

**ALASKA STATE LEGISLATURE**  
**HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES STANDING COMMITTEE**

February 23, 2008

9:04 a.m.

**MEMBERS PRESENT**

Representative Peggy Wilson, Chair  
Representative Bob Roses, Vice Chair  
Representative Wes Keller  
Representative Paul Seaton  
Representative Sharon Cissna  
Representative Berta Gardner (via teleconference)

**MEMBERS ABSENT**

Representative Anna Fairclough

**COMMITTEE CALENDAR**

HOUSE BILL NO. 337

"An Act establishing the Alaska Health Care Commission and the Alaska health care information office; relating to health care planning and information; repealing the certificate of need program for certain health care facilities and relating to the repeal; annulling certain regulations required for implementation of the certificate of need program for certain health care facilities; and providing for an effective date."

- HEARD AND HELD

HOUSE BILL NO. 345

"An Act amending the certificate of need requirements to exclude expenditures for diagnostic imaging equipment in certain circumstances."

- HEARD AND HELD

**PREVIOUS COMMITTEE ACTION**

BILL: HB 337

SHORT TITLE: HEALTH CARE: PLAN/COMMISSION/FACILITIES

SPONSOR(S): RULES BY REQUEST OF THE GOVERNOR

01/22/08	(H)	READ THE FIRST TIME - REFERRALS
01/22/08	(H)	HES, FIN
01/24/08	(H)	HES AT 3:00 PM CAPITOL 106

01/24/08 (H) Heard & Held  
01/24/08 (H) MINUTE(HES)  
01/31/08 (H) HES AT 3:00 PM CAPITOL 106  
01/31/08 (H) Heard & Held -- Assigned to  
Subcommittee  
01/31/08 (H) MINUTE(HES)  
02/09/08 (H) HES AT 9:00 AM CAPITOL 106  
02/09/08 (H) Heard & Held  
02/09/08 (H) MINUTE(HES)  
02/19/08 (H) HES AT 3:00 PM CAPITOL 106  
02/19/08 (H) Heard & Held  
02/19/08 (H) MINUTE(HES)  
02/23/08 (H) HES AT 9:00 AM CAPITOL 106

BILL: HB 345

SHORT TITLE: MEDICAL FACILITY CERTIFICATE OF NEED

SPONSOR(S): REPRESENTATIVE(S) KELLY

01/30/08 (H) READ THE FIRST TIME - REFERRALS  
01/30/08 (H) HES, FIN  
02/09/08 (H) HES AT 9:00 AM CAPITOL 106  
02/09/08 (H) Heard & Held  
02/09/08 (H) MINUTE(HES)  
02/19/08 (H) HES AT 3:00 PM CAPITOL 106  
02/19/08 (H) Heard & Held  
02/19/08 (H) MINUTE(HES)  
02/23/08 (H) HES AT 9:00 AM CAPITOL 106

**WITNESS REGISTER**

EVELYN MOON

Fairbanks, Alaska

**POSITION STATEMENT:** Testified during the hearing on HB 337 and HB 345.

LINDA GARCIA, Physician

Fairbanks, Alaska

**POSITION STATEMENT:** Testified during the hearing on HB 337 and HB 345.

CARONE STURM

Fairbanks, Alaska

**POSITION STATEMENT:** Testified on her own behalf, in support of HB 337.

CHRISTINE SCUTH

Fairbanks, Alaska

**POSITION STATEMENT:** Testified during the hearing on HB 337 and HB 345.

RICHARD COBDEN, M. D.  
Fairbanks, Alaska

**POSITION STATEMENT:** Answered questions during the hearing on HB 337 and HB 345.

DOUG ISAACSON, Mayor  
City of North Pole  
North Pole, Alaska

**POSITION STATEMENT:** Testified during the hearing on HB 337 and HB 337.

GREG MILLES, Physical Therapist  
Fairbanks, Alaska

**POSITION STATEMENT:** Testified as an individual in support of HB 345.

JILL THORVALD  
Fairbanks, Alaska

**POSITION STATEMENT:** Testified during the hearing on HB 337 and HB 345.

JEANNIE LONG  
Fairbanks, Alaska

**POSITION STATEMENT:** Testified during the hearing on HB 337 and HB 345.

STACIE KRALY  
Chief Assistant Attorney General  
Human Services Section  
Civil Division  
Department of Law  
Juneau, Alaska

**POSITION STATEMENT:** Answered questions during the hearing on HB 337 and HB 345.

JAY BUTLER, M.D.; Chief Medical Officer  
Office of the Commissioner  
Department of Health & Social Services (DHSS)  
Anchorage, Alaska

**POSITION STATEMENT:** Answered questions during the hearing on HB 337 and HB 345.

KARLEEN JACKSON, Commissioner  
Department of Health & Social Services (DHSS)

Juneau, Alaska

**POSITION STATEMENT:** Answered questions during the hearing on HB 337 and HB 345.

DERECK MILLER, Staff  
to Representative Mike Kelly  
Alaska State Legislature  
Juneau, Alaska

**POSITION STATEMENT:** Answered questions during the hearing on HB 337 and HB 345.

#### **ACTION NARRATIVE**

**CHAIR PEGGY WILSON** called the House Health, Education and Social Services Standing Committee meeting to order at [9:04:13 AM](#). Representatives Keller, Roses, Seaton, Gardner (via teleconference), and Wilson were present at the call to order.

HB 337-HEALTH CARE: PLAN/COMMISSION/FACILITIES  
HB 345-MEDICAL FACILITY CERTIFICATE OF NEED

[9:05:28 AM](#)

CHAIR WILSON announced that the only order of business would be HOUSE BILL NO. 337, "An Act establishing the Alaska Health Care Commission and the Alaska health care information office; relating to health care planning and information; repealing the certificate of need program for certain health care facilities and relating to the repeal; annulling certain regulations required for implementation of the certificate of need program for certain health care facilities; and providing for an effective date" and HOUSE BILL NO. 345, "An Act amending the certificate of need requirements to exclude expenditures for diagnostic imaging equipment in certain circumstances."

[9:07:11 AM](#)

CHAIR WILSON informed the committee that she has re-opened public testimony on HB 337 and HB 345 to those who have not previously testified.

[9:07:42 AM](#)

EVELYN MOON said that she would like to see the certificate of need (CON) program repealed in order to allow additional surgical options for the Fairbanks area. She related her personal story of medical care and expressed her hope that

politics would be put aside in order to provide more diverse medical choices in Fairbanks.

9:10:05 AM

REPRESENTATIVE GARDNER inquired as to whether the clinic at which Ms. Moon received treatment is operating at full capacity.

MS. MOON answered that she is on a waiting list for a surgical procedure that could be performed at Fairbanks Memorial Hospital if her doctor had operating privileges there.

9:11:30 AM

LINDA GARCIA, Physician, informed the committee that the difficulty with recruiting physicians to Fairbanks is due to the limited choices for employment. It is expensive to relocate to Fairbanks and risky to enter a medical system in which all medical facilities are financially linked. Dr. Garcia stated that the removal of the CON will allow more young physicians to be attracted to Fairbanks and open private practices there.

9:13:20 AM

CARONE STURM stated that she is a mother, a business owner, and a third generation Fairbanksan. She expressed her support of HB 337 and said that the existing CON law creates a barrier for many health care providers and Alaska citizens. Ms. Sturm expressed her hope that legislators will take special care to hear the problems of constituents, patients, and consumers of health care, that are due to physicians leaving and not having hospital privileges. She opined that competition is vital for a community the size of Fairbanks and she urged the committee's support for HB 337.

9:16:05 AM

REPRESENTATIVE GARDNER asked for the actual numbers of physicians leaving Fairbanks. She also inquired as to whether the problem could be solved if Fairbanks Memorial Hospital allowed hospital privileges to all qualified doctors.

MS. STURM expressed her belief that there is a five percent to six percent attrition rate of physicians. Her concern is the trend of increased attrition and difficulties with recruitment. Regarding the extension of privileges, she opined that the problem would continue because of the need of specialists. In

further response, she said that she has witnessed repeated accounts in which physicians have closed practices and residents are unable to find a specialist in Fairbanks.

[9:19:14 AM](#)

REPRESENTATIVE GARDNER reminded the committee that many physicians are retiring.

MS. STURM added that for that reason there is a need to make the environment attractive and competitive for new physicians.

[9:20:18 AM](#)

CHAIR WILSON stated that many areas of the state do not have access to physicians. She said that there are many other reasons for the shortage of doctors, such as the physical and economic environment in Alaska. In fact, there is no proof that the CON law is the problem and she emphasized the committee's need for facts, and not assumptions.

[9:22:30 AM](#)

CHRISTINE SCUTH said that she has had to travel to Anchorage for medical procedures. Her main concern is that there is a need for competition because the status of a nonprofit, like Fairbanks Memorial Hospital, creates a hold on the community. She opined that CON legislation is archaic and detrimental to the well being of Alaskans by not treating the health care industry like any other industry that can bring jobs to Alaska. This legislation is stopping industrial growth in Fairbanks, she said.

[9:25:41 AM](#)

RICHARD COBDEN, M. D., responded to Representative Gardner's question. He said that Fairbanks Memorial Hospital has eighty-five physicians on staff, and has lost six in the last year and two during the prior year. The positions lost were: two urologists, three internal medicine doctors, two orthopedists, and one general surgeon. One position has been temporarily filled. He further explained that there are five new applications to fill temporary locum tenens positions.

[9:27:34 AM](#)

REPRESENTATIVE SEATON clarified that the previous testimony was specific to Fairbanks Memorial Hospital.

[9:29:28 AM](#)

DOUG ISAACSON, Mayor, City of North Pole, informed the committee that his community of North Pole is near Fairbanks and is an area of population growth with an aging population. He reported that there is interest in opening a needed 100 bed nursing home facility in the borough; however, as the mayor, he is concerned that the present system restricts the ability of certain groups to open facilities in North Pole. Mr. Isaacson said that he understands the needs of the hospital, but there should also be a way in which to expand physician's facilities to the 30,000 citizens of the North Pole area. He opined that a group with a good business plan should be able to make investments without the restrictions of CON laws. In conclusion, Mr. Isaacson pointed out that KMD Services & Consulting disclosed that there were no patient consumer groups represented in its demographic study that was done for the state.

[9:33:23 AM](#)

GREG MILLES, Physical Therapist, informed the committee that over the course of time, free enterprise has been stifled; there are no outpatient surgery centers in Fairbanks. He stated that the smaller community of Wasilla has a surgery center, but there are no other options in Interior Alaska. Mr. Milles stated that health care in the Interior is compromised.

[9:35:19 AM](#)

JILL THORVALD informed the committee that she is the executive director for a medical clinic in Fairbanks. She spoke of the concept of charity and said that her clinic treats everyone who enters; in fact, it wrote off over \$100,000 alone last year. She opined that the hospital is extremely vital to the community; however, she supports the governor's legislation because bringing a surgery center to Fairbanks would create more business for the local hospital. Furthermore, the hospital provides services that residents can not do without.

[9:37:07 AM](#)

REPRESENTATIVE GARDNER asked for an explanation of how more physicians and more medical facilities would create more business.

MS. THORVALD explained that every health care provider relies, in some way, on services that can only be provided at the hospital.

[9:37:56 AM](#)

REPRESENTATIVE GARDNER stated that the rationale behind CON is partly that if there is excess capacity for medical services it will be filled.

MS. THORVALD further explained that many patients are going out of town or out of state for services. Surgery centers will bring more providers and more services will be needed; thus, there will be an increase of services that the hospital will provide.

[9:39:04 AM](#)

REPRESENTATIVE GARDNER said that she remains puzzled about why more services will be needed.

MS. THORVALD gave the example of a specialty clinic that uses laboratory, diagnostic, and emergency services at the hospital. She opined that the elimination of CON would create a better environment and encourage specialty physicians to enter the market.

[9:40:25 AM](#)

JEANNIE LONG stated that she recently had an arthroscopic procedure on her knee that cost \$15,000, but should have cost \$1,500. She opined that there should not be a CON [law].

[9:41:07 AM](#)

REPRESENTATIVE GARDNER asked on what Ms. Long based her cost estimate.

MS. LONG said that the estimate is based on a conversation with her surgeon.

[9:42:03 AM](#)

CHAIR WILSON asked for an explanation of the cost of Ms. Long's surgery.

[9:42:18 AM](#)

DR. COBDEN answered that hospital costs are not flexible and cannot be adjusted down, but costs can be adjusted in private facilities.

[9:43:16 AM](#)

CHAIR WILSON asked for clarification of Dr. Cobden's fees.

DR. COBDEN explained that the average cost for Ms. Long's hospital out-patient procedure is \$16,000: \$5,000 walk in fee; anesthesia; medication; nursing; and hidden costs. He opined that in an ambulatory surgery center the cost can average 30 percent to 50 percent less.

[9:45:02 AM](#)

Public testimony was closed.

[9:45:16 AM](#)

CHAIR WILSON announced that the committee would discuss the first two sections of HB 337, Version E. She stated that the committee's charge is to do what is best for Alaskans. Chair Wilson pointed out that Section 1, Version E, allows the Department of Health & Social Services (DHSS) to establish health care information on the Internet for consumers. She called the committee's attention to page 1, line 8, that states the "department may", and to the addition of "AS 18.09" on page 1, line 7.

[9:49:47 AM](#)

REPRESENTATIVE GARDNER opined that Section 1 is simply including the health care commission as one of the tools that the DHSS can use to accomplish the goals listed in the paragraphs that follow.

[9:50:27 AM](#)

REPRESENTATIVE SEATON noted that, under this section, the bill is not adding a health care commission, but rather the statewide health plan based on the health care commission's recommendations. Furthermore, he said that it seems that a separate statewide health plan is to be adopted as indicated on

page 2, line 6, subparagraph (A). Representative Seaton opined that the bill allows the DHSS to create a public health plan and add a statewide health plan.

[9:51:20 AM](#)

CHAIR WILSON clarified that, with the addition of the health care commission, the DHSS may take the advice of the commission.

REPRESENTATIVE SEATON agreed. He then stated that he was unsure of the difference between a statewide health plan and the public health plans and formal policies that are identified in subparagraph (B).

[9:52:06 AM](#)

STACIE KRALY, Chief Assistant Attorney General, Human Services Section, Civil Division, Department of Law, stated that the amendment creates the ability of the state to adopt a statewide health plan, if recommended by the health care commission created in Section 4 of the bill. She expressed her understanding that the statewide plan would be a more comprehensive state health plan for all purposes, as compared with a public health plan would be limited to public health issues that are the specific duties of the DHSS.

[9:52:54 AM](#)

JAY BUTLER, M.D.; Chief Medical Officer, Office of the Commissioner, Department of Health & Social Services (DHSS), described the statewide health plan as a plan to take care of the individual citizens in the state. He further explained that the public health plan addresses how to take care of the population.

[9:53:40 AM](#)

REPRESENTATIVE CISSNA asked whether the legislation incorporates what already exists in regard to a comprehensive plan that has not been developed due to the lack of a health care commission.

DR. BUTLER advised that his interpretation is that it is in addition to what has already been done with the public health law.

MS. KRALY stated that the DHSS has been working on comprehensive issues, related to the provision of health care, but has not

developed a comprehensive statewide health plan in many years. She explained that there are many reports issued by DHSS, but they do not comprise a state health plan; all of the programs need to be synthesized into one statewide program.

DR. BUTLER gave an example of a public health plan, Healthy Alaskans 2010, but noted that it does not address the issues of providing access to and coverage for health care to individual Alaskans.

[9:56:30 AM](#)

REPRESENTATIVE CISSNA observed that the commission pulls it all together. She then stated that public health is probably the most developed policy and this legislation addresses the recent technological phase. State costs are increasing, in part because of technology, which has not been sufficiently studied. She noted that her constituents need and want primary and preventative care and she expressed concern that the legislature is focused on advanced care. Representative Cissna urged the committee to make sure that prevention is addressed.

[10:00:00 AM](#)

CHAIR WILSON suggested reviewing the legislation to find an appropriate area where that can be addressed, perhaps on page 2, subparagraph "**(B)**", or on page 5, where the duties of the commission are itemized. Her goal is to decrease the cost of health care in Alaska, which has been accomplished in other states by establishing expected standards of care accompanied by a set of presenting symptoms. This procedure would save the cost of extra services and would result in cost savings overall. Chair Wilson urged the committee to consider instructing the health care commission, or the DHSS, to develop these standards.

[10:03:23 AM](#)

REPRESENTATIVE KELLER agreed and added his support for an efficient commission.

[10:03:44 AM](#)

REPRESENTATIVE SEATON cautioned that a set standard of care may mean that a Bush doctor will be required to comply; rural Alaska may face a different standard because of the lack of services. He would not want to say that the standard of care in a hospital

would be different than in a single-physician facility in another area.

CHAIR WILSON opined that the provider will make the final decision and the standard of care would be used for a normal case.

[10:05:57 AM](#)

REPRESENTATIVE CISSNA suggested that testimony from physicians and insurance representatives would be good to hear on this matter.

CHAIR WILSON advised that the commission itself would have to determine what expert testimony was necessary.

[10:07:09 AM](#)

REPRESENTATIVE ROSES stated his preference is to not refer to a standard of care, but rather to the proper protocols for procedures, diagnostics, or further testing.

[10:07:55 AM](#)

REPRESENTATIVE SEATON expressed his hope that any amendment on this subject will specify that the standards expire if not updated in a specific timeframe. In addition, he cautioned that the requirement of certain procedures will increase the liability of a rural doctor; the intent must be clear to the commission that not everyone has to go to Anchorage in order for the doctor to follow the standard of care.

CHAIR WILSON suggested that the terminology could be "best practices."

[10:09:40 AM](#)

REPRESENTATIVE GARDNER observed that insurance companies do what is being suggested in the "preapproval process." This process eliminates unnecessary testing, but there is also a risk because insurance companies are making medical decisions.

[10:10:48 AM](#)

REPRESENTATIVE ROSES emphasized that he does not want insurance companies to make decisions with regard to protocols and care practices because they are the money managers.

REPRESENTATIVE GARDNER agreed and said that physicians need to use their best judgment.

REPRESENTATIVE ROSES explained that his concern with protocol is that with more testing there is a greater chance for false positives and unnecessary procedures. He referred to a Utah study that was done on the basis of mitigating the extreme increases in liability insurance. This study showed that, by approaching cases strictly from a medical perspective, the amount of malpractice insurance, the number of lawsuits, the number of false positives, and the number of deaths in hospitals, was reduced. He agreed with Representative Gardner that insurance companies should not be making medical decisions.

[10:13:33 AM](#)

CHAIR WILSON called the committee's attention to the definitions on page 3, and page 8, and noted that there have been recommendations to improve the definition of "health care facility" in order to prevent litigation.

[10:14:49 AM](#)

REPRESENTATIVE ROSES expressed his intent to move forward to create a better environment with clearer understandings and if that mitigates future lawsuits, so be it. He referred to the recommendations indicated by the KMD Services & Consulting study in which the majority of the participants articulated that clearer definitions in statute were needed for the following: ambulatory surgery centers; physician's office exemptions; "excessive"; and "need." It was also suggested that the bill comply with Medicare guidelines.

[10:16:32 AM](#)

MS. KRALY agreed and added that there needs to be complete and accurate definitions for all facilities listed in the statute. She pointed out that there are technical difficulties with Version E to which the department has amendments. She opined that the legislature should use the negotiated rulemaking process as a starting point for the definitions, such as "a physician's office." Ms. Kraly said that she would have to review the federal Medicare guidelines and definitions for possible use; furthermore, these guidelines must be placed in statute rather than in regulation.

[10:19:18 AM](#)

REPRESENTATIVE GARDNER asked whether HB 337 is the place where the definitions should be put in statute.

MS. KRALY answered that the definitions should be included if the bill contains a CON component.

[10:19:44 AM](#)

REPRESENTATIVE ROSES observed that it appears that the majority of the problems lie in the lack of clear definitions. For example, there is also the question of defining what is meant by the population in an area and whether military bases are included.

[10:20:58 AM](#)

CHAIR WILSON commented that the military has its own physicians and hospitals.

MS. KRALY concurred and stated that it is appropriate for the legislature to define what population means in order to determine current capacity, future need, the possible inclusion of outlying areas, rural areas, and the possible exclusion of military and Indian Health Services components.

[10:22:20 AM](#)

REPRESENTATIVE ROSES pointed out that those with the TRICARE Military Health System do have the ability to go anywhere; however, not all physicians accept TRICARE insurance.

[10:22:44 AM](#)

REPRESENTATIVE CISSNA noted the importance of the commission being updated on local issues in Alaska. She related that during her visit to Akutan she noticed that the community preferred health providers of the same gender.

[10:24:14 AM](#)

REPRESENTATIVE GARDNER asked whether page 2, paragraph (9), addresses Representative Cissna's desire for preventative measures.

REPRESENTATIVE CISSNA said yes.

DR. BUTLER added that the discussion should also include the fact that prevention is the way to balance the increased costs of technology and medication.

[10:25:39 AM](#)

REPRESENTATIVE CISSNA referred to the part of the bill that relates to statewide updates from throughout Alaska. For example, the need for area-by-area updates on population health needs and any changes to a community due to the influx of new industry.

CHAIR WILSON clarified that these are changes in demographics.

[10:27:24 AM](#)

REPRESENTATIVE ROSES advised that the committee may want to include in the definitions a mobile or portable facility; for example, the mobile mammogram van.

[10:28:12 AM](#)

REPRESENTATIVE SEATON called the committee's attention to page 3, line 17 through 19, that establishes the purposes of the health care commission. He expressed his desire to assure that the committee is not discussing legislative intent beyond the purposes that are specified in paragraphs (1) and (2). If so, there is a need to include the additional purposes in the bill.

[10:29:18 AM](#)

REPRESENTATIVE GARDNER asked whether it is appropriate for the committee to review HB 407 due to its parallels with HB 337.

CHAIR WILSON announced that the committee will hear HB 403 prior to its final consideration of HB 337. She said that it is her intention to consolidate all three pieces of legislation and urged the committee to review HB 407 before the hearing.

[10:30:55 AM](#)

REPRESENTATIVE KELLER opined that it is the committee's job to establish a quality commission to make recommendations to DHSS. He warned that detailed decisions on the charge of the commission will not lead to the obvious problem before the committee, and that is whether to repeal CON.

[10:32:22 AM](#)

REPRESENTATIVE CISSNA related that her staff has reconciled parts of CSHB 337, Version E, and HB 407.

CHAIR WILSON stated that there are copies of that in the committee packet. She then opined that the committee needs to review the composition of the commission and determine what Alaskans and the legislature will accept. She pointed out that the bill establishes a commission appointed by the commissioner, and thereby, influenced by the governor. Chair Wilson expressed the need for legislators to be part of the commission, similar to the appointees on the Joint Legislative Education Funding Task Force.

[10:35:13 AM](#)

REPRESENTATIVE GARDNER noted her agreement and added that the governor's proposal includes commissioners and their designees that certainly have a role in the process, but do not have to sit on the commission.

[10:35:51 AM](#)

REPRESENTATIVE ROSES affirmed that the Joint Legislative Education Funding Task Force was a legislative task force; thus, the inclusion of legislative members. He opined that the commission should have less legislative participation; however, the current list sounds like a cabinet meeting. Representative Roses recommended that there should be representatives from the health care industry, the insurance industry, and consumers.

[10:37:05 AM](#)

REPRESENTATIVE SEATON agreed that the legislative task force had a legislative purpose to develop legislation, which is not the duty of the commission. He expressed his hope that the members of the commission are knowledgeable, in regard to achieving the duties of the commission, such as rural and urban health care providers, and consumers.

[10:38:44 AM](#)

REPRESENTATIVE KELLER supported the way the commission is presented in HB 337. He warned of the danger of having all of the stakeholders represented and said that this will result in a

problem in making decisions. Representative Keller suggested compiling a list of expert witnesses, but opined that the proposed commission [consists of] commissioners, department heads, and six public employees who do represent the state.

[10:40:11 AM](#)

REPRESENTATIVE CISSNA commented on the available benchmarks that compare Alaska with the rest of the nation in terms of health care costs and conditions. She pointed out that Alaska is at the top of numerous negative health care indicators which lead to the assumption that there is a need for [participation] by a broad group of stakeholders. If insurance representatives and consumers are left out, there are holes that cost in the end. She explained that the negative indicators support a change in policy and legislative work would need to be included in order to understand why and how to begin changes. Representative Cissna advised that legislators on the commission will provide a broader view.

[10:43:05 AM](#)

REPRESENTATIVE SEATON commented on the composition of the commission. He stated that on page 4, line 5, there is no diversity specified for the six public members and suggested that the DHSS could come forward with specifics on how to ensure representation from all areas of the state and Native and federal health care systems.

[10:44:22 AM](#)

REPRESENTATIVE ROSES stressed that it is important to specify that the small business representation should not come from those who provide medical services.

[10:45:17 AM](#)

CHAIR WILSON asked the committee to consider the contradiction regarding commission staff on page 4, line 22, that states that "the department may" with line 23, that states that "the commission shall."

[10:46:01 AM](#)

REPRESENTATIVE KELLER suggested that individual legislators could assign staff to assist the commission and provide a link between legislators and the commission.

[10:46:54 AM](#)

CHAIR WILSON referred to page 4, line 30, that states the duties of the commission and suggested that this could be a location to insert "best practices" or "protocols." She then referred to page 5, line 22, and asked for the standard amount of per diem allowed for a commission.

MS. KRALY responded that she will provide that information. She assumed that the per diem would be similar to the state rate that is about \$60 per day for food.

[10:48:07 AM](#)

REPRESENTATIVE SEATON advised that there are different commission rates of per diem.

[10:48:31 AM](#)

CHAIR WILSON turned to page 5, line 26, that establishes the Alaska health care information office in the DHSS. She then asked whether a person would be hired, or a DHSS employee assigned, to staff the office.

DR. BUTLER answered that the fiscal note includes staff to operate the information office. In further response to a question, he said that there will be two staff members.

[10:49:24 AM](#)

REPRESENTATIVE CISSNA recalled previous discussion that some of Alaska does not have access to the Internet, yet there is often a connection available through a satellite phone. She related that there is an effort by the United Way in Anchorage to make a health care phone connection by calling 211, and it is important for the state to cooperate and use overlapping information. Representative Cissna brought up the possibility that the state could make sure that the 211 phone number is available throughout the state, just as is 911 for emergencies.

[10:51:18 AM](#)

DR. BUTLER expressed his concern that the addition of a different medium to the project increases costs. He opined that the satellite connection is an excellent goal, but providing all of the health care information via telephone would be difficult

due to the large amount of information. Dr. Butler suggested that this could be an issue explored by the committee.

[10:52:22 AM](#)

CHAIR WILSON said that Alaska has better Internet access than any other state.

[10:52:40 AM](#)

REPRESENTATIVE CISSNA emphasized that United Way has already invested money and time into the 211 technology and an overlap, by the state, with that work will save money and duplication of health costs.

[10:53:40 AM](#)

CHAIR WILSON agreed that the committee may want to review what United Way is doing. She observed that the Alaska health care information office will be on the Internet and will provide health care provider costs for consumers across the state.

DR. BUTLER stated that there are two major components to the health information office: information on health care and information on prevention measures and personal responsibility for good health. He described the Michigan chief medical officer's website that starts with information on how to improve physical activity, diet, and information on specific diseases. In addition, there will be consumer information that will focus on health care and facilities.

[10:56:32 AM](#)

REPRESENTATIVE KELLER expressed his interest in tightening the language to include the actual costs of specific procedures.

CHAIR WILSON re-stated the need to know each individual providers' charge.

REPRESENTATIVE KELLER added that hospitals also have negotiated contracts for the reimbursement of procedures.

[10:58:21 AM](#)

REPRESENTATIVE GARDNER asked whether the state has a solid cost estimate for the health care information database and software.

DR. BUTLER affirmed that he has received a round figure estimate of \$200,000 for compiling the data that is already being collected. This estimate includes posting the data and maintaining the web site; he acknowledged that costs in Alaska may differ from those in other states.

REPRESENTATIVE GARDNER suggested providing the information incrementally as it becomes available.

DR. BUTLER agreed, and added that the DHSS does already collect hospital discharge data including length of stay, total charges, diagnosis, basic patient demographics, and discharge status. Currently, the database does not include charges by specific services and procedures; however, that data could be added along with emergency room and hospital out-patient visits.

[11:02:00 AM](#)

REPRESENTATIVE ROSES asked whether insurance companies' usual and customary fees are posted. The consumer will need to know what is charged and what is covered in order to shop around.

DR. BUTLER answered that all the data collected at this time is from the hospitals, not the insurance payers.

REPRESENTATIVE ROSES expressed his interest in expanding the reporting.

MS. KRALY pointed out that the premise of Sec. 18.09.130 was to work with various departments to gather and provide information, including insurance information. She confirmed that establishing the authority to obtain information on insurance allowances and coverage is a step in the right direction.

[11:03:57 AM](#)

REPRESENTATIVE ROSES opined that this information is not proprietary.

[11:04:50 AM](#)

CHAIR WILSON recalled that Ms. Kraly said that the committee should use the regulatory rulemaking authority.

MS. KRALY clarified that, if there remains a limited CON program, the DHSS will look at the negotiated rulemaking report in developing definitions for the CON program.

[11:05:53 AM](#)

REPRESENTATIVE SEATON asked whether customary and usual Medicare and Medicaid reimbursements are public information.

DR. BUTLER confirmed that that information could be part of what is under discussion.

REPRESENTATIVE SEATON observed that there are several sectors; Medicare and Medicaid, independent insurance, cash payers, and workers' compensation. He opined that information should be from the major insurance providers from the previous year and relevant to the facility. This may be a consolidation of insurance reporting.

[11:08:13 AM](#)

CHAIR WILSON announced that there would be a discussion of CON issues and that both bills are before the committee.

[11:08:57 AM](#)

REPRESENTATIVE SEATON asked for the source of Amendment 25G-2.

[11:09:30 AM](#)

CHAIR WILSON stated that this amendment was prepared by the governor's office to eliminate CON during a two-year transition.

MS. KRALY explained that Amendment 25G-2 was drafted on behalf of the governor's office to clarify the certificate of need components of Version E.

[11:10:05 AM](#)

REPRESENTATIVE SEATON asked whether the definitions in the amendment are to be considered.

CHAIR WILSON said yes, and urged the committee to review the amendment.

[11:11:34 AM](#)

CHAIR WILSON invited comments on the CON process.

[11:11:46 AM](#)

REPRESENTATIVE ROSES expressed his desire to study the amendment and to look for an adequate compromise that will serve to end the discussion on CON so that the committee can move on to more meaningful topics.

[11:13:01 AM](#)

CHAIR WILSON asked whether the committee wished to review her list of concerns or to review the governor's amendment.

[11:13:28 AM](#)

REPRESENTATIVE KELLER reiterated Representative Roses' request for time to review the amendment.

[11:13:59 AM](#)

REPRESENTATIVE SEATON asked whether the issues addressed in the letter dated the twenty-second of February, are also addressed in the amendment.

MS. KRALY expressed her understanding that the letter outlines the core concepts that are included in Amendment 25G-2. In addition, there is further information on Representative Kelly's bill in the letter.

[11:15:12 AM](#)

CHAIR WILSON listed concerns as follows: grandfathering-in existing centers; definitions; which entities would still need CON; the physician ownership percentage of exempt facilities; no self-referrals; a change in the amount of the threshold of investment; and language to exempt all tribal health entities.

[11:16:59 AM](#)

MS. KRALY stated that it was important to note that Amendment 25G-2 is a change to Version E, that includes a limited CON program, as opposed to the original bill that completely repealed CON law. The premise of the committee substitute is that there will be a CON required when building a residential psychiatric treatment facility or a nursing facility anywhere in the state. These exceptions were made because these facilities are primarily paid for by federal and state funds. The third type of facility that is subject to the limited CON program is any health care facility that would attempt to compete in a

community with a critical access hospital. She noted that a critical access hospital is designated by the DHSS and constitutes a small, rural hospital with 25 beds or less. Ms. Kraly explained that page 1, Sec. 2, of the amendment clearly identifies that a CON is needed in a critical access hospital community and that a CON is needed if building a residential psychiatric treatment center or a nursing home.

[11:20:01 AM](#)

REPRESENTATIVE ROSES asked how the amendment would affect a community such as North Pole.

MS. KRALY answered that a 100 bed nursing facility would require a CON; however, a 100 bed assisted living home would not require a CON.

CHAIR WILSON recalled disparate testimony about the population in North Pole.

[11:21:24 AM](#)

REPRESENTATIVE SEATON related his understanding that the North Pole facility would provide a wide diversity of services including nursing and assisted living services. He inquired as to the rationale behind making CON a requirement for residential psychiatric treatment centers and nursing homes.

MS. KRALY explained that for a nursing facility, there are the facility costs that are considered capital costs by Medicaid. The daily rates of residential psychiatric treatment centers include the cost of care and capital expenditures. Therefore, the capital expenditures and the cost of care are all rolled into the rate.

[11:23:49 AM](#)

REPRESENTATIVE SEATON surmised that the rate is different based upon how much capital is put into the facility, or whether there is a blanket rate that includes the operational cost of care and an amount to support the basic construction and maintenance of the facility.

MS. KRALY responded that capital costs and expenditures are a consideration of rates. More importantly, the cost of care is fully paid for through the Medicaid program; therefore, if there is a need to generate capacity with regard to Bring the Kids

Home initiative, the state must consider how the reimbursement scheme plays into the number of beds. She stressed that capital costs are part of the consideration, although they are not rolled in.

[11:25:39 AM](#)

REPRESENTATIVE SEATON asked for a further explanation of the cost reimbursement rate and facility capitalization.

[11:27:20 AM](#)

REPRESENTATIVE KELLER remarked:

If we overbuild nursing homes, for example, skilled care nursing homes, I don't see what the downside is, and I think that may be similar to what you're asking.

CHAIR WILSON said that the downside would be that there are not enough nurses to staff them.

[11:28:23 AM](#)

KARLEEN JACKSON, Commissioner, Department of Health & Social Services (DHSS), explained that nursing homes and residential psychiatric treatment centers are useful to keep patients at the lowest possible level of care, as opposed to the care level of surgery centers and hospitals. Nursing homes and residential psychiatric treatment centers also have different rates of reimbursement. Commissioner Jackson related that states without general CON laws usually retain these exceptions and that the DHSS suggested a two-year repeal.

[11:29:15 AM](#)

REPRESENTATIVE KELLER asked for clarification.

COMMISSIONER JACKSON remarked:

What we have done now, with the residential psychiatric treatment, a, beds in particular, is try to keep those high end beds under control, through the CON process. So that we don't overbuild those and so that we're making certain that those lower levels of care are available, available instead.

[11:30:04 AM](#)

CHAIR WILSON surmised that placement in a nursing home is more expensive for the state than home service by a personal care aide.

COMMISSIONER JACKSON agreed, and added that the DHSS wants to ensure that it is using the lowest level of care.

[11:30:23 AM](#)

REPRESENTATIVE CISSNA observed that health care is often not a choice issue when individuals are referred to an institution. In the case of available bed space in a large institution, there is a lot of pressure to fill those beds by referrals. She encouraged the committee to hear testimony from a variety of sources.

[11:31:49 AM](#)

MS. KRALY turned to page 2, of Amendment 25-G, concerning the definition of a "health care facility," and clarified two important components: exclusions of physician's office, and the exemption of facilities owned by the federal government and the Indian Health Service. In addition, under existing statute AS 18.07.111(15), there were two exemptions, a physician's office, and the Alaska Pioneer Homes; however, the Alaska Pioneer Homes are now assisted living facilities so that exemption has been removed.

[11:33:49 AM](#)

CHAIR WILSON asked for a definition of "acute care hospital."

MS. KRALY said that an acute care hospital is a major facility that is not a critical access hospital. To clarify, she stated that a major hospital that wanted to compete against a critical access hospital would need to have a CON.

[11:34:47 AM](#)

MS. KRALY advised that on page 2, line 25, and through page 3, line 24, the specific definitions for health care facilities are listed, as well as what constitutes a physician's office.

[11:35:17 AM](#)

CHAIR WILSON pointed out the inclusion of "mobile outpatient facility" on page 3, line 1.

MS. KRALY noted that many facilities are defined elsewhere in statute and those definitions were used; however, for facilities not previously defined, framework language from the negotiated rulemaking report was used.

[11:36:41 AM](#)

CHAIR WILSON inquired as to the new definitions.

MS. KRALY said that facilities that were not defined under the previous CON statute are the following: critical access hospital; independent diagnostic testing facility; intermediate care facility; kidney dialysis; nursing home; office of private physicians or dentists; and psychiatric hospital.

[11:38:41 AM](#)

REPRESENTATIVE SEATON pointed out a conflict between the definition of physician's office on page 2, line 20 and 21, and the definition on page 3, lines 19 through 21.

MS. KRALY confirmed that the intent is that the definitions would be the same to define the individual or group practice component discussed by the negotiated rulemaking report. She indicated that the definitions would be reviewed.

[11:40:32 AM](#)

REPRESENTATIVE ROSES clarified that the new definitions could have been in regulations before, but were not found in statute. He then asked whether the definitions align with Medicare guidelines.

MS. KRALY agreed that the definitions could have been in regulation. She said that some of the definitions contain a component of Medicare language.

REPRESENTATIVE ROSES expressed his concern that the definitions comport.

MS. KRALY concurred.

[11:42:10 AM](#)

REPRESENTATIVE SEATON asked whether "ambulatory surgical center" is incorporated under mobile facilities and whether that would include a facility traveling in a vessel or on an aircraft.

MS. KRALY confirmed that mobile facilities are not included in the ambulatory surgical center definition, as those are generally fixed facilities due to the complexity of the services provided. However, if this service exists, it should be addressed.

REPRESENTATIVE SEATON opined that this service exists in many parts of the world and its presence in remote areas of Alaska should be anticipated.

[11:45:16 AM](#)

COMMISSIONER JACKSON affirmed that the DHSS can review this service. She then suggested that the committee consider inserting language that will allow the addition of new services that become available.

[11:45:52 AM](#)

MS. KRALY called the committee's attention to page 3, line 27, through page 5, line 26 and advised that this part of the amendment is a change from Version E that provides a more clearly defined scope of what will be placed in the database on the web site. This language provides more direction and clarification in an attempt to be comprehensive, but not overwhelming. She offered that the committee may want to add additional information.

[11:47:20 AM](#)

CHAIR WILSON pointed out that the language specifies that the database "must include" all of the information and asked whether there should be some flexibility.

MS. KRALY acknowledged that this same question was brought forth during the Senate hearing and by Dr. Butler. The issue is the mandatory, versus discretionary, role about what information will be included. The DHSS is assuming that information is available to be readily downloaded, and is transferrable for use on the web. However, it may be advisable to use more discretionary language so information can be reviewed and withheld if it is deemed to be confusing to consumers. In addition, the health care office provision needs to be reviewed

to ensure that it is consistent with the permissive and mandatory language. Ms. Kraly assured the committee that these reviews will be completed prior to the next hearing.

[11:49:22 AM](#)

REPRESENTATIVE SEATON noted that on page 3, [paragraph] 2, the list of facilities does not include any private doctor's or dentist's offices, as those are excluded under the definition of health care facilities, as well as tribal health organizations health facilities. He asked whether these exclusions are intended.

COMMISSIONER JACKSON explained that it is difficult to obtain the information from these facilities; however, if the committee wishes to include this information, it can be included with additional cost and time.

CHAIR WILSON related hearing from someone in another state that indicated that perhaps two years is not enough time to accomplish the goal. If more time is allowed, more complete information could be provided.

[11:51:56 AM](#)

COMMISSIONER JACKSON suggested that language should be included that allows the commission to periodically update the information provided on the Internet.

MS. KRALY stated that the bill contains three components of legislation that are interrelated. She explained that the concept is, if the CON is replaced with the limited CON program, the health information will be the "substitute" for the certificate of review. This concept will replace the process of facility review with the report to the database. Therefore, this is the information that is currently being vetted and controlled through the CON process.

[11:53:37 AM](#)

REPRESENTATIVE SEATON referred to the requirements of the database and asked whether there is a need for two different levels of information. He opined that, if the DHSS is trying to disseminate what facilities are available, but then excludes all of the physician's and dental offices and the tribal community health care clinics, it seems like it is missing a big piece of what the database is there to do. The database is of one level

for consumer costs, and something else for the access of medical services. Consumers at least need to know where the services can be found.

[11:55:39 AM](#)

REPRESENTATIVE ROSES agreed that reporting the location and availability of independent health services is not a problem, whereas reporting costs would be a considerable amount of work that could result in less access to health care.

[11:56:46 AM](#)

REPRESENTATIVE CISSNA agreed that access is a large issue and a priority goal is getting out the basic information of what may be available to citizens quite close to home.

[11:57:46 AM](#)

REPRESENTATIVE SEATON expressed his belief that part of the information in the database that consumers really need to know is whether physicians take new Medicaid or Medicare patients. Just that information would be extremely helpful to residents.

The committee took an at-ease from 11:57 to 11:59 p.m.

[11:59:32 AM](#)

MS. KRALY clarified that in definitions under AS 18.07.111, the "health care facility" for purposes of certificate of need, also includes information from assisted living homes; rural health clinics; urgent care facilities; providers of home and community-based waiver services, and personal care attendants. This language is a more broadly stated definition section about who needs to report financial data.

[12:00:40 PM](#)

REPRESENTATIVE ROSES asked for clarification of the two-year concept for the limited CON program.

MS. KRALY explained that the original change under Version E was that there would be a limited CON for the three entities mentioned previously, with a sunset provision in two years; however, the two-year repeal is not currently included in the

amendment, although the repeal is supported by the governor at this point.

REPRESENTATIVE ROSES further asked about the partial repeal.

MS. KRALY continued to explain that the additional amendment will address a two-year repeal and a sunset provision for the three entities affected by the limited CON; critical access hospitals, residential psychiatric treatment centers, and nursing homes.

[12:02:15 PM](#)

CHAIR WILSON turned the committee's attention to HB 345. She then noted that the only change was to add "(f)" on page 2, line 5 through 7, that ensures that facilities that will affect critical access hospitals are required to have a CON. She then asked Ms. Kraly to address the new Section 3.

MS. KRALY explained that the current CON statute has a monetary threshold of \$1,100,050 that is increased by \$50,000 each year to an ultimate limit of \$1,500,000. Currently, the basic consumer price index inflation rate would put the threshold at \$2.1 million and the rate of health care inflation would put the threshold at \$7 million.

[12:06:37 PM](#)

REPRESENTATIVE ROSES asked whether there have been issues with regard to what is included in the \$1 million cost, for example, depreciation.

MS. KRALY answered that the current statute under AS 18.07.031 defines expenditures and provides legislative direction on what should be included. The statute references the present value of a lease and regulations have expanded upon that. She acknowledged that not everything considered in the monetary threshold is a true medical cost.

[12:07:52 PM](#)

REPRESENTATIVE ROSES further asked whether the amendment discussed today includes in its \$1 million threshold the old regulations on lease space and depreciation.

MS. KRALY responded that the amendment does not impact the definition of expenditure in AS 18.07.031.

REPRESENTATIVE ROSES observed that discussion of the inflation rate of the \$1 million should include a review of what has occurred in regulation as to cost, and what the current standards are.

[12:09:32 PM](#)

CHAIR WILSON opined that the largest difference between the bills is the 50 percent ownership in HB 345 versus 100 percent ownership in HB 337.

[12:10:08 PM](#)

REPRESENTATIVE SEATON stated that a group practice may have physician investors who do not practice in the facility. He asked for clarification of the governor's bill on that point.

MS. KRALY said that [HB 337] attempts to maintain a 100 percent physician ownership, whether physician investors practice in the facility or not; this definition tracks with the Center for Medicare Services (CMS) definitions.

REPRESENTATIVE SEATON asked for the reasoning behind the use of the CMS definition.

MS. KRALY explained that, when the DHSS attempted to define imaging facilities the public preferred the CMS known concepts. However; a legal ruling found that the DHSS could not use CMS definitions because the legislature had not approved the concept. Writing the core concepts in statute will comport with the rulemaking committee's suggestions.

REPRESENTATIVE SEATON further asked for the reasoning behind the requirement of 100 percent ownership by physicians, even when the investors may not be attending. If CMS allows that, the bill allows 50 percent.

MS. KRALY asked for the opportunity to provide a more thoughtful response and comparison at a later time.

[12:14:41 PM](#)

REPRESENTATIVE SEATON expressed his appreciation for her later response on that issue. He then said that HB 345 only deals with imaging centers and, due to the testimony from consumers about the lack of ambulatory outpatient surgery centers, he

would like to see ambulatory outpatient surgery centers addressed, also.

[12:15:51 PM](#)

DERECK MILLER, Staff to Representative Mike Kelly, Alaska State Legislature, opined that many hospitals have existing facilities that can provide services in a better manner than an imaging facility 100 percent owned and operated by a group of physicians. Hospitals prefer the exemption without the CON process and will not have that opportunity.

[12:17:06 PM](#)

CHAIR WILSON asked whether a grandfather clause would solve the problem.

MR. MILLER said that he is not sure.

CHAIR WILSON surmised that this proposal has arisen because hospitals have monopolies.

[12:17:56 PM](#)

REPRESENTATIVE ROSES opined that many physicians will not have the capacity to make the large capital investment required to start a health center without forming a partnership with a hospital. Limiting the ownership to 100 percent physician ownership may prevent new businesses; however, this proposal may also prevent monopolies from occurring.

[12:19:39 PM](#)

REPRESENTATIVE SEATON asked for clarification on whether hospitals can finance, with physicians, an imaging center or whether hospitals can have 50 percent physician ownership of a facility located in a hospital.

MR. MILLER related his understanding that a hospital would be a minority partner, up to 50 percent, in the equipment installed in the space that is being leased from the hospital by the physicians.

REPRESENTATIVE SEATON described two different models. The first is a separate imaging center with physicians on staff and outside investors of up to 50 percent. The second model is a hospital with physicians who may be able to leverage 50 percent

ownership in the hospital. He asked whether both models are allowed by the bill.

MR. MILLER said that he would have to clear that up.

[12:21:44 PM](#)

CHAIR WILSON asked Mr. Miller to explain Section 4.

[12:22:16 PM](#)

MR. MILLER explained that line 23 through 26 is an applicability clause that attempts to move away from pending lawsuits and equals legal language for "grandfathering in."

[12:23:25 PM](#)

REPRESENTATIVE SEATON referred to the 60,000 population limit and asked whether exclusions or inclusions for military or Native health care recipients are a worry.

MR. MILLER said that the language does not take into consideration the military population in an area. He further stated that he would provide that information to the committee.

[12:24:29 PM](#)

REPRESENTATIVE SEATON further asked whether the sponsor has any recommendations or changes on the net present value and the duration of that value to determine the threshold amount.

MR. MILLER said that, during the drafting of the bill, the \$1 million threshold was allowed with the understanding that the \$50,000 escalator would continue. He re-stated his intent to work with the DOL and the DHSS and to update the committee on the issue.

[12:26:20 PM](#)

REPRESENTATIVE ROSES assured the committee that, from the standpoint of commercial lending, no one will make a loan secured by equipment if the life of the loan is greater than the lease on the facility.

[12:26:55 PM](#)

CHAIR WILSON called for new amendments to be considered at the next meeting.

[12:27:32 PM](#)

REPRESENTATIVE SEATON asked whether amendments should address the basic bill or Amendment 25-G2.

[12:27:55 PM](#)

CHAIR WILSON asked the DHSS to break down Amendment 25-G2 into individual amendments.

[12:28:21 PM](#)

REPRESENTATIVE ROSES proposed amending the amendments.

[12:28:32 PM](#)

CHAIR WILSON gave a deadline for the submission of amendments.

[12:28:44 PM](#)

REPRESENTATIVE CISSNA asked whether there would still be further discussion.

CHAIR WILSON said yes.

[HB 337 and HB 345 were held over.]

[12:29:06 PM](#)

#### **ADJOURNMENT**

There being no further business before the committee, the House Health, Education and Social Services Standing Committee meeting was adjourned at 12:29 p.m.