

ALASKA STATE LEGISLATURE
SENATE HEALTH, EDUCATION AND SOCIAL SERVICES STANDING COMMITTEE

February 8, 2008

1:35 p.m.

MEMBERS PRESENT

Senator Bettye Davis, Chair
Senator Joe Thomas, Vice Chair
Senator Kim Elton
Senator Fred Dyson
Senator John Cowdery - via teleconference

MEMBERS ABSENT

All members present

COMMITTEE CALENDAR

SENATE BILL NO. 245

"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

PREVIOUS COMMITTEE ACTION

BILL: SB 245

SHORT TITLE: HEALTH CARE: PLAN/COMMISSION/FACILITIES

SPONSOR(S): RULES BY REQUEST OF THE GOVERNOR

01/19/08	(S)	READ THE FIRST TIME - REFERRALS
01/19/08	(S)	HES, FIN
01/25/08	(S)	HES AT 1:30 PM BUTROVICH 205
01/25/08	(S)	Heard & Held
01/25/08	(S)	MINUTE(HES)
02/08/08	(S)	HES AT 1:30 PM BUTROVICH 205

WITNESS REGISTER

JOEL GILBERTSON, Director
Strategic Development & Administration
Providence Health and Services

Anchorage, AK

POSITION STATEMENT: Suggested changes to SB 245.

KARLEEN JACKSON, Commissioner
Department of Health and Social Services (DHSS)
Juneau, AK

POSITION STATEMENT: Answered questions about and supported CSSB 245.

JEAN MISCHEL, Attorney
Legislative Legal and Research Services Division
Legislative Affairs Agency
Juneau, AK

POSITION STATEMENT: Answered questions on CSSB 245, Version K.

BOB URATA, Family Physician
Board of Directors
Bartlett Hospital
Juneau, AK

POSITION STATEMENT: Opposed repeal of Certificate of Need (CON).

TOM PIPER, Director
Missouri Certificate of Need (CON) Program
Jefferson City, MO

POSITION STATEMENT: Answered questions on Certificate of Need (CON).

ROD BETIT, CEO
Alaska State Hospital and Nursing Home Association
Juneau, AK

POSITION STATEMENT: Opposed repeal of Certificate of Need (CON).

PAUL FUHS, Lobbyist
Alaska Open Imaging Centers (AOIC)
Juneau, AK

POSITION STATEMENT: Supported SB 245.

SHAWN MORROW, CEO
Bartlett Regional Hospital
Juneau, AK

POSITION STATEMENT: Opposed repeal of Certificate of Need (CON).

JAMES SHILL, CEO
North Star Behavioral Health
Anchorage, AK

POSITION STATEMENT: Opposed repeal of Certificate of Need (CON).

RYAN SMITH, CEO
Central Peninsula Hospital (CPH)
Soldotna, AK

POSITION STATEMENT: Opposed repeal of Certificate of Need (CON).

MIKE MCNAMARA, Orthopedic Surgeon and President
Advisory Board
Alaska Surgical Center (ASC)
Anchorage, AK

POSITION STATEMENT: Opposed repeal of Certificate of Need (CON).

WES CLEVELAND, Attorney
American Medical Association
Department of State Legislation
Chicago, IL

POSITION STATEMENT: Supported repeal of Certificate of Need (CON).

PAULA EASLEY
Alaska Mental Health Trust Authority
Anchorage, AK

POSITION STATEMENT: Supported having a member of the Alaska Mental Health Trust Authority on the Alaska Health Care Commission.

WARD HINGER, Administrator
Diagnostic Health
Anchorage, AK

POSITION STATEMENT: Opposed repeal of Certificate of Need (CON).

ACTION NARRATIVE

CHAIR BETTYE DAVIS called the Senate Health, Education and Social Services Standing Committee meeting to order at [1:35:30 PM](#). Present at the call to order were Senators Elton, Dyson, Thomas, Cowdery via teleconference, and Davis.

SB 245-HEALTH CARE: PLAN/COMMISSION/FACILITIES

[1:36:42 PM](#)

CHAIR DAVIS announced the consideration of SB 245.

JOEL GILBERTSON, Providence Health and Services, Anchorage, AK, said his organization operates acute and long term care and behavioral health programs across the state including operations in Anchorage, Valdez, Kodiak, the Mat-Su Valley and Seward. Because the issues in this bill are so large, he would suggest

dividing it into multiple bills. He said he will address the three main pieces of the legislation. He said the Certificate of Need (CON) program adds tremendous value to the health care system. He said it has been an invaluable tool in making sure that there is a full continuum of care. To say that health care is ever going to be a free marketplace is probably asking a lot. It is one of the most regulated industries with federal and state laws requiring mandatory reporting of services and care. CON helps care givers and hospitals, especially, meet needs for required care to individuals who are suffering health care crises and don't have the ability to pay.

He said the outright repeal of CON came as a surprise because there has been a lot of good faith work between organizations and the state to reach a compromise.

MR. GILBERTSON said the other large pieces of this bill, a health information office and a health care commission, sound good but there needs to be more information sharing, and consumers need to be empowered to make better decisions. He said the question to ask regarding a health care information office is what value new information will add to the consumer. There already is a large amount of data being reported by health care facilities.

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MR. Gilbertson said to oversimplify is to distort. For example, to say we can take the top 100 procedures by facility and think that will represent a clear picture of what it means for a consumer regarding cost and quality is not accurate because there are so many things that go into the cost: who your physician is; how often a physician uses imaging equipment; how much he or she charges; how often a physician orders labs.

MR. GILBERTSON said he supports a health care commission but wonders if it can move reform forward. There's a reason no state has an information office, he said, because not doing it right would put inaccurate information in front of consumers. If it's going to work it needs to have key stakeholders, both consumers and providers, to have a robust dialogue.

SENATOR COWDERY joined the meeting.

SENATOR DYSON asked if it would it be a problem for the state to collect that data and make it available, since the federal government is already collecting health care data.

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MR. GILBERTSON said he thinks it would be great to start to use that common data and put into a central repository.

SENATOR DYSON asked if the bill would duplicate that effort.

MR. GILBERTSON said he didn't know yet. The department suggested looking at the cost and quality of the most common procedures. That raises additional questions because without the physician component, it's difficult for a consumer to look at the data and get accurate information.

SENATOR DYSON said he's not sure that just because it might not be perfect is a reason not to begin. There's no guarantee that the process will be effective but any information is better than no information.

MR. GILBERTSON said he was not suggesting there should not be a commission. His primary concern is having stake holders at the table and an evaluation process.

SENATOR DYSON asked who should evaluate the effectiveness of the commission.

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MR. GILBERTSON replied the legislature should provide ongoing monitoring. He suggested setting five-year strategic measurable goals and that the commission report back on an annual basis.

KARLEEN JACKSON, Commissioner, Department of Health and Social Services (DHSS), Juneau, AK, said the certificate of need (CON) program and what is being done to regulate it has up to now been seen through the lens of the provider. The reason this is called a health care transparency bill is because it is designed to look at health care from the perspective of the consumer and that is why it is important to consider all three components: the CON, the information office, and the health commission.

SENATOR ELTON moved to adopt the proposed committee substitute (CS) for SB 245, labeled 25-GS2050\K, as the working document.

SENATOR DYSON objected for discussion purposes.

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MS. JACKSON explained the changes in the committee substitute. Page 4, lines 7, 18 and 19 address changes in the composition of the commission. Two more public members are added. She expects

there will be more conversation about composition; the Mental Health Trust Authority has expressed interest in being at the table.

MS. JACKSON said the next change, on pages 6-8, relates to Sec. 18.09.110. The information office categorizes data according to access to health care, cost of health care, and quality. The idea is to accumulate information that could be posted on a website so consumers could make informed decisions.

SENATOR ELTON said the original bill talked about licensed facilities. He asked why it is not mentioned in the CS.

MS. JACKSON replied it is listed on page 6 at the bottom. There's a complete list organized by region and address of health facilities in the state.

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SENATOR ELTON asked how a health facility is defined.

MS. JACKSON said it is defined on page 3, line 3. A health care facility means a nursing home or a facility located in a community in which there is a critical access hospital as designated by the department.

MS. JACKSON said the repeal of CON is defined in bill sections 2 and 3, page 3, lines 2-26. The CS provides a two-year time delay of the repeal of CON for nursing homes, residential psychiatric treatment centers, and for communities with critical access hospitals. This language was drafted by the Department of Law.

SENATOR ELTON said he still wasn't clear since some facilities that offer medical care services are not included.

MS. JACKSON said that on page 3, line 18, it states that the offices of private physicians or dentists are not included.

CHAIR DAVIS asked Ms. Jackson to state her opinion of the changes.

MS. JACKSON said CON has been the one tool to try to deal with the costs of health care. She said that with this bill there will be better tools that will do a better job of keeping health care costs down while increasing access. It also assures that the commission will have the correct membership

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MS. JACKSON said that data posted with the information office will be consumer driven. She said the delayed repeal of CON around nursing homes and critical access hospitals addresses some of the concerns expressed. It would allow the immediate repeal around the most contentious issues that have provoked lawsuits. She supported the CS.

JEAN MISCHEL, Attorney, Legislative Legal & Research Services, Legislative Affairs, Juneau, AK, said Version K's effect is only on the CON. On page 3, the definition is significant regarding health care facility because it brings three categories of facilities under the CON program for the two year period of repeal. The previous version only required hospitals that had the designation critical access. This version of the bill now protects those hospitals from over competition. What the definition does is expand the types of health care facilities: any nursing home; any facility that's located in a community in which a hospital is designated as critical access; and residential psychiatric treatment centers (RPTC). The department wants the latter to be certified statewide. The other changes are on lines 10 and 11. The phrase "skilled nursing facility" was pulled out. It was causing confusion because it's an old fashioned term for a nursing home. Nursing home was defined on lines 25 and 26 to be consistent with the federal definition which includes skilled nursing facilities.

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MS. MISCHEL said the other difference in this version is an added transitional provision. Because there are now three categories of facilities that will still come under the CON, section 10 is new on page 11. It's like section 11 except it's modified by the new definition of health care facility. Any pending appeals for the two-year effective period would be dismissed only if they don't meet the new definition. Section 11 kicks in in 2010 when CON is repealed and that requires the department to dismiss all pending court actions.

MS. MISCHEL said there is a substantive problem that's easily fixed if the intent of the committee is to include RPTC statewide in the modified two-year period. RPTCs would be bracketed out on page 3, lines 9 and 10, and give those their own separate sub paragraph so that they could be applied statewide if the sponsor chooses.

SENATOR ELTON asked about the definition of health care facilities on page 3, line 8. The first criterion is a hospital that is designated by DHSS as a critical access hospital.

Following that a whole group of other conditions apply. He asked if DHSS chooses not to give that designation, would they then have created a facility that would not be covered.

MS. MISCHEL said yes, with the proviso that the designation of a facility as a critical access hospital has some federal implications so DHSS is constrained by federal law in deciding.

SENATOR ELTON said he'd like to know what the constraints are under federal law because he doesn't want DHSS to have sole discretion on whether or not they will include a facility.

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BOB URATA, Family Physician, Board of Directors, Bartlett Hospital, Juneau, AK, said he supports SB 245 except for the provisions that eliminate CON. Eliminating CON in a small market like Juneau will be detrimental to local residents. If it increases competition, it will do so only in services that are profitable and only for those who have the best health care coverage. Those with no insurance and even those with Medicare will need to go to community hospitals that have traditionally been the safety net of each community. The highly specialized clinics, such as imaging, will pick the highest paying patients and cause serious financial injury to the community hospital. Strong community hospitals are also a major part of a successful rescue response team. CON is a public process that prevents excess capacity in small markets. Health care dollars are used wisely and efficiently. Excess capacity will reduce quality particularly in surgery where doing a certain number of cases is required to maintain good outcomes.

DR. URATA said if there are too many cardiac surgical centers heart teams would become inefficient. This was demonstrated in a study of Medicare beneficiaries in 1994-1999 by University of Iowa, College of Medicine. Mortality was 20 percent lower in states with CON. Costs of health care per person were 33 percent to 160 percent lower in states with CON. This study was conducted by the big three American auto companies. Ford Motor Company found that inpatient and outpatient Magnetic Resonance Imaging (MRI) and coronary artery bypass surgery charges were 10 percent to 39 percent lower in states with CON. CON and community health care planning protects the consumer by including public input, maintaining accessibility to health care, and helping to contain costs. The consequence of unrestricted health care competition in small markets is a splintering of the provider delivery network, threatening the viability of safety net facilities by creating high profit niche

markets such as specialty hospitals and surgical clinics. He said he supports the creation of the health care commission but he would not eliminate CON in small markets.

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TOM PIPER, Director, Missouri Certificate of Need (CON) Program, Jefferson City, MO, said he has worked in this position for 24 years as well as working with and monitoring national organizations. He said he would talk about how CON relates to health care market entry, competition and protecting public interest. The slide on view shows that two-thirds of the US has CON, 36 states and the District of Columbia.

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MR. PIPER said the next slide shows state ranking according to the scope of their CON programs. Vermont is the most comprehensive and Louisiana is the least comprehensive. The next slide shows that Alaska's services are fairly broad compared to some other states. The next slide shows where CON started and where the program is today. The far left of the slide indicates the beginning of a cooperative public/private model. Business and insurance leaders in Rochester, New York organized to become the nation's first community health planning council. For the next ten years almost 30 states embraced similar a model before there was a national program mandating it. Sixty percent of the states voluntarily started health planning and CON to implement the planning. After the federal mandate ended in 1986 one quarter of the states deregulated.

In June 2003 Mr. Piper said he was asked to present the case for CON to the Federal Trade Commission (FTC) and the Department of Justice (DOJ) as part of hearings on health care competition, quality and consumer protection. Many were invited to make the case against regulation. In July 2004, the FTC and DOJ released a joint report. Many testifiers were disgruntled; private developers, entrepreneurs, lawyers and consultants didn't believe their proposals should be subjected to public scrutiny. Very few public interest groups were invited to participate. One of the recommendations following the hearings was that states reconsider whether CON best serves consumers.

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MR. PIPER said the FTC was hasty in drawing conclusions about competition to improve health care. The FTC goals have been integral to community health planning for a long time. That is demonstrated by the planning and regulatory processes that are in most CON states currently. Also, the difference between

states is in the management of the tension between public benefits and private investment. That's really the difference between long term and short term investment. He agrees that CON must be periodically reassessed.

MR. PIPER said that like any business, capital investments are passed onto the consumer either through charges, premiums or taxes. Competition in health care is different because providers control the supply of services, medical practitioners define the demand for care and consumers have insufficient information. They are not able to shop especially based on price. Higher capacity costs create higher charges as is amply demonstrated by the continuing escalation of health care insurance premiums. Consumers are insulated from the specific costs of care but they suffer under increased premium. Even with changing reimbursement systems incentives for providers are ineffective. Policy makers must look for new answers.

MR. PIPER said CON has been criticized since its inception. Many believe that it only tries to restrain market entry. It tries to lower capital outlays and cap technical innovation. Critics also believe that CON is more concerned with geography and access than with social system questions. Critics say quality is the factor that is left out. The most prevalent claim is that CON doesn't react to health care forces.

CON is a unique planning and regulatory tool covering a broad range. It is a planning-based, open-process, market compensator, quality enhancer, and competition promoter. It's practical redirecting resources to the areas of greater need and helps providers to achieve higher and more efficient levels of performance.

MR. PIPER said that evidence from business experience now shows how successful CON has been. The big three auto makers monitored their costs and the next slide shows the results. They undertook systematic analysis of their health care costs in states where they had at least 10,000 employees and insured dependents with comparable health care benefit programs. Daimler Chrysler Corporation showed that in 2000 their employees in CON states enjoyed health care costs 164 percent lower than in non CON states.

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MR. PIPER said General Motors spent almost one third less in CON states. The Ford study was broader in that it distinguished

between outpatient and inpatient hospital costs and found that CON states came in 20 percent lower than non-CON states.

Unlimited competition raises serious concerns. If the current version of SB 245 passes unrestricted health care competition that results will splinter the provider delivery network which would cause staffing shortages and lower quality. It would fragment the health care support system and threaten the safety net facilities, medical education institutions, and low-income neighborhood facilities. It would create high profit niche markets like specialty hospitals and ambulatory surgery. According to the publication Hospitals and Health Networks, supply drives demand putting traditional economic theory on its head. Areas with more hospitals and doctors spent more on health care services per person.

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MR. PIPER said public oversight is an effective tool to help balance the heavy weight of health care costs on the public. Health service pricing is rising at over eight percent annually. Family health spending is over \$12,000 per year. Premium costs are rising and there's more stress on the resources of the elderly. A balance can be established between regulation and competition by: promoting the development of community-oriented health service and facility plans which involve consumers, providers, businesses, and researchers; providing pricing and quality information to consumers so they have an educated choice; and providing a public forum to insure that the community has a voice.

SENATOR DYSON said the public needs access to all the cost data including discounts that are provided to different groups. Third-party payers often get a significant discount as does the government. The only people that pay list price are those that pay their own bills. He asked if the discount rates should be published.

MR. PIPER replied it should be available and that a lot of it already is available through hospitals, but in free-standing centers like radiation therapy centers, for example, it's difficult to get. He said that SB 245 has the potential to reveal a lot of that information, but there will be a lot of resistance.

SENATOR DYSON asked if there are any groups or any jurisdictions that are asking the providers to tell what portion of the bill is cost sharing.

MR. PIPER replied the best example is in Maine where they do it in cooperation with CON.

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ROD BETIT, CEO, Alaska State Hospital and Nursing Home Association (ASHNHA), Juneau, AK, delineated his association's position on SB 245. His association supports adoption of a statewide health plan. He said if that were implemented in conjunction with CON there would have been far fewer headaches.

His association supports establishment of the Alaska Health Care Commission. The association does have some issues regarding the membership in terms of who is on it and who gets to pick.

SENATOR DYSON asked if Mr. Betit had seen Version K.

MR. BETIT said he had and it does not specify who the new public members would represent. He would like to see those slots earmarked and he has some suggestions on how it can be more representative.

SENATOR DYSON asked if Mr. Betit was prepared to tell the committee how to fix this portion now.

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MR. BETIT said he has some ideas but thought it would be better to sit down and discuss them.

CHAIR DAVIS asked that people who have suggestions for changes in the bill present them to her office.

MR. BETIT said that with regard to establishing a health care information office and mandatory reporting, his association has been voluntarily reporting information from the hospital side. He is, however, not clear how the bill will accomplish what it is intending to do. He asked who is expected to report the data. The original bill defined who was to report differently than Version K. It can now be found on page 9, line 25. The earlier definition pertained to which facilities would be under CON. Page 9 pertains to who would have to report. According to the statute, that would include ambulatory surgical centers, assisted living homes, child care facilities, child placement agencies, foster homes, free-standing birth centers, home health agencies, hospices, hospitals, centers for mentally retarded, maternity homes, residential child care facilities, nursing homes, residential psychiatric treatment centers, rural health

clinics, runaway shelters, independent diagnostic testing facilities, etcetera. That is who would be expected to report under the bill as he understands it. The only ones reporting now are hospitals. He does not understand how a system including all these could be pulled together in three or four months to meet the July 2008 deadline. Doctors are also missing from the list. There is language in the bill regarding pharmacies and some drug prices. There is nothing in the bill that gives authority to DHSS to require pharmacists to report prices. His association wants the bill to move forward. They are giving all in-patient data to the state now including diagnosis, treatment, charges, reimbursement receipts, third-party insurers, length of stay, gender, age and residency. It was expanded this year to include all out patient and emergency department data.

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MR. BETIT said these reports are being handled by the Missouri Hospital Association. It compiles, edits and purges the raw data of confidential information, and then sends it back to the members and the department. All the financial data on the operations of every hospital is also reported to another company. Data on quality measures is reported to the federal Department of Health and Human Services, to the American Hospital Association and to the Institute of Health Improvement. That information is all available on the Internet. The association also reports on hospital and health care acquired infections. The legislature passed a bill last session that created a task force to define what the state should ask for. Fourteen other states have already done this. Only two have produced a report. It is wise to go slowly and learn from what other states are doing.

He noted that the Alaska Hospital Community Benefits Report was included in the bill packet to show how much is going back into the community from hospitals. The number is \$150 million across the state. The amount is also available by facility.

MR. BETIT questioned how the data will be collected, validated and kept current. He suggested one way would be to send the raw data that is sent to other expert data agencies. DHSS could then edit, purge confidential information, format and post it to its own data website. It would be a herculean effort and replicate costs that are already being invested. DHSS could likewise enter into an agreement with little or no cost to obtain the data from all the data agencies already producing reports and populate their own website with that data. That would be more expeditious. DHSS could do an online consumer inquiry system

from that information. Another option would be to provide links to the already existing data sites. That would be the simplest, least costly way.

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MR. BETIT questioned when data would begin to be reported. The healthcare commission piece of the bill says that it is in charge of data, not just cost, quality and access. He said it should be permissive rather than prescriptive. He said the bill also needs to state who needs to report. The way the bill is now written there is a very long list of people that need to report. He said timelines need to be extended.

MR. BETIT said the ASHNHA is opposed to repealing CON. He said it would have serious consequences and proposed deleting all the CON sections from the bill.

MR. BETIT said the bill packet has a rebuttal to the Federal Trade Commission report. It includes a critique of the federal report by the American Health Planning Association and a paper on why the ASHNHA thinks CON is an important tool for the state to keep.

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SENATOR ELTON thanked Mr. Betit for pointing out that pharmacies are missing from the list of entities that provide data. He asked if it's true that any hospital with a pharmacy would have to report the charges even though a pharmacy at Fred Meyers, for example, wouldn't have to report.

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MR. BETIT replied the way the bill's currently written, you could argue that could be the case. If you say all prices in a hospital, then all those prices would be available to the public even though others don't have to report.

PAUL FUHS, Lobbyist, Alaska Open Imaging Center, LLC, (AOIC), said AOIC believes that competition in the large medical markets in Alaska can benefit consumers. It supports representation of stakeholders on the commission. He said personal responsibility in leading healthy lifestyles is key to keeping the medical system from failing. Many things don't easily compare in terms of pricing. Information needs to be clearly defined. The previous legislation that passed created a compromised legal situation regarding how and where to install imaging equipment. Definitions regarding independent diagnostic testing facilities were not included. In one of AOIC's facilities in Fairbanks, the

commissioner said that under the rules of Medicaid and Medicare, it was a diagnostic radiology physicians' office. But a lawsuit was filed and the court ruled that due to the lack of definition, the office had to close. After considering a related case in Juneau, the Fairbanks office was able to reopen as 100 percent physician owned. Other cases have come up. He predicted that any decisions made will be appealed.

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MR. FUHS said AOIC was admonished by the legislature to figure this out and the administration actually sponsored negotiated rule making. Under those rules, everyone must agree 100 percent to move forward and that didn't happen. AOIC decided to adopt the solution Commissioner Jackson forged, which was to use Medicaid definitions. That required that offices be 50 percent owned by radiologists who would read the images.

MR. FUHS said critical access hospitals are reimbursed 100 percent by Medicaid because they are financially strapped. They have other subsidies as well because they are the only facilities in those communities.

Page 3, line 6, says that the definition of a facility is that it is located in a community. He questioned what that means: a city, a city within a borough, a village. He approved of the section of the bill that states that eventually all the lawsuits will be dismissed, but said that without definitions the situation can only get worse. Currently, people are looking for the oldest most dilapidated technology in order to comply. If they can buy it for less than \$1.2 million they can come in under the threshold.

SENATOR THOMAS joined the meeting.

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SHAWN MORROW, CEO, Bartlett Regional Hospital, Juneau, AK, said Bartlett is opposed to a repeal of CON, but supports the other elements of the bill. He said he came here from the state of Oklahoma which has no CON except for nursing homes and long term hospitals. He said that from 1992-2005, thirteen hospitals in Oklahoma closed. CON was not the sole cause of the closures but it was the cause of leaving those hospitals financially weakened. When HMOs came in the early 1990s, when the Balanced Budget Act of 1997 was instituted, the hospitals were not sufficiently financially stable to survive because of the siphoning off of so many high profit services.

MR. MORROW said population threshold is critical and has to do with the vulnerability of hospitals in certain markets. The population threshold is higher in those communities that have critical access hospitals. Petersburg, for example, with a population of 3,500 is a critical access hospital. Wrangell has a critical access hospital. He said he's glad to see language in the bill that protects those hospitals. Markets that are in 10,000 to 60,000 population range are large enough and have high enough volumes in surgery, diagnostic imaging, and orthopedics that they are very attractive to private investors, but hospitals in that market are limited. They only have two or three services that generate a profit so if those go away the hospitals is in a weakened state. There's a big difference between the vulnerability of a critical access hospital and a hospital in a community of 15,000 to 60,000. He doesn't think a repeal of CON would benefit anyone in the state.

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SENATOR DYSON asked if the Balanced Budget Act of 1997 was state or federal.

MR. MORROW replied that was a federal bill and it involved Medicare reimbursement.

SENATOR ELTON said he is still struggling with the definition of health care facility on page 3. He read, "A facility that is located in a community in which a hospital is designated by the department as a critical access hospital and..." It goes on to list different types of facilities. He asked if a diagnostic testing facility can be designated as a critical care hospital even if it is not a hospital.

MR. MORROW replied he understands that in order to receive critical access hospital designation you must be an acute care hospital. You cannot operate more than 25 beds and you cannot be within 15 miles of the next closest hospital under the exception. The general rule is within 25 or 35 miles of the next closest hospital.

SENATOR ELTON said he was still struggling with the definition as it reads. He said DHSS needs to clarify that because it sounds that if you want to call a kidney disease treatment center a health facility, you can't do it unless it's part of a critical access hospital.

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JAMES SHILL, CEO, North Star Behavioral Health, Anchorage, AK, said his organization has facilities in Anchorage and MatSu. They have 500 employees and 1100 admissions per year. They provide psychiatric acute care hospitalization and residential care to children and youth. He said he is opposed to the bill, specifically the CON portion. The state needs a balanced approach for mental health delivery. Mental health care is a continuum with once a week outpatient care on one side and psychiatric hospitals on the other side. Many studies have demonstrated that all the types of services along the continuum need to be funded and supported.

MR. SHILL was a member of the negotiating committee debating CON. Eighty-nine percent of the members voted to keep CON and he said the bill does not reflect that.

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RYAN SMITH, CEO, Central Peninsula Hospital (CPH), Soldotna, AK, said he's opposed to SB 245 and the repeal of CON. Although it is not a critical access hospital, CPH is the sole community provider located on the Kenai Peninsula. If the state does not insure there's a need for more health care infrastructure before it is introduced into the community, there's a risk of financial instability and harm to the community. The community has approved a \$49.9 million bond project for hospital expansion that is scheduled to be completed this summer. Since 1974 community taxpayers have contributed over \$43 million to the hospital with the protection of CON. The repeal of CON threatens the hospital/community relationship which has been demonstrably strong. At the invitation of Commissioner Jackson, Mr. Shill participated in the CON negotiating committee. The committee spent 5 days in Anchorage negotiating in good faith to reach a consensus on the issues identified by DHSS related to CON. The committee voted on 49 questions and voted 16 to 2 not to eliminate CON. It reached consensus on imaging ownership issues that would eliminate the litigation surrounding CON. He was surprised to receive a message from Commissioner Jackson thanking him for his participation on the committee accompanied by an announcement that the bill would call for the repeal of CON. This indicates a disconnect between the efforts of the CON negotiating committee and this bill. Since this bill was presented as giving the consumer perspective more weight, he questioned why there were 21 providers on the negotiating committee rather than 21 consumers. He said he would like the recommendations he and the other members of the negotiating committee made to be taken into account.

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MIKE MCNAMARA, Orthopedic Surgeon, President, Advisory Board, Alaska Surgical Center (ASC), Anchorage, AK, said the ASC has 26 partners and does about 5,500 cases a year, with 16 specialties. It does about 20 percent that is Medicare/Medicaid and Project Access. He is opposed to the repeal of CON. The original purpose of CON in Alaska was to prevent excessive, unnecessary duplication and development. He also expressed disappointment that more attention was not accorded the negotiating committee.

In Anchorage, the primary surgical centers are rarely at full capacity. The Alaska Surgical Center operated at only about 55 to 60 percent last year. Allowing additional surgical centers to develop when present centers are not full capacity will likely reduce vital peer oversight. There's a national shortage of operating room nurses. All the centers are understaffed with respect to specialized nursing and staff. Removing the CON would create undue competition for these staff where there is already a critical shortage. Competition does not lower costs but creates greater costs and overhead. The larger centers have the power to negotiate contracts with insurance companies, unions and third-party payers that allow reduced costs to the public. Unchecked development would reduce the negotiating power of these centers.

Mr. MCNAMARA agreed that in health care, supply generates demand. He encouraged the committee not to repeal CON and risk losing standards of care and a system that has been working well in Alaska. Not many years ago a patient was sent outside to the Mayo Clinic or Seattle for excellence of care that is now available here.

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WES CLEVELAND, Attorney, American Medical Association, Department of State Legislation, Chicago, IL, said that the weight of the peer-reviewed academic research evidence over three decades showed that CON has failed to achieve its reported purpose to restrain health care costs. In some studies CON has increased health care costs. In the Journal of Health Politics, Policy and Law, 1998, an article entitled, "Removal of CON", says, "There's no evidence of a surge in acquisitions of facilities or in costs following removal of CON." He said a number of states have reached similar findings. In February 2007, a CON study requested by the Illinois legislature concluded that "a review of the evidence indicates that CON rarely reduces health care costs and on occasion increases costs in some states."

CHAIR DAVIS asked him to send his written testimony to her office.

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PAULA EASLEY, Alaska Mental Health Trust Authority, Anchorage, AK, said the trust requests an amendment to the CS that would authorize including a trust representative on the Alaska Health Care Commission. In addition to the trust's statutory responsibility, the trust and the DHSS develop a comprehensive five year mental health plan and advise the state on mental health program funding. This year the trust will provide funding of more than \$27 million. The trust experience and knowledge from years of improving beneficiary health safety and quality of life would be invaluable to the new commission's work.

MS. EASLEY said a health care information office and the need to connect Alaskans with available services is evident. United Way has a statewide referral service. Similar to 911, people can dial 211 for general health care information, counseling, mental health services, crisis intervention, shelters, heating assistance, food banks, child and elder care, etcetera. Alaska 211 was recently granted an additional \$100,000 to continue adding and updating service provider information. This is an opportunity to reduce costs associated with establishing referral services in the Alaska health care information office. Rather than duplicating services it would be cost effective to link the state site to Alaska 211 for referrals. Each agency listed must provide extensive information which can be downloaded from the 211 site. Alaska 211 does not provide medical advice, hospital ratings, or comparison of prescription costs.

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WARD HINGER, Administrator, Diagnostic Health, Anchorage, AK, said that he served on the CON negotiating committee. He has been a health care administrator for more than 15 years. In addition to voting to continue CON in Alaska, 71 percent of the committee members saw the need to define physician offices as 100 percent physician-owned. His colleagues at Diagnostic Health share his perspective in supporting the continuation of CON. He said he would send additional supportive information.

CHAIR DAVIS asked committee members to submit questions or concerns to her office. She has additional amendments she would like the committee to consider. SB 245 was held in committee.

CHAIR DAVIS adjourned the meeting at [3:25:29 PM](#).