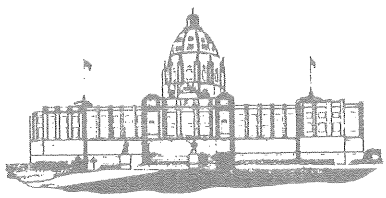
MINNESOTA SENATE

RESEARCH REPORT

HOSPITAL AND NURSING HOME SYSTEM GROWTH:

MORATORIA, CERTIFICATE OF NEED, AND OTHER ALTERNATIVES



Senate Counsel & Research

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MORATORIA, CERTIFICATE OF NEED, AND OTHER ALTERNATIVES

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INTRODUCTION

Dramatically different problems pertaining to the nursing home and hospital industries have confronted the Minnesota Legislature in recent years. Hospitals have suffered from declines in number of patient days, lengths of stay, and occupancy rates. 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, further increasing the number of empty beds in the state.

Nursing homes, on the other hand, have seemed in recent years to be operating in an atmosphere of excess demand. Minnesota has more beds per 1,000 elderly than most states and institutionalizes its elderly at a rate almost twice the national average (nine percent versus five percent, according to 1983 Minnesota Center for Health Statistics data). Even when additional beds were added to the system the industry continued to experience high occupancy rates. Because of the large state role in nursing home reimbursement through the Medical Assistance program, this was producing significant strain on state resources.

Part of the state response to problems in both industries was to establish moratoria on the construction of new facilities. Even though the problems pertaining to hospitals and nursing homes were different, until moratoria were established both industries were growing steadily at a time when most experts believed expansion was contrary to the state's interests. Growth was taking place despite existence of the certificate of need program (CON) which required review of proposed construction projects to determine whether they were needed.

The nursing home moratorium was first adopted in 1983 (Laws of Minnesota for 1983, Chapter 199). The original moratorium prohibited the certification of new nursing home beds to participate in the Medical Assistance program, but it was expanded by the 1985 Legislature to apply to licensed beds as well (Laws of Minnesota for 1985, First Special Session Chapter 3). The nursing home moratorium does not have an expiration date.

The hospital moratorium was adopted in 1984. It prohibits, until June 30, 1987, the establishment of any new hospitals as well as any construction or building modification 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 (Laws of Minnesota for 1984, Chapter 654). A driving force behind adoption of the hospital moratorium was the fact that Minnesota's CON law was scheduled to expire effective June 30, 1984. Even though the CON program had been criticized for failing to adequately control growth in the industry, it had imposed some discipline on the system and its termination prompted the enactment of the moratorium.

At some point the Legislature will be faced with policy decisions regarding the future expansion of the hospital and nursing home industries in Minnesota. The first decision deadline will occur prior to June 30, 1987, when the hospital moratorium is scheduled to expire. The broad options open to the state are to reinstate CON; replace it with another review system; extend the moratoria on hospital and nursing home construction either with or without modifications; or repeal the moratoria and let market forces determine the need for additional capacity in the two industries.

This report is intended to provide information that will facilitate legislative decisions regarding health facility expansion. The information in this report is based on interviews with government officials and representatives of the two industries, a 50-state survey regarding the status of CON laws, and a review of pertinent recent reports on CON and the moratoria. Chapter One reviews the history of the CON program and describes the current hospital and nursing home environment. Chapter Two describes the activities of other states. Chapter Three discusses some of the major issues that must be understood in order to make an informed policy choice about controls on health facility growth and summarizes the major issues upon which there is some agreement among health planners, state regulators, and industry representatives. Chapter Four describes the major options available to the Legislature. Included in the Appendix are highlights of interviews and the results of the 50-state survey.

Chapter One

Where Are We Now?

The Minnesota Legislature will soon be faced with difficult decisions concerning growth of the health care system. Moratoria are currently in place which prevent expansion of the hospital and nursing home systems. However, the scheduled sunset of the hospital moratorium in 1987 will force (1) a reexamination of the appropriateness of moratoria as a method of regulating health facility growth, and (2) a determination of the need, if moratoria are appropriate, for exceptions to allow construction of new facilities under special circumstances or to permit some changes in existing facilities. With the repeal of the certificate of need (CON) program in 1984 there is no longer any generally-applicable state mechanism for review and approval of these changes. This chapter includes a history and description of the CON program and the hospital and nursing home moratoria and describes the current hospital and nursing home environments.

The certificate of need program.

The CON program is a system of review and approval of capital expenditures, construction projects, and other activities of health facilities. The CON program is part of the federal health planning program. Most states have CON programs (see Chapter Two). The purpose of CON programs is to control growth and changes in the health care system in order to prevent inappropriate expansion of the system and to target limited resources to the areas of greatest need. Under a CON program health facilities are required to submit proposals for projects to regional agencies and the state for review. Projects that are not consistent with CON criteria are either denied or referred back to the facility for modification.

A CON program existed in Minnesota from 1971 to June 1984. The Minnesota CON program involved review of projects proposed by hospitals, nursing homes, boarding care homes, outpatient surgery centers, and some other types of health care facilities. Projects subject to review included new licensed facilities, new institutional services, acquisitions of facilities involving large capital expenditures, purchases of expensive medical equipment, construction and remodeling projects, and some changes in bed capacity. Any facility intending to undertake a project of this type was required to submit the proposal to a regional Health Systems Agency (HSA) for review. The HSA conducted a preliminary review according to state and federal guidelines and forwarded a recommendation to the state. State CON staff then made a determination based on the record submitted by the HSA

using criteria established in state and federal law and rules. The state could grant or deny a certificate of need or require modification of a facility's proposal prior to approval. The project could be commenced only if the facility either received a certificate of need or qualified for a waiver from full CON review. Certain types of projects such as those unrelated to patient care, acquisitions of existing facilities, and replacement of existing equipment were eligible for waivers. In most cases, to receive a waiver the facility had to demonstrate that the project was needed, that it was economically sound, and that it would not result in a substantial increase in patient charges.

Clinics and physician groups proposing to purchase medical equipment at costs over the thresholds for CON review were required to undergo a circumvention determination review even though they were generally exempt from CON requirements. The purpose of this review was to determine whether the project was in fact an attempt to circumvent the CON process by a covered facility (for example, a hospital going through a physician clinic to acquire equipment that would otherwise require a certificate of need). If the project was determined not to be a circumvention of CON, CON review was not required.

Problems with the certificate of need program. In recent years traditional CON programs have been criticized both in Minnesota and nationally for failing to adequately control the growth of the health care system. Historically, most health facility projects eventually received approval, at times even when a new facility appeared unnecessary. While it is possible that CON succeeded to a certain extent by forcing facilities to scale-down or modify their proposals or by discouraging marginal projects, for the most part CON did not substantially restrain the growth of the health care system.

A major reason for the limited success of CON in controlling an expanding health care system was the case-by-case system of review. Health care is an extremely important and sensitive issue affecting every citizen of the state. Every proposal for new health care facilities or services would in some way improve the availability of and access to health care. HSA's and state officials were hard pressed to justify denials on the basis that a given project was not "needed." In addition, HSA's and state agencies received a great deal of pressure from the local community and others in support of proposed projects. Without statewide limits on facility expansion or very specific criteria requiring denials, it was difficult to deny individual applications.

In March of 1984 the Minnesota Department of Health issued a report and recommendations concerning the CON program. The Department concluded that, although the CON program had some value in discouraging growth and had resulted in some cost savings, it did not place meaningful constraints on health

facility activity. Among other things, the Department recommended that the CON program be allowed to sunset as scheduled in 1984. The Department indicated that a system of state review of the health system was needed, but that the CON program was not the appropriate mechanism. The Department recommended that it be authorized to monitor and collect information about the health care system in order to make future recommendations for legislation.

The repeal of certificate of need. During the 1984 session the Minnesota Legislature was faced with difficult decisions concerning CON and health facility growth. According to laws enacted by the 1982 and 1983 Legislatures, the CON program would expire June 30, 1984, in the absence of new legislative action. A moratorium existed to control growth in the nursing home industry but the CON program was the only state control on hospital industry growth. While there was general agreement that the CON program had limited effectiveness in controlling health care system growth, the prospect of an unrestrained system created much concern. The Legislature decided to enact a hospital moratorium and allow CON to expire.

The hospital moratorium.

Until 1984 new hospitals were being proposed and built in spite of the fact that hospital occupancy rates were very low; that there were thousands of empty beds in the state; and that changes in mechanisms for receiving payment from Medicare, Medical Assistance, HMO's, and other buyers of hospital services were tightening sources of revenue. In fact, hospitals were gearing up planning efforts for new construction projects in anticipation of the sunset of CON even though the projects did not appear to make good business sense in the existing health care environment. The prospect of more hospital construction unrestrained by even the limited controls of the CON program created much concern for legislators, government officials, and hospitals and other providers. However, because the health care system was in a period of major change due to changing Medicare reimbursement and other factors, it was difficult to develop an appropriate alternative to CON. In order to prevent further growth of the system until a more knowledgeable decision could be made, a moratorium was enacted prohibiting construction or expansion of the hospital system.

The hospital moratorium prohibits the establishment of a new hospital or any other activity that increases a hospital's bed capacity, relocates beds from one location to another, or otherwise results in an increase or redistribution of hospital beds within the state (Minnesota Laws 1984, Chapter 654, Article 5, Section 57). There are exceptions for: (1) national referral centers that receive a large number of out-of-state patients; (2) projects for which certificates of need had been granted by May 1, 1984; (3) projects for which a certificate of need was denied,

if the denial is reversed on appeal; and (4) certain projects which were previously exempt from CON review. The Commissioner of Health is authorized to grant an emergency waiver to replace a needed facility that is destroyed by fire, flood, or similar disaster. The hospital moratorium will expire on June 30, 1987, if not extended by the Legislature.

The nursing home moratorium.

In 1983, a moratorium was established that prohibited the certification of any additional nursing home beds for participation in the Medical Assistance program. New beds were continually being added to the system even though the percentage of elderly Minnesotans in nursing homes was already much higher than the national average. The moratorium was established to encourage the development and use of alternative services for the elderly and to control skyrocketing state health care costs by limiting the number of nursing home beds in the state. In subsequent years it became clear that the nursing home system in the state was continuing to expand. While the moratorium precluded Medical Assistance payments for new beds, many new private-pay beds were being added, expanding the total supply of nursing home beds and indirectly resulting in increases in Medical Assistance costs. As a result, the moratorium was expanded in 1985 to prevent the addition of any new licensed nursing home beds.

The Commissioner of Health is required to submit an annual report to the Legislature assessing the impact of the moratorium by geographic area. In addition, the Commissioner of Energy, Planning, and Development, in consultation with the Commissioner of Health and the Commissioner of Human Services, is required to report in January 1986, and biennially after that, regarding:

--projections on the number of elderly Minnesotans, including Medical Assistance recipients;

--the number of residents most at risk of nursing home placement;

--the need for long-term care and alternative home and noninstitutional services;

--the availability of alternative services by geographic region; and

--the necessity or desirability of continuing, modifying, or repealing the moratorium in relation to the availability and development of the continuum of long-term care services (Laws of Minnesota for 1983, Chapter 199).

Reports received so far concerning the nursing home moratorium indicate that the moratorium has resulted in

substantial savings to the state Medical Assistance program and has, along with other state programs, stimulated the development of alternative services such as home health care. While there has been no strong pressure from the nursing home industry to repeal the moratorium, there has been pressure to create some exceptions, such as allowing beds to be redistributed within a facility.

Where are we now?

The health care system in Minnesota is currently in a period of change and uncertainty. Business, labor, government, and other interests are searching for and implementing new methods to control rising health care costs. Payment mechanisms used by both public and private payers are changing. For example, Medicare and Medical Assistance are no longer paying for hospital services on the traditional, retrospective, cost-based system. Instead, payments are made on a fixed, prospective basis. Private payment systems are also changing as HMO's gain strength and seek to control costs by contracting with hospitals for services on a capitated basis or by implementing other payment systems. The Medicare capital reimbursement system will be changing in the near future, and the nature of the system and its impact on hospitals remains to be seen. Nursing home reimbursement under the Medical Assistance program was recently overhauled to provide reimbursement for operating costs based on a facility's case mix of residents and property costs based on a rental concept of payment.

Another change taking place in the health care system is a blurring of the distinctions between nursing homes and hospitals. Nursing homes are taking care of sicker residents, many of whom in the past would have required hospitalization. Hospitals, on the other hand, are seeking new markets for services and new uses for available capacity. Many hospitals are providing subacute nursing services to patients both within the hospital facility and in the patient's home. Although the distinction between services offered by nursing homes and hospitals is blurring, they still operate within different environments.

THE CURRENT HOSPITAL ENVIRONMENT. The current hospital/acute care environment has the following characteristics:

(1) Low occupancy. Occupancy rates for hospitals are very low. According to recent data from the Metropolitan Health Board, occupancy rates for acute care in the seven-county metropolitan area fell below 50 percent of the licensed beds for the period January through May, 1985. Low occupancy raises questions concerning the cost of the excess capacity and the quality of services provided in low-capacity, low-volume settings.

(2) Relatively high number of beds in proportion to population. The proportion of hospital beds to population is higher than the national average. The Minnesota average is 5.68 beds for every 1,000 persons while the national average is 4.37. However, recent data indicate that Minnesota is moving closer to the national average.

(3) Changing market forces. Revenue sources are tightening and markets are becoming increasingly competitive. Hospitals' flexibility in setting charges and recouping costs is decreasing because of the tightening of payments from Medicare, Medical Assistance, HMO's, and other buyers of hospital services.

(4) Scarce capital resources. Hospitals are encountering increasing difficulty obtaining capital for purchases of equipment and other projects.

(5) Changing attitudes and business practices. The "build, build, build" mentality that characterized the last decade is decreasing as some hospitals begin to face serious economic problems. Hospitals are more likely to do thorough market analyses before planning new projects, facilities, or services. Increasingly, hospitals are entering into joint ventures with other hospitals and are sharing expensive new technology and equipment. Hospitals are expanding into other health care services such as home health care.

(6) New markets. In spite of overall low hospital occupancy rates, there is continued pressure for construction to serve growing areas of the state (the northwest suburbs of Minneapolis, for example) that lack nearby hospital facilities.

(7) Growth of large national chains. National proprietary health care chains have undergone a period of rapid expansion. Their access to capital makes it easier for these chains to purchase or construct hospitals.

THE CURRENT NURSING HOME ENVIRONMENT. The nursing home environment in the state has the following characteristics:

(1) High number of beds per 1,000 elderly. The number of nursing home beds in the state per 1,000 elderly is still far above the national average.

(2) High occupancy rates. In contrast to low hospital occupancy rates, nursing home occupancy rates are very high. The statewide average is 95 percent.

(3) New Medical Assistance reimbursement system. A new Medical Assistance reimbursement system tightens revenues for many facilities. Because of the Minnesota equalization law, the Medical Assistance rates also determine rates for private paying residents in Medical Assistance-certified facilities.

(4) Development of alternatives to nursing home care. Partly as an attempt to deal with rising health care costs, the state has been encouraging the development of home health care services and other alternatives to nursing home care.

(5) Heavier case mix. The severity of the medical problems of nursing home residents is increasing. This is due to a number of factors, including: (1) the incentives under new reimbursement systems for hospitals to discharge patients earlier; (2) the increasing number of older residents; and (3) the development of home health care and other alternatives for healthier clients.

(6) Competition from other providers. The expansion of alternative services for the elderly and the entry of hospitals into other health care markets and services, prompted in part by a wealth of excess capacity, have resulted in increased competition from other providers in the nursing services market. For example, many hospitals are providing subacute nursing care in swing beds and transitional care beds.

Current review mechanisms.

Because CON was repealed in 1984, there is no longer a state system of review of changes in the nursing home and hospital systems in the state. The only review process that remains in place is the federal "1122" review process. The 1122 review process requires review of all proposals by hospitals and nursing homes that involve a new service or an expenditure of more than $600,000. Local health service agencies make the initial review, the State Planning Agency makes a recommendation, and the regional Health and Human Services Department office in Chicago makes a final decision. The penalty for failure by facilities to go through the review process is loss of Medicaid and Medicare funding for the interest and depreciation on the capital costs associated with the project. While this review process technically applies to all hospitals and nursing homes, the sanctions for failure to comply have limited effectiveness and apply only if the facility participates in Medicare or Medical Assistance.

There is some indication that the 1122 review process is somewhat effective in tempering nursing home and hospital growth. Industry and community pressures encourage facilities to undergo the review process and comply with its requirements even if the process could be circumvented. Other states that have 1122 review but no CON program indicate that the 1122 review process has been effective in controlling expansion (see Chapter Two). However, according to Minnesota officials, the federal health planning appropriation expires September 30, 1986, and because of federal budget difficulties it is unlikely additional health planning funds will be forthcoming. For this reason it is likely that the federal 1122 program will end September 30.

During the time that strict moratoria prevent growth in the hospital and nursing home systems, lack of a review mechanism is of limited relevance. However, if the moratoria are repealed or substantial exceptions added, the lack of a mechanism for reviewing proposals may be of major importance. Also, some have argued that a review mechanism is needed for purchases of medical equipment, for changes in services, and for construction and remodeling of health facilities not covered by the hospital or nursing home moratoria.

Chapter Two

Activity in Other States

The 49 other states were surveyed to determine the status of their certificate of need (CON) laws and to ascertain if they have any other programs in place to control capital expenditures. Forty-six states responded. Only Arkansas, New Hampshire, and Oklahoma did not return the survey. The following summarizes the responses we received.

1. NINE STATES DO NOT HAVE CON. Eight states in addition to Minnesota do not currently operate a CON program, and California has repealed its CON law effective January 1, 1987. That will bring to ten the number of states that either never initiated CON, have repealed their CON law, or have abolished the agency that administered the program.

2. AT LEAST SEVEN STATES ARE CONSIDERING REPEALING CON. Respondents from an additional seven states said they are aware of plans or proposals to repeal CON. However, the likelihood of CON repeal in these states is uncertain at this time.

3. EIGHT STATES HAVE A CONSTRUCTION MORATORIUM. Respondents from eight states indicated they have a construction moratorium of some kind in place.

4. FIFTEEN STATES REQUIRE CAPITAL EXPENDITURE PLANS. Fifteen states impose a capital expenditure plan requirement on facilities. In general, this type of regulation requires facilities to maintain plans for future capital investments and update them on a regular basis. Projects generally may not be carried out unless they previously had been a part of the plan.

5. SIXTEEN STATES OPERATE AN 1122 REVIEW PROGRAM. Sixteen states operate the optional federal 1122 capital expenditure review program. The 1122 program applies to hospitals and nursing homes and covers capital expenditures and the addition of new services (see Chapter One). The experience of other states with the 1122 program is discussed in more detail later in this chapter.

In a series of recent publications on CON the Intergovernmental Health Policy Project (IHPP) has reported that no clear trends have developed regarding system capacity review. Some states have repealed CON and others are streamlining the review process by increasing the spending thresholds that trigger review and reducing the scope of projects subject to review. Other states are extending CON to services not previously

covered. Home health care is an interesting example of the differing approaches to CON. The IHPP reported that Kentucky revised its state health plan to require new home health services to go through CON, while Virginia enacted legislation exempting home health agencies from CON review.

THE STATES THAT DO NOT HAVE CON.

We took a closer look at the nine states in addition to Minnesota that have repealed or never operated a CON program (California has repealed its CON program effective January 1, 1987). Of the nine, five do not currently have a moratorium in place to restrict system expansion. They are Arizona, Idaho, Louisiana, New Mexico, and Utah. Idaho, Louisiana, and New Mexico have 1122 review programs in place that appear to be doing an adequate job of controlling system growth, according to officials in those states. Arizona and Utah do not have 1122 programs and appear to be experiencing substantial unneeded growth.

States with no controls on expansion.

ARIZONA's nursing home CON expired in July 1982. The review of hospital projects lapsed on March 15, 1985. According to a memo from Marlene K. Mariani, Executive Director of the Central Arizona Health Systems Agency, as of April 1985 the state had 11,243 nursing home beds, with an additional 6,140 under construction. That would bring the total number of beds in the state to 17,383, or 5,600 above the number she projects will be needed in 1990. Her memo states, "Given these preliminary indicators, there can be little doubt regarding the impact of deregulation on the supply of nursing home beds. However, the impact on prices due to empty beds, and the consequences of this for the consumer remain uncertain."

Also, according to a survey conducted by the state of Washington, since March 15, 1985, permit applications to construct 1,412 new hospital beds in Arizona have been filed, despite an average 1984 statewide occupancy rate of 56.8 percent. Whether all these beds will eventually be built is uncertain, according to that survey.

UTAH's CON expired on December 31, 1984. Utah has neither an 1122 process nor a moratorium to restrict new construction. According to Blaine Goff in the Utah Office of Health Planning and Policy, the state is experiencing substantial new construction of psychiatric hospital beds and nursing home beds. Mr. Goff said he expects some 600 freestanding inpatient psychiatric beds to be in operation by the end of 1986. A year ago the state had no freestanding psychiatric beds. When CON was in place requests to build these beds were routinely denied. The review agency used the rationale that because Utah had a surplus of hospital beds that could be converted to psychiatric use there

was no need for freestanding beds. Realistically, Mr. Goff said, about 200 of the 600 planned beds are actually needed, mostly for adolescent care. He said no significant proposals for new acute care beds have surfaced, primarily because of the bed surplus.

Substantial new building is expected to occur in the nursing home industry in Utah, although the extent of it is difficult to judge at present because of developments during the 1985 Utah legislative session, Mr. Goff said. Legislation was proposed to reinstate the CON program for nursing homes. In reaction to that, notices were filed of the intent to build some 2,800 new beds by providers who wanted to be grandfathered in if the legislation was approved. Mr. Goff said the legislation failed, but the notices of intent remain on file. He said he anticipates that by mid-1986 about 500 new beds will have been built, an increase of almost ten percent over the current supply of about 5,500 beds.

States with 1122 review.

IDAHO does not seem to be experiencing problems since it repealed CON in 1983. The 1122 review process is felt to be effective in controlling expansion there.

LOUISIANA never instituted a CON program. According to Bonnie Smith in the Department of Health and Human Services, the state had a moratorium in place from August 1, 1984, to April 20, 1985, for any facility subject to 1122 review. During that period the state health plan's goals were revised. The new criteria required that applicants with outstanding 1122 approvals either complete their projects or surrender their 1122 approvals. Most applicants are going ahead with their projects, she said. State officials are not sure if this construction spurt will result in overbedding, she said. In the future very few 1122 approvals will be granted, she added, because most regions of the state meet or surpass the capacity guidelines that exist for the 1122 program. Those guidelines allow four hospital beds per thousand population and 80 nursing home beds per thousand elderly. According to Ms. Smith, limited exceptions are permitted and future construction projects in Louisiana will probably have to meet one of the exceptions to get 1122 approval.

In NEW MEXICO, where CON expired in July 1983, the 1122 process has restrained growth, according to Sue Ellen Rael of the Health Planning and Development Division in the Health and Environmental Department. The only service area that has experienced significant growth has been freestanding psychiatric and substance abuse treatment facilities which are not subject to 1122 review. The nursing home bed supply has not been expanded significantly since CON expired. The New Mexico state health plan requires regional occupancy to exceed 90 percent before new beds may be authorized. Presently, only one of the seven regions exceeds that rate. In addition, the state's new Medicaid reimbursement system provides extremely limited capital

reimbursement for new nursing homes, further discouraging new development.

States with moratoria.

Two states that do not operate CON have imposed moratoria of some kind. KANSAS repealed CON effective July 1, 1985, and placed a moratorium on hospital construction until July 1, 1986. TEXAS did not repeal CON but rendered it ineffective by abolishing the Texas Health Facilities Commission, the CON review organization, on September 1, 1985. Review authority has not been delegated to any other agency. On September 1, 1985, a temporary moratorium was imposed allowing the Texas Department of Human Services to refuse to sign Medicaid contracts with facilities that do not have certificates of need. The Department plans to make the moratorium permanent prior to the expiration of the temporary moratorium.

CON replaced by a stronger system.

Wisconsin replaced its CON program with a stronger regulatory system. The long-term care resource allocation program applies to construction or total replacement of a facility; increases in bed capacity; capital expenditures over the review threshold; and major purchases of clinical equipment for nursing homes. The program establishes a statewide limit on licensed nursing home beds and requires nursing homes to go through an annual request for proposal process to gain approval for any projects covered by the program. The review criteria emphasize cost containment. The hospital capital expenditure review program requires review of major capital expenditures; substantial changes in services; the purchase or acquisition of a hospital; and the addition of new beds. It also applies to new ambulatory surgical centers and home health agencies. The review criteria for this program also emphasize cost containment. Hospitals are required to adopt five-year capital budgets each year, and the state is required to adopt a state medical facilities plan every three years. Enforcement tools include loss of licensure and a prohibition on recovery of depreciation, interest, principal and operating costs for any covered project not submitted for review.

Chapter Three

Working Toward a Policy Decision

Legislative decisions concerning the future of state controls over health facility growth will depend on the collective assumptions and beliefs of the Legislature. The position of a particular legislator is an individual decision that will depend upon that legislator's assumptions and opinions about the proper roles of health care providers, buyers and payers, consumers, and state government; the nature and mechanics of the health care marketplace; the proper approach to health care cost containment; the obligation of government to provide health care to the poor; and other factors. Because of the many assumptions and policy choices that must pave the way to decisions regarding controls on the health care system, it is not possible to recommend any particular legislative approach in this report. Instead, it is hoped that the information and decisionmaking framework provided here will make it easier for legislators to make the necessary choices.

Chapter Four describes in general terms the basic options available to Minnesota. The options presented and discussed are:

1. Reinstate the old CON program.

2. Establish a new review process or a modified CON program.

3. Continue the existing moratoria.

4. Continue the moratoria with modifications.

5. Repeal the moratoria.

Without legislative action, the existing nursing home and hospital moratoria would continue until June 30, 1987, at which time the hospital moratorium would expire. All other changes would require legislation.

This chapter provides information that may be useful to legislators faced with health planning decisions. It includes a discussion of the underlying policy issues and questions regarding health planning as well as a brief summary of the policy issues about which there appeared to be a certain degree of consensus among the state officials, health planners, and industry representatives that were interviewed during the preparation of this report.

POLICY ISSUES.

In order to make an informed choice among the available options, it is necessary to understand a number of underlying policy issues. These issues include: (1) the proper role of government in regulating health care, (2) the availability of health data, (3) transitional care, (4) geographic access, and (5) cost containment. In this chapter, these underlying issues are presented by posing questions that illustrate the decisions to be made in forming a position concerning health planning. The questions are intended to serve as a guide for walking through the decision-making process.

What is the proper role of government in health care?

The ultimate issue for legislators confronted with health planning questions is the proper role of government in the state health care system. To what extent should government intervene in the health care system? What should the nature of the intervention be? When should government stand back and allow competition and market forces to work? There is probably a need for some degree of state regulation over certain aspects of the system. For example, most people would agree that the state should protect consumers by requiring health facilities to meet minimum licensing standards designed to ensure that each facility has the necessary equipment and properly trained staff to provide quality health care services. However, there is disagreement about the extent to which government should regulate health care.

Should government be responsible for planning the direction of health care in the state? A statewide plan is likely to increase the consistency, rationality, and coordination of growth and changes in the health care system. Is this good or bad? Should growth take place in response to market forces rather than a statewide plan? If a plan is needed, who should develop the plan? A governmental agency? An independent board or commission? The Legislature? If a plan is developed, should the plan be mandatory or simply advisory?

Should government have an active role in controlling the delivery of health care? Good medical care is essential to the health and well-being of citizens of the state. Should government allow facilities to fail if they cannot compete? Even if this results in a lack of access to health care for citizens in some areas of the state? Should government act to control costs or should costs be left to market forces? Should cost controls apply only to governmental programs such as Medical Assistance or General Assistance Medical Care or should they apply to all health care? What methods should government use in exercising control?

In particular, there is disagreement about whether the government should control health facility construction and growth

or whether this should be left to market forces. The hospital and nursing home moratoria are strong governmental restrictions on system growth. Some believe the moratoria should be repealed in order to allow competitive forces to control health facility growth. Others believe that government should take a more active role, either as a facilitator of competition in the marketplace or by intervening more strongly with moratoria or CON-type controls in order to control health care costs.

The current Minnesota health care system illustrates the different degrees of governmental intervention that are possible. Although the state regulates quality in most segments of health care by setting minimum licensing standards for hospitals, nursing homes, doctors, nurses, and most other facilities and providers, there are no general licensing requirements or standards for home health agencies. The state approach to price regulation also varies greatly between hospitals and nursing homes. The state has a detailed ratesetting system for nursing homes that affects the charges for residents in nearly every nursing home, regardless of who pays for the care. The regulatory system for nursing homes also includes detailed cost reporting requirements. Hospitals, on the other hand, are not subject to general ratesetting. Price controls apply only to charges for patients on state health care programs (Medical Assistance and General Assistance Medical Care).

What information should be available concerning health care?

Good information will promote a more efficient and competitive health care system. For example, information about the charges and services of various hospitals would be useful to buyers such as HMO's, insurance companies, or governmental health programs that are interested in reducing health care costs. Good information is also valuable to consumers who are shopping for a particular kind of health care (such as a birthing room in a hospital). It is believed by some that the information currently available is inadequate and unusable for purposes of comparing charges, services, and quality. However, the release of price information could result in the loss of a competitive advantage for some facilities. Is the health data presently available adequate? Should government require facilities to furnish information regarding health care for use by the private sector or should information be generated by the demands of the marketplace? To what extent should health facility information be protected as a "trade secret"? Should government act as a facilitator of information gathering? Should reporting be mandatory or voluntary? Should information be collected and analyzed by government? By health facility associations? By an independent board or commission?

What is the role of transitional care and who should provide it?

An understanding of the transitional care debate is essential to a knowledgeable decision regarding health planning and controls on health facility growth. While there is no established definition of "transitional care" or "subacute" care, these terms generally refer to health care that falls somewhere between acute care normally provided in a hospital and nursing/custodial care generally provided in a nursing home or the patient's home. Concern has been expressed that hospitals are increasingly using their excess capacity to provide nursing care. Some have argued that this is contrary to the principles underlying the expressed state policy to limit the number of nursing home beds in the state. To what extent is transitional care an appropriate use of hospital beds? Does it matter whether the care is provided following a hospital stay or as an alternative to hospitalization? Is it fair to allow hospitals to use their excess capacity to tap the transitional care market when nursing homes are at nearly full capacity and are prohibited by the moratorium from building new beds? Or does it make sense to promote the use of hospital beds for transitional care in order to put these empty beds to use? Should nursing care, including transitional care, be provided only in nursing homes or should there be no restrictions on who can provide transitional care? Should transitional care services be licensed? Should there be minimum standards?

Legislation was enacted during the 1984 session requiring the Health Department to study transitional care and make a report and recommendations to the Legislature. This report may include answers to many of these questions about transitional care.

To what extent should geographic access to health care be assured?

A major consideration in the discussion of controls on health facility growth is whether and to what extent citizens of the state have a right to have health care available in or near their communities. Many rural hospitals have very low occupancy rates and are experiencing financial difficulties. If hospitals in these communities fail, residents may find themselves a considerable distance from the nearest hospital. Do citizens of the state have a right to have a hospital within a certain distance from their homes? If so, within what distance? Should government let market forces work to determine which hospitals survive? Or should government assistance be available to aid hospitals whose failure could create geographic access problems? If so, what criteria should be used for governmental assistance? With high occupancy rates in nursing homes and a moratorium which prohibits construction of new beds, are citizens in some communities forced to take up residence in nursing homes far removed from family and friends?

To what extent should cost containment enter into decisions about the delivery of health care in the state?

During the last decade there have been major increases in the cost of health care. This has increased the cost of health plan coverage and placed serious financial burdens on governmental health care programs such as Medicare and Medical Assistance. To what extent would the construction of new hospitals or nursing homes further increase the costs of health care for governmental health care programs? For health plans? For consumers? What affect does the excess hospital capacity in the state have on hospital costs? Which is more effective in controlling costs: competitive forces, governmental regulation, or a combination of both?

SUMMARY OF INTERVIEW HIGHLIGHTS.

A thorough understanding of health planning requires not only an understanding of these underlying issues, but also an awareness of the assumptions and beliefs of those who are involved in and affected by health planning decisions. The research for this report included interviews with state and metropolitan health planners and regulators and representatives of the hospital and nursing home industries. Highlights of these interviews appear in Appendix B. A review of Appendix B should provide a general understanding of the positions of those involved in health planning issues.

A search for consensus. There was no unanimous agreement among those interviewed regarding issues relating to controls on the expansion of the hospital and nursing home systems. However, there seemed to be somewhat of a consensus on the following issues:

1. The need for controls on hospital expansion. Most of those interviewed believed that, because of the many unused hospital beds in the state, there is a need for some mechanism for restraining expansion of the system. Most felt that there should be either a moratorium of some kind prohibiting new beds or a strong review mechanism that would allow growth only in limited situations. Everyone agreed that there would be some degree of growth of the hospital system if no controls were in place. However, a minority of those interviewed felt very strongly that system capacity should be left to market forces and competition, provided those hospitals that could not compete were not saved from closure by government intervention.

2. The ineffectiveness of CON. There was general agreement that the former CON program was not effective and that any new review system should have additional features to make it more effective. Most agreed that a review system should have specific criteria that would mandate denial of an application unless the

project was clearly needed. The process itself should be depoliticized and given more teeth. There was disagreement about whether review should be at the local or state level.

3. The need for an up-to-date state health plan. Most of those interviewed felt that there is a need for a current plan for the delivery of health care. An up-to-date plan would be an essential part of any new review system.

4. The increasing importance of quality issues. There was general agreement that quality issues would become more and more important. Quality issues arose in discussions of low-volume, low-capacity hospitals and services; the effects of competition; the need for information about hospitals for consumers; and so on.

5. The value of a wait and see stance for hospital matters. The pending Medicare capital reimbursement changes for hospitals were mentioned by several of those interviewed. There was general agreement that because the hospital environment is in a period of major change, the best approach might be to wait before making further changes affecting hospitals.

6. The importance of health care information. Everyone agreed that good health data is important and that there are inadequacies in the currently-available information. However, there was disagreement about the proper approach to this problem. The hospital industry generally believes that the current system of voluntary reporting is the best method and that progress is being made toward better information. Others believed that mandatory reporting is necessary.

Chapter Four

Minnesota's Options

Without legislative action in 1986 or 1987, the hospital construction moratorium will expire on June 30, 1987, and the nursing home moratorium will continue indefinitely. With the pending expiration of the hospital moratorium, legislators will be faced with difficult decisions concerning the appropriateness of governmental controls on the expansion of the hospital and nursing home systems. Previous chapters of this report have described past and present review systems, the current environment for hospitals and nursing homes, the activities of other states in this area, and the issues that underlie decisions concerning controls on hospital and nursing home expansion. This chapter describes the options available to the Legislature.

The general options for controlling growth in the hospital and nursing home systems are:

--reinstate the old CON program;

--establish a new review program, building on the strengths of CON and eliminating its weaknesses;

--continue the existing moratoria, allowing the current uncertain environment to stabilize before policy decisions are made;

--continue either or both of the existing moratoria, but with modifications or new exceptions to deal with problems that develop as a result of the current ban on new construction; and

--repeal either or both moratoria without installing another control mechanism.

1. REINSTATE CON. The Legislature could resurrect the CON program that expired on June 30, 1984. This would probably require an appropriation for staffing in the Minnesota Department of Health. It would leave the state with a system whose past effectiveness was judged to be moderate at best.

2. ESTABLISH A NEW REVIEW PROGRAM. The Legislature could establish a new review program. A review process could be used in several different contexts. It could replace either or both moratoria. It also could be used in conjunction with a moratorium to exercise controls over activities not covered by the moratorium, such as purchases of medical equipment or changes in services provided by a facility, or to allow review of

exceptions to the moratorium. For example, if an exception were created to the hospital moratorium allowing the establishment of a hospital in an area where there is an access problem for residents, the reviewing agency could consider all proposals for the new facility and select a provider according to established criteria. The new review program could build upon the strengths of CON while attempting to avoid problems that program experienced.

If a new review process is developed, the following issues should be addressed:

a. Relative Need and Affordability. A major criticism of CON is that it made no attempt to measure the need for a particular project in relation to all other projects being considered at that time. Nor did it make any assessment of the operating cost a project would generate after it was built or purchased. One way to include these components in a review process would be to establish a ceiling on the capital expenditures that could be approved annually and on the operating costs that could be added to the system and to require a batching of proposals submitted. If the total cost of proposed projects exceeded the ceiling, reviewers would be forced to give projects a priority ranking so that only the most necessary projects would be approved. The ceilings could be statewide or could be allocated on a regional basis.

b. Planning Framework. Reviewers also would be guided in their selection process by a state plan for health facilities. The plan could address issues such as the number of hospital and nursing home beds needed for a given population (the nursing home moratorium does this now to a certain extent); an explicit judgment regarding geographical access for residents in rural areas of Minnesota; if appropriate, a procedure for downsizing the hospital system to bring bed supply more in line with need; and perhaps some guidelines establishing a preference for projects that support certain public policy goals. For example, preference might be given to projects that include equipment sharing or other cooperative ventures between providers. Or preference might be given to projects that include alternative delivery components--for example, a nursing home with a home health component or adult day care component.

Federal law authorizes a capital expenditure planning system under which states may require health facilities to submit capital expenditure plans which summarize each hospital's long-term plan for growth and change. The state could use these plans to develop a statewide plan for capital expansion. A capital expenditure planning program could be incorporated into or coordinated with a new review system.

c. Applicability. If a new review program is established, the issue of applicability must be addressed. When addressing applicability issues, the Legislature may wish to examine the

issue of who is at risk if patient volume doesn't generate enough income to cover project costs. If it can be demonstrated that the risk is on the provider, not the public, perhaps less review of the project is warranted. For example, Oregon provides CON waivers for projects in hospitals receiving a substantial portion of their revenue on a capitated basis. If, as expected, the federal DRG reimbursement system adopts a flat percentage pass-though for capital costs rather than a cost-based reimbursement system, this will increase the risks for providers making major capital investments.

The review program could apply to changes in services as well as capital expenditures. For example, there is concern among government regulators that certain high-risk procedures must be performed in adequate volume if high quality is to be assured. In the competition for patients in the new environment facing hospitals, some facilities may attempt to provide services that do not meet these minimum levels. A review system could require assurances that certain minimum volume levels will be maintained.

A review program could also apply to purchases of expensive medical equipment, which are currently not covered by the moratoria. The CON program reviewed medical equipment purchases. In the last decade there have been rapid advances in medical technology resulting in many new, often expensive, kinds of medical equipment. In some cases, the cost of new equipment may not be justified by its value for patients. A review system could evaluate the cost-effectiveness of new equipment and determine whether proposed purchases of new equipment are appropriate. The review system could encourage equipment-sharing and avoid duplication of services in a particular region.

There is some sentiment that a review should be triggered by the service, equipment, or construction project itself, and should not depend on whether it is done by a hospital, nursing home, or physician clinic, or in some other setting. Nursing home industry representatives believe that whatever controls apply to their industry should apply to the hospital industry as well.

d. Procedure. If a new review program is created, a decision must be made about whether decisionmaking authority should be at the state or local level. The Legislature will need to develop a system that provides for the local input necessary when decisions are made allocating health care resources while at the same time strengthening local decisionmakers so they can resist proposals for unneeded projects.

3. CONTINUE THE EXISTING MORATORIA. Another approach to this issue would be to continue the existing moratoria until more is known about the need for additional nursing home or hospital beds in Minnesota. Demographics indicate a growing population of infirm elderly in the state. This trend may be offset somewhat

by the substantial state commitment to funding for alternative care services. Periodic reports from the Minnesota Department of Health and the State Planning Agency should alert the Legislature if serious bed shortages are developing in the nursing home industry. The existence of thousands of empty hospital beds seems to support continuing the moratorium on construction of new hospitals, barring significant geographical access problems, unless it is determined that a purely competitive system is more appropriate.

4. CONTINUE THE MORATORIA WITH MODIFICATIONS. Another approach would be to continue the existing hospital and nursing home moratoria, but with modifications. Modifications could include expansion of the moratoria to apply to additional facilities or activities, or exceptions to either or both moratoria to deal with problems that may develop because of the construction ban.

a. Expand the moratoria.

Some experts believe that the existing moratoria are not strong enough. One approach to the transitional care issue would be to extend the hospital or nursing home moratorium or establish a new moratorium that would prevent any provider from putting a bed into use for nursing services. Moratoria could be expanded to include facilities other than nursing homes and hospitals, such as physician clinics. Another option would be to attempt to reduce the excess hospital capacity in the state by establishing a moratorium on the renewal of licenses for unneeded beds.

b. Exceptions to the nursing home moratorium.

(1) Transitional care. The debate over so-called transitional care suggests that the nursing home industry is likely to seek relief from the moratorium. The nursing home industry thinks it is unfairly penalized under a system which bans construction of new nursing home beds, which generally experience high occupancy rates, while the hospital industry is expanding into transitional care in an effort to fill thousands of empty hospital beds. The report due to the Legislature on February 15, 1986, may offer guidance in how to regulate this emerging level of care.

(2) Relocation within a facility. A number of nursing homes have approached the Department of Health seeking permission to relocate beds within a facility, usually by converting three- or four-bed rooms to two-bed rooms.

(3) Replacing existing facilities. If the nursing home moratorium continues in effect into the foreseeable future, the issue of how to replace aging or damaged facilities will become more acute.

(4) Geographic access. The issue of geographic access and the adequacy of the existing exception to the moratorium in areas of the state where access to nursing home beds is perceived as not sufficient may become more pronounced over time. Demographic pressures, along with varying degrees of access to home health care, may require reconsideration of the existing moratorium language at some point in the future.

c. Exceptions to the hospital moratorium.

(1) Relocation of beds. An exception to the hospital moratorium could be made to allow relocation of existing beds. For example, a hospital could transfer beds from an existing facility to a new facility in an area where there is a market for the beds. The Minnesota hospital industry supports such an exception. However, relocation of beds would involve capital expenditures which could result in increased health care costs.

(2) Geographic access. At some point continuation of the hospital moratorium could create geographic access problems. An exception could be created to allow establishment of a new facility in an area where there is an access problem. Such legislative action should be preceded by a determination of what constitutes geographic access in terms of miles or minutes from a hospital. Construction could be allowed in this situation by using an RFP (request for proposal) method that would allow the most qualified provider to offer the needed services, rather than allowing construction on a first-come, first-served basis.

The hospital industry supports continuation of the moratorium in order to prevent out-of-state, for-profit hospital chains from expanding into Minnesota. According to the industry these chains would funnel profits out of the state to corporate headquarters located elsewhere. In addition, representatives of the hospital industry believe that for-profit hospitals have no incentive to provide care to charity patients and would shift as much of that burden as they could to other hospitals. The issue of how to deal with uncompensated care is an important one for the industry, which sees for-profit hospital entry into the Minnesota market as a further complication of this problem. On the other hand, Minnesota has a long history of for-profit nursing homes operating in the same environment as non-profits. Some officials we talked to suggested that the industry wants to fence out the for-profit chains simply to avoid more efficient competition.

5. REPEAL THE MORATORIA.

The moratoria could be repealed either in conjunction with the establishment of an alternative system of review or control or because the Legislature concludes that the moratoria are no longer necessary, that capacity expansion may be needed in some areas of the state, and that excess growth will not occur because

of the forces now at work in the system. Regarding the former, alternative systems of review and control are discussed above.

a. Repeal of the nursing home moratorium.

The Minnesota Association of Homes for the Aging argues that high occupancy rates in the nursing home industry demonstrate that expansion is warranted. According to the association, restricting expansion merely protects existing providers from competition and guarantees clients for poor quality homes. That is, a client may not be able to get into the high quality home which is the client's first choice and may be forced into a home of poorer quality simply because it is the only one with an available bed. According to the association, because the reimbursement system penalizes homes with low occupancy rates, unnecessary expansion would not occur. The association believes that pressure to repeal the moratorium will eventually come from consumers denied access to the nursing homes of their choice. However, evidence that no counties in the state qualify for the hardship exception to the moratorium seems to support continuing the moratorium. In addition, repeal of the nursing home moratorium could increase state Medical Assistance costs and slow the growth of alternative services.

b. Repeal of the hospital moratorium.

Regarding the hospital moratorium, officials disagree about the extent of the expansion that would occur if the hospital moratorium were repealed without having another control mechanism in place and whether or not any expansion at all would serve a worthwhile purpose. There seems to be agreement that several portions of the metropolitan area--especially the northwestern suburbs of Minneapolis--would be targets for new hospital construction if the moratorium expired. Some regulatory officials believe locating a hospital in this area would be a more efficient allocation of resources, provided the more remotely-located hospitals now serving this population were forced by this competition to reduce their capacity or shut their doors. Other officials argue that because of the overbedding supply, no new hospitals are needed in Minnesota in the foreseeable future.

Supporters of moratorium repeal argue that a purely competitive system would allow inefficient hospitals/nursing homes to fail while allowing new, more efficient operators into the market. The only state role under such a system, it is argued, would be to guarantee geographic access and quality care for the poor. According to this view, a moratorium is inappropriate because it fences out new providers and protects existing, sometimes inefficient, providers from healthy competition. By repealing the moratoria without instituting a substitute control mechanism, the Legislature would endorse the propositions that market forces are the only appropriate controls

on health care system growth or that some new nursing home or hospital beds are needed and that existing mechanisms--reimbursement systems, 1122 reviews, competitive pressures--will prevent unneeded expansion.

APPENDICES

Apendix A: Interview Highlights

Appendix B: Survey Responses from 46 States

Appendix A

Interview Highlights

The research for this report included interviews with associations representing health care facilities, with health planners, and with government officials. On some issues there was nearly universal agreement while on others there was great disparity. The following are highlights of the perspectives and insights of some of those interviewed.

MAHCF (Minnesota Association of Health Care Facilities).

1. Stronger health planning. MAHCF was generally in favor of increased health planning to promote an equitable, rational growth process. Without coordinated health planning, growth tends to occur on an unplanned first-come, first-served basis which may not benefit consumers. In some cases a competitive RFP (request for proposal) process could be used to select the most qualified provider to meet a particular need for health care services. The health planning process should be depoliticized to allow for objective decisionmaking to meet the needs of the state.

2. Exceptions to the nursing home moratorium. The nursing home moratorium should be modified. MAHCF will be proposing exceptions in the future.

3. Blurring of the distinction between nursing homes and hospitals. Hospitals are expanding into a wide range of health care services, including nursing services. Nursing homes are providing increasingly complex medical treatment. Because the distinction between these two kinds of health care providers are blurring, it is increasingly important that they be treated equitably. For example, it appears that there is a growing demand for transitional or subacute health care services. Because hospitals have excess capacity, they have the ability to expand into this area. Nursing homes, on the other hand, have higher occupancy and are prevented by the moratorium from increasing their nursing home bed capacity to reach this market. MAHCF believes health planning should ensure a level playing field for nursing homes, hospitals, and other health care providers. This could be accomplished by making licensure laws more flexible so that standards are tied more to services than to the type of provider and so that state regulators would have more discretion to modify existing licensure systems and implement new systems in response to changing health care environments.

4. More coordinated health care regulatory system. MAHCF emphasized the importance of a coordinated system of health planning, health care regulation, and reimbursement. Under the current system there are often inconsistencies between the different aspects of government involvement.

MAHA (Minnesota Association of Homes for the Aging).

1. Repeal the nursing home moratorium. MAHA opposes the existing nursing home moratorium. Some nursing home providers would like to expand, and new reimbursement mechanisms are effective to control inappropriate expansion. Under the current moratorium, consumers are not always able to be admitted to the nursing home of their choice. However, MAHA is not actively advocating repeal of the moratorium because it feels support for repeal should come from consumers, not providers.

2. Exceptions to the nursing home moratorium. If the moratorium is not repealed, MAHA supports modification of the moratorium to allow replacement of existing nursing home beds and to allow facilities to convert three- and four-bed rooms to two-bed rooms.

3. Health planning. MAHA believes an RFP approach would be the best method for allowing controlled growth of nursing home capacity. The decision should be objective and not left to state agency discretion.

4. More emphasis on quality. There should be greater emphasis on quality issues. The state Health Department should have more discretion in ensuring quality care.

5. Transitional care. Transitional care services should be outside of the moratorium so that nursing homes, hospitals, and other providers can compete on an equal footing. However, some mechanism should be considered for limiting expansion to existing licensed providers in order to prevent national proprietary hospital chains from tapping the Minnesota market.

MHA (Minnesota Hospital Association).

1. Opposes expansion of the current system. Most current hospitals favor preserving the moratorium. Expansion of current capacity would create problems for both new hospitals and existing facilities.

2. Exception to the hospital moratorium to allow reallocation of beds. There should be a limited exception to the moratorium to allow reallocation of existing beds without an overall capacity increase.

3. Wait and see stance. The hospital environment is undergoing a period of major change: trends are toward specialization, pooling and sharing of equipment, and integration into health systems; capital is becoming scarce; more Medicare changes are coming; and economic issues are becoming more important in decisions about construction or expansion. With all of these changes taking place, the best approach might be to wait and see how the environment evolves before making any major changes.

4. Health planning. If a CON-type review process is revived, the review process should be more local and access-oriented. A review process is not needed for medical equipment or for expansion into specialties or new services.

5. In the absence of controls, the hospital system will expand. Even though the changing hospital environment has dampened providers' enthusiasm for expansion, in the absence of a moratorium or CON-type review process there would be expansion of the hospital system. There would probably be six or eight new hospitals in the state. There are new markets such as the northwestern suburbs that would attract new hospitals. National proprietary chains would probably enter the state, targeting young, non-Medicare patients.

6. Transitional care. Transitional care services should be outside of the moratorium so that nursing homes, hospitals, and other providers can compete on an equal footing. However, some mechanism should be considered for limiting expansion to existing licensed providers in order to prevent national proprietary hospital chains from tapping the Minnesota market.

COCH (Council of Community Hospitals).

1. Continue the current hospital moratorium. COCH supported the moratorium in 1984 and favors its continuation. Expansion of the current hospital system is not good for the state and does not make good business sense for the provider. A repeal of or changes to the moratorium will benefit primarily out-of-state proprietary chains that have access to the necessary capital to enter the market. COCH believes allowing these chains to enter the Minnesota market is not good for the state because they will funnel money out of the state, and they are less likely to provide charity care. An exception to the moratorium to allow reallocation of existing bed capacity will probably expand the system by putting unused beds into use.

2. Changing hospital environment. The hospital environment is changing: there is greater concern about economic factors; and providers are more willing to enter into joint ventures and equipment pooling to increase their competitive advantage.

METROPOLITAN HEALTH PLANNING OFFICIALS.

1. Recognize the difference between acute care and long-term care. Acute care and long-term care have different methods, objectives, and incentives and should be treated differently.

2. Allow the acute care moratorium to expire. The acute care moratorium merely protects existing providers. In order to allow competition to work, the moratorium should be repealed and hospitals should be allowed to fail if they cannot compete. There might be a few new hospitals to serve new regional markets, but in the long run there would not be a major expansion of statewide capacity.

3. Mandatory reporting. There is a need for more and better information about hospitals. The state should move to a mandatory reporting system. Too much time and effort is required to get useful data under the existing voluntary system. The ideal reporting system would consist of a central repository of data that would allow numerous different analyses and interpretations by different organizations. Information must be timely, provider-specific, and accessible to the public, not just buyers and payers. Specific information is needed about bad debt and charity care.

4. Transitional care. A separate licensure system might be the best way to regulate transitional care. There should be an exception to the nursing home moratorium to allow competition in transitional care services. A strong utilization review system should be in place to prevent inappropriate use of transitional care services.

5. Quality. Quality issues will become more and more important. Quality questions arise when services, particularly specialized services, are provided by low-capacity, low-volume providers. Because a certain volume is necessary to maintain specialized quality, the state may need a service-oriented review process.

6. Review of medical equipment purchases. Some review process may be advisable for medical equipment purchases, but competitive forces should be allowed to work. The risk of new purchases should be on the provider, not on the public.

7. Health planning. There may be a need for mandatory formalized state health planning intervention for certain projects of regional or statewide significance. However, experience with the 1122 program indicates that, when there is a dispute about whether or not a particular project is subject to 1122 review, facilities already feel pressure to submit to a review when requested to do so. This occurs even though the penalties for bypassing 1122 are not significant.

STATE HEALTH PLANNING OFFICIALS.

1. Continue moratoria. Other states that have repealed CON and other capital expenditure review programs have experienced major expansion. Given the extent of the excess hospital capacity in Minnesota, the hospital moratorium should be extended indefinitely without exceptions. Some limited exceptions may be needed eventually to the nursing home moratorium to allow geographic access, but the exceptions should be made only after the need is demonstrated.

2. Need for information. More information is needed about hospitals. Capital expenditure plans should be required. There is a lack of good per capita health care spending information.

3. Health planning. CON never worked well. Moratoria-type control is more effective. Review should be at the state level, not local or regional. The review process should be depoliticized. Review should apply to major medical equipment purchases and other expenditures and projects.

STATE HEALTH OFFICIALS.

1. Definitions of geographic access. Any exception to moratoria to allow geographic access should include a clear definition of "access."

2. Health planning. There is a need for a specific and up-to-date statewide planning process.

3. Quality issues. Quality questions arise concerning low-volume, low-occupancy providers.

4. Failing hospitals. As economic pressures on hospitals increase, some hospitals are likely to fail. This raises public policy questions about the need for preserving geographic access by some kind of public subsidy or other support. Specific criteria are needed to ensure that assistance is only given to hospitals which should survive in order to preserve access.

5. Metropolitan/non-metropolitan systems. State health planning efforts should recognize the difference between the metropolitan area and the non-metropolitan regions of the state.

6. CON did not work well in Minnesota. While it is difficult to assess the effectiveness of the CON program, it probably did not adequately control expansion of the system.

APPENDIX B

Survey Responses from 46 States

Has your state repealed its certificate of need law?

Yes: 8 states
No: 38 states*

* Texas has not repealed CON but has discontinued the program by eliminating the review agency.

If not, are you aware of plans/proposals to repeal CON?

Yes: 7 states
No: 31 states
Not Applicable because CON repealed: 8 states

As a replacement for CON, or in addition to CON, does your state have other mechanisms in place to control capital expenditures, such as:

Construction moratorium?
Yes: 8 states
No: 35 states
No response: 3 states

Ceilings on capital expenditures?
Yes: 9 states*
No: 34 states
No response: 3 states

* It appears that at least six states misunderstood this question to refer to CON review thresholds rather than expenditure ceilings. The answers to this question should probably be disregarded.

A capital expenditure plan requirement?
Yes: 15 states
No: 25 states
No response: 6 states

1122 review?
Yes: 16 states
No: 24 states
No response: 6 states

Other?
Yes: 11 states
No: 21 states
No response: 14 states