Citizens League

Common ground. Common good.

Developing Informed Decisions

Seeking Market Reforms to Advise Medical Facility Expansion

Report of the Citizens League
Medical Facilities Study Committee

April 2006

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Executive Summary

Minnesota is in the midst of a wave of medical facility investment, yet we lack the basic information to make good decisions about the expansion of medical facilities. We don't have a functioning market to do it for us, and there is no process in place to inform decisions or to make needed changes.

There are three key concepts that frame the real state of the medical care system in Minnesota and are driving the current choices for medical facilities: cost, market failure and regulatory failure.

Cost: It is widely agreed that medical care costs are increasing at an unsustainable rate for citizens, businesses and governments in Minnesota and the nation. Medical care providers are likely to compete for more capacity in high-margin medical services, regardless of need. This can lead to higher cost through oversupply and overuse of high-margin services supported by supplier-induced demand.

Market Failure: The medical care system continues shifting towards consumer choice or "consumer-driven" care. To make these choices, consumers need ample information. A functioning market has an ample number of producers interacting with knowledgeable consumers. On this fundamental level, the market for medical care represents a substantial market failure.

Regulatory Failure: Minnesota's regulatory framework focuses on a very narrow segment of medical facilities–facility projects that involve the addition of inpatient hospital beds, the transfer of existing hospital beds to a different location, or both. Current regulation does not address other types of facility investments.

Findings and Conclusions

If the saying in real estate is, "location, location, location," then perhaps the saying in medical care should be, "information, information, information." The right kind of information provides a foundation for better planning and decisions. Minnesota must require information from all sectors of the medical care system to effectively chart a path for medical facility expansion that defines need, seeks market reform opportunities and avoids regulatory failure.

- Regulatory efforts in Minnesota do not align medical facility capacity with need and are, therefore, inadequate.
- The Legislature is not the preferred body to make decisions on facilities, but should establish a process to do so.
- Minnesota has a supplier-driven market. Medical care providers initiate the process to determine medical facility need. A process must be established where Minnesota defines "need" for medical care in medical facilities. This effort should develop a consumer perspective to balance the supplier-driven nature of the medical care market.
- Financial incentives encourage hospitals and others to cross-subsidize low margin services with profits from higher margin services, contributing to a lack of transparency in medical care financing.

Recommendations

Changes to establish market and regulatory reform in the medical care market must be approached in stages.

Stage 1: The Information Stage—Developing a Consumer Voice

The Citizens League recommends that the state establish a permanent, quasi-public body to act as a consumer voice in medical care decision-making and to initially oversee the gathering of statewide information to answer two fundamental questions:

- What medical services are currently available in all medical facilities?
- What is the capacity and use of existing medical facilities?

The membership of this statewide body must have a dominant majority (at least two-thirds) acting as consumers of medical care. It will balance consumer interests with supplier interests and help offset the tendency in medical care toward supplier-induced demand. The body could be called the Minnesota Medical Information Authority (MMIA) and should establish reporting thresholds for:

- Capital expenditures on facilities and technology,
- Expansion or addition of new medical services, or
- Expected revenue streams from a change or increase in operations.

Recommendation 1: The Legislature should establish the MMIA in the 2007 legislative session.

Recommendation 2: The report from the MMIA should be ready for action by the 2009 Legislature.

Stage 2: The Decision-Making Stage

Recommendation 3: Moratorium exception decisions should be transferred to the MMIA.

Recommendation 4: The Legislature should authorize competitive bidding for inpatient hospital beds to support medical services where the greatest needs have been identified.

Recommendation 5: The MMIA should report to the Legislature and make recommendations biennially. The 2011 Legislature should receive recommendations on the potential to test competitive bidding on medical services and facilities other than inpatient hospital beds and recommendations on other market reforms.

Stage 3: Market Reform

The MMIA should explore the possibility of expanding the competitive bidding process beyond hospitals to competition for other types of medical services and facilities. Ideally, competitive bidding or other market reform tools will act to reform a significant failure of the current market—the need for cross-subsidization.

Stage 4: Regulatory Reform

Once the competitive bidding process and/or other market reforms are in place to create significant price transparency, the MMIA can assess the benefits and risks of removing the inpatient hospital bed moratorium and make recommendations to the Legislature.

Developing Informed Decisions

This proposal is a vehicle to begin to address the seemingly intractable problems in the delivery of medical care—unsustainable costs, market and regulatory failure, and the imperative to construct a system where consumers have meaningful choices.

Introduction

The nation is *in the midst of a wave of medical facility investment and modernization, and Minnesota is no exception. Yet in Minnesota, we lack the basic information to make good decisions about the expansion of medical facilities. We don't have a functioning market to do it for us, and there is no process in place to inform decisions or to make needed changes.*

If nothing else was made clear during the 2005-2006 Legislature, the current decision-making process to expand hospital capacity in Minnesota was exposed as inadequate. For the first time since Minnesota established a hospital bed moratorium in 1984, there was competition to build a new hospital facility. At one point as many as 40 lobbyists were working at the Legislature in some capacity on this issue. Several providers of medical care reportedly spent millions of dollars in an effort to convince the Legislature that they should be the provider allowed to build a hospital in Maple Grove. Surely these resources could have been directed to a better purpose

There was no process to guide the Legislature or the providers in responding to this competitive situation, and this is not likely to be the only time that competition arises for building a new hospital. The Twin Cities metropolitan region and Greater Minnesota have a number of growth areas where suppliers of medical services may look to build hospitals in the near future.

Now is the time to establish a process for better decision-making that is supplied by the appropriate level of information before we are faced with another decision similar to the recently approved hospital in Maple Grove.

A Note on Scope

This report offers a process to make medical facility expansion decisions in Minnesota. The focus is on "medical care," defined as services delivered in medical facilities. The committee recognizes that the broader terms "health services" and "health care" include public health and other health services delivered outside of medical facilities.

The Citizens League Board of Directors did not establish this committee to address the specific moratorium exception decision to build a hospital in Maple Grove that was before the Legislature in 2005 and 2006. The committee, however, heard testimony about the Maple Grove experience. Our recommendations seek to assist the Legislature in dealing with future requests for medical facility expansion.

Findings

Finding 1: Regulatory efforts in Minnesota do not align medical facility capacity with need.

Finding 2: Minnesota has a supplier-driven market. Medical care providers initiate the process to determine medical facility need.

Finding 3: The process to determine need does not assess the amount of medical care needed across facility types, nor does it evaluate competitive proposals.

Finding 4: Financial incentives encourage hospitals and others to cross-subsidize low margin services with profits from higher margin services, contributing to a lack of transparency in medical care financing.

Goals of the Medical Care System

We expect medical facilities to support three general outcomes, or goals, of our medical care system: quality, access and value.

Quality: The Institute of Medicine defines quality as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." Medical facility capacity affects quality of care. If too many facilities provide certain services, providers do not perform those procedures with enough frequency. This can lead to a lack of expertise in performing the procedure, thus reducing quality.

Value: The goal is to receive optimal medical care at the lowest cost. Many researchers believe that if too many facilities provide certain services, utilization of those services will increase, thus increasing costs. The *Dartmouth Atlas of Health Care*, in its ongoing review of spending levels for Medicare enrollees in hospitals, has concluded that a greater concentration of medical facilities

is associated with higher rates of admissions, longer stays, more diagnostic tests and more elective surgical procedures.

Access: Access is defined by availability of each medical service based on geographic proximity, population and the type of need.

Although the provision of medical facilities must support all three goals, access is central to the charge of the Medical Facilities Study Committee. The committee specifically recognizes the relationship between access and cost.

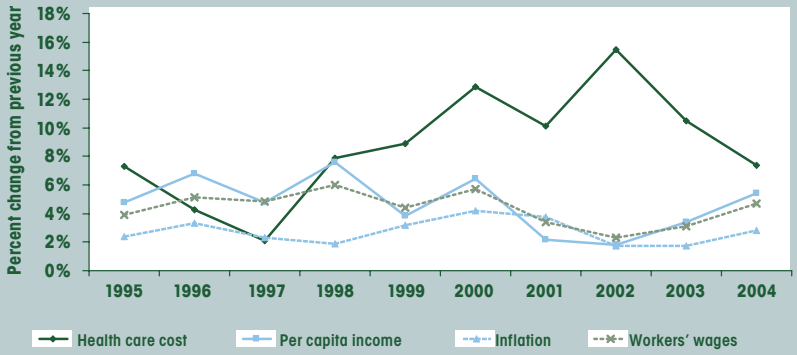
Key Concepts to Frame the Discussion

There are three key concepts that frame the real state of the medical care system in Minnesota and are driving the current choices for medical facilities: cost, market failure and regulatory failure.

Cost: It is widely agreed that medical care costs are increasing at an unsustainable rate for citizens, businesses and governments in Minnesota and the nation. Nationally, private health insurance premiums have near double-digit rate increases, outpacing growth in income, wages, and general inflation by a substantial amount.[1] In Minnesota, this also holds true *(see Figure 1)*.

Nationally, medical care spending accounted for 5.2 percent of the U.S. economy in 1960. By 2004, that percentage had more than tripled, accounting for 16 percent of the U.S. economy. *Figure 2* shows medical care spending is projected to account for 20 percent of the U.S. economy by 2015. In Minnesota, personal income growth is expected to increase 27 percent from 2000 to 2014.[2] During this period of significant income growth, medical care expenditures in Minnesota are expected to rise as a percent of personal income, from under 15 percent in 2000 to over 20 percent in 2014 *(see Figure 3)*.

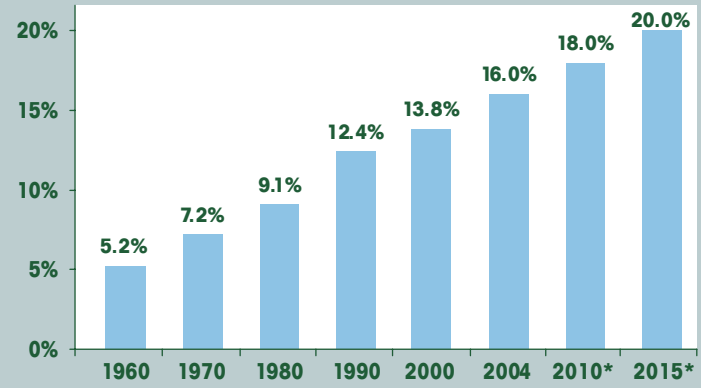
Figure 1: Key Minnesota Health Care Cost and Economic Indicators, 1995 to 2004



Notes: Health care cost is MN privately insured spending on health care services per person, and does not include enrollee out of pocket spending for deductibles, copayments/coinsurance, and services not covered by insurance.

Sources: Health care cost data from Minnesota Department of Health, Health Economics Program; per capita personal income from U.S. Department of Commerce, Bureau of Economic Analysis; inflation data from U.S. Bureau of Labor Statistics (consumer price index); workers' wages from MN Department of Employment and Economic Development.

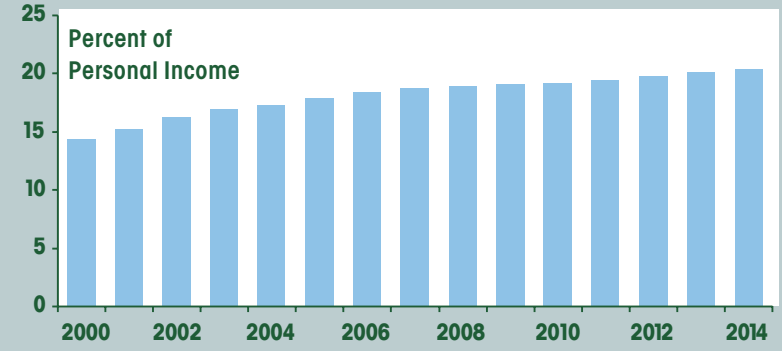
Figure 2: Health Care Spending as a Share of Gross Domestic Product



Source: Centers for Medicare and Medicaid Services

**Projected*

Figure 3: Health Care Spending as a Percent of Personal Income

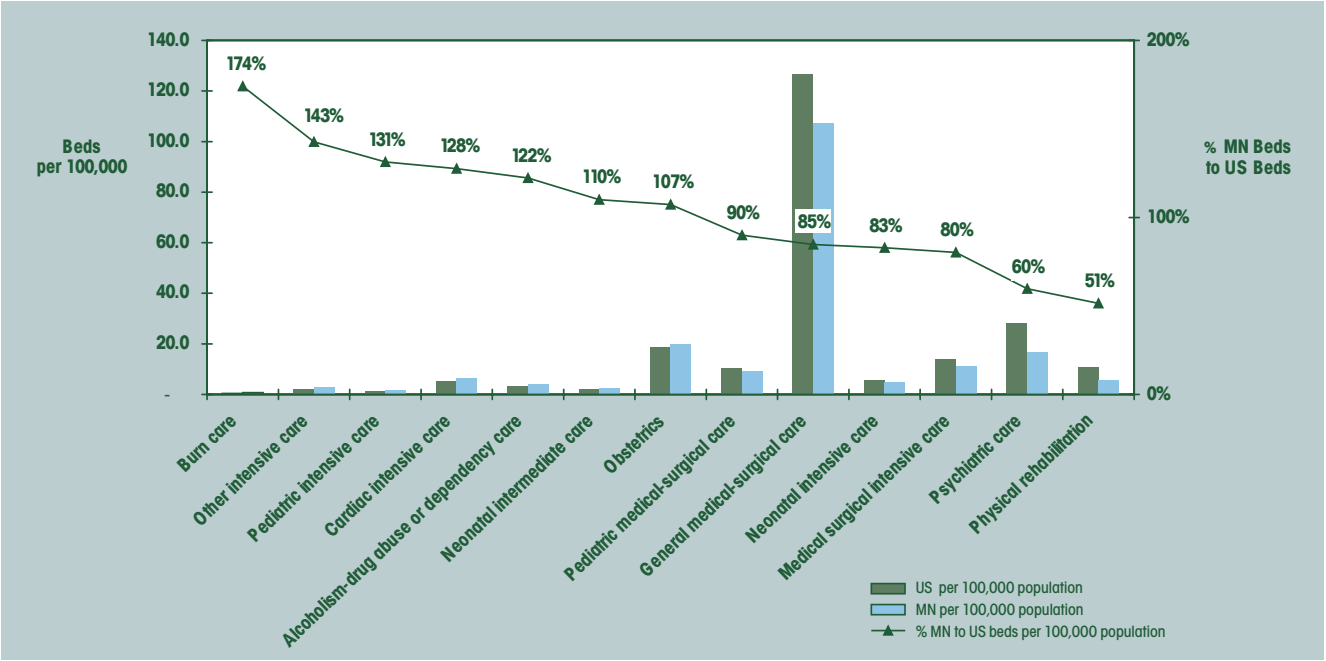


Source: Minnesota State Economist

[1] *Trends in Private Health Insurance Premiums and Cost Drivers, 2004*, Minnesota Department of Health Issue Brief 2005-02, August 2005.

[2] *Show Us the Money, "The Future," Citizens League Mind Opener Breakfast*, Tom Gillaspy, State Demographer, and Tom Stinson, State Economist, August 3, 2005.

Figure 4: A Comparison of U.S. and Minnesota Hospital Bed Capacity, 2003



Source: American Hospital Association and Minnesota Hospital Association

Some medical procedures yield significantly higher margins in relation to costs than other procedures. These high-margin procedures are often associated with technological advances. Medical equipment and facilities that support these procedures are proliferating and are one important driver behind the increased cost of medical care.

The business strategy of a medical care provider is likely to dictate more capacity for high-margin medical services regardless of need. As part of that decision, the provider will judge that a sufficient supply of patients can be referred to make the new facility cost-effective. This can lead to oversupply and overuse of high-margin services and is known as supplier-induced demand. The determination of need, therefore, is directly linked to cost.[3]

No comprehensive policy response addresses the problem of rapidly increasing cost. Minnesota has recently begun to define need for inpatient hospital beds, but has no such determination for any other medical facility or service.

Minnesota may have an oversupply of facilities in some areas of medical care and undersupply in others. For example, *Figure 4* compares the number of inpatient beds per 100,000 population in the U.S. and Minnesota for selected medical services.

- The national average for cardiac intensive care beds was 5.2 per 100,000 population in 2003. Minnesota had 6.6 cardiac beds per 100,000 (128 percent of the national average). Incentives in the current system may spur more cardiac beds in Minnesota.
- For psychiatric inpatient hospital beds, Minnesota–at 16.8 beds per 100,000 population–was well below the national average of 28.2 beds per 100,000 people.[4]
- Overall, Minnesota is around the national average for all hospital beds per 100,000 population at 334 compared to a national average of 332.

The national average for hospital beds is only one indicator that applies to one sector of medical care and we do not have the information to control for other factors,[5] but it is an indicator that should be examined, since we have few others. A recent simulation found that advances in technology and other factors that affect medical practice patterns will "dwarf" the impact of aging on future spending.[6] This finding suggests that we should not assume that the aging of the population will automatically lead to a need for more hospital beds, rather that we will need a more thorough assessment of other factors that will change the nature of medical care.

[3]"Variations in the Use of Supply-Sensitive Services," *Dartmouth Atlas Quick Report*, 2005.

[4]"Hospital Expansion in Minnesota: Is Growth Worth the Cost?" BlueCross BlueShield of Minnesota, July 2005.

[5]For example, the data does not control for whether or not Minnesota is a net importer for some types of medical services, or the impact of closing regional treatment centers on the number of psychiatric beds.

[6]"The Effect of Population Aging on Future Hospital Demand," Bradley C. Strunk, Paul B. Ginsburg and Michelle I. Banker, *Health Affairs*, March 28, 2006.

What we do know about medical facilities other than hospitals comes from a capital expenditure reporting requirement that was enacted as part of Minnesota Care in 1992 *(see Table 1)*. From 1993 to 2004, various types of imaging equipment made up the largest number of projects requiring a capital expenditure over $1 million (over $500,000 up until 2003). The Department of Health is not directed to ascertain the location and need for imaging equipment, nor is there an assessment of how often imaging machines are being added in hospitals, clinics or imaging centers.

Market Failure: The medical care system continues shifting towards consumer choice or "consumer driven" care. To make these choices, consumers need ample information. A functioning market has an ample number of producers interacting with knowledgeable consumers. On this fundamental level, the market for medical care represents a substantial market failure.

There are an ample number of producers and consumers, but it is nearly impossible for a consumer to be "knowledgeable." In Minnesota, more information is needed for even the largest purchasers to make choices based on cost and quality.

In addition, barriers to entering the medical care market are like no other market. Hospital protections, research and development costs, and professional society requirements all act as barriers to entering the medical care market. *Table 2* shows structures and conduct of functioning markets and how they differ from the medical care market. (See page 19 for further background on the market for medical care.)

Table 1: Health Care Capital Expenditures in Minnesota, 1993 to 2004

Expenditures over $500,000 from 1993-2002
Expenditures over $1 million from 2003-2004

Total expenditures were $4 billion over the 12-year period.

Over $400 million in 1997, 1999, 2002 and 2003

Of this $4 billion:

Urban Hospitals – 45 percent ($1.81 billion)
Urban Clinics – 33 percent ($1.32 billion)
Rural Hospitals – 19 percent ($758 million)
Rural Clinics – 3 percent ($150 million)

Hospitals

Capital expenditures for hospitals over 12-year period were $2.57 billion.
Hospitals account for 64 percent (inpatient and outpatient) of all expenditures
Hospitals in urban areas $1.81 billion
Hospitals in rural areas $758 million

Clinics

Capital expenditures for physician clinics over 12-year period were $1.55 billion.
Physician clinics account for 36 percent of all expenditures
Clinics in urban areas $1.32 billion
Clinics in rural areas $150 million

Top Spending

Mayo	20 percent
Allina	15 percent
Fairview	9 percent
Park Nicollet	5 percent
Health Partners	5 percent
St. Cloud Hospital	5 percent
Health East	4 percent
North Memorial	3 percent
Children's Hospitals and Clinics	3 percent
Hennepin County Medical Center	2 percent
Other	29 percent

Project Types

Imaging	386
• MRIs	141
• Other Imaging	121
• CTs	113
• PETs	11
Building, Renovation or Non-Patient	326
Physician Office Space	209
Computer, Laboratory, Phone or Monitoring	139
Surgery Care	90
Cardiac Care	84
Emergency Care	58
Radiation Therapy	41
Intensive Care	24
Outpatient Surgery	12

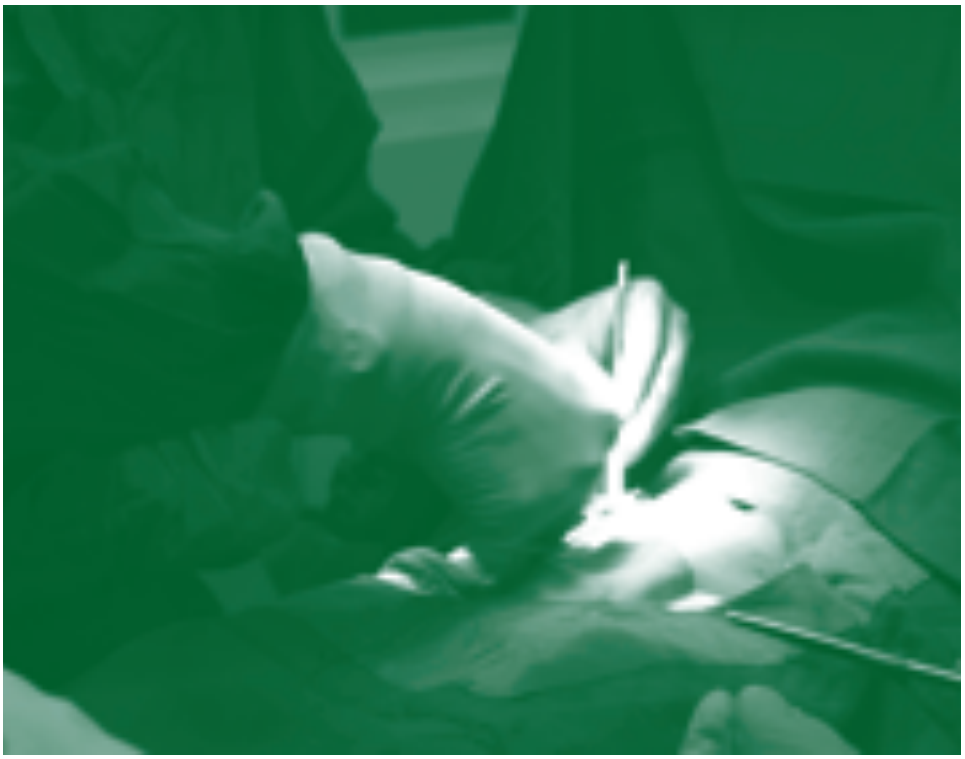
Source: Minnesota Department of Health, August 2005

Table 2: Market for Medical Care

Assumptions Underlying a Perfectly Competitive Market	Match with Market for Medical Care	Specific Differences
Market Structure		
Large number or buyers and sellers	Mixed	Many consumers Many physicians Few hospitals
Complete information (Absence of uncertainty)	No	Consumer ignorance of the product Risk and uncertainty of need
Firms operate independently (No one seller can influence price)	No	Price fixing (fee schedules) by doctors Cost reimbursement for hospitals
Free entry and exit of all producers	No	Barriers to entry (personnel licensure, hospital accreditation, certification-of-need programs, a limited number of medical schools)
The product is homogenous	No	Multiple, undefined products (services) Varied quality
The consumer is the key decision-maker	No	Physicians act as agents on behalf of consumers
Market Conduct		
Firms are price-takers	No	Hospitals and physicians are price-setters
Firms maximize their profits	No	In general, hospitals are nonprofit organizations which seek to maximize other objectives (e.g. growth, prestige)
The price consumers pay equals the price producers receive	No	Insurance (third-party payments) distorts this equality

Source: Cohodes 1982

Acute care situations drive many cost increases. Since most consumers possess a limited understanding of chronic and acute illness and the treatment options, better information will have limited impact on consumer (patient) choices for more complicated, acute care.



Acute situations may require the most expensive medical services and often give the consumer little or no time to consider cost-effective options. Therefore, free market principles are not likely to apply to many areas of the market for medical care. Generally, consumers cannot anticipate their need for urgent medical treatments, and therefore, must make decisions in an anti-competitive market.

Regulatory Failure: Minnesota's regulatory framework focuses on a very narrow segment of medical facilities – facility projects that involve the addition of inpatient hospital beds, the transfer of existing hospital beds to a different location, or both. Current regulation does not address other types of facility investments including:

- Hospital projects that use existing bed licenses in an existing location (through the use of about 4,700 "banked" but unused licenses),
- Service expansions that do not involve the addition of inpatient beds,
- Outpatient hospital projects, and
- Non-hospital projects such as freestanding ambulatory surgery centers or imaging centers.

As market failure tends to drive medical care costs, so does regulatory failure. Government policies have not created a consistent, functioning market that reasonably contains costs, a sign of regulatory failure.

Another product of regulatory failure is cross-subsidization. Lack of information on actual medical care costs has created a regulated payment system (Medicare and Medicaid) that results in payments for some types of medical care at high margins in relation to costs, and payment for other types of care at low margins in relation to cost.[7] This promotes investment in high margin services, such as cardiac care and orthopedic surgery, versus lower margin services such as mental health care. Providers, hospitals in particular, compete to provide the higher-margin services to fund the lower-margin services.

In addition to the cross-subsidization between different medical services, there is also cross-subsidization between medical care payors. Providers often have preferred contracts that offer discounted prices to health plans (payors). Patients not covered by a payor plan pay a higher retail price. "Retail" consumers, therefore, end up paying more to subsidize the preferred contract that a provider has with a third-party payor.

Cross-subsidization contributes to little or no price transparency for a given medical service; both types of cross-subsidization create a major barrier to the medical care consumer.

[7] "When the Price Isn't Right: How Inadvertent Payment Incentives Drive Medical Care," Paul B. Ginsburg and Joy M. Grossman, *Health Affairs*, August 9, 2005

Finding 1

In Minnesota, regulatory efforts do not align medical facility capacity with need. Indicators of this are:

- An inability to manage cost,
- Increasing capacity in medical care that may already exceed the need, and
- Areas of need that are not being met by new capacity.

Finding 2

Minnesota has a supplier-driven market. Medical care providers initiate the process to determine medical facility need. Even with the hospital moratorium, the Department of Health only performs the new public interest review (established in 2004) when a supplier wants to add inpatient beds.

Finding 3

The process to determine need for medical facilities throughout Minnesota only addresses inpatient hospital beds and does not assess the amount of medical care needed across facility types, nor does the process evaluate competitive proposals based on criteria such as quality and cost.

Finding 4

Financial incentives inherent in payment methods used by the federal government and third-party payors, encourage hospitals and others to cross-subsidize low margin services with profits from higher margin services. Cross-subsidization contributes to a lack of transparency in medical care financing. This stimulates competition for more profitable services to the point of oversupply, overuse and higher cost. Meanwhile, lower margin services are at risk of underinvestment.

Conclusions

Information, Information, Information

If the saying in real estate is, "location, location, location," then perhaps the saying in medical care should be, "information, information, information." Not because information is the only answer and will solve all the problems that we are trying to address (see Market Failure section on page 7), but because the right kind of information provides a foundation for better planning and decisions.

With changing medical technologies and treatments, gathering information and making decisions based only on the presence of inpatient beds is clearly inadequate.

The medical facility decision-making process in Minnesota is supplier-driven and depends on providers determining their "need" for facilities based on market perceptions and business strategies. In the medical care market, this can result in greater concentration of services, over-utilization, and greater cost than competition in a functioning market would typically produce.

All consumers—not just citizens—need better information to make medical care decisions. Public and private employers need much better information to purchase medical care; government needs much better information to avoid policies that result in regulatory failure and to have more ability to introduce market reforms that produce functioning markets within medical care. Without reasonable alignment between need and availability of medical facilities, decisions will be ineffective.

Over the course of 21 exceptions to the hospital moratorium (probably 23 after the 2006 session), the Legislature has never attempted to assess facility need in a general sense beyond inpatient hospital beds. With changing medical technologies and treatments, gathering information and making decisions based only on the presence of inpatient beds is clearly inadequate.

Even in the case of inpatient hospital beds, there has been little consistency in the Legislature's approach. As a case in point, the Maple Grove hospital was approved with a long list of requirements that must be fulfilled. Legislation moving forward to approve a new 25-bed hospital in Cass County will have no requirements in state law other than approval by the Cass County Board.

Projects can and do proliferate based on the business needs of individual providers. Some hospital projects may be undertaken to respond to the competitive threat posed by the expansion efforts of other providers for outpatient services.

Conclusion 1:

The current regulatory findings, which are based solely on inpatient hospital beds, are inadequate.

Conclusion 2:

The Legislature is not the preferred body to make decisions on facilities but should establish the process to do so.

Conclusion 3:

A process must be established where Minnesota defines "need" for medical care in medical facilities. This effort should develop a consumer perspective to balance the supplier-driven nature of the medical care market.

Conclusion 4:

Minnesota must require information from all sectors of the medical care system to effectively chart a path for medical facility expansion that defines need, seeks market reform opportunities and avoids regulatory failure. Information should be gathered and provided based on services, facilities and revenue generation.

Recommendations

Changes to establish market and regulatory reform in the medical care market must be approached in stages and must strive to meet the goals of quality, value and access. Any effort must begin with a comprehensive effort to gather necessary information.

Stage 1: ***The Information Stage — Developing a Consumer Voice***

- Recommendation 1: The Legislature should establish the Minnesota Medical Information Authority (MMIA) in the 2007 legislative session.
- Recommendation 2: The report from the MMIA should be ready for action by the 2009 Legislature.

Stage 2: ***The Decision-Making Stage***

- Recommendation 3: Moratorium exception decisions should be transferred to the MMIA.
- Recommendation 4: The Legislature should authorize competitive bidding for inpatient hospital beds.
- Recommendation 5: The MMIA should report to the Legislature and make recommendations biennially.

Stage 3: ***Market Reform***

Stage 4: ***Regulatory Reform***

"A regulatory agency may be considered a referee between legitimate consumer interests and legitimate producer interests. But consumer interests are broad and diffuse and therefore difficult to mobilize through a regulatory process; whereas producer interests are sharp, concentrated and, ironically, more easily mobilized in a regulatory process than in a market. Thus, a purely regulatory process unbalances the respective leverage of consumers and producers in favor of the producers. This is a central, almost inherent structural defect of command and control regulation that is extremely difficult to remedy."

– Walter McClure, *Structure and Incentive Problems in Economic Regulation of Medical Care,* Milbank Memorial Fund Quarterly, 1981.

Stage 1: The Information Stage – Developing a Consumer Voice

The Citizens League recommends that the state establish a permanent, quasi-public body to act as a consumer voice in medical care decision-making and to initially oversee the gathering of statewide information to answer two fundamental questions:

- What medical services are currently available in all medical facilities?
- What is the capacity and use of existing medical facilities?

Table 3, the Certificate of Need (CON) Matrix, can act as a starting point to evaluate how Minnesota should define services. The CON Matrix represents the various ways that the 37 states with a Certificate of Need process define services.

To the degree possible, this assessment should not be limited to the geographic boundaries of the state of Minnesota, but should include the medical "service areas" that Minnesotans use. For example, if a significant number of Moorhead residents are using medical care facilities in Fargo, North Dakota, that should be part of the analysis of need for that area. The "hospital referral regions" used in the Dartmouth Atlas offer one possible example of how to define medical service areas.

The membership of this statewide body must have a dominant majority (at least two-thirds) acting as consumers of medical care. The Department of Health and other state agencies should provide expertise to the body. It will balance consumer interests with supplier interests and help offset the tendency in medical care toward supplier-induced demand.

Table 3: The CON Matrix of 2005 Relative Scope and Review Thresholds: CON Regulated Services by State

Rank (no. of svcs. x weight)	Categories	Acute Care	Air Ambulance	Amb Surg Ctrs	Burn Care	Business Cmptrs	Cardiac Cath.	CT Scanners	Gamma Knives	Home Hlth	ICF/MR	Lithotripsy	Long Term Care	Med Off Bldg	Mobile Hi Tech	MRI Scnrs	Neo-ntl Int Care	Obstetric Svcs	Open Heart Svcs	Orgn Transplnt	PET Scnrs	Psychiatric Svcs	Rad Therapy	Rehab	Renal Dialysis	Res Care Fac	Subacute	Substance Abuse	Swing Beds	Ultra-sound	Other (items not otherwise covered)	Count (no. of svcs.)	compiled by Thomas R. Piper, Missouri CON program, Jefferson City, MO, 573-751-6403 — $ nrsg hm/hosp — Reviewability Thresholds: Capital	Med Eqpt	New Svc	Weight
28.8	Connecticut	■	■	■	■	■	■	■	■			■	■	■	■	■	■	■	■	■	■	■	■	■				■	■	■		24	1,000,000	400,000	0	1.2
26.0	Alaska	■	■	■	■		■	■	■	■		■	■	■	■	■	■	■	■	■	■	■	■	■	■		■	■	■		Assisted living	26	1,000,000	1,000,000	1,000,000	1.0
24.2	Georgia	■		■			■	■	■	■	■	■	■		■	■	■	■	■		■	■	■	■			■	■				22	1,322,151	734,695	any	1.1
22.5	Vermont	■	■	■		■	■	■	■	■	■	■	■		■	■	■	■	■	■	■	■	■	■	■			■	■			25	3.0/1.5M	1,000,000	500,000	0.9
21.6	Maine	■	■	■	1		■	■	■		■	■	■		■	■	■	■	■	■	■	■	■	■	■			■	■	■		24	2,400,000	1,200,000	110,000	0.9
20.7	West Virginia	■		■	■		■			■	■	■	■		■	■	■	■	■	■	■	■	■	■	■		■	■	■		Behavioral hlth	23	2,000,000	2,000,000	23 svcs	0.9
20.0	South Carolina	■		■			■	■	■	■	■	■	■		■	■	■	■	■		■	■	■	■			■	■				20	2,000,000	600,000	1,000,000	1.0
18.4	North Carolina	■	■	■	■		■		■	■	■	■	■		■	■	■		■	■	■	■	■	■	■	■		■			IC & others	23	2,000,000	750,000	n/a	0.8
17.0	Mississippi	■		■			■		■	■	■	■	■			■			■		■	■	■	■	■		■	■				17	2,000,000	1,500,000	any	1.0
16.8	Tennessee	■		■	■		■		■	■	■	■	■			■	■	■		■	■	■	■	■			■	■	■		hospice, meth	21	2,000,000	1,500,000	any beds	0.8
16.8	Dist. of Columbia	■	■	■			■	■	■	■		■	■	■	■	■	■	■	■	■	■	■	■	■	■		■	■	■			24	2,500,000	1,500,000	600,000	0.7
16.0	Kentucky	■		■			■		■	■	■	■	■		■	■	■		■	■	■	■	■	■		■	■				Mobile svcs	20	1,951,612	1,951,612	n/a	0.8
15.2	Rhode Island	■		■			■	■	■			■	■		■	■	■	■	■	■	■	■	■	■			■	■	■			19	2,000,000	1,000,000	750,000	0.8
15.0	New York	■		■	■		■	■	■	■	■	■	■		■	■	■	■	■	■	■	■	■	■	■		■	■	■	■		25	3,000,000	3,000,000	any	0.6
15.0	Hawaii	■	■	■	■		■	■	■	■	■	■	■		■	■	■	■	■	■	■	■	■	■	■		■	■	■			25	4,000,000	1,000,000	any	0.6
14.4	Maryland	■		■	■		■		■	■	■		■				■	■	■	■		■		■			■	■			fed. swing bed	16	1,600,000	n/a	any	0.9
14.4	Michigan	■	■	■			■	■	■			■	■		■	■	■		■	■	■	■						■			Hosp & Surg	18	2,500,000	any	any clin.	0.8
12.8	Washington	■		■	■		■			■		■	■				■	■	■	■		■		■	■		■		■		Hospice	16	var. by svc.	n/a	any	0.8
12.6	New Hampshire	■		■			■	■				■	■		■	■			■		■	■	■	■				■				14	1,952,870	400,000	any	0.9
12.1	New Jersey	■			■		■			■	■		■				■		■	■		■		■								11	1,000,000	1,000,000	any	1.1
11.4	Alabama	■	■	■			■		■	■			■				■	■	■	■		■	■	■	■			■	■	■	ESRD & ALC	19	4,108,000	2,054,000	any	0.6
10.4	Missouri						■	■	■		■	■	■		■	■					■		■		■	■					New hosp.	13	0.6M/1.0M	0.4M/1.0M	1,000,000	0.8
9.0	Illinois	■		■			■				■		■	■			■	■	■	■	■	■	■	■	■		■		■		Other	18	6,732,798	6,425,245	any	0.5
8.1	Iowa	■		■			■				■		■						■	■	■		■									9	1,500,000	1,500,000	500,000	0.9
8.0	Virginia	■		■			■	■	■		■	■	■		■	■	■	■	■	■	■	■	■	■				■			MSI, SPECT	20	5,000,000	n/a	n/a	0.4
7.0	Oklahoma										■		■									■					■				psych., chem.	5	500,000	n/a	any beds	1.4
6.3	Montana			■						■	■		■											■				■	■			7	1,500,000	n/a	150,000	0.9
6.3	Florida	■									■		■				■			■		■					■	■			Hospice	9	none	none	none	0.7
6.0	Arkansas									■	■		■									■				■						5	500,000	n/a	n/a	1.2
4.8	Massachusetts		■	■					■		■	■	■			■	■		■	■	■	■	■	■				■			ECMO	16	12,004,549	1,280,485	all	0.3
4.8	Delaware	■		■			■					■	■								■		■								Birthing ctrs.	8	5,000,000	5,000,000	n/a	0.6
4.4	Wisconsin										■		■														■				Others	4	1,000,000	600,000	any LTC	1.1
3.5	Nevada	■		■							■		■											■			■	■				7	2,000,000	n/a	n/a	0.5
2.4	Oregon												■																■			2	anyLTC/hs	n/a	LTC/hsp	1.2
0.5	Ohio												■																			1	2M renov	n/a	n/a	0.5
0.4	Nebraska												■											■								2	n/a	n/a	LTC >10%	0.2
0.4	Louisiana										■		■																			2	n/a	n/a	LTC/MR	0.2

Disclaimer: Rank order relates to volume of items reviewed, NOT intensity of analysis or conclusions which are based on Criteria and Standards and decisions

Source: Updated January 19, 2005, using most recent information available

A possible name for this body could be the Minnesota Medical Information Authority (MMIA). Its members should be *(see Table 4)*:

- The Commissioner of Health (1),
- Purchasers of medical care from both public and private sector (5),
- Three citizens with expert knowledge of some aspect of the medical care system (3), and
- Four citizens representing different consumer perspectives on medical care (4).

The purchasers should be mainly large purchasers in order to have some ability to influence the market for medical care. The MMIA should include the commissioners of the Department of Human Services and the Department of Employee Relations, and representatives from three private employers—two from the state's largest employers and one from a small employer. Citizens with knowledge of the medical care system (3) could include academics, those with experience in providing medical care, or those who administer plans for medical care. Citizens representing different consumer perspectives (4) could be selected on the basis of:

- One citizen who is insured through an employer,
- One citizen who purchases insurance at an individual and/or very small business level (less than 5 employees),
- One citizen who is uninsured, and
- One citizen who receives coverage for medical care through a government program.

This group must have a high degree of credibility and integrity. To help ensure the public interest, a process could be established for an administrative law judge to certify a pool of citizen candidates, who meet impartiality criteria and have little likelihood for conflict of interest. This process could also be used for the private employer candidates since some of Minnesota's largest employers may benefit from the high cost of medical care through the products or services they provide. The employer members must be consumers (they must purchase medical care for their employees). Members of the MMIA could be selected as follows:

- The Governor could choose the members from the pool with the advice and consent of the Legislature, or
- The House, the Senate and the Governor could each get a selected number of choices from the pool.

To develop the necessary expertise, the citizen/consumer positions must have some level of continuity. As noted in the quote from Walter McClure at the beginning of this section, consumers tend to have less representation in regulatory processes.

Table 4: Proposed Membership of the Minnesota Medical Information Authority (MMIA)

Commissioner of Health
to provide expertise on need and capacity from Department of Health data collection efforts and from the health economics program.
Five Purchasers of medical care from both the public and private sector
• Department of Employee Relations Commissioner
• Department of Human Services Commissioner
• Large Employer who is not a provider of medical care or insurer
• Large Employer who is not a provider of medical care or insurer
• Small Employer who is not a provider of medical care or insurer
Three Experts to be drawn from the following:
• academia
• providers of medical care, or
• administrators of medical care plan
Four Citizens representing different consumer perspectives
• One insured through an employer
• One who purchases insurance at an individual and/ or very small business level
• One who is uninsured
• One who receives coverage through a government program

The Legislature should establish the MMIA in the 2007 legislative session.

Initially, the MMIA should work with the Department of Health to establish a baseline of medical facilities and services that serve Minnesotans by:

- Examining existing authority to collect statewide information that can inform consumers on facility need and medical care cost and
- Reporting to the Legislature on what medical services are currently available and what is the current capacity and use of existing medical facilities.

If sectors of medical services or facilities have adequate capacity and more growth is not desirable, the Legislature should consider temporary controls during the first stage.

The MMIA will then determine what information should be required from all medical care providers when they increase capacity in the medical services they provide. The MMIA will establish reporting thresholds for:

- Capital expenditures on facilities and technology,
- Expansion or addition of new medical services, or
- Expected revenue streams from a change or increase in operations.

This determination must include the longer-term charge to establish information and data requirements that can lead to quality metrics. From a comprehensive data perspective, the medical care market is very data poor. Coordination of the patient, or the patient "hand-off," remains a huge obstacle to good data from which metrics can be developed. The public has better access to information about the price and quality of automobiles, for example, than it does about any medical care service. As a consumer, it is difficult to receive an accurate price estimate from an insurer or provider prior to receiving medical care. For routine preventive and non-emergency care, availability of this information before services could promote greater competition among medical care providers.

The Legislature will need to appropriate funding to establish the MMIA and any additional Department of Health functions. The MMIA would have a limited number of staff (less than five staff unless functions are identified beyond information gathering and dissemination).

If sectors of medical services or facilities have adequate capacity and more growth is not desirable, the Legislature should consider temporary controls during the first stage. Temporary controls should be designed to offset any tendency to overbuild for higher-margin services during the MMIA's information gathering stage before establishment of need.

Within 18 months of its formation, the MMIA should be required to report findings and recommendations to the Legislature. Although the nature of the MMIA effort must be comprehensive, it should have the authority to prioritize efforts with the Department of Health and other state agencies to achieve this timeline.

The report from the MMIA should be ready for action by the 2009 Legislature.

Stage 2: The Decision-Making Stage

After the MMIA's initial report, the Legislature and the MMIA will face another round of decisions. The Citizens League recommends that decision-making authority for moratorium exception decisions be transferred to the MMIA. Consequently, consumers will have the necessary voice in medical care supply decisions.

As outlined in the Minnesota Hospital Association's (MHA) Moratorium Task Force Report,[8] the Legislature should retain authority to either ratify or reject the MMIA's decision within one legislative session. Public hearings at key points in the process are also desirable.

The Legislature will provide an important check on the MMIA, but the Legislature's role should change from its current decision-making role to more of an oversight role.

With medical services and facilities baselines in place, the MMIA should require information on significant facility investments, service capacity expansions, or the creation of significant new revenue streams in the broadly defined areas of medical care that are established for information gathering in the first stage.

[8] "Moratorium Task Force Report", Minnesota Hospital Association, March 2005

On a project-by-project basis, the MMIA may employ an independent consultant who is an expert and disinterested professional with the ability to potentially provide:

- Cost research and analysis,
- Needs assessment,
- Community opinion surveys, and
- Financial and social impact on the community and investors.

Thresholds based on size of facility investment or amount of new capacity could be established to determine when to retain an independent consultant, or the decision could be left to the MMIA's discretion. The cost to retain an independent consultant and other additional costs can be assessed to the applicant for the new medical service capacity.

Testing a Market Tool

By allowing existing hospitals to retain significant numbers of unused licenses under the hospital moratorium, the state has constructed significant barriers to market competition for this additional and expensive area of medical care (see Comment section on page 18). When construction of a new hospital is allowed in this environment, the state in essence grants a franchise to the hospital operator. It is reasonable for the state to receive something for the economic value of allocating this limited resource, rather than just giving it away.

Under the current process, forces competing to build a hospital in Maple Grove reportedly spent millions of dollars, demonstrating the economic value of that franchise. Through a competitive bidding process, some of this money could have been allocated more efficiently towards needed medical care, rather than spent on lobbying efforts or mass mailings to persuade the public to favor one provider over another.

Criteria for awarding bids should include specifications of medical services to be provided and some elements (at least a minimum standard) for quality of care and ability to provide specified services. Competitors could outline how they will respond to criteria and specifications as part of a sealed bid. Awarding a hospital franchise should not be based solely on the highest bid.

The MHA's Moratorium Task Force has proposed to improve the process for decision-making under the current moratorium. That proposal is before the 2006 Legislature.[9] If the Legislature moves to enact the MHA proposal, enabling legislation should call for the Department of Health to develop a model and test criteria for

competitive bidding when proposals compete for inpatient hospital beds.

If competitive bidding begins in the Department of Health, the Legislature can decide whether the function stays in the Department or moves to the MMIA. If competitive bidding has not started, the Citizens League recommends that the Legislature authorize the MMIA to develop a competitive bidding process for inpatient hospital beds.

Ideally, competitive bidding or other market reform tools will act to reform a significant failure of the current market—the need for cross-subsidization.

The Legislature should authorize competitive bidding for inpatient hospital beds.

Regardless of the presence of competitive bidding and who conducts it, the MMIA should have the capacity to provide a proactive state function to identify need, and, at the very least, inform the public and investors whether the consumers think a proposed expansion is needed. Current law requires the Department of Health and the Legislature to react only when providers signal their desire to build inpatient hospital beds.

Proceeds from competitive bidding for inpatient hospital beds must support medical services where the greatest needs have been identified. Ongoing funding for the MMIA should come from fees paid by applicants seeking to expand capacity at a level that triggers reporting to the MMIA. Fees should be designed to cover the costs of specific regulatory processing and not become a backdoor way to fund all MMIA functions. The Legislature will need to maintain an ongoing appropriation.

An alternative to competitive bidding for inpatient hospital beds could be to directly require capacity in areas of need as part of project approvals.

The MMIA should report to the Legislature and make recommendations biennially.

The 2011 Legislature should receive recommendations on the potential to test competitive bidding on medical services and facilities other than inpatient hospital beds and recommendations on other market reform tools.

Stage 3: Market Reform

After the MMIA establishes a process to determine need and puts the new decision-making process in place, the MMIA should explore the possibility of expanding the competitive bidding process beyond hospitals to competition for other types of medical services and facilities.

If competitive bidding is applied more broadly across the medical care market, all proceeds should be used to provide greater medical services capacity where there is a demonstrated need.

Ideally, competitive bidding or other market reform tools will act to reform a significant failure of the current market—the need for cross-subsidization.

Stage 4: Regulatory Reform

Once the competitive bidding process and/or other market reforms are in place to create significant price transparency, the MMIA can assess the benefits and risks of removing the inpatient hospital bed moratorium and make recommendations to the Legislature. To consider removing the moratorium, the need for cross-subsidization must decline significantly.

Developing informed decisions

The report of the Medical Facilities Study Committee is purposefully not prescriptive about many of the details that follow from the establishment of the Minnesota Medical Information Authority (MMIA). That is by design. All efforts to align medical facility capacity with need for medical services must be informed to a much greater degree than is possible today.

Information is the basis to provide an improved system for medical care in Minnesota. Each set of decisions must be based on in-depth information and should not adhere to a rigid structure.

This proposal is a vehicle to begin to address the seemingly intractable problems in the delivery of medical care—unsustainable costs, market and regulatory failure, and the imperative to construct a system where consumers have meaningful choices.

Comment

Excess Licenses

Minnesota has nearly 12,000 inpatient hospital beds staffed or immediately available to be staffed. Existing hospitals have an additional 4,700 licensed beds that can be used without legislative approval if used on existing hospital sites. Some systems hold large numbers of unused licenses (sometimes referred to as "banked" beds) year after year (see Appendix). The presence of unused licenses increases the already substantial barriers to entering the hospital market. Excess licenses could also lead to major increases in capacity without a process to determine need. The Legislature should consider limiting the amount of excess licenses held by existing hospitals to a reasonable percentage of the beds currently in use.

Community Benefit

Minnesota has a largely not-for-profit health care community. In particular, hospitals and health plans in Minnesota are not-for-profit. The only standard behind their non-profit status is the definition of "community benefit" by the Internal Revenue Service (IRS) for tax purposes. The 2006 Tax Expenditure Budget published by the Minnesota Department of Revenue estimates $214 million in tax benefits for FY2006 alone for this nonprofit status. This number does not include all tax subsidies for non-profit medical facilities and health plans. It excludes, for example, the authority to issue tax-exempt bonds. Through the moratorium and the control of excess licenses, the state has granted what is essentially a franchise status and significant tax benefits to hospitals. Minnesota should collect information uniformly and develop a standard of community accountability to govern not-for-profit health care entities. An established standard for hospital and health plan non-profit status becomes more critical as more public hospitals turn into not-for-profit hospitals.

Education of Health Professionals

Minnesota must assure that the opportunities to educate and train medical professionals (including physicians, pharmacists, nurses, dentists, etc.) are improved and expanded as the needs in health care change. Market reform and regulatory reform efforts cannot overlook this critical foundation for our health care success.

Historical Background

Health insurance began in the 1930s when too many families could not pay for services and hospitals were in financial trouble due to the depression. Initially thought of as prepayments, employers began to offer medical insurance during World War II to attract and retain employees when federal regulations restricted wage increases. This began today's employer-based system for providing health care insurance. Since workers do not pay taxes on health benefits, unions sought to include these benefits in contracts.

An employer-based health insurance system with third-party payors results in a cost pass-through arrangement that essentially bills the American economy for large portions of our medical care. This arrangement does not exist in any other area of the economy. As a result, it is beginning to displace the financing of other government functions as costs increase.

Soon after the federal government established itself as a third-party payor by establishing Medicare, researchers described the new dynamic:

"In no other realm of economic life is repayment guaranteed for costs that are neither controlled by competition nor regulated by public authority and in which no incentive for economy can be discerned."

– Herman M. and Anne R. Somers, Medicare and the Hospitals, Brookings Institution, 1967

The federal government first provided funds for health planning agencies under the Hill-Burton Act passed in 1946. Throughout the 1970s, Certificate of Need (CON) regulations were established in every state and ultimately mandated by the federal government. The federal government repealed the CON mandate in 1986. Thirty-seven states still have CON laws.

Minnesota established a CON process in 1971. The Legislature repealed the CON law in 1984 and replaced it with the moratorium on inpatient hospital beds. That moratorium was originally set to expire in 1987 but was made permanent and is still in effect today.

Appendix

Bed Capacity In Minnesota Acute Care Hospitals, 2003 *(Sorted by number of unused licenses)*

Name	City	County	Licensed Beds*	Available Beds**	#Unused Licenses***	%Unused Licenses***
Fairview-University Medical Center	Minneapolis	Hennepin	1,700	729	971	57%
Hennepin County Medical Center	Minneapolis	Hennepin	910	422	488	54%
Rochester Methodist Hospital	Rochester	Olmsted	794	350	444	56%
Saint Marys Hospital	Rochester	Olmsted	1,157	823	334	29%
Abbott Northwestern Hospital	Minneapolis	Hennepin	926	627	299	32%
St. Joseph's Hospital	St. Paul	Ramsey	401	244	157	39%
Bethesda Rehabilitation Hospital	St. Paul	Ramsey	264	145	119	45%
Immanuel St. Joseph's - Mayo Health System	Mankato	Blue Earth	272	169	103	38%
United Hospital	St. Paul	Ramsey	556	457	99	18%
North Memorial Medical Center	Robbinsdale	Hennepin	518	432	86	17%
St. Mary's Medical Center	Duluth	St. Louis	380	298	82	22%
Fairview Southdale Hospital	Edina	Hennepin	390	322	68	17%
Valley Hospital at Hidden Lakes	Golden Valley	Hennepin	92	25	67	73%
Regions Hospital	St. Paul	Ramsey	427	360	67	16%
Unity Hospital	Fridley	Anoka	275	211	64	23%
St. Cloud Hospital	St. Cloud	Stearns	489	425	64	13%
Mercy Hospital	Coon Rapids	Anoka	271	212	59	22%
Methodist Hospital Park Nicollet Health Services	St. Louis Park	Hennepin	426	370	56	13%
District One Hospital	Faribault	Rice	99	45	54	55%
Grand Itasca Clinic and Hospital & C&NC	Grand Rapids	Itasca	95	49	46	48%
Lakeview Hospital	Stillwater	Washington	97	52	45	46%
Albert Lea Medical Center - Mayo Health System	Albert Lea	Freeborn	107	73	34	32%
Rice Memorial Hospital	Willmar	Kandiyohi	136	102	34	25%
Buffalo Hospital	Buffalo	Wright	65	34	31	48%
Community Memorial Hospital	Winona	Winona	99	68	31	31%
Owatonna Hospital	Owatonna	Steele	77	48	29	38%
United Hospital District	Blue Earth	Faribault	43	15	28	65%
Queen of Peace Hospital	New Prague	Scott	56	28	28	50%
Douglas County Hospital	Alexandria	Douglas	127	99	28	22%
Pipestone County Medical Center	Pipestone	Pipestone	44	19	25	57%
Falls Memorial Hospital	International Falls	Koochiching	49	25	24	49%
Riverview Healthcare Association	Crookston	Polk	49	25	24	49%
First Care Medical Services	Fosston	Polk	43	21	22	51%
St. Mary's Regional Health Center	Detroit Lakes	Becker	87	65	22	25%
Austin Medical Center - Mayo Health System	Austin	Mower	99	77	22	22%
Monticello-Big Lake Hospital	Monticello	Wright	39	18	21	54%
St. Luke's Hospital	Duluth	St. Louis	267	246	21	8%
Long Prairie Memorial Hospital & Home	Long Prairie	Todd	34	15	19	56%
Regina Medical Center	Hastings	Dakota	57	38	19	33%
Tri-County Hospital	Wadena	Wadena	49	31	18	37%
Fairview Ridges Hospital	Burnsville	Dakota	150	133	17	11%
St. Peter Community Hospital and Health Care	St. Peter	Nicollet	36	20	16	44%
Virginia Regional Medical Center	Virginia	St. Louis	83	67	16	19%
St. James Health Services	St. James	Watonwan	27	12	15	56%
Olmsted Medical Center	Rochester	Olmsted	61	47	14	23%
New Ulm Medical Center	New Ulm	Brown	62	48	14	23%
Miller-Dwan Medical Center	Duluth	St. Louis	165	151	14	8%
Swift County-Benson Hospital	Benson	Swift	31	18	13	42%
Glacial Ridge Health System	Glenwood	Pope	34	21	13	38%
St. Michael's Hospital & Nursing Home	Sauk Centre	Stearns	28	16	12	43%
Riverwood HealthCare Center	Aitkin	Aitkin	36	24	12	33%
Cuyuna Regional Medical Center	Crosby	Crow Wing	42	30	12	29%
Weiner Memorial Medical Center	Marshall	Lyon	49	37	12	24%
Fairview Red Wing Medical Center	Red Wing	Goodhue	50	38	12	24%
Saint Elizabeth's Medical Center	Wabasha	Wabasha	31	20	11	35%
Waseca Medical Center - Mayo Health System	Waseca	Waseca	35	24	11	31%
Glencoe Regional Health Services	Glencoe	Mcleod	49	38	11	22%
Fairview Lakes Regional Medical Center	Wyoming	Chisago	61	50	11	18%
Phillips Eye Institute	Minneapolis	Hennepin	20	10	10	50%
Sleepy Eye Municipal Hospital	Sleepy Eye	Brown	25	15	10	40%
Melrose Area Hospital - CentraCare	Melrose	Stearns	28	18	10	36%
Lake View Memorial Hospital & Home	Two Harbors	Lake	30	20	10	33%
Windom Area Hospital	Windom	Cottonwood	35	25	10	29%
Redwood Area Hospital	Redwood Falls	Redwood	40	30	10	25%
Stevens Community Medical Center	Morris	Stevens	54	44	10	19%
Kanabec Hospital	Mora	Kanabec	49	40	9	18%
St. Francis Regional Medical Center	Shakopee	Scott	70	61	9	13%
St. Joseph's Medical Center	Brainerd	Crow Wing	162	153	9	6%
Minnesota Valley Health Center	Le Sueur	Le Sueur	24	16	8	33%
Hendricks Community Hospital Association	Hendricks	Lincoln	26	18	8	31%
Cloquet Community Memorial Hospital & C&NC	Cloquet	Carlton	36	28	8	22%
Gillette Children's Specialty Healthcare	St. Paul	Ramsey	60	52	8	13%

Source: MDH, Health Care Cost Information System, 2003.

Name	City	County	Licensed Beds*	Available Beds**	#Unused Licenses***	%Unused Licenses***
St. Joseph's Area Health Services, Inc.	Park Rapids	Hubbard	50	43	7	14%
Ridgeview Medical Center	Waconia	Carver	109	102	7	6%
Mercy Hospital & Health Care Center	Moose Lake	Carlton	31	25	6	19%
Ely-Bloomenson Hospital & Nursing Home	Ely	St. Louis	32	26	6	19%
Westbrook Health Center	Westbrook	Cottonwood	13	8	5	38%
Granite Falls Municipal Hospital & Manor	Granite Falls	Yellow Medicine	30	25	5	17%
Pine Medical Center	Sandstone	Pine	30	25	5	17%
St. John's Hospital	Maplewood	Ramsey	184	179	5	3%
Bigfork Valley Hospital	Bigfork	Itasca	20	16	4	20%
Northfield Hospital & Long Term Care Center	Northfield	Dakota	37	33	4	11%
Hutchinson Area Health Care	Hutchinson	Mcleod	66	62	4	6%
Mahnomen Health Center	Mahnomen	Mahnomen	18	15	3	17%
Sibley Medical Center	Arlington	Sibley	20	17	3	15%
Springfield Medical Center - Mayo Health System	Springfield	Brown	24	22	2	8%
Murray County Memorial Hospital	Slayton	Murray	25	23	2	8%
Sioux Valley Canby Campus	Canby	Yellow Medicine	27	25	2	7%
Fairmont Medical Center - Mayo Health System	Fairmont	Martin	57	55	2	4%
Graceville Health Center	Graceville	Big Stone	15	14	1	7%
Fairview University Medical Center - Mesabi	Hibbing	St. Louis	175	175	0	0%
Children's Hospitals and Clinics, Minneapolis	Minneapolis	Hennepin	153	153	0	0%
Children's Hospitals and Clinics, St. Paul	St. Paul	Ramsey	116	116	0	0%
Lake Region Healthcare Corporation	Fergus Falls	Otter Tail	108	108	0	0%
Northwest Medical Center	Thief River Falls	Pennington	99	99	0	0%
North Country Health Services	Bemidji	Beltrami	98	98	0	0%
Cambridge Medical Center	Cambridge	Isanti	86	86	0	0%
Woodwinds Health Campus	Woodbury	Washington	70	70	0	0%
Worthington Regional Hospital	Worthington	Nobles	66	66	0	0%
St. Gabriel's Hospital	Little Falls	Morrison	49	49	0	0%
St. Francis Medical Center	Breckenridge	Wilkin	47	47	0	0%
Fairview Northland Regional Hospital	Princeton	Sherburne	41	41	0	0%
Lakewood Health System	Staples	Wadena	40	40	0	0%
Meeker County Memorial Hospital	Litchfield	Meeker	38	38	0	0%
Chippewa County-Montevideo Hospital	Montevideo	Chippewa	30	30	0	0%
Paynesville Area Health Care System	Paynesville	Stearns	30	30	0	0%
Perham Memorial Hospital and Home	Perham	Otter Tail	29	29	0	0%
Luverne Community Hospital	Luverne	Rock	28	28	0	0%
Mille Lacs Health System	Onamia	Mille Lacs	28	28	0	0%
Clearwater Health Services	Bagley	Clearwater	25	25	0	0%
Madelia Community Hospital	Madelia	Watonwan	25	25	0	0%
Ortonville Area Health Services	Ortonville	Big Stone	25	25	0	0%
Renville County Hospital	Olivia	Renville	25	25	0	0%
Roseau Area Hospital & Homes, Inc.	Roseau	Roseau	25	25	0	0%
Tracy Area Medical Services	Tracy	Lyon	25	25	0	0%
Wheaton Community Hospital	Wheaton	Traverse	25	25	0	0%
Cannon Falls Community Hospital	Cannon Falls	Goodhue	21	21	0	0%
Deer River HealthCare Center	Deer River	Itasca	20	20	0	0%
ELEAH Medical Center	Elbow Lake	Grant	20	20	0	0%
Jackson Medical Center	Jackson	Jackson	20	20	0	0%
Johnson Memorial Health Services	Dawson	Lac Qui Parle	20	20	0	0%
North Valley Health Center	Warren	Marshall	20	20	0	0%
Tyler Healthcare Center, Inc.	Tyler	Lincoln	20	20	0	0%
Minnewaska Regional Health System	Starbuck	Pope	19	19	0	0%
Divine Providence Health Center	Ivanhoe	Lincoln	18	18	0	0%
Lake City Medical Center - Mayo Health System	Lake City	Wabasha	18	18	0	0%
Albany Area Hospital and Medical Center	Albany	Stearns	17	17	0	0%
Cook County North Shore Hospital	Grand Marais	Cook	16	16	0	0%
White Community Hospital & C&NC	Aurora	St. Louis	16	16	0	0%
Appleton Municipal Hospital and Nursing Home	Appleton	Swift	15	15	0	0%
Kittson Memorial Healthcare Center	Hallock	Kittson	15	15	0	0%
LakeWood Health Center	Baudette	Lake Of The Woods	15	15	0	0%
Bridges Medical Services	Ada	Norman	14	14	0	0%
Cook Hospital & C&NC	Cook	St. Louis	14	14	0	0%
Madison Hospital	Madison	Lac Qui Parle	13	13	0	0%
Lakeside Medical Center, Inc. - Hospital	Pine City	Pine	10	10	0	0%
TOTALS			**16,390**	**11,700**	**4,690**	**29%**

*Licensed Beds: The number of beds licensed by the Department of Health, pursuant to Minnesota Statutes, sections 144.50 to 144.58.

**Available Beds: The number of acute care beds that are immediately available for use or could be brought online within a short period of time. Available beds should not include: labor rooms, bassinets, post-anesthesia beds, postoperative beds, or other non-routine beds.

*** Unused Licenses: The number and percent of total licenses that are not immediately available for use (calculations by Citizens League).

The Work of the Medical Facilities Study Committee

Charge to the Committee

Minnesotans care about good health but are concerned about the rising costs of medical care. There is no process that provides basic criteria to help Minnesotans determine when a new or expanded medical facility is necessary to provide access to acceptable levels of medical services and to keep the cost of those services as affordable as possible. In the case of our highest cost facilities—hospitals—the state does have the responsibility to conduct a public interest review, but there is no authority that extends directly from that review, nor is there consideration of hospital expansion in relation to the availability of other medical facilities that provide medical services on an outpatient basis.

The result is an ad-hoc process that relies on legislative approval and does not account for the overall needs and relative costs of our medical care system.

The Study Committee on Medical Facility Expansion is charged to determine the following:

- How effectively is the state able to determine service and facility needs for medical care throughout Minnesota?
- How do financial incentives affect investment in medical facilities?
- What should the process be that links medical care with medical facility need in an attempt to provide the most cost-effective medical care system for Minnesota?

The Citizens League Medical Facilities Study Committee held nine committee meetings over an 18-week period, starting October 27, 2005 and finishing on March 10, 2006.

Study Committee Membership

Duane Benson, Co-Chair	Tony Jaspers	Harry Sutton
Peter Gove, Co-Chair	Sister Mary Madonna	Tom Swain
Allan Baumgarten	Lorry Massa	Joseph Tashjian
Deb Boardman	Michael Morrow	Blair Tremere
Carrie Coleman	Ed Oliver	John Tschida
Gary Cunningham	Christine Rice	Jonathan Weiss
Kathleen Doran-Norton	Doug Robinson	Ron White
Candace Dow	Rochelle Schultz Spinarski	
Linda Ewen	Carolyn Smallwood	

The committee received testimony from the following individuals and organizations:

Scott Leitz and Julie Sonier, Minnesota Department of Health

Caroline Steinberg, American Hospital Association

Mark Shaw, Blue Cross and Blue Shield of Minnesota

Stefan Gildemeister and Elizabeth Lukanen, Minnesota Department of Health

David Durenberger, National Institute of Health Policy (NIHP), University of St. Thomas

Frank Cerra, Academic Health Center, University of Minnesota

Jacqueline Darrah, Halleland Lewis Nilan & Johnson

Kent Wilson, Minnesota Ambulatory Health Care Consortium

Dave Cress, North Memorial

David Wessner, Park Nicollet

Joseph Tashjian, St. Paul Radiology

Steve Parente, Carlson School of Finance

The Citizens League thanks the following sponsor for their generous support of this project:

Minnesota Blue Cross and Blue Shield of Minnesota, an independent licensee of the Blue Cross and Blue Shield Association

Staffing and Support:

Bob DeBoer staffed this committee with assistance from Sean Kershaw, Sarah Idowu, Rachel Foran and Trudy Koroschetz.

About the Citizens League

The Citizens League mission is to build civic capacity in Minnesota by:

- Identifying, framing and proposing solutions to public policy problems;
- Developing new generations of civic leaders who govern for the common good; and
- Organizing the individual and institutional relationships necessary to achieve these goals.

The Citizens League has been a reliable source of information for Minnesota citizens, government officials and community leaders concerned with public policy for over 50 years. Volunteer committees of Citizens League members study issues in depth and develop informational reports that propose solutions to public problems.

The Citizens League depends upon the support of individual members and contributions from businesses, foundations, and other organizations.

For more information visit the Citizens League website at www.citizensleague.net.

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1964-65	James R. Pratt	1978-79	Wayne Popham	1992-93	John Brandl		

Citizens League

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