

ALASKA STATE LEGISLATURE
SENATE HEALTH, EDUCATION & SOCIAL SERVICES COMMITTEE

February 4, 2002
1:31 p.m.

MEMBERS PRESENT

Senator Lyda Green, Chair
Senator Loren Leman, Vice Chair
Senator Gary Wilken
Senator Jerry Ward
Senator Bettye Davis

MEMBERS ABSENT

All Members Present

COMMITTEE CALENDAR

SENATE CONCURRENT RESOLUTION NO. 21
Supporting the development of adequate in-state treatment
capacity for severely disturbed children.
MOVED CSSCR 21(HES) OUT OF COMMITTEE

SENATE BILL NO. 256
"An Act relating to the certificate of need program; and
providing for an effective date."
HEARD AND HELD

PREVIOUS COMMITTEE ACTION

SCR 21 - No previous action to record.

SB 256 - No previous action to record.

WITNESS REGISTER

Mr. Jerry Burnett
Staff to Senator Lyda Green
Alaska State Capitol
Juneau, AK 99801-1182

POSITION STATEMENT: Testified for the sponsor of SCR 21 and SB
256

Mr. Russ Webb, Deputy Commissioner
Department of Health &
Social Services
PO Box 110601

Juneau, AK 99801-0601

POSITION STATEMENT: Discussed DHSS's activities regarding out-of-state placement at residential treatment facilities [SCR 21]

Mr. Richard Rainery, Executive Director
Alaska Mental Health Board
431 N Franklin St., Ste. 201
Juneau, AK 99801-1121

POSITION STATEMENT: Discussed the Board's activities regarding out-of-state placement at residential treatment facilities [SCR 21]

Ms. Kathy Cronen, CEO
North Star Behavioral Health Care System
1650 S. Bragaw St.
Anchorage, AK

POSITION STATEMENT: Supports SCR 21

Ms. Carey Edney
Director of Clinical Services
North Star Hospital
1650 S. Bragaw St.
Anchorage, AK

POSITION STATEMENT: Supports SCR 21

Mr. James Murphy
Good Samaritan Counseling Center
4105 Tudor Centre Dr.
Anchorage, AK

POSITION STATEMENT: Supports SCR 21

Mr. Dave Sperback
Chair, Psychologists Licensing Board
POSITION STATEMENT: Supports SCR 21

Dr. Dov Rappaport
No address provided
POSITION STATEMENT: Supports SCR 21

Mr. Wilfred Cassell
North Star Hospital
1650 S. Bragaw St.
Anchorage, AK
POSITION STATEMENT: Supports SCR 21

Mr. Tony Lombardo
Alaska Assn. Of Homes for Children
609 F St.
Anchorage, AK 99501

POSITION STATEMENT: Supports SCR 21

Mr. Elmer Lindstrom, Deputy Commissioner
Department of Health &
Social Services
PO Box 110601
Juneau, AK 99801-0601

POSITION STATEMENT: Expressed caution about changing the CON process

Mr. David Pierce
Certificate of Need Coordinator
Department of Health &
Social Services
PO Box 110601
Juneau, AK 99801-0601

POSITION STATEMENT: Answered questions about the CON process

Mr. Brian Slocum, Administrator
Tanana Valley Clinic
1001 Noble St.
Fairbanks, AK

POSITION STATEMENT: Supports SB 256

Mr. Jerome Selby
Regional Director, Planning & Development
Providence Hospital

POSITION STATEMENT: Opposed to SB 256

Dr. David McGuire
No address provided

POSITION STATEMENT: Prefers repealing the CON program

Mr. George Larson
Valley Hospital
950 E Bogard Rd.
Wasilla, AK 99654

POSITION STATEMENT: Supports SB 256

Mr. Rick Katz
Health South Corporation
No address provided

POSITION STATEMENT: Supports SB 256

Mr. Robert Gould
Fairbanks Memorial Hospital
1650 Cowles St.
Fairbanks, AK 99701

POSITION STATEMENT: Supports SB 256

Dr. Richard Cobden
Tanana Clinic
1001 Noble St.
Fairbanks, AK 99701

POSITION STATEMENT: Supports SB 256

Ms. Liz Woodyard
Fairbanks Memorial Hospital
1650 Cowles St.
Fairbanks, AK 99701

POSITION STATEMENT: Supports the CON process

Mr. Mike Powers
1650 Cowles St.
Fairbanks, AK 99701

POSITION STATEMENT: Believes the CON process needs further study

Mr. Dennis Murray
Heritage Place Nursing Home
Kenai, AK

POSITION STATEMENT: Opposed to SB 256

Ms. Lorraine Derr
Alaska State Hospital and Nursing Home Association
426 Main St.
Juneau, AK 99801

POSITION STATEMENT: Opposed to SB 256

Milton Willhide, CFO
Valdez Regional Health Authority
No address provided

POSITION STATEMENT: Opposed to SB 256

ACTION NARRATIVE

TAPE 02-5, SIDE A
Number 001

CHAIRMAN LYDA GREEN called the Senate Health, Education & Social Services Committee meeting to order at 1:31 p.m. Senators Leman, Davis and Chairwoman Green were present. The first order of business to come before the committee was SCR 21.

#SCR 21

SCR 21-TREATMENT FOR DISTURBED CHILDREN

MR. JERRY BURNETT, staff to Senator Lyda Green, explained that SCR 21 was introduced because there are over 300 severely

emotionally disturbed Alaskan children currently receiving treatment in residential facilities in other states. He stated,

Families are separated, sometimes for years. Flexibility to provide an appropriate mix of treatment between residential and community based care is lost when children must be sent out-of-state for treatment. Millions of state dollars and hundreds of jobs are being exported from Alaska. Alaska currently lacks the necessary facilities to provide the full continuum of community based and residential care in Alaska for the treatment of severely emotionally disturbed children. The largest gap in this continuum is the lack of residential treatment beds that can provide the necessary level of care. SCR 21 asks the Department of Health and Social Services to work with the Alaska Mental Health Board, the Alaska Mental Health Trust Authority, and other interested parties to strengthen this continuum of services and to establish a priority for the development of sufficient in-state residential care to serve emotionally disturbed children who would otherwise be placed in out-of-state facilities.

CHAIRWOMAN GREEN noted that legislators have received many comments over the years from concerned family members who spend time trying to figure out how to manage long distance relationships with their children in residential treatment facilities. The committee hopes to address that by encouraging continued care in Alaska.

MR. RUSS WEBB, Deputy Commissioner of the Department of Health and Social Services (DHSS), said that DHSS, health care providers, and child advocates agree it is preferable to serve children in-state as opposed to out-of-state whenever possible, for a variety of reasons. Over the last few years, a growing number of children have come into DHSS custody and a growing number of children are going out-of-state to receive care. DHSS appreciates the legislature's encouragement to address this issue. DHSS has been and will continue to focus on it and work with the Alaska Mental Health Board, health providers and family advocates. DHSS is entering into a broad-based initiative to look at the full continuum of care, not just residential care needs. The Division of Medical Assistance will soon have a contract in place to do a review of the children in out-of-state care to determine why they are there and what it will take to return them to Alaska. DHSS agrees this is an important matter to address and wants legislators to know it is already working hard on it.

MR. RICHARD RAINERY, Executive Director of the Alaska Mental Health Board, informed committee members that the goals stated in SCR 21 are goals the Board has had at the top of its priority list. The Board has a process in place to address these issues that brings in stakeholders from across the state. While the Board believes there is inadequate in-state residential capacity for children, as it looks at the ideal system of care in the state, it wants to also focus on the additional pieces of the continuum of care. It believes that community based care is the best option for most children and, with adequate services, could avert a lot of residential placements.

CHAIRWOMAN GREEN said that bringing those children back to Alaska will make any transition easier and she hopes that SCR 21 does nothing to negate the continuum of care approach as that is a well-established model.

MR. RAINERY agreed that returning those children to Alaska is the first step.

SENATOR LEMAN asked whether any information is available describing how many children are severely emotionally disturbed for a particular reason, such as fetal alcohol syndrome (FAS). He said he believes many of the problems in Alaska are caused by bad behavior of parents.

MR. RAINERY said he receives quarterly reports from DHSS that contain the diagnoses of children placed out-of-state.

SENATOR LEMAN asked for a one-page summary of those numbers.

CHAIRWOMAN GREEN took public testimony.

MS. KATHY CRONEN, North Star Behavioral Health Care System CEO, said out-of-state placement creates significant problems for children and the state because:

- It provides less than optimal clinical care because of a lack of involvement by families and support systems;
- It creates difficulties with discharge planning for ongoing care, which diminishes chances for long term success;
- Alaskan jobs are lost to treatment centers outside of the state - bringing those children back to Alaska will bring a minimum of 450 new jobs;
- Youth stay at North Star longer than necessary while awaiting long term placement, which is much more costly -

the cost of acute care hospitalization for mental health patients ranges from \$560 per day to \$1500 per day.

MS. CRONEN said the solution is to build more residential treatment beds in the state. North Star has land on which to build a treatment center in the Mat-Su Borough, creating both in-state treatment and new jobs for Alaskans. It is critical to bring Alaskan children home and expand the continuum of care.

1:45 p.m.

MS. CAREY EDNEY, Director of Clinic Services at North Star Hospital, informed members she oversees discharge planning and placement of all patients. She has a lot of experience in inpatient services over the years, and is concerned that inpatient utilization has increased over the last two years. She stated support for SCR 21 and to provide a wide range of services for children to hopefully reduce the number of repeated admissions for inpatient and residential stays. She estimates about 15 to 20 percent of the youth at her clinic are ready for and could be placed at a residential treatment facility if one was available in the state.

MR. JAMES MURPHY, owner/director of the Good Samaritan Counseling Centers, stated strong support for SCR 21. Because Alaska has no residential treatment facilities, many patients end up in acute care facilities when they would receive better treatment in residential treatment. Sending children and teenagers out-of-state disrupts family life and treatment.

MR. DAVE SPERBECK, a forensic psychologist, mental health director for the Department of Corrections and chair of the Psychologists' Licensing Board, told the committee he has considerable experience dealing with very disturbed children who grow up to become disturbed adults that require high levels of institutional and sometimes incarceration care. He stated that Senator Leman's comments about the extent to which children are conditioned to require intensive psychiatric treatment are accurate. Children rarely are born requiring inpatient psychiatric treatment and often are abused or neglected by families who require treatment with the child. It is impossible to make a family healthy when members are separated by distance. It is crucial to bring these children back to Alaska because they will reunite with their families. He stated full support for more in-patient residential treatment services in Alaska.

1:54 p.m.

MR. DOV RAPPAPORT, a medical doctor, stated support for SCR 21. He suggested creating a formal body made up of providers to provide an adequate continuum of care and benefit Alaskans and so that providers can share information.

MR. WILFRED CASSELL, previous head of the childrens' and adolescents' psychiatric ward at the Alaska Psychiatric Institute and current president of medical staff at North Star Hospital, said it is obvious that to uproot a person from a rural community to Anchorage for psychiatric treatment is a traumatic experience but Anchorage staff is able to handle it well because of good communication with rural caregivers. That problem is exacerbated when rural patients are transferred out-of-state because of the cultural gap. He likened it to moving the Aleuts during World War II. He said that many patients have ongoing medical complications. A break in the continuity of medical providers can be detrimental. Regarding the issue of discharge and follow-up, it is much easier for physicians in Alaska to communicate with the mental health providers in the community. He told members that North Star is experimenting with telemedicine and other new techniques to improve services.

MR. TONY LOMBARDO, Director of Advocacy for Covenant House Alaska, said he is testifying on behalf of the Alaska Association of Homes for Children (AAHC). The AAHC strongly advocates for community based services in which the family can participate in the treatment of their children and support the call to develop sufficient instate residential care facilities to meet the needs of Alaska's children. He stated appreciation for acknowledgement in SCR 21 that residential treatment beds are a critical component in a continuum of care for severely emotionally disturbed children. He strongly advocates for an instate residential facility to lower the recidivism rate for children.

CHAIRWOMAN GREEN noted that a constituent recommended an amendment that makes the following changes.

Page 1, line 15 would read: "involvement of a child's family, members of the child's support system and involved community providers"

Page 1, line 16 would read: "and leading to better outcomes and long-term success and improved client satisfaction; and

Page 2, line 3 would read: achieved when a child is discharged from an in-state residential treatment facility, focusing on transition and a variety of local, community-based services in the child's home of origin; and

Page 2, line 9 would read: interested parties to strengthen the full continuum of residential and community-based care to work in a coordinated, cooperative, collaborative and

partnering manner towards integration of services.

CHAIRWOMAN GREEN explained the purpose of the amendment is not to undo or undermine anything that is already in place. That new language would be added to reinforce to community members that they will continue to be involved.

SENATOR LEMAN moved to adopt Amendment 1. There being no objection, the motion carried.

SENATOR LEMAN said the sponsor statement refers to over 300 severely emotionally disturbed children while information from the Division of Family and Youth Services refers to 423 children. He asked for clarification.

DEPUTY COMMISSIONER WEBB explained that 423 is an unduplicated count of children who received care in out-of-state facilities during FY 01 that were funded by Medicaid. The 300 is an approximate number who may be receiving care at any given point in time. He noted the number of children who are in-state custody and in out-of-state care at any given point in time is about 50.

SENATOR WARD asked if Medicaid pays for travel.

DEPUTY COMMISSIONER WEBB said it does.

SENATOR WARD asked if the travel costs were included in the base figure.

CHAIRWOMAN GREEN thought it was included in the total amount.

SENATOR WARD asked if someone must escort the patient.

DEPUTY COMMISSIONER WEBB said yes.

SENATOR DAVIS asked what DHSS's timeline is to bring some of these children back to Alaska.

2:08 p.m.

DEPUTY COMMISSIONER WEBB said that private facilities are already under development and the Division of Medical Assistance has already entered into a contract to look at the needs and the full continuum of care. He said the Division will have to look at what impediments exist as to the development to the kinds of resources we need in the state, such as capital costs or regulatory issues.

CHAIRWOMAN GREEN asked if DHSS is looking at constructing a facility.

DEPUTY COMMISSIONER WEBB said DHSS does not plan to build any facilities; it buys care from private non-profit and for-profit agencies.

SENATOR DAVIS asked for ongoing reports from DHSS on this project.

SENATOR WARD asked if the 300 children who are in out-of-state facilities are in similar types of facilities.

DEPUTY COMMISSIONER WEBB said the commonality of those facilities is the level or type of care being provided.

CHAIRWOMAN GREEN said it is her intention to move this legislation out of committee today.

SENATOR LEMAN moved CSSCR 21(TRA) from committee with individual recommendations. There being no objection, the motion carried.

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The committee then took up SB 256.

#SB 256

SB 256-CERTIFICATE OF NEED PROGRAM

MR. JERRY BURNETT, staff to Senator Green, sponsor of SB 256, read the following statement into the record.

SB 256 simply increases the threshold for the certificate of need (CON) from \$1 million, which it currently is, to \$10 million. CON laws were designed to keep health care costs low by requiring advance approval by a state agency for most hospital expansions and major equipment purchases. In 1974, the U.S. Congress required all states to enact CON laws but had repealed that requirement by 1986 as Congress found that the CON process was not effective in controlling health care costs.

The current \$1 million threshold for CON in Alaska has been in effect since 1983. Over the past 19 years, construction costs have increased. With the \$1 million threshold, the Department of Health and Social Services

reviews applications for facility expansion and equipment that should simply be left to the providers in the marketplace.

Alaska is not facing an oversupply of hospital beds, health care providers, doctors, or health care workers in general. In your packet there are statistics from the Kaiser Family Foundation that show that per 1,000 population, Alaska ranks 46th in the number of hospital beds in Alaska, 51st in the number of health care workers as a percentage of the workforce, and 49th in the number of positions per capita. So, restricting the supply of health care resources in Alaska may not be the answer to keeping health care costs down. And, in fact, easing restrictions on the expansion of current services is more likely to lower health care costs through competition.

SENATOR LEMAN asked how much the CON process costs and how long it takes. He questioned whether the CON process adds substantially to the cost of a project in the \$1 million range.

MR. BURNETT said he has heard numbers that vary from \$20,000 to \$300,000 and that a CON can increase the cost of a project substantially, depending on whether the applicant has to contract for services or whether the applicant can bury the cost within other facility planning costs.

CHAIRWOMAN GREEN stated that the CON program has been discussed repeatedly and came up during the Medicaid discussions last summer. She continues to be intrigued that the state left this process in place when even the federal government repealed the requirement. She pointed out some states use a CON process for only one type of bed, while others have no process at all. She believes there is a lot of room for improvement in Alaska's process so she hopes testimony today will focus on what can be done to improve the process for all facilities in Alaska and provide good health care and choice for people.

2:16 p.m.

MR. ELMER LINDSTROM, Deputy Commissioner of the Department of Health and Social Services (DHSS), said he too has participated in a number of discussions on the CON process over the last few years. Those discussions tend to be difficult as the issue is particularly complex for DHSS because it wears a number of hats when providing health care and dealing with health facilities. DHSS operates the CON program; the program consists of one person

who reviews all applications. Many other health care processes become entangled with the CON process.

MR. LINDSTROM explained that DHSS is a big payer of health care services through the Medicaid budget. The DHSS fiscal note on this legislation speaks to the Medicaid budget and the CON, to the extent that it will or will not impact the number of new facilities that come on line in Alaska and consequently impact the Medicaid budget. In the area of long-term care, DHSS pays well in excess of 80 percent of the costs of those beds.

CHAIRWOMAN GREEN noted that SB 256 has done nothing to change the nursing home requirement.

TAPE 02-5, SIDE B

MR. LINDSTROM said that it is his impression, after reading the bill, that SB 256 will raise the threshold for construction of nursing home beds to the \$10 million level as well. He stated he discussed the issue with committee staff and believes the bill may contain a technical error.

CHAIRWOMAN GREEN said that it was not her intent to raise the threshold for construction of nursing home beds and that, to her recollection, the commissioner of DHSS placed a moratorium on nursing home beds several years ago.

MR. LINDSTROM clarified that legislation passed several years ago that differentiated between acute care and long-term care facilities. It basically gave DHSS a different standard for review for long-term care facilities by allowing DHSS to take Medicaid costs into consideration when reviewing the CON. That same provision does not apply to acute care facilities.

CHAIRWOMAN GREEN asked if Medicaid cost is a factor on all other CONs.

MR. LINDSTROM said cost is not a factor in terms of reviewing the CON for approval or disapproval. However, the fact that new facilities are built will be a factor in what Medicaid will ultimately pay.

CHAIRWOMAN GREEN asked where that is stated in DHSS's regulations.

MR. LINDSTROM replied,

Madam Chair, that would not be in regs, it's simply the

fact that if new facilities come on line and there are Medicaid folks going into those beds, we believe there would be an additional cost to Medicaid but it's not a criteria for review through the CON process.

CHAIRWOMAN GREEN asked if DHSS uses that as a basis for evaluating a facility, as to what the cost will be.

MR. LINDSTROM explained that it is not a criteria for review of a CON application for acute care beds but it is now a criteria for review for long term care facilities under the legislation that passed several years ago.

CHAIRWOMAN GREEN asked if all other hospital beds are considered to be acute care beds.

MR. LINDSTROM said, "In terms of the cost analysis, ... our ability to consider cost only relates to the long term care beds - the nursing home beds and everything else subject to the CON - it would not be a factor."

CHAIRWOMAN GREEN asked for clarification because Mr. Lindstrom previously said that cost was a consideration for acute care beds.

MR. LINDSTROM replied:

Madam Chair, the difference is - what do we think we will ultimately pay on Medicaid? We have to be cognizant of what new facilities may be coming on line and if there are additional facilities that may come on line by operation of this legislation and we believe that is likely the case, we believe then there would be an increased cost on Medicaid. But, that is not saying the same thing as we consider that cost as part of the CON application.

CHAIRWOMAN GREEN asked Mr. Lindstrom to direct her to that statute and regulation.

MR. LINDSTROM agreed to provide information to staff.

2:24 p.m.

SENATOR LEMAN referred to a DHSS document that states (page 3) "Medicaid pays 86 percent of long term care and about 20 percent of acute care costs," and said he is surprised that Medicaid pays such a high percentage of long term care costs. He asked which

facilities are excluded, besides Pioneer Homes.

MR. LINDSTROM explained that long term care beds, in this context, read nursing homes.

SENATOR WILKEN said he would like clarification of the cause and effect in relation to [Medicaid] costs. He presented the following example: if Alaska had one hospital and 100 sick people, those people would go to that hospital and be billed the appropriate [Medicaid] rate and the state would pick up its corresponding share. But, if the state had five hospitals and 20 people went to each, the state's costs would be higher because it has the same number of patients but more hospitals.

MR. LINDSTROM said the short answer is yes. When talking about reimbursement for hospitals, hospitals fall under a very complicated rate setting mechanism in Medicaid. The governing federal law requires the state to pay a fair reimbursement rate for an efficiently run facility. The rate includes all of the hospital's fixed costs that it must pay to stay in business. He said if the state had five hospitals with 20 patients each, it would be paying a premium for the luxury of having so many facilities because they would all have fixed costs that get rolled into the rate setting system. The cost per unit would be less if there was one facility that had the economies of scale.

CHAIRWOMAN GREEN asked how that would change with two hospitals with 50 patients each.

MR. LINDSTROM said Chairwoman Green is getting to the "nuts and bolts" of the CON process to determine what level of capacity is needed in a community to have a reasonably efficient patient setting.

CHAIRWOMAN GREEN said the purpose behind the CON program is to determine the need and establish capacity. She said she sees nothing that speaks to cost, which is what she wants to understand.

MR. LINDSTROM said what has plagued DHSS in discussions about the CON program is the tendency to go from the 100,000 foot level down to the specifics of a particular CON, either past, present or future and miss all of the complexities that fall in the middle. He stated,

At the 100,000 foot level, the notion of letting the market operate as it will, and that that will really give you, over time, the most efficient - and by I

think would say most cost effective system, you know, is probably kind of a truism and something that we agree to but the next level down you have to ask yourself what about the thing - what market are we talking about. We really don't believe that health care is like soap or like washing machines.

He went on to say that health care is a matter of life and death for many people. In this country for many decades there has been a great deal of statutory and regulatory oversight of the health care industry in general. If economic efficiency was the paramount issue, relative to health care, our system would look very different than it does today. Many small community hospitals probably would not exist. In many states in the Lower 48, small hospitals have been closing. He asked legislators to not lose sight of the unique nature of health care. DHSS does not want to do anything that would have the unintended result of closing or the diminution of services and access to health care in the state.

CHAIRWOMAN GREEN expressed concern that the level of scrutiny applied in the CON process by DHSS is not described anywhere in statute or regulation. She said she does not know how anyone can bring a CON application through the process if DHSS uses the criteria described by Mr. Lindstrom when the only place that criteria is to be used is for nursing home beds. She advised that if the statute needs to be changed, that should be done, but no one should sit with a monster in the room and pretend that it doesn't exist. She maintained that businesses are being disenfranchised when having to spend hundreds of thousands of dollars on a needs application, which she finds abominable. She cautioned the need to get past this primary discussion of what the current role is, when that role cannot be found in statute and that it is imperative to not place on applicants an artificial requirement. She also expressed concern about the cost of the CON application process. She noted that she has heard complaints from people who are not willing to testify because they have CON applications pending approval. She pointed out that the legislation that passed in 1983 required a CON for projects costing \$1,000,000 or more and that costs have risen substantially. She added that according to national statistics, Alaska ranks very low in its number of physicians and beds. She questioned whether the CON program could be deterring growth.

2:35 p.m.

SENATOR LEMAN said that although he does not want to see health care facilities in smaller communities close, the same argument

made by Mr. Lindstrom was made in 1989 during hearings about competition in the telephone market. At that time, opponents to competition cautioned that costs would be driven up by the need for double plants and other expenses. He argued against that and believed it would stimulate services and drive costs down, which is what has happened. He asked Mr. Lindstrom to describe why a competitive model cannot be applied to the CON process.

CHAIRWOMAN GREEN took a brief-at-ease.

SENATOR DAVIS commented that this issue would benefit from joint committee work or the appointment of a subcommittee.

CHAIRWOMAN GREEN said she hopes that problems are brought forward today and to take the discussion forward from there. She said she wants everyone to know that the intent of this bill is not to bash anyone but rather to find ways to improve health care in Alaska. She wants to make sure that the statutes and regulations in place do what the legislature originally intended. She also noted the need for a conversation about why Congress, which never repeals anything, repealed the CON requirement.

2:40 p.m.

MR. DAVID PIERCE, DHSS Planner, informed the committee he was available to answer questions about the CON program.

CHAIRWOMAN GREEN asked Mr. Pierce to provide committee members with the number of CON applications under review and an overview of all certificates of need - the average cost, time period of approvals, denials, withdrawals, and appeals since the program began. She said she wants to know what the dollar amounts were. She asked Mr. Pierce to be prepared to discuss how much time was spent on the certificates of need for the Alaska Psychiatric Institute (API) and why DHSS needed to go through that process after it was requested by the DHSS Commissioner and approved by the Legislature.

SENATOR LEMAN asked Mr. Pierce to address his previous questions about the cost of CONs and how long the process takes.

MR. PIERCE explained that he has 90 days, once an application is declared complete, to submit a recommendation to the commissioner. He is allowed a 30-day extension if he runs into difficulties, for example if he is reviewing more than one application or if an issue arises for an applicant that requires a change.

SENATOR LEMAN asked if applications are returned on a routine basis because they are incomplete.

MR. PIERCE said that he has 20 days from the time an application comes in to declare it incomplete. After that it is declared complete and the 90-day clock begins.

CHAIRWOMAN GREEN asked if the Fairbanks Renal Care facility CON has been approved.

MR. PIERCE said the application has not yet been declared complete but will be in a day or two.

CHAIRWOMAN GREEN asked how long the "hasn't been completed" process can last.

MR. PIERCE said that is where applicants can run into problems. If something is missing from an application, which could be as simple as a signature, the applicant has 60 days to respond to the request for the missing information. If the applicant doesn't respond quickly, the process can take up to another 60 days.

CHAIRWOMAN GREEN asked for an update on the Providence 60-bed facility application.

MR. PIERCE said that is due to be completed next Tuesday.

CHAIRWOMAN GREEN asked about the North Tower application and the Valdez Community Hospital application.

MR. PIERCE said they are both awaiting a final decision by the commissioner.

CHAIRWOMAN GREEN asked Mr. Pierce to provide the start dates of the projects on the updated list and whether the applications were approved or denied and that he be available to answer questions at future meetings.

SENATOR WARD asked Mr. Pierce to bring the committee a list of the states with a position similar to that of Alaska's CON Coordinator. He said he wants to find out whether other states use a similar procedure.

MR. PIERCE agreed.

CHAIRWOMAN GREEN then called the next person to testify.

MR. BRIAN SLOCUM, administrator of the Tanana Valley Clinic, stated support for SB 256. In response to previous questions, he cited an article written by Michael Turner from the CATO (ph) Institute, in which Mr. Turner quoted the Federal Trade Commission as saying that CON regulations increase the cost of hospital care nationwide by more than \$1.3 billion dollars annually. So, on a nationwide basis, regulation compliance diverts \$1.3 billion out of the health care treatment stream and into the paperwork stream. Mr. Slocum said another quote, by Roberta Ross in an article called Certificate of Need for Health Care Facilities: A Time for Re-examination, says the cost of applying for a certificate of need ranges from \$100,000 to \$300,000 per application. He said DHSS listed 22 CON applications over the last year on its website; that amounts to between \$2.2 and \$6.6 million. That does not include the amount of dollars spent by the state to deal with the applications or the cost of applicants who withdrew their applications.

SENATOR DAVIS asked how much the Tanana Valley Clinic has spent on CON application fees.

MR. SLOCUM said he does not have a precise number but estimated it at well over \$200,000 since it began the process.

CHAIRWOMAN GREEN asked if that implies that the cost of the CON is in relation to the size of the project.

MR. SLOCUM said the quote he has suggests that a major project costs between \$100,000 and \$300,000. He said regarding the question about the intent of the CON laws, the DHSS handout lists nine goals, none of which are listed in the legislation. He then quoted Mark Kaplan, who did an economic analysis of Florida's hospital CON program in the Florida State University Law Review in 1991. Mr. Kaplan said,

One may question the wisdom of continuing any form of state regulation that failed to produce its desired goal when implemented nationwide... As the review of Congress's intent indicates, the certificate of need had one goal: to save money. However, in those states, which retain their CON laws, the retention was often supported by new and creative justifications, many of which were unrelated to saving money. Commentators, in their traditional role of explaining the reasons behind events, have set forth many justifications explaining why states have kept the same old CON laws. All these justifications, however, are the crafty work of commentators, and not the motivation of state

legislatures. No state legislature has codified any of these new justifications as legislative intent. These justifications should therefore carry little weight in a proper analysis.

CHAIRWOMAN GREEN suggested extending the explanation on statute and regulation to the CON goals outlined by DHSS in its handout.

MR. SLOCUM told members the Tanana Valley Clinic had been applying for a CON for a number of years and was denied in 1999, along with a number of applicants. As a result, he researched the CON program to try to work through it. He discovered that 30 years of academic and scholarly analysis of the CON program finds zero support for its effectiveness. In fact, the research suggests that the CON program did not and does not work and has driven the cost of health care higher by promoting inefficiencies, generating application costs, and sheltering inefficient monopolies and preventing them from competing in an open marketplace. 29 states have either eliminated the CON program entirely or have done what SB 256 proposes to do. Other information in the packet suggests when states do remove or modify CON laws, no subsequent rise in health care costs occurs.

CHAIRWOMAN GREEN asked if the Tanana Valley Clinic treats clients who cannot pay.

MR. SLOCUM replied the nature of its position in the community makes it critical that it do so. The Tanana Valley Clinic is a 37 provider, multi-specialty group - the largest medical group in the state. It has been operating for 43 years and has always taken care of anyone who shows up. It is a private business but plays something of a quasi-public role. It has provided \$11 million in unreimbursed care in the last two years.

CHAIRWOMAN GREEN asked if the Tanana Valley Clinic pays taxes.

MR. SLOCUM said the Tanana Valley Clinic is the largest locally owned property tax payer in the Borough and the City of Fairbanks. Both mayors support the concept of having another ambulatory surgical center in the community because it would be consistent with its economic development policy to promote business and simplify governmental restrictions. The project the Tanana Valley Clinic has looked at would generate almost \$1 million in property taxes over the next 20 years versus having a not-for-profit institution, which would not pay those taxes.

CHAIRWOMAN GREEN asked if most hospitals have a 501(c)(3) status so do not pay property taxes.

MR. SLOCUM said that is correct.

2:59 p.m.

SENATOR WILKEN asked Mr. Slocum to comment on his question about the efficiency of one facility versus two facilities and the effect on the Medicaid match dollar in Alaska.

MR. SLOCUM said that is a good question. He believes there is truth to the fact that we are not just looking at pure economic efficiency when talking about health care, but one has to be careful in that analysis. The logical extension of that way of thinking is that having only be one institution in any community would be the most efficient. However, that is not what is normally done because there are benefits of competition. While there may be some efficiencies gained by limiting the number of entrants to the market, the competitive fight to reduce the cost of services and improve the quality of care is given up. The federal government wrestled with that problem a number of years ago and came up with a plan in the late 1980s that removed those kinds of supports from the federal reimbursement program. Typically, 20 or 30 years ago, it used a cost-plus reimbursement basis, which meant the higher the costs, the more states were reimbursed, resulting in more campuses. The cost to deliver health care continued to rise unchecked so it established a prospective payment system that little by little moved toward a payment mechanism that paid upfront to promote efficiency of services. He suggested the state may need to address that same question of balancing efficiency with competition.

MR. JEROME SELBY, Regional Director for Planning and Development at Providence Health Systems in Alaska, urged the committee to take a hard look at what appears on the surface to be a simple bill. SB 256 proposes a major shift in-state health policy. It has huge implications far beyond just cost control in areas of quality of health care and manpower shortages as well as any control of costs to the state regarding the Medicare and Medicaid programs. SB 256 would accomplish five things:

- It would shift dollars that now pay for low income and uninsured clients to private banks accounts, most likely in the Lower 48;
- It would allow unneeded facilities to be built;
- It would drive up health care costs in general and will take money away from critically needed facilities in Alaska, in particular tertiary care and special need care facilities;

- It would increase the state's health care budget;
- It will significantly increase manpower shortages already causing problems in Alaska's health care system.

CHAIRWOMAN GREEN maintained that Providence is probably the greatest offender of increasing the need for more nurses because it has requested the greatest number of dollars for expansion. She questioned whether the manpower argument holds.

MR. SELBY said it is a huge concern for Providence because it is already having difficulty getting enough nurses. Spreading the number of available nurses across more facilities will exacerbate the problem. While Providence has not had to divert patients because of a shortage of nurses, it is diverting patients because of bed shortages. Other Anchorage hospitals are diverting patients because of a shortage of nurses. He agreed that Providence most likely uses the CON program more than any other facility in the state but it has not found the program to be so onerous that it needs major adjustment. He believes the \$1 million threshold works fine because the cost of the technology has decreased, i.e. CAT scanners. He noted Providence does not separate CON costs of projects but it has spent considerably less than \$100,000 preparing each of its CON applications. He urged committee members to consider maintaining the CON program as a good public policy process that causes businesses to ask the hard questions. Those questions may be uncomfortable, but several times during the process Providence has amended its plan internally after those questions forced it to improve its plan. He suggested this bill needs careful analysis.

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SENATOR WILKEN asked Mr. Selby to clarify how SB 256 will shift money to bank accounts in the Lower 48.

MR. SELBY explained it will allow the stock options (?????) in the Lower 48 to come to Alaska and skim off the surgi-center type business, which is the profitable part. That money will go to the bank account where the center of operations is located, most likely in the Lower 48. Last year Providence shouldered a \$25 million absorption of underinsured and Medicare write-offs because it has some profitable services, such as surgery. That profit is shifted over to pay for services that do not pay their own way.

SENATOR WILKEN asked if Mr. Selby is saying that if a new facility for which a CON facility was granted was owned by Alaskans, it would shift money into Alaskans' bank accounts.

MR. SELBY said it would but it would still take money away from helping to pay for low-income and uninsured patients.

SENATOR WILKEN noted Mr. Selby suggested that increasing the threshold to \$10 million will increase the state budget and asked for an explanation.

MR. SELBY said the state will be paying for overhead in multiple facilities and the billings will be higher to recover the cost of constructing the facilities. Providence is concerned because its overhead costs do not change whether it is full or has 30 empty beds.

CHAIRWOMAN GREEN said she totaled up the cost of Providence's expansions over the past five years and its anticipated expansions under review and came up with \$80 million. She asked where Providence Hospital's home office is located.

MR. SELBY said the regional office is in Anchorage but the Providence Health System operates in four states: Washington, Oregon, Alaska and California. Each state is a region unto itself.

CHAIRWOMAN GREEN asked if any of the money made at Providence Hospital goes out-of-state.

MR. SELBY replied that basically everything it makes goes back into the state. It has some shared costs that it helps pay for, such as legal counsel. He added that most advertising is done in Alaska.

CHAIRWOMAN GREEN asked if she looked at Providence and the organizations of some of the large hospitals, she would find that aside from the profit-center discussion, the money stays within the state.

MR. SELBY pointed out that Providence is a not-for-profit organization so it does not pay shareholders and does not have a lot of overhead. Virtually all of the money goes back into providing health care and expansion.

3:14 p.m.

MR. RICK KATZ, representing Health South Corporation, stated support for changing the threshold and CON criteria as it will allow better access to ambulatory care. Health South Corporation has found on a national basis that the trend is to modify the CON

criteria to allow for more access to ambulatory care, which is a lower-cost alternative in a majority of situations. For example, in other states where Health South operates an acute facility and an ambulatory-surgi facility, the cost of an arthroscopy (ph) procedure in an ambulatory facility may be \$400 while the same procedure will cost \$5,000 in an acute care facility. He noted in one community of 100,000 on the West Coast that had one hospital, Health South opened an ambulatory-surgi facility. The hospital administrator commented four months later that the opening of the facility raised the bar in terms of quality of service in the community by adding an alternative and providing competition.

MR. KATZ offered to provide committee members with any type of assistance or information regarding CON processes in other states. He added that Health South Corporation provides about 12 percent of its care free-of-charge annually.

MR. GEORGE LARSON, CEO of Valley Hospital in the Mat-Su Valley, stated support for increasing the CON threshold to \$10 million or eliminating the program altogether. He asked members to consider the need to require all health care "boutiques" to eliminate cherry picking of patients to level the playing field with hospitals. He suggested that if the CON threshold is increased to \$10 million, renovations could be done faster. A \$1 million threshold will allow the boutiques to move in while Valley Hospital is going through the CON process for the major renovations it needs to do.

3:20 p.m.

DR. DAVID MCGUIRE said the original intent of the CON was to reduce the cost of health care. The federal government repealed the requirement in 1987 because it didn't work; it only added another layer of bureaucracy and was anti-competitive. He prefers an outright repeal but supports any legislation that will level the playing field. He expressed concern that the \$10 million threshold will still require an application to DHSS to verify that the proposed project will cost less than \$10 million. That very process will be burdensome. He urged the committee to consider requiring applicants to complete a simplified form or submit a simple statement verifying the fact that the project will cost less than \$10 million. An alternative is to repeal the CON for everything but nursing homes in some geographic areas.

MR. ROBERT GOULD, assistant administrator of finance at Fairbanks Memorial Hospital, stated opposition to SB 256 for the following reasons. First, the CON program prevents duplication of services

where there is no need, thereby reducing capital costs to both the state and consumers. Second, it prevents selective competition for selected services where the government reimbursement system appears favorable at this time. One area that has experienced changes in Fairbanks in the last year is in home health care services. Years ago there were a number of home health care agencies in the community. When Medicare and Medicaid changed their reimbursement systems for home health, every other enterprise left the market in Fairbanks. Fairbanks Memorial Hospital is the only one left to carry on that service as part of its mission even though it is not a profitable service. Third, the CON program preserves quality. With a limited population, the volume for many services is insufficient to maintain proficiency. Fourth, the CON program protects consumers that do not have a choice about their insurance. Employers make choices about insurance providers. Insurance companies negotiate contracts and decide who the consumer gets to see.

MR. GOULD said the difference between the phone industry and health care industry is that people can change their telephone company but unless they are willing to change their employer, they do not get the choice on their insurance. He offered the following suggestions to streamline the CON process.

- No CON should be required for relocation of a facility within a community.
- No CON should be required for remodeling when no new services will be added.
- The process should be modified to expedite areas where there are emergent needs.
- The focus should be on the key medical services in a community that need to be protected and reviewed from the standpoint of quality, cost and capital rather than on a \$10 million threshold.

CHAIRWOMAN GREEN asked Mr. Gould to transmit his suggestions to the committee in writing.

DR. RICHARD COBDEN, a physician at the Tanana Valley Clinic, stated support for SB 256 because it makes good sense from a patient's viewpoint. He said his patients appreciate access and availability of services at an affordable price. He agrees with Deputy Commissioner Lindstrom that the key to CON success is access but he disagrees with his interpretation. He believes access is most determined by one's ability to pay for services. He informed the committee that he believes Fairbanks Memorial Hospital offers the best services of any hospital he has ever worked in but it is expensive. He scheduled a patient for surgery

but two emergencies occurred so the operating room was not available at that time. Unfortunately the patient's insurance expired at midnight and he was unable to extend it. Consequently he was unable to have the surgery. He noted that is an example of the need for access in its most acute form. Having a facility in a community is great unless people cannot afford the services at that facility. He believes some patients do not have access to care when they have no alternatives.

MS. LIZ WOODYARD, an administrator at Fairbanks Memorial Hospital in charge of performance improvement and education, informed members that she previously worked for the State of Missouri with the CON process. She said the CON process helps serve the needs of the public and is important in looking at quality and volume of services provided. Missouri, like Alaska, has many rural areas. The CON program ensures the public that quality health care is being provided and that need is clearly defined and viable for a community, which also applies to education and workforce development issues.

MR. MIKE POWERS, administrator of the Fairbanks Memorial Hospital, stated that the hearing has brought forth a great deal of information to sort through - some accurate, some not. He noted regarding a competitive model, in a classic business or economic model, one is good, two is better, three is best but, in sole community hospitals, when dealing with health care the classic supply and demand curves do not work. In the classic conditions, buyers are well informed. In health care, buyers make infrequent decisions and are unsure of treatments, risks and outcomes. Government payers cover more than 50 percent of the typical bill. Buyers and sellers are not independent because insurance desensitizes people to the cost of care. He emphasized that sole community hospitals have a mission and simply cannot stop a service.

MR. DENNIS MURRAY, administrator at Heritage Place Nursing Home, informed members that he recently put an addition on Heritage Place after the moratorium was lifted and spent less than \$1 million because he did not want to go through the CON process. He was able to increase capacity by 12 beds at a cost of \$58,000 per bed. He suggested that the \$1 million threshold had a positive impact on his community because Heritage Place is the most cost-effective facility in Alaska right now. He opposes any change to the existing CON threshold.

SENATOR WILKEN asked Mr. Murray what his incentive would have been to design an addition for a lower cost if there was no CON program.

MR. MURRAY said that he got no reimbursement for the \$58,000 per bed cost because it did not meet the minimum threshold. He suggested, "Where there are no thresholds, the cost does go up because ultimately you will pay in increased Medicaid reimbursement."

3:40 p.m.

MS. LARRAINE DERR, President of the Alaska State Hospital and Nursing Home Association, stated opposition to SB 256. She informed committee members that she did a brief survey of hospitals in the state who have had recent CONs and came up with the following costs:

- Bartlett Hospital - \$20,000 on a CON for its \$40 million rebuild;
- Wildflower Court - 44 beds plus 11 assisted living beds - designed entire facility and completed the CON for \$83,169;
- Ambulatory-surgi center in Anchorage - between \$50,000 and \$75,000 for the CON application and preliminary planning.

MS. DERR pointed out that Ohio has 15 fewer hospitals today than it had in 1997, when Ohio's CON deregulation took effect. However, over the same period there has been a large increase in the number of diagnostic imaging centers (from 27 to 229) and ambulatory-surgi centers (from 27 to 179). She cautioned that there will be a proliferation of profitable services in Alaska when the CON is removed. The challenge for the state is to protect essential health services while ensuring quality of care in all practice settings.

MR. MILTON WILLHIDE (ph), CFO of the Valdez Regional Health Authority, stated that his organization has a CON pending in the Commissioner's office. Although the process was expensive - over \$100,000 and a year's time and labor - the Authority feels the process had great value in helping it to gather the financial information necessary to determine the feasibility of its project. He believes the CON requirement should be maintained and that the threshold should not be raised to \$10 million because that would remove a barrier to the entry into the market in sole community hospitals, such as Valdez. Those hospitals would be hardest hit by entities from the Lower 48 who could easily build many types of facilities for less than \$10 million. He stated support for the existing CON process with minor modifications.

CHAIRWOMAN GREEN asked Mr. Burnett to describe the proposed

committee substitute (CS). She noted she did not intend to take action on it today.

MR. JERRY BURNETT, staff to Senator Green, explained the changes made in the CS as follows.

Section 1 of the CS is the same as the original bill, which increases the threshold for a CON to \$10 million.

Section 2 of the CS allows for the relocation of any health care facility within a community without a CON provided the facility does not increase the number of beds or categories of services. The current statute only allows ambulatory-surgi facilities to relocate without a CON.

Section 3 adds two new requirements to the standard of review for non-nursing home beds: financial feasibility and long term viability of the project, and the forecast of the probable financial effect of the project on consumers and the state's fiscal condition. He stated that according to previous testimony, that is not currently reviewed but "it kind of, sort of is." He explained that all facilities that require a CON would be reviewed with standards similar to those for nursing homes.

Section 4 provides for a temporary moratorium on CONs for psychiatric beds until July 1, 2003.

Section 5 establishes a 6-member working group appointed by the Governor to analyze issues regarding psychiatric care services in Alaska and requires a report be completed by next year's legislative session.

Sections 6 and 7 contain effective dates.

MR. BURNETT said when the moratorium was placed on long-term care and nursing home beds, the testimony showed that 85 percent of nursing home care and acute juvenile psychiatric care was paid by Medicaid. That issue needs further study. The working group in Section 5 is modeled after 1995 legislation that set up a working group to study long-term care.

CHAIRWOMAN GREEN noted she anticipates a vast expansion of Medicaid dollars going to that area.

MR. BURNETT stated that any facilities with acute juvenile psychiatric care will be primarily funded by Medicaid through the state budget.

CHAIRWOMAN GREEN asked how that is formulated.

MR. BURNETT said that a person testifying on SCR 21 stated that acute psychiatric services can cost \$1500 per day so a 60-bed facility, such as the one at Providence, would amount to \$30 million per year.

CHAIRWOMAN GREEN announced that she will take SB 256 up on February 13 along with another bill. She noted that she will take further public testimony at the next meeting. With no further business to come before the committee, she adjourned the meeting at 3:52 p.m.

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