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End of Laws 1982 Regular and First Special Sessions

72nd Legislature
1982 Regular Session

Chapters 559 to 642(End)Pages 1135 to 1577

1982 First Special Session

Chapters 1 to 3(End)Pages 1582 to 1628

Laws 1982 begin with
Chapter 371

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offenses relating to controlled substances, or an attempt or conspiracy to commit any such offense or said of these offenses, as punishable under sections 609.185, 609.19, 609.195, 609.20, 609.225, 609.245, 609.25, 609.291, 609.321 to 609.324, 609.42, 609.48, 609.485, subdivision 4, clause (1), 609.52, 609.53, 609.54, 609.58, 609.625, 609.63, 609.76, 609.825, and chapter 152.

Sec. 7. Repealer.

Minnesota Statutes 1980, Section 609.53, Subdivision 2; and Minnesota Statutes 1981 Supplement, Section 609.53, Subdivision 2a, are repealed.

Sec. 8. Effective date.

Sections 1 to 5 are effective August 1, 1982 and apply to all crimes committed on or after that date. Section 6 is effective May 1, 1982, and applies to warrants issued on or after that date. Section 7 is effective August 1, 1982.

Approved March 23, 1982.

HEALTH CARE SYSTEM

CHAPTER 614

H.F.No. 1799

An Act relating to health; allowing certain nursing homes and hospitals to share an administrator; providing for evaluation of certain changes in certificate of need review; requiring certain price information to be reported and disseminated; requiring monitoring; amending the thresholds of review; providing for additional waivers; requiring reports; amending Minnesota Statutes 1980, Sections 144A.04, Subdivision 5; 145.833, Subdivision 5; 145.835, Subdivisions 3 and 4; Minnesota Statutes 1981 Supplement, Sections 250.05, Subdivision 4; 447.45, Subdivision 1; and 474.03; proposing new law coded in Minnesota Statutes, Chapter 144; repealing Minnesota Statutes 1980, Sections 145.832 to 145.845, as amended; and Minnesota Statutes 1981 Supplement, Sections 62D.22, Subdivision 6; 145.834; and 145.845.

Be it enacted by the Legislature of the State of Minnesota:

Section 1. Purpose.

The legislature finds that Minnesota has had certificate of need review since 1971 and that there is a need to evaluate the requirements of this law, the effect of the law on the current health care delivery system, and the effect of repeal of the law on the cost and quality of health care in

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Minnesota. The legislature further finds that the public may benefit from certain changes in the health care system but that supporting documentation, data, and information are lacking. It is the intent of the legislature that the Minnesota certificate of need act not be repealed prior to full consideration of the effects of such an action on the issue of cost for health care services. Alternative cost containment measures should be in place and documentation available that those measures will benefit the public interest and encourage the benefits of a price-competitive health care system for the citizens of Minnesota. It is the intent of the legislature that voluntary efforts to disseminate certain price information be encouraged and that mandatory efforts be undertaken only if voluntary efforts do not make satisfactory progress.

Sec. 2.

144.705. Collection, analysis and dissemination of diagnostic and price information

Subdivision 1. Price reporting. The commissioner of health shall encourage hospitals and professionals regulated by the health related licensing boards as defined in section 214.01, subdivision 2, or by the commissioner of health pursuant to section 214.13, to publish prices for procedures and services that are representative of the diagnoses and conditions for which citizens of this state seek treatment.

Subd. 2. Hospital reports. The commissioner of health may periodically establish a list of illnesses, injuries and medical conditions which is representative of the diagnoses for which the citizens of the state are hospitalized. The commissioner shall select illnesses, injuries, and conditions for inclusion in this list in a manner so as to adequately differentiate among patient characteristics which may influence the consumption of resources during treatment, such as the age of patients, patients' need for surgery, the presence of secondary diagnoses and medical complications. The establishment of this list shall not be subject to the provisions of sections 15.0412 to 15.0417. The commissioner may add to or delete from this list. For each of these illnesses, injuries and medical conditions, every hospital with a licensed capacity equal to or greater than 100 beds shall, within 120 days of the close of its fiscal year, report to the commissioner the following information for that fiscal year:

(a) the number of patients discharged;

(b) the shortest and longest lengths of patient stay in the hospital, the mean length of stay, and the respective lengths of stay at the 25th, 50th and 75th percentiles of the total range of lengths of stay;

(c) the lowest and highest prices for hospital services, the mean price, and the respective prices at the 25th, 50th and 75th percentiles of the total range of prices;

(d) a separation of the mean price into mean component prices, where applicable, for routine room and board, special care unit room and board, nursery services, delivery room use, operating room use, anesthesia services, pharmacy services, laboratory services, radiology services, supplies and other services; and

Underscoring and strikeouts are as shown in enrolled act

(e) any addition specified in rule. At the time it subdivided, each believes to be r

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(e) any additional or alternative information relating to prices that is specified in rules promulgated by the commissioner pursuant to this section. At the time it reports the information required to be reported by this subdivision, each hospital may also report any additional information that it believes to be relevant to the purposes of section 144.705.

Subd. 3. Health provider reports. For each health profession regulated by the health-related licensing boards as defined in section 214.01, subdivision 2, or by the commissioner of health pursuant to section 214.13, the commissioner of health shall periodically establish a list of procedures and services which are representative of the diagnoses and conditions for which citizens of the state seek treatment. The establishment of this list shall not be subject to the provisions of section 15.0412 to 15.0417. For each of these procedures and services, every regulated health care provider engaged in the private practice of his profession within the state shall post in a public area the established prices or provide a notice of the availability of the established prices of the procedures or services. The commissioner may request to receive a copy of these prices.

Subd. 4. Source of information. The information described in subdivision 2 may be directly compiled and submitted to the commissioner by the hospital, or in the interests of efficiency and at the hospital's option, the information may be submitted through any entity which collects or compiles all or portions of the information for several hospitals or providers. When information is furnished through such an entity, the commissioner shall pay the entity what he determines to be a reasonable fee for the costs of organizing and providing the information in the form called for by this section.

Subd. 5. Samples. The commissioner may, in the interests of efficiency, permit a hospital to submit the information described in subdivision 2 in the form of statistically valid samples of the patients discharged from the hospital during the fiscal year.

Subd. 6. Fostering price competition. The commissioner shall analyze the information provided under this section and shall disseminate the information and analyses so as to foster the development of price competition among hospitals required by subdivision 2 to make reports to the commissioner. Prior to initial dissemination of any hospital-specific information, the commissioner shall give the hospital opportunity for review and comment. In the initial dissemination of hospital-specific information the commissioner shall publish a summary of the hospital's comments, together with notice of a means of contacting a person designated by the hospital to provide further information.

Subd. 7. Rules. The commissioner may promulgate such rules pursuant to chapter 15 as are necessary to implement the provisions of this section.

Sec. 3. Minnesota Statutes 1980, Section 144A.04, Subdivision 5, is amended to read:

Subd. 5. Except as otherwise provided by this subdivision, a nursing home must have a full time licensed nursing home administrator serving the

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facility. In any nursing home of less than 25 beds, the director of nursing services may also serve as the licensed nursing home administrator. Two nursing homes having a total of 100 beds or less and located within 50 miles of each other may share the services of a licensed administrator if the administrator divides his full time work week between the two facilities in proportion to the number of beds in each facility. Every nursing home shall have a person-in-charge on the premises at all times in the absence of the licensed administrator. The name of the person in charge must be posted in a conspicuous place in the facility. The commissioner of health shall by rule promulgate minimum education and experience requirements for persons-in-charge, and may promulgate rules specifying the times of day during which a licensed administrator must be on the nursing home's premises. A nursing home may employ as its administrator the registered administrator of a hospital licensed pursuant to sections 144.50 to 144.56 if the individual is licensed as a nursing home administrator pursuant to section 144A.20 and the nursing home and hospital have a combined total of 150 beds or less, are under the same governing body and are located within one-half one mile of each other. A nursing home which is located in a facility licensed as a hospital pursuant to sections 144.50 to 144.56, may employ as its administrator the registered administrator of the hospital if the individual meets minimum education and long term care experience criteria set by rule of the commissioner of health.

Sec. 4. Minnesota Statutes 1980, Section 145.833, Subdivision 5, is amended to read:

Subd. 5. "Construction or modification" means:

(a) Any erection, building, alteration, reconstruction, modernization, improvement, extension, lease or other acquisition, or any purchase, lease or other acquisition of diagnostic or therapeutic equipment, by or on behalf of a health care facility which:

(1) Requires, or would require if purchased, a total capital expenditure, under generally accepted accounting principles, in excess of \$150,000 and ~~which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance \$600,000;~~ or

(2) Changes the bed capacity of a health care facility in a manner which increases the total number of beds, or distributes beds among various categories, or relocates beds from one physical facility or site to another, by more than ten beds or more than ten percent of the licensed bed capacity, whichever is less, over a two year period;

~~(b) Any expansion or extension of the scope or type of existing health services rendered by a health care facility if expansions or extensions of the scope or type of existing health services requires a capital expenditure in excess of \$50,000 during any continuous 12 month period for that service;~~

(c) The establishment of a new health care facility or any predevelopment activity by or on behalf of a health care facility which may result in a proposal reviewable according to sections 145.832 to 145.845;

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~~(c)~~ Any establishment of a new institutional health service, excluding home health services, by a health care facility which is to be offered in or through a health care facility and which was not offered on a regular basis in or through that facility within the 12 month period prior to the time when that service is intended to be offered; and

~~(d)~~ The purchase, lease or other acquisition of diagnostic or therapeutic equipment by a licensed medical doctor, a group of licensed medical doctors, or a professional corporation of licensed medical doctors organized pursuant to chapter 319A, which requires, or would require if purchased, a capital expenditure in excess of ~~\$150,000~~ \$400,000 for any one item of equipment and is determined by the state commissioner of health to be designed to circumvent the provisions of sections 145.832 to 145.845; and

(e) The purchase, lease or other acquisition of diagnostic or therapeutic equipment by, or on behalf of, a health care facility which requires or would require if purchased, a total capital expenditure in excess of \$100,000 for any one item of equipment.

Sec. 5. Minnesota Statutes 1980, Section 145.835, Subdivision 3, is amended to read:

Subd. 3. Physicians; notice of acquisition of equipment. A licensed medical doctor, a group of licensed medical doctors, or a professional corporation of licensed medical doctors organized pursuant to chapter 319A, proposing to purchase, lease or otherwise acquire one or more items of diagnostic or therapeutic equipment which require a capital expenditure in excess of ~~\$150,000~~ \$400,000 shall, prior to purchasing or acquiring the equipment, notify the health systems agency and the commissioner of health of the proposed acquisition or purchase.

The commissioner of health shall within 60 days of receipt of the notice determine whether or not the proposed acquisition or purchase is designed to circumvent the provisions of sections 145.832 to 145.845. A hearing shall be held if requested by the applicant or the health systems agency. The commissioner of health shall notify the applicant and the health systems agency in writing of its determination. If the commissioner of health determines that the proposed acquisition or purchase is not designed to circumvent the provisions of sections 145.832 to 145.845, no certificate of need shall be required of the applicant. If the commissioner of health determines that the proposed acquisition or purchase is designed to circumvent the provisions of sections 145.832 to 145.845, the applicant must obtain a certificate of need.

Sec. 6. Minnesota Statutes 1980, Section 145.835, Subdivision 4, is amended to read:

Subd. 4. Waivers. A proposed construction or modification may be granted a waiver from the requirements of section 145.834 by the commissioner of health if, based on the recommendation of the health systems agency, the commissioner determines that:

Underscoring and ~~strikeouts~~ are as shown in enrolled act

(a) The proposed capital expenditure is less than three percent of the annual operating budget of the facility applying for a waiver, ~~and the expenditure is required solely to meet mandatory federal or state requirements of law;~~ or

(b) The construction or modification is not related to direct patient care services, such as parking lots, sprinkler systems, heating or air conditioning equipment, fire doors, food service equipment, building maintenance, or other constructions or modifications of a like nature;

(c) The construction or modification is exclusively for ambulatory care services; or

(d) The construction or modification is for an experimental or demonstration project.

The commissioner of health, after consultation with the state planning agency and the health systems agencies, may by rule provide for the granting of waivers under other situations the commissioner of health deems appropriate and not inconsistent with sections 145.832 to 145.845 and 42 U.S.C., Section 300k, et seq.

Proposed criteria for waivers in clauses (c) and (d) of this section shall be published in the state register by June 1, 1982 and the public shall be given an opportunity to review and comment on the proposed criteria prior to implementation. The criteria are not subject to the requirements of sections 15.0412 to 15.0417. The criteria shall be published in the state register and implemented by August 15, 1982.

The request for a waiver shall be submitted by the applicant to the health systems agency at the same time the applicant submits a notice of intent to the health systems agency pursuant to subdivision 1. Within 30 days of the request, the health systems agency shall submit its recommendation on the issue of the waiver to the commissioner of health, but the recommendation shall not be binding on the commissioner of health. The commissioner of health shall notify the applicant and the health systems agency of the decision to grant or deny the waiver within 30 days of receipt of the recommendation from the health systems agency.

Sec. 7. Monitoring the effects; transitional period.

Subdivision 1. Development of performance indicators. The commissioner of health shall consult with the commissioner of energy, planning and development and the commissioner of public welfare and other interested persons to define industry economic performance indicators to be used to monitor the effect of the amendments to the certificate of need act on the costs of health care.

Subd. 2. Public review and comment. By August 15, 1982, the commissioner of health shall publish in the state register proposed industry economic performance indicators to be used to monitor the effect of sections 3 to 5 on the health care system. These indicators shall not be subject to the requirements of sections 15.0412 to 15.0417 but the public shall be given the opportunity to review and comment on the indicators prior to their imple-

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mentation. Final industry economic performance indicators shall be published in the state register and implemented by October 15, 1982.

Subd. 3. Monitor; report. The commissioner shall monitor the economic performance of the industry and shall provide the legislature with a report concerning the preliminary effects, especially the financial impact, on the health care system created by sections 3 to 5.

Subd. 4. Facility reports. All health care facilities which commence construction or modification projects not now reviewable pursuant to sections 3 to 5, but which would have been reviewed prior to implementation of this section, shall submit to the commissioner of health at the time of project commencement the following information:

(a) an estimate of capital expenditures associated with the construction or modification; and

(b) an estimate of expenses and revenues projected to be associated with the construction or modification for a period of five years after initial operation of the project involved.

Sec. 8. Minnesota Statutes 1981 Supplement, Section 250.05, Subdivision 4, is amended to read:

Subd. 4. The Gillette hospital board, acting through its board of directors, may contract with the governing body and the owners of the Ramsey county hospital and of any other hospital or institution, for the joint maintenance and operation of the Gillette children's hospital in conjunction with existing or contemplated facilities at the Ramsey county hospital. Contracts may include agreements for the joint employment and utilization of personnel, the joint purchase of supplies and equipment, and joint construction, acquisition, or leasing of space for offices, outpatient facilities, operating rooms, and other medical facilities for use in training in the care and treatment of crippled and handicapped children, the operation of a brace shop, and the conduct of patient education programs. No contract shall however, provide for the expenditure of funds for additional patient bed capacity. The Gillette hospital board shall be subject to the certificate of need act provided in sections 145.832 to 145.845. In any case wherein a certificate of need is required, the Gillette hospital board shall, at the time of application, notify the house committee on appropriations and the senate finance committee, whose opinion shall be advisory only.

Sec. 9. Minnesota Statutes 1981 Supplement, Section 447.45, Subdivision 1, is amended to read:

Subdivision 1. Any county, city, or hospital district, except cities of the first class and counties in which are located any cities of the first class, is authorized, in addition to and not in substitution for any other power granted to it by law, to issue revenue bonds by resolution or resolutions of its governing body to finance the acquisition and betterment of hospital, nursing home and related medical facilities, or any of them, including but without limitation the payment of interest during construction and for a reasonable period thereafter and the establishment of reserves for bond payment and for working capital, and, in connection with the acquisition of any existing hospital or nursing home facilities, to retire outstanding

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indebtedness incurred to finance the construction of the existing facilities. The authority granted by this section shall not apply to any facility to which sections 145.822 to 145.845 apply, unless a certificate of need has been issued.

Sec. 10. Minnesota Statutes 1981 Supplement, Section 474.03, is amended to read:

474.03. Powers

Any municipality or redevelopment agency, in addition to the powers prescribed elsewhere by the laws of this state, shall have the power to:

(1) Acquire, construct, and hold any lands, buildings, easements, water and air rights, improvements to lands and buildings, and capital equipment to be located permanently or used exclusively on a designated site and solid waste disposal and pollution control equipment, and alternative energy equipment and inventory, regardless of where located, which are deemed necessary in connection with a project to be situated within the state, whether wholly or partially within or without the municipality or redevelopment agency, and construct, reconstruct, improve, better, and extend such project;

(2) Issue revenue bonds, in anticipation of the collection of revenues of such project, to finance, in whole or in part, the cost of the acquisition, construction, reconstruction, improvement, betterment, or extension thereof and, in the case of an alternative energy project, in addition to the other powers granted by this chapter, to finance the acquisition and leasing or sale of equipment and products to others;

(3) Issue revenue bonds to pay, purchase or discharge all or any part of the outstanding indebtedness of a contracting party engaged primarily in the operation of one or more nonprofit hospitals or nursing homes, theretofore incurred in the acquisition or betterment of its existing hospital or nursing home facilities, including, to the extent deemed necessary by the governing body of the municipality or redevelopment agency, any unpaid interest on such indebtedness accrued or to accrue to the date on which such indebtedness is finally paid; and any premium the governing body of the municipality or redevelopment agency determines to be necessary to be paid to pay, purchase or defease such outstanding indebtedness; if revenue bonds are issued for this purpose, the refinancing and the existing properties of the contracting party shall be deemed to constitute a project under section 474.02, subdivision 1c. Industrial revenue bonds shall only be available under this provision if the commissioner of securities and real estate has been shown that a reduction in debt service charges to patients and third party payors will occur. All reductions in debt service charges pursuant to this program shall be passed on to patients and third party payors. These industrial revenue bonds may not be used for any purpose not consistent with the provisions of sections 145.822 to 145.845 or chapter 256B;

Nothing in this subdivision is intended to prohibit the use of revenue bond proceeds to pay outstanding indebtedness of a contracting party to the extent now permitted by law;

(4) Enter into a revenue agreement with any person, firm, or public or private corporation or federal or state governmental subdivision or agency

in such manner as the contracting party shall produce income of principal of revenue agreed to be required to pay including, but not limited to, against all liability operation there respect to the ment, during the term of the provisions of this section, though the contracting party may own property comprising

(5) Pledge all or any part of the assets of the municipality or redevelopment agency, whether or not segregated such assets, whether or not otherwise;

(6) Mortgage all or any part of the real estate of the municipality or redevelopment agency therefor, provided that the municipality or redevelopment agency itself except with

(7) Make all or any part of the assets of the municipality or redevelopment agency available for the performance of the obligations of its bonds; including, but not limited to, the construction of such terms and conditions as may be found necessary for the acquisition, and to be included in the terms and conditions of advertisement of other

(8) Enter into revenue agreements with municipalities, institutions as defined in section 145.01, and feasible for the mortgaging of such property for the maintenance of its revenues pursuant to revenue agreements with parties, which or such other parties as may be determined by the management

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in such manner that payments required thereby to be made by the contracting party shall be fixed, and revised from time to time as necessary, so as to produce income and revenue sufficient to provide for the prompt payment of principal of and interest on all bonds issued hereunder when due, and the revenue agreement shall also provide that the contracting party shall be required to pay all expenses of the operation and maintenance of the project including, but without limitation, adequate insurance thereon and insurance against all liability for injury to persons or property arising from the operation thereof, and all taxes and special assessments levied upon or with respect to the project and payable during the term of the revenue agreement, during which term a tax shall be imposed and collected pursuant to the provisions of section 272.01, subdivision 2, for the privilege of using and possessing the project, in the same amount and to the same extent as though the contracting party were the owner of all real and personal property comprising the project;

(5) Pledge and assign to the holders of such bonds or a trustee therefor all or any part of the revenues of one or more projects and define and segregate such revenues or provide for the payment thereof to a trustee, whether or not such trustee is in possession of the project under a mortgage or otherwise;

(6) Mortgage or otherwise encumber such projects in favor of the municipality or redevelopment agency, the holders of such bonds, or a trustee therefor, provided that in creating any such mortgages or encumbrances a municipality or redevelopment agency shall not have the power to obligate itself except with respect to the project;

(7) Make all contracts, execute all instruments, and do all things necessary or convenient in the exercise of the powers herein granted, or in the performance of its covenants or duties, or in order to secure the payment of its bonds; including, but without limitation, a contract entered into prior to the construction of the project authorizing the contracting party, subject to such terms and conditions as the municipality or redevelopment agency shall find necessary or desirable and proper, to provide for the construction, acquisition, and installation of the buildings, improvements, and equipment to be included in the project by any means available to the contracting party and in the manner determined by the contracting party and without advertisement for bids as may be required for the construction or acquisition of other municipal facilities;

(8) Enter into and perform such contracts and agreements with other municipalities, political subdivisions, and state agencies, authorities, and institutions as the respective governing bodies of the same may deem proper and feasible for or concerning the planning, construction, lease, purchase, mortgaging or other acquisition, and the financing of a project, and the maintenance thereof, including an agreement whereby one municipality issues its revenue bonds in behalf of one or more other municipalities pursuant to revenue agreements with the same or different contracting parties, which contracts and agreements may establish a board, commission, or such other body as may be deemed proper for the supervision and general management of the facilities of the project; provided, no municipality or

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redevelopment agency shall perform any contract or agreement with any school district in which the municipality or redevelopment agency issues its revenue bonds or otherwise provides for the construction of school facilities and the school leases or otherwise acquires these facilities;

(9) Accept from any authorized agency of the federal government loans or grants for the planning, construction, acquisition, leasing, purchase, or other provision of any project, and enter into agreements with such agency respecting such loans or grants;

(10) Sell and convey all properties acquired in connection with such projects, including without limitation the sale and conveyance thereof subject to such mortgage as herein provided, and the sale and conveyance thereof under an option granted to the lessee of the project, for such price, and at such time as the governing body of the municipality or redevelopment agency may determine, provided, however, that no sale or conveyance of such properties shall ever be made in such manner as to impair the rights or interests of the holder, or holders, of any bonds issued under the authority of this chapter;

(11) Issue revenue bonds to refund, in whole or in part, bonds previously issued by such municipality or redevelopment agency under authority of this chapter;

(12) If so provided in the revenue agreement, terminate the agreement and re-enter or repossess the project upon the default of the contracting party, and operate, lease, or sell the project in such manner as may be authorized or required by the provisions of the revenue agreement or of the resolution or indenture securing the bonds issued for the project; any revenue agreement which includes provision for a conveyance of real estate to the contracting party may be terminated in accordance with the revenue agreement, notwithstanding that such revenue agreement may constitute an equitable mortgage provided that no municipality or redevelopment agency shall have power otherwise to operate any project referred to in this chapter as a business or in any manner whatsoever, and nothing herein authorizes any municipality or redevelopment agency to expend any funds on any project herein described, other than the revenues of such projects, or the proceeds of revenue bonds and notes issued hereunder, or other funds granted to the municipality or redevelopment agency for the purposes herein contemplated, except as may be otherwise permitted by law and except to enforce any right or remedy under any revenue agreement or related agreement for the benefit of the bondholders or for the protection of any security given in connection with a revenue agreement, provided that the public cost of redevelopment of land paid by a city or its redevelopment agency shall not be deemed part of the cost of any project situated on such land;

(13) Invest or deposit, or authorize a trustee to invest or deposit, any money on hand in funds or accounts established in connection with a project or payment of bonds issued therefor, to the extent they are not presently needed for the purposes for which such funds or accounts were created, in accordance with section 471.56, as amended; and

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(14) Waive or require the furnishing of a contractors payment and performance bond of the kind described in section 574.26 and if such bond shall be required, then the provisions of chapter 514 relating to liens for labor and materials, shall not be applicable in respect of any work done or labor or materials supplied for the project, and if such bond be waived then the said provisions of chapter 514 shall apply in respect of work done or labor or materials supplied for the project.

Sec. 11. Regional health planning report.

The commissioner of energy, planning and development shall address the discontinuance of health systems agencies due to the elimination of federal funds and prepare recommendations to the legislature by January 2, 1983 concerning alternative organizational arrangements and funding sources which could maintain statewide or statewide and regional participation in a state health planning system.

Sec. 12. Repealer.

Minnesota Statutes 1980, Sections 145.832; 145.833; 145.835, as amended by Laws 1981, Chapter 356, Section 172; 145.836, as amended by Laws 1981, Chapter 356, Section 173; 145.837, as amended by Laws 1981, Chapter 356, Section 174; 145.838, as amended by Laws 1981, First Special Session, Chapter 4, Article I, Section 80; 145.839; 145.84; 145.841; 145.842; 145.843; 145.844; Minnesota Statutes 1981 Supplement, Sections 62D.22, Subdivision 6; 145.834; and 145.845, are repealed.

Sec. 13. Effective date.

Sections 1, 3 to 7 and 11 are effective the day following enactment. Section 2 shall become effective for a specified provider group on March 1, 1983 if the commissioner of health certifies to the health and welfare committees of the house and senate that the voluntary efforts by the provider group to promote price competition and to implement the reporting requirements of section 2 have not made satisfactory progress. This certification shall take the form of a written report delivered to the chairmen of the house and senate committees by January 2, 1983. Notice of the date of the delivery shall be published in the state register. Sections 8 to 10 and 12 are effective March 15, 1984.

Approved March 23, 1982.

JUVENILE JUSTICE AGENCY

CHAPTER 615

H.F.No. 1803

An Act relating to juveniles; designating a juvenile justice agency; providing for termination of jurisdiction over juveniles; providing for the apprehension of juvenile absconders and

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UTAH CODE ANNOTATED

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VOLUME 3
1981 Pocket Supplement

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CHAPTER 22

PRO-COMPETITIVE CERTIFICATE OF
NEED ACT

- Section
- 26-22-1. Short title.
- 26-22-2. Legislative findings — Purpose of chapter.
- 26-22-3. Definitions.
- 26-22-4. Projects subject to review.
- 26-22-5. Projects exempt from requirement for certificate of need.
- 26-22-5. Projects requiring certificate — Regulatory and statutory provisions covering applications — Publication of description of chapter.
- 26-22-7. Review of projects — Award or denial of certificate — Rules — Notice at hearing — Hearing examiners.
- 26-22-8. Health project review advisory committee — Duties and responsibilities — Members — Terms — Organization — Per diem — Conflict of interest.
- 26-22-9. Suspension of review — Order — Duration — Severing of multiple proposals.
- 26-22-10. Amendment of application — Rules.
- 26-22-11. Certificate of need — Summary award — Application — Decision — Emergency projects.
- 26-22-12. Criteria for review — Rules.
- 26-22-13. Certificates not transferable.
- 26-22-14. Rescission of certificate — Effect — Notice at hearing — Extensions or amendments.
- 26-22-15. Reports — Contents — Penalties — Exclusions.
- 26-22-16. Information to be public — Notice of status of review — Rules.
- 26-22-17. Rules of department, statewide health coordinating council, and committee — Coordination of procedures.
- 26-22-18. District court jurisdiction — Injunctions and civil penalties.
- 26-22-19. Judicial review — Time for filing — Jurisdiction.
- 26-22-20. Judicial review — Record filed by department — Powers of court — Orders.
- 26-22-21. Immunity from civil actions — Committee and statewide health coordinating council members held harmless.
- 26-22-22. Repeal of chapter.

26-22-1. Short title. This chapter shall be known and may be cited as the "Utah Pro-competitive Certificate of Need Act."

History: C. 1953, 26-22-1, enacted by L. 1951, ch. 126, § 21. Districts Act. New sections 26-22-1 to 26-22-22 were enacted by § 21 of the act. For present provisions, see 26-24-1 et seq.

Compiler's Notes.

Laws 1961, ch. 126, § 1 repealed old sections 26-22-1 to 26-22-42 (L. 1967, ch. 31, §§ 1 to 42; 1959, ch. 197, § 70), the County-wide Health

Law Reviews.

Utah Legislative Survey — 1979, 1980 Utah L. Rev. 155.

26-22-2. Legislative findings — Purpose of chapter. (1) The legislature finds that duplication and excess investment in and supply of health facilities, equipment, and services contribute to the rising cost of health services and the financial ability of the public to obtain necessary care. The legislature also finds that the prevailing systems of public and other third party payment for health care sometimes provide inappropriate economic incentives for new investment and service development and inadequately deter duplication and overinvestment. The legislature concludes that development of a facility for the provision of health services is affected with a public interest and such development should be granted only on an affirmative demonstration of the desirability of such facility and the services rendered therein, its necessity, and its economic appropriateness.

(2) The legislature finds that regulation of the growth and development of health services will not obviate the need for maintaining competitive conditions

(6) Upon review of a department decision, order, or action, the court may enter its order:

(a) Affirming and enforcing or otherwise requiring compliance with the agency action;

(b) Compelling agency action unlawfully withheld or unreasonably delayed;

(c) Remanding for further agency proceeding consistent with the court's opinion or order where agency action is held unlawful and set aside; or

(d) Reversing or modifying the agency action and substituting the court's order, where the agency action is held unlawful and to that extent set aside on grounds of law which are applicable without regard for further or alternative findings of fact or exercise of discretion by the agency.

History: C. 1953, 26-22-20, enacted by L. 1981, ch. 126, § 21.

26-22-21. Immunity from civil actions — Committee and statewide health coordinating council members held harmless. (1) No member of the committee, the statewide health coordinating council, and any health systems agency governing body or advisory committees or councils shall be subject to a civil action in court or be liable for the payment of damages for any action, failure to act or statement made in the performance of any function or responsibility required or authorized by this chapter if such member has acted within the scope of such function or responsibility and has acted in good faith.

(2) The department shall hold harmless the committee and statewide health coordinating council members for reasonable costs incurred in defending any civil action for which such members have immunity pursuant to subsection (1). Every health systems agency shall hold harmless health planning councils and health systems agency advisory committees, councils, or board members for reasonable costs incurred in defending any civil action for which such members have immunity pursuant to subsection (1).

History: C. 1953, 26-22-21, enacted by L. 1981, ch. 126, § 21.

26-22-22. Repeal of chapter. Chapter 22 of Title 26, Utah Code Annotated 1953, shall be repealed and have no force or effect after June 30, 1983, or at such earlier date as federal health planning funding to the state to support certificate of need terminates.

History: C. 1953, 26-22-22, enacted by L. 1981, ch. 126, § 21.

CHAPTER 23

ENFORCEMENT PROVISIONS AND PENALTIES

| Section | |
|----------|--|
| 26-23-1. | Legal advice and representation for department. |
| 26-23-2. | Administrative review of actions of department or director — Hearings — Judicial review. |
| 26-23-3. | Violation of public health laws or orders unlawful. |
| 26-23-4. | Unlawful acts by department officers and employees. |
| 26-23-5. | Unlawful acts concerning certificates, records and reports — Unlawful transportation or acceptance of dead human body. |
| 26-23-6. | Criminal and civil penalties and liability for violations. |
| 26-23-7. | Application of enforcement procedures and penalties. |

26-23-8. Representa
26-23-9. Authority
26-23-10. Religious
practice

26-23-1. Legal :
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History: C. 1953,
1981, ch. 126, § 22.

Compiler's Notes.

Laws 1981, ch. 126,
26-23-1 (L. 1967, ch.

26-23-2. Admin:
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REVISED STATUTES

ANNOTATED

1975-1982

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WEST PUBLISHING CO.

Repeal effective 8/2/84

§ 36-431

Note 1

licensure, supervision, regulation, or control, department of health services should advise facility operator that continued presence of persons needing hospital, personal, or nursing care or of more than four persons not otherwise exempt needing supervisory care is a violation of this section and §§ 36-430 (prohibiting unlicensed operations) and

§ 36-431.01. Violations; civil penalty

A. Any person who violates any provision of this chapter or any rule or regulation promulgated under authority of this chapter may be assessed a civil penalty by the director in an amount not to exceed three hundred dollars for each violation after a hearing conducted pursuant to title 41, chapter 6, article 1.¹ Each day that a violation continues shall constitute a separate violation.

B. Actions to enforce the collection of penalties assessed pursuant to subsection A shall be brought by the attorney general or the county attorney in the name of the state in the justice court or the superior court of the county in which the violation occurred.

C. Penalties assessed under this section are in addition to and not in limitation of other penalties imposed pursuant to this chapter.

Added by Laws 1978, Ch. 205, § 2

¹ Section 41-1001 et seq.

Notes of Decisions

1. In general

In the case of an unlicensed facility not exempted by § 36-402 listing services not subject to licensure, supervision, regulation, or control, department of health services should advise facility operator that continued presence of persons needing hospital, personal, or nursing care or of more than four persons not otherwise exempt needing supervisory care is a violation of this section and

§ 36-432. Repealed by Laws 1980, Ch. 231, § 64

See, now, § 36-113.

For purpose of Laws 1980, Ch. 231, see note following § 3-104.

§ 36-433. Certificate of need; exemptions

A. Any new or substantially modified medical services and health-related services and facilities of health care institutions used in rendering such new or substantially modified services shall, unless otherwise exempted, require a certificate of need under any of the following circumstances:

1. Capital expenditures which are over seven hundred fifty thousand dollars.
2. Acceptance of a donation if such acceptance will cause increased expenditures, apart from the donation, of seven hundred fifty thousand dollars or more within twelve months of the date of the donation for any item for which a certificate of need is required as provided in this subsection.
3. Increases in bed capacity of more than ten beds or ten per cent of the total bed capacity, whichever is less, over a two year period.
4. Changes in the use of one or more existing beds if such changes will result in increased expenditures of more than seven hundred fifty thousand dollars within twelve months of the change.
5. New medical services, consisting of obstetrical units, neonatal special care units, pediatric inpatient services, open heart surgery units, cardiac catheterization services, radiation therapy services, end stage renal disease services, computed tomographic scanning, neurosurgical units, spinal injury units and burn treatment units.

PUBLIC HEALTH AND SAFETY

36-431.01 (setting civil penalties for violations); in such event, the operator, if qualified, could obtain a license to provide the level of care which the patients' needs require or could elect to avoid or mitigate prosecution by having the patient leave within whatever time the department may reasonably allow. Op.Atty.Gen. No. 180-180.

§§ 36-430 (prohibiting unlicensed operations) and 36-431 (describing violations and setting the penalties therefor); in such event, the operator, if qualified, could obtain a license to provide the level of care which the patients' needs require or could elect to avoid or mitigate prosecution by having the patient leave within whatever time the department may reasonably allow. Op.Atty.Gen. No. 180-180.

PUBLIC HEALTH AND SAFETY

6. New medical services subsection, if it has been public hearing that such fifty thousand dollars of services.

7. Replacement of m and which costs in exce

8. A substantial change facility, which apart from operating cost of seven

B. An application for services prior to undertaking or development. If preparation for a certificate of applicant shall advise applying for the certificate then comment on the construction projects, the elements for filing a letter necessary to provide in possible opportunity in

C. The department review of applications by the form and content of information in connection necessary to perform the certain only to the following services or facilities:

1. The description, the cost, including method

2. The health problem services has for the ser

3. The ability of the al standards.

4. The relationship

5. The availability of services.

6. The relationship in which the services a

7. The efficiency and are similar to those pri

8. The qualification ing, staffing, equipmen

9. In the case of h service on the clinical access to such health which the proposed ser

10. The special need of their services to ind. are located, and of he:

11. The effect of c

12. The impact of t health services.

13. The impact, in existing or approved p of the proposed projec

6. New medical services, in addition to those services enumerated in paragraph 5 of this subsection, if it has been found by the director based on substantial evidence presented at a public hearing that such new services will require annual operating costs of seven hundred fifty thousand dollars or more within twelve months of the date of institution of such services.

7. Replacement of medical equipment which provides medical and other health services and which costs in excess of seven hundred fifty thousand dollars.

8. A substantial change in an existing medical service provided through a health care facility, which apart from any capital expenditure entails a new or increased annual operating cost of seven hundred fifty thousand dollars or more.

B. An application for a certificate of need shall be filed with the authorized local agency in the area where the institution is located and with the department of health services prior to undertaking any substantial expenditures in preparation for such offering or development. If predevelopment expenses, including those associated with an application for a certificate of need, will be more than one hundred fifty thousand dollars, the applicant shall advise the director and the authorized local agency in writing before applying for the certificate of need. The director and the authorized local agency may then comment on the proposed application for a certificate of need. In the case of construction projects, the department of health services may by regulations define requirements for filing a letter of intent prior to the application in such detail as may be necessary to provide information about the scope and nature of the project at the earliest possible opportunity in the course of planning the project.

C. The department of health services shall establish by regulation the procedures for review of applications by the authorized local agencies and shall issue regulations defining the form and content of such applications except as provided in subsection G. Requests for information in connection with a review shall be limited to only that information which is necessary to perform the review of the proposed services or facility. The regulations shall pertain only to the following information to be included in the application for the proposed services or facilities:

1. The description, the geographical areas to be served, the nature and purpose, and the cost, including method of proposed construction in the case of facilities.
2. The health problem or needs that the population served or to be served by the services has for the services.
3. The ability of the applicant to comply with all applicable professional and institutional standards.
4. The relationship of services reviewed to the long-range plan, if any, of the applicant.
5. The availability of less costly or more effective alternative methods of providing the services.
6. The relationship of services reviewed to the existing health care system of the area in which the services are provided or proposed to be provided.
7. The efficiency and appropriateness of the use of existing services or facilities that are similar to those proposed.
8. The qualifications and ability of the applicant to provide and obtain proper financing, staffing, equipment, management and operation of the proposed services or facilities.
9. In the case of health services proposed to be provided, the effect of the proposed service on the clinical needs of health professional training programs, the extent that access to such health professional training programs will be provided and the extent to which the proposed services will be accessible to all the residents of the area to be served.
10. The special needs and circumstances of entities which provide a substantial portion of their services to individuals not residing in the health service areas in which the entities are located, and of health care services organizations.
11. The effect of competition on the financing of the health services being reviewed.
12. The impact of the project on the applicant's cost of providing existing and proposed health services.
13. The impact, including financial impact and utilization impact, of other similar existing or approved projects, services or facilities on the proposed project, and the impact of the proposed project on other similar projects, services or facilities.

unless the acquisition involves establishment of new services or facilities or substantial modification of existing services or facilities which would otherwise require that the health care institution obtain a certificate of need.

Added by Laws 1975, Ch. 129, § 3, eff. June 11, 1975. Amended by Laws 1976, Ch. 112, § 8; Laws 1977, Ch. 172, § 12, eff. Jan. 1, 1978; Laws 1980, Ch. 214, § 7; Laws 1981, Ch. 250, § 2; Laws 1982, Ch. 315, § 1.

This section is repealed by Laws 1982, Ch. 315, § 7, effective August 2, 1984.

For legislative intent regarding termination of provisions added or amended by Laws 1980, Ch. 214, see note following § 36-401.

For legislative intent regarding termination of provisions added or amended by Laws 1981, Ch. 260, see note following § 36-421.01.

Another § 36-433, added by Laws 1971, Ch. 203, § 1, was renumbered as § 36-445.02. See Reviser's Note following § 36-445.

For effective date provision of Laws 1977, Ch. 172, see note following § 20-1707.

Repeal

1976 Reviser's Note:

In paragraph 9 [now paragraph 14] of subsection C "this subsection" was substituted for "subsection C of this section", pursuant to authority of section 41-1304.02.

Cross References

Application for certificate of need by recipient of a temporary certificate, see § 36-434.

Application for construction permit, see § 36-421.

Findings on application, see § 36-433.01.

Issuance of certificate, see § 36-421.

Library References

-Hospitals ⇒ 1.

C.J.S. Hospitals § 1 et seq.

Index to Notes

In general ½

Review 1

½. In general

An applicant for a certificate of need to establish a new health care institution may not be required by health systems agency to designate the planned location of the proposed service with any greater degree of specificity than that required by this section, the rules adopted pursuant thereto,

and the interpretation made thereof by the department of health services facility. Op.Atty.Gen. No. 179-95.

1. Review

When review of a local health agency's findings is not requested by an applicant, the findings must be adopted by the director of the Arizona department of health services unless the local agency's findings are determined to be arbitrary, capricious, or not supported by substantial evidence. Op.Atty.Gen. No. 179-10.

When review of a local health agency's findings is requested by an applicant, the director of the Arizona department of health services may entertain written or oral arguments from the parties in interest. Id.

Insertion of "initial" in provision of subsec. A, par. 1 of § 36-433.01 providing that no review of the authorized local agency shall take longer than one hundred forty-five days (now one hundred and five days) from the "initial" date of filing the application with the authorized local agency unless the agency and the applicant agree in writing for an extension of time required that the former one hundred forty-five day (now one hundred five day) review begin with the filing of the application with the agency and the department of health services; the completeness review was included within the one hundred forty-five day review. Op.Atty.Gen. No. 78-170.

§ 36-433.01. Review of certificate of need application; public hearing; written findings and recommendations; conflict of interests

A. The authorized local agency shall notify the applicant and other affected persons in writing of the beginning of the review. The director shall issue regulations defining the procedures for the review of the application which shall include the following provisions:

1. That no review by the authorized local agency shall take longer than one hundred five days from the initial date of filing the application with the authorized local agency, unless the agency and the applicant agree in writing to an extension of time.

2. That a public hearing shall be initiated within thirty days after the initial filing of the application and shall be concluded within thirty days after the initial session.

3. That the governing body of the local agency, with a majority of its members present, shall conduct a public hearing on any certificate of need application.

4. That written notice of the hearing shall be delivered to the applicant at least fifteen days prior to the hearing date. Such notice shall contain the names of the panel members

House Returns
To

Nancy - April Dennis

The Cost of Excess Beds in Orange County

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association

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conducted by: ERNST & WHINNEY

TABLE OF CONTENTS

| | |
|--|----|
| ABSTRACT | 1 |
| EXECUTIVE SUMMARY | 3 |
| I. INTRODUCTION | 11 |
| II. THE EXCESS BEDS ISSUE | |
| A. Evolution of the Issue | 12 |
| B. Public Policy | 13 |
| III. STUDY METHOD | |
| A. Objectives | 15 |
| B. Scope | 15 |
| C. Approach | 16 |
| IV. STUDY GROUP | 17 |
| V. COMPUTATION OF EXCESS BEDS | |
| A. Definition of Excess Beds | 19 |
| B. Variability of Hospital Census | 19 |
| C. Use of Statistical Distributions to Model Census Variability | 21 |
| D. The Poisson Model | 23 |
| E. Office of Statewide Health Planning Standards | 23 |
| F. Empirical Analysis of Actual Distribution of ADC | 23 |
| G. Estimate of Needed Beds | 25 |
| H. Estimate of Excess Beds | 25 |
| I. Conclusion | 27 |
| J. The Roemer Effect | 30 |
| VI. COST ESTIMATES | |
| A. Computation of Cost of Excess Capacity | 31 |
| B. Economic Estimates | 31 |
| C. Hospital Industry Estimates | 32 |
| D. Policy Alternatives | 33 |
| E. Consumer Approach | 34 |
| F. Analysis of Empirical Data | 35 |
| G. Conclusion | 39 |

ABSTRACT

A basic tenet of recent health care public policy has been that there are a large number of excess beds in the hospital industry, and that this excess capacity is costly to both consumers and third-party payers for health care. Economic estimates for the United States project that capacity could be reduced by as much as 20 percent without endangering the health status of Americans. Estimates of the potential cost savings from such a reduction range from 12-16 percent of annual hospital costs. Similar estimates for California project that a 22 percent reduction in the bed supply would result in a 12 percent reduction in annual expenditures. These economic estimates are characterized by assumptions that the costs that would be avoided if a hospital were to be closed exceed 50 percent of that hospital's total cost. These estimates further assume that excess beds give rise to unnecessary (and costly) utilization of hospital facilities.

Public policy has been implemented and is being conducted by local, state, and national health planning agencies. These agencies enforce hospital certificate of need laws which require hospitals to obtain planning approval before commencing major projects to replace or expand existing facilities. It is believed that a restrictive certificate of need program will ultimately yield the same 12-16 percent savings that would result from closure of hospitals. Orange County has been a particular target of this policy, because it has low occupancy and presumably a high number of excess beds.

This study was undertaken to answer two questions:

- o Are there excess beds in Orange County hospitals?
- o If so, are these excess beds costly to consumers and third-party payers?

18 of the 39 general acute hospitals in Orange County participated in the study. The study group hospitals account for more than half of Orange County patient days and costs. These hospitals provided data on the actual level of use of the hospital, and the actual payments from patients during 1977, 1978, and 1979.

As a result of a detailed analysis of the utilization data, it was found that there were a substantial number of excess beds in the study group hospitals--approximately 18 percent of licensed beds. It was also found that hospital utilization is growing, and the number of excess beds are diminishing. If population growth continues, there will be no excess beds in Orange County by 1985.

If there are a substantial number of excess beds, then it is commonly believed that this excess causes "excess" hospital use (unnecessary hospitalizations). It is clear that there are excess beds in the study group and in Orange County. However, data published by California Hospital Association on hospital usage per thousand population does not

reflect excess usage. On the contrary, hospital usage in Orange County is below the average for California, and California is significantly below the national average. Although this data is not conclusive, it does not appear that excess beds cause excess hospital usage in Orange County.

The cost analysis performed as part of this study focused on the money actually paid by consumers that was spent to maintain, replace, expand, and pay off the debt on hospital facilities. The vast majority of this money was spent on needed capacity. The portion spent on excess beds amounted to only 0.75 percent of total hospital costs, or approximately \$3.00 per patient day. The portion that was spent on excess capacity of all types amounted to 2 percent of total hospital costs, or \$8.60 per patient day.

These savings estimates of 1-2 percent are substantially below the 12-16 percent figures that are widely quoted. Given this low level of potential savings, it is not clear that a public policy directed at controlling the supply of hospital beds in Orange County can ever be successful in significantly impacting the costs of health care to the consumer.

EXECUTIVE SUMMARY

THE EXCESS BEDS ISSUE

It is widely believed by health planning agencies and other regulators of the health care industry that there are a substantial number of excess beds in the hospital industry, and that there are substantial costs to consumers, insurance companies, and government payers for health care because of this excess. There are two basic ideas that underlie the conclusion that there is a costly excess beds problem. These ideas are:

- o Hospitals have very high fixed costs. Fixed costs are those which must be incurred at any level of activity, and in the hospital industry are generally those costs associated with maintaining a given level of capacity to serve patients. It is commonly believed that these fixed costs represent as much as 60 percent of total hospital costs. Part of the argument that excess beds are costly goes that if there are too many beds, there is too much capacity. If the fixed costs of maintaining this capacity are 60 percent, then the cost of excess beds is 60 percent of the average cost per bed multiplied by the number of excess beds. This is an estimate of cost that would be avoided if the excess beds were not there.
- o Demand for hospital services expands to fill the beds available. This idea is called the Roemer effect, after the original researcher. Roemer found that the use rate of hospital services, measured in patient days per thousand population, was highly related to the availability of beds, measured in beds per thousand population. In other words, areas with a high ratio of beds per thousand population tended to have a higher level of patient days per thousand population. As it relates to the excess beds issue, the Roemer effect is interpreted to mean that excess beds cause overutilization of hospital services. If there are too many beds, then there will be "too much" utilization of those beds--in other words, unnecessary hospitalizations. The cost of these unnecessary hospitalizations contributes to the cost of excess beds.

Public policy has addressed this issue through the structure of federal, state, and local agencies created by the 1975 National Health Planning and Development Act (PL93-641). One of the major thrusts of these agencies has been to control the supply of hospital beds, in the belief

that such control would reduce the number of excess beds, and avoid the costs associated with this excess. The avoidance of the costs of excess beds is thought to make a major contribution to the containment of hospital costs.

Orange County has been a particular target of this policy, because it is believed that there are a substantial number of excess beds in Orange County hospitals.

ESTIMATES OF POTENTIAL SAVINGS RESULTING FROM REDUCTIONS TO THE BED SUPPLY

A number of economic estimates of the potential savings that would result from a reduction in the bed supply have been developed during the late 1970's. A key study is Reducing Excess Hospital Capacity by Walter McClure, published by InterStudy in 1976. This study concluded that a 20 percent reduction in hospital beds, accomplished by closing entire facilities, would result in a 16 percent reduction in annual hospital costs. In California, a California Hospital Association study authored by Zaretsky entitled The Economics of Excess Capacity concluded that a 22 percent reduction in the California bed supply would result in a savings of 12 percent of annual hospital costs. Zaretsky's results are lower because the Roemer effect was not included in the computation.

The basic methodology for these studies proceeds in two steps. In the first step, excess beds are estimated using the following formula:

- o $\text{Needed beds} = \frac{\text{average daily census}}{85 \text{ percent occupancy standard}}$
- o $\text{Excess beds} = \text{licensed beds} - \text{needed beds}$
- o $\text{Excess beds percent} = \frac{\text{excess beds} \times 100}{\text{licensed beds}}$

In the second step, the cost of potential savings from reduction of excess beds is computed:

- o $\text{Average cost per bed} = \frac{\text{total cost}}{\text{total beds}}$
- o $\text{Savings per bed} = \text{average cost per bed} \times \text{number of excess beds} \times 50\text{-}60 \text{ percent fixed costs}$
- o $\text{Total savings} = \text{savings per bed} \times \text{number of excess beds}$
- o $\text{Savings percentage} = \frac{\text{total savings} \times 100}{\text{total cost}}$

In some studies, additional potential savings are projected by estimating the number of unnecessary patient days "caused" by the availability of excess beds and multiplying these days by the average cost per day. These estimates are the estimate of the cost associated with the Roemer effect.

Virtually all of the economic estimates of potential savings assume that entire hospitals are closed, rather than portions of hospitals. While acknowledging the legal and social difficulty of government enforced closure of hospitals, most of the economic authors believe that a tight certificate of need program (which is recent government policy) will ultimately achieve the same results.

Central to all of these studies are five key assumptions. Specifically, these assumptions are:

- o That 85 percent occupancy is a realistic occupancy standard. *1 high?*
- o That licensed beds represent the number of beds that are available for use and which have costs associated with them. *// no*
- o That an excess supply of beds will result in costly overutilization of hospital facilities.
- o That fixed costs which relate to maintaining a hospital bed for one day exceed one-half of the average cost of a day's care in the hospital.
- o That a tight certificate of need program to restrict the supply of beds will ultimately achieve the same potential savings that would result from closing entire hospitals.

Hospital industry critics of these estimates of potential savings have repeatedly challenged these assumptions, claiming that they are not reasonable, and do not reflect the realities of hospital operations.

A STUDY OF ORANGE COUNTY HOSPITALS

The objective of this study was to investigate the excess bed issue in Orange County hospitals. Specifically, the objectives were to determine whether there were a substantial number of excess beds in Orange County during the 1977-1979 period and, if so, were these excess beds costly to consumers, insurance companies, and government payers.

The study included 18 of the 39 acute general care hospitals in Orange County, who voluntarily agreed to participate in the study. Since the hospitals self selected whether or not to participate, the sample of hospitals was not random and no statistical assertion of representativeness can be made. A review of occupancy statistics disclosed that the study group of hospitals was probably somewhat less likely to have excess beds than the nonparticipating hospitals. However, the differences between the two groups of hospitals are not so marked that the excess bed condition did not exist in the study group. Further, the study group contains hospitals which accounted for more than half of the patient days and costs of all Orange County hospitals. Hence the results for the study group cannot be dismissed as unrepresentative of the excess bed issue in Orange County.

It was the intent of the study to investigate the excess bed issue using actual data to the maximum extent possible, and to make as few assumptions as possible. This approach was taken in an attempt to arrive at rigorous results and to avoid the controversy that has surrounded the assumptions used in prior studies.

The approach used to investigate the excess beds issue contained the following key elements:

- o Actual hospital census data was analyzed for the three year study period, in order to determine the pattern of actual bed utilization. The number of needed beds for each hospital was set at a level below the number of beds that were actually used during peak periods. This level was set so that 1 out of 20 patients who actually used a particular hospital would have been turned away and forced to enter another hospital, had the actual beds available been equal to the defined level of needed beds. The 1 out of 20 turnaway level was judged to result in an acceptable level of patient and physician inconvenience. This methodology was employed rather than an arbitrary 85 percent occupancy standard assumption.
- o Interviews were conducted with hospital managers and California Health Facilities Commission (CHFC) disclosure data was reviewed in order to determine how many beds were actually available at a study hospital during the study time period. This data on available beds was used in place of an assumption that all licensed beds were available for use. Beds which exist only on the paper of the hospital's license are not excess beds in the sense that there are potential savings associated with them. These "phantom" beds could be removed merely by changing the hospital's license, but the hospital's operations, revenues, and costs would be unchanged.
- o An analysis was performed of actual financial data for the study group hospitals. The amount of money actually paid by consumers, insurance companies, and government payers was segregated into two categories:
 - Money which was used to pay for the day-to-day care of patients in the hospital, and
 - Money that was used to maintain, replace, expand, or pay off the debt on existing hospital facilities.

This second category of funds is the money which is in fact used to maintain or expand a hospital's capacity, and represents the costs that are the focus of the current certificate of need program. This analysis was performed in order to more accurately determine the potential savings that would result from the elimination of excess beds. No single fixed cost assumption was used in order to estimate potential savings.

FINDINGS AND CONCLUSIONS--EXCESS BEDS AND HOSPITAL UTILIZATION

There are 3838 licensed beds in the study group hospitals. The three year average of average daily census during 1977-1979 was 2305 patients per day. The conventional computation of excess beds would result in 1126 excess beds, or 29 percent of total licensed beds. (2305 ADC \div 85 percent = 2712 needed beds. 3838 licensed beds - 2712 needed beds = 1126 excess beds.)

As a result of interviews with hospital management and analysis of CHFC data, it was determined that there were an average of 339 beds (9 percent of licensed beds) that were "phantom" beds. We conclude that almost one-third of the "excess bed problem" in the study group relates only to the fact that there are more beds on hospital licenses than there are beds available for use. These phantom excess beds were removed from further analysis since there are not any cost savings associated with a reduction of beds only on the hospital's license.

The results of the analysis of hospital average daily census data provided an alternative to the 85 percent occupancy standard. A 1 out of 20 "turnaway" probability was used to determine the number of needed beds for each hospital. The application of this probability to a statistical model of the distribution of average daily census for the hospital resulted in the determination of the number of needed beds. These needed beds were added up for all study group hospitals. The resulting total was 2788 needed beds which is an 82.6 percent occupancy standard and 76 more beds than the 2712 needed beds that result from the 85 percent occupancy standard. These 76 beds represent approximately 2 percent of total licensed beds.

In summary, the results of the study's excess bed computation show that of the 29 percent of the study group hospital beds which are nominally excess beds, 9 percent are phantom beds which appear only on the hospital license and have no cost impact, and 2 percent would be required in order to maintain a turnaway probability of 1 in 20. The remaining 18 percent are true excess beds.

The study also showed that the average daily census was growing at a rate of slightly more than 4 percent per year (from 2211 in 1977 to 2401 in 1979). As a result, the number of excess beds declined over the same period (from 816 beds in 1977 to 635 beds in 1979). If the trend in patient days continues at 4 percent per year, then the number of needed beds will be equal to the number of available beds by 1985.

We conclude that there was a substantial number of excess beds in the Orange County study group, although the true number of excess beds is considerably below the amount that would normally be reported. Further, the number of excess beds is going down, because average daily census and the related number of needed beds are growing.

Given that there were a substantial number of excess beds in the study group during the 1977-1979 period, one would expect that there would be some overutilization of hospital services due to the Roemer effect.

It was not possible to calculate use rates for the study group, since the population served by the study group represents an unknown portion of the Orange County population. However, data published by the California Hospital Association does show the utilization for Orange County in total during 1978. The number of patient days per thousand population was:

| | |
|---------------|-------|
| Orange County | 816 |
| California | 867 |
| United States | 1,208 |

The utilization of hospitals in California is well under the national average, and Orange County is under the California average. Although this data for Orange County is not conclusive, it does raise questions about the causal relationship between the availability and use of hospital beds. It is unclear that the Roemer effect is a valid concept, at least for Orange County.

FINDINGS AND CONCLUSIONS--THE COST OF EXCESS BEDS

All of the economic estimates of potential savings assume that entire hospitals are closed. As a practical matter, no agency of the government is empowered to take this action. Health planning agencies are empowered to control the capital expenditures of hospitals through the certificate of need legislation. It is asserted by the authors of several of the estimates of potential savings that a tight certificate of need control on the bed supply will, in the long run, achieve the same results as closing hospitals.

Our approach focused on identifying the capacity costs of hospitals, and apportioning these capacity costs between excess capacity and needed capacity, as measured by needed beds and excess beds. Capacity costs represent that portion of the money received from patients and third-party payers which was spent to maintain, replace, expand, or repay the debt on hospital physical plant assets. While capacity costs are not the fixed costs used in the economic estimates, there are two compelling reasons why capacity cost is a viable concept for analyzing potential savings from reducing the bed supply:

- o Capacity costs are costs actually paid by the consumer or third-party payer. If hospital facilities were replaced using funds from sources other than patient revenues (e.g., debt or donations), then these assets did not cost the current consumer anything, and the cost of such projects is not part of current capacity cost. Conversely, if patient revenues were used to retire debt used to finance existing assets or to accumulate savings to finance future capital projects, they are being paid by the current consumer and are current capacity costs.

- c Capacity costs, not fixed costs, are the object of certificate of need controls. If a capital project does not receive a certificate of need, then the funds will not be spent, and current and future consumers will not be charged. No certificate of need approval is required to hire a new assistant administrator or director of nursing. Once hired, the costs of these personnel are largely fixed (unrelated to changes in volume). While it is true that these fixed costs could be avoided if the facility was closed down, no agency of government can enforce a hospital closure. More to the point, if the hospital was not needed and volumes and patient revenues declined enough so that it was approaching bankruptcy, these "fixed" costs would become variable costs--the personnel would be laid off.

Capacity costs for the study group ranged from 12-13 percent of consumer expenditures during the three year study period. We conclude that the potential for savings through capacity control is much smaller than generally estimated, because the total costs which are the target of regulatory control are less than 13 percent. This level of potential savings is substantially below the 50-60 percent of total cost used in the economic estimates.

Excess beds were used as an estimate of excess capacity, in order to split capacity costs between needed capacity and excess capacity. The results of this apportionment are that approximately 2 percent of total cost is related to excess capacity. This is equivalent to \$8.60 per patient day. This is the estimate of the total potential for cost reduction through certificate of need control.

The focus of regulatory control is on the supply of beds. The majority of capacity costs do not relate to patient beds, but to ancillary and support services (e.g., radiology equipment, data processing equipment). If the excess capacity costs are split between the cost of beds and the cost of expenditures for other capacity purposes, then the potential savings drop to .75 percent, or \$3.00 per patient day.

Economic estimates of the potential savings from a 20 percent capacity reduction range from 10-16 percent of total hospital expenditures. The results of our study indicated that a 18 percent reduction in capacity would be possible in the Orange County study group hospitals. Our estimate of the potential savings that would result from this capacity reduction range from 1-2 percent. The principal reasons for this substantial difference go back to the assumptions used in the economic estimates:

- o An 85 percent occupancy standard is generally assumed. Our study results support a slightly lower 83 percent occupancy standard.

- o Licensed beds are assumed to represent beds actually available for use. The results of our study indicated that 9 percent of licensed beds, or one-third of the excess beds, are "phantom" beds which exist only on the hospitals' licenses. There appears to be no savings associated with retiring these "phantom" beds.
- o Excess beds are assumed to cause excess utilization (Roemer effect). Our study did not address this assumption directly. However, California Hospital Association statistics for all Orange County hospitals do not support the idea that there is significant overutilization in Orange County.
- o It is assumed that fixed costs exceed one-half of total costs, and that these fixed costs could be avoided through elimination of excess capacity via a tight Certificate of Need program. In fact, the target costs of Certificate of Need programs are not fixed costs, but capacity costs. These costs represent only 13 percent of total costs in our study group--a dramatically smaller fraction than the 50-60 percent that has been commonly used.

In short, the economic estimates overestimate excess beds largely because they count phantom beds as excess beds. These estimates overestimate potential savings because they assume that fixed costs, not capacity costs, are the target of Certificate of Need regulation. Potential savings may also be overestimated because utilization is assumed to decline with the bed supply. After these factors have been taken into account, the potential savings drop from 10-16 percent to 1-2 percent for our study group. Given this low level of potential savings, it is unclear that a public policy directed at controlling the supply of hospital beds can ever have a significant impact on the cost of health care to the Orange County consumer.

THE COST OF EXCESS BEDS IN ORANGE COUNTY
1977-1979

I. INTRODUCTION

It is widely believed by health planning agencies and other regulators of the health care industry that there is a substantial excess capacity in the hospital industry, and that this excess capacity is costly to consumers, insurance companies and government payers for health care. Public policy has been directed at this perceived problem through an extensive network of health planning agencies, regulations and laws. The hospitals in Orange County have been particular targets of this policy, because of allegations of extensive excess hospital beds in the County.

This study was undertaken to assess the "excess bed problem" in Orange County. The objectives of this study were to estimate the number of excess beds in Orange County, and to estimate the costs of these beds to consumers and third-party payers. An additional objective of the study was to describe how this issue has evolved, and to discuss policy alternatives in light of the findings for Orange County.

Section II of this report describes how "excess beds" became an issue, and what the public policy response has been. Section III describes the approach taken in the study. Section IV describes the group of hospitals that agreed to participate. Section V discusses the alternative ways to measure excess beds, and presents the findings regarding excess beds in the study group. Section VI discusses policy alternatives and ways to measure the costs associated with excess beds which are consistent with various policy options. Conclusions are presented regarding the potential effectiveness of the policies currently being employed.

II. THE EXCESS BEDS ISSUE

EVOLUTION OF THE ISSUE

During the last twenty years, there has been considerable debate and discussion regarding the "excess bed problem" in the United States. The pace of the debate accelerated in 1976 when two studies of the problem were published. In a study by InterStudy published in 1976 called Reducing Excess Hospital Capacity, the principal finding was "(there is) substantial evidence of excess hospital capacity which contributes significantly to medical cost escalation with little or no benefit to health." 1) This study recommended a phased 20 percent reduction in capacity, and estimated savings of up to 16 percent of total hospital expenditures. In the same year, a study published by the Institute of Medicine of the National Academy of Sciences found "that significant surpluses of short-term general hospital beds exist or are developing in many areas of the United States and that these (surpluses) are contributing significantly to rising hospital care costs." 2)

Economic analysis of California hospitals by Zaretsky in 1977 was consistent with the national conclusion that a significant excess bed problem exists. That study concluded that "economic incentives for an appropriate balance between use and capacity are absent in the health industry. This has led to a current situation, especially in California, where capacity is substantially in excess and this excess is costly." 3) Zaretsky estimated that a reduction in capacity of 22 percent would result in a 12 percent savings in annual cost.

In a report published by the California Health Facilities Commission (CHFC), using 1978 data for Orange County, excess beds are estimated at 25.5 percent of licensed beds. The report goes on to state, "CHFC research indicates that 10.5 percent to 21 percent of statewide hospital total operating costs are related to excess capacity." 4)

There are two basic ideas that underlie the conclusion that excess beds are costly. The first idea is that hospitals have very high fixed costs. Fixed costs are those costs which must be incurred at any level of activity. Economic estimates of fixed costs published during the early 1970's indicated that fixed costs exceed 50 percent of total hospital costs. 5) Thus if there are too many hospitals and too many beds, then retiring beds will cause some level of fixed costs to be avoided. In particular, "retiring entire hospitals produces substantially more savings than an equivalent reduction closing portions of several hospitals." 1) Zaretsky, in commenting upon his cost estimate for empty beds, states "it is best to interpret this \$20,000 per empty bed estimate as based upon the most cost effective way of eliminating empty beds--retiring entire institutions--rather than across-the-board cuts in beds in a large number of hospitals." 3)

The second basic idea that underlies that costly excess bed problem is frequently called the Roemer effect, after the original researcher. In work published in 1959, Roemer and Shain found that the use rate of hospital services, expressed in patient days per thousand population, was highly correlated with the availability of beds, expressed in beds per thousand population. They concluded that "hospital beds that are built tend to be used." 6) In other words, demand for hospital services seems to expand to meet the supply of beds available. Roemer and Shain further inferred that "the ultimate control over money spent for hospitalization . . . is the volume of beds provided."

PUBLIC POLICY

The passage of the National Health Planning and Resources Development Act in 1975 created a structure of national, state, and local planning agencies for the purpose of developing and implementing health planning policy. The law required states to adopt certificate of need programs for approving capital expenditures by hospital. Excess beds/capacity has been a concern of these agencies from the outset of the program. The stated purposes of the local Health Systems Agencies include "restraining increases in the cost of providing health service and preventing unnecessary duplication of health resources." 7) This law was amended in 1979, and the emphasis on eliminating excess beds/capacity was heightened. "The identification and discontinuance of duplicate or unneeded services and facilities" 8) became a national health priority.

In California, certificate of need legislation was initially adopted in 1976. The California law basically conforms to the requirements of the federal law. The Orange County Health Planning Council, which is the local planning agency, established a goal in their 1979 Health Systems Plan of "reduction of excess capacity through elimination or redistribution of health and medical care services and/or resources." 9)

Within the legal and organizational structure created by PL 93-641, the Secretary of Health and Human Services (HHS) is charged with developing guidelines for use by state and local agencies in health planning. In 1978, the first set of national guidelines were published. 10) These guidelines are directed, in part, at bed supply. A general guideline of four beds per thousand population was established. This guideline is based upon the Institute of Medicine's Report and the Interstudy report cited earlier. 11) Achievement of this guideline would mean a 10 percent reduction to the supply of beds. 10)

The National Guidelines also set specific occupancy standards for hospitals. The occupancy standard for general acute hospitals is 80 percent. This level is well above current national average of 75 percent. 10)

This federally mandated structure of agencies and regulation is currently being challenged by the Reagan Administration, as part of the emphasis on cost control in government and de-regulation.

California Office of Statewide Health Planning and Development guidelines for occupancy and bed are more sophisticated than the national guidelines, in that they take the number of patients by type of medical service within a planning area into account. Occupancy standards are generally established between 60 and 85 percent on a service-by-service basis, depending on the average daily census for that service in the health facilities planning area.

In summary, public policy has responded to the perceived "costly excess bed" problem by establishing goals to reduce beds. These goals have been implemented through the various levels of health planning agencies and the certificate of need process. It has been widely believed that the impact of placing capacity limits on hospitals will be to substantially reduce or contain the costs of health care to consumers, insurance companies, and government programs.

III. STUDY METHOD

OBJECTIVES

The objectives of the study were:

- o To estimate the number of excess beds in Orange County
- o To estimate the costs that are associated with operation and maintenance of all beds
- o To estimate the cost of excess beds
- o To discuss alternative courses of action for regulators and providers, in response to the "excess bed problem."

SCOPE

18 of the 39 general acute hospitals in Orange County chose to participate in this study. Since the hospitals self-selected whether or not to participate, no assertion can be made that the study group is a random sample of Orange County hospitals. Accordingly, the quantitative findings of the study are limited to the 18 hospitals which did participate.

The study included the collection and analysis of actual daily census and annual financial data for the three years 1977-1979. Fiscal year data for hospital fiscal years ending during this 36-month period was used and not adjusted to a common year-end. This procedure was used because we believed that such an adjustment would introduce more error than it would eliminate.

The focus of the study was to use actual data in place of assumptions wherever possible. This emphasis on actual data was made in an effort to arrive at realistic results, and in an effort to avoid the controversy that has attended the assumptions of prior studies.

The use of actual data had several consequences:

- o Excess beds were computed based upon the actual utilization of a particular hospital in a given study year. Excess beds are commonly used as an estimate of excess capacity, a convention which was followed in this study as well. Although not a perfect estimate by any means, excess beds can at least be measured unlike excess capacity.
- o The actual data reflects the actual use of the study group hospital, not what "should have" happened. Hence, the Roemer effect is not explicitly considered in the data analysis, and it is assumed that the actual usage of the hospitals was appropriate. Although the Roemer effect was not considered in the data

analysis, Orange County use rate data does tend to support the assumption that the actual usage was not inappropriate, and the Roemer effect can be ignored in developing estimates of potential savings from bed reductions.

- o No opportunity cost analysis was performed. To the extent that phantom beds are being used for productive functions and these functions would require space if the space originally designed for beds was not constructed, there is an opportunity cost associated with "phantom bed" space. The study assumes that phantom bed space is being productively utilized, and that the actual costs reflect the economic value of that space. No analysis was made of the costs that would have been incurred to provide space for those functions (e.g., leasing outside space) had the bed space not been constructed in the first place.
- o No fixed cost/variable cost assumptions were made. Rather, the money actually paid by consumers and third-party payers was analyzed and segregated into operating costs and capacity costs--the costs of maintaining, replacing, expanding, and paying off the debt on existing facilities. Capacity costs become the basis for estimating potential savings from reducing beds or capacity, rather than an assumption that an assumed level of fixed costs would be avoided through capacity reduction.

APPROACH

The approach taken to estimate the number of excess beds consisted of a statistical analysis of daily census data for each study group hospital. The number of beds needed for patients who actually used the hospital was compared to the number of beds that were available for use. This analysis results in an estimate of the number of excess beds in the hospital. These estimates were aggregated to estimate the total number of excess beds in the study group.

The approach taken to estimating the cost of the excess beds was to analyze the financial statements of the study hospitals for each year in the study period. Payments from patients and third-parties were identified as either related to day-to-day operations of the hospital, or to capacity costs. Capacity costs were then divided between "needed" beds and "excess beds" in order to estimate the cost of an excess bed. These excess bed costs were then aggregated to estimate the total cost of excess beds in the study group.

As part of the development of the approach, a review of the literature was performed in order to determine the strengths and weaknesses of the various methods that have been used. In the sections which follow, the results of this review will be discussed as a preface to a discussion of the specific methods and findings of this study.

IV. THE STUDY GROUP

During the 1977-1979 study period, there were 44 hospitals in Orange County. Of these 44 hospitals, 39 are acute general hospitals and 5 are psychiatric or rehabilitation hospitals. The 5 specialty hospitals were excluded from the study because they have substantially different operating characteristics than the acute general hospitals.

Of the 39 general acute hospitals, 18 agreed to participate in the study for all three years. At least one hospital from each of the 7 geographic health facilities planning areas was included in the study group. The group included both proprietary and non-profit hospitals. The study group hospitals ranged in size from 56 beds to 493 beds, with the average being 213 beds. The non-participating hospitals ranged in size from 24 beds to 268 beds, with an average size of 160 beds.

Table 1 presents a statistical comparison of the participating and non-participating hospitals. Table 1 shows that the overall occupancy in Orange County during the study period was low, although it improved from 1977 to 1979. Low occupancy is a preliminary indication that an excess bed condition probably does exist.

The occupancy for the study group is higher than the occupancy for the non-participating hospitals. The lower occupancy for the non-participating hospitals probably reflects the self-selection process. That is, hospitals with low occupancy and excess beds would be less willing to participate in a study of this type. Because of this self-selection, the study group is not a random sample of the hospitals in the County, and the quantitative findings are limited to the group studied. However, the study group does contain more than half of the patient days, revenues, and costs for the County. Hence findings for this group account for the majority of hospital care and hospital costs in Orange County.

TABLE I
 Statistical Comparison of Study Group
 to Non-Participating Hospitals (A)

| | <u>Study Group</u> | <u>Non- Participating Hospitals</u> | <u>Total</u> |
|-----------------------|------------------------|---|--------------|
| <u>1977</u> | | | |
| Number of Hospitals | 18 | 21 | 39 |
| Licensed Beds | 3,838 | 3,341 | 7,179 |
| Average Occupancy (B) | 57.46% | 50.44% | 53.68% |
| <u>1978</u> | | | |
| Number of Hospitals | 18 | 21 | 39 |
| Licensed Beds | 3,838 | 3,363 | 7,201 |
| Average Occupancy (B) | 58.79% | 50.19% | 54.10% |
| <u>1979</u> | | | |
| Number of Hospitals | 18 | 20(C) | 38(C) |
| Licensed Beds | 3,838 | 3,266 | 7,104 |
| Average Occupancy | 60.32% | 52.94% | 56.44% |

(A) Source: California Health Facilities Disclosure Reports

(B) Average of individual hospital occupancies,
 where occupancy = $\frac{\text{patient days} \div 365}{\text{Licensed beds}}$

(C) One hospital was closed in 1979

V. COMPUTATION OF EXCESS BEDS

DEFINITION OF EXCESS BEDS

Although excess beds are alleged to be a major problem with the United States health care system, "the precise meaning of 'excess' as applied to hospital beds, has always been characterized by considerable ambiguity." 11) Excess beds have been defined to be beds which are never used; beds which are seldom used (excess reserve capacity); and beds which are misused (overutilized).

The most common definition of excess beds is based upon an occupancy standard. The 1976 InterStudy recommendations were based on an 85 percent occupancy standard. 1) The 1978 Health Planning Guidelines set a standard of 80 percent for general acute hospitals. 10) Using this guideline, excess beds would be computed as:

$$o \text{ Needed beds} = \underline{\text{average daily census (ADC)}}$$

80%

$$o \text{ Excess beds} = \text{Licensed beds} - \text{needed beds}$$

This type of approach, using an 85 percent occupancy standard, was used by the Orange County Health Planning Council in its 1980 Inventory of Health Services and Facilities to compute estimated excess beds in 1985. Calculations derived from data in the Inventory show: 12)

| | <u>Average Daily Census</u> | <u>Required Beds</u> | <u>Licensed Beds</u> | <u>Excess Beds</u> | <u>Percent of Licensed Beds</u> |
|------|-------------------------------------|--------------------------|--------------------------|------------------------|---|
| 1978 | 3,748 | 4,409 | 6,629 | 2,220 | 33.5% |
| 1985 | 4,598 | 5,430 | 6,629 | 1,199 | 18.0% |

It is statistics like these that give rise to the allegations of substantial excess beds.

VARIABILITY OF HOSPITAL CENSUS

Occupancy standards have played a critical role in the regulation of health providers. There has been considerable controversy regarding what is an appropriate standard. Walter McClure, the author of the 1976 InterStudy report, describes 85 percent as "an average rate which is both efficient and achievable in practice." 1) MacStravic, in a recent article for CHA Insight, comments that "the old Hill-Burton standard of 85 percent still echos in the halls of planning and regulatory agencies, making up in familiarity what it lacks in sense." 13)

Hospitals cannot sustain 100 percent occupancy. They need to maintain a reserve capacity to accommodate fluctuations in the daily census, and to accommodate the different needs of different patients. This reserve capacity, added to the average daily census, constitutes the number of beds that are truly needed. Some of the often-cited 14) reasons for maintaining a reserve capacity include:

- o Random nature of admissions—certain types of admissions are not predictable. For example, obstetrics, perinatal, and intensive care admissions. Capacity must be maintained to accommodate the random nature of these admissions.
- o Certain types of patients require distinct patient facilities. For example, a patient requiring intensive coronary care cannot be accommodated in a normal medical/surgical bed. A hospital may have empty beds, but be "full" in a particular medical service. The more different units there are, the more reserve capacity is required, since a reserve for each unit must be maintained.
- o Within a particular unit, certain patients are incompatible. For example, smokers and non-smokers, males and females, and patients with contagious diseases cannot be placed in the same room. If a hospital has all private (one-bed) rooms, then these constraints add little or nothing to required reserve capacity. For a hospital with three-bed wards, these constraints can dramatically reduce the effective capacity of the hospital.
- o For units where admissions can be scheduled, there is frequently a drop in census over the weekend, because neither physicians nor patients wish to be in the hospital on a weekend.

A number of authors have demonstrated that control over these factors can substantially reduce required reserve capacity. For example, Hancock, et al state that medical/surgical occupancies in excess of 90 percent are achievable through admissions scheduling. 15)16) Gianfrancesco documents that a reduction in reserve capacity is possible if specialization (distinct patient facilities) is eliminated. 17) "Thompson and Fetter examined the implication of (patient incompatibility) restrictions for the attainable occupancy of a medical/surgical service. They concluded that if there is the potential to transfer patients from one room to another, patient incompatibilities have a negligible effect on attainable occupancy." 18)

This idea that census fluctuations can be controlled and occupancy standards raised is attractive to regulators. For example, the California Statewide Method for Estimating Bed Requirements, in commenting upon occupancy patterns, states: "The census is generally lower on weekends than during weekdays. This pattern is one largely determined by preference. Both physicians and patients often prefer that admission be deferred until a weekday and that discharge be arranged before the weekend. This practice may be endorsed by hospital management when it is

difficult to arrange weekend staffing at the same levels used during the week. Statewide policy does not provide for planning for excess capacity to accomodate such available variations in census, and thus no provisions have been explicitly made for it" 19)

It should be pointed out that much of the work which concludes that higher occupancy standards are achievable through control over census variability consists of simulations of what would happen if such controls were possible, not analysis of actual data. 15)16)18)

In the real world of hospital administration, admission scheduling may not be possible because of medical staff resistance. Special care units and other distinct patient care facilities exist and are maintained in order to care for patients in the most appropriate way. Patient incompatibilities do prevent beds from being filled, because both patients and physicians resist room transfers for the convenience of the hospital. Notwithstanding Statewide policy, there is a drop in census over the weekends to accomodate patient and physician preferences. As MacStravic points out, "whether such controls (of census variability) can be implemented in every hospital is open to question." 20)

USE OF STATISTICAL DISTRIBUTIONS TO MODEL CENSUS VARIABILITY

Although the impact of all of the above factors on an individual patient is not necessarily random, the combined impact of these factors on a population of patients is random. As a result, the distribution of average daily census data will generally look like a normal distribution--the well known "bell shaped curve." This fact has proved important to health planners, because it is possible to relate a given occupancy standard to a turnaway probability--the probability that a patient will arrive and be turned away because there is no bed available. The key factor which relates a given occupancy standard to a turnaway probability is the variability of the average daily census, as measured through the standard deviation. The greater the variability (standard deviation), the higher the turnaway probability at a given level of occupancy. As an illustration, Figure 1 shows two hypothetical distributions of average daily census. At the same level of occupancy, they have dramatically different turnaway probabilities.

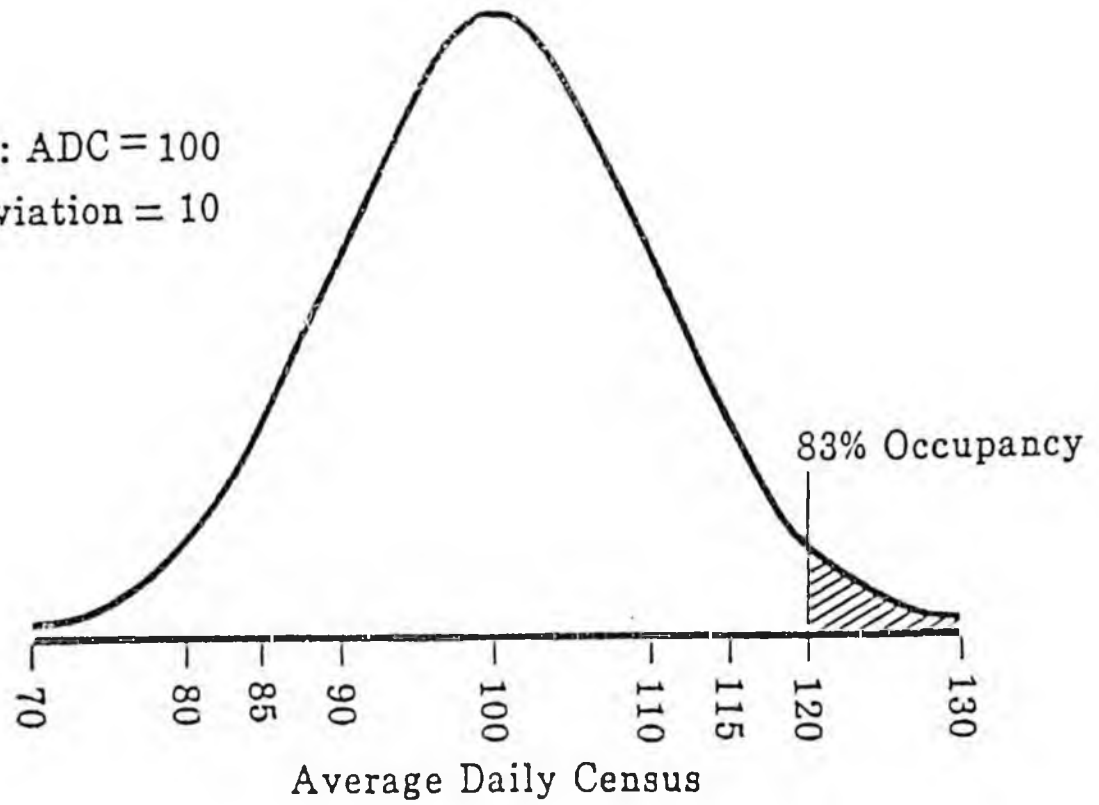
Case A has an average census of 100, and a standard deviation of 10. At an occupancy standard of 83 percent, 120 beds are "needed." At this level of beds, the turnaway probability is about 2 percent. In other words, patients will be turned away about seven days out of the year.

Case B has considerably more variability as indicated by a standard deviation of 20. The bell shaped curve is flatter. There is less clustering in the middle and more incidence of extreme values. At the same 83 percent occupancy standard, the turnaway probability rises to about 16 percent, or 58 days out of the year.

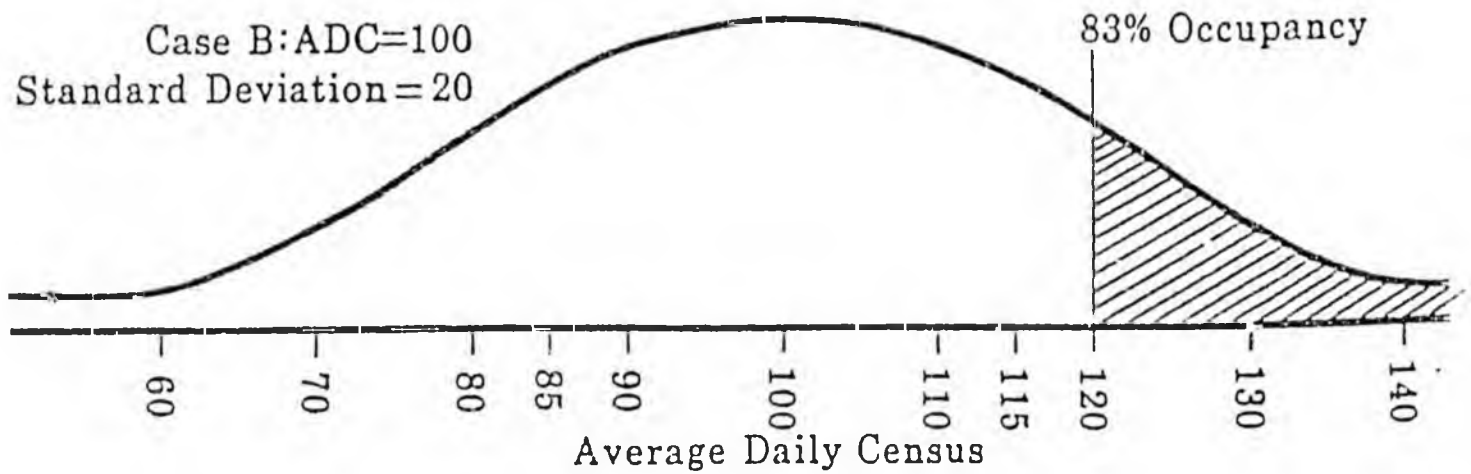
Figure 1:

Two Hypothetical Distributions of Average Daily Census

Case A: ADC = 100
Standard Deviation = 10



Case B: ADC = 100
Standard Deviation = 20



THE POISSON MODEL

A frequently used model for hospital census is a special case of the normal distribution, called the Poisson distribution. In the Poisson distribution, the standard deviation of the distribution is equal to the square root of the average daily census (mean). Case A is an example of a Poisson distribution, since the standard deviation is 10, which is equal to the square root of the average daily census ($\sqrt{100}$). This statistical model is particularly convenient, since all it requires is a single value (average daily census) to estimate both the mean and the variability of the distribution.

OFFICE OF STATEWIDE HEALTH PLANNING STANDARDS

Although the Poisson model is widely used, a number of studies have shown that it is not an accurate reflection of the distribution of hospital use (see for example, MacStravic 20)). The California Office of Statewide Health Planning and Development (OSHPD) has developed standards for needed beds based upon a statistical model which results in needed beds estimates higher than the values which would result from the Poisson distribution. The OSHPD standards are intended for application to a health facilities planning area, and not an individual hospital.

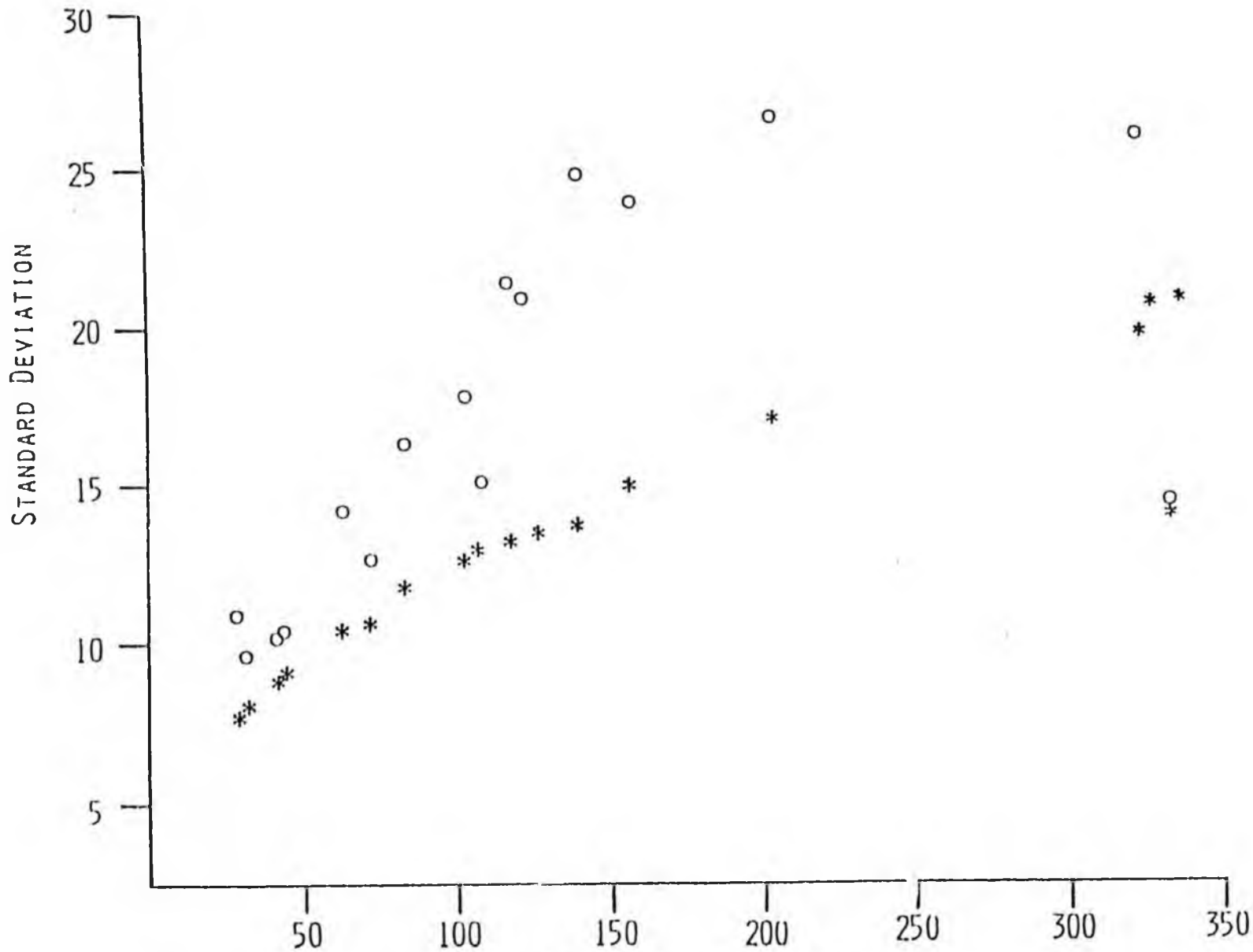
EMPIRICAL ANALYSIS OF ACTUAL DISTRIBUTION OF ADC

Daily census values were collected for three years from the 18 study hospitals. In total, fifty-four years of data (3 x 18) were collected. For each year, the average daily census, the standard deviation, and frequency distribution were computed.

The actual frequency distributions were compared to a normal distribution specified with the empirical mean and standard deviation. The Kolmogorov-Smirnov one sample test was used to assess whether or not the actual distributions conformed to a normal distribution. 21) For all hospitals and years except one, the actual distribution was not significantly different from the normal distribution at the .01 significance level. We conclude that the distribution of average daily census values is a normal distribution.

Having established that the population is normal, we compared it to a Poisson normal distribution. We compared the actual variability (standard deviation) to the variability that would be associated with a Poisson normal distribution (i.e., standard deviation equal to \sqrt{ADC}). Figure 2 portrays the results for 1979. As shown in the figure, the observed variability (standard deviation) was always greater than the Poisson estimate. Similar results were obtained for 1977 and 1978. We conclude that a Poisson normal distribution does not fit the actual data, and would consistently underestimate the beds required to accommodate the peak periods actually observed in the data.

* POISSON ESTIMATE ADC
 o OBSERVED STANDARD DEVIATION



* 1979 DATA ONLY--SIMILAR PATTERN OBSERVED IN 1977 AND 1978

ESTIMATE OF NEEDED BEDS

We assumed that a turnaway probability of 5 percent (18 days a year) was appropriate for an individual hospital. Using this probability, needed beds were computed for each hospital for each year using the following formula:

$$\text{Needed beds} = \text{ADC} + 1.645 \times \text{standard deviation.}$$

The 1.645 factor is an estimate of reserve capacity required so that patients are turned away one time out of twenty (5 percent). Table 2 summarizes the results for the study group.

Note that the occupancy standard implicit in the selection of a 5 percent turnaway probability ranges from 82 percent to 83.3 percent as ADC increases. This result is consistent with MacStravic's findings for clusters of hospitals 20) and slightly higher than the standard computed from OSHPD guidelines 19).

ESTIMATE OF EXCESS BEDS

The common computation for excess beds is: licensed beds - needed beds = excess beds. This computation ignores the fact that not all the beds on the license may in fact physically exist. It is not uncommon, particularly in older hospitals which have renovated their plant, to have space that was originally used for nursing units being currently used for some other purpose. Another situation is where a small multi-bed room is being used as a semi-private or private room. Hospitals make these adjustments in response to the demands and needs of patients, physicians, and employees. We will call beds on the license that do not physically exist "phantom" beds. Phantom beds are commonly included in the count of excess beds. If the hospital's license were changed, then these beds would not be counted. It is difficult to imagine what cost savings would accrue to the community solely as a result of a change in licensed beds. For this reason, we attempted to determine the number of phantom beds, so that they could be eliminated from the count of excess beds.

Management from each hospital in the study group was asked two questions:

- o How many beds could you put into service within twenty-four hours without eliminating space currently being used for other productive purposes? (Assume sufficient staff would be available.)
- o If the three hospitals closest to you closed over the weekend, how many patients could you take on Monday? (Assume sufficient staff would be available.)

TABLE 2
 Estimate of Needed Beds for Study Group
 Turnaway Probability = .05

| <u>Year</u> | <u>ADC</u> | <u>Needed Beds</u> | <u>Implicit Occupancy Standard</u> |
|-------------|------------|------------------------|--|
| 1977 | 2,211 | 2,694 | 82.0% |
| 1978 | 2,302 | 2,787 | 82.6% |
| 1979 | 2,401 | 2,883 | 83.2% |

The point of these two questions was to determine the number of available beds at the hospital. The difference between this number and the number of licensed beds is considered to be phantom beds.

The available bed results obtained in this manner were basically consistent with available beds reported on the California Health Facilities disclosure report.

Table 3 presents a summary of findings for the three years 1977-1979. Table 4 presents a comparison to the conventional computation. Note that the average daily census is growing at approximately 4.3 percent per year. At that rate of compound growth, assuming an 83 percent occupancy standard, then needed beds would approximate available beds in 1985. Note also that the reserve beds component remains relatively constant over the three years.

True excess beds are going down as ADC increases. The average level over the three years was 18 percent. This amount is far lower than the 29 percent that would be developed with the conventional computation. 2 percent of the difference is accounted for in the use of an 82-83 percent occupancy standard, versus 85 percent. However, the majority of the difference is the 9 percent of the licensed beds which are phantom beds.

CONCLUSION

Analysis of actual average daily census data in the study group confirms that average daily census distributions are normal. Observed variability in the data exceeded the variability predicted from a Poisson-normal model. Use of Poisson models to estimate bed need will understate the true beds needed to accommodate the fluctuations in daily census.

Conventional computations of excess beds first compute needed beds as average daily census divided by an occupancy standard, and then subtract this amount from licensed beds. 85 percent is the current generally used standard.

Needed beds for the study group were determined using a 5 percent turn-away criteria for individual hospitals. The resulting occupancy standard was 82-83 percent. This result is consistent with the findings of MacStravic 20) and OSHPD guidelines 19).

In computing excess beds, beds not physically available were subtracted from licensed beds. The resulting available beds were compared to needed beds. The average level of excess beds was determined to be 18 percent of licensed beds. This amount is significantly smaller than the 29 percent figure arrived at through the conventional computation.

We conclude that there are a substantial number of excess beds in the study group, but the true level of excess beds is significantly below the result obtained through the conventional computation.

TABLE 3
 Components of Bed Complement
 1977-1979

| | 1977 | | 1978 | | 1979 | |
|----------------------|---------------------|--------------------|---------------------|--------------------|---------------------|--------------------|
| | <u>Amount</u> | <u>Percent</u> | <u>Amount</u> | <u>Percent</u> | <u>Amount</u> | <u>Percent</u> |
| Average daily census | 2,211 | 58% | 2,302 | 60% | 2,401 | 63% |
| Reserve beds | <u>483</u> | <u>12</u> | <u>485</u> | <u>13</u> | <u>482</u> | <u>13</u> |
| Needed beds | 2,694 | 70 | 2,787 | 73 | 2,883 | 75 |
| Excess beds | <u>816</u> | <u>21</u> | <u>683</u> | <u>18</u> | <u>635</u> | <u>17</u> |
| Available beds | 3,510 | 91 | 3,470 | 90 | 3,518 | 92 |
| Phantom beds | <u>328</u> | <u>9</u> | <u>368</u> | <u>10</u> | <u>320</u> | <u>8</u> |
| Licensed beds | <u><u>3,838</u></u> | <u><u>100%</u></u> | <u><u>3,838</u></u> | <u><u>100%</u></u> | <u><u>3,838</u></u> | <u><u>100%</u></u> |

TABLE 4
Comparison of Study Results to Conventional Computation

| | <u>Study Results</u> 1977-1979 Average | | <u>Conventional</u> <u>Computation</u> at 85% Occupancy | |
|----------------|--|--------------------|--|--------------------|
| | <u>Amount</u> | <u>Percent</u> | <u>Amount</u> | <u>Percent</u> |
| | Average daily census | 2,305 | 60% | 2,305 |
| Reserve beds | <u>483</u> | <u>13</u> | <u>407</u> | <u>11</u> |
| Needed beds | 2,788 | 73 | 2,712 | 71 |
| Excess beds | <u>711</u> | <u>18</u> | <u>1,126</u> | <u>29</u> |
| Available beds | 3,499 | 91 | 3,838 | 100 |
| Phantom beds | <u>339</u> | <u>9</u> | <u>0</u> | <u>0</u> |
| Licensed beds | <u><u>3,838</u></u> | <u><u>100%</u></u> | <u><u>3,838</u></u> | <u><u>100%</u></u> |

THE ROEMER EFFECT

The Roemer effect in essence states that patient days expand to fill the beds available. Hence in an area with a substantial number of excess beds, it would be expected that the relative use of hospital facilities would be higher than in areas without excess beds. One of the assumptions frequently used to project savings from reducing the bed supply is that reducing beds will curtail unneeded hospitalization that is assumed to take place in an overbedded area.

It is clear from our study that the study group and Orange County in general does have a substantial number of excess beds. If the Roemer effect is valid, then we would expect to see relatively higher utilization in Orange County relative to other areas in California and in the country.

It was not possible to develop use rates for the study group hospitals because the population served by these hospitals is the same population served by non-participating hospitals. However, a review of data published by the California Hospital Association disclosed the following use rates (patient days per thousand population) for 1976: 22)

| | |
|---------------|---------|
| Orange County | 815.9 |
| California | 866.5 |
| United States | 1,204.3 |

Orange County is lower than the California average, and well below the national average. While not conclusive, these statistics do not support the idea that there was substantial overutilization of hospital facilities at a time where there were excess beds. It is not clear that the Roemer effect is valid, at least for Orange County.

VI. COST ESTIMATES

COMPUTATION OF COST OF EXCESS CAPACITY

Economic estimates of the cost of excess capacity generally proceed according to the following method:

- o $\frac{\text{Excess beds}}{\text{Total beds}} = \text{Percent excess capacity}$
- o $\text{Percent excess capacity} \times \text{fixed cost percent} = \text{percent savings from capacity reduction.}$

Computations of this type have resulted in savings estimates ranging from 12 percent to 16 percent of annual hospital expenditures.

ECONOMIC ESTIMATES

Central to the belief that excess beds are costly is the idea that hospitals have high fixed costs--costs which must be sustained at any level of activity. Estimates of the savings that would result from the reduction of capacity generally assume that entire hospitals are closed, and all of the fixed cost associated with operating the hospital is avoided.

The economic studies in the middle 1970's assumed that fixed costs represented over half of a hospital's total costs. The InterStudy report uses 50 percent as the estimate of fixed costs. 1) Zaretsky uses 60 percent in his 1977 study. 3)

These economic estimates of high fixed costs are based on econometric studies of the marginal cost/average cost (MC/AC) ratio. This ratio represents an estimate of the proportion of average cost that would be incurred to take care of an additional case or patient day. It is commonly interpreted as the proportion of costs which are variable. Hence $1 - (\text{MC/AC})$ is taken to be the proportion of costs which are fixed.

Early values of the MC/AC ratio were developed by Lave and Lave in 1972. Their conclusion was that "marginal cost is between 40 and 65 percent of average cost." 5) Hence, if variable cost is 40 percent, fixed cost is 60 percent. This assumption was used by the Federal government in developing the Phase IV Economic Controls Program for hospitals and was also used in all the early estimates of excess capacity costs.

A number of other economic authors have studied this issue with widely varying results. Lipscomb, et al surveyed this work in 1978. 23) There was considerable variability in the estimates arrived at. The MC/AC ratio was estimated to range from 21 percent to 105 percent. This wide range makes the selection of an appropriate variable and fixed cost ratio for purposes of estimating savings from excess bed reductions a highly judgmental process. In a recent article by Schwartz and Joskow, 11) the

authors review the Lipscomb survey and conclude that 80 percent is a "best guess" of the marginal cost/average cost ratio. They point out that the amount could easily range from 60 percent to 90 percent. Using the related fixed cost proportion of 20 percent and a 7 percent capacity reduction, these authors conclude that the potential savings are slightly in excess of 1 percent of total hospital expenditures—a significantly lower result than previously estimated.

Although $(1-MC/AC)$ is commonly used to estimate the proportion of costs which are fixed, and the savings that would result from a capacity reduction, there is a theoretical problem inherent in the use of this ratio. This problem has to do with the relevant range for making estimates. Lipscomb, et al point out that "the (MC/AC) ratios . . . are most reliable (in a predictive sense) for output levels in the neighborhood of the mean output levels, with which they were derived." 23) However, all authors acknowledge that the most significant savings would result from closing entire hospitals. 1)3) Although $(1-MC/AC)$ may estimate the fixed cost proportion for a hospital at its average level of output, there is no assurance of the accuracy of this proportion if a hospital were to be closed down and have its output reduced to zero.

In summary, the economic estimates of the savings that would result from the reduction of capacity vary from a savings of 16 percent of expenditures associated with a 20 percent reduction in beds 1) to a savings of 1 percent of expenditures associated with a 7 percent reduction in beds. 11) This variability is a direct result of the assumptions employed for the MC/AC ratio and the complementary fixed cost ratio. In addition, there is some theoretical question as to the applicability of MC/AC ratios derived at mean levels of output to a situation where entire hospitals would go from mean output levels to zero output levels.

HOSPITAL INDUSTRY ESTIMATES

The contention that hospitals have very high fixed costs has been repeatedly denied by representatives of the hospital industry. In a report published in the Investor Owned Hospital Review in 1975, an estimate of 10 percent was put forward. 24) A financial executive for a major proprietary hospital chain was quoted in 1978 as saying, "The fixed costs of an empty bed in his corporation's hospitals are only 8.5 percent of the costs of a full bed." 25) The estimates provided by industry representatives are typically based upon the way a hospital classifies its costs.

Salaries, employee benefits, professional fees, supplies, and purchased services are typically classified as variable. Only interest and depreciation are viewed as "capacity" costs, in that they relate directly to the original acquisition of the assets. According to the California Health Facilities Commission, these costs accounted for approximately 5 percent of total hospital costs in Orange County during 1978. 4)

Critics of this approach point out that depreciation is based upon the historical cost, and understates the true cost of capacity in a replacement sense. They also point out that none of these are fixed costs in salaries, supplies, and purchased services (e.g., utilities) that are not included in the cost estimate.

POLICY ALTERNATIVES

In the 1976 InterStudy report, Walter McClure points out that "the savings produced by reducing excess hospital capacity could be substantial, but depend crucially on how it is done." 1) Four major alternatives have been identified: 1)3)11)

- o Across-the-board bed reductions;
- o Retiring services in individual hospitals;
- o Closing entire institutions; and
- o A moratorium on new construction (through a tight certificate of need program).

Virtually all authors agree that across-the-board bed reductions and retirement of individual services produce small savings. Hence, closing institutions or a moratorium on new construction seem to offer the potential for the greatest savings.

There are a number of problems associated with the policy of closing hospitals. In the first place, no agency of government is empowered to take this action. As the 1978 Health Guidelines point out, "Health Systems Agencies have no authority under Federal law to close existing hospitals or services, nor is the Federal government authorized to do so." 10)

Even if government regulators had the authority to close hospitals, it is unclear that it could be used. In a 1979 InterStudy report entitled Conversion and Other Policy Options to Reduce Excess Hospital Capacity, McClure and Kligman reported the results of 17 case studies. They conclude that "financial pressure, not planning pressure, appear to be the principal agent in retiring a hospital." They go on to state, "we suspect planners will have great difficulty acquiring authority to close hospitals on 'necessity' grounds, and even greater difficulty trying to exercise it if they do get it . . . Attempting to close an unnecessary hospital by delicensure in the absence of financial pressure violates the basic tenets of regulatory behavior." 26)

The remaining policy is a moratorium or set of controls over hospital construction/capital expenditures. It is asserted that this policy will ultimately result in the same savings that would be achievable through closure of hospitals. 1)3)11) This is in fact the policy that is being executed through the certificate of need laws in California and elsewhere. This policy is not directed at fixed costs, but at capital expenditures. It is felt that control over capital expenditures will limit the capacity costs of hospitals, where capacity costs are those

costs associated with the maintenance, replacement, or expansion of capital assets. Tight controls over capital expenditures and capacity costs are viewed as especially relevant in areas such as Orange County with substantial excess capacity, as measured by excess beds.

CONSUMER APPROACH

The cost analysis approach taken in this study was to determine what portion of the money actually paid by consumers was used to maintain, replace, expand, and pay off the debt on hospital plant assets. These costs are termed capacity costs, and are differentiated from the money paid by consumers for day-to-day operation of the hospital. Capacity costs are the costs which are the object of regulatory control. Essentially we were trying to test the assertion that a tight certificate of need program would result in substantial savings to the consumer, insurance companies, and government third-party payers. We have termed this approach the consumer approach, since it focuses on the money actually paid by consumers and insurers.

The starting point for this approach is annual hospital net revenue. This is the amount of money paid or payable to hospitals from consumers or insurers. Net revenue is then divided into two classifications: operating costs and capacity costs. Operating costs include the money spent to operate the hospital, except for the costs associated with the Housekeeping, Operation of Plant, and Maintenance of Plant cost centers. Increases to working capital constitutes an increase to operating costs. Working capital decreases reduce operating costs.

Capacity costs are monies expended or put aside to maintain, renovate, replace, or pay off debt on plant assets. Capacity funds include Housekeeping costs, Operation and Maintenance of Plant costs, interest and principal payments on long-term debt originally used to finance capital equipment, the equity portion of capital expenditures for renovation and replacement of capital assets, and the funding of reserves which will be used to finance future asset additions. To the extent that capacity costs were paid from sources other than net revenue from patients, (e.g., withdrawals from funded reserves or new long-term debt) these sources are subtracted from total capacity costs to arrive at the portion funded by net revenues from patients.

Capacity costs can be further subdivided into costs related to patient rooms (beds) and costs related to capacity for ancillary and support services. This division is accomplished either through specific identification of capacity costs to their purposes, or through an allocation based upon square feet.

Capacity costs can fluctuate from hospital to hospital and from year to year. For example, a major construction program will increase capacity costs for one year. The same hospital will have a much lower level of capacity costs the following year after the construction project is completed. In order to smooth out the fluctuations, totals for the study group and averages across three years are used.

In summary, the consumer approach is directed at identifying that portion of the money actually paid to hospitals by consumers that was used to maintain, renovate, replace, and pay off the debt on hospital plant assets. It is these same funds that are the object of certificate of need regulation.

ANALYSIS OF EMPIRICAL DATA

For each study group hospital for each year, CHFC financial statements were obtained and analyzed. Capacity costs were identified from the departmental income statement and the sources and applications of funds statement. Interviews were conducted with financial officers of each study group hospital to specifically identify capacity costs as bed-related or non-bed-related. Capacity cost and bed-capacity cost were divided by total available beds in order to determine per bed capacity costs. These per bed amounts were applied on a hospital by hospital basis to the estimated excess beds in order to arrive at the estimated cost of excess beds. These excess bed costs were aggregated for all hospitals.

Table 5 shows the total operating and capacity costs for the three years in the study. Table 6 shows the results of the apportionment of capacity costs between beds and other capacity.

The Estimated Cost of Excess Capacity appears in Table 7. These estimates were developed by apportioning capacity costs between the needed beds (at a 1 in 20 turnaway probability) and excess beds. Phantom beds were not included in the analysis. In this context, the proportion of excess beds to available beds is used as an estimate of excess capacity. Given the assumption that excess beds measure excess capacity, then Table 7 shows that an average 18 percent excess capacity condition cost the consumer 3.15 percent of his annual expenditures on hospital care. This amount approximates \$8.60 per patient day, or \$10,400 per excess bed per year.

Table 7 also shows the outcome when the study results are focused on beds per se. These estimates reflect an apportionment between bed related capacity funds and other capacity funds. Of the 3.15 percent excess capacity cost estimate, .75 percent related to beds and 2.4 percent related to other capacity. The excess bed cost averaged \$3.03 per patient day and \$3,640 per excess bed.

TABLE 5
 Apportionment of Net Patient Revenue
 (000's Omitted)

| | <u>1977</u> | <u>1978</u> | <u>1979</u> |
|---|------------------|------------------|------------------|
| Net patient revenue | <u>\$291,508</u> | <u>\$339,356</u> | <u>\$392,222</u> |
| <u>Operating Costs</u> | | | |
| Salaries, benefits, fees, supplies | \$244,661 | \$290,058 | \$331,582 |
| Income taxes | 2,264 | 1,612 | 2,580 |
| Increase in working capital | 4,729 | 2,941 | 7,997 |
| Increase in non-current assets related to operations | 5,767 | 1,448 | 417 |
| Less: Non-operating revenue related to operations | <u>(1,333)</u> | <u>(1,967)</u> | <u>(1,717)</u> |
| NET OPERATING COSTS | <u>256,088</u> | <u>294,092</u> | <u>340,859</u> |
| <u>Capacity Costs</u> | | | |
| Housekeeping and plant maintenance expenses (including utilities) | 19,156 | 22,476 | 25,026 |
| Purchase of property, plant, and equipment | 30,245 | 12,419 | 22,008 |
| Interest | 7,998 | 8,305 | 9,991 |
| Principal payments | 6,920 | 3,357 | 3,196 |
| Increase in assets designated for future acquisition of property | 723 | 2,757 | 683 |
| Increase (decrease) in non-current assets related to capacity | <u>(996)</u> | <u>2,631</u> | <u>(771)</u> |
| Less: Additional long-term debt Non-operating revenue related to capacity | <u>(26,989)</u> | <u>(3,640)</u> | <u>(3,653)</u> |
| NET CAPACITY COSTS | <u>35,420</u> | <u>45,264</u> | <u>51,363</u> |
| TOTAL OPERATING AND CAPACITY COSTS | <u>\$291,508</u> | <u>\$339,356</u> | <u>\$392,222</u> |
| <u>Capacity Costs as Percent of Net Patient Revenue</u> | <u>12.2%</u> | <u>13.3%</u> | <u>13.1%</u> |

TABLE 6
 Apportionment of Capacity Cost Between Beds and Other Capacity
 (000's Omitted)

| | <u>1977</u> | <u>1978</u> | <u>1979</u> |
|---------------------------------------|-----------------|-----------------|-----------------|
| Bed capacity cost | \$11,276 | \$11,807 | \$15,820 |
| Other capacity cost | <u>24,144</u> | <u>33,457</u> | <u>35,543</u> |
| Total Capacity Cost | <u>\$35,420</u> | <u>\$45,264</u> | <u>\$51,363</u> |
| Bed-capacity cost as percent of total | <u>31.8%</u> | <u>26.1%</u> | <u>30.8%</u> |

TABLE 7
 Estimated Cost of Excess Capacity
 (000's Omitted)

| | <u>1977</u> | <u>1978</u> | <u>1979</u> | <u>Average</u> |
|-------------------------------------|-------------|-------------|-------------|----------------|
| Net patient revenue | \$291,508 | \$339,356 | \$397,222 | |
| Excess beds | 816 | 683 | 635 | 711 |
| Patient days | 807,015 | 840,230 | 876,365 | 841,203 |
| <u>Excess Capacity Cost</u> | | | | |
| Total excess capacity cost | \$ 6,788 | \$ 7,290 | \$ 7,673 | |
| Percent of net patient revenue | 2.33% | 2.15% | 1.96% | 2.15% |
| Per excess bed (in dollars) | 8,319 | 10,674 | 12,085 | \$ 10,360 |
| Per patient day | \$8.41 | \$8.68 | \$8.76 | \$8.62 |
| <u>Excess Bed Capacity Cost</u> | | | | |
| Total excess bed capacity cost | \$ 2,463 | \$ 2,393 | \$ 2,795 | |
| Percent of net patient revenue | .84% | .71% | .71% | .75% |
| Per excess bed (in dollars) | 3,018 | 3,504 | 4,402 | \$ 3,641 |
| Per patient day | \$3.05 | \$2.85 | \$3.19 | \$3.03 |

CONCLUSION

Economic estimates of the cost of excess beds/capacity range from a potential for a 16 percent savings associated with a 20 percent capacity reduction to a potential for a 12 percent savings associated with a 22 percent capacity reduction. These estimates rely heavily on an assumed proportion of fixed costs which exceeds half of total costs. Estimates of this fixed cost proportion are not consistent, and of questionable reliability for that reason. In addition, these estimates assume that entire hospitals are closed, presumably through government action. Hospital closure is a policy alternative that is neither legal nor likely to be particularly effective if it were legal.

The policy alternative that is in fact being executed is a tight certificate of need program. This program is alleged to have the same cost reduction potential as closure of hospitals. A certificate of need program focuses specifically on capital expenditures and more generally on the level of funds required to maintain, renovate, or replace capital assets.

Direct measurement of money actually paid to hospitals that went to maintain, renovate, replace, or provide for capital assets resulted in much lower estimates of potential savings. Over the three year study period, these capacity funds averaged 18.5 percent of hospital net revenue. During a time period when an excess beds/capacity condition of 18 percent prevailed, the costs associated with this excess amounted to only 3.2 percent of hospital expenditures. The costs associated with excess beds per se were only .76 percent of hospital expenditures.

* We conclude that a tight certificate of need program will not yield savings that are even close to the 10-16 percent of expenditures estimates. - They are directed at costs which in total account for less than 20 percent of hospital expenditures. Since a substantial majority of these capacity costs are for the purposes of maintaining and enhancing "non-excess" capacity, then potential savings must fall well below 5 percent.

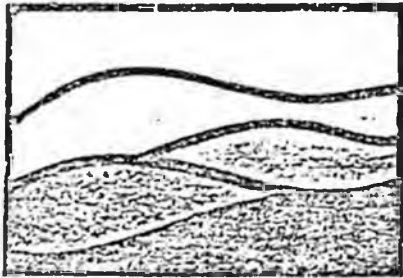
We also conclude that the regulatory focus on beds per se is even less likely to yield significant results. Beds are not a good measure of capacity in the first place, and the funds to maintain beds per se are a trivial portion of the total.

Based upon the analysis presented in this paper, the basic assumption that excess beds are costly--an assumption which is at the foundation of current health planning law and regulation--is open to serious challenge. It is unclear that there are significant costs associated with excess capacity in Orange County hospitals. It is then equally unclear whether a policy directed at capacity control can ever succeed in impacting the costs of health care to the consumers of Orange County.

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Transition Briefing Memo

21

October 28, 1982

1. CERTIFICATE OF NEED IS STILL PLANNING'S "CENTER RING" ACTIVITY

Despite the fact that 15 states have written "sunset" provisions to end Certificate of Need in the next two years, review of proposed capital investments is still the number one priority of many State Agencies and HSAs.

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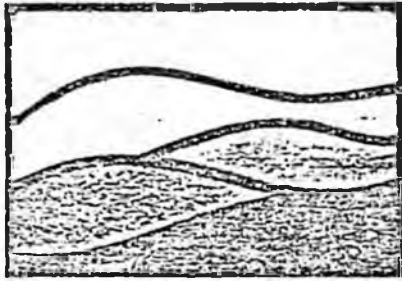
Western Center for Health Planning

703 MARKET STREET - SUITE 535 · SAN FRANCISCO, CALIFORNIA 94102 · (415) 546-7601

Sponsored by the Western Consortium for Continuing Education for the Health Professions, Inc., Schools of Public Health and University Extensions, University of California at Berkeley, University of California at Los Angeles, University of Hawaii. Affiliate: Graduate Program in Health Services Administration, University of Southern California.

CORRECTION

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Assistant Secretary for Health*, the consultants made the following findings:

- CON has been an effective inhibitor of rising capital expenditures in a study of five states (Colorado, Florida, Maryland, Massachusetts and Oregon), in the period 1974-78;
- CON/capital expenditures review programs were successful in averting 13 percent of hospital projects and saving 16 percent of the proposed capital investments;
- The CON process is not dominated by teaching hospitals or facilities with higher rates;
- CON programs have a dampening effect on the amount of capital investment in the state;
- New capital investments increase costs--over a 10-year period \$1 of new capital is estimated to generate \$1.84 of additional operating costs, in constant dollars;
- Increases in operating costs due to new capital investment was highest in proprietary hospitals (\$0.33), compared with government (\$0.20) and community hospitals (\$0.16);
- Capital investments in equipment generate a larger increase in annual operating costs; and
- If every hospital annually reinvested 5 percent of its operating budget in new capital stock (beds, equipment, other), the operating costs would be increased by 10 percent each decade even without inflation.

The consultants concluded that if competitive approaches to controlling health care costs are to succeed, it may be necessary to continue capital expenditure review programs and controls until cost-reducing competitive systems are functioning. They predict the immediate effect of deregulating

*Development of an Evaluation Methodology for Use in Assessing Data Available to the Certificate of Need (CON) and Health Planning Programs", Final Report, Arthur D. Little, Inc., Cambridge, MA, April, 1982.

hospital investment in the name of competition will be a surge in hospital operating expenditures. Health Planning has the potential to significantly lower hospital costs, an important policy finding in light of the Administration's proposed elimination of both planning and Certificate of Need.

2. ROCHESTER'S "MINICAP" PROJECT reported a 10 percent increase in hospital costs in 1982, barely half the national rate of 18.7 percent. Nine Rochester (New York) hospitals are participating in the second year of a five-year experiment in voluntarily living within a community-wide revenue cap.

The Rochester program was profiled in the Western Center's recent conference "Hospital Rate Regulation: Lessons for California from Mandated and Private Approaches". Hospitals improved their fiscal position this year with all nine in the black despite declining admissions and a difficult economy. The experimental reimbursement program provides predictable income, greatly enhancing liquidity and cash position. New York hospitals are under great financial pressure now with nine out of ten voluntary hospitals operating in the red for at least two of the five years from 1974-78. The Rochester experience is demonstrating that implementing a voluntary financial discipline -- with appropriate mechanisms -- can be beneficial both to the hospitals and the community. The program, with cooperation of the local Health Systems Agency and State agency has allowed service improvements and capital investments in the hospitals. A contingency fund helps hospitals adjust to changes in patient volume during the year, and subsidizes operating revenues for approved Certificate of Need projects.

A copy of the report, "Affordable Health Care: Rochester Area Hospitals Strategies for the 80's," is available from the Western Center's Reference Service. For more information about the program, contact James A. Block, M.D., President, Rochester Area Hospitals' Corporation, 220 Alexander Street, Suite 608, Rochester, New York 14607.

3. SPECIAL PLANS AND PROJECTS

Congressional extension of funding for health planning suggests that the emphasis upon "transition" may be shifting back to planning. A number of agencies have developed special plans, or intend to do so in the coming year. These "special plans" are often the outcome of studies or implementation efforts. The special plans are usually problem-specific, or focus on the special health needs of a particular population group or region within the Health Service Area. Outside

funding or "co-production" with a cooperating agency has made a number of these special plans possible.

Western Center staff have developed a list of possible "special plans" which HSAs and State agencies might develop, including:

- "Year 2000" Health Plan
- Regional Capital Investment Plan
- Community Health Promotion Plan
- Regional "Quality of Life" Assessment
- Medicaid Plan
- Health Plan for the Aged
- Community Services Cutback Plan
- Block Grant Plan
- County Health Plan (City or other local region)
- "Boomtown" Plan
- Categorical Disease Plan, e.g., Regional Cardiac Care Plan
- Rural Health Plan
- Facility-Specific Plan, e.g., Free-standing Emergency Rooms Plan

The Center is conducting a survey in November of all HSA special plans. The result will be a published compendium of all of the plans, with a short description, funding, outside resources and responsible staff. The special plans will be abstracted for computerization as part of a national project by all three Centers to develop a "Plan Document File" for computerized search of all plans developed by Health Systems Agencies and State planning agencies. Copies of the special plans will be available through the Western Center's Reference Service. For information, contact Rus Coile, Western Center staff, telephone: (415)546-7601.

This project has been funded with Federal Funds from the Health Resources Administration, Department of Health and Human Services, under contract ERA 232-79-0037. The contents of this publication do not necessarily reflect the view or policies of the Department of Health and Human Services, nor does mention of trade names, commercial products, or organizations imply endorsement by the U.S. Government.



**South Central
Health Planning and Development, Inc.**

1135 West Eighth Avenue • Suite 1 • Anchorage, Alaska 99501

(907) 278-3631

April 11, 1983

Joe Josephson
Alaska State Senate
Pouch V
Juneau, Alaska 99811

Dear Senator Josephson:

As you consider Committee Substitute for Senate bill 85 "An act suspending the Certificate of Need program" we would hope that you would consider the following additional information.

Health care costs continue to rise at rates higher than other sectors of the economy. In the last federal fiscal year health care costs rose 11.4%, more than double the overall rate of inflation. Hospital costs rose 15.2%. The consumer price index for medical care for Anchorage rose 12.3% between January, 1981 and January, 1982.

The only cost containment provision that would remain on the books in Alaska if CSB85 were to pass would be the prospective reimbursement section which addresses only Medicare reimbursement. The revenue sharing portion does reduce state funds for hospitals as well. However, there is nothing remaining to address hospital cost increases overall, no protection for the consumer.

You should also be aware that while Alaska is considering the rather drastic action of suspending the Certificate of Need program, other states are strengthening theirs. In addition, Congress has just finished deliberating and passed provisions within the Social Security bill which will have significant impact on the regulation of capital expenditures. The relevant parts of the final version of the bill (as it was resolved in conference agreement) are attached. Generally, they say:

- 1) that there will be a form of prospective reimbursement adopted nationwide,
- 2) that Medicare will continue to reimburse facilities on a reasonable-cost basis until 1986,
- 3) that at that time Medicare payment related to new capital projects will be made only if a State has a capital expenditures review mechanism (1122) in place,
- 4) that the maximum threshold a State may use for determining which capital projects are subject to the Section 1122 review process would be increased from \$100,000 to \$600,000.

Page two

Alaska is not currently contracting with the Federal government to do Section 1122 reviews because they so closely parallel (duplicate) the Certificate of Need Review. If our Certificate of Need law is suspended or repealed and not replaced with 1122 right away, this could have the effect of creating a three year window on capital expenditures review. This might prove detrimental as there would be the incentive to "build it all now" by existing facilities and by outside facilities looking at Alaska as a new market.

We would be glad to discuss this further with you. Please don't hesitate to call me or Susan Callan of this agency.

Sincerely,

A handwritten signature in cursive script that reads "Margaret McClure Wilson".

Margaret M. Wilson
Executive Director

MMW/ab

Enclosure

C. TOTAL PROPORTION OF OUTLIER PAYMENTS

Present law

No provision.

House bill

Under the House bill, the Secretary would be required to provide additional payments for outlier cases amounting to not less than 4 percent of total DRG related payments.

Senate amendment

Under the Senate amendment, the Secretary would be required to provide additional payments for outlier cases amounting to not less than 5 percent, and not more than 5 percent, of total projected or estimated DRG related payments.

Conference agreement

The conference agreement follows the Senate amendment.

9. CAPITAL EXPENSES

A. CAPITAL IN GENERAL

Present law

Under present law, medicare reimburses hospitals for the reasonable costs of capital (including depreciation, interest and rent).

House bill

Under the House bill, capital expenses, as defined by the Secretary, would be specifically excluded from the prospective payment proposal and would continue to be reimbursed on a reasonable cost basis.

Senate amendment

Under the Senate amendment, capital expenses, as defined by the Secretary, would be specifically excluded from the prospective payment system until October 1, 1986, during which time they would continue to be reimbursed on a reasonable cost basis. After October 1, 1986, such expenses would no longer be excluded.

Conference agreement

The conference agreement follows the Senate amendment. The managers intend that capital, as defined by the Secretary, includes return on equity. The managers also note that the Secretary is required to complete, within 18 months, a thorough review of the methods by which capital, including return on equity, can be incorporated into the prospective payment system. The managers expect that additional legislation will be enacted by Congress to deal with capital-related issues under the prospective payment system before October 1, 1986. However, if the Secretary has implemented a system of prospective payment for capital without legislative action and the mandatory section 1122 capital planning approval provision has gone into effect, the conferees intend that the Secretary

will adjust the prospective payment for capital to reflect a disapproval project under section 1122.

B. RETURN ON EQUITY

Present law

Under present law, medicare reimburses proprietary institutions a return on equity.

House bill

The House bill provides for the phase-out of return on equity for hospitals under the prospective payment system over the three-year transition period during which the cost-based payment is being phased out (75% in the first year, 50% in the second year and 25% in the third year). No payment for a return on equity would be made for cost reporting periods beginning on or after October 1, 1986.

Senate amendment

No provision.

Conference agreement

Under the conference agreement, effective with respect to cost reporting periods beginning on or after the date of enactment, the rate of return on equity will be reduced from one and one-half times to an amount equal to the rate of interest paid by the Federal Treasury on the assets of the Hospital Insurance Trust Fund.

C. NEW CAPITAL

Present law

No provision.

House bill

The House bill expresses the intent of Congress that, in implementing a system for including capital-related costs under a prospective payment system, costs related to capital projects initiated on or after March 1, 1983, may be distinguished and treated differently from projects initiated before such date.

Senate amendment

The Senate amendment expresses the intent of Congress that, in implementing a system for including capital-related costs under a prospective payment system, costs related to capital projects initiated on or after the effective date of the implementation of such system may or may not be distinguished and treated differently from projects initiated before such date.

Conference agreement

The conference agreement follows the Senate amendment. The managers believe no assurances can be given that, under a new system of paying for capital, projects obligated (as defined by regulations under section 1122) after the date of enactment of this legislation will continue to be paid on a reasonable cost basis.

D. SECTION 1122 CAPITAL APPROVAL

Present law

Under present law, the Secretary is authorized to exclude from reimbursement to providers certain costs related to capital expenditures that have been disapproved by a section 1122 planning agency.

House bill

Under the House bill, at the end of 3 years, medicare would not make payment for a new capital project unless the State had a section 1122 capital approval process and the capital expenditures had been recommended by the State under such mechanism.

Senate amendment

The Senate amendment changes for cost reporting periods prior to October 1, 1986: (1) the financing of reviews of capital projects from the Hospital Insurance Trust Fund to general revenues; (2) increases the amount of capital projects that is subject to the 1122 approval process from \$100,000 to \$600,000; (3) exempts from the review process expenditures made by or on behalf of a health care facility where 75 percent of the patients using the services of such facility are enrollees in HMO's or CMP's and such expenditures are for services and facilities needed by such organization to operate efficiently; and (4) requires hospitals to make their overall expenditure plans and capital budgets available to section 1122 agencies.

Conference agreement

The conference agreement follows the provision in the House bill with the following modification: the requirement that medicare payment for new capital projects be conditional on section 1122 approval would be effective October 1, 1986, only if no legislation were enacted by that date which includes capital-related costs in the prospective reimbursement system. In addition, effective upon enactment: (1) the financing of reviews of capital projects would be made from general revenues; (2) the maximum threshold a State may use for determining which capital projects are subject to the section 1122 review process would be increased from \$100,000 to \$600,000; States would be permitted to set a lower threshold; (3) in order for a health care facility, where 75 percent of the patients are HMO or CMP enrollees, to be exempt from the section 1122 review process because needed services and facilities are not otherwise readily accessible, the organization must establish that one of the following five conditions is met:

- (a) the facilities are geographically dispersed
- (b) the facilities are not available under a contract of reasonable duration
- (c) full and equal medical staff privileges are not available
- (d) the arrangements are not administratively feasible, or
- (e) the services are more costly than if provided by the HMO or CMP; and

**PLEASE NOTE: THE FOLLOWING PAGES WERE TREATED
AS A UNIT IN THE ORIGINAL DOCUMENT**

alaska
state
hospital
association

Dennis L. DeWitt
PRESIDENT

(907) 536-1790
319 Seward St., Juneau, Alaska 99801

JOE -

2/25/83

This is The INFORMATION ON The
Bed need INCREASE we talked
about

DENNIS

PROVIDENCE
HOSPITAL

3200 PROVIDENCE DRIVE - POUCH 6604
ANCHORAGE, ALASKA 99502
PHONE: (907) 276-4511



SERVING IN THE WEST SINCE 1856

February 24, 1983

TO: Dennis DeWitt
FROM: Kaaren Riehl 
RE: Municipal Health Commission Meeting - February 23, 1983

Attached is the part of the minutes from the Joint Project Review Committee meeting of February 12, 1983, where both Providence Hospital and Humana Hospital Alaska applications were discussed concurrently and the recommendations were developed to approve both, since the bed need was higher than projected.

To update you further, the Anchorage Municipal Health Commission met on February 23, 1983, and acted on the four main motions from the Joint Project Review Committee meeting of the 12th in the following order:

Motion #4 Page 3 It was moved to approve the applications of Providence Hospital and Humana Hospital Alaska on the basis they have met all eleven (11) criteria and therefore are in fact approvable under Phase I.

Motion passed - unanimous

Motion #6 Page 4 To deny both applications on the basis that Lake Otis Hospital, as a viable operation, would satisfy all the identified bed needs for the Municipality of Anchorage.

Motion failed, 1 yes, 20 no

Motion #8 Page 5 Whereas the population growth in Anchorage has increased dramatically and appeared to be growing at a faster rate than assumption 2 in the Position Paper on acute care beds needs projects; and

Whereas it appears from other sources the population outside the Anchorage area is growing at a rate faster than the projected in assumption 7; and

Whereas the eligibility changes for service at public health hospitals in Alaska results in larger numbers seeking private health care; and

Whereas substantial planning time and facility disruption during construction should be minimized in hospitals; and

Whereas construction costs will probably be cheaper in 1983-85 than in 1990; and

Whereas constructed beds would only be staffed and open as community-wide utilization rates indicate a need;

Therefore the Committee provides for an increase in the identified bed need number, allowing an additional 14 beds to accommodate potential individuals recently declared ineligible for public health service, to total a base need of 620 in planning horizon 1995 and additionally allow a deviation factor of 16% to accommodate the uncertainties of planning for 1995 horizon.

16% = 99 beds
Total Now
719 beds

Motion passed, 13 yes, 8 no

Motion #5
Page 3

Whereas the bed population, and use projections do not consider Lake Otis Hospital, and

Whereas Lake Otis Hospital has not shown progress toward completion to the planning horizon 1995, and

Whereas population and use needs are in question, and

Whereas both current applicants have met all review criteria and have shown ability and resources to immediately proceed to meet the need identified,

Hereby move to recommend to the Municipal Health Commission and the South Central Health Planning and Development, Inc. *in order to avoid the risk of having insufficient beds in 1995, that both applications of Providence Hospital and Humana Hospital Alaska be approved.*

Motion passed, 17 yes, 4 no, with amendment in last paragraph in italics.

JOINT PROJECT REVIEW COMMITTEE
Summary Minutes
February 12, 1983
Step 11 of Phase I

The Chair reconvened the meeting at 1:30 p.m.

Chair, P. Gallagher asked the applicants and Committee if there were any objections to L. Korn participating in the discussion as outlined in Step 11, as he was not present during Providence Hospital's review on February 11th. No objections were made.

David Williams, staff member from the State Division of Health Planning and Development, was asked by the Chair to advise the Committee what his office will be looking for from the Phase I review. Mr. Williams indicated that all motions from this point on must be clearly stated, giving findings (reasons) which support each recommendation.

A. Review of Scope of Need Statements In Relationship to the Sum Total of the Applications

attached
The Executive Director, Margaret Wilson, of the South Central Health Planning and Development, Inc. summarized (a) development of community bed need projections involved in the adopted local and regional Health Systems Plans, (b) the prescribed public review process, and (c) recent January, 1983, review and updating of the community bed need projections for acute care and development of bed need projections for in-patient rehabilitation. She noted that the position paper on acute care bed need projections for Anchorage, adopted 1/12/83 by the Health Commission did not vary significantly from the acute care bed need projections (as adopted by the Assembly) using a high-range population figure for Anchorage and factoring in for possible changes in Indian Health Service policy, and recent 1981 hospital utilization data. The planning horizon in the position paper is 1995.

The Committee discussed, as reflected in the motions, the adopted community bed need projections and assumptions for acute care and rehabilitation, and rejected the following three motions aimed at increasing and modifying bed need projections:

- (1) It was moved by R. Fain, seconded by D. Van Wieringen that the Jt. HSA/MHC Project Review Committees, given the lead time associated with actually opening a new bed in the community, the escalating cost of construction of new beds, and questions about the utilization of population groups such as natives, their non-native dependents, and the military, should adopt a more realistic planning horizon for the purposes of this review of the year 2000.

Roll call vote: S. Anderson, conflict; D. Bantz, no; L. Calhoun, no; K. Carpenter, no; R. Fain, yes; P. Gallagher, no; L. Korn, yes; S. Lesko, no; S. Norrell, no; J. Sewell, no; J. Tanner, no; D. Van Wieringen, no; M. Wolfe, yes.

Motion failed: 3 yes, 9 no, 1 conflict

(2) It was moved by M. Wolfe, seconded by R. Fain to

Move the following action:

Whereas the population growth in Anchorage has increase dramatically and appeared to be growing at a faster rate than assumption 2 in the Position Paper on acute care bed needs projects; and

Whereas it appears from other sources the population outside the Anchorage area is growing at a rate faster than projected in assumption 7; and

Whereas the eligibility changes for service at public health hospitals in Alaska results in larger numbers seeking private health care; and

Whereas substantial planning time and facility disruption during construction should be minimized in hospitals; and

Whereas construction costs will probably be cheaper in 1983-85 than in 1990; and

Whereas constructed beds would only be staffed as utilization rate indicates a need;

Therefore the Committee provides for an increase in the identified bed need numbers, allowing an additional 13 beds to accomodate potential individuals recently declared ineligible for public health service, to total a base need of 619 in planning horizon 1995 and additionally allow a deviation factor of 15% to accomodate the uncertainties of planning for 1995 horizon.

Roll call vote: S. Anderson, conflict; D. Bantz, no; L. Calhoun, no; K. Carpenter, no; L. Charles, yes; R. Fain, yes; P. Gallagher, no; L. Korn, yes; S. Lesko, no; S. Norrell, no; J. Sewell, no; J. Tanner, no; D. Van Wieringen, yes; M. Wolfe, yes.

Motion failed: 5 yes, 8 no, 1 conflict

(3) It was moved by S. Norrell, seconded by D. Van Wieringen to increase the bed need estimates shown on the Table Section 5, under acute bed needs, by 20%, each figure.

Roll call vote: S. Anderson, conflict; D. Bantz, no; L. Calhoon, no; K. Carpenter, no; L. Charles, yes; R. Fain, yes; P. Gallagher, no; L. Korn, yes; S. Lesko, no; S. Norrell, yes; J. Sewell, no; J. Tanner, no; D. Van Wieringen, yes; M. Wolfe, no.

Motion failed: 5 yes, 8 no, 1 conflict

B. Consideration of Approvability of All Applications in Phase I

#1

(4) It was moved by M. Wolfe, seconded by R. Fain to approve the applications of Providence Hospital and Humana Hospital Alaska on the basis they have met all eleven (11) criteria and therefore are in fact approvable under Phase I.

Roll Call vote: S. Anderson, conflict; D. Bantz, yes; L. Calhoon, yes; K. Carpenter, yes; L. Charles, yes; R. Fain, yes; P. Gallagher, yes; L. Korn, yes; S. Lesko, yes; S. Norrell, yes; J. Sewell, yes; J. Tanner, yes; D. Van Wieringen, yes; M. Wolfe, yes.

Motion carried: 13 yes, 0 no, 1 conflict

C. If Appropriate, Consideration of Approving All Applications As Reviewed

#4

(5) It was moved by D. Van Wieringen, seconded by J. Sewell that

Whereas the bed population, and use projections do not consider Lake Otis Hospital, and

Whereas Lake Otis Hospital has not shown progress toward completion to the planning horizon 1995, and

Whereas population and use needs are in question, and

Whereas both current applicants have met all review criteria and have shown ability and resources to immediately proceed to meet the need identified,

Hereby move to recommend to the Municipal Health Commission and the South Central Health Planning and Development, Inc. that both applications of Providence Hospital and Humana Hospital Alaska be approved.

Discussion on the motion: Each applicant was asked whether their proposals could be modified to some lesser scope of service than proposed. Each applicant responded no, their proposals were based on the entire, integrated proposal.

The Chair noted that it would expect a second-scenario motion addressing Lake Otis Hospital's beds following roll call vote.

Roll call vote: S. Anderson, conflict; D. Bantz, no; L. Calhoon, yes; K. Carpenter, no; L. Charles, yes; R. Fain, no; P. Gallagher, no; L. Korn, yes; S. Lesko, yes; S. Norrell, no; J. Sewell, yes; J. Tanner, yes; D. Van Wieringen, yes; M. Wolfe, yes.

Motion carried: 8 yes, 5 no, 1 conflict

The second scenario motion was made by D. Van Wieringen, seconded by R. Fain

#2

- (6) To deny both applications on the basis that Lake Otis Hospital, as a viable operation, would satisfy all of the identified bed needs for the Municipality of Anchorage.

Discussion:

- o This motion was made to satisfy legal requirements; recommend defeating the motion.
- o Staff reminded the Committee that it is incumbent on them to be absolutely clear on the rationale and findings that support the actions that have been taken.

Roll call vote: S. Anderson, conflict, D. Bantz, no; L. Calhoon, no; K. Carpenter, abstain; L. Charles, no; R. Fain, no; P. Gallagher, yes; L. Korn, no; S. Lesko, no; S. Norrell, no; J. Sewell, no; J. Tanner, no; D. Van Wieringen, no; M. Wolfe, no.

Motion failed: 1 yes, 11 no, 1 conflict, 1 abstention

D. Motion To Move All Applications To Phase II

- (7) It was moved by K. Carpenter, seconded by R. Fain, that the proposals from Humana Hospital Alaska and Providence Hospital go to Phase II review because the services proposed collectively requested exceed community adopted bed need projections.

Roll call vote: S. Anderson, conflict; D. Bantz, yes; L. Calhoon, yes; K. Carpenter, yes; L. Charles, yes; R. Fain, yes; P. Gallagher, yes; L. Korn, no; S. Lesko, no; S. Norrell, yes; J. Sewell, no; J. Tanner, no; D. Van Wieringen, no; M. Wolfe, no.

Motion carried: 7 yes, 6 no, 1 conflict

The Chair declared that the Committee now had approved two conflicting motions, in that adopted community bed need was less than the number of beds requested, and called for clarification of the intent of Committee's actions.

- (8) It was moved by M. Wolfe, seconded by L. Korn

To move the following action:

#3
Whereas the population growth in Anchorage has increased dramatically and appeared to be growing at a faster rate than assumption 2 in the Position Paper on acute care beds needs projects; and

Whereas it appears from other sources the population outside the Anchorage area is growing at a rate faster than the projected in assumption 7; and

Whereas the eligibility changes for service at public health hospitals in Alaska results in larger numbers seeking private health care; and

Whereas substantial planning time and facility disruption during construction should be minimized in hospitals; and

Whereas construction costs will probably be cheaper in 1983-85 than in 1990; and

Whereas constructed beds would only be staffed and open as community-wide utilization rates indicates a need;

Therefore the Committee provides for an increase in the identified bed need numbers, allowing an additional 14 beds to accommodate potential individuals recently declared ineligible for public health service, to total a base need of 620 in planning horizon 1995 and additionally allow a deviation factor of 16% to accommodate the uncertainties of planning for 1995 horizon.

Discussion:

- ° Project Review Committee acts as advisory to the Municipal Health Commission and HSA Board, and has the right to consider and accept information which changes figures and projections.
- ° This review is dealing with feeling about the way Anchorage really is, which is more unpredictable than the rest of the country. There is no empirical way to prove this.
- ° Inappropriate for the Committee to use any bed projections other than those as adopted in the local and regional Health Systems Plans.
- ° The Committee was reminded that in order to alter, adjust, or modify adopted bed need projections that empirical justification is required.

° A deviation factor means plus or minus, and assign some degree of error to give flexibility to planning.

Roll call vote: S. Anderson, conflict; D. Bantz, no; L. Calhoon, yes; K. Carpenter, no; L. Charles, yes; R. Fain, no; P. Gallagher, no; L. Korn, yes; S. Lesko, no; S. Norrell, yes; J. Sewell, no; J. Tanner, yes; D. Van Wieringen, yes; M. Wolfe, yes.

Motion carried: 7 yes, 6 no, 1 conflict

- (9) It was moved by L. Calhoon, seconded by D. Van Wieringen to reconsider the motion (#7) to move into Phase II.

Voice vote: Motion carried

- (10) It was moved by L. Calhoon, seconded by D. Van Wieringen that the proposal from Humana Hospital Alaska and Providence Hospital go to Phase II review because the services proposed collectively requested exceed community adopted bed need projections.

Roll call vote: S. Anderson, conflict; D. Bantz, no; L. Calhoon, no; K. Carpenter, yes; L. Charles, no; R. Fain, yes; P. Gallagher, no; L. Korn, no; S. Lesko, no; S. Norrell, no; J. Sewell, no; J. Tanner, no; D. Van Wieringen, no; M. Wolfe, no.

Motion failed: 2 yes, 11 no, 1 conflict

- (11) Move to adjourn was made by L. Korn, seconded by R. Fain

Roll call vote: S. Anderson, conflict; D. Bantz, yes; L. Calhoon, yes; K. Carpenter, yes; L. Charles, no; R. Fain, yes; P. Gallagher, no; L. Korn, yes; S. Lesko, no; S. Norrell, no; J. Sewell, no; J. Tanner, yes; D. Van Wieringen, no; M. Wolfe, no.

Motion failed: 6 yes, 7 no, 1 conflict

The Committee suggested that the Chair/Vice Chair write a formal finding of fact to be sent to the Municipal Health Commission and the Health Systems Agency.

The Chair indicated this be taken under advisement.

It was moved by R. Fain, seconded by D. Bantz, that the meeting be adjourned.

Voice vote: motion carried

The meeting was adjourned at 4:30 p.m.

A POSITION PAPER
A REPORT ON ACUTE CARE
BED NEED PROJECTIONS
FOR ANCHORAGE

Acute care bed need projections for civilian, non-Native hospital services in Anchorage are included in the South Central Health Planning and Development (SCHPD) Health Systems Plan 1982-1986 and the Anchorage Health Systems Plan 1982-84 (herein referred to as the Plans). The methodology, assumptions, and analyses in both documents was developed jointly by SCHPD and Municipal Health Commission (MHC) staff.

Assumptions Underlying Community Bed Need Projections

The assumptions underlying the projections contained in the planning documents include:

1. Population distributions by age for the Municipality (excluding military) are assumed to be appropriate for the civilian non-Native (CNN) population in Anchorage.
2. The official Municipal 1985 projected total population is 231,000. The assumptions used to support this projected figure are viewed by experts to be optimistic. Therefore, this 1985 figure is likely to be high. Projections based upon a lower range of population growth are available in the SCHPD 1982 Health Systems Plan.
3. Age categories will remain approximately the same through 2000. Figures assume that the slowly increasing average age of the population will not significantly affect the use of Anchorage hospitals for the study period.
4. The availability of 80 to 100 skilled nursing beds in the Anchorage Pioneer Home will allow growing numbers with chronic conditions to have access to a skilled and/or intermediate level of care (Nakoyia's beds will likely come open as eligible patients transfer to the Pioneer Home).
5. There will be no major change in the array of services (beds) at Elmendorf Air Force Base Hospital and no substantial change in policy with respect to military use of private sector facilities.
6. Native use of private sector services may be effected by some changes in federal budgetary restraints, which effect other PHS facilities outside Anchorage (Bethel, Bristol Bay).
7. The population outside Anchorage will continue to increase at approximately the same annual rate which is lower (less than 3.0%) than the rate for the Anchorage area (greater than 3.0%). The same proportion of Alaskans will continue to use health services outside Alaska.

8. The non-Anchorage patient days may be effected by the new or expanded services of non-Anchorage facilities, such as in Palmer, Soldotna, Homer, Cordova.
9. It is possible that length-of-stay will increase in medical/surgical services or pediatrics. As more routine surgeries, typically requiring a shorter stay, are done on an outpatient basis, average acute length-of-stay might increase. Obstetric use rates will probably not increase, and may decline with increased use of alternative birthing opportunities. However, the addition of a neonatologist, more non-Anchorage high risk obstetric cases may be treated in Anchorage.
10. References to existing beds in projections refers to those acute care hospital beds in private facilities (Providence and Humana Hospital Alaska) that are officially licensed as such by the State of Alaska, as of the date of this paper (December 1982). (Providence 250 and Humana 199.) Note: Humana Hospital Alaska has 199 licensed acute beds and intends to request that the 21 beds currently used for the Chemical Dependency Unit (CDU) be used as general acute care when needed. Assuming that conversion, the community supply of licensed acute care beds would then be 250 plus 199 to equal 449 beds.

Table I: Comparison of Community Bed Need Projections
1985-1995

A summary of the analysis included in the plans is included in the first column of Table I. Figures are expressed as ranges due to the use of different population projections used in the SCHPD(HSA) and MHC planning process. Throughout this paper the lower figures in the left are from the SCHPD Plan and the higher figures on the right are from the MHC plan (see SCHPD plan for details).

The bed need projections in the plans were based on 1980 utilization data from Providence and Humana Hospitals. In order to determine how more recent information might affect the projections, staff obtained 1981 utilization and population data and re-calculated the bed projections. Utilization and patient origin data for 1981 were obtained from both hospitals. Results of the calculations are shown in the second column of Table I.

Table I also includes projections of community bed need contained in the most recent Certificate of Need applications submitted by Providence Hospital and Humana Hospital Alaska. Humana projected community bed need to 1985 and 1990. Providence estimated community bed need for 1995. Summaries of the projections contained in those applications are included in Table I.