritas, Inc. for 2000, 2004 and 2009. We estimated 2003 population by assuming a constant average annual growth rate from 2000 to 2004. We projected forward to 2015 by applying the same average annual growth rate estimated by Claritas from 2004 to 2009.

Estimating the Impact of the Proposed Hospital on Existing Hospitals That Serve Residents of the Maple Grove Area

In order to calculate the impact of the proposed hospital on existing hospitals that serve residents of the Maple Grove area, we estimated the potential impact on discharges, inpatient days, and occupancy rates at each of the eleven hospitals. First, based on the applicants' submissions,[18] we calculated the total number of bed days that the new Maple Grove facility is designed to accommodate, incorporating information from the applicants on both the size of the facility and the expected occupancy rate. We calculated the impact on existing hospitals by assuming that the new facility would in fact provide the volume of inpatient services consistent with the proposed size and occupancy rate anticipated by the proposal. We also assumed that all of the patients served by the Maple Grove Hospital would come from within the applicant's defined service area. Our estimate of the impact of the facility is therefore a conservative estimate, representing an upper bound on the volume of inpatient services that would be shifted away from existing hospitals.

To estimate the impact on individual hospitals, we assumed that the hospital's market share of the services provided to Maple Grove area residents at hospitals other than the proposed new facility would be the same as its current market share among the group of eleven existing hospitals. Essentially, this assumes that people who do not receive services at the proposed Maple Grove hospital will maintain the same travel patterns that currently exist. As noted in the main text of the report, however, there is a high level of uncertainty about how travel patterns may change. There are two main factors contributing to this uncertainty: first, the possibility of as many as three large new ambulatory care centers in the community, which would likely have an impact on physician referral patterns; and second, the possibility that a system-affiliated hospital in Maple Grove could affect the pattern of referrals to other hospitals for services not provided directly at the proposed Maple Grove hospital. For each hospital, we estimated the impact of the proposed Maple Grove hospital on existing hospitals as the difference between a) projected volumes in the absence of a new hospital and b) projected volumes incorporating the loss of volume from the addition of a new facility in Maple Grove.

Analyzing Potential Payer Mix Shift

To estimate the potential effect of the proposed Maple Grove hospital on payer mix for existing hospitals, we calculated the distribution of insurance coverage at the zip-code or zip-code-group level for the core service areas of several hospitals. For this analysis, we limited the list of hospitals to those that are either 1) most likely to be affected by the proposed Maple Grove hospital, or 2) major providers of uncompensated care in the region. We used data from the 2001 Minnesota Health Access Survey, which was a health insurance survey of over 27,000 Minnesota households,

[18] For the Tri-Care proposal, we assume an 80-bed hospital for 2009 that will increase to 120 beds in 2015. Fairview Health Services' design anticipates also an 80-bed hospital in 2009, which it projects to expand to 240 beds in 2015. Because NMHC has indicated that they are only seeking legislative approval for the transfer of 80 beds at this time, this analysis assumes 80 beds in both 2009 and 2015. (NMHC has indicated that it may request another exception from the hospital moratorium in order to expand its proposed Maple Grove hospital in the future.)

to estimate insurance coverage for zip codes, or for groups of zip codes where there was insufficient data to estimate it at the zip code level. We aggregated these estimates of insurance status by zip code to the geographic area from which the top 75 percent of a hospital's discharges originated in 2003, as defined above in the projection of future demand for hospital services.

Next, we weighted our estimates of the sources of insurance coverage in the geographic area according to the proportion of the hospital's discharges from each zip code or group of zip codes.. This provided an approximation of the distribution of insurance coverage in the geographic area from which the hospital draws most of its patients. We repeated this analysis for 2009 and 2015 for 1) the projections of inpatient volumes in the absence of a new hospital and 2) the projections with the proposed new hospital.

Appendix 3
American College of Surgeons Classification of Trauma Centers

American College of Surgeons Committee on Trauma Classification System of Trauma Center Level

ACS Levels and Descriptions

Level I
Provides comprehensive trauma care, serves as a regional resource, and provides leadership in education, research, and system planning.

A level I center is required to have immediate availability of trauma surgeons, anesthesiologists, physician specialists, nurses, and resuscitation equipment. American College of Surgeons' volume performance criteria further stipulate that level I centers treat 1200 admissions a year or 240 major trauma patients per year or an average of 35 major trauma patients per surgeon

Level II
Provides comprehensive trauma care either as a supplement to a level I trauma center in a large urban area or as the lead hospital in a less population-dense area.

Level II centers must meet essentially the same criteria as level I but volume performance standards are not required and may depend on the geographic area served. Centers are not expected to provide leadership in teaching and research.

Level III
Provides prompt assessment, resuscitation, emergency surgery, and stabilization with transfer to a level I or II as indicated.

Level III facilities typically serve communities that do not have immediate access to a level I or II trauma center.

Level IV & V
Provides advanced trauma life support prior to patient transfer in remote areas in which no higher level of care is available.

The key role of the level IV center is to resuscitate and stabilize patients and arrange for their transfer to the closest, most appropriate trauma center level facility.

Level V trauma centers are not formally recognized by the American College of Surgeons, but they are used by some states to further categorize hospitals providing life support prior to transfer.

Source: MacKenzie EJ et. al. National Inventory of Hospital Trauma Centers. JAMA 2003 Mar 26; 289(12):1516.

To obtain additional copies of this report, please contact:

Minnesota Department of Health
Minnesota Health Information Clearinghouse
P.O. Box 64975
St. Paul, Minnesota 55164-0975
(651) 282-6314; (800) 657-3793
TDD (651) 215-8980

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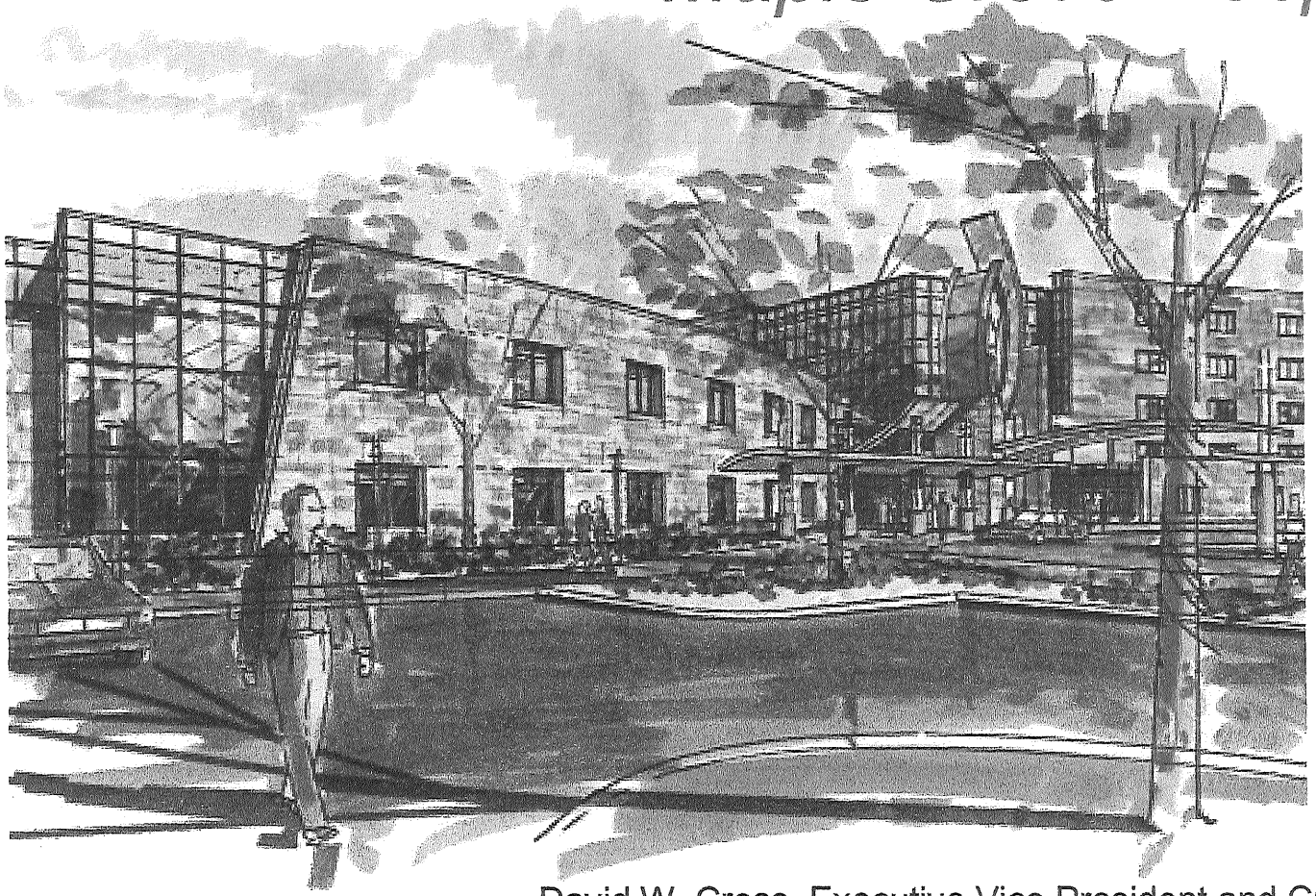
North Memorial Medical Center

Maple Grove Hospital



David W. Cress, Executive Vice President and COO
Patricia A. Cooksey, Vice President of Business Development
Robert J. Town, PhD., University of Minnesota

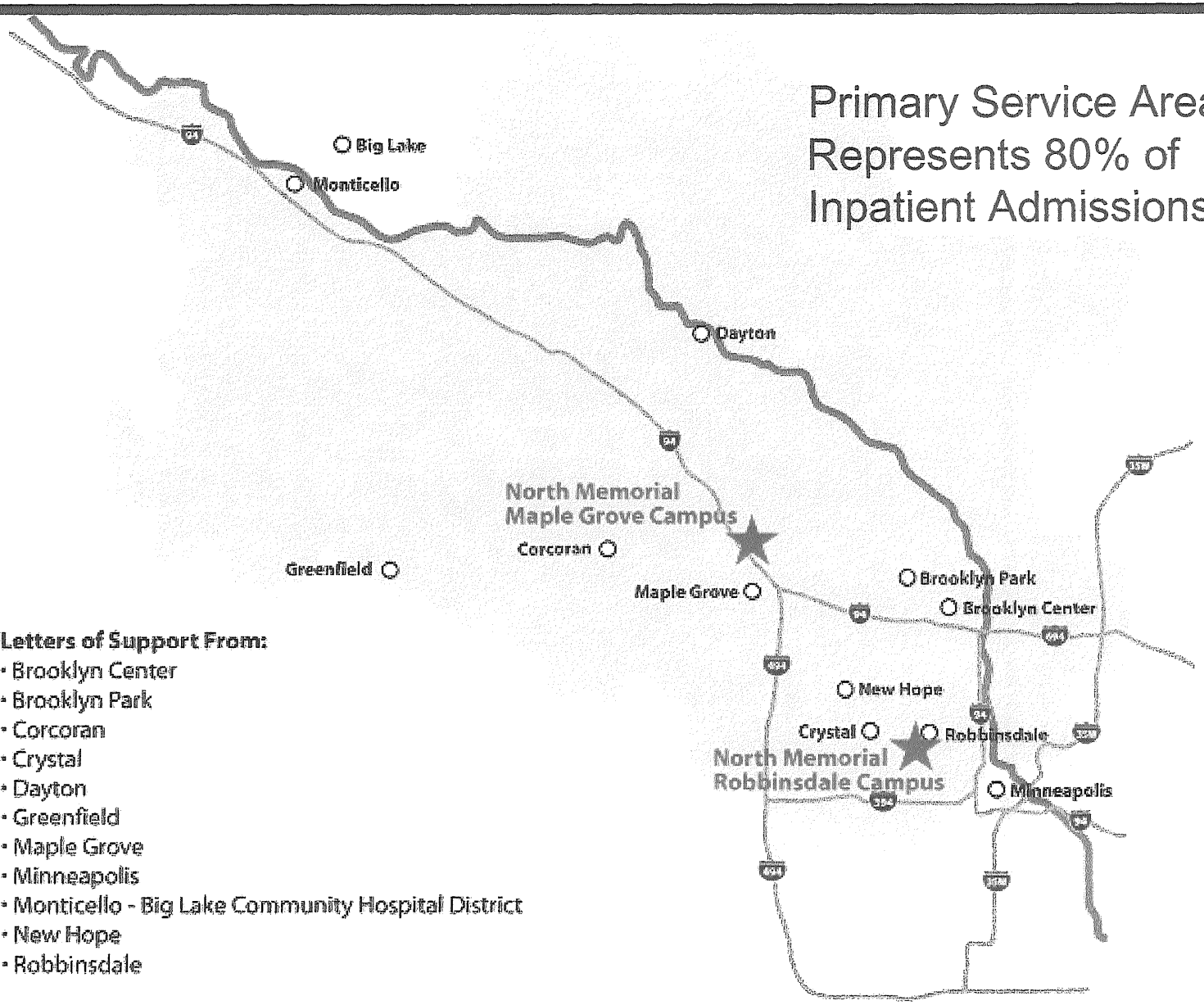
North Memorial Medical Center

50 Years of Service to the Community

- Independent Health Care Organization
- Level 1 Trauma Center
- Emergency Services
- Ambulance Services
- Women & Children's Services/NICU
- Heart Center
- Stroke Center
- Humphrey Cancer Center
- Primary Care Physicians, 279 on Staff
- Specialty Physicians, 606 on Staff

North Memorial Medical Center

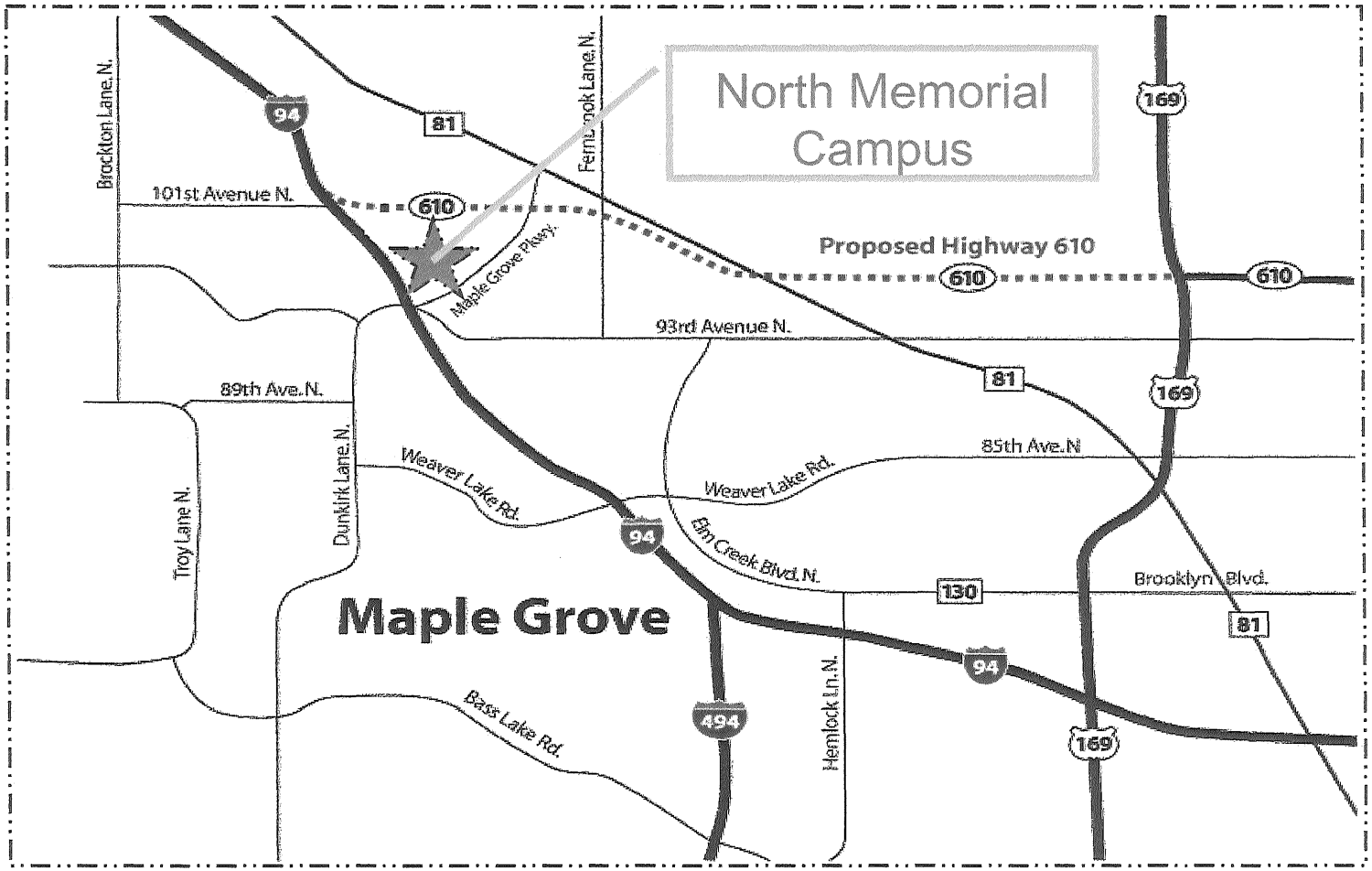
Primary Service Area: Represents 80% of Inpatient Admissions



Letters of Support From:

- Brooklyn Center
- Brooklyn Park
- Corcoran
- Crystal
- Dayton
- Greenfield
- Maple Grove
- Minneapolis
- Monticello - Big Lake Community Hospital District
- New Hope
- Robbinsdale

North Memorial Medical Center



- Development and concept approval by Maple Grove City Council (12/04), including required road improvements.
- The Highway 610 extension is not required for our project.

North Memorial Medical Center

Our Plan

Phase I

- Develop a health care campus on our 30 acre site in Maple Grove
  - Emergency Services, Outpatient Surgery, Imaging and Medical Office Building scheduled to open fall 2006
  - Inpatient hospital including 80 beds scheduled to open in 2008 following legislative approval in 2005
    - Medical/Surgical, Obstetrics, Pediatrics, Behavioral Health, Oncology

Phase II

- Expand inpatient hospital capacity up to 260 beds and build future Medical Office Buildings

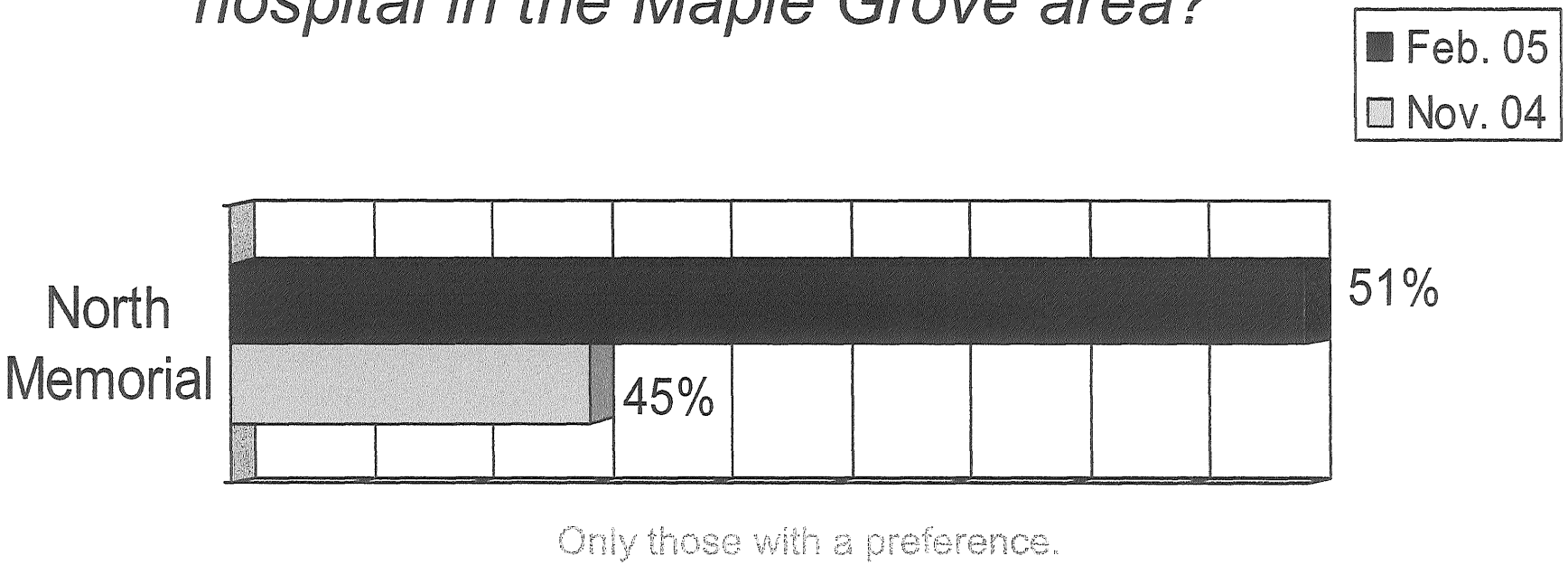
North Memorial Medical Center

Our Request

Authorize the Transfer of Eighty (80) Existing, Licensed and Staffed Beds From Our Robbinsdale Campus To Our Maple Grove Campus.....

North Memorial Medical Center

Who would you most like to see build a hospital in the Maple Grove area?



Only those with a preference.

- *Consumer research conducted by Padilla Speer Beardsley*
  - *Independent research firm*
  - *November 2004; repeated in February 2005*

North Memorial Medical Center

Letters of Support

- ***Brooklyn Center***, Myrna Kragness, Mayor
- ***Brooklyn Park City Council***, Steve Lampi, Mayor
- ***Corcoran City Council***, Thomas C. Cossette, Mayor
- ***Crystal***, ReNae J. Bowman, Mayor
- ***Dayton City Council***, Douglas Anderson, Mayor
- ***Greenfield City Council***, Lawrence Plack, Mayor
- ***Maple Grove***, Mark Steffenson, Mayor
- ***Minneapolis City Councilman***, Don Samuels
- ***New Hope***, Martin Opem Sr., Mayor
- ***Robbinsdale***, Mike Holtz, Mayor

- ***HealthPartners***, Mary Brainerd, President and CEO
- ***Hennepin County Board of Commissioners***, Mike Opat
- ***Minnesota Neonatal Physicians***, Bruce Ferrara, MD, President
- ***Monticello-Big Lake Community Hospital District,*** Board of Directors
- ***Ridgeview Medical Center***, Robert Stevens, President

North Memorial Medical Center

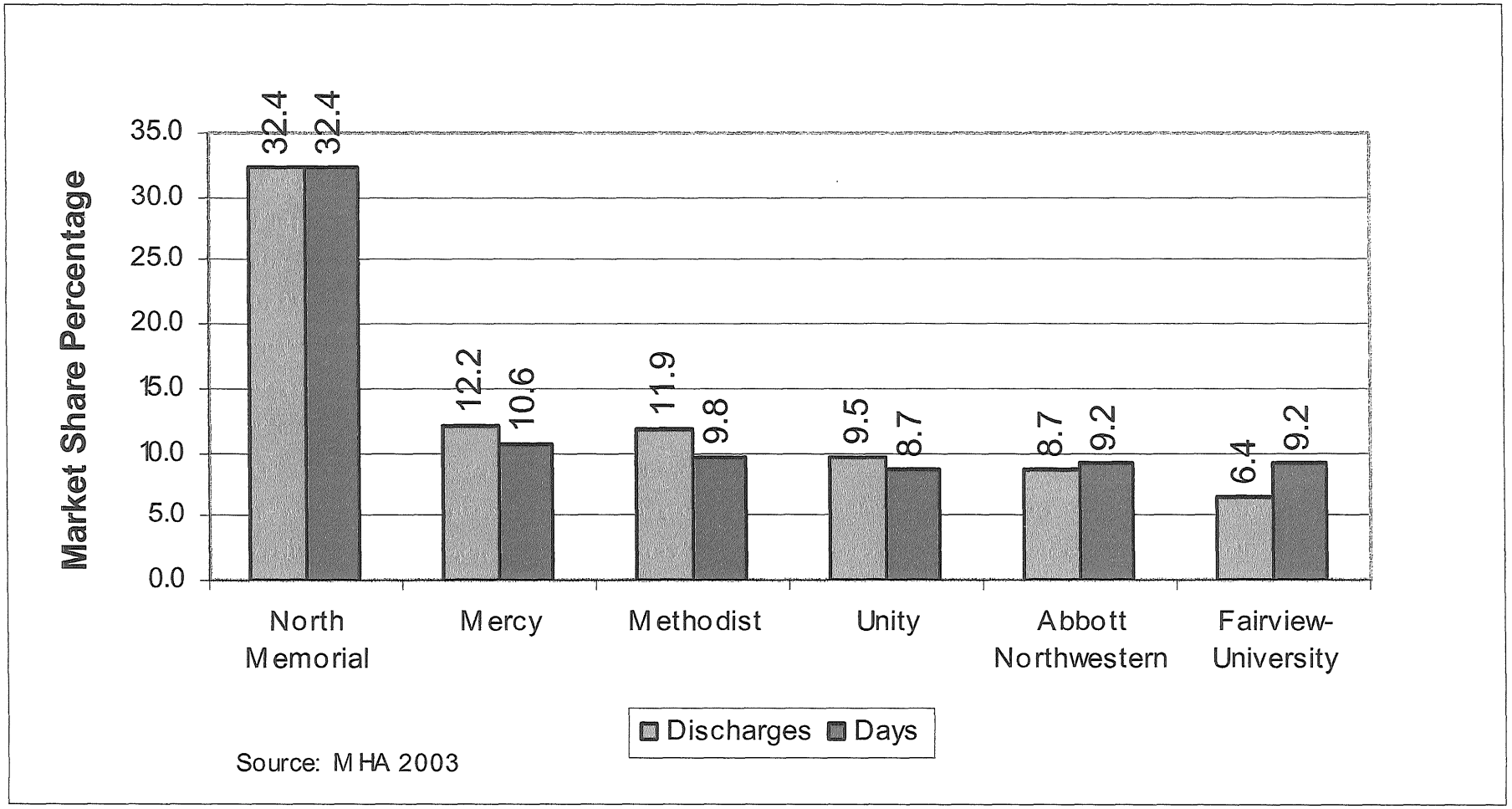
Sample of Affiliations/Universities:

Physician Residency, Nursing and EMT Programs

- University of Minnesota
- HCMC
- Regions
- Anoka Ramsey Community College
- Anoka-Hennepin Technical College
- Augsburg College
- Bethel University
- Century College
- College of St Catherine
- Dakota Technical College
- Hennepin Technical College
- Mpls Community and Technical College
- Minnesota State University, Mankato
- Normandale Community College
- North Hennepin Community College
- South Central Technical College - Mankato
- St Paul Technical College
- St Scholastica
- University of Minnesota – Duluth
- Winona State University

North Memorial Medical Center

Maple Grove Area Market Share



Source: MHA 2003

North Memorial Medical Center

- ✓ *The current Twin Cities market is highly concentrated*
- ✓ *Other proposals will increase this already highly concentrated market*

Herfindahl-Hirschman Index for Adult Inpatient Services Under the Different Maple Grove Proposals

- ✓ *Current Twin Cities Herfindahl-Hirschman Index is 1,914*

Proposal	HHI
North Memorial	1,867
Park Nicollet/Allina	1,963
Fairview	1,921

North Memorial Medical Center

- ✓ *Hospital prices in the Twin Cities will likely be higher if other proposals are implemented*
- ✓ *North Memorial's proposal will result in more competition for inpatient services in the Twin Cities market*

Proposal	Lower Bound		Upper Bound	
	Estimated Price Change	Impact on Hospital Expenditures	Estimated Price Change	Impact on Hospital Expenditures
North Memorial	**-.2%**	**-$17.6 million**	**-.5%**	**-$43.6 million**
Park Nicollet/Allina	.2%	$17.6 million	.5%	$43.6 million
Fairview	.02%	$1.76 million	.08%	$7.0 million

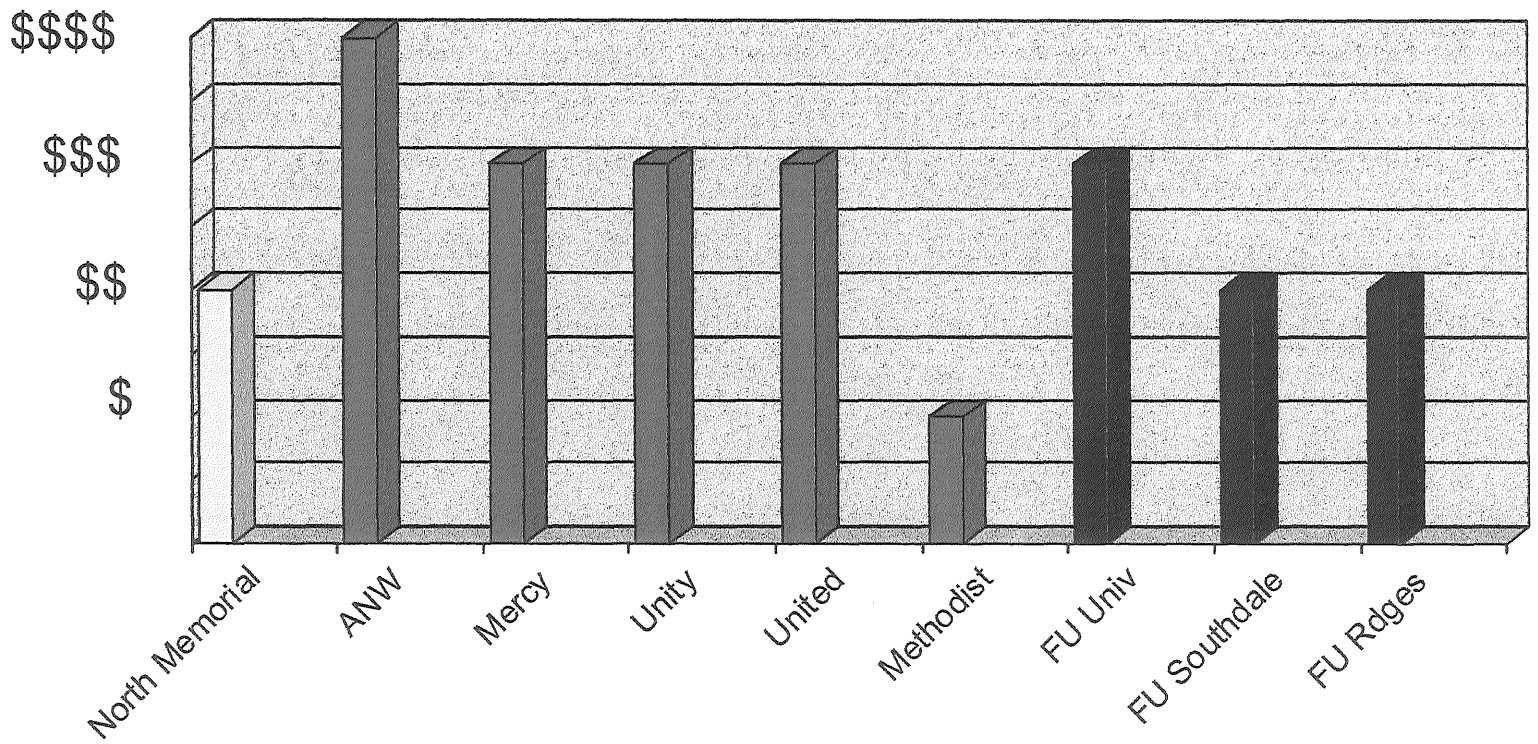
North Memorial
Medical Center

"The legislature has a unique opportunity to positively affect health care competition for the State of Minnesota.... "

Robert J. Town, PhD
University of Minnesota
and
National Bureau of Economic Research
Cambridge, MA
March 21, 2005

North Memorial Medical Center

Hospital Cost To Consumers

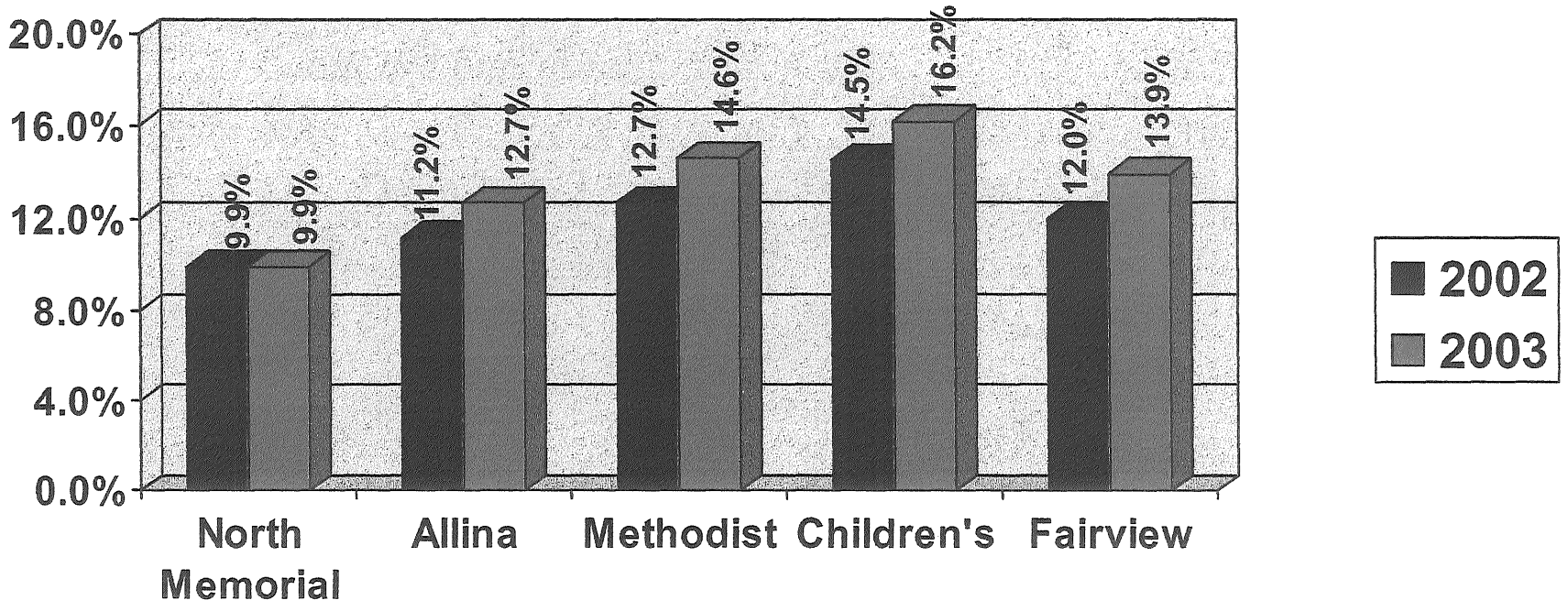


Source:

2004 Blue Cross Blue Shield of Minnesota "Healthcare Facts" Website

North Memorial Medical Center

Administrative Costs as a Percentage of Operating Revenue



Source:

Minnesota Hospital Association

North Memorial Medical Center

Financial Plan

- North Memorial's current credit rating of A2 by Moody's Investors Service demonstrates financial strength and financial capacity to issue necessary debt to fund our plan
- No other health care system proposal under consideration has a higher aggregate credit rating
- North Memorial will be able to access capital markets efficiently and cost effectively

Piper Jaffray & Co.

March 28, 2005

North Memorial Medical Center

North Memorial's Proposal

- Is in the public interest
  - Increases competition in the Twin Cities marketplace
  - Improves access to health care
  - Preserves resources in the local community
- Will develop a complete and comprehensive health care campus
  - Transfer of existing licensed and staffed beds
  - Most cost effective plan for the community
  - Medical expertise in Trauma, Emergency, Orthopedics, Heart, Stroke, Cancer, Obstetrics, Pediatrics and Neonatology...
- ***We Are the Major Provider of Health Care to the Maple Grove Community***

As part of North Memorial's communications effort, an information piece was mailed to all residents in Maple Grove and the surrounding communities to inform them of the plans for a North Memorial Health Care campus in Maple Grove. Below are some of the comments received from residents:

"It would be WONDERFUL to have a North Memorial 'North Branch' here in Maple Grove. There is definitely room for all the people and new construction homes that are going in on the Brooklyn Park/Maple grove/Champlin border! I love North Memorial and the talented/caring staff they currently have."

- Brooklyn Park resident

"My family has used North Memorial for years and I am very happy you will have an annex so close."

- St. Michael resident

"I think this is a great idea!! I have always gone to North Memorial in Robbinsdale, for the birth of my three children and for emergencies with my parents. We have always been very pleased with the service provided. I am currently attending NHCC in hopes of being accepted into the nursing program this fall, I would be interested in any information on jobs that may be opening up with the new building in Maple Grove. I would be interested in anything to start out. Please keep me informed of the progress."

- Maple Grove resident

"Congratulations! I see this as an area of need and growth in the area and a good opportunity for North Memorial. North is our hospital of choice and I'm looking forward to this expansion."

- Brooklyn Park resident

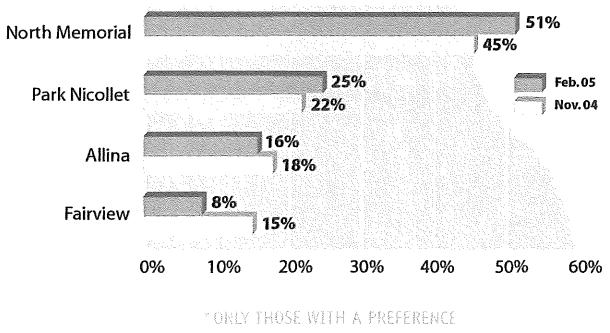
"I think that North Memorial is an exceptional hospital/health care facility. My biggest request would be that this facility would be the one that Champlin residents would use for a 'default' ambulance service. Currently (I believe) we are required to go to Mercy if we have to dispatch an ambulance. I am not satisfied with Mercy's health care, and would prefer North Memorial to be available to me as a Champlin resident. Thank you for your consideration of my opinions."

- Champlin resident

North Memorial Health Care

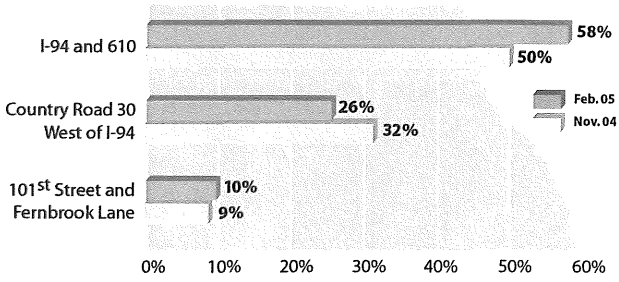
Making the right choice for health care in Maple Grove

Who would you most like to see build a hospital in the Maple Grove area?



*ONLY THOSE WITH A PREFERENCE

If a hospital were added in the Maple Grove area, where is the ideal location?



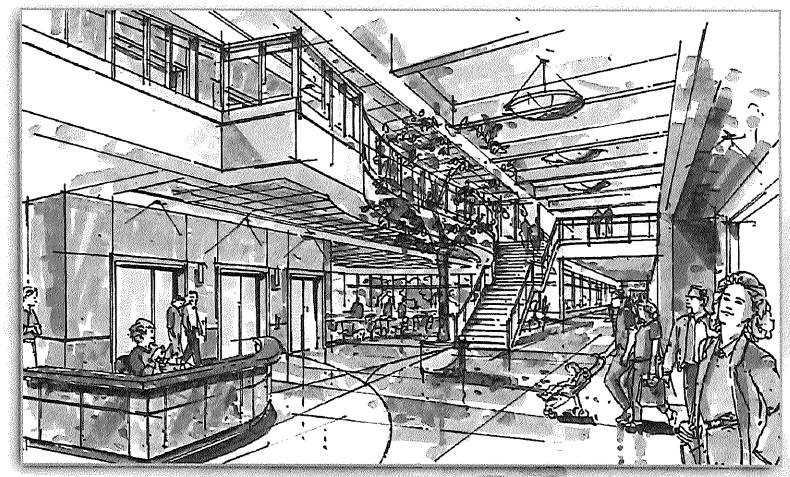
The right care – when you need it. Where you need it.

- North Memorial will be the first organization in Maple Grove to offer **round-the-clock urgent/emergency services** staffed by **board-certified emergency medicine physicians** as a part of its Outpatient Center planned to open in 2006.
- North Memorial is proposing to build **a full-service community hospital by 2008** if approved by the state legislature in 2005. The hospital will include pediatric beds.
- North Memorial is the patient's choice for building a hospital. **Fifty-one percent (51%) of area residents expressing a preference named North Memorial** as the preferred builder of a Maple Grove hospital.
- North Memorial is the only hospital proposing a Maple Grove hospital with **Level I Trauma experience** – experience that will benefit Maple Grove area residents. A new **ambulance base** will be located in Maple Grove beginning in 2006 – providing faster access to emergency care and transportation.
- North Memorial is used by more Maple Grove area residents than any other hospital – **one-third of the Maple Grove community uses North Memorial for their hospital care**. North Memorial offers the best continuity of care for patients.
- Competition in health care keeps costs down and choices up. **North Memorial is the only independent hospital proposing to build in Maple Grove**. A recent evaluation of the competing hospital proposals by a University of Minnesota health economist states that "...patient welfare is best served when hospitals vigorously compete. Hospital prices are lower and the quality of care is higher."
- North Memorial has received **local and national awards and certifications** for its quality and service. We provide excellence in all services-ranging from **heart care**, **cancer care** and **trauma** to **OB-GYN**, **pediatrics** and **senior care**.

For more information on North Memorial's plans in Maple Grove, please visit **northmemorial.com/maplegrove.**

North Memorial Health Care

North Memorial
Health Care



Artist's renderings of the North Memorial Maple Grove campus

Letters of Support

Letters of Support that have been received:

Brooklyn Center, Myrna Kragness, Mayor

Brooklyn Park City Council, Steve Lampi, Mayor

Corcoran, Thomas C. Cossette, Mayor

Crystal, ReNae J. Bowman, Mayor

Dayton City Council, Douglas Anderson, Mayor

Greenfield, Lawrence S. Plack, Mayor

Maple Grove, Mark Steffenson, Mayor

Minneapolis City Council, Don Samuels

New Hope, Martin E. Opem Sr., Mayor

Robbinsdale, Mike Holtz, Mayor

HealthPartners, Mary Brainerd, President & CEO

Hennepin County Board of Commissioners, Mike Opat

Minnesota Neonatal Physicians, Bruce Ferrara, MD, President

Monticello-Big Lake Community Hospital District, Board of Directors

Ridgeview Medical Center, Robert Stevens, President

City of Brooklyn Center
A Millennium Community

February 21, 2005

Commissioner Dianne Mandernach
Department of Health
85th East Seventh Place, Suite 400
St. Paul, Minnesota 55101

Dear Commissioner Mandernach,

I would like to add my thoughts regarding the report your department is preparing relating to a future hospital in the city of Maple Grove. I am the Mayor of the city of Brooklyn Center and appreciate having North Memorial Medical Center and it's excellent staff as the major medical facility used by our community.

I would support North Memorial as the hospital to build its new facility in Maple Grove because:

North Memorial Medical Center is the only Level I Trauma Center facility proposing a hospital. My family and I have personal experience in the excellence of the trained staff and facilities needed in the event of a major medical emergency. They have cared for us many times in the almost 40 years we have been in this area.

North Memorial has proposed moving beds from Robbinsdale to Maple Grove, moving beds where the need is. They are currently in the process of adding a new heart center and emergency department in Robbinsdale. Not taking away the quality of care expected by the people using their facilities, but adding and improving on site.

Maple Grove will benefit in many ways with North Memorial as a independent hospital in their community, and North Memorial will continue to grow and become the medical facility the citizens can count on, as we do here in Brooklyn Center.

I would urge you to endorse North Memorial's plan for a hospital. Bring a new Hospital and it's excellent staff and state of the art equipment to the people of Maple Grove and surrounding area.

I hope my personal endorsement of North Memorial will add to your positive thoughts to bring a quality facility to Maple Grove.

Sincerely,

Myrna Kragness

Myrna Kragness
Mayor of Brooklyn Center MN

6301 Shingle Creek Parkway
Brooklyn Center, MN 55430-2199
City Hall & TDD Number (763) 569-3300
FAX (763) 569-3494

Recreation and Community Center Phone & TDD Number
(763) 569-3400
FAX (763) 569-3434

RESOLUTION #2005-78

RESOLUTION IN SUPPORT OF NORTH MEMORIAL HEALTH CARE'S PROPOSED NEW HEALTH CARE CAMPUS AND HOSPITAL IN MAPLE GROVE

WHEREAS, North Memorial Health Care has a long track record of service in the "northwest corridor" communities; and,

WHEREAS, North Memorial is sincere in its desire to serve our community and they have already invested significantly in the northwest communities by serving our area residents in multiple ways; and,

WHEREAS, North Memorial has the leading market position in cardiology, ENT, general medicine, gynecology, neonatology, neurology, obstetrical and newborn care, cancer, orthopedics, urology, trauma, and emergency medicine; and,

WHEREAS, North Memorial's paramedics, emergency physicians and emergency transport personnel have trained and worked with northwest communities' first responders for decades; and,

WHEREAS, the services offered by North Memorial are needed in growing communities including Brooklyn Park;

THEREFORE, BE IT RESOLVED, that the City of Brooklyn Park endorses the plans of North Memorial to build an outpatient health care campus in Maple Grove and their vision for a hospital on this campus in the future.

The foregoing resolution was introduced by Council Member Meyer and duly seconded by Council Member Gearin.
The following voted in favor of the resolution: Gearin, Lampi, Mata, Meyer, Schmitz, Simmons, and Trepanier.
The following voted against: None.
The following was absent: None.
Where upon the resolution was adopted.

ADOPTED: March 28, 2005

STEVE LAMPI, MAYOR

March 29, 2005

Senator Warren Limmer
121 State Office Building
100 Reverend Martin Luther King Jr. Drive
Room 121
St. Paul, MN 55155

Dear Senator Limmer:

I understand that soon you will be involved in downselecting a hospital for the Maple Grove area. Certainly by now you have received considerable advice on this matter, but I hope you will allow me to express my support for the North Memorial plan.

I grew up in Robbinsdale through the 1960's and have been a resident of Maple Grove and now Corcoran since that time. For my family and for my neighbors' families, the quality and convenience of the North Memorial health care system has made it the preferred system. It is not surprising that the largest percentage of local residents prefer that North Memorial build the hospital.

Putting aside the biases and the claims, let's examine the three things that I think distinguish North Memorial from the competition.

1) North Memorial is the only group to propose a Level 1 Trauma Center. Everything else being equal, this factor by itself should swing the balance in favor of North Memorial.
2) North Memorial has an ambulance based at Corcoran City Hall (and other similar remote locations) 24 hours a day, 365 days a year. It responds rapidly to emergencies here in our area. The other proposers could have provided a similar service, but it was North Memorial that recognized the community need and provided the solution.
3) North Memorial is the only independent—and it is local. Local management translates into a better understanding of the needs of the community.

I know that all three groups are well respected and offer high quality health services. The area will obviously benefit from a new health care complex no matter who builds it. But, there are some real and measurable differences. Please consider those that I have mentioned above.

Sincerely,

Thomas C. Cossette

Thomas C. Cossette
Mayor of Corcoran
793-494-9937

cc Gerald R. Pedlar
Director
Property & Facilities
North Memorial Health Care
3300 Oakdale Avenue North
Robbinsdale, MN 55422

MAR 1 4 2005

CITY of CRYSTAL

4141 Douglas Drive North • Crystal, MN 55422-1696
Telephone: (763) 531-1000 • Fax: (763) 531-1188
Website: www.ci.crystal.mn.us

Commissioner Dianne Mandernach
Department of Health
85th East Seventh Place, Suite 400
St. Paul, MN 55101

February 21, 2005

Dear Commissioner Mandernach:

I would like to take this opportunity to share my perspective regarding the report your department is preparing relating to the future hospital in the Maple Grove area. I represent the Crystal community and I am well acquainted with North Memorial Medical Center.

I support North Memorial's goal to build a hospital in Maple Grove because North Memorial has always been a great friend and neighbor in our community. They have not only sponsored events and provided volunteers they have demonstrated partnerships with the city of Crystal and our local school district (Robbinsdale Area School). When I served as a member of the Robbinsdale School Board, they provided the usual school education programs and helped to finance the cost of our annual district-wide arts calendar.

One of the partnerships is with West Metro Fire Department which serves both Crystal and New Hope. The fire department no longer responds to emergency health calls because it is now done by North Memorial Medical Center's ambulance service. Since NMMC is close and their ambulances are parked in our community, we benefit in two ways:

1. Less strain on the fire department resources along with actual monetary savings
2. Top-notch medical care strategically located to citizens at a time when a citizen needs it most.

North Memorial Medical Center has grown its facility in Robbinsdale during a time when many businesses have taken flight. Their presence in our community provides not only great medical care at all levels, but also provides important jobs that add to the prosperity of our community. They continue to need access to growing communities in order to stay strong and I am convinced they will serve the community of Maple Grove as well as they have served our communities.

I would urge you to endorse North Memorial's plan for a hospital in Maple Grove. NMMC has proven itself to be an excellent neighbor and community partner for the city of Crystal. I know they will continue this tradition of excellence with the city of Maple Grove.

Respectfully,

ReNae J. Bowman
Mayor of Crystal
763/531-2074

City of Dayton

12260 S. Diamond Lake Rd.
Dayton, Minnesota 55327

(763) 427-4589
Fax (763) 427-3708

March 21, 2005

Commissioner Diane Mandernach
Minnesota Department of Health
85 East 7th Place, Suite 400
St. Paul, MN 55101

Dear Commissioner Mandernach:

At their meeting of March 8th, the Dayton City Council unanimously directed me to write a letter of support for North Memorial Health Care relating to the construction of a new hospital in the City of Maple Grove to service the Northwest metro area. As we understand it, your department is preparing a report on a future hospital in the northwest metro area and we would urge you to support North Memorial's plan for a hospital.

North Memorial has long provided our residents excellent medical services, but a new hospital located closer to our community would enhance access to those top-notch medical services. North Memorial is also the only proposer of Level I Trauma Services, which would also enhance access to needed medical services for our growing community. It also makes sense that moving beds from Robbinsdale to Maple Grove will save money in the long run by redistributing beds to where they are needed and not increasing competition for North Memorial's current clientele with new beds from another firm. Overall, this is a "win/win" situation - Dayton residents get enhanced medical services from a trusted health care provider, while North Memorial retains its financial viability by moving the beds where they are now needed most.

We endorse the plans of North Memorial' plans for a new hospital for reasons above and hope that you will also approve of both the expansion of hospital services and North Memorial's plans to do so in Maple Grove. if you should have questions regarding this letter of support, please do not hesitate to contact me at the phone number above.

Sincerely,

Douglas Anderson,
Mayor of Dayton

City of Greenfield
6390 Town Hall Drive
Greenfield, Minnesota 55357-9663
763-477-6464

April 5, 2005

Senator Warren Limmer
127 State Office Building
100 Constitution Avenue
St. Paul, MN 55155-1206

Dear Senator Limmer:

I am writing to offer my support for North Memorial Medical Centers proposal for bringing health care services and a hospital to the City of Maple Grove to service the surrounding communities. The organization has a long track record of service in our area.

North Memorial's paramedics, emergency physicians and emergency transport personnel, including air care have trained and worked with northwest communities' police and firefighters for decades. Their trauma and emergency medicine programs are regional leaders. These services are needed in the growing area of the northwest corridor of the metropolitan area. I believe North Memorial is in a unique position to offer these services to the residents of this area. I support their plans for an outpatient health care campus including a hospital in Maple Grove.

North Memorial Medical Center has served the City of Greenfield and its residents for many years. It is our desire that North Memorial would continue to serve our community with the expansion of a Maple Grove facility. I urge your support for North Memorial's plans in the City of Maple Grove.

Yours truly,

Lawrence S. Plack
Mayor
City of Greenfield

City of
Maple Grove
12800 Arbor Lakes Parkway, P.O. Box 1180, Maple Grove, MN 55311-6180 763-494-6000

November 5, 2004

Dianne Mandernach
Commissioner of Health
85 E. 7th Place
St. Paul, MN 55101

Dear Commissioner Mandernach:

As Mayor of Maple Grove, I am pleased North Memorial has submitted a review process paper to the Minnesota Department of Health for the potential development of a hospital in Maple Grove.

As you are probably aware, Maple Grove and the surrounding suburbs are among the fastest growing communities in Minnesota. We are excited to have a hospital in our community. With a 37.4 percent growth in population between 1990 and 2000 for Maple Grove and eight neighboring suburbs, the need for a hospital to serve the northwest metropolitan area is obvious.

Clearly, with the snarl of congested traffic patterns in the northwest metro area, putting a hospital and its emergency services in the heart of our community would certainly be instrumental in saving lives. The area also is in need of more OB/Gyn services. There are a tremendous number of young families in our region. We also are concerned about the behavioral needs of our citizens, especially teenagers.

We are pleased North Memorial, with its current presence in this area, is interested in adding more community-based care in Maple Grove. We look forward to having a first-rate health care hospital linked to leading, nationally recognized medical centers.

Thank you for your time and attention on this matter. If I can be of any further assistance, please don't hesitate to call me at 763-560-5700.

Sincerely,

Mark Steffenson
Mayor

Minneapolis
City of Lakes

City Council

Don Samuels
Council Member, Third Ward

350 South 5th Street - Room 307
Minneapolis MN 55415-1383

Office 612 673-2203
Fax 612 673-3940
TTY 612 673-2157

January 14, 2005

Commissioner Dianne Mandernach
Minnesota Department of Health
Golden Rule Building
85 East 7th Place
P.O. Box 64882
Saint Paul, MN 55164-0882

Dear Commissioner Mandernach:

I am writing as a public official interested in the decision the Minnesota Department of Health will be making regarding a hospital in Maple Grove, Minnesota. As a Minneapolis City Council Member, and a community leader in the north Minneapolis area, I am very familiar with North Memorial Medical Center, one of the organizations submitting a proposal to build a hospital in Maple Grove.

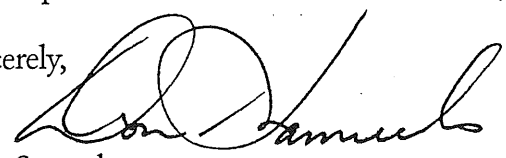
I believe one of the considerations in your evaluation should be the quality of care from the hospital, but also the quality of the hospital as a community partner. North Memorial has been a strong and steady community partner for Minneapolis as well as a provider of excellent care. For example, their education department works with North High School to expose high school students to health care careers, and Carol Kelsey, North's education director services on the Career Center advisory board.

They are also a long-time sponsor of Healthy Neighbors, a program focused on neighborhood revitalization on the north side of Minneapolis and the Jordan neighborhood.

I respect that your department has a difficult task in reviewing proposals to build in Maple Grove. I do urge you to consider these facts in making your decisions: 1) North Memorial was the first hospital to focus on the northeast side of Minneapolis, and has earned a strong following and one-third of the market share in the Maple Grove area; 2) North has a proven track record as a good community partner and they would be a good partner in the northwest corridor communities, and 3) giving North Memorial the opportunity to grow in the suburban areas would help keep them strong in the urban area. The larger hospital systems have other branch hospitals where they can extend their reach. North Memorial is an independent, one-location hospital, and they need to have access to patient growth areas to keep them strong. Please consider North Memorial as the best partner for a new hospital in Minnesota.

Thank you for your acknowledgement that this decision needs to be made with Minneapolis and Robbinsdale in mind— not just Maple Grove.

Sincerely,



Don Samuels
Minneapolis City Council

Commissioner Dianne Mandernach
Department of Health
85th East Seventh Place, Suite 400
St. Paul , Minnesota 55101

Dear Commissioner Mandernach:

I would like to take this opportunity to share my opinion regarding the report your Department is preparing relating to a future hospital in the Maple Grove area (North West Metro). I represent the New Hope community, which is a part of the North West Metro Area that is currently served by The North Memorial Medical Center. As the Mayor of New Hope and as a resident of North Memorial's service area I am knowledgeable of the excellent care this hospital provides for New Hope's residents as well as the entire area.

I support North Memorial to be the prefer hospital for this needed expansion.

1) North Memorial is the only Hospital that is a Level 1 Trauma Center of all those Applying for consideration. Their Staff is well trained, and able to handle all Emergencies. North Memorial should be given extra consideration for this level of experience.
2) North Memorial is currently serving this community and receives about 20% of its current patient base from the immediate Maple Grove, Rogers, Elk River area the very residents the expansion is to serve. If this portion of North Memorials base is allowed to be served by a different medical facility it could have a very negative effect on North's ability to serve the entire North West Metro Area and my City's residents.
3) North Memorial purposed a very well planned expansion allowing for the improved care of the entire North West Metro area, for the continued great care at it's Robbinsdale Base and the new treatment facility/hospital in Maple Grove.
4) North Memorial Supports my community emergency medical response and transport and their air lift fleet covers a large area of MN. . Again weakening North Memorial by not allowing them access to maintain their current clientele and this controlled expansion will surely hurt North Memorial's ability to maintain itself as a true health care leader and a valuable community member/ contributor.

In summary, I strongly urge you and your staff to endorse North Memorial as the Hospital of choice for the planned Maple Grove expansion as well as their plan to make it happen

Sincerely,

Martin E. Opem Sr.
Mayor of New Hope

CITY OF NEW HOPE

4401 Xylon Avenue North • New Hope, Minnesota 55428-4898 • www. ci.new-hope.mn.us
City Hall: 763-531-5100 • Police (non-emergency): 763-531-5170 • Public Works: 763-592-6777 • TDD: 763-531-5109
City Hall Fax: 763-531-5136 • Police Fax: 763-531-5174 • Public Works Fax: 763-592-6776

bcc: Jerry Pedlar

City of Robbinsdale

4100 Lakeview Avenue North
Robbinsdale, Minnesota 55422-2280
Phone: (763) 537-4534
Fax: (763) 537-7344
www.robbinsdalemn.com

February 14, 2005

Commissioner Dianne Mandernach
Minnesota Department of Health
85 East 7th Place
Suite 400
St. Paul, MN 55101

Dear Commissioner Mandernach:

I would like to take this opportunity to share my perspective regarding the report your department is preparing relating to a future hospital in the Maple Grove area. I serve as Mayor of Robbinsdale, which is the home of North Memorial Medical Center, and I'm well acquainted with North Memorial and its staff.

I would support North Memorial as the organization to build a hospital in Maple Grove because:

- North Memorial is a good neighbor as proven by their participation in the Robbinsdale community, with sponsorship of events and providing numerous volunteers in our community.
- North Memorial Medical Center is the only Level I Trauma Center facility proposing a hospital. As such, they have the experience and depth of trained staff to respond to any level of trauma or injury. Our residents have benefited many times from the care and healing of this trauma staff.
- North Memorial has proposed a very rational approach for moving beds from Robbinsdale to Maple Grove. They are moving the beds to where the patients are moving. Yet, they are also still investing in our Robbinsdale area, with new outpatient services in our neighborhood and by continuing to improve the current hospital.
- As a single, independent hospital, North Memorial needs access to growing communities, such as Maple Grove, in order to stay strong. I'm concerned that if larger hospital systems are the only ones allowed access to new markets that North Memorial's long-term stability could be harmed, which has a direct negative impact on Robbinsdale.

In summary, I would urge you to endorse North Memorial's plan for a hospital in Maple Grove. North has proven itself to be an excellent community partner in Robbinsdale and I know they would continue this tradition of excellence and citizenship in Maple Grove.

Sincerely,

Mike Holtz
Mayor of Robbinsdale

MH:mm

HealthPartners®

November, 2004

To Whom It May Concern:

For over seven years, HealthPartners has enjoyed a positive and successful relationship with North Memorial Medical Center. The decision to make North Memorial a significant partner in our west-metro strategy was based on their high standards and proven track record in the community they serve. It was also based on selecting a partner that demonstrated the same commitment to patient care and desire to continuously look for ways to improve care.

North Memorial is a health care organization that is well respected by physicians. Over 20 years ago, North worked collaboratively with primary care physicians to help establish clinics to serve the northwest region; they encouraged physicians to practice in the area. They are committed to improving care and their actions demonstrate that commitment, with a current marketshare of greater than 50 percent.

It is a well known fact, for several decades, that their Level I Trauma services and emergency transport system have provided peace of mind to the west and northwest regions. In addition, North is the trusted partner for Minneapolis Children's providing top level newborn intensive care services. North offers its partners value by delivering a full range of the best inpatient and outpatient specialty services, including general medical, surgery, cardiology, obstetrics, orthopedics, neurology, and emergency services.

When we began our evaluation process to select a west-metro hospital partner, we looked for qualities that reflect a hospital's long term commitment to a community, the provision and mix of a full-range of specialty services and high ratings with respect to patient satisfaction. North delivered on our selection criteria, and continues to do so.

North has demonstrated its desire to serve all patients in an exceptional manner. Our recent patient satisfaction survey results show that patients rank them at a 95% or greater level in all areas. Examples of areas assessed included: overall satisfaction with hospital care, willingness to recommend the hospital to others, the attention received from nurses and being treated with respect and dignity.

We trust North Memorial as a proven partner in providing the kind of care and service that we expect for the benefit of our patients, our members and the community.

Sincerely,

Mary Brainerd

Mary Brainerd
President & Chief Executive Officer
HealthPartners

MIKE OPAT
COMMISSIONER

612-348-7881
FAX-348-8701
mike.opat@co.hennepin.mn.us

BOARD OF HENNEPIN COUNTY COMMISSIONERS
A-2400 GOVERNMENT CENTER
MINNEAPOLIS, MINNESOTA 55487-0240

November 29, 2004

To Whom It May Concern:

I understand North Memorial Health Care has a comprehensive plan for bringing expanded health care services to the Maple Grove community. As an elected official that represents a number of Northwest suburbs, I strongly encourage you to embrace North Memorial's proposal.

I am very familiar with the outstanding care North Memorial provides and the organization's commitment to our area. When we launched the Northwest Corridor Partnership to transform County Road 81, North Memorial was our first private partner. I know North Memorial is committed to this region for the long-term.

North Memorial has already made significant investments in the Maple Grove area and is a recognized leader in cardiology, ENT, general medicine, gynecology, neonatology, neurology, obstetrical and newborn care, oncology, orthopedics and urology.

As you know, North Memorial's paramedics, emergency physicians and emergency transport personnel have trained and worked with northwest communities' first responders for decades, and their trauma and emergency medicine programs are regional leaders. These services are needed in Maple Grove, and North Memorial is uniquely qualified to provide them. I strongly support their plans for a Maple Grove outpatient health care center and their vision for a hospital on this campus.

Research suggests thousands of area residents already consider North Memorial their "home-town" hospital. I urge your support for North Memorial's plans for expanded health care in Maple Grove. Please contact me if you have questions or would like further information.

Sincerely,

Mike Opat
Hennepin County Board of Commissioners

Monticello-Big Lake Community
HOSPITAL DISTRICT

April 11, 2005

tor Warren Limmer
100 Rev. Dr. Martin Luther. Blvd., Room 121
St. Paul, MN 55155-1206

Dear Senator:

The Monticello - Big Lake Hospital District is pleased to support North Memorial Health Cares initiative to build a hospital in Maple Grove. We have had a consulting agreement with North Memorial Health Care since 1990. The agreement includes:

Open and active networking of management and staff. It is the intent for District management and staff to develop a peer relationship(s) with management and staff at NMHC. Advice and consultation should flow freely through telephone conversations, mailing, and site visits. The intent is for this exchange of information to be done efficiently and at the lower level in the organization as possible. This networking will include but will not be limited to:

- *JCAHO accreditation assistance.*
- *Improving process improvement programs.*
- *Improving clinical programs and providing clinical experience when appropriate.*
- *Maintaining a safety and hazardous waste program.*
- *Strategic planning assistance.*
- *Information management processes review.*
- *Financial processes review.*
- *Participation in ongoing education programs at NMHC.*

In addition we have a contract with North Memorial for Emergency Department 24/7 physician staffing.

We are currently working with North Memorial and Monticello Clinic to build a new clinic facility. Many of the specialists on our staff are affiliated with North Memorial and the new clinic will provide space for new specialists and enhancements for the current specialists.

All the while Monticello - Big Lake Hospital District has maintained its independence and developed as a health care facility to serve the needs of our District residents.

The rapid growth of Maple Grove and its need for additional medical services and a hospital would be well served by North Memorial Health Care.

Sincerely,

P Hamond, Chairman

Linda Doerr, Vice Chair

Bob Dawson, Treasurer

Mark Philbrook, Secretary

Jim Agosto, Director

Marvin Rydberg, Director

Richard Helms, Director

Doug Schneider, Director

1013 Hart Boulevard * Monticello, MN 55362
Phone (763) 295-2945 * www.mblch.com

Ridgeview MEDICAL CENTER

500 South Maple Street • Waconia, MN 55387-1791
952/442-2191 800/967-4620

December 21, 2004

Scott Leitz, Director
Health Economics Program
Minnesota Department of Health
85 East 7th Place, Suite 300
St. Paul, MN 55101

Re: Hospital Bed Moratorium Law as it relates to a proposed hospital in Maple Grove, Minnesota

Dear Mr. Leitz:

As President of Ridgeview Medical Center, Waconia, Minnesota, I'm pleased to provide input into the proposal to build a new hospital in Maple Grove, Minnesota.

This letter is not directed at the specific needs for additional hospital beds within this marketplace. I'm assuming that the Minnesota Department of Health, as well as the prospective applicants, have done their due diligence in regards to the need for a hospital in this marketplace and its affect on area facilities that would provide similar services.

My comments are related to which applicant is best suited to be awarded an exemption from the state's hospital bed moratorium law to construct a hospital within this community. Although all three health systems have provided excellent care and have the financial where-with-all to build and operate an acute care hospital, one of these health systems has compelling differences that should weigh heavily in their favor. Of the three applicants for this exemption, North Memorial Health Care has two factors that tip the scales in its favor. The first significant advantage is that North Memorial Health Care currently serves the majority of patients from this marketplace. Patients obviously have the confidence and knowledge of North Memorial that they actively seek this organization out for their healthcare services.

Secondly, North Memorial Health Care is a single hospital health system. They do not manage or have ownership interest in any other acute care facility in the state of Minnesota. The other two applicants have considerable acute care hospital holdings not only in Minnesota, but also surrounding this marketplace. To award an exemption to construct hospital beds to either the Fairview Health System or Park Nicollet/Allina would continue the current consolidation of health care services within the seven county

metro area and Minnesota as a whole. This would reduce competition without any demonstrable difference in quality or cost.

Assuming that a demonstrated need for acute care hospital beds is determined, I would then encourage the Department of Health to strongly consider North Memorial Health Care as the desired entity to build an acute care hospital in Maple Grove, Minnesota. Should you have any questions or concerns regarding this letter, please don't hesitate to contact my office directly.

Sincerely,

Robert Stevens
President

Cc: Mike Werner, Chairman, Ridgeview Medical Center Board of Directors
Bcc: Dave Cress, Executive Vice President/COO, North Memorial Medical Center

Economic Study

The Impact of North Memorial, Park-Nicollet / Allina / Children's and Fairview Proposals to Build a Maple Grove Hospital on Hospital Competition in the Twin Cities

Robert Town, Ph.D.
University of Minnesota
School of Public Health
and
National Bureau of Economic Research,
Cambridge, MA

Executive Summary

The goal of this analysis is to estimate the impact of the three different Maple Grove hospital proposals on hospital competition in the Twin Cities hospital market. This analysis is based on the results of an econometric model of patient hospital choice for inpatient care. The estimates and resulting simulations suggest four related conclusions:

- The current Twin Cities hospital market is "highly concentrated."
- The North Memorial proposal will result in more competition for inpatient services in the Twin Cities marketplace.
- The Park Nicollet / Allina / Children's and the Fairview Maple Grove proposals will enhance each organization's market power in the metropolitan Twin Cities area resulting in a highly concentrated market becoming more concentrated.
- Hospital prices in the Twin Cities will likely be higher if either the Park Nicollet / Allina / Children's or Fairview Proposals for a Maple Grove hospital are implemented over the North Memorial Proposal.

The lack of hospital competition can be harmful to patient health and patient pocketbooks. Research has shown that an increase in hospital competition leads to lower prices for inpatient care. Furthermore, recent analysis shows that an increase in hospital competition reduces health insurance premiums. Research also suggests that increased hospital competition improves the quality of patient care. Thus, the evidence suggests that patient welfare is best served when hospitals vigorously compete. Hospital prices are lower and the quality of care is higher.

The most widely used measure of competition in the economics literature is the Herfindahl-Hirschman Index (HHI). The HHI is calculated by summing the squared market shares for all of the market participants for a defined product and geographic market. The higher the HHI, the more concentrated the market. Table 1 presents the HHIs for the metropolitan Twin Cities in 2003 and the implied HHIs for each of the three Maple Grove hospital proposals if they were implemented.

Table 1
Herfindahl-Hirschman Index for Adult Inpatient Services under the Different Maple Grove Proposals

Proposal	HHI
North Memorial Proposal	1,867
Park Nicollet / Allina Proposal	1,963
Fairview Proposal	1,921
Current Twin Cities HHI is 1,914	

The results in Table 1 indicate that currently the Twin Cities market is according to the US Department of Justice and Federal Trade Commission "highly concentrated."[1] Relative to other metropolitan areas its size, the Twin Cities market is approximately 20% more concentrated than the median metropolitan area with a population between 2.5 and 3.5 million.

The results in Table 1 show that the North Memorial's proposal for Maple Grove will reduce the HHI and therefore increase hospital competition in the Twin Cities market. The post-construction HHI is estimated to be 1,867 — 2.5% ***decline*** in market concentration. In contrast, both of the Park Nicollet / Allina / Children's and Fairview proposals are predicted to lead to higher concentrations with the Park Nicollet / Allina / Children's proposal ***increasing*** concentration approximately 2.6%. Currently, the Allina system has an approximate 32% market share and the Fairview system has an approximate 19% market share.

Several studies have found that increasing concentration in hospital markets leads to higher hospital prices in California. Using the parameter estimates from two studies that serve to provide an upper and lower bound on the price effects, I calculate the impact of the different proposals on the price of adult inpatient care and the annual total hospital expenditures for the non-Medicare population in the Twin Cities.[2] Table 2 summarizes these results. The North Memorial proposal modestly reduces prices while the other two proposals are predicted to modestly increase the price of inpatient hospital services.

Table 2
Estimated Price Impact from Maple Grove Proposals

Proposal	Lower Bound		Upper Bound	
	Estimated Price Change	Impact on Annual Hospital Expenditures	Estimated Price Change	Impact on Annual Hospital Expenditures
North Memorial Proposal	-.2%	-$2.1 million	-.5%	-$5.2 million
Park Nicollet / Allina / Children's Proposal	.2%	$2.1 million	.5%	$5.2 million
Fairview Proposal	.02%	$209,000	.08%	$834,000

[1] According to the US DOJ/FTC *Merger Guidelines* a market with a HHI between 1,000 and 1,800 is considered "moderately concentrated," and a market with a HHI over 1,800 is considered "highly concentrated."

[2] The estimates from Dranove and Ludwick (1999) provide the upper bound and the estimates from Keeler, Melnick and Zwanziger (1999) provide the lower bound. Both studies are published in the *Journal of Health Economics*, 18 (1). Hospital revenue information is from Medicare Cost Reports.

The decision of which hospital system should build in Maple Grove will impact hospital competition into the foreseeable future. In order to get a sense of the long term impact of the different proposals on health care expenditures I calculate the 10-year present discounted value expressed in current dollars of the hospital expenditures effects in Table 2. Table 3 presents those calculations.

Table 3
Estimated Cumulative 10-year Impact of Maple Grove Proposals

Proposal	Lower Bound		Upper Bound	
	Estimated Price Change	Impact on Hospital Expenditures	Estimated Price Change	Impact on Hospital Expenditures
North Memorial Proposal	-.2%	-$17.6 million	-.5%	-$43.6 million
Park Nicollet / Allina / Children's Proposal	.2%	$17.6 million	.5%	$43.6 million
Fairview Proposal	.02%	$1.76 million	.08%	$7.0 million

Note: Calculations assume discount factor of 4%

Over a 10-year period there is an approximate $87 million differential impact on health care expenditures between the North Memorial and the Park Nicollet / Allina / Children's Proposal using the upper bound estimates. The estimated differences in the impact between the North Memorial and Fairview proposals are smaller, but nonetheless substantial. If the Fairview proposal is implemented hospital expenditures over this 10-year period are expected to increase $50 million over North Memorial proposal.

Affiliations

Physician Residency Programs

Affiliation Agreements
Between
North Memorial Health Care
and
Universities/Affiliation in the State of Minnesota
April 2005

University/Affiliation	Physician Residency Programs
University of Minnesota	Anesthesia Colon/Rectal Surgery Family Practice General Surgery Neurology Oral Surgery Plastic Surgery
Smiley's Clinic	Family Practice
HCMC	Emergency Medicine Vascular Surgery
Regions	Emergency Medicine

Nurses and Other Health Care Professionals

Education Affiliation Agreements
Between
North Memorial Health Care
and
Colleges/Universities in the State of Minnesota
April 2005

College/University	Degree Program(s)
Anoka Ramsey Community College	RN, AS (2 year program) Physical Therapy Assistant
Anoka-Hennepin Technical College	Medical Assistant Phlebotomy Surgical Technology Occupational Therapy Assistant (OTA) Practical Nursing Sterile Processing
Argosy University	Medical Laboratory Technician Histology Technician Medical Assistant
Augsburg College	Physician Assistant (PA) Social Work
Bethel University	Nursing, RN, BSN
Century College	Nursing, AA (2 year) Pharmacy Tech Paramedic

College/University	Degree Program(s)
Dakota County Technical College	Biomedical Equipment Technology
Hennepin Technical College	Health Unit Coordinator Emergency Medical Technician -Basic (EMT-B) -Intermediate (EMT-I) -Emergency Room Technician -Phlebotomy
Inver Hills Community College	Nursing, AA (2 year) Paramedic
Lake Superior College	Respiratory Care Practitioner Nurse Refresher
Minneapolis Community and Technical College	Perioperative Nursing
Minnesota State University, Mankato	Speech Pathology Cardiac Rehab Nursing, BSN
Normandale Community College	Nursing, AS (2 year) Dietetic Technician, AD
North Hennepin Community College	Noninvasive Cardiology Technology Nursing Assistant Nursing, RN, AD

College/University	Degree Program(s)
College of St. Catherine	Medical Records/Health Information Specialist, AAS Nursing, AAS Occupational Therapy Assistant (OTA) Occupational Therapist Phlebotomy Physical Therapist, MPT Physical Therapy Assistant Respiratory Therapist, AAS Social Work, BSW & MSW Sonography, AAS
St. Paul Technical College	Respiratory Care Practitioner Medical Laboratory Technician
St. Scholastica, College of	Physical Therapy, MA Occupational Therapy Nursing
University of Minnesota	Communication Disorders Dietetics, BS and Masters Genetic Counseling, Graduate Program Occupational Therapy, BS and Masters Physical Therapy, Masters Nursing, BS & Masters Pharmacy
University of Minnesota – Duluth	Communication Sciences and Disorders
Winona State University	Clinical Nurse Specialist, Masters

Nurses and Other Health Care Professionals

Education Affiliation Agreements
Between
North Memorial Health Care
and
Out-of-State Colleges/Universities
April 2005

College/University	Degree Programs(s)
Creighton University *Omaha, Nebraska*	Nursing
Graceland University *Independence, Missouri*	Nursing
North Dakota State University *Fargo, North Dakota*	Lifestyles Management
St. Louis University *St. Louis, Missouri*	Physician Assistant
University of Iowa *Iowa City, Iowa*	Physical Therapy
University of North Dakota *Grand Forks, North Dakota*	Physical Therapy
University of South Dakota *Vermillion, South Dakota*	Physician Assistant
University of Wisconsin System • *Eau Claire* • *LaCrosse* • *Madison* • *River Falls*	Occupational Therapy Physical Therapy Speech Pathology

Emergency Medical Technician/Paramedic

Education Affiliation Agreements
Between
North Memorial Health Care
and
College/Affiliation
April 2005

College/Affiliation	Clinical Internship Programs
Anoka Ramsey Community College	Shared with hospital for RN's
Avera Mckennon Hospital	Emergency Medical Technician/Paramedic
Century College	Shared contract with the hospital
Emergency Training Associates	Emergency Medical Technician/Paramedic
Hennepin Technical College	Emergency Medical Technician
Inver Hills Community College	Emergency Medical Technician Emergency Medical Technician/Paramedic
Lake Superior State College	Emergency Medical Technician/Paramedic
North Hennepin Community College	Shared with hospital for RN's
South Central Technical College (Mankato)	Emergency Medical Technician/Paramedic
University of Iowa Hospital and Clinics	Emergency Medical Technician/Paramedic

Minnesota Hospital Public Interest Review:

Maple Grove Tri-Care Partnership Proposal for a New Inpatient Facility in Maple Grove, Minnesota

Minnesota Department of Health

March 2005

MINNESOTA MDH DEPARTMENT OF HEALTH

Office of Health Policy, Statistics and Informatics
Health Economics Program
PO Box 64882
St. Paul, Minnesota 55164-0882
(651) 282-6367
www.health.state.mn.us

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, maintaining and improving the health of all Minnesotans

March 11, 2005

The Honorable Jim Abeler
Chair, Health Care Cost Containment Division
Minnesota House of Representatives
509 State Office Building
100 Rev. Dr. Martin Luther King Jr. Blvd.
Saint Paul, Minnesota 55155

The Honorable Linda Berglin
Chair, Health and Human Services
Budget Division
Minnesota Senate
Room 309, State Capitol
75 Rev. Dr. Martin Luther King Jr. Blvd
Saint Paul, Minnesota 55155-1606

The Honorable Fran Bradley
Chair, Health Policy and Finance
Committee
Minnesota House of Representatives
563 State Office Building
100 Rev. Dr. Martin Luther King Jr. Blvd.
Saint Paul, Minnesota 55155

The Honorable Becky Lourey
Chair, Health and Family Security
Committee
Minnesota Senate
Room G-24, State Capitol
75 Rev. Dr. Martin Luther King Jr. Blvd
Saint Paul, Minnesota 55155-1606

To the Honorable Chairs:

Minnesota Statutes 144.552 requires any hospital seeking to increase its number of licensed beds or an organization seeking to obtain a hospital license to submit a plan to the Commissioner of Health. The Commissioner is required to review each plan submitted under Minnesota Statutes 144.552 and issue a finding on whether the plan is in the public interest. The law requires that the Commissioner provide a copy of the finding on whether the plan is in the public interest to the chairs of the House and Senate committees having jurisdiction over health and human services policy and finance.

In November 2004, the MDH received three proposals from entities planning to seek a license to build a new hospital in Maple Grove, Minnesota. North Memorial Health Care and Fairview Health Services each submitted a proposal, and the third proposal was submitted by a partnership between Allina Hospitals and Clinics, Park Nicollet Health Services, and Children's Hospitals and Clinics (the "Maple Grove Tri-Care Partnership"). Consistent with the requirements of Minnesota Statutes 144.552, we have reviewed each of the three plans that we received. Because the law does not specifically contemplate situations in which more than one proposal may be submitted for the same geographic area, we reviewed each of the plans individually. A separate report and findings for each of the plans submitted to MDH for public interest review is enclosed.

All three of the reports find that it is in the public interest to construct a new hospital in Maple Grove. From a local perspective, the Department concurs that the community can support a hospital of the size and scope proposed, and that a new facility would provide more convenient access to services for residents in the community. From a statewide perspective, the Department finds that existing inpatient hospital capacity is likely to experience increasing strains over the next decade, and that construction of some new capacity may be necessary to relieve those strains. Because hospitals that currently serve the Maple Grove area collectively account for about one third of total hospital admissions in Minnesota, this issue is a statewide concern. The three proposals address this issue to varying degrees. Also to varying degrees, all three proposals specifically address issues of statewide concern such as a shortage of inpatient behavioral health services. In considering whether to grant an exception to the hospital moratorium, the legislature may wish to give strong consideration to whether certain services, such as inpatient behavioral health services, should be included as a requirement under any moratorium exception granted.

While the Department finds that it is in the public interest to construct a new hospital in Maple Grove, we believe that it is unlikely that the construction of three new inpatient facilities in Maple Grove would be in the public interest. As noted above, the legislation establishing the public interest review process did not contemplate a situation in which there would be simultaneous proposals to expand hospital capacity in the same geographic area. A direct comparison of the three proposals and recommendation as to which proposal is best is beyond the scope of the Department's authority under the law.

I look forward to working with into the future on issues of hospital capacity in Minnesota.

Sincerely,

Dianne M. Mandernach

Dianne M. Mandernach
Commissioner
P.O. Box 64882
St. Paul, Minnesota 55164-0882

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As required by Minnesota Statute 3.197: This report cost approximately $75,000 to prepare including staff time, printing and mailing expenses

Table of Contents

1. Background

Since 1984, Minnesota law has prohibited the construction of new hospitals or expansion of bed capacity of existing hospitals without specific authorization from the Legislature (Minnesota Statutes 144.551). As originally enacted, the law included a few specific exceptions to the moratorium on new hospital capacity; other exceptions have been added over time, and there are currently 18 exceptions to the moratorium that are listed in the statute. Many of these exceptions apply to specific facilities, but some define an exception that applies more broadly (for example, an exception that allows for the relocation of a hospital within five miles of its original site under some circumstances).

The moratorium on licensure of new hospital beds replaced a Certificate of Need (CON) program that provided for case-by-case review and approval of proposals by hospitals and other types of health care providers to undertake large projects such as construction and remodeling or purchases of expensive medical equipment. The CON program was in effect from 1971 until it was replaced by the hospital moratorium in 1984. The CON program was criticized for failing to adequately control growth, but at the same time there was substantial concern among policymakers about allowing the CON program to expire without placing some other type of control on investment in new capacity.

At the time the hospital moratorium was enacted, policymakers were concerned about excess capacity in the state's hospital system, its impact on the financial health of the hospital industry, and its possible impact on overall health care costs. According to a 1986 Minnesota Senate Research Report on the hospital moratorium, "Declining occupancy has resulted in thousands of empty hospital beds across the state, in financial difficulty for some hospitals, and in efforts by hospitals to expand into other types of care. In spite of the excess hospital capacity in the state, hospitals continued to build and expand until a moratorium was imposed...."[1] The moratorium was seen as a more effective means of limiting the expansion of hospital capacity than the Certificate of Need program it replaced. One drawback of the moratorium, however, has been that there is no systematic way of evaluating proposals for exceptions to the moratorium in terms of the need for new capacity or the potential impact of a proposal on existing hospitals.

[1] "Hospital and Nursing Home System Growth: Moratoria, Certificate of Need, and Other Alternatives," Minnesota Senate Research Report, by Dave Giel and Michael Scandrett, January 1986.

2. Hospital Public Interest Review Process

In 2004, the Legislature established a new process for reviewing proposals for exceptions to the hospital moratorium (Minnesota Statutes 144.552). This "public interest review" process requires that hospitals planning to seek an exception to the moratorium law submit a plan to the Minnesota Department of Health (MDH). Under the law, MDH is required to review each plan and issue a finding on whether the plan is in the public interest. Specific factors that MDH is required to consider in the review include:

- Whether the new hospital or hospital beds are needed to provide timely access to care or access to new or improved services;
- The financial impact of the new hospital or hospital beds on existing acute-care hospitals that have emergency departments in the region;
- How the new hospital or hospital beds will affect the ability of existing hospitals in the region to maintain existing staff;
- The extent to which the new hospital or hospital beds will provide services to nonpaying or low-income patients relative to the level of services provided to these groups by existing hospitals in the region; and
- The views of affected parties.

Finally, the law requires that the public interest review be completed within 90 days, but allows for a review time of up to six months in extenuating circumstances. Authority to approve any exception to the hospital moratorium continues to rest with the Legislature.

In November 2004, MDH received three separate filings for public interest review of a proposal to build a new hospital in Maple Grove, Minnesota. North Memorial Health Care and Fairview Health Services each submitted proposals, and a joint proposal from Allina Hospitals and Clinics, Park Nicollet Health Services, and Children's Hospitals and Clinics (collectively, the "Maple Grove Tri-Care Partnership") was also submitted. The law that established the public interest review process does not specifically contemplate situations in which more than one proposal for an exception may be submitted for the same geographic area. With regard to the three applications for public interest review that MDH has received for the Maple Grove area, we have reviewed each plan separately according to the criteria established in the law. It is important to note that each of the three proposed projects also involves the construction of large new outpatient facilities that will provide a broad range of services such as primary and specialty care, ambulatory surgery, and diagnostic imaging, with construction beginning as early as 2005; however, Minnesota law does not restrict the ability to construct outpatient facilities in the same way as it does for inpatient facilities, and those portions of the proposed projects are therefore outside of the scope of MDH's public interest review.

Our review of each proposal included several different components. Some of these components, such as soliciting public input, reviewing historical and projected data on population demographics and hospital use, and reviewing previously published research on relevant topics, were overlapping among the three proposals. Other aspects of our review, such as estimating the potential impact of the proposed facility on other hospitals in the region and evaluating each proposal in light of the specific criteria listed in the law, were conducted separately for each proposal.

The remainder of this report is organized as follows:

- Section 3 provides a summary of the comments from the public and other affected parties that we received related to the need for a hospital in Maple Grove;
- Section 4 presents information on trends in the use of hospital services and how the use of hospital services is projected to change as a result of future demographic changes, from a statewide and regional perspective and also for the local hospital market serving residents of the Maple Grove area;
- Section 5 evaluates Tri-Care's plan to build a hospital in Maple Grove in light of the criteria for review that are specified in Minnesota Statutes 144.552;
- Section 6 concludes the report with a summary of the analysis and findings, along with other factors that policymakers may wish to consider in evaluating this proposal for an exception to the hospital moratorium.

3. Public Input

We used three strategies to collect input on the views of affected parties. First, we sent a letter to all hospital administrators in Minnesota notifying them of the plans that had been filed and soliciting their input if they wished to provide any. Second, we published a notice in the December 6, 2004 State Register as a general notice to interested parties that we had received three plans and providing an opportunity to comment on the proposals. Third, we held a public meeting in Maple Grove on January 11, 2005 to solicit input from the community on the need for a hospital in Maple Grove and the impact that a hospital in Maple Grove might have on other hospitals in the region. In addition, we posted an electronic copy of each of the filings that we received on MDH's website, in order to provide convenient access to the proposals to anyone who might wish to comment. Copies of written comments that we received about this proposal for an exception to the hospital moratorium are included in Appendix 1.

The public meeting that MDH held in Maple Grove on January 11 was intended to provide a forum for public input to MDH on the general need for a hospital in Maple Grove. An estimated 300 people attended the meeting, and 42 citizens provided comments. Many of the comments shared similar themes, which are summarized below:

- Concerns about health and safety:
    - Citizens are concerned about the distance to the nearest hospital (11 miles to North Memorial in Robbinsdale) and by the amount of time that it takes to travel there due to frequent traffic congestion.
    - Citizens and health care professionals alike believe that the Maple Grove area needs to have more timely access to emergency and trauma services. According to one person, the closest emergency care is "20 to 30 minutes away on a good day" and there is a need for more timely access.
    - Some health care professionals expressed specific public safety concerns about the lack of access to emergency care. They reported that the distance to the nearest emergency room deters some people from seeking emergency care that they really need (or causes them to delay seeking care), and they reported that urgent care centers currently located in Maple Grove are increasingly being used by people who are too sick to be treated there because of the lack of convenient access to a hospital emergency room.
- Shortages of specific services:
    - Several people commented on the need for additional mental health and chemical dependency services, due to a shortage of inpatient beds available to treat these conditions.

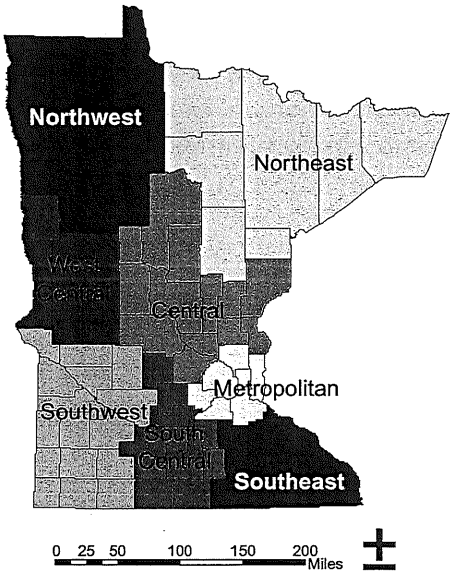
- Convenient access to services:
  - Community residents expressed a desire for more convenient access to health care services, particularly obstetric care, pediatric care (including specialty pediatric services), and cancer treatment.
  - Although many of the comments that focused on convenient access to services related to services that are likely to be provided in an outpatient setting, several people expressed a desire that any hospital that is built in Maple Grove should be a "full service" hospital providing a complete range of care without the need for patients to be transferred to other hospitals to receive more complex services.
- Collaboration between health care providers and the community:
  - Several people provided comments that emphasized the need for any organization that builds a hospital in Maple Grove to work collaboratively with the community (schools, churches, etc.) to identify and address community needs.
- Impact on other hospitals in the region:
  - Several community residents, some of whom are employed by North Memorial, expressed concerns about a potential adverse impact on North Memorial if one of the other two proposals were to be approved, about North Memorial's ability to survive as an independent institution, and about potential further consolidation of the hospital market into a market controlled by one or two large hospital systems.

4. Trends in the Use of Inpatient Hospital Services and Projected Impact of Future Demographic Change

State and Regional Trends

As noted above, one of the reasons for the original enactment of the hospital moratorium was that there was perceived to be a significant amount of excess capacity in Minnesota's hospital system. Since the moratorium was enacted, occupancy rates for Minnesota's hospital system as a whole have continued to be relatively low in comparison to licensed capacity. For example, in 2003 the system as a whole had an occupancy rate of about 42 percent of licensed beds; however, there is substantial variation in occupancy rates among different regions of the state – in 2003, occupancy rates ranged from a low of 28 percent in the South Central region to a high of 48 percent in the Twin Cities Metropolitan region (see map for region definitions).

Regional Definitions



In some ways, however, analyzing occupancy rates based on licensed beds can be misleading because many hospitals (particularly in the Twin Cities Metropolitan and Southeast regions) have large numbers of beds that are licensed but are unused. In some cases, these licensed beds may not even be able to be used within a facility's current physical capacity (i.e., a facility would have to undertake a major construction project in order to make use of these licensed beds). As a result, counting all of these licensed hospital beds when calculating occupancy rates is likely to overstate

the true capacity of Minnesota's hospital system. When occupancy rates are calculated based on "available beds",[2] the statewide hospital occupancy rate was 59 percent in 2003, ranging from a low of 28 percent in the Southwest region to a high of 71 percent in the Twin Cities Metropolitan region.

Because of advances in technology (e.g., the ability to do many procedures on an outpatient basis that formerly would have required a hospital stay), changes in standards of care, changes in health insurance payment systems, and other factors, use of inpatient hospital services in Minnesota (both admissions and total number of inpatient days) declined through the mid-1990s despite population growth. As shown in Table 1, even though Minnesota's population grew by about 20 percent from 1987 to 2003, the number of hospital admissions grew more slowly over the same period (14 percent) and the number of inpatient hospital days actually declined by 16 percent.

Table 1

Historical Trends in Use of Inpatient Hospital Services

	Percent change in:		
	Inpatient Admissions	Inpatient Days	Minnesota Population
1987 to 1994	-6.5%	-20.2%	8.9%
1994 to 1998	7.9%	-1.6%	4.4%
1998 to 2003	13.4%	7.1%	5.2%
1987 to 2003	14.4%	-15.9%	19.6%

Source: MDH, Hospital Cost Containment Information System, 1987 to 2003. 1987 was the first year of data collection.

There are several factors that are likely to influence future use of hospital services. Population growth will continue to play an important role, and aging will begin to be a more important factor as the baby boom generation reaches the age at which use of hospital services begins to increase sharply. In addition, technological advance will continue to be a very important determinant of future use of hospital services, with some new technologies likely increasing the use of inpatient services and others decreasing the use of services. Changes in the prevalence of disease (for example, due to rising rates of overweight and obesity) are also likely to play a role.

According to MDH estimates, population growth and the changing age distribution of the population are expected to result in an overall 36 percent increase in inpatient hospital days statewide between 2000 and 2020. As shown in Figure 1, this estimated increase varies by region: growth in the Central and Metropolitan regions is expected to be strongest, with growth in inpatient days of 53 percent and 40 percent, respectively. As a result, if the number of available beds were unchanged, occupancy rates would rise as well. The highest projected occupancy rates in

[2] The definition of "available beds" is the number of acute care beds that are immediately available for use or could be brought on line within a short period of time.

2020 are for the Metropolitan region (94 percent), Southeast region (85 percent) and Central region (76 percent), compared to a statewide average of 77 percent (see Figure 2). If occupancy rate calculations are performed using the number of hospital beds licensed in 2003 instead of available beds, the estimated future occupancy rates are much lower – 63 percent in the Metropolitan region, 53 percent in the Southeast region, 64 percent in the Central region, and 55 percent statewide.

Figure 1

Projected Growth in Inpatient Days by Region, 2000 to 2020

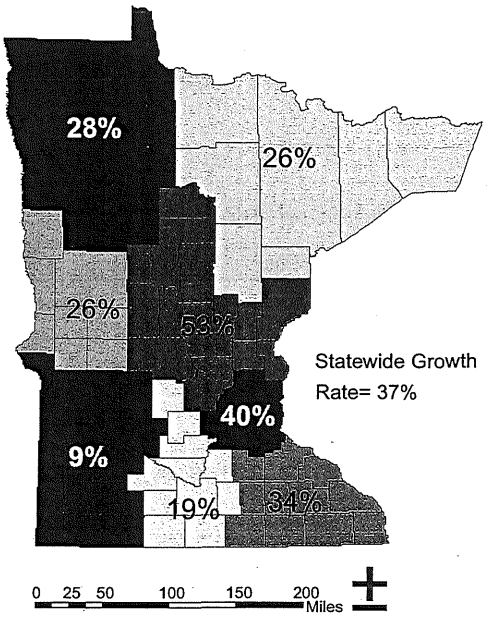
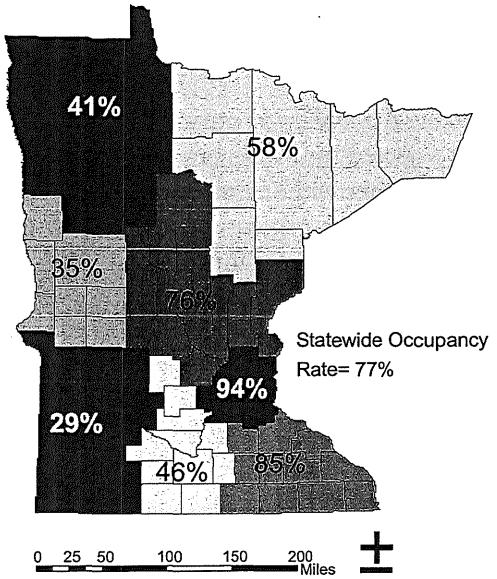


Figure 2

Projected Occupancy Rates as % of 2003 Available Beds by Region, 2020



In other words, there is clearly no shortage of licensed hospital beds in the state as a whole, nor is a shortage likely to materialize in the next fifteen years. However, the fact that the aggregate number of licensed beds in the state appears to be sufficient over this time period does not necessarily mean that there is no need for new physical hospital capacity, particularly in certain areas of the state experiencing rapid growth. There are several reasons why this may be the case:

- First, as noted earlier, occupancy rates vary widely across the state. Based on the number of currently available beds, occupancy rates projected for 2020 in the Metropolitan region (94 percent) and Southeast region (85 percent) are very high. The degree to which hospitals in these regions may be able to expand the number of available beds to meet future demand without undertaking major construction projects to increase physical capacity is uncertain. (This issue is discussed more specifically with regard to the Maple Grove area below.)

- In addition, average occupancy rates measured over a full-year period do not capture variations in occupancy rates that occur during the year. This consideration is important because even though a hospital's annual occupancy rate may not seem high enough to create concerns about whether capacity is sufficient, there are likely a number of times during the year when the hospital's occupancy rate is substantially higher than the average experienced over the entire year. As a result, using occupancy rates that measure capacity use over a full-year period may understate the degree to which the hospital system may be operating at or near capacity constraints at certain times.

It should also be noted that hospitals' ability to make full use of their licensed beds within existing facilities is limited by the relatively recent shift in the hospital market (both in Minnesota and nationally) toward private instead of semi-private hospital rooms. Consumer preferences have played an important role in many hospitals' business decisions to convert semi-private to private rooms, as well as concerns about patient safety and compliance with patient privacy laws.[3]

While Minnesota's hospitals likely have the ability to expand the number of available beds to some degree at existing facilities to meet projected future demand, it may also be the case that future demand in high-growth areas cannot be met without some major construction projects, either the construction of new hospitals or the expansion of existing facilities. If it is likely that some type of major construction project will be necessary to meet future needs, then the question before legislators as they consider granting an exception to the hospital moratorium becomes more a question not of whether new hospital capacity is needed, but where the new capacity should be located.

Trends in the Maple Grove Area

The Maple Grove area is experiencing rapid population growth. Although each of the proposals for an exception to the hospital moratorium in Maple Grove defines the area somewhat differently, population growth is projected to be much faster than the statewide average regardless of the specific geographic definition chosen. The Maple Grove area is expected to grow approximately 3 to 4 times faster than the projected statewide growth rates of 4.7 percent from 2003 to 2009 and 5.0 percent from 2009 to 2015.

The plans submitted to MDH by the hospitals seeking an exception to the moratorium identify several hospitals that currently serve significant numbers of residents of the Maple Grove area. Figure 3 shows the locations of each of the eleven hospitals that currently serve most residents of the Maple Grove area. Key utilization and financial indicators for these hospitals in 2003 (the most recent year of data that is available) are listed in Table 2. Recent trends in admissions, the total number of inpatient days, and occupancy rates are described in Table 3. For these eleven hospitals as a group, the occupancy rate as a percentage of available beds increased from 69 percent in 1999 to 74 percent in 2003.

[3] Michael Romano, "Going Solo: Private-Rooms-Only Provision for New Hospital Construction Stirs Controversy," Modern Healthcare, November 29, 2004.

Figure 3

Hospitals Serving the Maple Grove Area

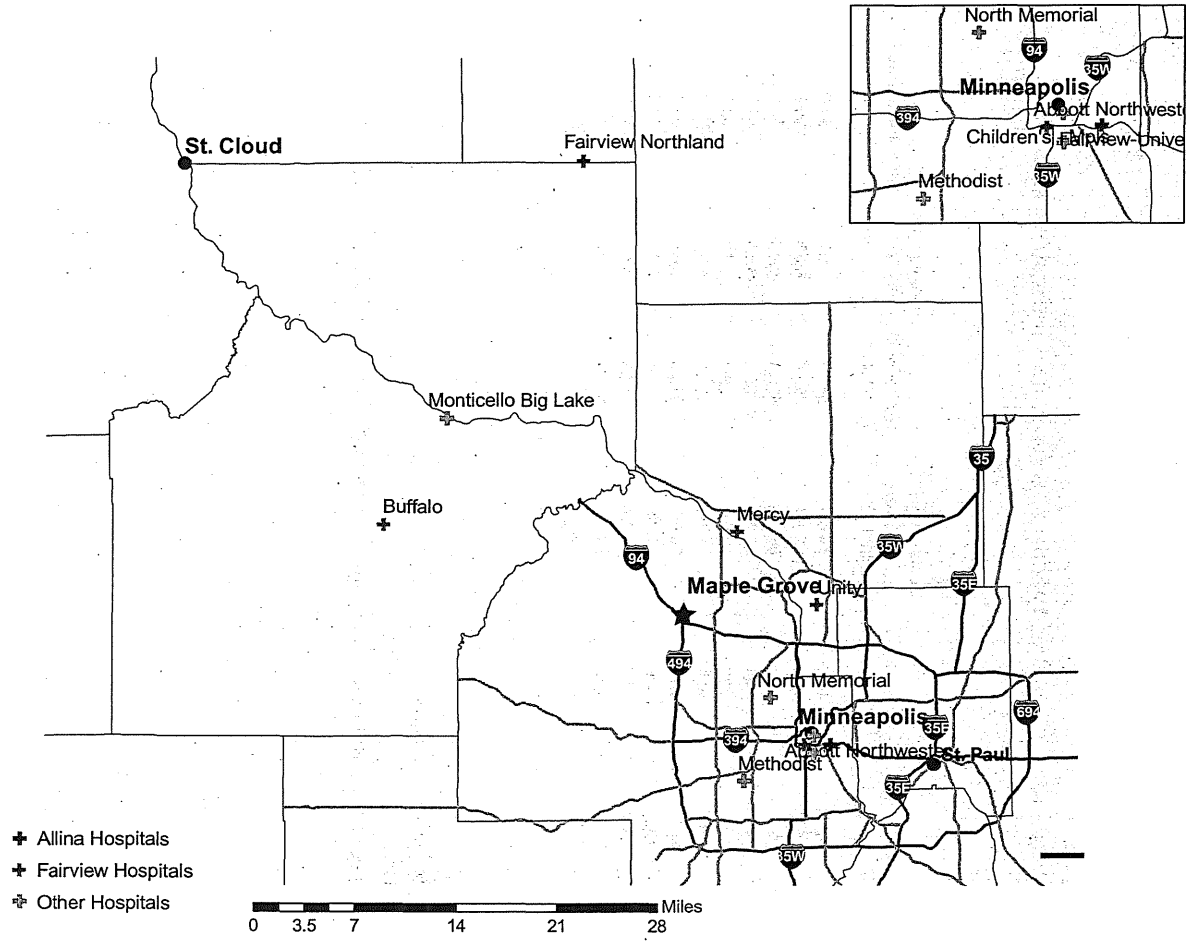


Table 2

Hospitals Serving Maple Grove Area Patients: Capacity and Financial Indicators for 2003

	Distance from Maple Grove	Licensed Beds	Available Beds	Occupancy Rate (as % of Available Beds)	Net Income ($ millions)	Net Income as % of Revenue	Uncompensated Care* ($ millions)	Uncompensated Care as % of Operating Expenses
Abbott Northwestern Hospital	20 miles	926	627	75.5%	$44.1	7.5%	$6.0	1.1%
Buffalo Hospital	32 miles	65	34	59.7%	$2.9	8.8%	$0.7	2.4%
Children's Hospitals and Clinics, Minneapolis	19 miles	153	153	84.6%	$12.1	5.9%	$1.8	0.9%
Fairview Northland Regional Hospital	35 miles	41	41	51.4%	($2.2)	-3.6%	$1.5	2.3%
Fairview-University Medical Center	20 miles	1,700	729	69.6%	$39.5	5.7%	$3.8	0.6%
Hennepin County Medical Center	19 miles	910	422	71.3%	($7.2)	-1.8%	$21.8	5.3%
Mercy Hospital	11 miles	271	212	78.6%	$15.3	6.8%	$3.4	1.6%
Methodist Hospital Park Nicollet Health Services	17 miles	426	370	71.3%	$17.5	5.3%	$2.3	0.7%
Monticello-Big Lake Hospital	22 miles	39	18	57.1%	$1.2	5.4%	$1.0	3.9%
North Memorial Medical Center	11 miles	518	432	74.0%	$23.6	7.8%	$3.3	1.0%
Unity Hospital	14 miles	275	211	66.1%	$1.7	1.1%	$3.0	2.0%
Statewide average				59.4%		5.3%		1.6%

*Uncompensated care is adjusted by a ratio of hospital costs to charges.
Source: MDH, Health Care Cost Information System.
Distance from Maple Grove is measured as the driving distance from the Maple Grove Community Center, according to MapQuest.

Table 3

Trends for Maple Grove Area Hospitals

	1999	2000	2001	2002	2003
Total available beds			3,260	3,158	3,249
Inpatient admissions	176,550	180,772	185,029	190,882	190,475
Inpatient days	822,799	849,862	854,346	857,519	858,746
Occupancy rate*	69.1%	71.4%	71.8%	74.4%	72.4%

*calculated based on available beds. For 1999 and 2000, calculation is based on 2001 available beds (data were not collected in 1999 and 2000).
Source: MDH, Health Care Cost Information System.

Projections for Hospitals Currently Serving the Maple Grove Area

Each of the three plans that were submitted to MDH for a public interest review contained an analysis of the ability of the Maple Grove area to sustain a hospital. While the question of whether the community can support a hospital is important, it is a different question from whether there is a need for a new hospital in the community. The legislation that established the public interest review process directs MDH to evaluate proposals for exceptions to the hospital moratorium based on the question of the need for the proposed facility, not whether the community can support a new facility.

As the starting point for MDH's analysis of the Maple Grove area, we analyzed the need for a new hospital from the perspective of the hospital system as a whole. Our analysis began with an estimate of what will happen to occupancy rates at hospitals that currently serve the majority of patients living in the Maple Grove area in the absence of a new hospital being built in Maple Grove. These "baseline" estimates incorporate projected changes in population and demographics in the market areas served by these hospitals. The baseline estimates also incorporate a range of assumptions about future hospital use rates, due to the inherent uncertainty in projecting changes in use of services due to factors like technological change.[4] This set of estimates formed the starting point for our analysis, and was the same for each of the three plans submitted to MDH for public interest review.

The overall results from this baseline analysis are presented in Table 4. As shown in the table, the occupancy rate for the eleven hospitals included in this analysis was 74 percent of available beds in 2003.[5] The occupancy rate is projected to increase to 79.4 percent in 2009, and 85.5 percent in 2015 (assuming no increase in available beds). It is important to note that this increasing strain on hospital capacity affects more than just residents of the Maple Grove area. Because the eleven

[4] More detail on the methodology we used to create the baseline estimates is included in Appendix 2. This discussion of the results of our analysis does not identify individual hospitals because the data we used to perform the analysis were collected under MDH's authority provided by Minnesota Statutes 62J.301, and Minnesota Statutes 62J.321 Subd. 5(e) prohibits the release of analysis that names any institution without a 21-day period for review and comment.

[5] This figure differs from Table 3 because it uses a different data source.

hospitals included in our analysis account for about one-third of total hospital admissions in Minnesota, the issue of rising occupancy rates is an issue that will likely have a much broader impact.

Table 4

Projections for Hospitals Serving Maple Grove Residents

	2003 Actual	2009 Projected	2015 Projected
Number of discharges	193,402	207,828 Range: 187,045 to 228,610	224,267 Range: 201,840 to 246,304
Number of inpatient days	877,448	943,712 Range: 849,341 to 1,038,084	1,016,040 Range: 914,436 to 1,115,288
Occupancy rate: 2003 available beds	74.0%	79.4% Range: 71.5% to 87.4%	85.5% Range: 77.0% to 93.9%
Occupancy rate: as % of maximum physical capacity		69.6% Range: 62.7% to 76.6	75.0% Range: 67.5% to 82.3%

Source: MDH Health Economics Program. Data sources include Minnesota hospital discharge database, Health Care Cost Information System (HCCIS), and population projections from Claritas, Inc.

As part of the public interest review process, we also conducted an informal survey of hospitals that currently serve patients living in the Maple Grove area to find out whether those hospitals have the physical capacity to expand the number of available beds at their current locations to meet expected growth in demand. We asked these hospitals about the maximum number of beds that they could operate on a permanent basis without undergoing major construction.[6] While there may be issues with the quality of this self-reported data, based on the results of that informal survey, if each of the eleven hospitals increased its number of available beds to the maximum level that would be feasible with its current physical capacity, the projected occupancy rates for 2009 and 2015 are 69.6 percent and 75.0 percent, respectively. One important thing to note about this analysis, however, is that the hospitals that currently serve the largest numbers of Maple Grove area residents did not report much ability to expand the number of available beds without a major construction project; the only hospital that reported having the ability to make a large number of additional beds available without a major construction project is one of the hospitals that is most distant from Maple Grove, and currently serves a small share of the Maple Grove market.

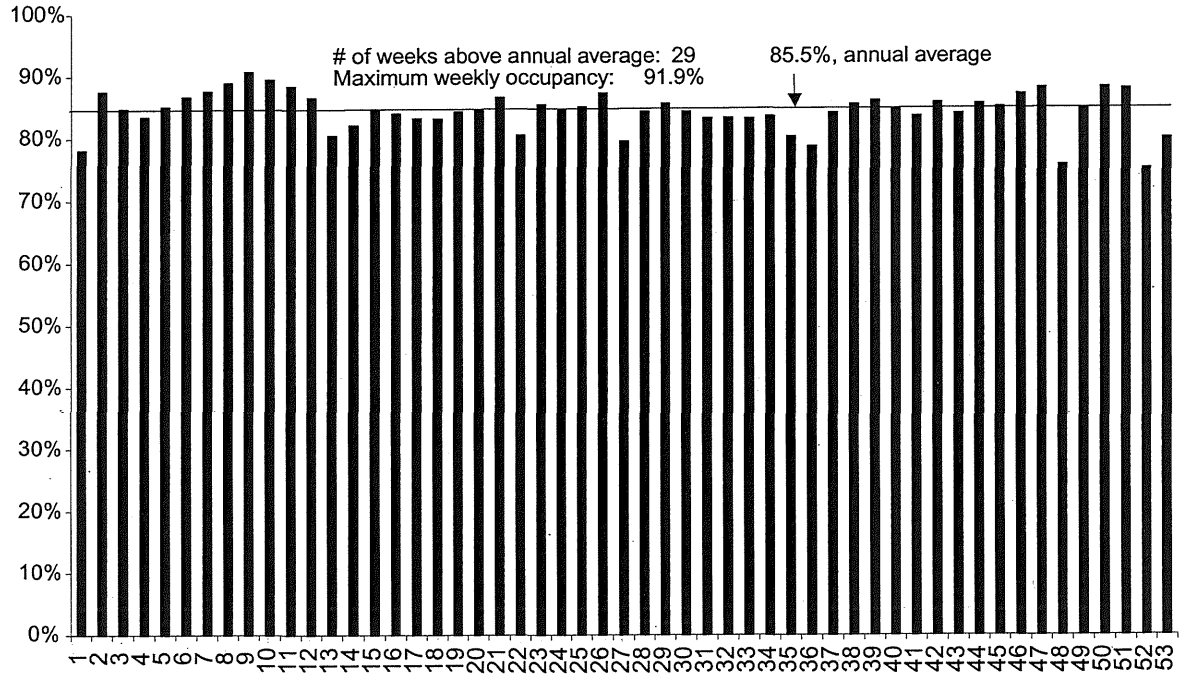
At certain times during the year the occupancy rate for the group of eleven hospitals currently serving most Maple Grove residents is expected to be substantially higher than the average occupancy rate over the entire year. In 2009, the highest projected weekly occupancy rate for the eleven hospitals as a group is 85.4 percent; in 2015, the peak weekly occupancy rate is projected to

[6] We asked the hospitals to answer this question within the context of their current business plan – for example, if their business plan calls for all private rooms and they would not consider converting rooms to semi-private rooms in order to serve a larger number of patients, then they would report their maximum physical capacity based on a configuration of all private rooms.

be 91.9 percent for the group of hospitals currently serving residents of the Maple Grove area. Figure 4 provides an illustration of the variation in projected occupancy rates at different times of the year for the group of eleven existing hospitals that serve residents of the Maple Grove area.

Figure 4

2015 Weekly Projected Occupancy Rates for Hospitals Serving Residents of the Maple Grove Area



Occupancy rates calculated based on available beds.

One key question that arises from this analysis is at what point should a hospital's (or group of hospitals') occupancy rate be considered "too high"? Unlike some other industries, which strive to operate at or near full capacity, hospitals are different. Because the level of demand at any given time is somewhat unpredictable, hospitals generally attempt to operate at a level below full capacity in order to be able to meet unexpected surges in the need for services. In addition, operating at a level too close to full capacity can lead to costly inefficiencies, such as delays in the ability to admit new patients or transfer patients between units.

One approach to answering the question of the "right" occupancy rate would be to define a specific benchmark level above which the occupancy rate is considered too high. Alternatively, one could define a specific number of hospital beds that is needed given an area's population. Both of these approaches have been used extensively in the past, particularly under Certificate of Need regulatory structures. However, more recent analysis of this question has pointed out that the question of

what an appropriate occupancy rate should be requires a much more complex approach than identifying a single number that applies to all hospitals, but instead depends on both hospital size and the number and size of distinct units within the hospital.[7] There is no agreed-upon standard for occupancy rates or threshold for when an occupancy rate should be considered too high in either hospital industry trade publications or peer-reviewed academic research publications. Industry experts that we spoke to indicated that 70 to 80 percent occupancy is an appropriate range, and that costly inefficiencies may occur at occupancy levels above 85 percent.

Analysis of Specific Proposals

After projecting what occupancy rates at hospitals serving patients from the Maple Grove area would be in the absence of a new hospital, the next step in our analysis was to estimate the impact of a new facility in Maple Grove on admissions, inpatient days, and occupancy rates at these hospitals. Since each of the three proposals to build a hospital in Maple Grove is unique, this analysis was performed separately for each proposal and the results are presented below in the discussion of the specific proposal as it relates to each of the criteria specified in the law.

Importantly, the analysis of each proposal is specific to the service area that was defined by the applicant as the proposed primary service area. The three proposed service areas range in size from 10 to 22 zip codes. For a variety of reasons, such as variation in existing physician affiliations and referral patterns, we believe it is possible that the proposed Maple Grove hospital's service area (the geographic area from which it draws most of its patients) may vary depending on which, if any, of the three proposals is approved by the Legislature. The "true" service area for any new hospital can only be observed after the fact; as a result, it is likely that all of the applicants' proposed service areas are different from what the service area for a hospital built in Maple Grove would eventually be. In this case, there is an especially high degree of uncertainty about the proposed hospital's service area due to the likelihood that as many as three large new ambulatory care centers may be built in the community, which we would expect to have an impact on patterns of hospital referrals. For these reasons, MDH did not attempt to independently define a service area for the proposed Maple Grove hospital.

We used a similar approach to analyze the impact on hospitals currently serving patients from the Maple Grove area in terms of the potential financial impact on these hospitals, including the potential impact on their ability to provide services to nonpaying or low-income patients. These results are also included below in the discussion of how the proposal relates to each of the evaluation criteria in the law.

[7] See, for example, Linda V. Green, "How Many Hospital Beds?" Inquiry v. 39, Winter 2002/2003.

5. Review of Tri-Care's Proposal for an Exception to the Hospital Moratorium

This section describes the joint proposal by Park Nicollet Health System, Allina Hospitals and Clinics, and Children's Hospitals and Clinics for an exception to the hospital moratorium in order to build a new hospital in Maple Grove. Following a brief description of the proposed project, we evaluate the proposal in light of each of the five factors specified in the statute that established the public interest review process.

Background and Project Description

This application for a public interest review for an exception to the hospital moratorium involves three large Minnesota-based health care systems: Park Nicollet Health System, Allina Hospitals and Clinics, and Children's Hospitals and Clinics. The parties involved are equity partners in the venture. The three parties involved have adopted the name Maple Grove Tri-Care Partnership to describe their venture. The name "Tri-Care" will be used in this review.

Park Nicollet Health System owns Methodist Hospital in St. Louis Park and operates a large multi-specialty clinic, providing care in 45 medical specialties and subspecialties with 543 physicians on staff. Methodist Hospital in St. Louis Park has 426 licensed beds of which 326 are available for patient care. In addition to other areas around the Twin Cities metropolitan region, Park Nicollet currently also has clinics located in Maple Grove and Plymouth, in the service area for the proposed hospital. Methodist hospital currently serves patients in the Maple Grove area.

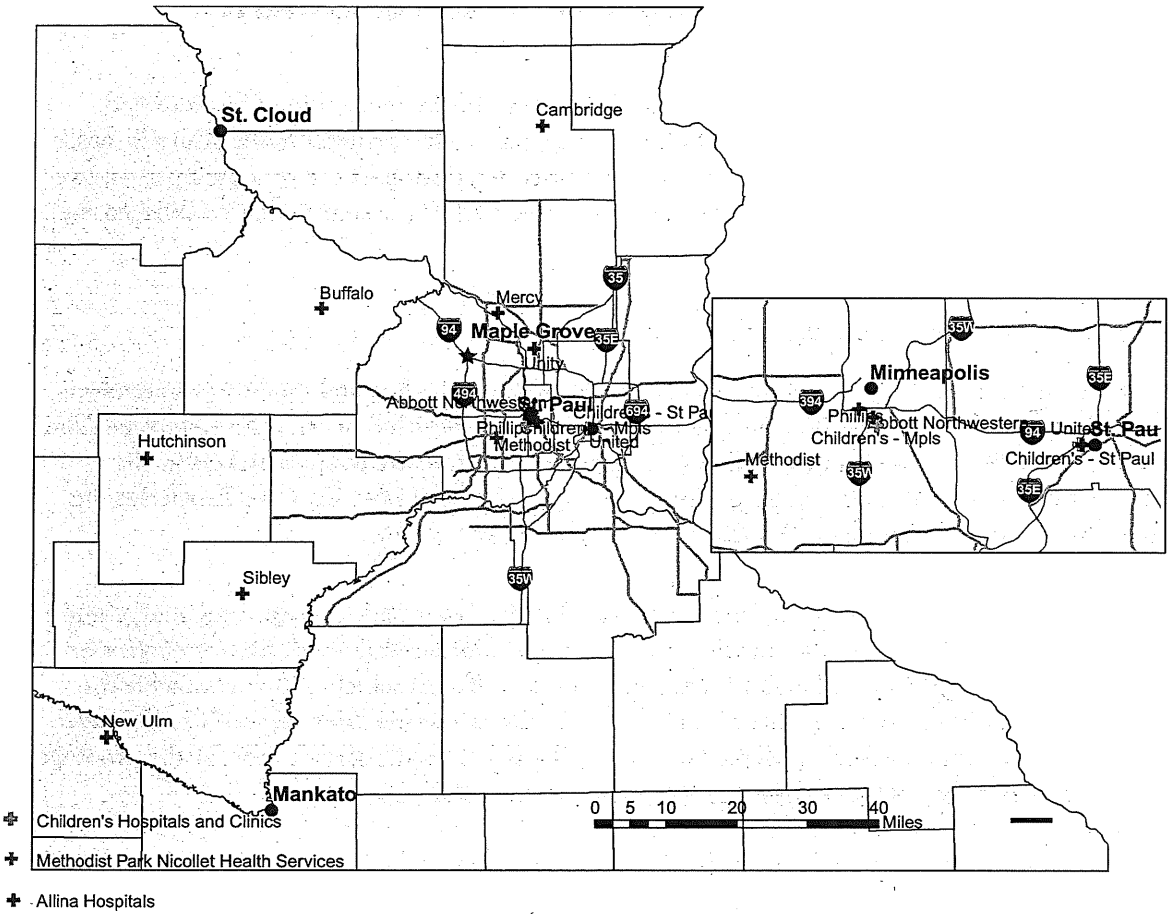
Allina Hospitals & Clinics owns and operates 11 hospitals in Minnesota, 42 clinics, hospice services, pharmacies, medical equipment, and emergency medical transportation services. Allina owns four of the hospitals currently serving Maple Grove residents: Mercy Hospital, Unity Hospital, Buffalo Hospital, and Abbott Northwestern Hospital. In addition, Allina operates hospitals in Cambridge, New Ulm, Owatonna, Minneapolis, River Falls, Shakopee, and St. Paul. Allina clinics operate around the Twin Cities and in areas beyond the metropolitan area borders. In or near the service area proposed for the Maple Grove hospital, Allina operates clinics in Maple Grove, Plymouth, Champlin, Elk River, and Buffalo.

Children's Hospitals and Clinics is a large pediatric health care organization with pediatric specialty hospitals in Minneapolis and in St. Paul. The Minneapolis Children's hospital serves pediatric patients in the Maple Grove area. Children's also operates an outpatient surgery, diagnostic and rehabilitation center in Minnetonka.

Figure 5 shows the locations of hospitals currently owned and operated by members of the proposed Tri-Care partnership.

Figure 5

Hospitals Owned by Tri-Care Partners



The Tri-Care application also noted collaboration with various community organizations including the Northwest Hennepin Family Collaborative, Osseo School District 279, and St. Mary's Carondolet Caring Clinics.

Tri-Care proposes to build an acute care hospital on an 84-acre site located at the intersection of Dunkirk Lane and 97th Avenue North in Maple Grove, Minnesota. In addition to the proposed acute care hospital, Tri-Care proposes to construct physician clinic offices, outpatient diagnostic and treatment services, and other ancillary services. Park Nicollet currently holds an option to purchase the parcel of land located at the site, which, according to the information submitted to MDH, requires no transportation infrastructure upgrades for public access to the site.

Tri-Care is proposing a phased construction timetable with 60 to 100 new acute care beds to be built on the Park Nicollet site by 2008. Tri-Care further propose to expand the facility to 100 to 150 acute care beds by 2012, and to 250 beds by 2020. The first phase of the hospital project is

projected to cost $72 million. No cost figures for the additional hospital phases or the cost of other components of the proposed campus were provided in the application. As noted earlier, Minnesota law does not restrict the ability of a health care provider to construct outpatient facilities, and the ambulatory care center portion of Tri-Care's proposed Maple Grove campus is outside of the scope of the public interest review process established under Minnesota Statutes 144.552.

The proposed hospital-based services to be provided by Tri-Care are as follows:

- Inpatient general medical/surgical services
- Intensive care
- Maternal labor and delivery
- Level II neonatal intensive care
- Normal newborn care
- Inpatient behavioral health services may be added in the future
- Level II trauma and emergency services[8]
- Diagnostic and treatment services:
- Imaging
    - CT
    - MRI
    - Radiographic Fluoroscope
    - Ultrasound
    - Nuclear medicine
    - DEXA scan
    - Mammography
    - Stereotactic local, breast
- Non-invasive cardiac diagnostics:
    - EKG
    - Echocardiography
    - Cardiovascular stress test
    - Cerebrovascular arterial studies
    - Holter monitoring
    - Non-invasive vascular studies
    - Pacemaker analysis
- Other Diagnostic Services
    - Audiologic testing
    - Speech evaluation
    - Pulmonary function testing
    - Laboratories

[8] See Appendix 3 for a description of the differences between Level I, II, III, and IV emergency services as defined by the American College of Surgeons.

- Therapies
  - Physical therapy
  - Occupational therapy
  - Cardiac rehabilitation
  - Speech therapy
  - Dialysis
  - Radiation therapy
- Procedural Care
  - Outpatient surgery
  - Endoscopy

The proposed hospital bed complement is for all new licensed beds, not currently licensed beds to be reallocated from existing capacity. The initial bed configuration proposed by Tri-Care is shown in Table 5.

Table 5

Tri-Care's Proposed Breakdown of Inpatient Beds by Service Category

Medical/Surgical/Pediatric	48 to 64 beds
Intensive Care	8 to 16 beds
Subtotal, Acute Care	56 to 80 beds
Obstetrics	12 to 16 beds
Total	68 to 96 beds
Level II Neonatal Intensive Care Unit	6 to 8 beds
Newborn Nursery	12 to 16 bassinets

Source: Tri-Care submission to MDH

Primary Service Area

Tri-Care proposes a hospital primary service area of twenty-two Zip Codes, spanning Hennepin, Sherburne, and Wright counties in the northwest corridor of the Twin Cities metropolitan area. The communities included in the service area are Albertville, Big Lake, Maple Grove, Buffalo, Champlin, Dayton, Elk River, Hamel, Hanover, Loretto, Monticello, Osseo, Rockford, Rogers, St. Michael, New Hope, Plymouth, and Brooklyn Park.

The population in Tri-Care's proposed service area is projected to increase by 16.2 percent between 2003 and 2009, and by an additional 16.2 percent between 2009 and 2015; these growth rates are substantially higher than the projected statewide population growth of 4.7 percent between 2003 and 2009 and 5.0 percent from 2009 to 2015.[9] In addition to rapid population growth in the proposed service area, the most rapid projected population growth is among the population aged 55 years or older; while this is also true for the state as a whole, growth among this population is

9 Population projections for 2009 are from Claritas, Inc.; projections for 2015 were developed by MDH assuming the same annual growth rate from 2009 to 2015 as projected by Claritas for 2004 to 2009.

expected to be much faster in the service area defined by Tri-Care compared to statewide growth (32.9 percent from 2003 to 2009 compared to 13.5 percent statewide). This combination of rapid population growth and an aging population is expected to increase the demand for hospital services by residents of this area. Based on MDH's analysis, the number of hospitalizations of residents of this area is expected to increase by 20.6 percent from 2003 to 2009, and by an additional 21.0 percent from 2009 to 2015.

Factor 1: Whether the new hospital or hospital beds are needed to provide timely access to care or access to new or improved services

In order to assess the impact of all three proposals for a Maple Grove hospital that MDH received in terms of whether the hospital is needed to provide timely access to care, we analyzed the impact of each of the proposals on future occupancy rates at existing hospitals that serve residents of the Maple Grove area. We also looked at how the proposals addressed specific service areas such as mental health, obstetrics, and emergency services that were identified by community members as areas of need for additional services.

Capacity of existing facilities

Residents of the Maple Grove area were hospitalized in many hospitals throughout the state during 2003, but eleven metro area hospitals provided the bulk of inpatient acute care to residents during that year. These facilities are also dependent, to varying degrees, upon this area for an ongoing proportion of their inpatient volume. The eleven hospitals are: North Memorial, Mercy, Methodist, Abbott Northwestern, Buffalo, Monticello-Big Lake, Hennepin County, Fairview-University, Minneapolis Children's, Unity, and Fairview Northland.

As noted earlier, MDH analysis projects that in the absence of any new hospital capacity being built, occupancy rates at these 11 hospitals are projected to increase from 74.0 percent in 2003 to 79.4 percent and 85.5 percent in 2009 and 2015, respectively. In 2009, six of the eleven hospitals are projected to have occupancy rates above 75 percent; by 2015, ten of the eleven will have occupancy rates above 75 percent and four will exceed 90 percent. As discussed earlier, the usefulness of annual occupancy rates as a measure of the degree to which existing capacity is strained has some limitations, but it can still be useful as a rough guide.

If Tri-Care's proposal for an exception to the hospital moratorium is approved, the addition of new hospital capacity is expected to reduce occupancy rates at existing area hospitals below the rates that are projected if no new hospital is built. Because Tri-Care's proposal involves expanding the size of the hospital over time, the effect of the new hospital on existing hospitals would also increase over time. In our analysis of Tri-Care's proposal, we assumed that the Maple Grove hospital would have 80 beds in 2009 and 120 beds in 2015.[10] Under this scenario, the projected occupancy rate for the group of eleven existing area hospitals would be 77.8 percent in 2009 (compared to 79.4 percent if

[10] Additional assumptions and the methodology we used for our analysis are described in more detail in Appendix 2.

no hospital were built), and 82.4 percent in 2015 (compared to 85.5 percent if no hospital were built). In other words, the impact of Tri-Care's proposed Maple Grove hospital would be to reduce occupancy rates at existing hospitals serving the Maple Grove area by 1.6 percentage points in 2009 and 3.1 percentage points in 2015. It is important to note that our projections show that, even if a new facility is built and a certain level of volume is diverted to the new facility, occupancy rates for the existing hospitals are projected to continue to increase due to the combination of population aging and population growth that are projected.

Some hospitals that currently serve Maple Grove area residents would experience a larger impact than others as a result of the Tri-Care proposal. Hospitals that currently serve the largest share of patients from the service area that Tri-Care anticipates for the Maple Grove hospital would likely experience the largest impact. At the eleven existing hospitals, the impact of Tri-Care's proposal on occupancy rates ranges from a decline of 0.5 percentage points to 9.6 percentage points in 2009 compared to the projection with no new hospital; for 2015, the decline in occupancy rates ranges from 0.7 percentage points to 17.4 percentage points compared to no new hospital being built.

Although it is not possible to state definitively what occupancy level is "right" for a hospital or the hospital system as a whole, it seems reasonable to conclude that hospitals in the Maple Grove area will experience increasing strains on capacity in the absence of any new capacity being added to serve patients from this area over the next ten years. As noted earlier, if no new capacity is added, MDH projections show that in 2015 ten of the eleven existing area hospitals will have occupancy rates above 75 percent, and four would have occupancy rates above 90 percent. Under Tri-Care's proposal, we estimate that these strains on capacity would be modestly reduced: only 8 of the eleven hospitals would have occupancy rates above 75 percent in 2015, and only 2 would have occupancy rates above 90 percent.

As noted earlier in this review, it is also important to recognize the considerable diversity of size and service capability among these eleven hospitals. For example, the tertiary care facilities operate many specialty units, such as cardiac, cardiovascular, stroke, orthopedic, and research services that often require specially equipped beds. Some of these beds may not be open to other patients. In another example, the American College of Obstetrics and Gynecologists recommends a target occupancy level of 75% for maternity units given the emergent nature of the care provided. Given the current trend toward specialty units, an overall occupancy level may be more a reflection of the mix of services available than generally available capacity to be filled

Distance and Time to Existing Facilities

The plan submitted by Tri-Care argues "the combination of an aging population, traffic congestion, and general population growth poses serious challenges for medical and emergency services in the Maple Grove area. Because many times it can take up to 30 minutes to reach an emergency room, community leaders have openly expressed strong concern about urgent care needs for the area." At the public meeting in Maple Grove, we heard anecdotal stories of people who delay seeking emergency treatment due to the distance from a hospital emergency room, or people who inappropriately use urgent care clinics when they really need to go to a hospital emergency room.

In addition, a recurring theme expressed by numerous Maple Grove residents at the MDH public hearing January 11, 2005 was a concern about family and children's safety, given the driving distance to the nearest Level I trauma center at North Memorial, traffic congestion, and the number of traffic lights encountered en route. North Memorial Health Care and Hennepin County Medical Center are the only American College of Surgeons-verified Level I Trauma Centers in Hennepin County. Driving times can vary substantially depending upon the route taken, time of day, weather and traffic conditions. Helicopter transport with advanced life support is available in the area for the most critical medical emergencies.

Ambulance transport times from Albertville, Buffalo, Champlin, Hanover, Otsego, Rockford and St. Michael to North Memorial averaged over 30 minutes. Within the Hennepin County portion of the service area, North Ambulance provides EMS transportation, both ground and air. EMS transport times may be extended if a emergency department is diverting ambulances to other facilities. EMS diversions may occur if emergency department beds or other beds are full at a hospital, a staff shortage exists, or on-call specialist physicians are unavailable.

Although a reduction in travel time will mean quicker access to hospital care for Maple Grove area residents, it is unclear to what degree having more timely access will improve health outcomes. As part of the public interest review process, MDH conducted a review of published research on the impact that distance and/or travel time to a hospital have on health outcomes. While there is not a large amount of published research on this topic, some researchers have found evidence that increased distance to the nearest hospital is associated with higher mortality from emergent conditions such as heart attacks and unintentional injuries.[11] However, other non-distance or non-time-related factors, such as short Emergency Medical Service (EMS) response times and sophisticated on-scene medical interventions can also improve survival and, in some time-sensitive conditions such as heart attack, stroke, and certain traumas, sustain longer advanced life support transport distances and times. So, while distance to a hospital ER may be a factor for consideration, a well-functioning and timely EMS system also plays an important role in ensuring patient outcomes.

Access to Specific Services: Mental Health, Obstetrics, and Emergency Services

At the public meeting on January 11, 2005, residents of the Maple Grove area expressed concerns about access to three specific types of hospital services: mental health, obstetrics, and emergency services. Several community residents stated that there was a shortage of inpatient mental health services; for obstetrics and emergency/trauma services, convenience and a desire for more timely access were the main concerns.

With regard to inpatient mental health services, MDH analysis shows that about 92 percent of all hospitalizations of residents of the Maple Grove area (as defined by Tri-Care) occur at one of the eleven hospitals that we identified as serving a significant number of Maple Grove area residents.

[11] Thomas C. Buchmueller, Mireille Jacobson, and Cheryl Wold, "How Far to the Hospital? The Effect of Hospital Closures on Access to Care," National Bureau of Economic Research Working Paper No. 10700, August 2004.

For psychiatry and chemical dependency services, however, when residents of the Maple Grove area are hospitalized they are much more likely to be hospitalized at a facility other than one of the eleven hospitals that serve most of this market (20 percent and 14 percent of the time for psychiatric and chemical dependency services, respectively). In other words, residents of the Maple Grove area who need to be hospitalized for psychiatric care or chemical dependency are much more likely to leave their local hospital market to receive care than residents who are hospitalized for other reasons. This is consistent with a statewide pattern that individuals who are hospitalized for psychiatric or chemical dependency services are less likely to be hospitalized in their local area. The issue of mental health and chemical dependency inpatient capacity in Minnesota has been discussed at length elsewhere.[12]

Tri-Care's proposal for a Maple Grove hospital, noting that "community demand for behavioral health services is high," indicates a plan in Phase I to provide outpatient and observation services in these areas, as they "construct a viable model for inpatient services." Thus, the initial focus of Tri-Care on behavioral health will be around outpatient services and the use of inpatient behavioral health inpatient beds at other facilities operated by the three partners in Tri-Care.

An additional area of concern for Maple Grove area residents was timely access to obstetric services. Because the population in this area is younger on average than the state as a whole, obstetric admissions represent a higher share of total inpatient admissions from the Maple Grove area than for the state as a whole. In 2003, about 21 percent of hospital admissions from the service area defined by Tri-Care were for obstetric services, compared to 16 percent statewide. The Maple Grove hospital proposed by Tri-Care would include 12 to 16 obstetric beds in Phase I.

Finally, Maple Grove area residents have expressed concerns about timely access to emergency and trauma services. As noted above, there is not much clear evidence about how closer access to an emergency room will affect health outcomes. It should be noted, however, that the emergency services proposed by Tri-Care would meet the American College of Surgeons (ACS) criteria for designation as a level II trauma center, which means that the hospital would provide "comprehensive trauma care either as a supplement to a level I trauma center in a large urban area or as the lead hospital in a less population-dense area." The ACS notes that "Level II centers must meet essentially the same criteria as level I (facilities) but volume performance standards are not required..."

In summary, Tri-Care's proposed Maple Grove hospital does include the obstetric and emergency services mentioned as being of most concern to community residents. The Phase I plans for Tri-Care do not include plans for inpatient behavioral health services, focusing rather on outpatient services. The application does indicate the potential for future inpatient mental health services. The proposed hospital would not offer new or improved services that are not already available at other hospitals nearby.

12 See, for example, "Minnesota Mental Health and Chemical Dependency Treatment Utilization Trends: 1998 to 2002," Minnesota Department of Health, Health Economics Program Issue 2004-07, November 2004.

Factor 2: The financial impact of the new hospital or hospital beds on existing acute-care hospitals that have emergency departments in the region

For a number of reasons, there is a high degree of uncertainty involved in predicting the financial impact of any of the three proposals to build a Maple Grove hospital on existing hospitals that currently serve residents of the Maple Grove area. The potential for three large new ambulatory care centers in Maple Grove providing a wide range of specialty care services would almost certainly have a significant impact on which hospitals residents of the Maple Grove area are referred to by their physicians for inpatient services. The combination of this change (which may occur even if the Legislature does not approve any exceptions to the hospital moratorium) with the addition of a new hospital makes it especially difficult to predict the impact on existing hospitals.

In addition, although MDH has access to hospital discharge data that allowed us to analyze and project hospital discharges, inpatient days, and occupancy rates, we do not have any data that allows us to translate the impact of a new hospital on the volume of services provided into an estimate of the specific financial impact of a new hospital on existing hospitals in the region. If a hospital loses patients that it would have served in the absence of the new hospital being built, it not only loses potential revenue but also avoids costs (such as staffing and supplies) that it would have otherwise incurred. Because we do not have information available to us that allows us to calculate the net financial impact of the proposed hospital on other existing hospitals in the region, in this section we focus instead on changes in the volume of business and occupancy rates.

Applicant's analysis

Tri-Care's analysis submitted to MDH concludes that because hospitals located in the area are currently at, or nearing, their functional capacity, and because population growth in the Maple Grove service area is expected to add demand for nearly 200 beds in the next fifteen years, the net impact of a new hospital upon existing hospitals will be limited. They hypothesize that most of the admissions to the Maple Grove hospital will occur at the expense of the nearby Allina hospitals in Coon Rapids, Fridley, and Buffalo, with additional primary and secondary care admissions diverted from Abbott Northwestern in Minneapolis and Methodist Hospital in St. Louis Park. Because the level of care for the proposed Tri-Care Maple Grove hospital excludes high intensity, tertiary level services, the impact upon other existing facilities offering such services is predicted by Tri-Care to be small.

Tri-Care cites two recent examples in the Twin Cities metropolitan area where new hospitals or hospital beds have been constructed without an adverse impact upon surrounding facilities. The Woodwinds Hospital in Woodbury and St. Francis in Shakopee share some demographic and projected growth similarities with a potential new facility in Maple Grove. Tri-Care's application analysis concluded that "after three years in operation, the greatest decrease any one hospital experienced was Healtheast's St. John's, who despite a 3.9% decrease in volume from the Woodwinds service area, has experienced an increase in total admissions." "Although the new St. Francis facility in Shakopee has seen a 76% increase in average daily census since 1999, it hasn't hurt other facilities in the southwest metro, which have grown 4%."

MDH analysis

There are two ways of looking at the financial impact of a new hospital on existing hospitals: first, in relation to a hospital's current business; and second, in relation to what would have occurred in the absence of the new hospital. The impact of Tri-Care's proposal on existing hospitals in the Maple Grove area varies by hospital, with hospitals that currently serve a large share of the Maple Grove market likely to experience the biggest impact. This is illustrated by the projections described earlier that compare projected occupancy rates at each of the eleven hospitals to the occupancy rates that would be projected in the absence of a new hospital.

When comparing the impact of Tri-Care's proposal in relation to the current patient volume and occupancy rates at existing hospitals, the results of our analysis found that growth in overall demand for services will offset the impact of increased competition for patients from the Maple Grove area. That is, assuming that a new hospital as described in Tri-Care's application were to be constructed in Maple Grove, we estimate that ten of the eleven existing hospitals that currently serve patients from the Maple Grove will experience increases in the total number of inpatient days in 2009 and 2015 compared to 2003; however, it is important to note that, in many cases, the increase in volume is much slower than it would have been in the absence of a new hospital. (The only hospital that is projected to experience a decline in inpatient days in 2015 compared to 2003 as a result of the Tri-Care proposal is a member of the Tri-Care partnership.)

The two facilities not affiliated with the Tri-Care proposal for which we estimate the largest volume impact compared to what would have occurred absent a new facility are North Memorial Health Care and Monticello-Big Lake Hospital. Both North Memorial and Monticello-Big Lake have a relatively high dependency on the Tri-Care proposed service area. In fact, these two facilities have the highest dependency on the proposed service for patients among the eleven existing hospitals that currently serve the Maple Grove area.

One other area of potential impact worth noting is in the area of trauma designation and emergency room services. North Memorial is one of two hospitals in Hennepin County providing American College of Surgeons (ACS) verified Level I trauma services. The Maple Grove hospital proposed by Tri-Care is planned to ultimately operate a Level II trauma service. As noted in ACS criteria, Level IIs typically provide comprehensive trauma care either as supplemental to a Level I center in a large urban area, or as the lead hospital in a less population-dense area. When it begins operating as a Level II trauma center, the proposed Maple Grove hospital may compete with North Memorial for emergency visits and, thus, potentially draw some number of emergency visits and admissions through the ER away from North Memorial, depending on the severity of conditions of the individuals receiving care at the proposed Tri-Care Maple Grove facility.

Additional Factors for Consideration

There are three additional factors that may be important in analyzing the potential financial impact of Tri-Care's proposal on existing hospitals that serve patients from the Maple Grove area.

- First, the impact is likely to vary by type of service. Because profitability varies by type of service, this is an important consideration. We did not attempt to specifically estimate the impact on existing hospitals by type of service.

- Second, there is a high degree of uncertainty about how physician referral patterns may change as a result of the new hospital and the multiple new ambulatory care centers that are currently being proposed. Even if the proposed Tri-Care hospital does not directly provide highly specialized services (such as open heart surgery), its association with the partners in the Tri-Care proposal could have an impact on referrals to non-system affiliated hospitals. Our analysis does not incorporate this possible change, but instead uses the information that we have on current travel patterns of patients from the Maple Grove area. However, it is important to note that the change is a possibility that could have an impact.

- The third area relates to patient preference. A common theme heard in our public meeting in Maple Grove was the desire of the community to nearby hospital services. An MDH literature review also showed that patients prefer hospitals closer to home when alternative choices are available. Consumer preferences for nearby hospital services may act as a mitigating factor to any potential shift of highly specialized services away from North Memorial toward system-affiliated hospitals that are more distant from Maple Grove than North Memorial.

In summary, for the 11 primary hospitals providing care to residents in the applicants proposed service area, our analysis finds that the inpatient volumes, even with the construction of a new facility as described in the Tri-Care application, would continue to increase above 2003 levels. However, the increases would generally be at levels that are below what otherwise would have occurred without the construction of a new facility in Maple Grove, with some facilities having larger affects than others Other factors that are important to consider include the fact that the effect of a new hospital will likely vary by service type; that there is a possibility that physician referral patterns may be altered as a result of the new hospital construction; and the impact that patient preference will have on those referral patterns.

Factor 3: How the new hospital or hospital beds will affect the ability of existing hospitals in the region to maintain existing staff

The Tri-Care partners estimate that 2,500 of their current employees reside in the Maple Grove area with an unknown number likely to transfer to the proposed facility in order to work closer to home. Tri-Care notes that regardless of the existence of a Maple Grove hospital, increasing demand for health services due to a growing and aging population in the local primary service area will challenge all hospitals to provide enough care capacity and to recruit an adequate workforce. Should a Maple Grove hospital be built, Tri-Care estimates that there will be a shift of workforce

from existing facilities, including their own, to the new facility. Their proposed 60 to 100 bed hospital will require an estimated 360 to 680 employees, depending upon the initial number of beds constructed. Citing the experience of the Woodwinds Hospital in Woodbury, the partners anticipate a need for 138 registered nurses, 9 pharmacists, and 23 radiology technicians within the first few years of operation.

While MDH is unable to predict the specific workforce shifts that may occur from surrounding facilities, there are several factors that may directly or indirectly influence potential job-seeking behavior by persons considering employment in any new facility in Maple Grove. First, for employees living in Maple Grove or the Northwest corridor, the opportunity to work closer to home to reduce commuting time and costs may prove to be an important consideration. Second, for employees working in unionized hospitals with significant earned seniority, potential loss of that seniority may mitigate their willingness to move to a different employer, although the exact effects are unknown.

In recent years, shortages of particular types of medical staff (especially nurses) have resulted in competition among hospitals to attract and retain staff, both in Minnesota and nationally. One reason why there is concern about the impact of a new hospital on the ability of existing hospitals in the region to maintain their staff is that if competition among hospitals for staff intensifies, this would drive up wages at all area hospitals (and therefore contribute to rising health care costs).

According to the Minnesota Department of Employment and Economic Development, the job vacancy rate for nurses in the seven-county Twin Cities metropolitan area was 3 percent in the fourth quarter of 2004. Although the job vacancy rate for nurses in the Twin Cities has declined over the past four years (in the fourth quarter of 2000, the job vacancy rate for nurses was 8 percent), it is still higher than the overall job vacancy rate in the Twin Cities (2 percent in the fourth quarter of 2004).[13] Although the nursing shortage in the Twin Cities appears to have eased somewhat compared to 2000, many factors will likely contribute to continuing shortages into the future. These factors include rising demand for health care services due to population growth, the aging of the population, and technological advance; in addition, Minnesota's nursing workforce is older than average – as these workers begin to retire, shortages will occur if they are not replaced by newly trained professionals.[14]

In comparison to the existing 11 hospitals serving residents of the Maple Grove area, the size of Tri-Care's proposed facility is not large. In 2003, the existing hospitals as a group had 3,249 available beds; Tri-Care's proposal would add 60 to 100 beds initially, with the possibility of up to 250 beds by 2020. In other words, while Tri-Care's proposal would add to the local demand for hospital

[13] Minnesota Department of Employment and Economic Development, Job Vacancy Surveys for fourth quarter 2000 and fourth quarter 2004.

[14] Minnesota Department of Health, Health Economics Program, "Labor Availability and Health Care Costs: Report to the Minnesota Legislature," October 2002.

staff, it is unlikely to have a large impact on the labor market because the proposal is small relative to the existing market; the other factors contributing to labor shortages that are described above may well have a larger impact on staffing shortages than the new hospital capacity proposed by Tri-Care.

Factor 4: The extent to which the new hospital or hospital beds will provide services to nonpaying or low-income patients relative to the level of services provided to these groups by existing hospitals in the region

In their application, the Tri-Care partners estimate that on an annualized basis, Park Nicollet and Allina provided a total of $5.4 million in hospital uncompensated care (UC) during 2004 to the Maple Grove service area as defined in their proposal. Overall, the partners in Tri-Care provided $25.8 million in uncompensated care statewide. This amounted to 1.2% of their operating expenses.

In addition to the hospital uncompensated care, the Tri-Care proposal describes the Healthy Communities Initiative facilitated by the Park Nicollet Foundation. According to the Tri-Care proposal, this initiative is intended to respond to the health care needs of children and families who are underserved or underinsured.

In addition to concerns about the level of UC that will likely be provided by the new hospital, a related concern is whether the new hospital will change the payer mix of existing hospitals in the region that provide relatively large amounts of UC. For example, if a large number of privately insured patients are attracted to the new hospital, this could adversely affect the ability of existing facilities that provide large amounts of UC to continue to serve nonpaying patients. Compared with the state as a whole, the service area proposed by Tri-Care for the Maple Grove hospital has a higher share of residents with private group insurance and a lower share of residents with public coverage, as shown in Table 6. The uninsurance rate for Tri-Care's proposed Maple Grove service area is not statistically different from the state average, although it is directionally lower than the statewide average (the difference is within the margin for error). In spite of what may be a somewhat lower level of uninsured in the community compared to statewide, based on comments from people who attended the January 11, 2005 public meeting, there may also be significant pockets of unmet need in the area.

Table 6

Sources of Health Insurance Coverage, 2001

	Tri-Care's proposed Maple Grove service area*	Minnesota
Private	**83.8%**	74.6%
Group	**80.5%**	69.6%
Individual	3.3%	4.9%
Public	**11.4%**	20.1%
Uninsured	4.7%	5.4%

*As defined by Tri-Care, includes 22 zip codes.
Source: MDH Health Economics Program analysis of 2001Minnesota Health Access Survey
Numbers in bold indicate a statistically significant difference (95% level) from statewide rate.

In order to analyze the potential impact of the proposed Tri-Care Maple Grove hospital on the payer mix of other existing hospitals, we used data from the Minnesota Health Access Survey[15] to estimate sources of health insurance coverage in Tri-Care's proposed Maple Grove service area. We combined these estimates with information on hospital discharges and travel patterns to estimate 1) the insurance coverage distribution for populations served by hospitals that currently provide significant amounts of UC to patients living in this area, and 2) how this distribution would change if Tri-Care's proposed Maple Grove hospital were built. The distribution of coverage in the area served by an existing hospital could change, for example, if the proposed Maple Grove hospital were to draw patients from zip codes with higher than average rates of private insurance coverage. According to our analysis, the payer mix of existing hospitals that provide large amounts of UC would not be changed significantly by Tri-Care's proposed Maple Grove hospital. For example, we estimate that the share of the population in North Memorial's service area that is enrolled in public programs would increase by less than one percentage point by 2015 and the proportion enrolled in private insurance would decrease by a little over one percentage point. Findings for other hospitals providing high levels of uncompensated care were similar.

In summary, while our analysis did show a very small shift away from private coverage and a minor shift toward public coverage, the impacts are very small and likely to be very limited.

Factor 5: The views of affected parties

As described above, the process that we used to solicit the views of affected parties included a letter to all hospital administrators in Minnesota, a notice in the State Register, and a public meeting held in Maple Grove. The views of citizens of the Maple Grove area, as expressed at the public meeting on January 11, 2005, pertain mainly to the need for a hospital and for specific services and are reflected above in the discussion of Tri-Care's proposal with regard to the first four statutory review criteria.

[15] Although this survey was updated in 2004, we used 2001 data because it has a much larger sample size and produces better estimates of health insurance coverage for small geographic areas.

North Memorial Health Care (NMHC) is the only entity that has expressed concerns about Tri-Care's proposal to build a hospital in Maple Grove. Depending on which geographic area is chosen for analysis, NMHC has either the highest or second-highest market share of any hospital serving the Maple Grove area. According to NMHC, about 30 percent of its admissions are from this area, and so there is significant potential for NMHC to be affected by Tri-Care's proposal to build a hospital in Maple Grove. NMHC has expressed several specific concerns about the Tri-Care proposal:

- NMHC believes that "current occupancy rates are appropriate and that there is no current need to increase hospital bed capacity." (NMHC's proposal for a Maple Grove hospital would transfer currently staffed beds from NMHC's Robbinsdale campus.)

- NMHC states that approval of Tri-Care's proposal could result in "destructive competition that could so financially damage a hospital that, in the end, it would result in a profound anticompetitive effect that would leave health care consumers and purchasers with fewer options," and cites the state's ambulance law as an example of a statutory framework which is similar in construction to the public interest review law.

- NMHC argues that approval of Tri-Care's proposal would create "an anti-competitive hospital environment that could make it virtually impossible for any independent provider not aligned with a large system to successfully compete in this market." Further, NMHC argues that Tri-Care's proposal would result in an undesirable increase in hospital market concentration in the Twin Cities area.

- NMHC states that the service area chosen by Tri-Care was "chosen in a calculated effort to diminish the apparent impact on North Memorial" and that the actual impact of the proposal on NMHC would be large.

- NMHC states that it will not experience admissions growth at its Robbinsdale facility that will help to offset the impact of the proposed Tri-Care Maple Grove hospital. According to NMHC, "North Memorial is located in an urban area that is not predicted to grow, except in the Maple Grove area and beyond....Each of [the] population areas around the current North Memorial Robbinsdale urban location is projected to decline in population, unlike the Maple Grove area, which is predicted to grow 9% over the next five years." Population projections from the Metropolitan Council indicate that most of the communities surrounding NMHC are in fact expected to grow, although at a slower rate than many more suburban communities; between 2000 and 2010, Brooklyn Park is expected to grow by 10.6 percent, Columbia Heights by 8.0 percent, and Robbinsdale by 6.2 percent.

- NMHC expresses concerns that a system-affiliated hospital built in Maple Grove, such as that proposed by Tri-Care, would act as a "feeder" of more complex cases to other hospitals in the system.

- NMHC argues that independent, non-system hospitals have administrative and other advantages over larger systems.

- NMHC states that none of the stated reasons for the Tri-Care partnership actually provide any evidence that the collaboration is useful to patients.

- NMHC is also concerned about the potential impact of Tri-Care's proposed Maple Grove hospital on NMHC's ability to retain its existing staff, since a large percentage of NMHC staff live in the Maple Grove area.

- Finally, NMHC argues that Tri-Care's proposed Maple Grove hospital would disproportionately attract privately insured patients away from NMHC in Robbinsdale, resulting in a higher percentage of NMHC patients being low-income or uninsured, and less resources (profits from privately insured patients) to subsidize their care.

Tri-Care has responded to these stated concerns as follows:

- With regard to collaboration, Tri-Care stated:

    - That the St. Francis Regional Medical Center in Shakopee is an example of how collaboration benefits patients and community.
    - That the collaboration has led to competition in Shakopee.
    - That partnering allows the parties to draw on the relative strengths of each organization.
    - That Northwest Metro area residents endorse the idea of partnership.

- With regard to administrative and other system costs, Tri-Care responded that system ownership doesn't automatically increase hospital costs, and that fixed infrastructure costs are spread across more than one hospital.

- With regard to NMHC's contention that "current occupancy rates are appropriate and that there is no current need to increase hospital bed capacity," Tri-Care responds that a "non-tertiary community hospital in Maple Grove will decompress existing bed capacity by allowing less complex patients to be admitted in Maple Grove, freeing up beds at the soon-to-be overstressed west metro tertiary facilities to care for sicker patients." Tri-Care argues that NMHC's proposal to transfer 80 active beds to Maple Grove will result in "strain" on "existing facilities at North Memorial's Robbinsdale hospital and the other West metro tertiary facilities."

- Tri-Care states that the impact of a new Maple Grove hospital will be minimal for three reasons:

    - Physicians and physician referral patterns are a key determinant of patient admissions, and it is difficult to shift physician loyalty and referral patterns;
    - Northwest suburban population growth and aging will increase volumes at all hospitals;
    - The experience of the construction and operation of Woodwinds Hospital and St. Francis Regional Medical Center showed minimal impact on existing facilities in the service areas for those hospitals, and that the experience in Maple Grove will prove similar.

- Tri-Care states that "using a statutory scheme such as the Ambulance Law to make a decision on who should be awarded the license in Maple Grove" is flawed. Tri-Care states that the hospital services are not equivalent to ambulance services, and that "using the Ambulance law to make the Maple Grove hospital is tantamount to creating service areas across the state where only one hospital is allowed to provide inpatient services – all in the name of eliminating 'the deleterious effect' of competition. Such a strategy would only lead to the creation of monopolies."

- Tri-Care states that they determined their 22 ZIP code service area based on the combined actual patient origin for the two clinics operated by Park Nicollet and Allina in the Maple Grove area, and that the projected inpatient volumes incorporate similar patterns.

- Tri-Care states that they continue to believe the "development of a Maple Grove hospitals and health campus will not exacerbate the staffing issues in Minnesota."

- Tri-Care argues that in most cities between 2 and 4 million, concentration of hospital ownership appears to similar to that in the Twin Cities, and that one new hospital would not change the Twin Cities mix appreciably.

6. Discussion and Recommendations

The 2004 Legislature established a new step in the process for seeking an exception to Minnesota's hospital moratorium, putting in place a Public Interest review by the Minnesota Department of Health. The proposals to build new inpatient capacity in the Maple Grove area present the first opportunity to apply the new law.

The public interest review law requires a hospital seeking to increase its number of licensed beds or an organization seeking to obtain a hospital license to submit a plan to the MDH. The commissioner is required to review the plan and issue a finding on whether the plan is in the public interest. As mentioned earlier in this report, there are a number of statutory factors the MDH must consider during its review, in addition to other factors the MDH believes are relevant to the review.

The public interest review statute does not define "public interest" nor does it define for which "public" the analysis should be conducted. There could be a variety of different "publics": the citizens of the proposed service area, the citizens of communities not in the proposed service area that could be affected by the proposal, or the citizens of Minnesota. In addition, the statute does not provide direction to MDH on the analysis of situations where more than one hospital is intending to seek an exception to the hospital moratorium for the same or similar geographic area. We received three separate requests for reviews at approximately the same time in November 2004: Fairview Health Services, North Memorial Health Care, and the Maple Grove Tri-Care Partnership. The MDH reviewed all three proposals simultaneously under the public interest review law relative to the statutory factors in Minn. Stat. 144.552, and is issuing separate findings on each plan. The finding in this report is specific to the Tri-Care proposal.

The previous section of the report examined the proposal of Tri-Care in light of the five specific factors MDH must consider as part of the public interest review process. This final section of the report highlights several issues that the Legislature may wish to consider in its deliberations on proposals brought before it for new inpatient capacity in the Maple Grove area. These issues are outlined below.

Ability to Support versus Need for a Hospital

During the review process for the Maple Grove hospital proposals, MDH has heard from the community, as well as from those who are interested in seeking an exception to the hospital moratorium to build new inpatient capacity in Maple Grove, that the community can support a new hospital. Based on analysis of population growth in the service areas defined by the three applicants, the likely use of services in the community, and the clearly-stated community desire for inpatient hospital capacity in the community, the Department concurs that the community could support a hospital of the size and scope in the proposals. That is, if a new inpatient facility as described in any of the three applications were constructed, it is unlikely that the hospital would fail due to insufficient usage.

However, it is also important to distinguish between support and need. Specifically, while the ability of a community to support a hospital is an important consideration, the hospital public interest review law requires the MDH to conduct an examination of need. That is, whether a given community can support a hospital is a separate question than whether a new hospital in a given community is necessary to ensure the health outcomes of the residents of the community. Analysis of need must also take into account the capacity of existing facilities that currently serve residents of the community, the likely health care needs of the residents of the community, and any other factors that might influence the availability of services for members of a given community.

In our projections of hospital occupancy, we estimate that, absent any new facility being constructed, the overall occupancy rate of hospitals currently serving the Maple Grove area will grow from 74.0% in 2003 to approximately 79.4% by 2009 and 85.5% by 2015. As mentioned earlier in this report, these estimates of occupancy rates will also vary by facility, depending on patient flows and the expected growth in areas served by these various hospitals. There is no single "right" rate of occupancy. To some degree, the rate of occupancy at which facilities can and should operate depends on the mix of services being provided at that facility. However, based on the projected occupancy figures, it is reasonable to conclude that hospitals serving the Maple Grove market will face increasing capacity strains within the next several years. It is also important to note that the 11 facilities that currently serve Maple Grove also account for approximately one-third of statewide admissions, so the likely increased strain on capacity has an impact on geographic areas beyond Maple Grove as well.

As the Legislature considers proposals to build a new inpatient facility in Maple Grove, it may wish to consider whether the estimated growth in occupancy rates at existing facilities is sufficient to merit the construction of a new facility. Should the legislature determine that some new inpatient capacity is needed to address rising occupancy rates at area hospitals, then the question for policymakers to consider is not whether new capacity should be added, but rather how and where this new capacity should be added: by expansion of existing facilities to the extent that is feasible, or through the construction of a new facility.

Hospital Competition and Consolidation

Another issue for consideration is the degree to which the addition of a new hospital in Maple Grove will add to or decrease hospital competition. This is an important issue because, on balance, peer-reviewed studies show that increases in hospital concentration lead to higher hospital prices.[16] The Twin Cities hospital market already operates with a certain degree of "systemness." That is, several hospital systems have a relatively large share of the inpatient market in the metro area: Allina-affiliated hospitals have approximately 30% of the market, Fairview hospitals approximately 20%, and HealthEast hospitals around 10%.

16 See, for example, David Dranove and Richard Lindrooth, "Hospital Consolidation and Costs: Another Look at the Evidence," Journal of Health Economics, Volume 22, Issue 6, November 2003.

There are two ways to think about the issue of hospital competition and concentration for the Twin Cities market: metro-wide and local. A hospital constructed in Maple Grove by an existing hospital system, such as Fairview, Allina, or Children's, would likely increase the level of Twin Cities-wide concentration. However, it's important to note that all of the proposed hospitals for Maple Grove are relatively modest in size and may be unlikely to substantially increase the level of Twin Cities-wide hospital market concentration. In addition, it's difficult in advance to know the exact impact that a new facility in Maple Grove owned by an existing system will have on market concentration overall, since the exact effect depends on patient flow patterns that can only be observed after the fact.

On the other hand, a new hospital constructed in Maple Grove by an existing facility with substantial existing market share in the immediate local area, such as North Memorial Health Care, may increase local concentration levels. This increase in local concentration may be mitigated, at least to some degree, by the fact that North Memorial's proposal does not result in an increase in overall bed capacity. The degree to which prices are increased due to increases in either local or Twin Cities-wide concentration depends on whether prices are set at a local level for services or whether they are set system- and Twin Cities-wide.

Bed Types and Services Provided

Another consideration for the Legislature in considering granting an exception is the mix of bed types and services provided in any new hospital constructed in Maple Grove. For example, the expected rapid increase in the population of childbearing age in the Maple Grove area is likely to increase the need for obstetric services.[17] In addition, because differentials exist in payment rates by type of service, hospital beds used for different services generate different levels of profitability. For instance, beds for cardiac care are generally profitable, while those used for behavioral health are generally less profitable. Over time this can lead to a situation where Minnesota may have sufficient capacity or over-capacity for profitable services, and an undersupply of beds for services that are less profitable. Evidence suggests that Minnesota may have sufficient supply of certain types of beds and services, but may lack adequate inpatient behavioral health capacity.[18]

In general, all three proposals respond to the likely need into the near future for obstetric services in the Maple Grove area. Two of the three proposals (Fairview and North Memorial) propose to include some level of additional inpatient behavioral health capacity in their initial inpatient construction (12 and 4 beds, respectively), while the third (Tri-Care) does not specifically plan the construction of new inpatient capacity, although it states its intent to "construct a viable model for inpatient services."

[17] The population aged 18 to 44 is in the Maple Grove area is projected to grow between 18.3% and 33.9%, depending on the service area defined, compared to 1.7% statewide.

[18] See "The Shortage of Psychiatrists and of Inpatient Psychiatric Bed Capacity," Minnesota Psychiatric Society Task Force Report, September 2002 and "Minnesota Mental Health and Chemical Dependency Treatment Trends: 1998-2002," Minnesota Department of Health, Health Economics Program, Issue Brief 2004-07, November 2004.

In considering the proposals to build new inpatient capacity in Maple Grove, the legislature may wish to give strong consideration to whether certain services, such as behavioral health inpatient capacity, should specifically be included as a requirement under any moratorium exception granted. For instance, the legislature could require that a certain percentage of beds of any exception granted be used for behavioral health services.

Potential Health Care System Costs

Although not included as a specific statutory criterion under the public interest review law, health care cost is also a policy issue important to the consideration of inpatient hospital construction and expansion. As a matter of policy, states have generally taken some interest in monitoring or in some way constraining the expansion of inpatient hospital facilities. For instance, hospital CON laws still operate, in some form, in 37 states.[18] States have generally shown an interest in inpatient hospital capacity, as it relates to health care cost, for two reasons. First, hospitals are expensive to construct and operate, and those costs are built into the health care system and subsequently into health insurance premiums. Second, some argue that duplication of services increases health care costs under the argument that, in health care, supply of services is likely to induce demand for those services. Laws, such as Minnesota's construction moratorium law, that restrict the construction of new inpatient facilities unless approved in advance, can have the effect of reducing potential duplication of services.

While we did not attempt to estimate the specific impact that the addition of a new inpatient facility in Maple Grove would have on health care costs, it is likely that the construction of any new facility will add at least some additional cost to Minnesota's health care system, although the proposed construction costs of all three proposed projects are relatively modest in comparison to overall state hospital spending. The extent to which the construction of a new hospital is duplicative of existing services and is therefore likely to induce excess demand depends in large part upon whether the existing facilities serving the Maple Grove area have sufficient capacity to serve the population into the future or whether those facilities are sufficiently strained to merit additional capacity. That is, if existing capacity is insufficient to provide services to the Maple Grove community into the future, then policy issues related to construction cost and the potential of induced demand may be less of a concern.

Summary and Recommendations

Reviews related to the construction of a new inpatient facility in the Maple Grove area are the first under the new public interest review process passed by the 2004 Legislature. The law requires that the MDH issue a finding as to whether the proposal is in the public interest.

As mentioned earlier in this section, the legislation does not define "public" for the purposes of "public interest" and therefore the "public" can be defined in a variety of ways. One potential "public" could be the persons living in the Maple Grove area. With regard to the ability of the community to support a hospital, MDH believes that the community can support a hospital and should one be constructed in the Maple Grove area, it is unlikely that the hospital would fail due to

lack of use. In addition, the construction of a new facility as proposed would provide more convenient access to services for residents in the community. Therefore, we believe it would likely be in the public interest of members of the Maple Grove community if a new hospital were to be constructed.

In examining whether Tri-Care's proposal is in the public interest for Minnesota as a whole, the analysis is more complicated because it must also take into consideration issues such as system capacity, potential cost impact, and the statutory factors, such as the effect of the new inpatient construction on existing facilities, examined in section 5 of this report.

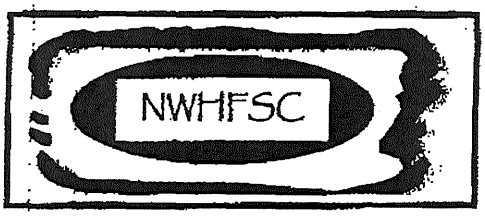
As shown earlier, we project that occupancy rates for hospitals serving the Maple Grove community will increase over the course of the next ten years, and will be at levels that are relatively high by 2015. Based on this analysis, we conclude that hospitals serving the Maple Grove market will face increasing capacity constraints in the next 10 years. In addition, because the hospitals that serve Maple Grove also account for approximately one-third of the state's overall admissions, the strain on these facilities also has an impact on geographic areas beyond the Maple Grove area. MDH concludes that allowing construction of new inpatient capacity of the size and scope proposed by Tri-Care would relieve, at least to some degree, these expected capacity strains.

In conclusion, after examining the proposal submitted by Tri-Care in relation to the factors specifically required by Minn. Stat. 144. 552 and other relevant factors, the Minnesota Department of Health has the following findings and recommendations:

- Tri-Care's proposal to build a new inpatient facility in Maple Grove, Minnesota is in the public interest; and
- The legislature should consider requiring that a certain percentage of hospital beds of any exception granted for the Maple Grove area be dedicated for behavioral health services.

Appendix 1

Copies of Comments on the Proposal



Working together. Supporting family success.

Northwest Hennepin Family Services Collaborative 11200 93rd Avenue North, Maple Grove, Minnesota 55369 / 763-391-7253

October 13, 2004

Mr. Michael Johnson
Senior Vice President
Park Nicollet Health Services
6500 Excelsior Boulevard
St. Louis Park, Minnesota 55426

Dear Mr. Johnson:

Thank you for the energy and commitment that Park Nicollet is contributing to exploring the possibility of a medical campus in the northwestern suburbs of Hennepin County. The Northwest Hennepin Family Services Collaborative especially appreciates the Park Nicollet Foundation's efforts to engage the community in meaningful dialogue about gaps and barriers in services through the Convening On Needs meetings that have been taking place in Maple Grove for over one year.

As you are aware, there is a large gap in medical services in the following areas:

- primary care
- mental health
- emergency health services
- inpatient services
- dental
- eye screening and correction

Access to medical services is a critical issue for families, especially families with children. While transportation continues to be an issue in the northwestern corridor, Park Nicollet's efforts to bring medical partners together to address the gap in medical services will go a long way to begin to ameliorate the lack of services.

I look forward to continuing to work with you and others at Park Nicollet as you move your work forward.

Sincerely,

Jonette M. Zuercher

Jonette M. Zuercher, MMA
Project Coordinator

BUFFALO
HOSPITAL
Allina Hospitals & Clinics

January 5, 2004

Scott Leitz, Director
Health Economics Program
Minnesota Department of Health
85 E. 7th Place, Suite 300
St. Paul, MN 55101

Dear Mr. Leitz,

I'm pleased to respond to the Department of Health's letter requesting comments to applications proposing to build a new hospital in the Maple Grove area. As the President of Buffalo Hospital, and interim President Owatonna Hospital, I appreciate the opportunity to provide my thoughts on this matter.

I realize the scope of the law, *Minnesota Statutes 144.552*, limits the focus of the Department's efforts to determining whether or not the area can support the construction of a new facility. However, since three separate proposals have been submitted, there seems to be ample evidence that the population and demographic changes in the area can support new inpatient capacity.

Therefore, the primary purpose of this letter is to explain why I believe the partnership proposal submitted by Allina Hospitals & Clinics, Park Nicollet Health System and Children's Hospitals & Clinics is the preferred option. Collaboration is the most cost-effective way to provide the services that Maple Grove residents want, and a new hospital in Minnesota should reflect this new way of thinking.

Without a collaborative hospital being built, the possibility exists for each health system to build its own expensive technology-driven facilities. Strategic partnerships prevent duplication. For example, instead of Buffalo Hospital building its own heart hospital, we have an extremely well coordinated program to rapidly transfer heart attack patients from Buffalo to Mercy Hospital in Coon Rapids.

Another reason I support the collaborative approach is that Allina has a stake in the success of Buffalo Hospital. Given the proximity of Buffalo to Maple Grove, whoever builds new inpatient capacity in the area could make or break the bottom line of this community hospital. Allina has invested millions of dollars in Buffalo Hospital, including a recent addition to our campus. Most recently, we were the beta site for a new electronic medical record system. Allina has a longstanding tradition of supporting the Buffalo community, and I believe this commitment will continue. Indeed, there will be opportunities to enhance that support and commitment with a greater presence in the area.

As the number of health care facilities increase to meet the demands of a growing and aging population, let us be smarter about creating a truly improved health care system.

Sincerely,

Mary Ellen Wells

Mary Ellen Wells
President, Buffalo Hospital

1324 Fifth North Street
P.O. Box 577
New Ulm, MN 56073

Hospital 507-233-1000
Clinic 1-800-795-1211
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NEW ULM
MEDICAL
CENTER
Allina Hospitals & Clinics

January 5, 2005

Scott Leitz, Director
Health Economics Program
Minnesota Department of Health
85 E. 7th Place, Suite 300
St. Paul, MN 55101

Dear Mr. Leitz,

As President of New Ulm Medical Center, I would like to respond to your letter regarding the possibility of a new hospital in the Maple Grove area. I am glad that Minnesota is entertaining the idea of a new hospital in a community that appears to have a demonstrated need for one.

However, emotions are charged about health care costs these days, and I think Minnesota must choose a path that truly improves the health care system overall. I believe the partnership of Allina Hospitals and Clinics, Park Nicollet Health Services and Children's Hospitals and Clinics offers the best chance for an innovative model of community health care.

Because health care professionals continually learn from each other, I hope Minnesota supports this new way of thinking about health care. The decision should be based on what is the best for patients.

Sincerely,

Lori Wightman, President
New Ulm Medical Center

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Unity Hospital
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www.allina.com

MERCY & UNITY HOSPITALS
Allina Hospitals & Clinics

January 5, 2005

Scott Leitz, Director
Health Economics Program
Minnesota Department of Health
85 E. 7th Place, Suite 300
St. Paul, MN 55101

Dear Mr. Leitz,

As President of two hospitals that are already serving the citizens of Maple Grove, I have great interest in the ongoing process to assess the need to expand healthcare services in that community to include an inpatient hospital. For almost 40 years, Mercy and Unity Hospitals have been providing nationally recognized healthcare in the northwestern suburbs of the Twin Cities.

As the population of the Maple Grove area continues to grow, it is understandable that the city and its citizens are asking for expanded access to healthcare services. The cross-system collaborative proposal from Allina and its partners expand through partnership, the existing presence in Maple Grove of Allina Hospitals & Clinics, Park Nicollet Health Services and Children's Hospital & Clinics and will provide the most comprehensive medical capabilities available.

I have participated in the success of a similar partnership in Shakopee where I was President of St. Francis Regional Medical Center. St. Francis, a strategic partnership between Allina, Park Nicollet and the Benedictine Health System, demonstrates how inter-health system collaboration can be the most creative, financially prudent and effective way to meet the health care needs of a community.

Sincerely,

Venetia H M. Kudrle

Venetia H. M. Kudrle
President
Mercy & Unity Hospitals

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CAMBRIDGE
MEDICAL
CENTER
Allina Hospitals & Clinics

January 5, 2004

Scott Leitz, Director
Health Economics Program
Minnesota Department of Health
85 E. 7th Place, Suite 300
St. Paul, MN 55101

RE: Maple Grove Hospital

Dear Mr. Leitz,

Thank you for your interest in my comments regarding the construction of a new hospital in Maple Grove. I serve as the President of Cambridge Medical Center in Cambridge, Minnesota.

I feel my facility will not be directly affected by the construction of a new hospital in Maple Grove, either in patient volumes or staffing. However, I want to express my support for the collaborative proposal submitted by Allina Hospitals & Clinics, Park Nicollet Health Services and Children's Hospital and Clinics. There are many reasons to support this partnership model, but I believe the most important reason is such a facility will provide care in the community where people live, work and attend school. I know how important the Cambridge Medical Center is to the Isanti County community and the work here demonstrates Allina's commitment to providing services where they are needed.

I know firsthand that Allina has a proven track record of focusing on care delivery in communities. In 1995, Memorial Hospital and PMA collectively joined Allina Health System, allowing the clinic and hospital to pursue a $12 million dollar remodeling and expansion project. This was funded by Allina. The merger of the hospital and clinic combined to form the Cambridge Medical Center. The infusion of capital from Allina Hospitals & Clinics is responsible for helping to make Cambridge Medical Center an important and vibrant health care provider for this region.

With ever-increasing pressure on health care dollars it seems that a strategic partnership to build facilities makes sense. It is provides the best way to share expertise, experience and expense.

Sincerely,

Dennis J. Doran
President, Cambridge Medical Center

ST. FRANCIS
Regional Medical Center

1455 ST. FRANCIS AVENUE
SHAKOPEE, MN 55379-3380

952-403-3000

January 6, 2004

Scott Leitz, Director
Health Economics Program
Minnesota Department of Health
85 E. 7th Place, Suite 300
St. Paul, MN 55101

Dear Mr. Leitz,

This letter is in response to your request for comments regarding the construction of a new hospital in the Maple Grove area. I serve as the President of St. Francis Regional Medical Center, which is located in Shakopee, Minnesota. St. Francis is a collaboration of Allina Hospitals & Clinics, Park Nicollet Health Services and the Benedictine Health System. I have been the President of St. Francis for the past three years.

I understand the law requires your Department to assess the need and impact of a new hospital in the Maple Grove area. Because I run the St. Francis Regional Medical Center, I feel I am in a good position to comment on the success of a collaborative model. Additionally, since Shakopee is a rapidly growing suburb, like Maple Grove, I believe the demographics are quite similar to the St. Francis service area enabling viable comparisons.

In 1996, St. Francis opened the doors of a new campus. Since that time, patient volumes have grown dramatically, new services have been added, and the overall quality of health services available to the local residents has improved. We recently had the ground breaking for the 3rd expansion of St. Francis since 1996. The success of St. Francis signals that Allina and Park Nicollet have a track record of successfully partnering to deliver community health care services.

St. Francis has also enjoyed an excellent relationship with Children's Hospital. In the late 1990's, St. Francis brought Children Hospital in as a partner to help us improve the overall quality of care that we provide to pediatric patients. Children's Hospital actually provided management and nursing staff for our pediatric inpatient unit for more than three years until we had developed the ability to manage the service internally. Children's continues to work with us on a routine basis to improve the care we offer to our smallest patients.

The ability to draw upon the resources of Park Nicollet, Allina, and Children's would provide the Maple Grove area the highest quality patient care and administrative services they want and need. Maple Grove, like Scott County, is among the fastest growing regions in the state. Given the experience in the Scott County area, I know patients want services close to home, with the ability to access more advanced tertiary care at affiliated facilities when necessary.

Another important consideration is that the growth of St. Francis has not come at the detriment of other local hospitals. The rapid population growth in a burgeoning suburb allows for the development of a new facility without negatively impacting others. My understanding of Maple Grove is that it is far enough away from other facilities that the development of a new campus would not significantly risk the viability of any other hospitals.

In 2005, health care providers are facing tough decisions about resource allocation. Demand continues to grow; however, the capital available to meet these needs is in short supply. The future of quality affordable health care delivery will depend on creative and innovative ways of providing care. That is why collaborations for major capital projects, like a new inpatient facility, must be a key part of the state's future health care infrastructure. The commitment of Park Nicollet, Allina, and the Benedictine Health System leadership as well as support from Children's Hospital has certainly made St. Francis a success story. If you have any questions, please feel free to contact me at 952-403-2400. Thank you for taking the time to consider my comments.

Sincerely,

Tom O'Connor
President St. Francis Medical Center

333 North Smith Avenue
St. Paul, MN 55102-2389
651-241-8816
mark.mishek@allina.com

Mark G. Mishek, President

UNITED
HOSPITAL
Allina Hospitals & Clinics

January 10, 2005

Scott Leitz, Director
Health Economics Program
Minnesota Department of Health
85 E. 7th Place, Suite 300
St. Paul, MN 55101

Dear Mr. Leitz,

I am writing in response to your letter requesting comments concerning the effect a new hospital in Maple Grove might have on other hospitals. This situation reminds me of the establishment of Woodwinds Hospital in Maplewood several years ago, and the controversy surrounding the planned closing of St. Joseph's Hospital in St. Paul.

What has happened since then demonstrates that even the smartest forecasters cannot always predict the future accurately. Woodwinds appears to be a healthy suburban hospital, and St. Joseph's is on a course of growth and renewal. Other hospitals, including United Hospital in St. Paul, of which I am President, were not adversely affected by Woodwinds. In fact, United is experiencing healthy growth at this time

A similar situation exists in Maple Grove, but times have changed. The difference today is the real concern over health care costs and a heightened responsibility to be good stewards of resources.

That is why I am a believer of collaboration and strongly support the proposal by Allina Hospitals and Clinics, Park Nicollet Health Services and Children's Hospitals and Clinics. The new hospital would have the advantage of working with institutions that provide world-class medical care with the financial ability to quickly provide the services that people in Maple Grove want.

These health care providers also have a tradition of community involvement, and their experience will help the new hospital mature with the community. Whether the need is prevention, primary, emergency, critical or charity care, this partnership represents the best in all specialties and for all ages.

Sincerely,

Mark D Mishek

Mark Mishek, President
United Hospital
Allina Hospitals & Clinics

Appendix 2
Methodology

This appendix provides additional details on MDH's analysis of the application for public interest review. It describes the methods and data that we used to:

- Project future utilization and occupancy rates at hospitals currently serving residents of the Maple Grove area in the absence of a new hospital being built in Maple Grove;
- Estimate the impact of the proposed Maple Grove hospital on existing hospitals that serve residents of the Maple Grove area; and
- Analyze the potential shift in payer mix at existing hospitals as a result of the proposed Maple Grove hospital.

Projecting Hospital Use and Occupancy in the Absence of a New Hospital

This analysis focused on eleven hospitals that were identified as (a) holding a significant market share of the discharges from the Maple Grove area (as defined by the applicant); (b) having a high dependency on patients from the Maple Grove area (even if the hospital does not have a large share of the total market, it may be very dependent on the Maple Grove area as a source of admissions), or (c) being a major safety-net hospital provider in the region. The hospitals included in this analysis were Abbott Northwestern Hospital, Buffalo Hospital, Children's Hospital in Minneapolis, Fairview Northland Regional Hospital, Fairview-University Medical Center, Hennepin County Medical Center, Mercy Hospital, Methodist Hospital Park Nicollet Health Services, Monticello-Big Lake Hospital, North Memorial Medical Center, and Unity Hospital.

We used Minnesota hospital inpatient discharge data from calendar year 2003, excluding discharges of normal newborns. This data includes information on the patient's zip code and age. First, we calculated occupancy rates for each of the eleven hospitals and for the eleven hospitals as a group in 2003.

Next, we projected inpatient volumes and occupancy rates to 2009 and 2015. In order to take account of population growth and demographic change that may be occurring in a particular hospital's service area, we looked specifically at the zip codes from which most of the hospital's patients originate. We chose to define this area as the geographic area (group of zip codes) from which the top 75 percent of the hospital's discharges of Minnesota residents originated in 2003. For each of the eleven hospitals, we calculated hospital-specific and age-specific hospitalization rates for the population living in the geographic area as defined above. We used projections of future

[19] Population estimates by zip code and age were obtained from Claritas, Inc. for 2000, 2004 and 2009. We estimated 2003 population by assuming a constant average annual growth rate from 2000 to 2004. We projected forward to 2015 by applying the same average annual growth rate estimated by Claritas from 2004 to 2009.

population (by age group) in the same geographic area to project future hospital volumes.[19] The geographic areas that comprised the remaining 25 percent of the hospital's discharges of Minnesota residents were treated as a group for the purpose of projecting future use of hospital services, and we assumed that the number of discharges of non-Minnesota residents would grow at the same rate as discharges of residents of the state.

The major assumptions that we made in this analysis are as follows:

- We assumed that hospitalization rates by age group would be the same as they were in 2003. To take account of potential future changes in hospitalization rates, we also created projections assuming a range of future use rates – either a 10% increase or 10% decrease in hospitalization rates for each age group. Factors that could cause future hospitalization rates to increase include rising levels of disease (for example, conditions associated with obesity) or technological change; on the other hand, technological change can also be a major driver of reductions in hospitalization rates. (Changes in overall hospital utilization due to the projected aging of the population are accounted for already by the fact that the analysis is done separately for each age group.)

- We assumed that the average length of stay would also be unchanged compared to 2003. Although the average length of a hospital stay declined in Minnesota from 5.1 days in 1993 to 4.3 days in 2003, the average length of stay has been stable over the past five years.

- We assumed that average annual population growth for the geographic areas defined for each hospital would be the same for 2009 to 2015 as projected by Claritas, Inc. for 2004 to 2009. To the degree that this method might overstate or understate actual population growth during this period, our estimates of future hospital use would also be overstated or understated.

- Finally, we assumed that the group of zip codes from which each hospital receives its core business (the geographic area accounting for 75% of discharges) would remain the same over time.

Finally, because calculating occupancy rates over an entire year does not adequately capture variations in occupancy rates that occur at different times of the year, we projected seasonal occupancy rates for 2009 and 2015 by assuming that the distribution of inpatient days across the year would be the same as it was for 2003. In order to account for hospital days that occurred in 2003 but are missing from our data set because the patient was not discharged until 2004, we used hospital days from patients who were admitted in 2002 but not discharged until 2003 as a proxy.

Estimating the Impact of the Proposed Hospital on Existing Hospitals That Serve Residents of the Maple Grove Area

In order to calculate the impact of the proposed hospital on existing hospitals that serve residents of the Maple Grove area, we estimated the potential impact on discharges, inpatient days, and occupancy rates at each of the eleven hospitals. First, based on the applicants' submissions,[20] we calculated the total number of bed days that the new Maple Grove facility is designed to accommodate, incorporating information from the applicants on both the size of the facility and the expected occupancy rate. We calculated the impact on existing hospitals by assuming that the new facility would in fact provide the volume of inpatient services consistent with the proposed size and occupancy rate anticipated by the proposal. We also assumed that all of the patients served by the Maple Grove Hospital would come from within the applicant's defined service area. Our estimate of the impact of the facility is therefore a conservative estimate, representing an upper bound on the volume of inpatient services that would be shifted away from existing hospitals.

To estimate the impact on individual hospitals, we assumed that the hospital's market share of the services provided to Maple Grove area residents at hospitals other than the proposed new facility would be the same as its current market share among the group of eleven existing hospitals. Essentially, this assumes that people who do not receive services at the proposed Maple Grove hospital will maintain the same travel patterns that currently exist. As noted in the main text of the report, however, there is a high level of uncertainty about how travel patterns may change. There are two main factors contributing to this uncertainty: first, the possibility of as many as three large new ambulatory care centers in the community, which would likely have an impact on physician referral patterns; and second, the possibility that a system-affiliated hospital in Maple Grove could affect the pattern of referrals to other hospitals for services not provided directly at the proposed Maple Grove hospital. For each hospital, we estimated the impact of the proposed Maple Grove hospital on existing hospitals as the difference between a) projected volumes in the absence of a new hospital and b) projected volumes incorporating the loss of volume from the addition of a new facility in Maple Grove.

Analyzing Potential Payer Mix Shift

To estimate the potential effect of the proposed Maple Grove hospital on payer mix for existing hospitals, we calculated the distribution of insurance coverage at the zip-code or zip-code-group level for the core service areas of several hospitals. For this analysis, we limited the list of hospitals to those that are either 1) most likely to be affected by the proposed Maple Grove hospital, or 2) major providers of uncompensated care in the region. We used data from the 2001 Minnesota Health Access Survey, which was a health insurance survey of over 27,000 Minnesota households,

[20] For the Tri-Care proposal, we assume an 80-bed hospital for 2009 that will increase to 120 beds in 2015. Fairview Health Services' design anticipates also an 80-bed hospital in 2009, which it projects to expand to 240 beds in 2015. Because NMHC has indicated that they are only seeking legislative approval for the transfer of 80 beds at this time, this analysis assumes 80 beds in both 2009 and 2015. (NMHC has indicated that it may request another exception from the hospital moratorium in order to expand its proposed Maple Grove hospital in the future.)

to estimate insurance coverage for zip codes, or for groups of zip codes where there was insufficient data to estimate it at the zip code level. We aggregated these estimates of insurance status by zip code to the geographic area from which the top 75 percent of a hospital's discharges originated in 2003, as defined above in the projection of future demand for hospital services.

Next, we weighted our estimates of the sources of insurance coverage in the geographic area according to the proportion of the hospital's discharges from each zip code or group of zip codes.. This provided an approximation of the distribution of insurance coverage in the geographic area from which the hospital draws most of its patients. We repeated this analysis for 2009 and 2015 for 1) the projections of inpatient volumes in the absence of a new hospital and 2) the projections with the proposed new hospital.

Appendix 3
American College of Surgeons Classification of Trauma Centers

American College of Surgeons Committee on Trauma Classification System of Trauma Center Level

ACS Levels and Descriptions

Level I
Provides comprehensive trauma care, serves as a regional resource, and provides leadership in education, research, and system planning.

A level I center is required to have immediate availability of trauma surgeons, anesthesiologists, physician specialists, nurses, and resuscitation equipment. American College of Surgeons' volume performance criteria further stipulate that level I centers treat 1200 admissions a year or 240 major trauma patients per year or an average of 35 major trauma patients per surgeon

Level II
Provides comprehensive trauma care either as a supplement to a level I trauma center in a large urban area or as the lead hospital in a less population-dense area.

Level II centers must meet essentially the same criteria as level I but volume performance standards are not required and may depend on the geographic area served. Centers are not expected to provide leadership in teaching and research.

Level III
Provides prompt assessment, resuscitation, emergency surgery, and stabilization with transfer to a level I or II as indicated.

Level III facilities typically serve communities that do not have immediate access to a level I or II trauma center.

Level IV & V
Provides advanced trauma life support prior to patient transfer in remote areas in which no higher level of care is available.

The key role of the level IV center is to resuscitate and stabilize patients and arrange for their transfer to the closest, most appropriate trauma center level facility.

Level V trauma centers are not formally recognized by the American College of Surgeons, but they are used by some states to further categorize hospitals providing life support prior to transfer.

Source: MacKenzie EJ et. al. National Inventory of Hospital Trauma Centers. JAMA 2003 Mar 26; 289(12):1516.

To obtain additional copies of this report, please contact:

Minnesota Department of Health
Minnesota Health Information Clearinghouse
P.O. Box 64975
St. Paul, Minnesota 55164-0975
(651) 282-6314; (800) 657-3793
TDD (651) 215-8980

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David Wessner

Maple Grove Tri-Care Partnership

Three leading health care systems partnering to create one extraordinary hospital in Maple Grove.

Senate Health Policy Committee
Chair, Sen. Becky Lourey
April 12, 2005

Clarke Smith, M.D., Children's Hospitals and Clinics of Minnesota
Rickie Ressler, Allina Hospitals & Clinics
David Wessner, Park Nicollet Health Services
Susan Tabor, BSN, Director of Behavioral Health, United Hospital

Maple Grove TRI-CARE partnership

Park Nicollet Children's ALLINA

Discussion Points

- What Do Area Residents Want?
- The Proposal
- The Site
- The Partnership
  - *Distinct Advantages*
- Compare Proposals

Maple Grove TRI-CARE partnership

Park Nicollet Children's ALLINA

What Do Area Residents Want?

Recent public opinion survey of NW Metro Area residents:

Residents overwhelmingly support a new hospital.

- ***By a margin of 82%-13%, residents believe that a new hospital will be needed***
- ***93% of residents believe it will be needed within five years***

Maple Grove TRI-CARE partnership

Park Nicollet Children's Hospitals and Clinics ALLINA

What Do Area Residents Want?

Residents view the partnership between Park Nicollet, Allina and Children's Hospital as the best proposal.

- ***37% believe the Tri-Care Partnership is the best***
- ***21% support North Memorial***
- ***Only 3% for Fairview***

Maple Grove TRI-CARE partnership

Park Nicollet Children's Hospitals and Clinics ALLINA

What Do Area Residents Want?

Most important attributes of a new hospital:

- ***My health insurance covers services (80%)***
- ***Provides specialized treatment and diagnostic services (70%)***
- ***Ability to refer patients to the largest number of specialized physicians in the Twin Cities (67%)***

Not very important:

- ***Already operates a community hospital in this area (22%);***
- ***amenities, such as retail stores or office space (3%)***

Maple Grove TRI-CARE partnership

Park Nicollet · Children's · ALLINA

The Proposal: A Full Hospital Within 3 Years

Phase I (2006-2008):

80-bed hospital and comprehensive outpatient services anchoring a 96-acre healthcare campus

- ***Emergency and urgent care services***
- ***Inpatient and outpatient surgery***
- ***Pediatric care***
- ***12 bed child/adolescent behavioral health unit***
- ***Obstetrical care***
- ***Non-invasive cardiology***
- ***Radiation and chemotherapy***

Maple Grove TRI-CARE partnership

Park Nicollet · Children's · ALLINA

The Proposal: Future Plans

Phase II (2008-2012)

- *40-50 bed hospital expansion*
- *Additional healthcare resources (e.g. assisted living facility, wellness center, eating disorders institute, etc.)*

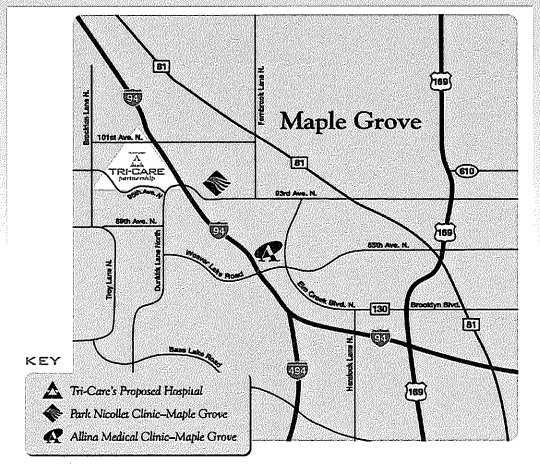
Phase III (2012 and beyond)

- *Up to 250 beds, based on community need*

Maple Grove TRI-CARE partnership

Park Nicollet | Children's | Allina

The Site: A Superior Location

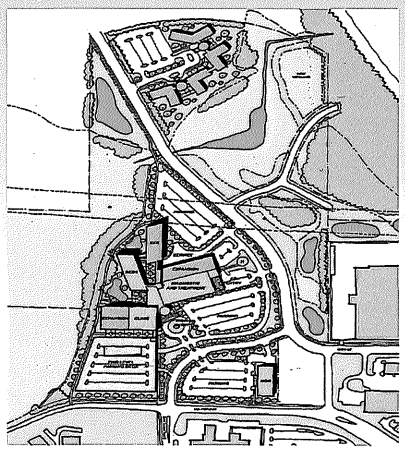


- Convenient access from I-94
- On Dunkirk Lane and 97th Av. N.
- Accessible now

Maple Grove TRI-CARE partnership

Park Nicollet | Children's | Allina

The Site: A Superior Location



- **62 useable acres**
- **Can accommodate significant future growth in hospital and related services**
- **Preserves 34-acres of wetlands as community amenity**
- **Provides restful healing environment**

Maple Grove TRI-CARE partnership

Park Nicollet Children's Allina

The Tri-Care Partnership

Park Nicollet Health Services

- *Park Nicollet Clinic, Methodist Hospital, Co-owner - St. Francis Regional Medical Center. Clinics in Maple Grove, Plymouth, and Brooklyn Center.*

Children's Hospitals and Clinics of Minnesota

- *Largest pediatric organization in Midwest, 8th largest in U.S. Family-centered care model. Full-range of pediatric specialty services, critical care and clinics.*

Allina Hospitals & Clinics

- *11 hospitals, 65 clinics, including Abbott Northwestern, Mercy & Unity and Buffalo hospitals. Co-owner - St. Francis Regional Medical Center; Clinics in Maple Grove, Buffalo, Champlin, Coon Rapids, Elk River, Plymouth and Ramsey.*

Maple Grove TRI-CARE partnership

Park Nicollet Children's Allina

Why a partnership?

Three times the experience

- *This is the only proposal that brings the strength of a partnership to this community.*

Access to the most specialists

- *Residents will have unparalleled access to specialists, including pediatric specialists.*

A hospital for all residents

- *Our hospital will be open to residents, regardless of health plan or primary physician's health system affiliation.*

The community knows us, we the community

- *With 7 clinics in the service area and a 30-year history, we know this community and residents know us.*

Maple Grove TRI-CARE partnership

Why a partnership?

- **Attract and develop a large and diverse medical staff**
- **Provide choice of programs (heart, cancer) to the community**
  - *while sharing key capital intensive resources (beds, imaging, labs)*
- **Bring needed experience to a new hospital**
  - *Family centered competencies of Children's*
  - *Hospital management depth of Allina*
  - *Lean production of Park Nicollet*
  - *Experience in implementing EMR and physician order entry*

Maple Grove TRI-CARE partnership

Why a partnership?

- **Equity sharing keeps services in the hospital**
  - *instead of fragmenting into a myriad of duplicative services*
- **Brings all the resources needed to meet growing community needs**
  - *without consuming all available capital*
- **High volume and efficiency with low capital expenditure**
  - *creates low cost/high value health care*
- **St. Francis is proof of the concept**
  - *Top 100 Hospital in 2004*
  - *Top 1%ile of hospitals under 100 beds nationally*

Maple Grove TRI-CARE partnership

Park Nicollet Children's ALLINA

Solucient Top 100 Hospital Criteria

- *Risk-adjusted mortality index*
- *Risk-adjusted complications index*
- *Risk-adjusted patient safety index*
- *Severity-adjusted average length of stay*
- *Expense per adjusted discharge, case mix- and wage-adjusted*
- *Profitability (operating profit margin)*
- *Cash to total debt ratio*
- *Tangible assets (net PPE) per adjusted discharge*
- *Growth in percent community served*

Maple Grove TRI-CARE partnership

Park Nicollet Children's ALLINA

Tri-Care Partnership:
Behavioral Health Services Collaboration

Continuum of Care

Proposed Programs	Program Description
12 Bed Child/Adolescent In-patient Unit Ages 6-18	Acute in-patient unit with emphasis on stabilization of acute psychiatric crisis. Physical plant design to offer moving and locking hallway door to allow for flexibility and physical separation by age based on need. In-hospital education to be provided by MGO School district.
24/7 Crisis Evaluation, Initial Stabilization, and Referral Services, all ages (A & R) located in or adjacent to E.D.	Mental health and/or substance abuse crisis service. Evaluate, stabilize, and determine placement. If admitted at Maple Grove hospital, process admission.
23 Hr Observation Unit	Distinct (separate) unit designed to provide initial treatment and observation not to exceed 23.59 hours. Patients either discharged or admitted to inpatient program.
Child and Adolescent Partial Hospital Program, Ages 6 -18	Alternative to in-patient care and combined with education component.
Psychiatric Out-Patient Clinic, All ages, possibly with Intensive Out-patient Therapy program.	Monday through Friday clinic model approach.
Out-patient Chemical Dependency treatment Program, Ages 16+	Primary & Relapse Treatment. Could also be offered as an "after school program".

Maple Grove TRI-CARE partnership

Park Nicollet · Children's · Allina

COMPARE PROPOSALS	MAPLE GROVE TRI-CARE PARTNERSHIP	FAIRVIEW HEALTH SERVICES	NORTH MEMORIAL
Proposer(s)/Partnerships	TRI-CARE a partnership of: Park Nicollet Allina Children's	Fairview alone	North Memorial alone
Full Service Hospital	Yes	Yes	Yes
Hospital Open	2008	Phased-in over time	Phased-in over time
Site Access	Convenient access off I-94	Access off Cty. 81/ Fernbrook Lane	Depends on Dunkirk Extension
Most Physician Affiliations	✓		
Access to Most Specialty Physicians	✓		
Access to Most Specialized Pediatric Care	✓		
Community Preference *Recent community survey asked, "Which proposal do you most support?"*	✓ 37%	3%	21%

COMPARE EXPERIENCE	MAPLE GROVE TRI-CARE PARTNERSHIP	FAIRVIEW HEALTH SERVICES	NORTH MEMORIAL
Metro Hospitals	10	3	1
Patients Served* *Combined acute inpatient admissions (2003)*	137,300	65,667	27,768
Physician Affiliations*	6,778	3,265	884
RNs*	4,878	2,190	820
Community Experience *Number of owned primary care clinics in NW suburbs*	7	1	3
Affiliated Hospital Usage by NW Metro Residents**	45%	11%	30%

* *Book of Lists, Twin Cities Business Journal, 2005*
** *Minnesota Hospital Association*

Maple Grove TRI-CARE partnership

Park Nicollet · Children's · Allina

Tri-Care Partnership: Summary / Q and A

- We're committed to this community – providing care in the community today
- Maple Grove and Northwest metro area residents want a choice of the best services available
- The Tri-Care Partnership has distinct advantages for the community and region
- Our proposal will give area residents access to the most specialists and physicians, while leveraging critical capital intensive assets in a cost effective manner
- Questions

Maple Grove TRI-CARE partnership

Park Nicollet Children's ALLINA

Allina Hospitals Clinics
Behavioral Health Bed Capacity Summary
2004

UPDATED NOVEMBER 2004 by: Susan Tabor, Donna Kryzmarcek, Jeri Peters, Steve Schneider, Mary Wagoner, and Diane Timmer (ANW)

Metro Hospitals

Hospital	Geriatric Psych		Adult Psych		Adult CD		Child/Adolescent Psych		Child/Adolescent CD		Total Staff Bed Capacity
	# Beds Available	# Beds Used/Staff	# Beds Available	# Beds Used/Staff	# Beds Available	# Beds Used/Staff	# Beds Available	# Beds Used/Staff	# Beds Available	# Beds Used/Staff	
Abbott Northwestern	0	0	69	63	0	0	24	24	0	0	87
Mercy	0	0	32	32	0	0	0	0	0	0	32
Unity	0	0	0	0	24	24	0	0	0	0	24
United	15	15	28	28	0	0	16	16	0	0	59
Metro Hospitals	**15**	**15**	**129**	**123**	**24**	**24**	**40**	**40**	**0**	**0**	**202**

202

Regional Hospitals

Hospital	Geriatric Psych		Adult Psych		Adult CD		Child/Adolescent Psych		Child/Adolescent CD		Total Staff Bed Capacity
	# Beds Available	# Beds Used/Staff	# Beds Available	# Beds Used/Staff	# Beds Available	# Beds Used/Staff	# Beds Available	# Beds Used/Staff	# Beds Available	# Beds Used/Staff	
Cambridge	0	0	14	14	21	21	0	0	16	16	51
New Ulm*	0	0	12**	12	8	8	0	0	0	0	20
Owatonna	0	0	10	10	0	0	0	0	0	0	10
Regional Hospitals	**0**	**0**	**24**	**36**	**29**	**29**	**0**	**0**	**16**	**16**	**81**

81

Total Allina	**15**	**15**	**153**	**159**	**53**	**53**	**40**	**40**	**16**	**16**	**283**

283

* New Ulm will be moving to 12 beds from 5 beds after expansion

** New Ulm also admits older adolescents to it's adult IP unit

METRO AND REGIONAL OP SERVICES

Hospital	O.P. CLINIC	ADULT PH	ADOL.PH	ADULT DAY TX.	ADOL. DAY TX	ADOL. DAY TX	CD	*ARMHS (adult rehabilitative mental health services)*
ANW	X	X	X(childPH also)				Assmnt & Referral Srvcs	
Mercy	X	X		X			Assmnt & Referral Srvcs	
Unity	X						X	
United	X	X	X	X			Assmnt & Referral Srvcs	
Cambridge								
New Ulm*							Out-patient CD program	
Owatonna							X	X

MAPLE GROVE HOSPITAL PROPOSALS SIDE-BY-SIDE

KEY COMPARISONS	FAIRVIEW	TRI-CARE: PARK NICOLLET/ALLINA/CHILDRENS	NORTH MEMORIAL
Where and what they want to build	A 26.7-acre site in Maple Grove for the medical campus. The site is bounded by the proposed Hwy 610 corridor to the north; Fernbrook to the east; a proposed senior housing complex and church to the south along 99th street; and an undeveloped parcel to the west. Phase 1: Ambulatory Care Center of 126,000 square feet, providing services in specialty clinics, primary care, mental health and chemical dependency; ambulatory surgery, imaging/cardiology/laboratory, women's center, medical oncology/ cancer center, and pharmacy/ ophthalmology/optical/ rehabilitation. Phase 2: Expansion of ambulatory care base and development of 72-100 bed acute care hospital with a minimum of additional 146,000 square feet. Services are added and expanded. Future Phases: Continued expansion of acute, diagnostic, therapeutic and support services. Addition of beds incrementally to a total of 284.	A health campus located on 84 acres of property located at the intersection of Dunkirk Lane and 97th Avenue North in Maple Grove. Note that only 50 of the 84 acres are suitable for construction. Phase 1: Development of clinical services, outpatient diagnostic and treatment services, other ancillary services (such as imaging, outpatient surgery, and others), and a 60-100 bed hospital. Phase 2: Expansion of the number of beds to 100-150 in the year 2012. Assisted living and long term care may be added if demand exists and partnerships can be developed. Phase 3: Addition of beds to reach 250 beds by 2020.	A 30-acre health care campus of a proposed 157-acre development at the intersection of I-94 and the proposed extension of Hwy 610. Phase 1: Establishment of an ambulatory care facility, which will be a combination of medical offices for primary care and specialty physicians, Children's Hospitals and Clinic's pediatric specialty clinics, outpatient surgical suites, medical diagnostic labs and urgent/emergent care. Phase 2: Transfer of 80 *existing* hospital beds from its Robbinsdale campus to the Maple Grove campus. Final Phase: On an as needed basis, expansion of the inpatient hospital, ambulatory care areas and medical clinics.
How many beds	Transfer from Fairview-University Medical Center 72-100 beds by 2009, increasing to as many as 284 beds within a ten to fifteen year period following initial occupancy of the hospital.	Phase 1 will include construction of 60-100 beds. Phase 2 will involve expanding the number of beds to 100-150 in the year 2012. Phase 3 includes the addition of beds to reach 250 beds by 2020. It is undetermined whether these beds will be transfers or new.	Transfer 80 existing licensed beds from the Robbinsdale facility.

MAPLE GROVE HOSPITAL PROPOSALS SIDE-BY-SIDE

KEY COMPARISONS	FAIRVIEW	TRI-CARE: PARK NICOLLET/ALLINA/CHILDRENS	NORTH MEMORIAL
When they want to build	Ambulatory Care Center will break ground this spring and begin providing care as early as 2006. Upon approval, Fairview will rapidly proceed with planning, design, construction and occupancy of the acute care facility between 2006-2009; planning will take between 6-12 months and could begin building as early as 2006.	As soon as approval is received. Road construction on Hwy 30 and the I-94 overpass, which are short term projects, may also be factors. Phase 1 should be completed by 2008.	Phase 1 construction is scheduled to begin in spring 2005 and expected to open in fall 2006.
Partners	University of Minnesota Physicians (UMPhysicians). Other partners that are already a part of Fairview include Fairview Physician Associates, The Institute for Athletic Medicine, Behavioral Healthcare Providers, and Ebenezer. Fairview University Children's Hospital is also a part of Fairview and will be a partner.	The Healthy Communities Initiative that is facilitated by Park Nicollet and includes Northwest Hennepin Family Collaborative, Osseo School District 279, St. Mary's Carondolet Caring Clinics, and the Plymouth, Maple Grove and Brooklyn Center Park Nicollet Clinics.	Phase 1 will be in partnership with North Memorial affiliated physician provider groups, which includes primary care physicians and specialists. Health Partners will partner as well but will not have a clinic presence.
What infrastructure is necessary	Maple Grove Parkway is a key transportation concern for the hospital. Hwy 610 is not necessary for the project to go forward but is an important issue for the residents of the Northwest suburbs.	Hwy 30 and the I-94 overpass probably need to be upgraded first (short term projects), but discussions with the city are ongoing.	Hwy 30 and the I-94 overpass probably need to be upgraded first (short term projects), but progress for their completion is in the works.
How much it costs and do they have the money	The Phase 1 Ambulatory Care Center development estimated cost is $47 million. The acute care facility has an estimated cost of $64.8 to $90 million. Funding is already accounted for in Fairview's strategic capital plan.	A *68 bed hospital*, net of major equipment and IT infrastructure is projected to cost $72 million, but this does not include the medical office building. Park Nicollet/Allina plan to use debt capacity and anticipate no problems.	The total cost for Phases 1 & 2 is $117.2 million. North Memorial plans to use its current debt capacity, which is in line to cover the costs of the project.
Market share	12% of *their defined* Primary Service Area (PSA) (10 zip codes) in 2003 for discharges.	41.5% of *their defined* Primary Service Area (PSA) (22 zip codes) for discharges (excluding newborns).	32.4% of *their defined* Primary Service Area (PSA) (13 zip codes) for both discharges and days.

Posted on Wed, Apr. 06, 2005

Are improved health care facilities driving up costs?

Minnesota's hospitals and specialty care centers have spent $1.2 billion on upgrades since 2002. But are improved facilities driving up the cost of health care?

BY JENNIFER BJORHUS
Pioneer Press

When Scott Batulis looks around St. Joseph's Hospital, in St. Paul, he can't help noticing what needs fixing: the grooves that 80 years of use have worn into the stone stairs of the chemical-dependency treatment building; the semi-private rooms with curtain dividers, outdated in an era when patients expect hotel-like hospital stays; the hospital's maze of corridors in which a growing number of outpatients get lost.

So to Batulis, who's headed St. Joseph's since late 2002, a planned new building for outpatient services isn't a frill. Neither is a new skyway and helipad. They're necessities. The $70 million expansion and renovation the hospital announced in February will keep St. Joseph's in the game.

Elsewhere in downtown St. Paul, similar thinking is driving HealthPartners to build a $22 million specialty-care building, and United Hospital a $50 million neuroscience institute.

Individually, the projects appear to make good business sense. Like health care providers around the country, St. Paul's hospitals are trying to meet ever-higher consumer expectations. That means chasing aging baby boomers, competing for reimbursement dollars and using more-profitable services to subsidize others. St. Paul is just one cluster of a health care capital-spending boom under way across Minnesota as health care providers of all stripes spend millions on facilities and equipment.

And though no one can draw a direct connection to higher insurance rates, critics say the projects look like runaway spending at a time when employers and workers are screaming about spiraling health care costs.

BY THE NUMBERS

Since the start of 2002, hospitals and specialty centers have launched at least $1.2 billion worth of capital projects, according to a Pioneer Press review of the state Department of Health's database.

There have been at least 120 major expansions, renovations or remodels of clinics, hospitals and specialty centers around the state in the last three years. By this fall, there will be three state-of-the-art cardiac facilities within minutes of the Bloomington intersection of Minnesota 100 and Interstate 494. In the Twin Cities alone, at least $130 million has been spent adding or replacing expensive imaging equipment such as magnetic resonance imaging, or MRI, scanners.

And there's more on the horizon. State Health Department data doesn't yet include several new projects such as St. Joseph's $70 million expansion, or separate proposals for a new hospital in Maple Grove that range from $72 million to $299 million. The University of Minnesota is mulling a $500 million project that eventually would replace the Riverside branch of the Fairview-University Medical Center. Other metro area hospitals are preplanning major new expansions yet to be announced, industry sources say.

"I've been doing this for 20 years, and I've never seen this much interest in the medical real estate market," said Stephen Brown, head of health care real estate for Bloomington-based commercial real estate firm United Properties.

The state numbers are conservative, since many projects go unreported. State law had required health care providers to report only capital projects above $500,000 — a threshold raised to $1 million in 2003.

WHO PAYS?

Critics say the boom is contributing to Minnesota's soaring health care costs. Minnesota insurers have been raising

premiums an average of 9 percent to 16 percent a year for several years now, according to the Minnesota Council of Health Plans. It expects similar hikes around 10 percent for 2004 and 2005.

Though building and equipment costs certainly are not the only factor behind rising health care costs —prescription drugs, labor and an aging population needing care all play a role — insurers and some health care experts rank the construction and capital expenses very high on the list of cost drivers.

"These costs go directly to the people of Minnesota and it makes their health care more unaffordable," said Mark Shaw, vice president of network finance and payment for Eagan-based insurer Blue Cross Blue Shield, which raised concerns about the impact of costly expansions a few years ago with a white paper. "To do nothing (about big capital investments) would be to encourage a crisis," Shaw said.

Bloomington-based HealthPartners is both an insurer and a hospital owner undergoing its own multimillion-dollar expansion, yet its CEO has publicly questioned the costs of growth. HealthPartners Chief Executive Mary Brainerd began a recent business breakfast talk in Minneapolis by observing that health care is the No. 1 growth area for construction in the Twin Cities, even as rising health care costs top business concerns.

"There's a building boom in health care," Brainerd said.

Even the experts can't say exactly how much the boom is driving health insurance spending. Scott Leitz directs the state Health Department's health-economics program, which collects the data from providers about new capital projects, but that information tends to describe broad categories, like "hospital services," which can include labor costs as well as renovations, construction or equipment purchases.

Health care executives don't like to talk about how they finance improvements. Brainerd would only say that HealthPartners is financing Regions' expansion in St. Paul from the hospital's annual capital pool and that the costs will be covered through "normal revenue."

Batulis and Bob Gill, chief financial officer for St. Joseph's parent, HealthEast, said St. Joseph's $70 million expansion probably will be financed through restructuring existing debt, cost-cutting, the possible sale and lease-back of its corporate headquarters and a campaign for major donations.

The state's major insurers insist consumers eventually pay for renovations and new equipment through higher insurance rates. That worries Julie Brunner, executive director of the Minnesota Council of Health Plans.

"We aren't against appropriate expansion," said Brunner, whose organization represents the state's eight nonprofit insurers, including Blue Cross Blue Shield, Medica and HealthPartners. "I think the question is, how many of what type of specialty facility is appropriate? Are we expanding in areas where the population needs service?"

And when pressed, Gill acknowledged HealthEast will pressure insurance companies for higher reimbursements as it drafts its operating budget.

"To say that because we're going to build a new hospital at St. Joseph's that we're going to have to increase our rates to Medica or Blue Cross by X, Y and Z numbers is not necessarily the case," Gill said. But then he added: "You're right, it effectively translates to that."

THE STATE'S ROLE

The state has attempted to handle such questions in two ways: by requiring hospitals and other providers to report major capital projects to the state Health Department and by the state's long-standing moratorium on new hospital beds.

Critics say the measures aren't enough.

The bed moratorium is limited to just that — hospital beds. It doesn't apply to other projects or to nonhospital, for-profit health care companies, which also are spending big.

The reporting requirement is primarily a data-gathering tool. The law doesn't allow the Health Department to change or stop the projects providers self-report. Minnesota got rid of its so-called "certificate of need" program, requiring providers to get state approval for big capital projects, in the 1980s after it was deemed ineffective. About 30 states still have such programs.

Instead, Health Department staff put questionable projects on "prospective review," which means the provider will have to get state approval for future capital projects. In a decade, they've put three projects on review. Two went ahead anyway, said Leitz.

Providers are required to explain to the state how spending will impact what they charge patients and third-party payers. But a brief review of recent filings shows they frequently report the spending will have no impact on charges. Some say the changes could even be reduced because of gains in efficiencies.

As Leitz sees it, increased capital spending over the past decade is in part a reflection of the increasing importance of expensive medical equipment such as MRI scanners.

"There's no question from an economic perspective, technology has tended to drive much of what we've seen in health care cost growth — and it's likely given us better access to services, probably better outcomes," said Leitz. "It's just come at a cost. It's a trade-off that we've made."

PUBLIC, BUSINESS INVOLVEMENT

Health care reform advocates argue the public has had little voice in the trade-offs. Except for the proposed new hospital in Maple Grove, the role big facilities' spending plays in spiraling health care costs has largely flown under local radar screens. Medical facilities are still generally viewed as community assets. Last year, the governor formed a new Health Care Cabinet, but facilities spending no longer is on its agenda. Even Attorney General Mike Hatch, a crusader on health care reform, hasn't touched the issue.

"Nobody is asking that question in this building," Hatch said in an interview, referring to his office. "They probably ought to be, but they're not. It's a major question. There's no accountability with regard to expenditures right now."

What's needed, reform advocates say, is for all the stakeholders to meet and discuss the growth, and for the public to be involved.

"If we're having to make trade-offs between convenience and cost, nobody's allowing us to do it," said former U.S. Sen. Dave Durenberger, now head of the National Institute of Health Policy. The general public is very aware that health care expansions are costing them — they just don't know where to turn, he said.

Business leaders agree. Carolyn Pare, head of the Buyers Health Care Action Group, said the spending frustrates her members. The Bloomington-based group includes such Minnesota companies as 3M Co. and Target Corp. The state needs better ways to assess whether communities truly need the expansions providers want, she said.

Kathy Mock, head of legislative affairs for Blue Cross, suggests creating stakeholder groups, along the lines of the mental health group that formed two years ago after Attorney General Hatch and Blue Cross settled his 2001 lawsuit against the insurer. That 25-person group, which includes insurers, providers and advocates for the mentally ill, is drafting recommendations for improving the state's mental health care.

At the state Capitol, there has been no consistent approach to the capital expenses issue. Two years ago, lawmakers decided to allow only hospitals or affiliates to build new radiation clinics. Last year, they passed a bill that requires diagnostic imaging facilities and outpatient surgery centers to submit detailed financial information, and requires doctors to disclose to patients whether they own any part of the facilities to which they are referring them.

Too frequently, the decisions are a matter of who hires the best lobbyists and "whoever is in the room," said state Sen. Sheila Kiscaden, IP-Rochester.

"We just have not found a workable way to make these decisions," she said.

One avenue opened last year when lawmakers passed a law requiring the state health commissioner to do a public-interest review of any expansions requiring exemptions to the state's hospital bed moratorium. The reviews are to include public meetings with affected communities. The Health Department has gone through the process once so far, concluding in March that Maple Grove needs its own hospital because it's growing so quickly.

This year, Kiscaden plans to introduce a bill that would require the Health Department to post projects costing $5 million or more on its Web site. Concerned citizens could request a public hearing; an administrative law judge could handle disputes.

"We need a process that isn't just a political lottery for people to be able to resolve these questions," Kiscaden said.

Jennifer Bjorhus can be reached at jbjorhus@pioneerpress.com or 651-228-2146.

Senator Berglin moves to amend S.F. No. 1840 as follows:

Page 4, line 20, delete "the"

Page 4, line 21, before the period, insert ", or adds new licensed beds"

Senator Kiscaden moves to amend S.F. No. 1840 as follows:

Page 4, line 21, before the period, insert "and demonstrates to the satisfaction of the commissioner that the new hospital will:

(i) have a significant commitment to providing uncompensated care, including discounts for uninsured patients, coordination with community health centers and other providers of care to low-income uninsured persons, and coordination with other hospitals providing uncompensated care and serving public program participants;

(ii) provide a full continuum of behavioral health services, including mental health services for children and adolescents, and alternatives to inpatient care;

(iii) have an electronic medical records system and a commitment to invest in information technology improvements;

(iv) be a site for workforce development for a broad spectrum of health care-related occupations; and

(v) coordinate with other health care providers to reduce the duplication of high-cost services and technology."

Senator Higgins moves to amend the SCS1840A-2 amendment to S.F. No. 1840 as follows:

Page 1, line 17, delete "and"

Page 1, line 19, before the period, insert "; (vi) not significantly increase market concentration of hospital services in the area; and (vii) not have a significant negative impact on hospitals in the surrounding area"

Senator Wergin moves to amend the SCS1840A-2 amendment to S.F. No. 1840 as follows:

Page 1, line 17, before the semicolon, insert "and have a significant commitment to providing clinical training programs for physicians and other health care providers, including, but not limited to, obstetrics and gynecology, pediatrics, psychiatry, and pediatric psychiatry, in coordination with other medical education training programs in the state;

(v) not increase the number of licensed beds in Hennepin county. In analyzing this criterion, the commissioner must compute the costs and benefits of moving existing licensed but not staffed beds with the costs and benefits of moving currently staffed and licensed beds and must examine the availability over time of additional beds to meet the needs of the growth in the community"

Page 1, line 18, delete "(v)" and insert "(vi)"

Senator Kelley moves to amend S.F. No. 1840 as follows:

Delete everything after the enacting clause and insert:

"Section 1. [REPEALER.]

Minnesota Statutes 2004, sections 144.551 and 144.552, are repealed."

Delete the title and insert:

"A bill for an act relating to health; repealing the hospital construction moratorium and the public interest review of proposed hospital projects; repealing Minnesota Statutes 2004, sections 144.551; 144.552."

Senator Kelley moves to amend S.F. No. 1840 as follows:

Page 4, line 18, delete everything after "(19)" and insert " one or more projects to construct hospitals in the city of Maple Grove on sites approved by the city, provided that:

(i) each hospital is constructed and operated by an entity that participated in the public interest review under section 144.552 prior to April 1, 2005;

(ii) each hospital provides a full continuum of health care services, including emergency medical services, surgery, obstetrics, and behavioral health services, including mental health services for children and adolescents;

(iii) each hospital makes a significant commitment to providing uncompensated care; and

(iv) each hospital operator has agreed to participate with the University of Minnesota in the training of health professionals"

Page 4, delete lines 19 and 20

Page 4, line 21, delete everything before the period

MAPLE GROVE HOSPITAL PROPOSALS SIDE-BY-SIDE

KEY COMPARISONS	FAIRVIEW	TRI-CARE: PARK NICOLLET/ALLINA/CHILDRENS	NORTH MEMORIAL
Where and what they want to build	A 26.7-acre site in Maple Grove for the medical campus. The site is bounded by the proposed Hwy 610 corridor to the north; Fernbrook to the east; a proposed senior housing complex and church to the south along 99th street; and an undeveloped parcel to the west. Phase 1: Ambulatory Care Center of 126,000 square feet, providing services in specialty clinics, primary care, mental health and chemical dependency, ambulatory surgery, imaging/cardiology/laboratory, women's center, medical oncology/ cancer center, and pharmacy/ ophthalmology/optical/ rehabilitation. Phase 2: Expansion of ambulatory care base and development of 72-100 bed acute care hospital with a minimum of additional 146,000 square feet. Services are added and expanded. Future Phases: Continued expansion of acute, diagnostic, therapeutic and support services. Addition of beds incrementally to a total of 284.	A health campus located on 84 acres of property located at the intersection of Dunkirk Lane and 97th Avenue North in Maple Grove. Note that only 50 of the 84 acres are suitable for construction. Phase 1: Development of clinical services, outpatient diagnostic and treatment services, other ancillary services (such as imaging, outpatient surgery, and others), and a 60-100 bed hospital. Phase 2: Expansion of the number of beds to 100-150 in the year 2012. Assisted living and long term care may be added if demand exists and partnerships can be developed. Phase 3: Addition of beds to reach 250 beds by 2020.	A 30-acre health care campus of a proposed 157-acre development at the intersection of I-94 and the proposed extension of Hwy 610. Phase 1: Establishment of an ambulatory care facility, which will be a combination of medical offices for primary care and specialty physicians, Children's Hospitals and Clinic's pediatric specialty clinics, outpatient surgical suites, medical diagnostic labs and urgent/emergent care. Phase 2: Transfer of 80 *existing* hospital beds from its Robbinsdale campus to the Maple Grove campus. Final Phase: On an as needed basis, expansion of the inpatient hospital, ambulatory care areas and medical clinics.
How many beds	Transfer from Fairview-University Medical Center 72-100 beds by 2009, increasing to as many as 284 beds within a ten to fifteen year period following initial occupancy of the hospital.	Phase 1 will include construction of 60-100 beds. Phase 2 will involve expanding the number of beds to 100-150 in the year 2012. Phase 3 includes the addition of beds to reach 250 beds by 2020. It is undetermined whether these beds will be transfers or new.	Transfer 80 existing licensed beds from the Robbinsdale facility.

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