ASHNHA

ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

June 29, 2018

Ms. Donna Steward
Executive Director, Office of Rate Review
State of Alaska, Department of Health & Social Services
3601 C Street, Ste 978
Anchorage, AK 99503

Dear Ms. Steward,

The Alaska State Hospital and Nursing Home Association ("ASHNHA") would like to thank you for leading the Department of Health and Social Services' effort to reform its certificate of need ("CON") regulations.

Per your comments at the Department's listening session on June 6, 2018, we understand that the Department seeks written suggestions from the public concerning possible changes to the CON regulations by June 30, 2018. Similarly, the Department would like suggestions from the public concerning possible changes to the "Alaska Certificate of Need Review Standards and Methodologies," which is a regulatory document adopted by reference and used by the CON program, by July 15, 2018. It should be noted that the review standards and methodologies are dated December 9, 2005, which suggests that they have not been updated to meet industry standards for nearly 13 years.

Per the listening session, the Department intends to complete its draft of changes to the CON regulations within the next eight weeks. While ASHNHA supports the need for changes to CON regulations, producing meaningful changes to a complex, multifaceted regulatory structure such as CON after a single listening session with providers is ambitious, especially with only eight weeks to complete internal drafting. As both the Department and providers have recognized, the regulatory framework and the CON standards and methodologies are deeply flawed, especially given the rapid evolution of the health care industry since 2005 when the standards and methodologies were last updated.

Accordingly, ASHNHA urges the Department to continue engaging with providers as it works through its ideas for updating the CON regulations. In the meantime, ASHNHA has been working with its members to provide the following comments:

Net Present Value of a Lease

7 AAC 07.010 details expenditures that must be included when determining whether a certificate of need is required by a facility. 7 AAC 07.010(a)(8) specifies that "leasing" of equipment or space must be included as an expenditure. 7 AAC 07.010(a)(8)(A) requires that the expenditure amount from a lease be calculated using a "net present value" formula. However, the net present value formula is confusing, ineffective, and does not represent the true purpose of a net present value calculation, which is essentially to discount future cash flows to a present value. To eliminate confusion and stop facilities from entering into abnormally short-term leases to avoid CON review, ASHNHA recommends that the

Department adopt the following definition for "net present value:"

(A) the net present value of the lease; for purposes of this subparagraph, "net present value" is the sum of all lease payments made over the term of the lease discounted by a specified rate. Net present value shall be calculated using the following algebraic expression:

$$\textbf{\textit{Net Present Value}} = \sum_{y=1}^{N} \frac{Cy}{(1+d)^y}.$$

(i) For purposes of this algebraic expression, "N" equals the term of the lease, "y" equals year, "C" is total lease payments made for the year, and "d" is the discount rate, which equals the annual average Consumer Price Index for All Urban Consumers in Anchorage, Alaska for the most recently completed calendar year, as published by the United States Department of Labor Bureau of Labor Statistics.

(ii) For purposes of this algebraic expression, if the lease is for space, the term of the lease shall equal five years or the actual length of the lease, whichever is greater. If there is no annual lease payment defined in the lease agreement for a given year, for that given year, "C" shall equal the average of the annual lease payments that are defined in the lease agreement.

Definition of "Independent Diagnostic Testing Facility"

There have been situations in which independent diagnostic testing facilities sought exemption from CON as an "office of private physicians." In fact, when the definition provided under 7 AAC 07.900(23) for independent diagnostic testing facilities is read in conjunction with the definition for office of private physicians under 7 AAC 07.001(b), it results in a confusing, circular reference. To alleviate the confusion and prevent independent diagnostic testing facilities from unjustly evading CON review, ASHNHA recommends adding the following subsection (or something to this effect) to 7 AAC 07.900(23):

(C) if an entity is enrolled with Medicare as an independent diagnostic testing facility or otherwise subject to 42 CFR 410.33 as those provisions relate to an independent diagnostic testing facility, then it meets the definition of independent diagnostic testing facility for purposes of this chapter, regardless of whether (A) or (B) are satisfied.

42 CFR 410.33(g) references Medicare enrollment of independent diagnostic testing facilities. More specifically, it is our understanding that the CMS 855b form is used by independent diagnostic testing facilities to enroll in Medicare. While it is also used by physician groups, attachment 2 in section 1 of the 855b form is for independent diagnostic testing facilities "only." Therefore, this would mean if an entity completes that section, then it is at least "otherwise subject to 42 CFR 410.33 as those provisions relate to an independent diagnostic testing facility." Accordingly, that entity meets the proposed definition of independent diagnostic testing facility for certificate of need purposes.

Definition of "Hospital"

With the rapid evolution of health care, there are models of care that do not currently exist in Alaska that may or may not be beneficial to its health care system and its overall cost of care.

A specialty hospital is an example of this type of model. It may be possible for these models to attempt to evade CON review by claiming they do not fall within the definition of "health care facility" in AS 18.07.111, or alternatively, if they do meet that definition, attempt to claim exemption as an "office of private physicians."

To ensure that the State is given the opportunity to weigh in on future models of care as they relate to capacity and cost, ASHNHA recommends amending the definition of "hospital" in 7 AAC 07.900(21) as follows:

(21) "hospital" has the meaning given in AS 47.32.900. For purposes of this chapter, hospital also includes specialty hospitals, such as but not limited to orthopedic hospitals, cardiovascular hospitals, surgical hospitals, women's health hospitals, and freestanding emergency departments, regardless if they satisfy 7 AAC 07.001(b)(1), 7 AAC 07.001(b)(3), or 7 AAC 07.001(b)(4).

Expenditures for Nonclinical Purposes; Routine Maintenance; Routine Replacement of Equipment

Understanding what the Department considers to be an expenditure for a nonclinical purpose can be confusing because it requires referencing multiple sections of the regulations. However, this appears to be reasonably clear so long as one confusing subsection is deleted. 7 AAC 07.010(e) excludes an expenditure for a nonclinical purpose if it satisfies a two-part test. Part two of the test—7 AAC 07.010(e)(2)—makes sense and should stay in place. However, part one of the test—7AAC 07.010(e)(1)—is confusing because it requires the facility to be an enrolled Medicaid provider and the expenditure at issue to be a non-reimbursable cost under the prospective payment system, which is a complicated rate methodology detailed in another area of the regulatory code.

Rather than continue this confusion and put the Department in the position of having to determine whether a reimbursement would be reimbursable under 7 AAC 150, ASHNHA recommends striking 7 AAC 07.010(e)(1) and simply relying on 7 AAC 07.010(e)(2) as the primary analysis for whether an expenditure should be excluded for relating to a nonclinical purpose.

AS 18.07.031(e) states that an "expenditure" does not include costs associated with routine maintenance and routine replacement of equipment at an existing health care facility. Both "routine maintenance" and "routine replacement of equipment" are defined in regulation at 7 AAC 07.900(33)-(34). While the definition of "routine maintenance" is reasonably clear, 7 AAC 07.900(33)(A)(i) has been interpreted to include service agreements for major pieces of equipment. For example, there have been independent diagnostic testing facilities that have acquired substantial pieces of imaging equipment, but have successfully evaded CON review by structuring the lease or purchase for an artificially low base price, and coupling it with an excessively high service agreement. Since the service agreement is interpreted to be exempt, only the artificially low base price is counted as an expenditure.

To close this loophole, the Department should add clarifying language that excludes service agreements from the definition of "routine maintenance" in 7 AAC 07.900(33)(A)(i), and list "service agreements for equipment" as an expenditure under 7 AAC 07.010.

"Routine replacement of equipment" should continue to be exempt from CON expenditures, but the definition in 7 AAC 07.900(34) needs revision. Subsection (B) states that routine replacement of equipment:

> does not include replacement of medical equipment that increases the technological capacity of the equipment or facility so long as the increase does not result in a change in the scope of services that are being provided; (emphasis added)

With the constant evolution of technology, especially in health care, ASHNHA believes that the CON program should encourage the replacement of equipment to offer patients in Alaska access to the most cutting edge, modern treatment options.

Consequently, the Department should strike "not" (specifically the "not" that is underlined above) in 7 AAC 07.900(34) so that technological advances can occur so long as they do not result in a change in the scope of services being provided by the facility.

Phased Activities

7 AAC 07.025(d) explains that multiple projects or project activities, and the expenditures thereof, will be considered a single activity with a single set of expenditures for CON purposes under certain circumstances. The circumstances exist as three scenarios in (d)(1)-(3) and can be summarized as follows: (1) two or more components of the activity are financed together plus constructed or acquired together; (2) one component of the activity is dependent upon completion of another component of the activity, and neither component alone would "meet the objectives of the certificate of need applications;" or, (3) constructed activities are built at the same time or in a continuing manner with no more than 120 days between completion of one activity and commencement of the next activity.

These thresholds are both confusing and easily avoidable by providers who seek to keep activities below the $1.5 million expenditure limit. First, (d)(2) does not seem practical or applicable because it infers that there is a CON application to compare to a set of activities. Often, providers avoiding this phased activity classification have not submitted a CON application. (d)(1) is a good test in theory except it is simple to incorporate independent entities to finance activities separately. Finally, (d)(3) is extremely limited because waiting four months between construction activities can be accommodated by any project with little to no adverse effects.

At a minimum, the Department should consider replacing this three-part framework with a defined look-back period during which expenditures "directly related" to a project should be considered as a single set of expenditures for purposes of AS 18.07.031. Directly related expenditures should not include routine maintenance or operational expenses, and the look-back period should be two to three years.

This concept will only work if the Department enforces it, which means there should be some type of penalty for failure to provide the Department with applicable expense information upon notice and request. Perhaps a facility's license can be suspended if the facility fails to timely

comply with a request.

Formulas from Review Standards and Methodologies

7 AAC 07.025(a)(3) essentially requires CON applications to meet the "certificate of need review standards and use[] the methodologies identified in the department's document entitled *Alaska Certificate of Need Review Standards and Methodologies*, dated December 9, 2005, and adopted by reference." This regulation presumably is for purposes of enforcing AS 18.07.041 and AS 18.07.043. AS 18.07.043 clearly provides the framework for the general review standards in the *Alaska Certificate of Need Review Standards and Methodologies*. Other than that, AS 18.07.041 is broad and essentially calls for a CON to be issued if "the availability and quality of existing health care resources or the accessibility to those resources is less than the current or projected requirement for health services required to maintain the good health of citizens of this state."

This is important to note because the *Alaska Certificate of Need Review Standards and Methodologies* include a variety of standards and methodologies that use rigid formulas based on historic usage rates to project future need. Again, both the Department and the health care industry have recognized that these rigid formulas are deeply flawed because they can only work if historic usage of a service was at a correct level. Simply stated, if historic usage does not represent appropriate access to care, then it is problematic to be forced to use a methodology or formula that projects needed capacity based on a figure that does not represent actual care needs.

At initial glance, 7 AAC 07.025(b) creates the appearance of discretion and a workaround to these flawed formulas. Unfortunately, this is not the case because it only permits the CON program to recommend that the Commission waive a review standard. Most of the flawed formulas exist as methodologies, and 7 AAC 07.025(c) expressly prohibits the Department from waiving a methodology adopted by reference in the *Alaska Certificate of Need Review Standards and Methodologies*.

Rather than focusing on what can or cannot be waived, the department should strike this altogether so that if something truly needs to be waived, it can be waived by the Commissioner for "special or extraordinary circumstances" under 7 AAC 07.070. In conjunction with this change, the Department needs to eliminate all of the standards and methodologies in the Alaska Certificate of Need Review Standards and Methodologies other than the General Review Standards. It should replace those standards and methodologies with service benchmarks that represent best practices and national standards.

Finding benchmarks for each service listed in the *Alaska Certificate of Need Review Standards and Methodologies* is a major undertaking, requiring a longer process and more engagement by providers than the Department has outlined for the current review. Again, ASHNHA urges the Department to increase dialogue with providers about these concepts so that it can achieve comprehensive, lasting changes to the regulatory system. ASHNHA is working with its members to find and provide benchmarks to the Department, but meeting the Department's July 15 deadline for comment is impossible. Nonetheless, we will continue our efforts and we are always available to the Department and other providers for additional dialogue.

Relocation of Ambulatory Surgery Centers; Disproportionate Treatment of Skilled Nursing Facilities

While these last issues can only be solved through a statutory change, they must be recognized by the Department. First, AS 18.07.031(c) effectively exempts a single class of providers—ambulatory surgery centers—from CON review in a way that allows them to relocate at an unlimited expense under very simple conditions. No other facility or provider type in Alaska is given this privileged status and it creates an enormous competitive advantage that has largely contributed to the explosion in ambulatory surgery centers over the last 10 years in our state.

This provision should be struck in full so that ambulatory surgery centers are treated the same as every other facility subject to CON.

Another example of disproportionate treatment is the excessive limitations placed on skilled nursing facilities. Unlike all other facilities subject to CON, skilled nursing facilities are required to apply for full CON review and approval in any instance in which they seek to add a single bed. This is despite the fact that adding a limited number of beds can appropriately be accomplished with an expenditure that is below the $1.5 million CON threshold. Alaska has the fewest skilled nursing facility beds per capita in the country, and it is well below states with the next lowest bed counts. Systems of care require access to all levels of care.

This limitation on skilled nursing facilities creates cumbersome barriers to establishing or expanding a level of care that is often desperately needed in communities. Again, this policy, and the adverse consequences thereof, needs to be openly discussed so Alaskans have an opportunity to remove unnecessary barriers to care.

In closing, ASHNHA would like to again thank you for leading the Department of Health and Social Services' effort to reform its CON regulations. This is an ambitious and worthy endeavor, and we encourage additional dialogue with all providers as the Department continues its progress.

Sincerely,

Becky Hultberg
President/CEO