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GAO

United States General Accounting Office
Washington, DC 20548

Human Resources
Division

B-197538

MARCH 13, 1980

The Honorable Patricia Roberts Harris
The Secretary of Health, Education, and
Welfare AGC00022

Dear Mrs. Harris:

Subject: Unreliability of the American Health Planning Association's Savings Estimate for the Health Planning Program (HRD-80-49)

In early 1979 the American Health Planning Association, a national organization representing areawide and State health planning agencies established under the National Health Planning and Resources Development Act of 1974, completed a survey of the impact of the health planning program. The Association reported that planning agencies had disapproved or discouraged proposed capital investment projects totaling $3.4 billion between August 1976 and August 1978. It also estimated that planning agencies had saved the health care system at least $8 for every $1 spent on health planning. About $2.2 billion of the $3.4 billion related to data developed from responses to a questionnaire that the Association sent to health systems agencies (HSAs) and State health planning and development agencies (State agencies) throughout the United States. The other $1.2 billion related to data shown in a consultant's study of the Los Angeles County area. The Association further estimated that disapproval of these projects would save at least another $10 billion in related operating costs during the 1980s.

As part of our current study of the implementation of the health planning act, we found that data supporting the Association's $3.4 billion total savings estimate were unreliable and, therefore, not an accurate measure of the health planning program's impact. Specifically, of the $2.2 billion related to HSA and State agency reviews of proposed projects, $1 billion could not be supported from

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data in the questionnaire responses, and $1.2 billion was questionable because of deficiencies in the questionnaire development process. Also, the $1.2 billion savings estimate for Los Angeles County is unreliable and inconsistent with other survey data the Association used in computing its total savings estimate.

Our conclusions relate only to the reliability of the Association's overall savings estimate; they should not be interpreted as meaning that the health planning program has not prevented unneeded investment in the health care system. The issue of savings is difficult to address and requires a detailed analysis of the action taken on each proposed capital investment, with considerable input from health planning agencies' staffs and other knowledgeable persons. This became evident when we did work to further evaluate the Association's savings estimate at selected HSAs. We identified instances where health planning agencies have succeeded in preventing unnecessary capital investment in the health care system and in modifying proposals to better meet the needs of health service area residents.

BACKGROUND

Health planning agencies strive to contain health care costs through two laws:

1. The National Health Planning and Resources Development Act of 1974 (Public Law 93-641).

2. Section 1122 of the Social Security Act, 1972 Amendments (Public Law 92-603).

Public Law 93-641 established a network of health planning organizations--HSAs and State agencies--to contain health care costs and improve access to quality health care. It also requires States to administer Certificate-of-Need laws to review and determine the need for (1) proposed new institution-based health services, (2) changes in services, and (3) purchases of expensive equipment. State Certificate-of-Need programs must be approved by HEW. Under such programs, HSAs review proposed projects and make recommendations to the State agency. The State agency approves or disapproves the project after considering the HSA's recommendation.

Section 1122 of Public Law 92-603 provides that the Medicare, Medicaid, and Maternal and Child Health programs will not allow reimbursement to health care organizations for depreciation, interest expenses, or return on equity for capital expenditures in excess of $100,000, unless these items are approved by the State agency. HEW has final approval authority and can override the State agency decision. In many States, this law reinforced existing project review functions, thereby providing a stronger mechanism for preventing the establishment of unneeded health care facilities. Through agreements with HEW, State agencies may participate in the section 1122 approval process by providing recommendations to HEW.

All States have either a section 1122 agreement with HEW or a Certificate-of-Need program.

In September 1978, the Association sent questionnaires to HSAs and State agencies to collect data on the results of their reviews of proposed new institutional health services during the 2-year period ended August 1, 1978. The Association summarized responses from 166 HSAs and 3 State agencies. It also obtained data from a consultant's study on project review activities in Los Angeles County. In February 1979 the Association reported the following:

--HSAs and State agencies reviewed proposals for capital investment projects totaling about $12 billion; projects totaling $3.4 billion were disapproved or discouraged. The proposed projects included 16,000 new hospital beds; projects involving 7,900 beds were disapproved or discouraged. Further, proposed projects included 114,000 nursing home beds; projects involving 49,000 were disapproved or discouraged.

--The operating cost savings associated with the disapproved projects will amount to at least $10 billion during the 1980s.

The Association's report distinguished between official and unofficial disapprovals. Official disapprovals were proposed projects actually submitted to the planning agencies for review and formally disapproved. Unofficial disapprovals were proposed projects not actually submitted to the planning agencies because the applicants were discouraged by the planning agencies, or submitted and withdrawn before the HSA

governing board took final action. The $3.4 billion estimated savings consisted of about $2.2 billion in official disapprovals and about $1.2 billion in unofficial disapprovals.

The information in the Association's February 1979 report was supplied to Members of Congress and used by both the Association and HEW during congressional hearings. Although the Association's report described the difficulty of accurately documenting health planning impact using a questionnaire survey, Association officials testified before the Congress in March 1979 that, using conservative estimates, health planning agencies saved $8 in unnecessary capital investment for every $1 spent on health planning. The $8 to $1 savings-to-investment ratio was based on official disapprovals. At the same hearings, HEW officials testified that the Association's survey was tangible evidence of the impact of these agencies.

THE ASSOCIATION'S ESTIMATED SAVINGS ARE UNRELIABLE

The data supporting the Association's $3.4 billion savings estimate were unreliable because:

--The questionnaire responses from HSAs did not support a conclusion that their actions had actually prevented an unnecessary capital investment of $1 billion in health care facilities.

--The questionnaire was not properly developed, making $1.2 billion of the savings estimate questionable.

--The estimated $1.2 billion savings for Los Angeles County was based on unreliable data from a consultant's study, which were inconsistent with other survey data used by the Association in computing its savings estimate.

Questionnaire responses do not support savings

In summarizing questionnaire responses, the Association included $1 billion in estimated savings for projects for which the data did not support a conclusion that the planning agencies had prevented an unneeded capital investment in the

health care system. 1/ Our estimate is based on review of a statistical sample of all HSA questionnaire responses received by the Association. We reviewed 56 responses, involving 534 project proposals included in the savings estimate. For 194 of the 534 project proposals, the questionnaire data did not support a conclusion that savings had actually been realized for one or more of the reasons discussed below.

--State agency decision: Under State Certificate-of-Need programs and section 1122 agreements with HEW, State agencies make final approval or disapproval decisions on proposed projects after considering HSA recommendations, although HEW can overrule the State agency decision under the section 1122 program. Included in our sample were 90 projects for which the Association reported savings even though (1) the State agency disagreed with the HSA's recommendation and approved the project (35 instances), (2) the State agency decision was pending (23 instances), or (3) the HSA did not record the State agency decision (32 instances). Without State agency disapproval, we do not believe the Association should have included these proposed projects in the savings estimate.

--Qualifying comments: Our sample also included 76 projects for which the HSA questionnaire response indicated savings may not have occurred or were not attributable to HSA and State agency actions. For example, the Association included (1) disapproved or withdrawn projects that had already been resubmitted, were expected to be resubmitted, or had been built

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1/Based on our statistical sample, we estimate, with 95-percent confidence, that the Association's estimated savings of $2.2 billion developed from data included in responses to a questionnaire sent to HSAs and State agencies (which excludes the study covering Los Angeles County) includes $994,784,000, plus or minus $84,687,000, for which the Association's data do not support a claim of savings. Although we found transcription errors in computing total savings from individual responses, these errors do not materially affect the unsupported savings. See enclosure I for a description of the statistical sampling methodology used in our analysis.

despite the disapproval, (2) projects withdrawn because of factors other than health planning, such as inability to obtain project financing, (3) projects that were deemed needed or were approved, and (4) projects that were not appropriately classified as a new investment in the health care system.

--Multiple submittals: Our sample also included 42 projects for which the Association had failed to identify and remove from the savings estimate instances where the same proposal had been submitted more than once. They had either been (1) initially disapproved but later approved by the HSA or (2) disapproved on successive occasions by the HSA. For the latter group, the Association counted each disapproval separately in the savings estimate.

Deficiencies in the questionnaire

There were several deficiencies in how the Association's questionnaire was developed--the transmittal letter contained statements that would tend to bias respondents; the questionnaire was not pretested; and most important, the questionnaire did not request sufficient data for the Association to conclude when a savings resulted from the health planning agencies' efforts. Consequently, we believe the remaining $1.2 billion of the estimated savings developed from the questionnaire is also unreliable.

The Association biased the questionnaire by emphasizing in its transmittal letter the need for cost savings data to secure adequate congressional appropriations. The letter stated:

"* * * The information pertaining to 'cost savings' is most urgently needed in order to improve our chances for securing adequate appropriations in fiscal years 1979 and 1980. I must add that our prospects for adequate appropriations are not very bright at this moment. * * *"

In our opinion, this statement would tend to influence health planning agencies to include questionable savings.

The Association did not pretest its questionnaire, even though this is standard procedure. According to Association officials, there was not enough time for pretesting because of imminent program reauthorization hearings. In a pretest, a draft questionnaire is given to a sample of potential respondents. After individually monitoring its completion, the questionnaire is discussed thoroughly with each respondent to determine any difficulties encountered and identify any ambiguous or biased questions. Any problems are corrected before final issuance of the questionnaire. This procedure provides greater assurance that respondents will understand the questions and provide useful data. Pretesting would have given the Association an opportunity to identify and correct many of the problems we found.

The Association's questionnaire did not request sufficient information to conclude that the health planning program prevented an unneeded capital investment that resulted in a savings, nor did it define what was to be considered as a savings. Instead, it requested the planning agencies to provide information on all proposed project review activities. The information requested was not sufficient to determine whether actual savings had resulted. For example, the questionnaire did not ask planning agencies (1) whether or not the project was needed, (2) whether the health planning program was responsible for the disapproval or withdrawal, or (3) whether the disapproval or withdrawal represented the final action on the project. As shown by our analysis of a sample of projects, applicants may be revising project plans for future submission, and other factors (such as lack of financing) may have discouraged the capital investment. (See p. 5.)

In January 1979 the Association again surveyed health planning agencies to obtain project review information. The results of this survey may also be questionable because its questionnaire had many of the same deficiencies as the earlier one.

To help improve the questionnaire, we have offered to provide technical assistance to the Association so that future surveys will have greater reliability.

Study of activities
in Los Angeles County

Because HEW terminated the HSA for Los Angeles County before it began to review proposals for new institutional health services, the Association did not have data for that area. However, the Association used data from a study prepared by a consultant under contract to the HSA. These data should not have been included in the savings estimate, because they were unreliable and inconsistent with other data the Association used.

Under the California program, certain proposed projects for replacing or remodeling existing facilities may be granted an exemption from the Certificate-of-Need review and approval process. For projects where an exemption is denied, the applicant must follow the normal Certificate-of-Need review and approval process before proceeding with the project.

The Association's savings estimate included $1.2 billion which, according to the consultant's study, represented the total estimated cost of projects denied an exemption from the California Certificate-of-Need program. We believe that including these data in the savings estimate is inappropriate, because the projects are still subject to the Certificate-of-Need review and approval process.

The consultant told us that the Association should not have included the savings associated with the denials of exemptions because the data in the study had not been verified and were unreliable. According to the consultant, proposals denied an exemption should not be considered savings unless they are followed to their final outcome. He added that, had he been contacted, he would have discouraged the Association from using these data.

Data published in June 1978 by the California Department of Health also demonstrated that the consultant's data were unreliable. For approximately the same period for which the consultant had reported denials of exemptions totaling $1.2 billion for the Los Angeles County area, the State agency had reported denials totaling only about $650 million for all of California--including Los Angeles County.

ESTIMATED OPERATING COST SAVINGS ARE UNRELIABLE

The Association reported that at least $10 billion in operating costs would be saved during the 1980s as a result of the savings in capital investments. Because most survey respondents did not provide useful operating cost data, the Association computed savings using a ratio of $3 of operating cost savings for every $1 of capital investment saved. However, because the Association's capital cost savings estimate is unreliable, the Association's estimate of operating costs savings is also unreliable.

ASSOCIATION COMMENTS AND OUR EVALUATION

The Association's comments on our report (see enc. II) do not provide information that would change our conclusion that its $3.4 billion claimed savings estimate is unreliable and should not be used as a measure of the impact of health planning agencies. Throughout its comments, the Association presented issues that were outside the scope of our audit, which was to assess the reliability of the Association's $3.4 billion savings estimate. We addressed these comments to the extent they relate to the development or reliability of the savings estimate.

The Association is concerned that our report "risks a serious distortion" of the health planning program, because it deals too negatively with a small portion of the large and complicated question of the nature and effect of the health planning program. Our report clearly states that it should not be interpreted as meaning that the health planning program has not successfully prevented unneeded investment in the health care system. In our opinion, it only rectifies the distortions concerning the savings estimate, which were introduced by the Association in its survey report and during its congressional testimony.

Our detailed evaluation is organized to correspond with the numbered captions in the Association's comments.

I. THE SURVEY INSTRUMENT

In this section of its comments, the Association:

--Denied that its survey transmittal letter was biased.

--Suggested that the lack of a pretest did not adversely affect the survey instrument.

--Indicated that it did assess whether specific projects were needed.

Survey transmittal letter

We want to emphasize that our report does not assert that the Association was biased in its study--only that its survey transmittal letter contained comments that would tend to bias the questionnaire respondents. The paragraph quoted in our report states:

> "* * * The information pertaining to 'cost savings' is most urgently needed in order to improve our chances for securing adequate appropriations in fiscal years 1979 and 1980. I must add that our prospects for adequate appropriations are not very bright at this moment. * * *"

In our opinion, this was too strong to be overcome by the statements also included in the transmittal letter which were referred to in the Association's comments:

> "It is important to emphasize two other points regarding the data needed. First, we are interested in the whole picture of health planning--the problems and impediments as well as the successes and accomplishments. Second, the data reported must be as 'hard' as possible, and we must be able, in our analysis, to distinguish between solid facts and estimates or impressions that are not part of the written record and/or derived from expert testimony. * * *"

As a practical matter, we believe the statements referred to by the Association might put respondents more at ease in submitting soft as well as hard data, because the Association suggests it will analyze the data to pull out hard facts from estimates or impressions. Our work suggests strongly that the Association did not carry through on its promise to conduct a thorough analysis of the data submitted.

Also, the Association's argument that it included the first quoted paragraph merely to get attention is not very persuasive, since the paragraph appears in the middle of the second page of the three-page transmittal letter.

Pretesting the survey instrument

The Association commented that the lack of pretesting the survey questionnaire was not important because (1) it was developed by reputable researchers and suggested modifications were solicited and received from many knowledgeable persons, including members of HSA staff and staff of the Bureau of Health Planning, and (2) few changes had to be made to the followup questionnaire.

Regardless of who developed the survey instrument and provided comments, the facts remain that the survey instrument did not:

--Define what was to be considered savings.

--Request sufficient information to conclude that a savings resulted from preventing unneeded capital investment.

Our report suggests that the Association could have obtained a better savings estimate if it had asked planning agencies whether:

--A project was needed.

--The health planning program was responsible for the disapproval or withdrawal.

--The disapproval or withdrawal represented the final action on the project.

The HSAs we visited could provide the data referred to above. They generally had excellent documentation (applications, staff summaries of the project application, subarea council discussions and recommendations, and executive committee and board minutes) regarding their review of specific projects.

The Association's argument that the few changes required for the followup questionnaire validated the original questionnaire is not persuasive, since the followup questionnaire contained many of the same problems (referred to above) as the first.

Assessing whether projects were needed

The Association stated that its questionnaire did ask whether a project was consistent with the health systems plan and that this was the best available proxy for determining the need for a project. This may be an acceptable proxy if health systems plans were specific about health service area needs. However, our current review indicates that health systems plans generally lack such specificity. Interestingly, the Association did not consider the HSA responses to the question of consistency with the health plan in computing its estimated savings.

We believe that obtaining the health planning agencies' judgments on the need for specific projects is the best evidence of need.

II. THE VALIDITY OF THE NUMBERS

The Association made several comments regarding our conclusion that $1.0 billion of the $2.2 billion savings estimate was not supportable.

Data on State agency actions are not necessary

The Association does not agree with our conclusion that HSA disapprovals should not be counted as savings until the State agency's action is known. Also, the Association suggested that State agency actions are usually consistent with HSA recommendations.

Both the Certificate-of-Need and section 1122 project review programs provide for final decisions to be made by the State agency after receipt of HSA recommendations. We believe recognition of State agency action is necessary before including projects in the savings estimate. The Association's congressional testimony and report imply that State agency decisions were used in computing its savings estimate. In fact, only three State agency responses were used by the Association in computing its savings estimate. Also, even though the HSA questionnaire form indicated State agency decisions, the Association chose not to use this information. We believe that the Association should have made it clear in its February 1979 survey report and congressional testimony that its savings estimate was based on HSA actions only.

In its comments, the Association contended that it "sought to identify, and quantify as accurately as possible, what the planning agencies were doing." The use of the term "planning agencies" again seems to imply that State agency decisions were considered.

The Association's contention that State agency actions are usually consistent with HSA recommendations is well taken and could be accurate. However, its claim that most State agency reversals are overturns of HSA-recommended approvals was not supported by our analysis. Data we developed from our sample indicated 34 instances where the State agency disagreed with the HSA disapproval recommendations and approved the project. There were 16 instances where the State agency overturned an HSA recommendation of approval.

Withdrawals and multiple submissions

The Association stated that including multiple submissions of the same project in the estimated savings was not serious. We disagree. For example, one applicant submitted three proposals to construct an extended care facility. The HSA and State agency disapproved the first and second proposals--at about $3.6 million and $2.7 million, respectively--and approved the third proposal for about $2.0 million. The Association included $6.3 million in its savings estimate--the estimated costs of the first and second proposals. We believe that the Association should have included only $1.6 million--the difference between the cost of the largest proposal and the cost of the proposal finally approved.

The Association's comments indicate a misinterpretation of our report regarding withdrawals. We did not question counting withdrawals as savings unless the project had been resubmitted or when HSA qualifying comments indicated a savings may not have occurred, such as when it was indicated that the applicant planned to resubmit the project.

The Association's comment that it counted withdrawals "most frequently" as unofficial savings rather than official savings illustrates, in our opinion, the lack of precision in compiling the savings estimate.

GAO failed to consider all savings

The Association stated that, if it were wrong in every case, the total savings would not be affected significantly and that any errors would be counterbalanced by savings we did not consider. All savings included in the Association's $3.4 billion estimate were considered in our review. Whether unreported savings, undocumented savings resulting from project approvals, or moratoriums placed by planning agencies on new hospital bed construction would counterbalance the errors we found in the savings estimate, as suggested by the Association, is a matter of speculation.

Association did not extrapolate its findings to the entire country

The Association stated that we failed to recognize that its savings estimate was not, as it could have been, extrapolated to cover the entire country and indicated that the savings estimate is, therefore, understated nationally. Considering the unreliability of its savings estimate, we believe that the Association used good judgment in not extrapolating the savings nationwide.

III. LOS ANGELES

The Association stated that Los Angeles is a special case. We agree. The Association's comments go on to say that, because the claimed savings were so large ($1.2 billion), it believed they should have been included in the Association's survey report. We disagree. We believe the size of the estimated savings made it more important that the Association establish the validity of the savings estimate. This was not done.

The $1.2 billion savings estimate for Los Angeles County results from disapprovals of Certificates-of-Exemption, not disapprovals of Certificates-of-Need, which, along with section 1122 project review disapprovals, are the basis for the remainder of the $3.4 billion savings estimate. The Certificate-of-Exemption process in California allows a medical facility project to be undertaken (without obtaining a Certificate-of-Need) as long as it does not increase the size of the facility or expand the services offered. The consequences of having a Certificate-of-Exemption disapproved basically puts a proposed project in the same position as those projects not eligible for a Certificate-of-Exemption; that is, it must go through the normal Certificate-of-Need process.

The Association attached to its comments a letter from a California State agency official. This official attested to the unreliability of the consultant's study and commented that apparently only a few projects denied a Certificate-of-Exemption were later submitted under the Certificate-of-Need process. We contacted the State agency official and he told us that this comment was based on opinions of other State agency officials and not on any formal analysis or study of Certificate-of-Exemption denials.

The State agency official also commented in the letter that projects denied a Certificate-of-Exemption should be counted as savings, because a project that does not proceed after denial is saving money. We believe, however, that the relationship between savings and Certificate-of-Exemption denials is not that clear cut. To determine that a proposal denied a Certificate-of-Exemption was not submitted for a Certificate-of-Need is difficult. For example, a proposal denied a Certificate-of-Exemption as project "XYZ" may have been revised and submitted under the Certificate-of-Need process as project "XYA," thereby eliminating part or all of the savings resulting from the denial of the Certificate-of-Exemption. In addition, lack of submission into the Certificate-of-Need process could mean that the proposal submitted for a Certificate-of-Exemption was not serious to begin with. Finally, projects denied Certificates-of-Exemption may be submitted into the Certificate-of-Need process in the future.

Although there are undoubtedly savings resulting from denials of Certificates-of-Exemption, the denial, in itself,

is not sufficient evidence to justify including it in a savings estimate. In our opinion, Certificates-of-Exemption should be analyzed on a case-by-case basis, including verification from the applicant that the project had not been revised and submitted for a Certificate-of-Need and will not be submitted.

Of greater importance, however, is the fact that the Association failed to adequately disclose what the Los Angeles County data represented. The Association's report did not define Certificate-of-Exemption, and neither the Association's testimony nor its survey report specified that the $1.2 billion represented Certificate-of-Exemption disapprovals. Ironically, the consultant's report did contain Certificate-of-Need data for Los Angeles County totaling about $8 million. Nevertheless, the Association chose to include a combined total of Certificate-of-Need disapprovals and Certificate-of-Exemption denials of $1.2 billion.

IV. ADDITIONAL DATA SUPPORTING THE ASSOCIATION'S CONCLUSION

In this section, the Association attempted to verify or substantiate its reported savings estimate by referring to other studies and efforts. The Association referred primarily to its second survey and an HEW report on State agency actions on capital expenditure proposals.

Although we have not examined the Association's second survey data or HEW's report in detail, we would make the following observations:

--As mentioned earlier, our review of the Association's second survey questionnaire instrument showed that it had many of the same problems as the first.

--The HEW study focused on project approvals and did not make savings estimates.

We do not believe that the reference to these studies is relevant for substantiating the Association's $3.4 billion savings estimate.

V. OTHER MAJOR SHORTCOMINGS IN THE GAO REPORT

In this section of its comments, the Association:

--Commented on several items outside the scope of our work.

--Questioned our sampling methodology.

Items outside our scope of work

The Association stated that in performing our study we neglected the most important dimensions of its survey. It claimed that our audit overlooked, among other things, (1) the aggregate size of the project review actions of planning agencies, (2) the nature and size of project approvals, (3) the differentiation between renovations and new construction, and (4) actions on requests for new beds.

Again, we wish to emphasize that we examined only the validity of the Association's $3.4 billion savings estimate. If the items the Association said we neglected were so important, we wonder why it also failed to address them in its congressional testimony.

Sampling methodology

The Association claims there are several shortcomings in our sampling methodology:

--The sample was not representative of all projects reviewed by HSAs or of HSAs nationwide.

--It was assumed that "disputed savings" would be correlated with "claimed savings."

--The distribution of the data was such that there is a danger of obtaining biased results.

The Association is correct in its observation that we did not sample all HSA-reviewed projects and that our sample was not representative of HSAs nationwide. However, because our sample was never intended to accomplish these objectives, it is difficult for us to view them as shortcomings. Simply stated, our sample of projects was drawn to test the validity of the Association's $3.4 billion savings estimate, which it

referred to in congressional testimony. Considering this objective, we would have been subject to criticism if our sample was not weighted to HSAs having the largest savings estimate. Our sampling methodology was designed also to insure that we included an appropriate number of HSAs with small reported savings. In our opinion, appropriate sampling methodology was used to accomplish our objective, and the results obtained were valid.

The Association's second and third comments suggest a misunderstanding of statistical sampling concepts. The degree to which a sample correlates to the sampled universe is expressed in terms of the sampling error. In this case, a small sampling error was computed ($84,687,000 sampling error of a total disputed savings of $994,784,000), thus indicating a high degree of reliability of the disputed savings.

The Association expressed concern that the distribution of our data could create the danger of obtaining biased results. Our sample was taken from the Association's savings estimate. Therefore, our data could be biased only to the extent the savings estimate is biased.

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In summary, the Association's report and congressional testimony give the impression that the Association had conducted a thorough survey and that it included tangible and reliable data on the impact of the health planning program. Our review, however, showed that the survey was hastily done and that the Association lacked support for its savings estimate. In commenting on our report, the Association contends that it "was forthright about what it was counting and the rationale for that approach." In our opinion, the matters discussed in our report, the Association's comments, and our response to those comments suggest that this position would be difficult to sustain.

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We are providing copies of this report to the Association; the Director, Office of Management and Budget; and the Chairmen of various interested congressional committees and subcommittees.

Sincerely yours,

Gregory J. Ahart
Director

Enclosures - 2

ENCLOSURE I

STATISTICAL SAMPLING METHODOLOGY

We obtained from the Association a list of the 166 HSAs responding to its survey questionnaire with their respective savings estimate totals compiled by Association staff. We ranked the HSAs by total savings estimated and then stratified the universe into three groups based on these amounts. The table below shows the strata selected, universe size (number of HSAs), and sample size.

Strata (savings)	Universe	Sample
Over $100 million	2	2
$20 - $100 million	29	15
Under $20 million	135	39

We analyzed each of the two HSAs estimating over $100 million in savings. The selection of sampled HSAs in the second and third strata was done by random numbers table. The HSAs sampled had a total savings estimate of $955 million (44 percent) of the universe total of $2.2 billion.

Our analyses of the sampled HSA questionnaire responses showed that the Association had included $502 million in its savings estimate that was not supported by data in the questionnaire response.

Using appropriate stratified cluster sample formulas, we computed $994,784,000 in disputed savings with an associated sampling error of $84,687,000 at the 95-percent confidence level.

ENCLOSURE II

AMERICAN HEALTH PLANNING ASSOCIATION

December 21, 1979

Mr. Gregory J. Ahart
Director, Human Resources Division
United States General Accounting Office
Room 6864
441 G Street, N.W.
Washington, D.C. 20548

Dear Mr. Ahart:

This responds to your request for our review and comment on your draft report of the GAO audit of our survey of the health planning agencies. I appreciate your having allowed us the time to develop a full response.

The GAO draft report concludes that the $3.4 billion in disapproved or discouraged proposed capital investments (thereby saving $8 for every $1 spent on health planning), which the AHPA reported from its survey of the planning agencies, "was unreliable and therefore may not be an accurate measure of the health planning program's impact." Our analysis of the GAO conclusions and of the audit on which they are based leads us to conclude that most of the GAO allegations are not supportable.

Certainly, in an effort as complex as trying to measure the impact of health planning agencies, there is room for serious disagreement as to the conclusions -- disagreements based on differences in methods, approaches, assumptions, and interpretations. But if such disagreements are to highlight the issues rather than confuse and cloud them, the bases of all lines of argument must be explicit, clear, and defensible. Unfortunately, the GAO's draft report does not satisfy those criteria. In particular, a large proportion of the differences in any estimates of "savings" which thoughtful observers would reach concerning this program will depend mostly on differences in methods, approaches, and assumptions. In its survey report, AHPA was forthright about what it was counting and the rationale for that approach. The GAO, in its review, does not make its approach equally as evident. Through extensive discussions with your staff, we have learned what methodological approaches the GAO report is based on. We urge you to make that information explicit in the report itself.

Before commenting on specific problems in your audit, I want to note my appreciation for your staff's offer to help us improve our survey instrument so that the GAO might be satisfied with future reports of our data. I have already told your staff that we accept that offer and look forward to working together in the future.

ENCLOSURE II

Parenthetically let me note that there are some obvious similarities between the ways in which the planning agencies work and the activities of the GAO itself. Certainly there are "impact measurement" problems in common. I recently read, in the November 10, 1979 issue of the National Journal, an article on the GAO's problems in evaluating "social programs." The GAO's director, Comptroller General Elmer B. Staats, responded to the criticisms in the following way:

> In the past three years, he said, the agency has saved the government more than $11 billion in "quantifiable" savings, 77 per cent of which came as a result of GAO recommendations that executive branch agencies adopted without congressional direction. The rest of the savings, he said, resulted from changes required by Congress.
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> The GAO also saves the government an "unquantifiable" amount of money each year, Staats said, by keeping government officials on their toes through the threat of a GAO investigation.

The Comptroller General's comments suggest that the GAO staff has extensive experience in calculating cost savings, and we look forward to learning more about that.

We organize our reactions to the GAO draft report in the following way: First we examine the GAO's concerns over the reliability of our survey instrument. If the GAO concerns about the reliability of the instrument had real merit, then our results would be thrown into question. Upon consideration, we find that the GAO's concerns are without merit.

The second part of our response deals with the validity of our numbers. As a general rule, we find that our numbers are, to the extent they are in error, on the low side of the ledger. That is, the AHPA numbers are probably understatements of reality; and our errors in that direction were by design. The 8:1 "savings ratio" is a particularly low estimate of the agencies' impact. We also challenge the GAO report's view of how one should count "savings" attributable to health planning.

The third section deals with the Los Angeles data. We were not and are not satisfied with the adequacy of that data. The GAO critique of the data is also uneven. The California SHPDA has some pertinent comments to offer on the subject, mostly in support of our conclusions, and we quote them.

In the fourth section we look at other, more recenlty acquire data -- some collected by AHPA, others by HEW. By comparing our original survey data with similar data collected by others, we can and do find current, external indications that our survey findings were in the right vicinity and direction.

Fifth, we discuss a variety of criticisms of the GAO report, particularly GAO shortcomings not already discussed in the first four sections. In particular, we comment on the GAO's narrow vision of the issues in question. We find that the vision is so constricted that it:

* missed more than it included,

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* viewed the audit of claimed savings outside of the context of the amount reviewed and approved by planning agencies, and

* contained a methodologically questionable sample.

In the final section, we offer a set of recommendations as to what the GAO ought to do with its draft audit report.

I. THE SURVEY INSTRUMENT.

The GAO report suggests that at least $1.2 billion of the counted "savings" are unreliable because "of deficiencies in the questionnaire development process." The GAO charges: (1) that our transmittal letter "contained statements that would tend to bias respondents;" (2) that the questionnaire was not pretested; and (3) that it requested insufficient data to determine when an agency's action actually resulted in "savings." The first two points are discussed in this section, and the third point is discussed in section two.

On the matter of "bias," the audit report quotes two sentences from the AHPA transmittal letter:

> The information pertaining to "cost savings" is most urgently needed in order to improve our chances for securing adequate appropriations in fiscal years 1979 and 1980. I !Harry Cain1 must add that our prospects for adequate appropriations are not very bright at this moment.

The GAO then asserts (page 9), "In our opinion, this statement would tend to influence health planning agencies to include questionable savings."

We would point out that the planning agencies are continually barraged by survey requests from all sides, and our aim was to get their attention, to let them know why this survey was no idle exercise. The high response rate we got indicates that our survey effectively competed for the agencies' attention.

The GAO suggestion that we encouraged biased reporting, however, seems to us neither acurate nor even defensible. Moreover, the GAO's selection of those two sentences -- out of context -- raises questions about the GAO's own objectivity. Let us quote another three sentences from the same transmittal letter:

> It is important to emphasize two other points regarding the data needed. First, we are interested in the whole picture of health planning -- the problems and impediments as well as the successes and accomplishments. Second, the data reported must be as "hard" as possible, and we must be able, in our analysis, to distinguish between solid facts and estimates or impressions that are not part of the written record and/or derived from expert testimony.

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The questions of intent, tone, and implicit suggestion are important here; so we are attaching a copy of the full AHPA transmittal letter. We ask that GAO include it in their final report. Let the readers make their own judgments.

The GAO complaint about the alleged lack of pretesting during the questionnaire development is not substantial given both the way the questionnaire was developed and its subsequent record. Though AHPA did develop the form with great speed (approximately one week), we had the extensive participation of very reputable survey researchers, and we solicited and received suggested modifications from many knowledgeable people (including members of HSA staff who were to complete the questionnaires as well as staff of the Bureau of Health Planning). The resulting survey instrument was one that had been examined by researchers, practicians, and the target audience for the questionnaire. In addition, the AHPA staff subsequently talked by phone with most of the respondents to ensure that the survey questions were clearly understood and uniformly interpreted.

The level and quality of the data we did receive and the very few changes that were necessary before the survey instrument was used for the second time, suggest that the GAO's criticism is not significant. Though we would have preferred to have had more time to formally pretest, we remain pleased by the adequacy of our "crash effort". The GAO report (page 9) asserts: "Pretesting would have given the Association an opportunity to identify and correct many of the problems we found." It is clear to us that few, if any, of the methodological disagreements between the AHPA and the GAO could have been resolved by a pretest. [Incidentally, the GAO report complains (page 10) that "the questionnaire did not ask planning agencies (1) whether the project was needed." Our questionnaire did ask, for every project, whether the HSA action on the project was "consistent with (the) HSP/AIP: yes, no, or NA." That seems to us to be the best available proxy for the elusive question of need.]

[Two significant problems with the survey effort were not even referred to in the GAO report. They are: (1) many of the agencies did not have internal data collection and retrieval systems which would have facilitated responding (though most have corrected that and can now respond more easily); and (2) staff turnover in the agencies created problems in their "institutional memory" as to what had happened one to two years earlier.]

II. THE VALIDITY OF THE NUMBERS.

The GAO report dismisses $1.0 billion on the grounds of our having counted the wrong things. A large part of the GAO argument rests on the fact that our survey relied mostly on HSA actions, and the GAO charge that "HSA disapprovals" should not be counted as "savings" until the SHPDA is known to have upheld the HSA action. We do not agree.

If the GAO audit insists on counting only SHPDA actions as final, then consistency of methodology would require that SHPDA overturns of HSA approvals must be counted as well as overturns of disapprovals. We can, on the basis of our data (supported by many SHPDA reports), demonstrate that less than 5% of HSA actions are overturned by SHPDAs, and most of those are SHPDA

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overturns of HSA Approvals. Hence, our data on that score, by mostly counting only HSA actions are underestimates of "final" disapprovals.

The GAO report asserts that our instrument did not seek sufficient data "to determine whether actual savings had resulted." Apparently the GAO would admit "actual savings" only in the case of a SHPDA denied project that was never subsequently acted on, the funds for which were available at the time of application and were not thereafter invested in some other part of the health care system. We are quick to admit that we did not seek to track the project proposals to their ultimate destinies. We sought to identify, and quantify as accurately as possible, what the planning agencies were doing. Long term research questions about ultimate effects are interesting, worthwhile targets. Perhaps, with the baseline data we have provided, some researchers will find the time and resources to go further. We hope so.

One thing we did do, which the GAO report scarcely acknowledges, is to separate "official" actions from "unofficial" actions on the grounds that the "official" actions are much easier to document and track through time (though we believe that the latter are of significant importance and that importance will only increase over time).

Beyond that, the GAO report asserts that we inappropriately counted "withdrawals" as savings, and we sometimes counted multiple submissions of the same projects. Those concerns are understandable, but not, we think, serious for several reasons. First, it is unquestionably difficult to determine which withdrawals will not be resubmitted and of those, which should be credited to HSA action. We chose to count them all, but most frequently counted them as "unofficial" savings rather than "official" denials.

Second, we have to take a count at a given point in time. In the future, any proposed project may be resubmitted (including official SHPDA disapprovals). It is not only debatable as to how much time should elapse before a resubmittal should be counted (one year? two? three?), but we would argue that at least as a function of due process, and as a measure of agency action, every review should be counted, resubmittal or not. Please consider the analogy of the court system. Are cases counted only once, regardless of the number of retrials, appeals, etc? Using the GAO's counting methods, one could conclude that the court system is not doing much, for only the final actions by the Supreme Court would be considered legitimate indicators of output.

Third, and most importantly, if we were wrong in every case, the total number of such "mistakes" would not significantly affect the total figures, and would be more than counterbalanced by savings not even considered by the GAO (discussed in Section Five, below).

One final point is important to note in any discussion of the validity of the AHPA numbers. The GAO report fails to note that we did not (though most advocates, and even many careful social scientists, would) extrapolate our findings to cover the whole country. We clearly stated, and showed why, our data reflected CON/1122 "official review" experience for only 75% of the country. (The "unofficial" figures were even less comprehensive, as they were supplied by less than 50% of our respondents. In this case, our statement on "unofficial" savings is based on only 50% of the responding HSAs. We did not double or in any other way increase the figure.) We did not say, "The planning agencies of the country saved.....," though subsequent citations of our

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figures usually applied them to the whole country. If we erred, we wanted to err on the low side. As "national" figures, the $3.4 billion and 8:1 ratio are surely low estimates of agency impact. In section IV, below, we extrapolate the data for the first time in order to compare our data with HEW's new data (submitted to HEW by the SHPDAs only).

III. LOS ANGELES.

Los Angeles is a special case. At the time those figures came to our attention, we did not know how reliable they were and tried but were unable to verify their reliability. As the figures were so large, and did represent data on nearly 4% of the total U.S. population, we believed and maintain that they belonged in our report -- but in a very separate, separable category as our main table of data (copy here attached) reflects. The GAO report's comments on the data led us to ask the California SHPDA staff if they could tell us: (1) whether in fact Certificate of Exemption (COE) denials were good proxies for CON denials, and (2) what might account for the large discrepancies between the consultant's figures and subsequent SHPDA publications.

In essence, the SHPDA's response (copy attached) is:

(1) "It appears that few COEs for replacement and remodeling were resubmitted under the CON program...COE denials should be considered savings...because a project that does not proceed after denial of a COE is, in fact, saving money and a direct result of the planning agencies' actions. Decisions to grant or deny a COE do involve some judgment on the need for the project."

(2) "The major reasons for the...discrepancies between... consultant's report...and state statistics....were transcription and reporting inaccuracies in the consultant's report...."

Given what we know now, the SHPDA's new, aggregate figures are much more accurate than any we had, and would have been used had we had them. The SHPDA figures for California, however they are interpreted, are impressive. Our response rate from the California HSAs (50%) was much lower than the response rate from the rest of the country. Hence, California's experience is quite under-reported. If the consultant's figures (which at the time we had no cause to doubt) are twice too high, the results are still consistent with the thrust of our analysis. Certainly counting zero savings in Los Angeles, as the GAO report apparently recommends, would create an even greater error.

IV. ADDITIONAL DATA SUPPORTING THE AHPA CONCLUSION.

In addition to earlier studies* of capital expenditure review which found disapproval activity not unlike AHPA's findings, we have examined more recent data which would bear directly on the reasonablness of our first survey findings.

*e.g., Lewin and Associates, Inc., Evaluation of Efficiency and Effectiveness of Section 1122 Review Process, (1975) and Bicknell and Walsh, "Certificate of Need: The Massachusetts Experience," New England Journal of Medicine, (May, 1975).

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Data from the second survey we undertook -- covering the period of July through December, 1978 -- are now on computer, and we are beginning a series of analyses of that and earlier data. Though we are now able to provide much cleaner breaks of the data (e.g., separating withdrawals from disapprovals), the data for this subsequent six-month period are not out of line with the first survey report.

In addition to the AHPA data, HEW has just compiled its first report on SHPDA ("official") actions on capital expenditure proposals during the first half of 1979. The HEW report includes all states except New York and is somewhat broader in scope and more recent than the AHPA report. Please review the HEW report and compare it with ours. Note that using our "official" columns, excluding Los Angeles, the figures are strikingly similar in terms of magnitude and disposition. Extrapolating our official figures to the entire United States (which we did not do in the report) would suggest that for the 1976-78 period the agencies annually reviewed $5.63 billion and approved $4.96 billion. HEW's data suggest that the comparable figures for 1979 will be approximately $5.0 billion reviewed and $4.7+ billion approved. Even with inflation, those figures suggest the expected trend: some decrease in requests and an increased rate of approval. (Official figures for 1979 highlight the importance of our monitoring the HSAs' "unofficial" actions if we are to understand the full impact of the planning program.)

V. OTHER MAJOR SHORTCOMINGS IN THE GAO REPORT.

In devoting all their resources to trying to document claims of "savings" (i.e., discouraged and disapproved capital investments proposals), your staff neglected most of the important dimensions of our study. Completely overlooked were the importance of the aggregate size of the review action being handled by these agencies (our major finding #1, and on a per capita basis, finding #6); the nature and size of the approvals'; the differentiations between renovations and new construction; actions on requests for new beds; differences between hospitals and long term care facilities; the context in which the review activity takes place, especially plan development and the provision of technical assistance; and the difficulties of relying on disapprovals, or disapproval rates, especially related to numbers of projects without reference to proposed levels of investment, as measures of anything.

Even within the narrow focus on "savings", the GAO report is negligent. It does not make the point that, over time, many "approvals" can result in "savings," nor the point that the level of approvals relative to the size of the population can reflect "savings" (or the lack thereof); nor the point that a planning agency decision to have a moratorium on new beds (resulting in no applications for new beds) can result in "savings."

One example should reveal the consequences of the GAO's narrow focus. Let us say that two HSAs, serving roughly the same size populations for the same period, sent us these data:

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	HSA #1	HSA #2
Amount of proposed capital investment reviewed:	$20,000,000	$150,000,000
Amount approved:	$19,000,000	$125,000,000
Amount denied:	$ 1,000,000	$ 25,000,000

We do have cases akin to this example. Your audit's focus is entirely on the "amount denied." Thus, HSAs like #1 got little attention, and only the disapproved projects in #2 were examined. But if the GAO is interested in looking at the HSAs' effect on the level of new investment in health care, your audit mostly addresses the wrong question. The more important question is, how much was approved, and for what purposes? (We did express this concern to your staff, many times, but clearly to no avail.)

Not only was the GAO statistical sample very heavily weighted with agencies reporting large numbers (dollar volume) of disapprovals (and thus, "errors" in counting disapprovals are more likely to appear), but the GAO sample, as analyzed, provides no sense of the denominator against which "disapprovals" can be judged. Nor does it, even by its own standards, give credit where credit is due. We would estimate that the 534 project proposals ("savings" proposals) which GAO examined in its sample would have amounted to less than one-tenth of the project proposals reviewed by the sampled planning agencies. Of the 534 project proposals "for which savings were claimed," the GAO found 195 to be questionable. Even if that were correct, they found about two-thirds to be unquestionable.

Finally, there are several additional shortcomings in the GAO methodology. Instead of detailing each of these shortcomings, we will cite the major items. In developing their sample, the GAO did not attempt to make their sample representative of all projects reviewed by HSAs nor representative of HSAs in the nation. Furthermore, the GAO assumed that "disputed savings" would be correlated with "claimed savings," but they never tested this basic assumption.

In addition, we examined some of the data GAO analyzed and believe that the distribution of the data is such that there is a danger of obtaining biased results. GAO could remedy this error by subsampling projects within the sampled HSAs, changing the groups or strata they sampled, or testing for the extent of the "design effect."

We would be pleased to discuss these methodological problems with your staff at their convenience.

VI. WHAT TO DO WITH THE GAO REPORT.

For all the foregoing criticisms, our major concern over the GAO audit relates to the context in which it is presented to the public, including especially the Congress. In our view, your report, presented with our comments attached, provides a fair and interesting discussion of one aspect of the health planning program to those who already know quite a bit about the subject.

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For those who know little about the subject, (unfortunately, a large majority of the public) this report risks a serious distortion of their perception of the planning program. You and we know that this audit reports (in our view, too negatively) on a very small piece of a very large, complicated, and important question: what is the nature and effect of the health planning program?

Because you are already in the field, doing a more comprehensive evaluation of this program, you will soon have a broader context in which to present this audit. We recommend that you hold release of this report until that time. We hope you will give us an opportunity to work with your staff on the broader evaluative questions. We are particularly concerned that the kinds of conceptual and methodological problems we encountered in your staff's audit of our survey not be extended to the whole field.

Sincerely,

Harry P. Cain II, Ph.D.
Executive Director

HPC/nc

GAO note: Page references in this enclosure may not correspond to page numbers in the final letter report.

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AMERICAN HEALTH PLANNING ASSOCIATION

This letter was sent to all planning agency Executives on August 25, 1978.

This is the first step in a major effort by AHPA to collect, analyze and make public some reliable national data regarding the performance of the Health Planning Agencies. Our need for your help in this effort is immediate. In the paragraphs to follow I will describe the data we need, why we need it, when we need it, and how we can improve our communication on this subject.

The attached reporting form will speak for itself in terms of the data we need. We focus on action and outcome, not much on process. Some of the data, particularly relating to impact on costs, are more urgently needed, but the remainder will soon be much in demand as well. We have tried to limit our request to data that you probably have on hand -- or could have on hand the next time we need it. If the data are not available in the desired form, give us what you have.

In an effort to save time and paper we have developed only one form -- to be used by HSA's, SHPDA's, and 1536 agencies. We presume that where one or another data item is not appropriate, you can simply signify by "NA". However, the use of one common form may prove to be inadequate. As you will note at the end of the reporting form, we encourage you to critique the form and to suggest any other ways we should try to get pertinent data on these and other major questions concerning your agency's performance.

It is important to emphasize two other points regarding the data needed. First, we are interested in the whole picture of health planning -- the problems and impediments as well as the successes and accomplishments. Second, the data reported must be as "hard" as possible, and we must be able, in our analysis, to distinguish between solid facts and estimates or impressions that are not part of the written record and/or derived from expert testimony. When you use "softer" data, please include only that of which you are reasonably confident, and clearly characterize it, e.g., by showing a range or the word "approx".

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Why do we need the data? As far as the health planning program goes, the legislative-administrative arena in Washington is divided into two camps: the believers and the dis-believers. Each camp is well armed with anecdotes and an ideology or mythology that supports its position. When policy related to health planning is under discussion, whether it relates to HSAs' and SHPDAs' need for appropriations, their potential role in national health insurance, their actual contribution to cost containment, or to resource development, or to anything else, representatives of the two camps will argue passionately for and against the planning program. The outcome is mostly a function of the current distribution of political power. Statistical data are not used as evidence by anyone. Such data do not exist.

The Planning Act requires the Secretary of HEW to evaluate the health planning agencies systematically, and to continually monitor all their activities. As you know, BHPRD developed a reporting form to be used to obtain the necessary information. That reporting form is very long and complex, but it does cover the ground. Unfortunately, the form has not been cleared for use, and there is no immediate prospect that it will be.

In the expectation that HEW ultimately will have its reporting system in operation, I have endeavored to make this AHPA effort entirely consistent with the most current draft of the proposed HEW reporting system. Therefore, the material you put together for this effort, and any changes in your internal information systems you create as a consequence, should be equally useful for future inquiries from the Federal government. (Let me mention a point of history and possible future reference in this regard. When I was with BHPRD, I ultimately assigned the reporting system development and oversight responsibility to Ms. Helen Thornberry. Recently Helen left HEW and has begun to work for a private research group in Washington, The Codman Research Group, Inc. I have contracted for the research and evaluation services of the Codman Group in general, and Helen in particular, to help me put together the attached form. I intend to continue using their services until we have a form and the necessary systems for analysis which will satisfy us all. If you want to discuss particular problems in the form, and writing to me will not suffice, please call Ms. Thornberry by phone at (202) 331-0160.)

I need your response to this request no later than September 15, 1978. The information pertaining to "cost savings" is most urgently needed in order to improve our chances for securing adequate appropriations in fiscal years 1979 and 1980. I must add that our prospects for adequate appropriations are not very bright at this moment, and I shall write you more on this matter in the near future.

I also urge you to fill out as many of the other information items as you can, and in your narrative criticism tell us why you are not able to fill out the others.

During the period of September 18 - 29, 1978 we will do some intensive analysis of the results, and take the following actions:

1. Present the most relevant data and analyses to HEW and to the Congress, particularly those that would be useful in the appropriations process;

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2. Revise the reporting form to reflect the results of this test;

3. Report the results back to you during October, presenting the revised form in the process;

4. Urge you to develop any changes in your internal data systems needed to enable you to complete the revised form;

5. Ask you to complete the revised form next February in order to have current data for the substantative deliberations of the next Congress. Thereafter, I would envision a routine semi-annual collection and analysis of this data, but I again invite your comment on the timing as well as on any other characteristics of the system.

In conclusion, I simply reiterate the need for these data. In my view, the intelligence which we could develop through this vehicle is essential (though not sufficient) to ensure a future health planning program that grows and changes in ways designed only to improve its contributions to the health and health care systems of the taxpayers of this country. (I might add that a very high response rate will give us more than good data. It will reflect an important attitude on the part of the health planning community: we like to know the facts.) Thank you for your help.

Sincerely,

Harry P. Cain II, Ph.D.
Executive Director

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STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY EDMUND G. BROWN JR., Governor

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
714 P STREET
SACRAMENTO, CALIFORNIA 95814

October 11, 1979

Elayne S. Kornblatt
Division of Evaluation
American Health Planning Association
1601 Connecticut Avenue, N.W., Suite 700
Washington, DC 20009

Dear Ms. Kornblatt:

I received your letter with the draft copy of the GAO's letter report. I have reviewed their report and my comments are included below referenced to the relevant page in the report. Please note that my comments are based only on the draft report since I have not seen the Association's 1978 survey or supporting data.

You asked specifically for answers to two questions. The first dealt with the extent to which denied COEs were resubmitted as CONs. It appears that few COEs for replacement and remodeling were resubmitted under the CON program. The second question referred to discrepancies between a consultant's report on Los Angeles COE denials and state statistics. The major reasons for the discrepancy were transcription and reporting inaccuracies in the consultant's report (see attachment). In addition, the data reported by the Office was for the first year, while the consultant's data extended into the second year.

Some of my general comments related to the report are:

a. It would seem appropriate for the GAO to comment on "Understated Savings" as well as "Overstated Savings". This category would include savings in those states not included in the Association's report.

b. On page 8, second paragraph, the report refers to "(2) factors other than health planning, such as inability to obtain financing..." that should not be recorded as savings attributable to planning agencies efforts. The GAO should be aware that project financing arrangements often are affected by the planning agency's actions, not always directly measurable.

c. On page 9, second paragraph, the report asserts that Certificate of Exemption denials should not be credited as savings. As I mentioned above, the consultant's calculations were incorrect, however savings from COE denials should be considered savings. This is because a project that does not proceed after denial of a COE is, in fact, saving money and a direct result of the planning agencies actions. Decisions to grant or deny a COE do involve some judgment on the need for the project.

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d. The report, on pages 12-13, briefly discusses the operating cost savings associated with capital projects denied. While some of their concerns have merit, based on the literature it is clear that operating costs represent much larger savings than even the sizeable capital expenditures. Their acknowledgment of this would give their report more credibility and assign appropriate credit to the planning agencies.

Lastly, the report briefly recognizes that project review savings from denied projects are not an "accurate measure of planning agency performance...." This important fact is related to such issues as projects that were discouraged before reaching the CON application stage (thus no hard data exists) as well as savings associated with more rational distribution of health care services and improved access. The report should, I believe, expand on these so that health planning efforts are not too narrowly judged on a paucity of data.

I am enclosing a copy of our most recent summary of CON and COE actions. If I can be of any further help, please contact me at (916) 322-5834.

Sincerely,

Dan A. Ermann
Special Assistant to the Director

Attachments

cc: Dr. Henry Zaretsky