COMMITTEE REPORT

HOUSE

(11)

FURTHER:

3/4/83

Date: 4-18-83

Mr. Speaker:

The Committee on FINANCE has had SSHB 19

An Act repealing the certificate of need program; and providing for an effective date.

under consideration and reports it back as follows:

[ ] do pass [ ] do not pass

[ ] do pass with attached amendments(s)

[X] replace with CS for SSHB 19 (Fin) [ ] same title [X] new title

and recommends no recommendations

[ ] AND attaches a "Letter of Intent" [X] New Fiscal Note [ ] Zero Fiscal Note Attached

[ ] reports it back without recommendation

[ ] referred to the ______ Committee

MEMBERS SIGNING DO PASS

MEMBERS HAVING OTHER RECOMMENDATIONS:

(no rec)

(No Rec)

(no rec)

CHAIRMAN

H 60

Original sponsors: Fritz, Hayes,
Zharoff, et al

IN THE HOUSE BY THE FINANCE COMMITTEE

CS FOR SPONSOR SUBSTITUTE FOR HOUSE BILL NO. 19 (Finance)

IN THE LEGISLATURE OF THE STATE OF ALASKA

THIRTEENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to the certificate of need program, state aid for health facilities, Medicaid, and general relief medical assistance; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. AS 18.07.021 is amended to read:

Sec. 18.07.021. STATE HEALTH PLANNING AND DEVELOPMENT AGENCY. The division of planning, policy, and program evaluation [OFFICE OF PLANNING AND RESEARCH] in the department is the state health planning and development agency designated under 42 U.S.C. Sec. 300m(b)(3), (Sec. 3, P.L. 93-641) [SEC. 1521(b)(3), P.L. 93-641]. The division [OFFICE] shall perform the functions enumerated under 42 U.S.C. Sec. 300m-2, (Sec. 3, P.L. 93-641) and [SEC. 1523,P.L. 93-641,] administer the certificate of need program [OUTLINED IN AS 18.07.041 - 18.07.111,] and other functions prescribed in this chapter.

* Sec. 2. AS 18.07.021 is amended to read:

Sec. 18.07.021. STATE HEALTH PLANNING AND DEVELOPMENT AGENCY. The division of planning, policy, and program evaluation in the department is the state health planning and development agency designated under 42 U.S.C. Sec. 300m(b)(3), (Sec. 3, P.L. 93-641). The division shall perform the functions enumerated under 42 U.S.C. Sec. 300m-2(a)(1)-(3), (a)(6)-(8), (b) and (c) [42 U.S.C. SEC. 300m-2], (Sec. 3, P.L. 93-641), [AND ADMINISTER THE CERTIFICATE OF NEED PROGRAM] and other functions prescribed in this chapter.

* Sec. 3. AS 18.07.031 is repealed and reenacted to read:

Sec. 18.07.031. CERTIFICATE OF NEED REQUIRED. (a) A person may not undertake the following unless authorized under the terms of a certificate of need issued by the division:

(1) construction of a health care facility at a cost of $1,000,000 or more;

(2) alteration of the bed capacity of a health care facility;

(3) addition or elimination of a category of health services provided by a health care facility;

(4) expenditure of $1,000,000 or more for diagnostic medical equipment to be used in a health facility.

(b) The requirement of (a)(4) of this section does not apply to expenditures for replacement equipment with the same or a similar capability as the equipment replaced.

(c) The legislature may not appropriate, nor may a person receive, state money for construction that requires a certificate of need or for a purchase of equipment that requires a certificate of need unless the certificate has been issued or modified under this chapter.

* Sec. 4. AS 18.07 is amended by adding a new section to read:

Sec. 18.07.033. REVIEW OF APPLICATIONS FOR CERTIFICATE OF NEED. (a) The division, and then the commissioner, shall review applications for certificates of need. The division and the commissioner may consult with a health systems agency or a municipal health commission concerning an application for a certificate of need. Approval of an application for a certificate of need may not be conditioned on approval of the application by a health systems agency or a municipal health commission.

(b) Not later than 90 days after an applicant has submitted a completed application for issuance or modification of a certificate of need, the application shall be reviewed by the commissioner and granted or denied.

* Sec. 5. AS 18.07.041 is amended to read:

Sec. 18.07.041. STANDARD OF REVIEW FOR APPLICATIONS FOR CERTIFICATES OF NEED. The division [OFFICE] shall issue [GRANT] a sponsor a certificate of need or modify a certificate of need if the availability and quality of existing health care resources or the accessibility to those resources is less than the current or projected requirement for health services required to maintain the good health of Alaska citizens.

* Sec. 6. AS 18.07.061 is amended to read:

Sec. 18.07.061. MODIFICATION AND TERMINATION OF ACTIVITIES. The certificate holder shall apply to the division [OFFICE] for a modification of the certificate before terminating part of the activities authorized by the terms of issuance, but the certificate holder is not required to obtain the acquiescence of the division [OFFICE] before terminating all the activities authorized by the certificate. If a certificate holder terminates all of the activities authorized by a certificate, the certificate holder is required to notify the division [OFFICE] 60 days before termination and to surrender the certificate to the division [OFFICE] within 30 days of termination.

* Sec. 7. AS 18.07.071 is amended to read:

Sec. 18.07.071. TEMPORARY AND EMERGENCY CERTIFICATES. (a) The division [OFFICE] shall grant a sponsor an emergency certificate for the construction of a health care facility for which a certificate is required under AS 18.07.031 if the sponsor shows, by affidavit or formal hearing, that the act of construction consists of effecting

emergency repairs.

(b) The division [OFFICE] may grant a sponsor a temporary certificate for the temporary operation of a category of health service, if the sponsor shows by affidavit or formal hearing

(1) the necessity for early, immediate, or temporary relief, and

(2) adverse effect to the public interest by reason of delay occasioned by compliance with the requirements of AS 18.07.041 and application procedures prescribed by regulations under this chapter.

(c) A temporary certificate granted under (b) of this section confers no vested rights on behalf of the applicant. The division [OFFICE] shall impose those special limitations and restrictions concerning duration and right of extension which the division [OFFICE] considers appropriate. No temporary certificate may be granted for a period longer than necessary for the sponsor to obtain review of the action certified by the temporary certificate under AS 18.07.051. Application for a certificate of need under AS 18.07.041 must commence within 60 days of the date of issuance of the temporary certificate.

* Sec. 8. AS 18.07.081(a) is amended to read:

(a) The division [OFFICE], a member of the public who is substantially affected by activities authorized by the certificate, or another applicant for a certificate of need may initiate a hearing to obtain modification, suspension or revocation of an existing certificate of need by filing an accusation with the commissioner as prescribed under AS 44.62.360. No revocation, modification, or suspension of an outstanding certificate may be undertaken unless it is in accordance with AS 44.62.330 - 44.62.630.

* Sec. 9. AS 18.07.081(c) is amended to read:

(c) A certificate of need shall be suspended if an accusation is filed before the commencement of activities authorized under AS 18.-07.041 which charges that factors upon which the certificate of need was issued have changed, or new factors have been discovered which significantly alter the need for the activity authorized. A suspension of a certificate may not exceed 60 days. At the end of this period or sooner, the division [OFFICE] shall revoke or reinstate the certificate.

* Sec. 10. AS 18.07.101 is amended to read:

Sec. 18.07.101. REGULATIONS. The commissioner shall adopt, in accordance with the Administrative Procedure Act (AS 44.62), regulations which establish procedures under which sponsors may make application for certificates of need required by this chapter and which govern the review of those applications by the division [OFFICE], establish requirements for a uniform statewide system of reporting financial and other operating data, and otherwise carry out the purposes of this chapter.

* Sec. 11. AS 18.07.111 is amended by adding a new paragraph to read:

(13) "division" means the division of planning, policy, and program evaluation in the Department of Health and Social Services.

* Sec. 12. AS 18.26.220 is repealed and reenacted to read:

Sec. 18.26.220. FACILITY COMPLIANCE WITH HEALTH AND SAFETY LAWS AND LICENSING REQUIREMENTS. In order to receive financial assistance under this chapter, a medical facility shall comply with AS 18.20 and the licensing requirements of this chapter.

* Sec. 13. AS 29.89.030(a)(1) is repealed and reenacted to read:

(1) to a municipality that has the power to provide hospital facilities and services and that exercises that power, $250,000 per hospital for those hospitals with 10 or more acute care beds, and

$50,000 per hospital for those hospitals with less than 10 acute care beds; money received under this paragraph may be used only for hospitals and shall be apportioned among qualifying hospitals as the municipality determines;

* Sec. 14. AS 47.07.070 is repealed and reenacted to read:

Sec. 47.07.070. PAYMENT TO HEALTH FACILITIES. (a) The commission shall determine prospectively the rate of payment to a health facility under this chapter and AS 47.25.120 - 47.25.300 based on a fair rate for reasonable costs incurred by the facility. The commission shall by regulation list the factors it considers in making its rate determinations under this section.

(b) In determining a rate of payment to a health facility under this section, the commission shall consider the proportionate share of the facility's financial requirements for patient care for

(1) costs of current operations, including salaries and wages; purchased services, supplies, insurance, leases, depreciation, taxes, interest expense, maintenance and other health facility operating expenses; and

(2) education, research, and appropriate capital development.

(c) In determining a rate of payment to a health facility under this section, the commission may consider whether the rate of utilization of the facility has been reduced because of improvement or careless development of the facility.

* Sec. 15. AS 47.07 is amended by adding new sections to read:

Sec. 47.07.071. REPORTS BY HEALTH FACILITIES. Not later than 120 days after the end of each fiscal year of a health facility, the facility shall submit to the commission a report on the facility's financial performance during the fiscal year.

Sec. 47.07.072. REPORT BY THE COMMISSION. Not later than September 30 of each year, the commission shall submit to the governor a report on the prospective payments made under this chapter during the current fiscal year and an estimate of the prospective payments that will be made during the remainder of the current fiscal year and the next fiscal year. The report shall state the assumptions that are used as a basis for the estimates.

Sec. 47.07.073. UNIFORM ACCOUNTING, BUDGETING, AND FINANCIAL REPORTING. (a) The commission by regulation shall require a uniform system of accounting, budgeting, and financial reporting for health facilities receiving prospective payments under this chapter. The regulations shall provide for the reporting of revenues, expenses, assets, liabilities, and units of service. The commission shall specify the date the system becomes effective for each health facility.

(b) In adopting regulations under this section, the commission shall consider

(1) accounting, budgeting, and financial reporting procedures used by health facilities;

(2) variations among health facilities in the types of health care services provided by health facilities;

(3) other factors the commission considers relevant, including the size and organizational structure of health facilities and the methods used by health facilities to obtain payments.

(c) The commission may waive or modify a requirement for accounting, budgeting, or financial reporting for a health facility if waiver or modification is

(1) necessary to avoid excessive costs to the facility; and

(2) consistent with the policies of this chapter.

(d) Notwithstanding other provisions of this section, the commission may, by regulation, modify the system of accounting, budgeting, and financial reporting required under this section for a health facility having less than 25 acute care beds in order to reduce the operating costs of that facility.

Sec. 47.07.074. AUDITS AND INSPECTIONS. As a condition of obtaining payment under AS 47.07.070, a health facility shall allow

(1) the department and the commission reasonable access to the financial records of medical assistance beneficiaries; and

(2) inspection of financial records by state and federal agencies to the extent required by federal law.

Sec. 47.07.075. APPLICATION OF ADMINISTRATIVE PROCEDURE ACT. Actions of the commission under AS 47.07 and AS 47.25.120 - 47.25.300 are subject to the provisions of the Administrative Procedure Act (AS 44.62).

* Sec. 16. AS 47.07.080 is amended by adding new paragraphs to read:

(6) "commission" means the Medicaid Rate Commission;

(7) "health facility" includes a hospital, skilled nursing facility, intermediate care facility, intermediate care facility for the mentally retarded, rehabilitation facility, inpatient psychiatric facility, home health agency, rural health clinic, and outpatient surgical clinic.

* Sec. 17. AS 47.07 is amended by adding new sections to read:

ARTICLE 2. MEDICAID RATE COMMISSION.

Sec. 47.07.110. MEDICAID RATE COMMISSION ESTABLISHED. The Medicaid Rate Commission is established in the Department of Health and Social Services.

Sec. 47.07.120. COMPOSITION OF COMMISSION. The commission consists of five members as follows:

(1) the chief executive officer of a health facility that is licensed by the state but not owned or operated by the state or federal government and that is subject to the budget review process under this chapter;

(2) the commissioner of administration, the commissioner of health and social services, or the appointed designee of either commissioner;

(3) a physician licensed to practice medicine in the state who is actively engaged in the practice of medicine and who is not employed by the state;

(4) a certified public accountant with relevant experience;

(5) a person representing consumers of health services who does not have a direct or indirect interest in an entity that provides health care services.

Sec. 47.07.130. APPOINTMENT OF MEMBERS. Members of the commission are appointed by the governor and serve at the pleasure of the governor.

Sec. 47.07.140. TERM OF MEMBERSHIP. The term of a member of the commission appointed under AS 47.07.120(1), (3), (4), or (5) is three years. A member may not be appointed to a successive term. The terms of the members shall be staggered. A member appointed to fill a vacancy serves for the unexpired term of the member. A term shall be measured from January 1 of the year in which the term of the vacant position begins, regardless of when the vacancy is filled.

Sec. 47.07.150. COMPENSATION. A member of the commission serves without compensation but is entitled to per diem and travel expenses authorized by law for boards and commissions under AS 39.20.180.

Sec. 47.07.160. OFFICERS. At the first meeting of each year, the commission shall elect a chair from among its members.

Sec. 47.07.170. MEETINGS AND QUORUM. The commission shall meet as often as is necessary to conduct its business. Three members of the commission constitute a quorum.

Sec. 47.07.180. DUTIES. The commission shall review proposed payment rates and budgets of health facilities and establish payment rates for health facilities under this chapter and AS 47.25.120 - 47.25.300.

Sec. 47.07.190. EMPLOYMENT OF PERSONNEL. The commission may employ and determine the salary of an executive director. With the approval of the commission, the executive director may select and employ additional staff. The commission shall be assisted by the officers or personnel of the department as the commissioner of health and social services shall direct. The executive director of the commission is in the exempt service under AS 39.25.

* Sec. 18. AS 47.25 is amended by adding a new section to read:

Sec. 47.25.195. PAYMENT TO HEALTH FACILITIES FOR TREATMENT OF NEEDY PERSONS. (a) The department may make payments to a health facility for the treatment of a needy person.

(b) A health facility receiving a payment under this chapter is subject to the requirements of AS 47.07.070 - 47.07.075.

(c) For purposes of this section, "health facility" includes a hospital, skilled nursing facility, intermediate care facility, intermediate care facility for the mentally retarded, rehabilitation facility, inpatient psychiatric facility, home health agency, rural health clinic, and outpatient surgical clinic.

* Sec. 19. INTERIM PROSPECTIVE PAYMENT SYSTEM. The department shall establish an interim system of prospective payments for health facilities under this Act for the period July 1, 1983 to June 30, 1984.

* Sec. 20. During the second regular session of the Fourteenth Alaska

State Legislature, and every third regular session thereafter, the legislature shall review the certificate of need program (AS 18.07.031 - 18.07.111) and the state aid for hospital and health facility construction program (AS 29.90). If after review the legislature determines that continuation of these programs is in the public interest, a bill may be introduced to continue the programs.

* Sec. 21. The sponsor of a hospital or health facility construction project who is receiving or entitled to receive state aid under AS 29.90 on June 30, 1986, shall continue to receive state aid until the sponsor has received an amount which, combined with state matching money for construction of the hospital or health facility, equals 25 percent of the total project cost. Money received for construction may not be used for any other purpose.

* Sec. 22. AS 18.07.031 - 18.07.101, 18.07.111(1) - (4), 18.07.111(7) - (9), 18.07.111(11), AS 29.90 and AS 47.80.140(b) are repealed.

* Sec. 23. AS 18.07.111(10) and AS 47.07.080(1) are repealed.

* Sec. 24. Sections 2, 12, 21, and 22 of this Act take effect July 1, 1986.

* Sec. 25. Sections 1, 3 - 11, 13 - 20, and 23 of this Act take effect immediately in accordance with AS 01.10.070(c).

THE LEGISLATURE OF THE STATE OF ALASKA
THIRTEENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. CSSSHB 19 (Finance)
Title Relating to C.O.N. and state aid for health facility
Requested by House Finance Date 4/13/83

II. FISCAL DETAIL
Agency Affected Dept. Health & Social Services
Program Category Affected Health Facility Development
BRU, Program, Or Subprogram(s) Affected Health Planning & Development
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 83	FY 84	FY 85	FY 86	FY 87	FY 88
100 PERSONAL SERVICES		84,693	90,621	96,965	103,753	111,015
200 TRAVEL		27,000	28,890	30,912	33,076	35,391
300 CONTRACTUAL		70,000	20,000	20,000	20,000	20,000
400 COMMODITIES		2,000	2,140	2,290	2,450	2,621
500 EQUIPMENT		6,000	1,000	1,000	1,000	1,000
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC						
TOTAL		189,693	142,651	151,167	160,279	170,027

FUNDING (Thousands of Dollars)

	FY 83	FY 84	FY 85	FY 86	FY 87	FY 88
GENERAL FUND		99,115	74,535	78,985	83,745	88,839
FEDERAL FUNDS		90,578	68,116	72,182	76,534	81,188
OTHER (Specify Source)						

POSITIONS

	FY 83	FY 84	FY 85	FY 86	FY 87	FY 88
FULL TIME		2	2	2	2	2
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instruction, Section III)

See Attachment A

IV. DATE 4/13/83 PREPARED BY Al Adams, Chair APA
AGENCY House Finance Committee
PHONE 465-3706

Original: Legislative Finance
cc: Budget & Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/82)

ATTACHMENT A

100 Personal Services		
1) Executive Director	R24 $4,251 X 12 =	51,012
2) Clerk Typist III	R8 1,487 X 12 =	17,844
		68,856
	Benefits .23%	15,837
		$84,693
200 Travel and Per Diem 5 Commission Members X 12 meetings X average cost of $450	=	27,000
300 Contractual (Data Processing Assistance)		70,000
400 Commodities		2,000
500 Equipment		
1) Desks, Chairs and Files Word Processor		6,000
		$189,693

Three existing Auditor III positions from the Division of Public Assistance will be transferred for Commission use as well as travel funds, etc.

Note that 47.7% of this budget will be supported with federal funds.

Position Paper

on

Sponsor Substitute for House Bill 19

"For an Act repealing the certificate of need program; and providing for an effective date."

Sponsor Substitute for House Bill 19 repeals those portions of AS 18.07.021 which provide the statutory authority for the Department to administer a certificate of need program and repeals references to certificate of need in other sections of the Statute as well.

The Administration supports Sponsor Substitute for House Bill 19 as it is currently written.

The Department recommends that the Committee review statutory provisions which relate to health facility development including the following:

Medicaid Programs

The state's participation in the Medicaid program (State dollars fund approximately 52 percent of total program costs) has grown from $1 million in 1972 to nearly $38 million in FY 82 and total costs including federal participation have grown from $2 million to nearly $74 million in this same period. Ninety-two percent of patients in Alaska's long term care facilities are supported by the Medicaid program which means that the state (and federal) government has nearly the full burden of all operational costs for the facility. These Medicaid costs increase when additional beds are added, new equipment is purchased or new services (including new types of manpower) are offered. The Division of Public Assistance must effect a provider agreement with any qualified provider who seeks this agreement.

Capital Budget 2990 Sec. Rev. Sharing Const # SB 85

Alaska has provided substantial financial assistance in the development of health care facilities. The 12th Legislature provided more than $36.6 million by line item appropriation to expand one hospital, replace two others and provide planning assistance for two rural hospitals. The number of requests for state funding has steadily increased.

Revenue Sharing

Alaska has a revenue sharing program (AS 29.90.010) which provides 25 percent plus interest of hospital construction costs to all non-profit hospitals. This program, administered by the Department of Community and Regional Affairs, provides further support for hospital construction projects in addition to any front-end capital funds provided by the state. This additional health facility construction resource underscores the importance of determining the actual need

POSITION PAPER/Department of Health & Social Services

for construction, before the State is committed to pay for a major portion of such construction.

Non-profit hospitals each receive a quarter of a million dollars in operating assistance each year through the state's revenue sharing program (AS 29.89.030). Nursing homes and other health facilities also receive assistance based on the number of beds they have. There are no specific requirements as to how such funds are to be expended. Not only are existing health facilities assured of these funds in addition to other state support, but new facilities are encouraged by the availability of these funds.

Recommended by: Phoebe A Lindsey
Phoebe A. Lindsey, Director
Division of Planning, Policy
and Evaluation

Date: February 18, 1983

Approved by: Robert London Smith
Robert London Smith, Ph.D.
Commissioner
Department of Health and
Social Services

Date: 2/22/83

STATE OF ALASKA
PRELIMINARY STATEMENT OF FISCAL IMPACT

Bill No: House Bill 19 Date on Bill: 1/24/83
Title: An Act repealing the certificate of need program;and providing for an effective date
Sponsor: Representatives Fritz, Hayes, Zharoff, Cato, Lindauer, Szymanski
Requestor:

1. Estimated fiscal impacts on:

a. Expenditures:

			FY 83	FY 84	FY 85	FY 86			
Capital			0	0	0	0			
Operating			0	0	0	0			
Total			0	0	0	0			

b. Revenues:

Revenue			0	0	0	0			

2. Source of funds to offset fiscal impact of bill:

3. Assumptions:

4. Disclaimer:
This statement has not been reviewed by the OMB in the Office of the Governor. It does not represent the policy of the Sheffield Administration or the final estimate of fiscal impact.

Prepared By: Dave W. Williams DW [signature] Phone: 465-3038
Division: State Health Planning and Development Date: 2-14-83

Approved by Commissioner: [signature] Smith, M.D. Date: 2/22/83
Department: Health and Social Services Date:

6. Distribution:
Original to Legislative Finance
Copy to OMB
Copy to Sponsor

STATE OF ALASKA
PRELIMINARY STATEMENT OF FISCAL IMPACT

Bill No: SS House Bill 19 Date on Bill: 1/24/83
Title: An Act repealing the certificate of need program;and providing for an effective date
Sponsor: Representatives Fritz, Hayes, Zharoff, Cato, Lindauer, Szymanski
Requestor:

1. Estimated fiscal impacts on:

a. Expenditures:

			FY 83	FY 84	FY 85	FY 86			
Capital			0	0	0	0			
Operating			0	0	0	0			
Total			0	0	0	0			

b. Revenues:

Revenue			0	0	0	0			

2. Source of funds to offset fiscal impact of bill:

3. Assumptions: —

4. Disclaimer:
This statement has not been reviewed by the OMB in the Office of the Governor. It does not represent the policy of the Sheffield Administration or the final estimate of fiscal impact.

Prepared By: Dave W. Williams DW [signature] Phone: 465-3038
Division: State Health Planning and Development Date: 2-14-83

Approved by Commissioner: Robert London Smith, Ph.D. Date: 2/22/83
Department: Health and Social Services Date:

6. Distribution:
Original to Legislative Finance
Copy to OMB
Copy to Sponsor

Rec'd 5-27-83

Position Paper
S.S. for House Bill 19 am

An Act repealing the certificate of need program, amending or repealing provisions relating to state aid for health facilities, Medicaid and general relief medical assistance; and providing for an effective date.

Sponsor Substitute for House Bill 19 am proposes amendments to state law which primarily affect three areas of the Department of Health and Social Services' responsibility: 1) the certificate of need program, 2) coordination of the certificate of need program with the Alaska Medical Facility Authority, and 3) prospective reimbursement under the Medicaid and General Relief Medical Assistance Programs.

I. Certificate of Need

The bill effectively repeals the certificate of need program. The Administration supports this portion of SSHB 19 am.

II. Coordination of the Certificate of Need Program with the Alaska Medical Facility Authority

The bill repeals and reenacts AS 18.26.220. The apparent reason for the proposed changes in this portion of state law is to remove the references to the certificate of need program.

The Department of Health and Social Services supports this change in state law in order to maintain consistancy with the proposed repeal of the certificate of need program as set out in SSHB 19 am.

III. Prospective Reimbursement - Medicaid and General Relief Medical Assistance Programs

A. General Overview

Hospital and Nursing home rates in Alaska have traditionally been established retrospectively, that is, costs are estimated at the beginning of a fiscal year and an "interim payment" determined. At the end of the fiscal year, the total interim payments made is compared to the allowable costs of the facility. The difference is either collected from or paid to the facility. This process is referred to as "cost settlement".

Propsective payment, on the other hand, provides for establishment of the payment rate prior to the fiscal year as a result of discussions between each facility and the State, each facility must then operate and provide care at this predetermined rate for the fiscal period.

While the retrospective method assures providers that all of their allowable costs will be reimbursed, a fundamental weakness of these retro-

spective systems is the lack of incentives to control staffing levels, equipment purchases, wage increases, and service expansion.

In view of reduced federal revenues and a new state spending limit, Alaska needs improved cost containment and predictability from its medical reimbursement system. The system must not only consider price, but also eligible groups and service coverages before the budget year commences. It also must consider the differences in "rural" and "urban" health delivery problems.

B. Problems with Retrospective Cost-Based Reimbursement Systems

- Tendency toward ineffective cost containment -- The key problem with a retrospective system is the lack of incentives to control expenditures so that unnecessary costs are avoided.
- Dependence upon auditing and monitoring procedures -- A retrospective system must have a tight, effective auditing system to monitor costs in order to curb abuses of the system.
- Tendency of the system to become inflexible -- Decisions are often made by accountants based on "generally acceptable accounting principles" rather than on the merits of each individual facility's situation.
- State is uncertain of total program costs until the fiscal period is well over -- Final cost figures may not be known to the State until 6 months after a fiscal year ends.
- Cost Shifting occurs where unallowable costs under Medicaid are borne by other payors (insurance and private payors).

C. Advantages of a Prospective Payment System

- Based on the principle that predetermined rates will result in lower costs. A 1982 study by THE URBAN INSTITUTE concluded that prospective systems lower the rate of increase in hospital spending by several percentage points a year, after an initial start-up period.
- Predictability of costs to the State. Prices are agreed upon by the facilities and the State before the fiscal period starts.
- Predictability of revenues to the facilities. The industry can negotiate wages, purchases and other business decisions with a set service price in mind.
- The technique encourages development of more sophisticated budgeting and cost monitoring capabilities. These are desirable management tools and will permit the State to see how a facilities' budget is built and discuss their assumptions in each of the major cost categories.

D. Disadvantages of a Prospective Payment System

- Administrative costs are generally greater than those of a retrospective system. However, administrative costs vary greatly according to the design of the system, and as such, this factor is not of significant concern when compared to the total dollars being monitored in the health area.

- Arbitrary cost limiters ("FREEZES", "LIDS") may be introduced into the prospective system to balance costs versus revenues. This eventually places hospitals and nursing homes in a "no win" situation since the rates do not fairly reflect efficiently run facilities' costs.

- If rates are not applied industry wide, cost shifting can still occur if Medicaid rates are set unrealistically low by the State based on arbitrary limiters.

E. Operation of a Prospective Payment System

There are a wide variety of prospective payment systems operated in the acute care and long term care sectors around the nation.

A common element of a prospective rate payment setting mechanism is an allowable rate of increase in per diem cost for the following year. This percentage is normally calculated through application of economic indicator such as U.S. Department of Labor wholesale and consumer price indexes. The percentage is then routinely applied to actual cost from the previous period to arrive at the prospective rate. Determination of allowable rates of increase can be undertaken either on an individual facilities or groups of facilities.

Another element of a prospective payment system is more precisely defined cost categories combined with a uniform method of reporting costs to the State. A common cost breakdown would be labor vs. non-labor with further categorization inside these areas. The following example uses "natural" expense categories in reporting facility costs.

- Labor expenses
  - physician's fees
  - management
  - clerical
  - technical (e.g., LPNs', therapists)
  - registered nurses
  - household services (e.g., dietary, housekeeping workers)

- Non-labor expenses
  - food
  - utilities
  - drugs and supplies
  - maintenance of personnel
  - other

While some level of categorization is necessary to assure accuracy of prediction, the model outlined above may require an excessive level of accounting time and expertise for some of Alaska's smaller facilities.

The compromise approach shown below may suffice:

- Salaries and fringe benefits

- Non-labor expenses
  - administrative and general
  - household and maintenance
  - dietary
  - professional care

F. State Reimbursement Trends

To date, approximately thirty-four states have instituted a prospective system of reimbursement for nursing home services under Medicaid, and sixteen states have instituted a propsective system of reimbursement for hospital services under Medicaid. These prospective systems have taken many forms, each state's structure is a little different. However, they share the same philosophical purposes: "to encourage economy and efficiency, and to establish a uniform system of accounting, budgeting, and reporting in determining a health facility's future reimbursement".

G. Why Alaska Should Consider Prospective Payment Now

1. Total overall spending is growing at 20% each year in Medicaid/GR Medical.

   In any period, total spending is always a function of: 1) the number of recipients, 2) the volume of services used, and 3) the unit price of service. With an automatic cost-of-living increase that expands Alaska's eligible population, coupled with no unit price control or volume limits, Alaska currently has no ability to effectively control growth in medical costs.

   According to a recent study by THE URBAN INSTITUTE, Medicaid payments rose at an annual rate of 15.5 percent from FY73 to FY79 nationally. Alaska had the highest annual rate of increase at 41.8 percent during this same period. Since FY79, costs have increased in excess of 20 percent annually in Alaska.

   These three factors (recipients, volume, and unit price) need to be considered collectively in any fiscal year. Currently, critical decisions concerning eligible populations, service coverages and unit price are handled independent of each other and do not produce a final cost figure until the fiscal year is past. If total spending is to be contained at a level below 20%, these factors must be considered collectively before each fiscal year starts.

2. Federal funding for Medicaid is reduced in FY84 and later years. The State is facing an unknown dollar cutback in federal funding for FY84. Unless additional State funding replaces these lost federal revenues, critical decisions must be made to bring program spending in line with available resources.

3. Prospective Systems reduce costs in the long term. The Urban Institute recently concluded that "a concensus is now developing that

POSITION PAPER/Department of Health & Social Services

prospective rate setting is effective in lowering the rate of increase in hospital spending by several percentage points a year, at least in mature rate setting programs after an initial start-up period".

H. Why Doesn't the Department of Health and Social Services Simply Adopt Prospective Payment by Regulation?

The Legislature must specifically endorse adoption of a prospective system in Alaska. The Alaska Attorney General has ruled in a 1982 opinion that present Alaska Statutes prevent adoption of a prospective payment system by regulation. The Legislature must change Alaska Statutes to clearly authorize the Department to adopt a prospective system.

I. What Options Exist?

1. Do Nothing. This strategy would leave reimbursement in the present retrospective environment and require the Department to pass reductions in federal revenues on to hospitals and nursing homes through reduced rates. Most recent calculations place hospital and nursing home revenue reductions at 8% and 24% respectively for FY84. This strategy would not require any additional funds beyond the FY84 Governor's request for Medical Assistance but would severly impact Alaska facilities.

2. Remain on retrospective system and replace lost federal revenues with State funds, if State law permits. This strategy will require replacement funds and may require a statute change as well. There is some doubt whether the present statutes would permit the Department to pay rates in excess of the federal limits.

3. Same as option #2 but reduce persons eligible and medical services available. Under existing Alaska law, the Department is empowered to eliminate certain medical services and certain eligibility groups if funds were deemed inadequate for FY84. If it were determined that the Department could pay in excess of new federal limits with all State funds, or legislation were passed to permit this, the Department could make reductions in services and eligible groups to stay within its FY84 request.

4. Adopt Prospective System and replace lost federal revenues with State funds. This strategy will cost roughly the same as Option #2 but FY84 costs could be predicted with greater certainty. Assuming no changes were made in medical services covered or persons eligible, this option would save the State from 1 to 3% annually compared to Option #2 after the initial start-up period.

5. Adopt Prospective System but reduce persons eligible and medical services available. Herein lies the true value of a prospective system. Once the prospective rules are established and the rates (unit price) for services agreed upon for the fiscal year, eligible groups and medical services are then balanced aginst unit price to operate within the available appropriation. If no changes were made in persons covered or services offered, the price for this option would be the same as Option #4. If major reduction in eligibles or

services were made, the costs for this option could be reduced proportionately.

6. Seek Relief from Congress. This is always an option but not one with as much potential in light of Alaska's present financial image. Nonetheless, there is provision within the new federal changes for special negotiation with the Secretary of Health and Human Services regarding "rural" hospitals. Alaska could pursue this option in conjunction with one of the strategies described in Option 1 through 5 above.

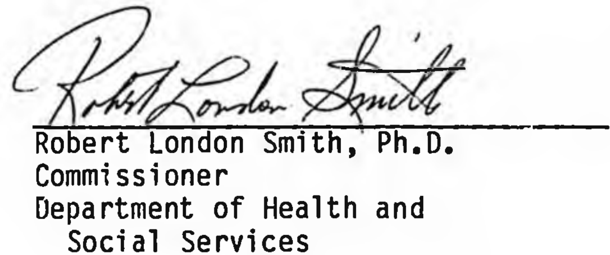
J. Summary

Alaska must balance eligible populations, medical services covered and unit price against available funds to define an affordable FY84 medical program. While a prospective system will not in and of itself make this totally possible, it could provide a business environment in which critical decisions will be made before the fiscal year starts.

Department's Position

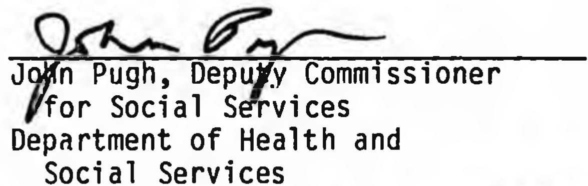
The Department of Health and Social Services supports this legislation as proposed.

5/25/83
Date



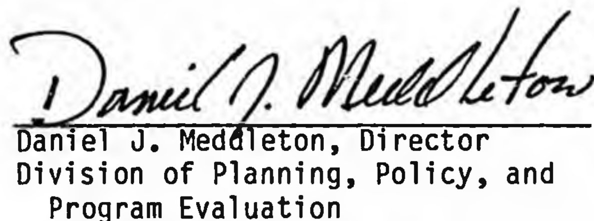
Robert London Smith, Ph.D.
Commissioner
Department of Health and
Social Services

May 24, 1983
Date



John Pugh, Deputy Commissioner
for Social Services
Department of Health and
Social Services

May 19 1983
Date



Daniel J. Meddleton, Director
Division of Planning, Policy, and
Program Evaluation

May 19, 1983
Date

Rod Betit, Director
Division of Public Assistance

STATE OF ALASKA
FISCAL NOTE

Revision Date , 1983

I. REQUEST
Bill/Resolution No.: SSHB 19 am
Title: Prospective Rate Setting
Sponsor:
Requestor:

II. FISCAL DETAIL
Agency Affected: Health and Social Services
Program Category Affected: Medical Assistanc
BRU, Program of Subprogram(s) Affected:
Medicaid/General Relief Medical

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 83	FY 84	FY 85	FY 86	FY 87	FY 88
100 PERSONAL SERVICES		84.7	90.6	97.0	103.8	111.0
200 TRAVEL		27.0	28.9	30.9	33.1	35.4
300 CONTRACTUAL		70.0	20.0	20.0	20.0	20.0
400 COMMODITIES		2.0	2.1	2.3	2.4	2.6
500 EQUIPMENT		6.0	1.0	1.0	1.0	1.0
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC						
TOTAL OPERATING		189.7	142.6	151.2	160.3	170.0
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

	FY 83	FY 84	FY 85	FY 86	FY 87	FY 88
GENERAL FUND		99.1	74.5	79.0	83.7	88.8
FEDERAL FUNDS		90.6	67.1	72.2	76.6	81.2
OTHER (Specify Source)						

POSITIONS:

	FY 83	FY 84	FY 85	FY 86	FY 87	FY 88
FULL-TIME		2	2	2	2	2
PART-TIME						
TEMPORARY						

III. SOURCE OF FUNDS TO OFFSET FISCAL IMPACT OF BILL:

IV. ANALYSIS: Attach a separate page for any Analysis

Prepared By: [signature] Phone: 465-3355
Division: Public Assistance Date: 5/24/83

Approved by Commissioner: Robert Londen Smith Date: 5/25/83
Department: H&SS

Distribution:
Original to Legislative Finance
Copy to Office of Management and Budget (for Legislature introduced bills)
Copy to Department (for Governor introduced bills)
Copy to Sponsor
Copy to Requestor (if different from Sponsor)

3/8/83

<u>FISCAL NOTE REVIEW</u>

100	Personal Services			
	1) Executive Director	R24	$4,251 X 12 =	$51,012
	2) Clerk Typist III	R 8	1,487 X 12 =	17,844
	Benefits .23%			68,856
				15,837
				84,693
200	Travel and Per Diem			
	1) 5 Commission Members X 12 meeting X $450			$27,000
300	Contractual (Data Processing Assistance)			$70,000
400	Commodities			$ 2,000
500	Equipment			$ 6,000
	1) Desks, Chairs and Files Word Processor			
				$189,693

Three existing Auditor III positions from the Division of Public Assistance will be transferred for Commission use as well as travel funds, etc.

FY'85 and succeeding fiscal years based on 7 percent increase.

Introduced: 1/24/83
Referred: Health, Education &
Social Services and Finance

BY FRITZ, HAYES, ZHAROFF,
CATO, LINDAUER, SZYMANSKI,
MCBRIDE AND BUSSELL

1 IN THE HOUSE

2 SPONSOR SUBSTITUTE FOR HOUSE BILL NO. 19 am

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 THIRTEENTH LEGISLATURE - FIRST SESSION

5 A BILL

6 For an Act entitled: "An Act repealing the certificate of need program,
7 amending or repealing provisions relating to state
8 aid for health facilities, Medicaid and general
9 relief medical assistance; and providing for an
10 effective date."

11 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

12 * Section 1. AS 18.07.021 is amended to read:
13 Sec. 18.07.021. STATE HEALTH PLANNING AND DEVELOPMENT AGENCY.
14 The division of planning, policy, and program evaluation [OFFICE OF
15 PLANNING AND RESEARCH] in the department is the state health planning
16 and development agency designated under 42 U.S.C. Sec. 300m(b)(3),
17 (Sec. 3, P.L. 93-641) [SEC. 1521(b)(3), P.L. 93-641]. The division
18 [OFFICE] shall perform the functions enumerated under 42 U.S.C.
19 Sec. 300m-2(a)(1) - (3), (a)(6) - (8), (b) and (c), (Sec. 3, P.L.
20 93-641) [SEC. 1523,P.L. 93-641, ADMINISTER THE CERTIFICATE OF NEED
21 PROGRAM OUTLINED IN AS 18.07.041 - 18.07.111, AND OTHER FUNCTIONS
22 PRESCRIBED IN THIS CHAPTER].

23 * Sec. 2. AS 18.07.111 is amended by adding a new paragraph to read:
24 (13) "division" means the division of planning, policy, and
25 program evaluation in the Department of He[illegible]h and Social Services.

26 * Sec. 3. AS 18.26.220 is repealed and reen[illegible]ed to read:
27 Sec. 18.26.220. FACILITY COMPLIANCE [illegible]H HEALTH AND SAFETY LAWS
28 AND LICENSING REQUIREMENTS. In order to receive financial assistance
29 under this chapter, a medical facility shall comply with AS 18.20 and

the licensing requirements of this chapter.

* Sec. 4. AS 29.89.030(a)(1) is repealed and reenacted to read:

(1) to a municipality that has the power to provide hospital facilities and services and that exercises that power, $250,000 per hospital for those hospitals with 10 or more acute care beds, and $50,000 per hospital for those hospitals with less than 10 acute care beds; money received under this paragraph may be used only for hospitals and shall be apportioned among qualifying hospitals as the municipality determines;

* Sec. 5. AS 47.07.070 is repealed and reenacted to read:

Sec. 47.07.070. PAYMENT TO HEALTH FACILITIES. (a) The commission shall determine prospectively the rate of payment to a health facility under this chapter and AS 47.25.120 - 47.25.300 based on a fair rate for reasonable costs incurred by the facility. The commission shall by regulation list the factors it considers in making its rate determinations under this section.

(b) In determining a rate of payment to a health facility under this section, the commission shall consider the proportionate share of the facility's financial requirements for patient care for

(1) costs of current operations, including salaries and wages; purchased services, supplies, insurance, leases, depreciation, taxes, interest expense, maintenance and other health facility operating expenses; and

(2) education, research, and appropriate capital development.

(c) In determining a rate of payment to a health facility under this section, the commission may consider whether the rate of utilization of the facility has been reduced because of improvement or careless development of the facility.

1 * Sec. 6. AS 47.07 is amended by adding new sections to read:
2 Sec. 47.07.071. REPORTS BY HEALTH FACILITIES. Not later than
3 120 days after the end of each fiscal year of a health facility, the
4 facility shall submit to the commission a report on the facility's
5 financial performance during the fiscal year.
6 Sec. 47.07.072. REPORT BY THE COMMISSION. Not later than Sep-
7 tember 30 of each year, the commission shall submit to the governor a
8 report on the prospective payments made under this chapter during the
9 current fiscal year and an estimate of the prospective payments that
10 will be made during the remainder of the current fiscal year and the
11 next fiscal year. The report shall state the assumptions that are
12 used as a basis for the estimates.
13 Sec. 47.07.073. UNIFORM ACCOUNTING, BUDGETING, AND FINANCIAL
14 REPORTING. (a) The commission by regulation shall require a uniform
15 system of accounting, budgeting, and financial reporting for health
16 facilities receiving prospective payments under this chapter. The
17 regulations shall provide for the reporting of revenues, expenses,
18 assets, liabilities, and units of service. The commission shall
19 specify the date the system becomes effective for each health facil-
20 ity.
21 (b) In adopting regulations under this section, the commission
22 shall consider
23 (1) accounting, budgeting, and financial reporting proce-
24 dures used by health facilities;
25 (2) variations among health facilities in the types of
26 health care services provided by health facilities;
27 (3) other factors the commission considers relevant, in-
28 cluding the size and organizational structure of health facilities and
29 the methods used by health facilities to obtain payments.

1 (c) The commission may waive or modify a requirement for accounting, budgeting, or financial reporting for a health facility if waiver or modification is

4 (1) necessary to avoid excessive costs to the facility; and

5 (2) consistent with the policies of this chapter.

6 (d) Notwithstanding other provisions of this section, the commission may, by regulation, modify the system of accounting, budgeting, and financial reporting required under this section for a health facility having less than 25 acute care beds in order to reduce the operating costs of that facility.

11 Sec. 47.07.074. AUDITS AND INSPECTIONS. As a condition of obtaining payment under AS 47.07.070, a health facility shall allow

13 (1) the department and the commission reasonable access to the financial records of medical assistance beneficiaries; and

15 (2) inspection of financial records by state and federal agencies to the extent required by federal law.

17 Sec. 47.07.075. APPLICATION OF ADMINISTRATIVE PROCEDURE ACT. Actions of the commission under AS 47.07 and AS 47.25.120 - 47.25.300 are subject to the provisions of the Administrative Procedure Act (AS 44.62).

21 * Sec. 7. AS 47.07.080 is amended by adding new paragraphs to read:

22 (6) "commission" means the Medicaid Rate Commission;

23 (7) "health facility" includes a hospital, skilled nursing facility, intermediate care facility, intermediate care facility for the mentally retarded, rehabilitation facility, inpatient psychiatric facility, home health agency, rural health clinic, and outpatient surgical clinic.

28 * Sec. 8. AS 47.07 is amended by adding new sections to read:

29 ARTICLE 2. MEDICAID RATE COMMISSION.

1 Sec. 47.07.110. MEDICAID RATE COMMISSION ESTABLISHED. The
2 Medicaid Rate Commission is established in the Department of Health
3 and Social Services.

4 Sec. 47.07.120. COMPOSITION OF COMMISSION. The commission
5 consists of five members as follows:

6 (1) the chief executive officer of a health facility that
7 is licensed by the state but not owned or operated by the state or
8 federal government and that is subject to the budget review process
9 under this chapter;

10 (2) the commissioner of administration, the commissioner of
11 health and social services, or the appointed designee of either com-
12 missioner;

13 (3) a physician licensed to practice medicine in the state
14 who is actively engaged in the practice of medicine and who is not
15 employed by the state;

16 (4) a certified public accountant with relevant experience;

17 (5) a person representing consumers of health services who
18 does not have a direct or indirect interest in an entity that provides
19 health care services.

20 Sec. 47.07.130. APPOINTMENT OF MEMBERS. Members of the commis-
21 sion are appointed by the governor and serve at the pleasure of the
22 governor.

23 Sec. 47.07.140. TERM OF MEMBERSHIP. The term of a member of the
24 commission appointed under AS 47.07.120(1), (3), (4), or (5) is three
25 years. A member may not be appointed to a successive term. The terms
26 of the members shall be staggered. A member appointed to fill a
27 vacancy serves for the unexpired term of the member. A term shall be
28 measured from January 1 of the year in which the term of the vacant
29 position begins, regardless of when the vacancy is filled.

1 Sec. 47.07.150. COMPENSATION. A member of the commission serves
2 without compensation but is entitled to per diem and travel expenses
3 authorized by law for boards and commissions under AS 39.20.180.
4 Sec. 47.07.160. OFFICERS. At the first meeting of each year,
5 the commission shall elect a chair from among its members.
6 Sec. 47.07.170. MEETINGS AND QUORUM. The commission shall meet
7 as often as is necessary to conduct its business. Three members of
8 the commission constitute a quorum.
9 Sec. 47.07.180. DUTIES. The commission shall review proposed
10 payment rates and budgets of health facilities and establish payment
11 rates for health facilities under this chapter and AS 47.25.120 -
12 47.25.300.
13 Sec. 47.07.190. EMPLOYMENT OF PERSONNEL. The commission may
14 employ and determine the salary of an executive director. With the
15 approval of the commission, the executive director may select and
16 employ additional staff. The commission shall be assisted by the
17 officers or personnel of the department as the commissioner of health
18 and social services shall direct. The executive director of the
19 commission is in the exempt service under AS 39.25.
20 * Sec. 9. AS 47.25 is amended by adding a new section to read:
21 Sec. 47.25.195. PAYMENT TO HEALTH FACILITIES FOR TREATMENT OF
22 NEEDY PERSONS. (a) The department may make payments to a health
23 facility for the treatment of a needy person.
24 (b) A health facility receiving a payment under this chapter is
25 subject to the requirements of AS 47.07.070 - 47.07.075.
26 (c) For purposes of this section, "health facility" includes a
27 hospital, skilled nursing facility, intermediate care facility, inter-
28 mediate care facility for the mentally retarded, rehabilitation facil-
29 ity, inpatient psychiatric facility, home health agency, rural health

1 clinic, and outpatient surgical clinic.

2 * Sec. 10. INTERIM PROSPECTIVE PAYMENT SYSTEM. The department shall
3 establish an interim system of prospective payments for health facilities
4 under this Act for the period July 1, 1983 to June 30, 1984.

5 * Sec. 11. The sponsor of a hospital or health facility construction
6 project who is receiving or entitled to receive state aid under AS 29.90 on
7 the day preceding the effective date of this Act shall continue to receive
8 state aid until the sponsor has received an amount which, combined with
9 state matching money for construction of the hospital or health facility,
10 equals 25 percent of the total project cost. Money received for construc-
11 tion may not be used for any other purpose.

12 * Sec. 12. AS 18.07.031 - 18.07.101, 18.07.111(1) - (4), 18.07.111-
13 (7) - (11); AS 29.90; AS 47.07.080(1) and AS 47.80.140(b) are repealed.

14 * Sec. 13. This Act takes effect immediately in accordance with AS 01.
15 10.070(c).

CERTIFICATE OF NEED:

REVISION OR REPEAL

Prepared in
the
Public Interest
by
the

ALASKA HEALTH COALITION
February, 1983

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EXECUTIVE SUMMARY

Alaska's Certificate of Need (CON) Law was enacted by the State Legislature in 1976, following passage of Public Law 93-641, the National Health Planning and Resource Development Act of 1974. Provisions in the CON law require that non-federal health care institutions apply for and receive a Certificate of Need from the State of Alaska before proceeding with major capital investments which will result in new construction, alterations or renovations, and/or new services. The Thirteenth Alaska Legislature currently has before it companion bills, HB 19 and SB 85, which provide for repeal of the CON law. The purpose of this paper is to review the data available on the effectiveness of the CON process, both nationally and within the State of Alaska, and to present alternatives for consideration by the Legislature regarding public review of capital expenditures for health care facilities.

Evidence is presented that the CON program has had an effect on limiting the amount of capital expenditures. Furthermore, current economic research has demonstrated that, for every dollar of capital investment made in a health care facility, an accompanying increase in operating costs can be expected amounting to 184% of the original investment in ten years.

Evidence gathered on Alaska's experience with the Certificate of Need program indicated that it has been effective in deterring and/or guiding capital investment within the health-care industry and has stimulated improved planning within the health-care institutions themselves. Examples are presented which illustrate how the process created this impact.

Several issues are discussed relating to recognized concerns within the current CON process. These issues include: 1) costs attendant to developing a CON application; 2) delays in the review process; 3) loss of community control; 4) marketplace economics; and, 5) the dollar-threshold limits which require a CON.

The conclusion drawn from this review was that, although there are problems with the current CON process, revision of the law is preferable to outright repeal. Recommendations for revision of the law are provided and include:

1. Raising threshold levels.
2. Exempting non-clinical capital expenditures.
3. Expediting reviews of equipment replacement.
4. Specifying time limits on reviews.
5. Providing legislators with information on the outcome of reviews in their districts.
6. Providing for a sunset review of the process.

CERTIFICATE OF NEED PROGRAM

PURPOSE

The most controversial aspect of the health planning effort, in Alaska and nationwide, has been the Certificate of Need (CON) program. Borrowed from public utility regulations, the earliest CON program was enacted by New York in 1964. Twenty-six other states instituted CON programs in the next ten years, and, with the passage of Public Law 93-641, CON was mandated for all states. Alaska's Certificate of Need statute (18.07.031-.111) was enacted by the State Legislature in 1976 and amended in 1981.

As originally designed, the CON program was implemented to curb rapidly escalating costs of health care by stemming uncontrolled capital investments in new health-care facilities, services, and high-technology equipment. To accomplish this goal, the CON program had several primary objectives: 1) to prevent unnecessary duplication of services and facilities; 2) to reduce the number of available hospital beds or at least not allow the growth of hospital beds to exceed guidelines established in the State Health Plan; 3) to promote an equitable and efficient allocation of resources; and 4) to determine if less costly alternatives to expensive capital expenditures were available to accomplish the same purpose.

WHO MUST APPLY

The State of Alaska requires approval of capital expenditures for projects which meet or exceed certain thresholds:

1. Capital expenditures in excess of $150,000 toward building, improving, or purchasing a health care facility, including lease or purchase of equipment, costs of any study surveys, designs, and site acquisitions and preparations.

2. Any change within a two-year period in the licensed bed capacity of a health care facility amounting to 10 beds or 10 percent, whichever is the lesser, which increases or decreases the number of beds or redistributes beds among different categories of service.

3. Any addition or elimination of a major type of service offered in or through the health care facility.

A project meeting or exceeding these thresholds is required to obtain a Certificate of Need from the State of Alaska prior to implementation.

THE PROCESS

An applicant enters the CON review process by submitting a "Letter of Intent" to the Department of Health and Social Services (DHSS) and to the appropriate health systems agency describing briefly the scope of the proposed activity. If the DHSS determines that the project is subject to CON review, the applicant develops a formal application and submits it to the State agency and the regional health systems agency. In most cases, a pre-application conference is scheduled with the applicant to minimize any potential misunderstandings and to achieve an agreement on what would represent a successful application. Once the State agency certifies that the application is "complete" -- that it contains sufficient information necessary to conduct an objective review -- the agency has 90 days to review the application and to submit an analysis to the Commissioner of DHSS for final action. Within the 90-day review period, the regional health planning agency has 60 days to review and seek public comments on the appropriateness of the proposed application. The HSA submits its findings and recommendations to the Commissioner. Once the Commissioner has considered the information that has been submitted, he decides whether or not to issue a Certificate of Need to the applicant. The Commissioner notifies the applicant in writing of the decision. Copies of the decision are sent to the Health Systems Agency and are published in regional newspapers.

EFFECTIVENESS

Nationwide

Nationally, credible information is just beginning to emerge regarding the effect of capital expenditures review. Although this topic has been of interest for many years, much of the early literature is of little value because of a basic lack of understanding about the process and outcome of capital expenditure review programs.[1] Two recently completed studies in the State of Massachusetts have reported CON impacts.[2,3] The first analyzed hospital capital investment among short-term general voluntary hospitals between 1967-1976. The results were that, by 1976 and beyond, CON review reduced all dimensions of project scale and cost by as much as two-thirds of that originally proposed. The second study found that the formal and informal actions of the CON agency from 1972-1976 resulted in small, but statistically significant, reductions in the rate of hospital investment.

Two studies conducted in 1982 by Arthur D. Little, Inc., shed additional light on the potential impact of capital expenditures review.[4,5] The first study analyzed the effect of capital expenditures review decisions in five states: Colorado, Florida, Maryland, Massachusetts, and Oregon (chosen for their geographical and regulatory differences). Based on their analysis, CON programs appeared to be effective in limiting the amount of capital expenditures undertaken. Furthermore, they discovered that, for every dollar of capital investment, there was a definite increase in operating costs. They projected that, over a ten-year period, a dollar of capital investment generates additional operating costs with a present value of $1.84 (exclusive of

depreciation and debt service). They concluded from these results that CON programs have the potential to play an important role in curbing hospital cost inflation.[4]

A second report by Arthur D. Little, Inc., involved an analysis of information from a six-state study.[5] For the states of Virginia, South Carolina, Washington, New Jersey, Iowa and Colorado, Arthur D. Little undertook a review of Certificate of Need programs for the twelve-month period beginning July 1, 1979 to June 30, 1980. Three significant findings were reported: 1) certain capital costs were not incurred as a result of the CON review program; 2) the objectives contained in individual state plans and health systems plans tended to deter capital expenditure projects; and, 3) pre-application conferences -- health planners and providers working together to avoid project denial -- were effective means of reducing the "administrative costs" of the review process as well as excessive capital expenditures.[5]

Alaska

Currently (February 1983) there are five projects under review by the Department of Health and Social Services that total $106,000,000. Two additional applications are anticipated, totalling $20,820,000. These seven applications ($126.8 million) provide an interesting contrast with the more than 30 projects which were approved for $149,000,000 in the previous five years (1977-1982).

Two projects with a combined total of $12,400,000 have been denied during the past five years. In addition, several other Letters of Intent have been received by the Department for which applications were never received. It is impossible to estimate how many applications or letters of intent were never submitted because of the presence of the CON law.

The Alaska CON Program has been effective in accomplishing three things. First, it seems reasonable to expect that CON has deterred misdirected projects that could not withstand the test of public scrutiny. It has, therefore, acted to uphold existing plan standards. Secondly, it has guided institutional actions into areas which are compatible with the goals and objectives of the State as reflected in State and regional health plans. Thirdly, the presence of the CON program has promoted better planning on the part of the health care institutions throughout the State.

Deterrent Effects

Although the deterrent effect of Certificate of Need is admittedly difficult to demonstrate, there is evidence from the number of "Letters of Intent" which never resulted in an application that CON is a deterrent. A specific example of this phenomenon was observed during a recent effort by four different applicants to provide inpatient alcoholism treatment services in and around Anchorage. The Department of

Health and Social Services and the local health systems agency identified a need for 40-80 alcohol-treatment beds in the area. Due to pre-application planning, only two of the four applications were completed for final consideration. Both were subsequently approved.

Improved Institutional Planning

Situations in which the CON process provides expert guidance and stimulates better institutional planning do not always result in smaller, less-expensive projects. For example, Valley Hospital in Palmer submitted an application to complete a minimal and temporary renovation of their 30-year old facility at a cost of $2,000,000. Part of the renovation included additional insulation to prevent heat loss through the roof. At the suggestion of the Department, a structural engineer was asked to study the ability of the roof to withstand the increased load of snow which would not be melted because of the insulation. The Department also requested a life-cycle cost analysis which would determine the cost of a temporary renovation as opposed to costs of major renovation. The results of these inquiries demonstrated that the roof was not designed to withstand the extra load of snow and that, when total operating expenses and capital costs were considered for a 25-year period, it would be less expensive to forgo the minimal renovation and proceed with a major renovation. The result of this review was an approval for a major renovation project -- at a long-term cost savings.

Petersburg General Hospital filed a letter of intent for $3,400,000 to renovate an existing acute care facility. Following an architectural assessment of the facility and a life-cycle cost analysis requested by the State, it was determined that the cost of new construction would be preferable to renovation. Subsequently, a CON was approved for $7,150,000. Obviously, the CON process is not punitive, but rather seeks to use health care resources to gain the maximum benefit for the community.

Hospitals in Homer and Fairbanks submitted proposals for review which contained "shelled-in" space for which no use was intended for the immediate future. In Homer, the Department requested further assessment of the situation to identify a solution to future use of the shelled-in space. As a result the plans were redrawn for the renovation and expansion and included the proposed use of the shelled-in space.

Better Conformance with Identified Community Needs

In Fairbanks, the CON process stimulated a community discussion of the need for inpatient psychiatric services and a concern for approving the construction of two shelled-in floors that did not have an identified use. Because of discussions at the local level during the review by the health systems agency, the hospital agreed to specify the intended use of the shelled-in space and, furthermore, to enter into a planning process with the community during the following year to determine the most appropriate configuration for the proposed services.

Summary

Although it is difficult to place a dollar figure on the impact of the Certificate of Need program over the past six years, it appears that Alaska's program has effectively deterred and guided capital investment within the health care industry and has stimulated improved planning within the institutions themselves. Because of the CON program, Alaskans have saved millions of dollars in operating costs which would have resulted from unneeded expansion of facilities and services. Moreover, the State Legislature and the Administration should feel some measure of assurance that, because of the CON process, the millions of dollars in public funds that have flowed from the State to health care facilities for construction and operation are being used for projects which meet an identified need, do not duplicate existing services, and are financially feasible.

PROBLEMS WITH THE CON PROCESS AND RECOMMENDATIONS FOR IMPROVEMENT

INTRODUCTION

Proponents and opponents of the Certificate of Need program agree that the current CON process requires substantial changes. Opponents cite several reasons for their decision to push for repeal of the current law. Among the reasons are: 1) significant costs are involved in developing a CON application and proceeding through the review; 2) delays in implementation are caused by an extended review period; 3) the CON process removes community control; 4) market-place economics should control capital investment; and 5) threshold limits which trigger a CON review are too low.

COSTS

No one denies that there are costs attendant to developing a CON application. The majority of those costs, which have been estimated to run as high as $40,000 for the more complex projects, can be attributed to personnel costs. Most of these costs would continue in the absence of CON if a facility did a credible job of planning for future services. In order to gain public support, justify the financial feasibility of a construction project, and obtain adequate architectural designs, planning still must occur. The costs of institutional planning will not disappear in the absence of CON.

DELAYS

Extended review schedules have in some cases resulted in delays in construction start-up time which have been not only frustrating but also costly. It seems reasonable that the cause for these delays can be identified and corrected by revising the regulations regarding CON review. For example, provisions could be made to expedite review of capital equipment replacement and to set a time limit for a decision by the Commissioner subsequent to a recommendation by a regional health planning agency. Also, by raising the threshold limits which require a CON, there will be approximately 25% fewer reviews to do. This should improve the efficiency of the review process.

COMMUNITY CONTROL

Concern has been expressed that the CON process removes community control from local jurisdictions in the case of municipally-owned facilities and local advisory boards with respect to corporately-owned facilities. However, local governments and advisory boards do not necessarily maintain a regional or statewide perspective when it comes to considering new services and facilities. In other words, persons who

serve on local hospital advisory boards are chosen for their expertise and dedication in local issues; often, however, a project will have regional or statewide implications that cannot be properly addressed at the local level. The CON process, at the very least, offers local, regional and statewide perspectives on the need and appropriateness of a proposed project. Instead of removing community control, the CON process bestows some control on the community at large.

In addition, a trend is evident that an increasing amount of public funds are being appropriated by the legislature for construction and renovation. It seems reasonable that in a time of decreasing state revenues, citizens should have an opportunity to influence the distribution of these funds so that they meet state and regional needs instead of local demand. The CON process ensures public participation in these decisions.

MARKETPLACE ECONOMICS: COMPETITION vs. "REGULATION"

In recent years, there has been a popular theory that the problems in U.S. health services can be blamed on excessive government intervention and regulations. It has been argued that high costs and related problems could be solved by a "return to the free market and competition."[6] Two recent articles argue to the contrary.[7,8]

Roemer and Roemer, well-known health-economics experts, examined the past and present operations of free trade and competition in the health care system and found that not one of at least five conditions necessary for competition existed.[7] In addition, they found that the free market created a geographic maldistribution of health manpower, causing serious problems for rural populations. Furthermore, they discussed the paradoxical problem which has been demonstrated for every component of the health care industry of "supply creating demand" rather than the reverse, which is true in an effectively operating market. Supply creates demand in the health care industry fundamentally because the seller (doctor) rather than the buyer (patient) makes most of the decisions on what health services are to be obtained.[7]

Needlemen, another health economist, expressed a similar opinion.[8]

> An effective market is one in which there is competition on the basis of both price and quality, and in which those who sell services are limited in their ability to influence the volume of services they sell and are constrained in the prices they set by competitive pressures. By this definition, <u>an effective market for health care services does not exist in most communities. Competition exists but it is rarely price competition</u>; indeed the nature of current competition based on scope of services, amenities, and convenience is to encourage <u>price increasing</u> behavior. (Emphasis added).[8]

Arthur D. Little, Inc., summarized the policy implication of the debate surrounding competition and regulation. They reported that, in the absence of Certificate of Need regulations, hospitals will compete more vigorously by offering improved facilities to recruit physicians and patients. The resulting "building boom" will drive up operating expenditures over the next ten years by $1.84 for every dollar invested, exclusive of depreciation and debt service.

THRESHOLD LIMITS

Alaska regulations specify that a CON is required for any capital expenditure in excess of $150,000. There is general agreement that this threshold is far too low. Federal regulations have already changed to accomodate a significant increase in CON thresholds. The threshold levels which trigger a CON review should be increased from $150,000 to at least $600,000 for capital expenditures; $400,000 for major medical equipment; and $250,000 for operating expenses associated with new services.

CONCLUSIONS

Recent evidence nationally and available information from the Certificate of Need Program in Alaska indicate that the program has been effective in deterring unjustified projects, guiding capital investment projects, and stimulating improved institutional planning. Together these effects have served to meet the health care needs of the public, prevent duplication of costly services, and restrain the increasing costs of health care. Acute problems with the CON process are correctable by amending the law.

Options available to the Legislature can be placed into three categories: 1) keep the law as it is and maintain the status quo; 2) repeal the law in its entirety; or, 3) revise the law to correct recognized problems.

MAINTAIN CURRENT CON PROCESS

The State would continue to operate the program in its current form. This option assumes the CON process is working efficiently and requires only minor changes.

Because of recognized problems, this option appears to have little merit. Threshold levels are too low, most non-clinical expenditure reviews are a nuisance for applicants and reviewers, and delays in the review process are unacceptable.

REPEAL THE CON LAW

This option assumes that the Certificate of Need process has been entirely ineffective and that marketplace incentives will arise to control capital investments and health care costs.

It also assumes that public review of health care capital expenditures are unimportant and that health care consumers should not have a voice in determining the appropriateness of services in their community.

A competitive pricing market does not exist within the health care services industry of any community in Alaska. In addition, the State of Alaska did not renew its Section 1122 agreement with the federal government in 1981 because the Certificate of Need law was in place.[9] (Section 1122 of PL 92-603 required that health care facilities, which received federal monies under Titles XVIII and XIX, be subject to review to ensure consistency with state health plans.) Repeal of the CON law would leave the State entirely without a capital expenditure review process for health care facilities; therefore, the State would have to rely principally on either the competitive market or incentives established under some kind of a prospective reimbursement system to control costs and allocate resources. (Hospitals are currently reimbursed by the federal government under Medicare and Medicaid on a retrospective basis; that is, after the costs have already occurred. Under this

reimbursement mechanism, there is no real incentive for containing costs. Prospective reimbursement, on the other hand, would require that hospitals negotiate the rate or cost of a service a year in advance. The government and other third-party insurers would reimburse the hospital only at the negotiated rate; therefore, costs exceeding the rate would be borne by the hospital, and, conversely, the hospital would make money if costs were kept below the negotiated rate.)

Because a competitive pricing market does not exist anywhere in Alaska, eliminating the CON program will likely lead to new, unneeded services and facilities which will result in increased operating costs. These costs are passed directly on to the buyers (patients and tax-payers).

Prospective reimbursement, on the other hand, comes in various forms and generally has been found to be more difficult to enact and implement than Certificate of Need. Generally speaking, prospective reimbursement is likely to be successful only where there has been political support for Certificate of Need.[6]

Finally, repeal of CON serves the interests of the health services establishment only. Those who control health-care costs would also be controlling capital investments. Consumers could not have a voice in determining the most appropriate and affordable level of service for their community or region.

MODIFY THE CON PROCESS

This option assumes that the CON program has been effective and can be modified to make it more efficient. The scope of the CON program could be scaled back by raising threshold levels and exempting certain non-clinical capital expenditures. Under this option, the CON program could be reduced further if a market capable of insuring an appropriate allocation of services emerged or to complement a prospective reimbursement system.

RECOMMENDATIONS

The Alaska Health Coalition recommends that negotiations take place among members of the Alaska State Hospital Association, the Legislature, and the Administration to work out revised CON regulations.

The Coalition further recommends that the following revisions be considered as a starting point for the negotiations.

1. Increase the threshold level which triggers a CON review from $150,000 to at least:
   a. $600 000 for capital expenditures
   b. $400,000 for major medical equipment
   c. $250,000 for operating expenses associated with new services.
2. Exempt all non-clinical capital expenditures. The bill should indicate that non-clinical services which are not subject to review include, but are not limited to: parking, telephone systems, day care, mailrooms, heating and air conditioning, blood bank, dietary/cafeteria, laundry and linen, medical records, business office, housekeeping, central supply, library, reception, and data processing. This exemption would apply only if one of these non-clinical projects was the main purpose of the application. For example, a project proposing a new facility could still include review and consideration of the non-clinical activity if it were part of a larger project.
3. Expedite review of capital equipment replacement.
4. Specify a time limit for a decision by the Commissioner subsequent to a recommendation by the regional health planning agency.
5. Provide that each legislator be informed of all projects in his/her district, especially regarding the outcome of the review.
6. Consider a sunset provision of four or more years to review effectiveness of the CON process.

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4. Arthur D. Little, Inc. Development of an Evaluation Methodology for Use in Assessing Data Available to the Certificate of Need (CON) and Health Planning Programs. Final report prepared for DHHS/Office of Assistant Secretary for Health. Contract #233-79-4003. April 1982.

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7. Roemer, M.I. and John E. Romer. The Social Consequences of Free Trade in Health Care: A Public Health Response to Orthodox Economics. International Journal of Health Services. 12(1):111-129. November 1982.

8. Needlemen, Jack. Competition and State Health Planning Programs: Options for State Action. Alpha Center for Health Planning. Bethesda, Maryland. DHHS/BHP. HRA Contract #232-79-0035. June 1982.

APPENDIX

NATIONAL HEALTH PLANNING AND DEVELOPMENT ACT OF 1974

INTRODUCTION

Public Law 93-641, (National Health Planning and Resource Development Act), passed by the U.S. Congress in 1974, established a national health planning program which was implemented in each state and several American territories. The intent of Congress was to integrate previously sponsored programs (Hill-Burton, Regional Medical Program, Comprehensive Health Planning), retain the best features of each, and address major national, state, and local concerns about the current planning, development, and operation of the nation's health care system. To address these concerns, the Act authorized the designation and funding of state and regional health planning agencies and set forth several functions these agencies had to perform in order to further the "achievement of equal access to quality health care at a reasonable cost."

HEALTH SYSTEMS AGENCIES

Health Systems Agencies (HSAs) were designated as local or regional bodies with the responsibility for preparing and implementing plans designed to improve the health of the residents of its health service area; to increase the acceptability, accessibility, continuity and quality of health services of the area; to restrain increases in the cost of providing health services; and, to prevent unnecessary duplication of health resources. These functions were carried out by interested consumers and providers working together to identify community and regional problems and to develop strategies and recommendations to help alleviate those problems.

HSAs were established as either private, non-profit corporations or public entities governed by boards that had to have a consumer majorities. Operational funds have been awarded through both Federal (PHS) and State (DHSS) sources. In Alaska, the Governor designated three health service areas which were each to be served by an HSA. Alaska's three HSAs are: Northern Alaska Health Resources Association, Inc. (Fairbanks), serving northern Alaska; South Central Health Planning and Development, Inc. (Anchorage), serving south central Alaska, including the Aleutian chain; and Southeast Alaska Health Systems Agency (Ketchikan), serving Alaska's panhandle.

South Central
Health Planning and Development, Inc.
1135 West Eighth Avenue • Suite 1 • Anchorage, Alaska 99501
(907) 278-3631

March 7, 1983

Al Adams
Pouch V - Mail Stop 3100
Juneau, Alaska 99811

Dear Representative Adams:

At the March 5, 1983 meeting of South Central Health Planning and Development, Inc., the Board voted to direct staff to represent the attached position on the Certificate of Need repeal bill. The paper attached was originally put out by the Alaska Health Coalition, a loosely organized group made up of executive directors and presidents of the boards of the three Health Systems Agencies, president of the Municipal Health Commission, and president of the Statewide Health Coordinating Council.

The position paper points out that there is merit in the Certificate of Need program in Alaska and that problems with the existing law can be corrected by amending the law.

In reviewing the repeal bills before the House, your Committee might want to consider the Certificate of Need issue within the larger context of public expenditures for hospitals and inpatient health care services.

If you have any questions about the position paper please do not hesitate to contact me or Susan Callan at our office.

Sincerely yours,

Margaret McClure Wilson

Margaret M. Wilson
Director

MMW/cr

Editor's notes. — Section 1524, P.L. 93-641 and § 237, P.L. 94-63, referred to in this section, may be found in 42 U.S.C. § 300m-3 and 42 U.S.C. § 2689t, respectively.

Sec. 18.07.021. State Health Planning and Development Agency. The office of planning and research in the department is the state health planning and development agency designated under § 1521(b)(3), P.L. 93-641. The office shall perform the functions enumerated under § 1523, P.L. 93-641, administer the certificate of need program outlined in AS 18.07.041 — 18.07.111, and other functions prescribed in this chapter. (§ 2 ch 275 SLA 1976)

Editor's notes. — Sections 1521(b)(3) and 1523, P.L. 93-641, referred to in this section, may be found in 42 U.S.C. §§ 300m(b)(3) and 300m-2, respectively.

Article 2. Certificate of Need Program.

Section
31. Certificate of need required
41. Standard of review for applications for certificates of need
51. Terms of issuance of the certificate
61. Modification and termination of activities
71. Temporary and emergency certificates
81. Proceedings for modification, suspension, and revocation
91. Injunctive relief; penalties; right of action
101. Regulations
111. Definitions

Collateral references. — 40 Am. Jur. 2d, Hospitals and Asylums, §§ 1-5.

41 C.J.S., Hospitals, §§ 1, 2, 4, 5.

Validity and construction of statute requiring establishment of "need" as precondition to operation of hospital or other facilities for the care of sick people. 61 ALR3d 278.

Sec. 18.07.031. Certificate of need required. No person may undertake the following unless authorized under the terms of a certificate of need issued by the office:

(1) construction of a health care facility;

(2) alteration of the bed capacity of a health care facility;

(3) addition or elimination of a category of health services provided by a health care facility. (§ 2 ch 275 SLA 1976)

Sec. 18.07.041. Standard of review for applications for certificates of need. The office shall grant a sponsor a certificate of need or modify a certificate of need if the availability and quality of existing health care resources or the accessibility to those resources is less than the current or projected requirement for health services required to maintain the good health of Alaska citizens. (§ 2 ch 275 SLA 1976)

Sec. 18.07.051. Terms of issuance of the certificate. Each certificate issued shall specify terms of issuance describing the nature and extent of the activities authorized by the certificate. (§ 2 ch 275 SLA 1976)

Sec. 18.07.061. Modification and termination of activities. The certificate holder shall apply to the office for a modification of the certificate before terminating part of the activities authorized by the terms of issuance, but the certificate holder is not required to obtain the acquiescence of the office before terminating all the activities authorized by the certificate. If a certificate holder terminates all of the activities authorized by a certificate, the certificate holder is required to notify the office 60 days before termination and to surrender the certificate to the office within 30 days of termination. (§ 2 ch 275 SLA 1976)

Sec. 18.07.071. Temporary and emergency certificates. (a) The office shall grant a sponsor an emergency certificate for the construction of a health care facility for which a certificate is required under AS 18.07.031 if the sponsor shows, by affidavit or formal hearing, that the act of construction consists of effecting emergency repairs.

(b) The office may grant a sponsor a temporary certificate for the temporary operation of a category of health service, if the sponsor shows by affidavit or formal hearing

(1) the necessity for early, immediate, or temporary relief, and

(2) adverse effect to the public interest by reason of delay occasioned by compliance with the requirements of AS 18.07.041 and application procedures prescribed by regulations under this chapter.

(c) A temporary certificate granted under (a) and (b) of this section confers no vested rights on behalf of the applicant. The office shall impose those special limitations and restrictions concerning duration and right of extension which the office considers appropriate. No temporary certificate may be granted for a period longer than necessary for the sponsor to obtain review of the action certified by the temporary certificate under AS 18.07.051. Application for a certificate of need under AS 18.07.041 must commence within 60 days of the date of issuance of the temporary certificate. (§ 2 ch 275 SLA 1976)

Revisor's notes. — In subsection (a), a reference to AS 18.07.031 was substituted for a reference to AS 18.07.041 by the revisor of statutes pursuant to AS 01.05.031.

Sec. 18.07.081. Proceedings for modification, suspension, and revocation. (a) The office, a member of the public who is substantially affected by activities authorized by the certificate, or another applicant for a certificate of need may initiate a hearing to obtain modification, suspension or revocation of an existing certificate of need by filing an

accusation with the commissioner as prescribed under AS 44.62.360. No revocation, modification, or suspension of an outstanding certificate may be undertaken unless it is in accordance with AS 44.62.330 — 44.62.630.

(b) The certificate holder may obtain modification of an existing certificate by utilizing the application procedure enumerated in regulations adopted under this chapter.

(c) A certificate of need shall be suspended if an accusation is filed before the commencement of activities authorized under AS 18.07.041 which charges that factors upon which the certificate of need was issued have changed, or new factors have been discovered which significantly alter the need for the activity authorized. A suspension of a certificate may not exceed 60 days. At the end of this period or sooner, the office shall revoke or reinstate the certificate.

(d) A certificate of need may be revoked if

(1) the sponsor has not shown continuing progress toward commencement of the activities authorized under AS 18.07.041 after six months of issuance;

(2) the applicant fails, without good cause, to complete activities authorized by the certificate;

(3) the sponsor fails to comply with the provisions of this chapter or regulations adopted under this chapter;

(4) the sponsor knowingly misrepresents a material fact in obtaining the certificate;

(5) the facts charged in an accusation filed under (c) of this section are established; or

(6) the sponsor fails to provide services authorized by the terms of the certificate.

(e) It is unlawful for a person to file an accusation seeking suspension or revocation of a certificate of need under this section, knowing that the charges stated in the accusation are untrue or that his charges do not constitute grounds for revocation or suspension under this chapter. (§ 2 ch 275 SLA 1976)

Sec. 18.07.091. Injunctive relief; penalties; right of action. (a) Injunctive relief against violations of this chapter or regulations adopted under this chapter may be obtained from a court of competent jurisdiction at the instance of the commissioner, a holder of a certificate of need who is adversely affected in the exercise of the activities conducted in violation of the certificate, or any member of the public substantially and adversely affected by the violation. Upon written request by the commissioner, the attorney general shall furnish legal services and pursue the action for injunctive relief to an appropriate conclusion.

(b) A person who files an accusation seeking suspension or revocation of a certificate of need, knowing that his charges are untrue or that his charges do not constitute grounds for revocation or suspension

under this chapter, is guilty of a misdemeanor and upon conviction is punishable by a fine of not more than $1,000. The sponsor or holder of a certificate of need injured by the violation of AS 18.07.081(e) may recover damages for loss incurred by reason of delay caused by a suspension. (§ 2 ch 275 SLA 1976)

Cross references. — As to sentences for misdemeanors, see AS 12.55.135.

Sec. 18.07.101. Regulations. The commissioner shall adopt, in accordance with the Administrative Procedure Act (AS 44.62), regulations which establish procedures under which sponsors may make application for certificates of need required by this chapter and which govern the review of those applications by the office, establish requirements for a uniform statewide system of reporting financial and other operating data, and otherwise carry out the purposes of this chapter. (§ 2 ch 275 SLA 1976)

Sec. 18.07.111. Definitions. In this chapter

(1) "commencement of activities" means the visible commencement of actual operations on the ground for the construction of a building, the alteration of the bed capacity of a health care facility, or the provision for or deletion of an existing category of health services to consumers, which operations are readily recognizable as such, and which operations are done with intent to continue the work until such activities are completed;

(2) "commissioner" means the commissioner of health and social services;

(3) "complete activities" means the substantial performance of the work required to comply with the terms of issuance of the certificate of need to which all parties participating in those activities have obligated themselves to perform;

(4) "construction" means the erection, building, alteration, reconstruction, improvement, extension or modification of a health care facility under this chapter, including lease or purchase of equipment, excavation or other necessary actions;

(5) "council" means the Statewide Health Coordinating Council organized and operated in accordance with § 1524, P.L. 93-641;

(6) "department" means the Department of Health and Social Services;

(7) "health care facility" means a private, municipal, state or federal hospital, psychiatric hospital, tuberculosis hospital, skilled nursing facility, kidney disease treatment center (including freestanding hemodialysis units), intermediate care facility, and ambulatory surgical facility; the term excludes

(A) an Alaska Pioneers' Home administered by the Department of Administration under AS 44.21.020 (10) and AS 47.25.010 — 47.25.100; and

(B) the offices of private physicians or dentists whether in individual or group practice;

(8) "category of health services" means a major type, program, unit, division, or department of care provided through a health care facility whether inpatient or outpatient, including an outpatient department, psychiatric wing, kidney dialysis program, radiotherapy, burn unit, or newborn intensive care unit, except that "service" does not include the lawful practice of a profession or vocation conducted independently of a health care facility and in accordance with applicable licensing laws of the state;

(9) "health systems agency" means an entity organized and operated in accordance with § 1521(b), P.L. 93-641, engaging in health planning and development functions in a specified health service area of the state;

(10) "office" means the office of planning and research in the Department of Health and Social Services;

(11) "secretary" means the secretary of the United States Department of Health, Education and Welfare. (§ 2 ch 275 SLA 1976; am § 2 ch 25 SLA 1981)

Effect of amendments. — The 1981 amendment, retroactive to June 29, 1976, in paragraph (7), added the subparagraph designation (B) preceding "the offices of private physicians" and added subparagraph (A).

Editor's notes. — Section 1 of ch. 25, SLA 1981, provides: "The purpose of this Act is solely to clarify and confirm that Alaska Pioneers' Homes are not, and never have been, subject to the provisions of AS 18.07."

Section 1524, P.L. 93-641, referred to in paragraph (5), and § 1521(b), P.L. 93-641, referred to in paragraph (9), may be found in 42 U.S.C. § 300m-3 and 42 U.S.C. § 300m(b), respectively.

The United States Department of Health, Education and Welfare, referred to in paragraph (11), has been redesignated as the Department of Health and Human Services.

Chapter 08. Emergency Medical Services.

Section

10. Administration
20. Advisory Council on Emergency Medical Services
30. Composition
40. Term of office
50. Compensation and per diem
60. Meetings
70. Special committees
80. Regulations
82. Issuance of certificates
84. Certificate required
86. Immunity from liability
88. Penalty
90. Definitions

Collateral references. — 39 Am. Jur. 2d, Health, §§ 9-18.

39A C.J.S., Health and Environment, §§ 3-17.

extension which the office considers appropriate. No temporary certificate may be granted for a period longer than necessary for the sponsor to obtain review of the action certified by the temporary certificate under AS 18.07.051. Application for a certificate of need under AS 18.07.041 must commence within 60 days of the date of issuance of the temporary certificate. (§ 2 ch 275 SLA 1976; am § 42 ch 59 SLA 1982)

Effect of amendments. — The 1982 amendment, effective May 28, 1982, deleted "(a) and" preceding "(b) of this section" in the first sentence of subsection (c).

Sec. 18.07.091. Injunctive relief; penalties; right of action.

NOTES TO DECISIONS

Applied in South Cent. Health Planning & Dev., Inc. v. Commissioner of Dep't of Admin., Sup. Ct. Op. No. 2359 (File No. 5633), 628 P.2d 551 (1981).

Sec. 18.07.111. Definitions. In this chapter

(1) "commencement of activities" means the visible commencement of actual operations on the ground for the construction of a building, the alteration of the bed capacity of a health care facility, or the provision for or deletion of an existing category of health services to consumers, which operations are readily recognizable as such, and which operations are done with intent to continue the work until such activities are completed;

(2) "commissioner" means the commissioner of health and social services;

(3) "complete activities" means the substantial performance of the work required to comply with the terms of issuance of the certificate of need to which all parties participating in those activities have obligated themselves to perform;

(4) "construction" means the erection, building, alteration, reconstruction, improvement, extension or modification of a health care facility under this chapter, including lease or purchase of equipment, excavation or other necessary actions;

(5) "council" means the Statewide Health Coordinating Council organized and operated in accordance with § 1524, P.L. 93-641;

(6) "department" means the Department of Health and Social Services;

(7) "health care facility" means a private, municipal, state or federal hospital, psychiatric hospital, tuberculosis hospital, skilled nursing facility, kidney disease treatment center (including freestanding hemodialysis units), intermediate care facility, and ambulatory surgical facility; the term excludes

(A) an Alaska Pioneers' Home administered by the Department of Administration under AS 44.21.020(10) and AS 47.25.010 — 47.25.100; and

(B) the offices of private physicians or dentists whether in individual or group practice;

(8) "category of health services" means a major type, program, unit, division, or department of care provided through a health care facility whether inpatient or outpatient, including an outpatient department, psychiatric wing, kidney dialysis program, radiotherapy, burn unit, or newborn intensive care unit, except that "service" does not include the lawful practice of a profession or vocation conducted independently of a health care facility and in accordance with applicable licensing laws of the state;

(9) "health systems agency" means an entity organized and operated in accordance with § 1521(b), P.L. 93-641, engaging in health planning and development functions in a specified health service area of the state;

(10) "office" means the office of planning and research in the Department of Health and Social Services;

(11) "secretary" means the secretary of the United States Department of Health, Education and Welfare.

(12) "certificate" means a certificate of need issued by the office under AS 18.07.041 or AS 18.07.071. (§ 2 ch 275 SLA 1976; am § 2 ch 25 SLA 1981; am § 43 ch 59 SLA 1982)

Effect of amendments. — The 1982 amendment, effective May 28, 1982, added paragraph (12).

NOTES TO DECISIONS

Health care facility. — Federal law defines a skilled nursing facility in a manner which includes such facilities when they are contained in larger institutions such as pioneer homes (42 C.F.R. § 100.102(e)(4) (1979)). Alaska state law was meant to be no less comprehensive. South Cent. Health Planning & Dev., Inc. v. Commissioner of Dep't of Admin., Sup. Ct. Op. No. 2359 (File No. 5633), 628 P.2d 551 (1981).

Chapter 16. Regulation of Abortions.

Sec. 18.16.010. Abortions.

NOTES TO DECISIONS

Quoted in Cleveland v. Municipality of Anchorage, Sup. Ct. Op. No. 2390 (File No. 4956), 631 P.2d 1073 (1981).

northern alaska health resources association, inc.

February 03, 1983

The Honorable Albert Adams
Alaska State Legislature
Pouch V (MS 3100)
Juneau, Alaska 99811

Dear Representative Adams:

The Board of Directors of the Northern Alaska Health Resources Association has discussed the issue of repeal of the Certificate-of-Need (CON) law as currently proposed in HB 19. We reached agreement that a modified CON process is preferable to repeal. Although we recognize that there are problems with the current process, we believe that they can be solved by making major revisions in the regulations rather than by repealing the law. There is little disagreement that the threshold limits that trigger CON review are too low or that review of many non-clinical expenditures is a nuisance. Moreover, the process should be tightened up so that reviews are completed in a timely and efficient manner.

There are several reasons why we believe the CON process should be retained; however, the most important reason has to do with citizen participation in deciding what health care services and facilities are most appropriate and affordable for a specific community or region of the state. The issue has not been whether a CON should be approved or denied but rather that a discussion or negotiation has taken place between the community and health-care facility regarding local, regional and statewide needs. The Certificate-of-Need process has been a forum for these discussions and has served to guide the appropriate development of health care services and facilities throughout the state.

A recent trend has been to appropriate increasing amounts of public funds for construction or expansion of health care facilities in Alaska (i.e., $31,500,000, FY 81-82). Moreover, we are seeing the cost of health care increasing at a rate which has been consistently higher than the general rate of inflation. It has been demonstrated that capital investment contributes significantly to the growth of total hospital expenditures. Although it is true that general inflation, sophisticated technology, and increasing staff requirements also contribute to rising costs of hospital care, hospital capital investments add to the operating costs by an amount in excess of the value of the investment. In April, 1982, Arthur D. Little, Inc., a health economics consulting firm under contract with the National Center for Health Services Research, estimated that the present value of additional operating expenditures in the next ten years is $1.84 for every dollar invested in capital improvements, exclusive of depreciation and debt service. Uncontrolled

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capital expenditures for more or bigger health care facilities can only serve to drive up operating costs at an accelerated rate. These increased costs are ultimately passed on to the patient or community. We believe that people must continue to have the opportunity and responsibility through the CON process to determine what level of health services they are willing to pay for. Competition in the health care field essentially does not exist, especially in Alaska where most communities cannot afford more than one health care facility; therefore, the only way that we can keep a lid on overbuilding is through a capital expenditures review program similar to the current Certificate-of-Need program.

Several states have already revised their CON process (among them Colorado and New Mexico) with full support of their respective state hospital associations. Revision of Alaska's CON process must occur if we expect to see the process work as it was designed to do. The following revisions are offered for consideration:

1. Increase the threshold level which triggers a CON review from $150,000 to <u>at least</u>:

   a. $600,000 for capital expenditures
   b. $400,000 for major medical equipment
   c. $250,000 for operating expenses associated with new services.

2. Exempt all non-clinical capital expenditures. The bill should indicate that non-clinical services which are not subject to review include, but are not limited to: parking, telephone systems, day care, mailrooms, heating and air conditioning, blood bank, dietary/cafeteria, laundry and linen, medical records, business office, housekeeping, central supply, library, reception, and data processing. This exemption would apply only if one of these non-clinical projects was the main purpose of the application. For example, a project proposing a new facility could still include review and consideration of the non-clinical activity if it were part of a larger project.

3. Expedite review of capital equipment replacement.

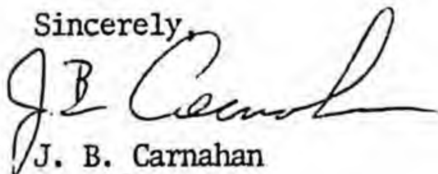
4. Specify a time limit for a decision by the Commissioner subsequent to a recommendation by the regional health planning agency.

5. Provide that each legislator be informed of all projects in his/her district, especially regarding the outcome of the review.

6. Consider a sunset provision of four or more years to review effec iveness of the CON process.

In summary, there is little disagreement that there are problems with the current CON process; however, the forum that the CON process provides for community discussion about the relative merits of a proposed project far outweigh what we perceive to be correctable problems. We recommend revision of the CON process rather than repeal.

Sincerely,



J. B. Carnahan
President

JBC:flr

cc: William Sheffield
Governor

Robert London Smith, Ph.D.
Commissioner, DHSS

Alaska Health Coalition

Southeast Alaska HSA

South Central Health Planning
and Development, Inc.

CERTIFICATE OF NEED PROGRAM

The Certificate of Need program was instituted by the Federal government, along with health planning concepts as a tool to stem the rapid growth rate of the health care industry(currently consuming nearly 10% of the GNP).

Certificate of Need is a review process conducted by the state health planning agency, including local input and public hearings, to determine the need for new health facility construction and equipment acquisition. The review process takes into consideration other facilities in the geographic area, or other facilities serving the same patient population.

Certificate of Need carries sanctions from the Federal government tied to other monies received by the state in Public Health areas, mainly related to block grants. No state has ever had funding denied on the basis of non-compliance with the program, nor has any other state attempted to repeal this program.

The current administration in Washington has contemplated the elimination of the program for over two years, intending to replace it with a form of marketplace competition to control growth. However, since the health care industry has never behaved as other business enterprises do (the growth rate in health care always exceeds the inflation rate common in any other industry, and is currently between 15 and 17% yearly and on the rise), the Reagan policy makers have been unable to conceive of a plan to replace Certificate of Need.

Much discussion has revolved around the value of the program, since the major attribute appears to be the discouragement of frivolous ventures which could not be justified to the review process. This program is the only control mechanism available to the state at this time to control duplication and unnecessary facilities and services.

The current threshold levels for review are artifically low in comparison to costs in the industry, as an attempt to raise the levels to federally approved standards by the 1982 Senate HESS Committee did not pass the legislative process. (approved levels are now $400,000 for equipment and $600,000 for construction plus a yearly inflationary factor).

A health planning bill passed the House in Congress in December of 1982 but was stymied in the Senate by the addition of a gasoline tax. Efforts are currently evident in Washington to retain the program and raise the threshold to one million dollars for all levels, although it is difficult to second guess what may happen. Sanctions against non-compliance have been suspended through September 30, 1983 by a continuing resolution, but even in this light many other states have opted to raise threshold levels for review process (Colorado has raised levels the highest, to $750,000).

Arguments for the repeal of the program mostly relate to the costliness of the review process, and that marketplace economics will control growth. In order to consider these arguments, one has to look at the questions asked in the review process:

The relationship of the proposed project to the applicable local and State Health Plans as well as any long-range plans (if any) for the health facility;

The need that the population to be served has for the proposed project;

The availability of less costly or more effective alternatives;

The immediate and long-term financial feasibility of the proposal, as well as the probable impact of the proposal on the costs of and charges for providing health care services;

The relationship of the purposes proposed to be provided to the existing health care system;

The availibility of resources (including health manpower, management personnel, and funds for capital and operating needs) for the provision of the services proposed;

The relationship, including the organizational relationship, of the health services proposed to be provided to ancillary or support services; and

The costs and methods of the proposed construction, including the costs and methods of energy provision.

These eight standards would, presumably have to be justified anyway in any attempt to receive financing through an institution, and would appear to be good planning policy. The most expensive plan ever submitted to the state of Alaska reportedly cost $25,000, although consultants and planners need not be hired. Most hospitals in the state have done C.O.N. applications internally or have borrowed planners from other facilities (Soldotna, Kenai and Valdez use resources of the Fairbanks Memorial Hospital). Many hospitals have also used their proposals for bid applications for construction. C.O.N. also includes public input locally through a hearing process which may not be available otherwise.

Marketplace competition does not work in the health care industry, and would be particularly ineffective in Alaska since all locations except Anchorage have no alternative institutions. The basic premise of market place economics assumes a willing , competent and knowledgeable buyer who is offered a reasonable opportunity to make a choice for competitive pricing to occur. Since physicians have relationships to one particular hospital where they have priviledges, and refer their patients there for treatment, this line of thinking will not support such a statement. Small hospitals in this state are moving in the direction of more regional care through expansion to more specialized services within the community. Planning for the inter-relationship of these services with large facilites may not be accomplished without a unified state planning function (It should be noted here that the state health planning agency has been defunded in the FY 84 Executive budget)

Current expansion plans in Anchorage support the fact that marketplace economics is not a viable solution. Even though the Municipal Health Commission in Anchorage has projected that Anchorage will need only 456 to 514 beds in 1990, plans by Humana and Providence, if allowed to procede unheeded would add 178 to 236 unnecessary beds to the community. Competition in this case seems to apply to construction and not to fair pricing.

The two Certificate of Need applications currently being considered for the Anchorage area are:

Humana - 93 beds - $20 million ($56 million with interest) 65% occupancy
Providence - 150 beds - $80 million ($185.6 million with interest) 90% occupancy.
(These do not include any reference to the approved Certificate of Need for the Lake Otis Hospital - 125 beds)

What effect do these proposals have on state revenues, and what would be the further effect if the Certificate of Need program were repealed allowing facilities to build at will?

Revenue Sharing for Hospitals AS 29.90 provides a yearly amount of $250,000 or $1,000 per bed to hospitals for operating expenses.

C & RA Hospital Construction Assistance provides for repayment of a quarter of the construction costs(including interest) within the first five years, with no repayment clause for situations like the sale of the Teamster Hospital to Humana.

How will insurance premiums be affected by repeal?

The Medicaid Program(52% state funds) and the General Relief Medical Program(100% state funds) will also be affected by any construction, since the Medicare guidelines allow a percentage of construction costs related to applicable patient caseload to be added to reimburseable costs. The state's Medicaid program alone has risen from $4 million in 1972 to almost $70 million in 1984 (projected, but due to an additional increase through added caseload of up to 2,000 from withdrawal of Indian Health Service non-native dependents).

When visiting Providence Hospital last year with the Senate HESS Committee, we were told that the percentage of Medicaid clients was 13, even considering a 10% client caseload, this will add over $18 million to the Medicaid budget for Providence proposed construction alone. If the Federal "CAP" on Medicaid goes into effect, these costs will simply be shifted to other third party payors and not absorbed by the hospitals, whether or not the beds remain unused.

The health insurance industry and the Municipal Health Planning Commission of Anchorage are opposed to the repeal of Certificate of Need, and the Legislature <u>must</u> ask itself if we can afford to give up the only control on health expenditures available to the state.

Transition Briefing Memo 21

October 28, 1982

1. CERTIFICATE OF NEED IS STILL PLANNING'S "CENTER RING" ACTIVITY

Despite the fact that 15 states have written "sunset" provisions to end Certificate of Need in the next two years, review of proposed capital investments is still the number one priority of many State Agencies and HSAs.

In the West and across the nation, the number of applications and the dollar value of hospital proposals have been rising dramatically. Last year, California experienced a 50 percent increase in the number of CON applications. The proposed capital cost of all proposals in California climbed nearly 100 percent from 1980, totalling $696 million in 1981. Add to that $309 million for replacement projects, which were exempt under the California CON statute, and the total is more than $1 billion in health facility capital investment in California 1981.

In Denver, five hospitals completed to build a new facility in the South Denver metro area. The proposals were denied after the Governor and the employers' coalition testified in opposition. In Contra Costa County, a bedroom surburb of the San Francisco Bay Area, the Alameda-Contra Costa HSA has received seven letters of intent for applications whose capital cost may exceed $100 Million. Many agencies similarly report a surge of CON applications in the past 18 months.

Given limited staff resources and volunteer energy, some agencies are questioning how much priority they should give to Certificate of Need and capital expenditure review.

A new study by Arthur D. Little, Inc., suggests that CON and capital expenditure review are definitely cost-effective. In a study prepared for the Office of the

Western Center for Health Planning

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Sponsored by the Western Consortium for Continuing Education for the Health Professions, Inc., Schools of Public Health and University Extensions, University of California at Berkeley, University of California at Los Angeles, University of Hawaii. Affiliate: Graduate Program in Health Services Administration, University of Southern California

Assistant Secretary for Health*, the consultants made the following findings:

- CON has been an effective inhibitor of rising capital expenditures in a study of five states (Colorado, Florida, Maryland, Massachusetts and Oregon), in the period 1974-78;
- CON/capital expenditures review programs were successful in averting 13 percent of hospital projects and saving 16 percent of the proposed capital investments;
- The CON process is not dominated by teaching hospitals or facilities with higher rates;
- CON programs have a dampening effect on the amount of capital investment in the state;
- New capital investments increase costs--over a 10-year period $1 of new capital is estimated to generate $1.84 of additional operating costs, in constant dollars;
- Increases in operating costs due to new capital investment was highest in proprietary hospitals ($0.33), compared with government ($0.20) and community hospitals ($0.16);
- Capital investments in equipment generate a larger increase in annual operating costs; and
- If every hospital annually reinvested 5 percent of its operating budget in new capital stock (beds, equipment, other), the operating costs would be increased by 10 percent each decade even without inflation.

The consultants concluded that if competitive approaches to controlling health care costs are to succeed, it may be necessary to continue capital expenditure review programs and controls until cost-reducing competitive systems are functioning. They predict the immediate effect of deregulating

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*Development of an Evaluation Methodology for Use in Assessing Data Available to the Certificate of Need (CON) and Health Planning Programs", Final Report, Arthur D. Little, Inc., Cambridge, MA, April, 1982.

hospital investment in the name of competition will be a surge in hospital operating expenditures. Health Planning has the potential to significantly lower hospital costs, an important policy finding in light of the Administration's proposed elimination of both planning and Certificate of Need.

2. ROCHESTER'S "MINICAP" PROJECT reported a 10 percent increase in hospital costs in 1982, barely half the national rate of 18.7 percent. Nine Rochester (New York) hospitals are participating in the second year of a five-year experiment in voluntarily living within a community-wide revenue cap.

The Rochester program was profiled in the Western Center's recent conference "Hospital Rate Regulation: Lessons for California from Mandated and Private Approaches". Hospitals improved their fiscal position this year with all nine in the black despite declining admissions and a difficult economy. The experimental reimbursement program provides predictable income, greatly enhancing liquidity and cash position. New York hospitals are under great financial pressure now with nine out of ten voluntary hospitals operating in the red for at least two of the five years from 1974-78. The Rochester experience is demonstrating that implementing a voluntary financial discipline -- with appropriate mechanisms -- can be beneficial both to the hospitals and the community. The program, with cooperation of the local Health Systems Agency and State agency has allowed service improvements and capital investments in the hospitals. A contingency fund helps hospitals adjust to changes in patient volume during the year, and subsidizes operating revenues for approved Certificate of Need projects.

A copy of the report, "Affordable Health Care: Rochester Area Hospitals Strategies for the 80's," is available from the Western Center's Reference Service. For more information about the program, contact James A. Block, M.D., President, Rochester Area Hospitals' Corporatopn, 220 Alexander Street, Suite 608, Rochester, New York 14607.

3. SPECIAL PLANS AND PROJECTS

Congressional extension of funding for health planning suggests that the emphasis upon "transition" may be shifting back to planning. A number of agencies have developed special plans, or intend to do so in the coming year. These "special plans" are often the outcome of studies or implementation efforts. The special plans are usually problem-specific, or focus on the special health needs of a particular population group or region within the Health Service Area. Outside

funding or "co-production" with a cooperating agency has made a number of these special plans possible.

Western Center staff have developed a list of possible "special plans" which HSAs and State agencies might develop, including:

- "Year 2000" Health Plan
- Regional Capital Investment Plan
- Community Health Promotion Plan
- Regional "Quality of Life" Assessment
- Medicaid Plan
- Health Plan for the Aged
- Community Services Cutback Plan
- Block Grant Plan
- County Health Plan (City or other local region)
- "Boomtown" Plan
- Categorical Disease Plan, e.g., Regional Cardiac Care Plan
- Rural Health Plan
- Facility-Specific Plan, e.g., Free-standing Emergency Rooms Plan

The Center is conducting a survey in November of all HSA special plans. The result will be a published compendium of all of the plans, with a short description, funding, outside resources and responsible staff. The special plans will be abstracted for computerization as part of a national project by all three Centers to develop a "Plan Document File" for computerized search of all plans developed by Health Systems Agencies and State planning agencies. Copies of the special plans will be available through the Western Center's Reference Service. For information, contact Rus Coile, Western Center staff, telephone: (415)546-7601.

This project has been funded with Federal Funds from the Health Resources Administration, Department of Health and Human Services, under contract HRA 232-79-0037. The contents of this publication do not necessarily reflect the view or policies of the Department of Health and Human Services, nor does mention of trade names, commercial products, or organizations imply endorsement by the U.S. Government.

PROVIDENCE
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SERVING IN THE WEST SINCE 1856

January 26, 1983

The Honorable Albert P. Adams
Alaska State House of Representatives
State Capitol
Pouch V
Juneau, Alaska 99811

Position Paper on HB 19 and a companion bill being submitted to the Senate -- pertaining to an "Act repealing the certificate of need program."

Dear Representative Adams:

Providence Hospital joins the rest of the hospitals in this state in requesting the repeal of the certificate of need law and endorsing House Bill 19 (Fritz and Hayes) and the companion bill about to be submitted to the Senate. The process which this law sets in place is cumbersome and wasteful and totally inappropriate for Alaska.

The major impetus for the law was to control excess hospital beds in many large cities and to help control rising health care costs. The belief was that by controlling the number of beds, capital expenditures and new services, costs would be contained. The results have been much less than desirable throughout the country, and, in Alaska, have been needless, wasteful, cumbersome and costly.

The lack of success in Alaska is better termed overkill. Designed for areas of heavy population, excess hospital beds and competition, the law does not work and is inappropriate for our small state for several reasons:

- The law only covers private facilities, and does not cover public health, military or state owned institutions.
- Alaska has only one city with more than one hospital, and there are only three hospitals in the whole state (eligible for review) of over 100 beds.
- The law is reactive to existing decision making processes. Hospitals in Alaska already have local public review and approval designed in their own budget review processes. Many hospitals are owned by

municipalities, and all have governing boards or advisory boards of local citizens. These citizens and municipalities should have control of the expansion and budgetary decisions of their own institutions. Several other layers of bureaucracy and review are cumbersome, costly and inefficient. For our Certificate of Need, the following is an actual review cycle showing the different bureaucratic levels we had to go through just to have a decision made on one project.

Letter of intent to file certificate of need

Pre-application conference (HSA, Municipal Health Commission, State)

Public Hearing on Certificate of Need Application (State)

Joint Project Review (HSA and Municipal Health Commission)

Concurrent Review (HSA and Municipal Health Commission)

Board Review (Municipal Health Commission)

Board Review (HSA and Southcentral Health Planning & Development Agency)

Commissioner's Review (State)

From the time of holding the application conference to the ultimate decision by the Commissioner, the process has taken over a year.

- The law places a costly burden on all institutions who have to prepare and submit Certificates of Need. The documents which need to be prepared are massive, require hundreds of hours of preparation and at least 35 each need to be produced for the review boards and other parties. The 110 day minimum time period for a review is unrealistic, and often times, the institutional cost of delaying implementation means an eventual increase in price of the piece of equipment or construction project due to inflation.

- The law also passes on a cost to the public in that state, regional and local staff are needed to coordinate the program, prepare staff analyses and hold public meetings. We are estimating that the cost of state, regional and local staffs have increased the cost of health care by at least $8,000,000 in the last six years.

- The dollar limit for what must be reviewed is absurdly low. In 1982 alone, Providence spent hundreds of man hours and other monies preparing six CON applications for such things as a $167,000 replacement incinerator (the old one being 25 years old was required to be replaced by both State and EPA codes!); a CT scanner and Cath lab replacement; and a $250,000 computer enhancement for an x-ray machine. Believe it or not, the STATE did not give approval on the incinerator until the 90th and final day for a decision to be made.

The Alaska State Hospital Association is unanimous in endorsing the repeal of the CON law. We have also received indications from several legislators and the Alaska Medical Association that repeal of the CON law would be best for a growing state such as Alaska.

We are supportive of local planning for Alaska's health care needs. The process, however, should be positive and proactive -- encouraging institutions to respond to needs in the community -- not negative, reactive and cumbersome.

Your support in repealing the certificate of need law in Alaska would be appreciated. With an early response and passage of HB 19 or the companion bill in the Senate, a tremendous and costly burden will be lifted from Alaska's hospitals.

Thank you for your consideration.

Sincerely,

Al M. Camosso
Administrator

3/6/83 Seattle P.I.

Hospital costs may be fueled by agency cuts

By Robert Pear
New York Times

WASHINGTON — The amount of money spent to build and renovate hospitals has increased dramatically in the last two years.

The increased spending — and resulting increased hospital bills — is apparently due in part to Reagan administration efforts to abolish the federal health-planning program designed to prevent excessive spending.

State officials report a surge of investment proposals from hospitals responding to the administration's attempts to remove controls on the construction of health-care facilities.

The administration says the use of federal money for health planning is inconsistent with its strategy of trying to restrain medical costs by promoting competition in health-care services.

But some state officials said the government's effort to curtail regulation is leading to a "building boom" in hospitals that could further drive up medical costs, already rising nearly three times as fast as the Consumer Price Index.

(Washington state hasn't seen any boom, according to one state official. Frank Chestnut, supervisor of the certificate of need unit at the state Office of Health Planning and Development, said hospital capital spending here has increased, but at a slowing rate. The state approved 386 new hospital beds last year, as opposed to 478 in 1981, he said. Proposals from hospitals for new capital expenditures declined from $284 million in 1981 to $242 million in 1982.)

Robert M. Crane of the New York State Health Department said providers of health care are acting on the theory that "the health-planning system is in disarray, so let's build while we can."

The Alpha Center, a private, non-profit corporation partly supported by the federal government, did a telephone survey of 35 states to determine the value of capital outlays approved by state health-planning agencies in the last four years. Capital outlays finance the construction and modernization of hospitals and nursing homes and the purchase of major medical equipment.

Total outlays in the 35 states increased from $4 billion in 1979 to nearly $11 billion last year.

Health officials and economists suggested several reasons for the increase in spending on hospital construction and equipment.

These included inflation, the need to replace or renovate hospitals built with federal money in the 1950s and 1960s, and the intense competition among hospitals to obtain the latest medical technology.

New York state officials are considering whether to impose a one-year moratorium on major capital spending projects so that hospitals and nursing homes can systematically plan their growth for the next five years.

Supporters of health planning say the increase in capital spending shows the need to continue federal support. But critics cite the figures as evidence that the program has not worked.

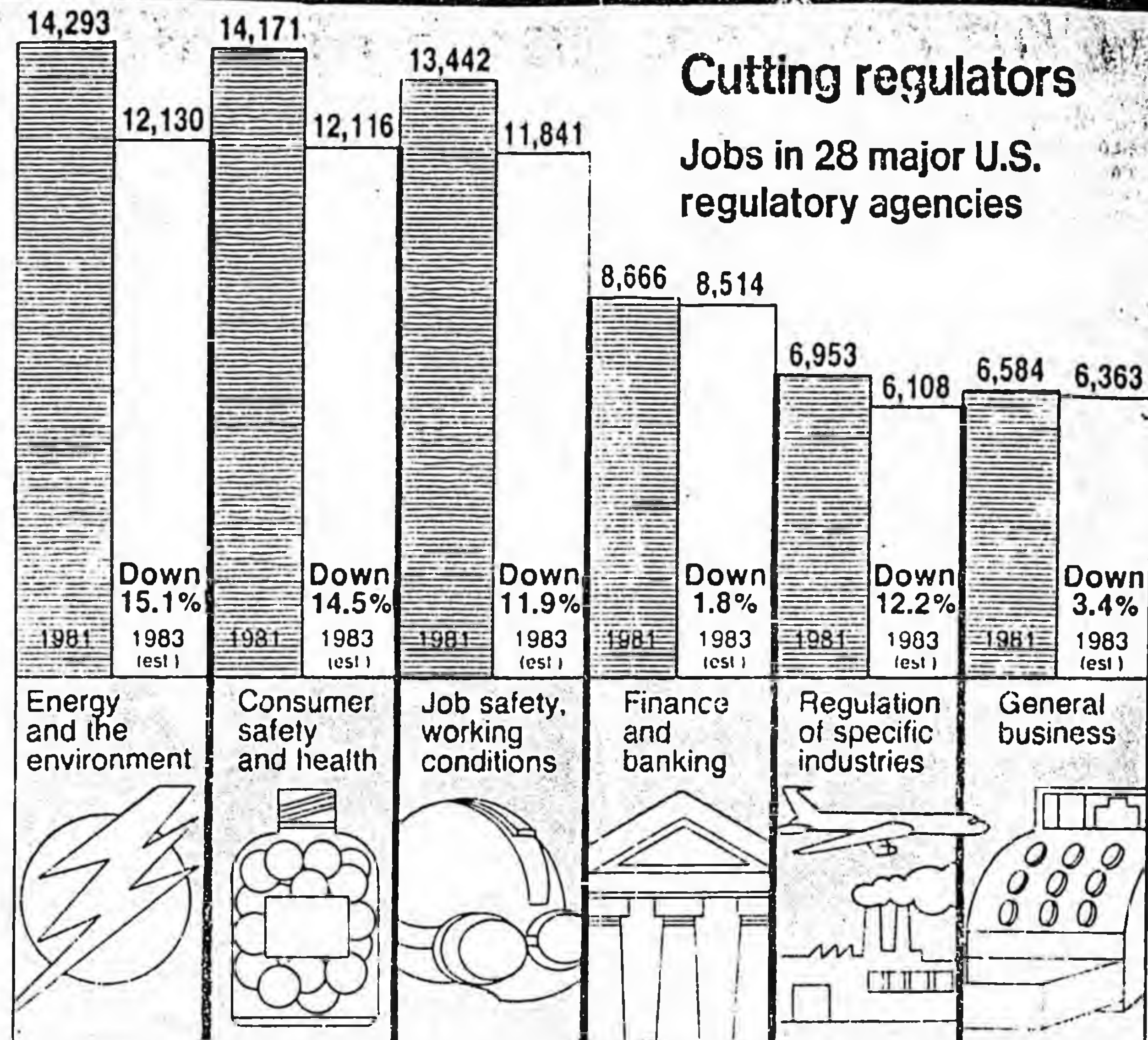
When Congress established the health-planning program in 1974, it directed states to scrutinize the need for hospital investment in new facilities, services and equipment.

A recent study by the Congressional Budget Office said there was no evidence that such reviews had restrained the growth in hospital investment and costs. But it added, "Some applications have been altered, withdrawn or denied as a result of the review process."

Health economists have estimated that each dollar spent by a hospital on plant and equipment increases operating costs by 30 cents a year. The government helps pay these costs by reimbursing hospitals for the depreciation of their facilities and the interest on money borrowed for construction.

The administration has sharply cut federal health-planning funds, from $128 million in the fiscal year 1981 to $65 million last year and again this year. In prior years, federal outlays rose steadily, to a high of $167 million in 1980.

Jay B. Constantine, a health-policy consultant, said: "Hospitals know there will be restraints on reimbursement for capital expenditures after several years. So obviously, they are racing to make those expenditures now, while health planning is in a weakened state, before the lid comes on."



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Cardiology

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Leo B. Bustad M.D.

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Internal Medicine
Gilbert P. Blankinship M.D.

March 16, 1983

Representative Albert P. Adams
Pouch V
Juneau, Alaska

Dear Representative Adams:

I am writing this letter to encourage you to repeal the present "Certificate of Need law" which requires multilayered local and Department of Health and Social Service review of all health facilities which anticipate expansions costing more than $150,000 and the development of new services costing any amount.

This law was joisted upon Alaska and many other states under the guise of "cost saving" and "planning." There were financial inducements for states to develop these laws.

The Certificate of Need law requires that applications for new services and expenditures for expansion of health facilities be reviewed by quasigovernmental boards made up of consumers and "providers" organized into health systems agencies. The State of Alaska has three health systems agencies. I sit as a board member on the South Central Alaska HSA (South Central Health Planning and Development, Inc.).

After participating in this review process, I have observed that the Certificate of Need law requirements are neither planning nor cost saving. A sizeable fraction of my fellow board members agree.

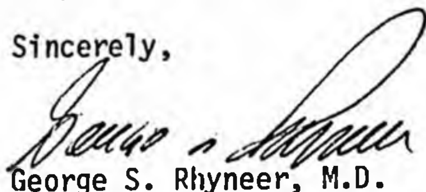
In support of the Certificate of Need law, some national health planners and federal government agencies claim that the Certificate of Need legislation has prevented unnecessary duplication of services in some parts of the country. This may or may not be true in New York City, Los Angeles and Philadelphia; but the law certainly prevented the early distribution of CAT scanners in many communities, thus dooming some of its citizens in those areas to unnecessary operations, dangerous alternative tests and misery, possibly death. Thus, is the history and potential of this law.

As to cost savings - evidence for this is difficult to find elsewhere, and cannot be demonstrated in Alaska at all. In fact, we have been trying to improve services and availability of medical care in Alaska, only to have a law eat into our limited financial resources by requiring publication of expensive application documents, many which have cost thousands of dollars - dollars which small communities like Glennallen, Palmer, Kodiak, Valdez and Cordova do not spend foolishly. Even the larger communities must put up with unnecessary expenses and maddening delays due to the review process.

Finally, the law has nothing to do with health planning at all; in fact, it is the antithesis of planning. If you check with the health workers in your community, you will find that it is the local professionals who have done the planning. When a community has required new or improved facilities, it has been a community need, recognized by all, and planned by the appropriate hospital service boards with community business and leader support that has generated the plan for community health. After these professionals have spent hundreds or thousands of hours and thousands of dollars planning, applications are reviewed by amateurs for several hours at most.

Talk with your own physician, hospital administrator, community hospital board member or civic leaders. Please work to eliminate this harmful law by supporting House Bill 19.

Sincerely,



George S. Rhyneer, M.D.

2801 DeBarr Road
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Anchorage, Alaska
99508
Telephone 907 276-1131

**Humana Hospital
Alaska**

March 11, 1983

The Honorable Representative Milo H. Fritz
Pouch V
Juneau, Alaska 99811

Dear Representative Fritz:

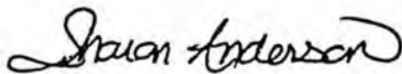
I have researched the literature regarding the effectiveness of Certificate of Need and I am sending you a summary (however lengthy) of my findings for your use on HB 19.

I hope you will find this helpful, please call me if I can be of further assistance. (276-1131, Extenstion 330)

At your request I was able to locate a chart which indicates the State and Local Taxes in various states (Money Magazine, February 1983). This, too, is included.

Best of luck to you. I appreciate the opportunity to assit you and look forward to meeting you.

Sincerely,



Sharon A. Anderson
Director of Planning & Professional Relations

SAA:in
Enclosure

STATE AND LOCAL TAXES

		Average for all incomes	Average and (rank) for selected income brackets (adjusted gross)				
			$20,000 to 30,000	$30,000 to 40,000	$40,000 to 50,000	$50,000 to 100,000	$100,000 to 200,000
1	NEW YORK	$4,088	$2,940 (1)	$4,013 (1)	$5,395 (1)	$8,648 (1)	$26,975 (1)
2	MASSACHUSETTS	3,364	2,753 (2)	3,484 (3)	4,604 (3)	6,447 (4)	16,982 (4)
3	DISTRICT OF COLUMBIA	3,260	2,350 (5)	3,222 (5)	4,135 (5)	6,293 (5)	13,391 (15)
4	MARYLAND	3,134	2,451 (4)	3,276 (4)	4,070 (6)	5,798 (10)	14,675 (10)
5	WISCONSIN	3,099	2,538 (3)	3,524 (2)	4,632 (2)	6,947 (2)	17,831 (2)
6	MINNESOTA	2,98[illegible]	2,163 (9)	3,186 (6)	4,2[illegible]4 (4)	6,820 (3)	17,557 (3)
7	MICHIGAN	2,878	2,327 (6)	3,106 (7)	3,921 (7)	5,275 (13)	12,938 (16)
8	DELAWARE†	2,870	1,852 (17)	2,504 (17)	3,57[illegible] (13)	5,864 (9)	14,475 (11)
9	NEW JERSEY	2,862	2,045 (11)	2,775 (12)	3,425 (17)	5,174 (16)	11,942 (19)
10	RHODE ISLAND	2,861	2,228 (8)	2,926 (8)	3,789 (9)	5,736 (11)	16,703 (5)
11	CALIFORNIA	2,795	1,933 (15)	2,646 (14)	3,662 (12)	5,918 (8)	13,998 (12)
12	HAWAII	2,775	2,084 (10)	2,858 (10)	3,827 (8)	5,555 (12)	16,386 (6)
13	VERMONT	2,678	2,250 (7)	2,817 (11)	3,701 (11)	6,003 (7)	15,451 (9)
14	OREGON†	2,513	2,011 (12)	2,887 (9)	3,714 (10)	5,259 (14)	16,217 (7)
15	CONNECTICUT*	2,488	1,638 (26)	2,136 (29)	2,711 (29)	4,765 (21)	8,467 (34)
16	VIRGINIA	2,448	1,978 (13)	2,382 (22)	3,424 (18)	4,774 (20)	11,421 (20)
17	PENNSYLVANIA	2,343	1,942 (14)	2,541 (16)	3,156 (23)	4,421 (25)	9,592 (29)
18	NEBRASKA	2,337	1,812 (18)	2,476 (19)	3,435 (16)	4,937 (17)	13,758 (13)
19	MAINE	2,297	1,751 (21)	2,768 (13)	3,526 (14)	6,164 (6)	16,137 (8)
20	NORTH CAROLINA	2,226	1,768 (20)	2,468 (20)	3,461 (15)	5,212 (15)	13,512 (14)
21	ILLINOIS	2,194	1,733 (22)	2,224 (28)	2,754 (27)	3,997 (31)	8,667 (33)
22	COLORADO	2,147	1,723 (23)	2,500 (18)	3,184 (22)	4,237 (27)	7,396 (38)
23	IOWA	2,127	1,679 (25)	2,257 (27)	2,944 (26)	4,819 (19)	12,276 (17)
24	UTAH	2,093	1,886 (16)	2,608 (15)	3,353 (19)	4,712 (23)	9,372 (31)
25	KENTUCKY	2,067	1,688 (24)	2,362 (23)	3,072 (24)	4,215 (28)	9,086 (32)
26	GEORGIA	2,028	1,555 (29)	2,264 (26)	3,040 (25)	4,482 (24)	9,609 (26)
27	IDAHO	2,012	1,776 (19)	2,422 (21)	3,213 (21)	4,858 (18)	11,325 (21)
28	KANSAS	1,968	1,559 (28)	1,996 (33)	2,523 (34)	3,879 (33)	9,446 (30)
29	SOUTH CAROLINA	1,935	1,625 (27)	2,348 (24)	3,289 (20)	4,718 (22)	11,97[illegible] (18)
30	NEW HAMPSHIRE*†	1,909	1,532 (30)	2,043 (30)	2,705 (30)	3,348 (38)	7,570 (37)
31	OHIO	1,827	1,408 (34)	1,956 (35)	2,624 (32)	3,992 (32)	10,166 (25)
32	MISSOURI	1,790	1,431 (33)	1,964 (34)	2,753 (28)	[illegible]98 (34)	7,716 (36)
33	ARIZONA	1,770	1,492 (31)	2,035 (31)	2,682 (31)	4,[illegible]65 (26)	[illegible],200 (39)
34	MONTANA†	1,751	1,456 (32)	2,286 (25)	2,573 (33)	4,050 (30)	10,324 (23)
35	OKLAHOMA	1,686	1,228 (40)	1,[illegible]3 (36)	2,224 (38)	3,629 (36)	9,681 (25)
36	ARKANSAS	1,654	1,341 (37)	2,028 (32)	2,509 (35)	4,162 (29)	9,676 (27)
37	WEST VIRGINIA	1,637	1,211 (41)	1,559 (42)	2,076 (41)	3,309 (40)	10,663 (22)
38	ALASKA*	1,612	1,149 (42)	1,387 (45)	1,620 (45)	2,349 (44)	4,115 (48)
39	ALABAMA	1,556	1,346 (36)	1,838 (37)	2,226 (37)	3,439 (37)	6,443 (40)
40	NEW MEXICO	1,540	1,126 (44)	1,751 (39)	2,290 (36)	3,722 (35)	10,212 (24)
41	MISSISSIPPI	1,516	1,287 (38)	1,753 (38)	2,108 (39)	3,322 (39)	8,452 (35)
42	INDIANA	1,480	1,249 (39)	1,712 (40)	1,942 (42)	2,805 (41)	5,585 (42)
43	SOUTH DAKOTA*	1,407	1,397 (35)	1,438 (43)	1,924 (43)	2,730 (42)	3,504 (50)
44	NORTH DAKOTA	1,406	1,143 (43)	1,652 (41)	2,105 (40)	2,666 (43)	5,681 (41)
45	WASHINGTON*	1,258	1,041 (45)	1,389 (44)	1,578 (46)	1,944 (48)	4,201 (47)
46	TEXAS*	1,186	837 (48)	1,168 (49)	1,486 (48)	1,859 (50)	[illegible] (49)
47	FLORIDA*	1,173	849 (47)	1,199 (47)	1,703 (44)	2,086 (46)	4,545 (44)
48	TENNESSEE*	1,132	932 (46)	1,244 (46)	1,556 (47)	2,180 (45)	4,539 (45)
49	NEVADA*	1,062	834 (49)	1,192 (48)	1,225 (50)	1,889 (49)	4,794 (43)
50	LOUISIANA	1,002	757 (51)	1,017 (50)	1,262 (49)	1,954 (47)	4,475 (46)
51	WYOMING*	890	770 (50)	882 (51)	1,223 (51)	1,380 (51)	2,686 (51)
	ALL STATES	$2,414	$1,854	$2,491	$3,257	$4,857	$9,651

*States with no personal income tax. Connecticut taxes only capital gains and dividends; New Hampshire and Tennessee tax only interest and dividends.

†States with no sales tax.

Source: Internal Revenue Service

The Certificate of Need (CON) law provides one of the "tools" HSAs use in their attempt to control health care costs by preventing unnecessary investment by, and expansion of, health care facilities.

The Certificate of Need law has not accomplished its purpose, and should be repealed.

I have six main points which support this position and will provide in-depth information on each:

1. Several studies indicate that CON programs have not demonstrated the capacity to restrain cost increases.

2. Certificate of Need focuses on the issue of "excess system capacity" to the exclusion of the issues of immediate cost to the patient and the long-term cost savings to the overall system. CON is an entry barrier to technologically innovated firms.

3. Several states have concluded that CON is a failure and have enacted laws repealing the CON review process, either as of a specified date certain in the future or conditionally upon repeal of the federal health planning law.

4. Certificate of Need is not synonymous with health planning. For many years hospital boards have performed the role of Community involvement in health care planning, with enormous success.

5. The current programs for licensure, registration, credentialing, and accreditation of health care providers and institutions safeguard the quality of health care services and protect consumers.

6. Certificate of Need is inconsistent with a price competitve approach to containing health care costs.

1. Several studies indicate that CON programs have not demonstrated the capacity to restrain cost increases.

A review of the literature on effectiveness of certificate of need programs indicates that over 100 papers and/or studies have been completed. This information has been summarized, in part, under a contract with HEW. The summary, "Certificate of Need Programs: A Review, Analysis and Annotated Bibliography of the Research Literature," examined a number of general hypotheses concerning the effectiveness of CON. Some of the findings of the more significant hypotheses include:

1. CON will not control cost increases.

2. CON is expensive to administer.

3. CON stifles innovation in delivery mechanisms.

4. CON programs are hampered by the difficulty of developing standards.

In February, 1981, the Office of the Legislative Auditor of the State found:

> "no empirical evidence that Certificate of Need programs reduce hospital costs, and little evidence that they reduce capital investments."

One of the more comprehensive studies of CON was published by David S. Salkever of John Hopkins University and Thomas N. Bice of Washington Certificate of Need Laws on Health Care Costs and Utilization," concluded:

> "In summary, our analysis points to the (perhaps) surprising conclusion that CON controls have contributed to cost inflation; thus they have tended to produce the very result which they were designed to prevent. The presumption of its (CON) effectiveness is clearly not warranted by the available evidence."

2. Certificate of Need focuses on the issue of "excess system capacity" to the exclusion of the issues of immediate cost to the patient and the long-term cost savings to the overall system. CON is an entry barrier on technologically innovated firms.

A study conducted by Ernst and Whinney on Excess Bed Capacity in California found:

> "We also conclude that the regulatory focus on beds _per se_ is even less likely to yield significant results. Beds are not a good measure of capacity in the first place/and the funds to maintain beds _per se_ are a trivial portion of the total."
>
> "It is then equally unclear whether a policy directed toward capacity control can ever succeed in impacting the costs of health care to the consumers."

Certificate of Need inhibits entry and exit from the market and has been a cost-producing rather than a cost-containing mechanism.

3. Several states have concluded that CON is a failure and have enacted laws repealing the CON review process, either as of a specified date certain in the future or conditionally upon repeal of the federal health planning law. These include Arizona, Kansas, Minnesota, New Mexico, Arkansas and Colorado.

Many other states are considering legislation to repeal CON laws. George Kent, the executive director of Kentucky's state Certificate of Need program said in tesitmony to the state's subcommittee on health care financing and cost containment:

> "The state program set up to guide medical development and curtail health care costs is a failure."
>
> "The only difference between the medical care situation in Kentucky and the Titanic is that the Titanic had a band."

4. Certificate of Need is not synonymous with health planning. For many years hospital boards have performed Community involvement in heatlh care planning, with enormous success. These representatives of the community volunteer their time and want access to health care, expanded and improved.

As pointed out by Henry Foley, PhD, (University of California, San Francisco, School of Medicine, Health Policy Program) regarding those many citizens involved in the certificate of need review process:

> "To those involved and overworked volunteers, it should be honestly admitted that the government oversold the cost containment aspects of health planning (CON)."

5. The current programs for licensure, registration, credentialing, and accreditation of health care providers and institutions safeguarding, and quality of health care services and protect consumers. These programs should continue.

6. Certificate of Need is inconsistent with a price competitve approach to containing health care costs.

The January 13, 1983 issue of The New England Journal of Medicine states:

> "It (The Certificate of Need Program) interferes with competition in the health-care sector." "Under P.L. 93-641, the certificate- of-need program attracted more attention that the process of developing advisory plans. In fact, it is unfortunate that health planning came to be equated with the certificate-of-need function."

"Finally, the health-planning and review process has so far lacked a sense of economic reality."

Curran, William, J.D., "An End to Federal Regulation, the Good, the Bad, and the Unnecessary", March 18, 1982, New England Journal of Medicine states:

"These programs (CON) have grown in a decade or so from a few branches providing needed emphasis on rationality and priority setting to a forest and then a jungle of confusing pronouncements."

Economists led by Stanford professor Alain C. Enthoven aritculate the market place principal, and competition as the solution to soaring costs that government regulation has been unable to quell. (Enthoven, A.C., The Competition Strategy: Status and prospects. New England Journal of Medicine. 1981: 304:109-12)

John F. Horty, a lawyer who remains the driving force behind the National Council of Community Hospitals said:

"We believe change is coming. We want to help shape it. Competition isn't going to serve every hospital, nor should it, but it will sharpen internal decision making and serve the public interest for better than a regulatory model." (Iglehart, J.K., Drawing the Lines for the Debate on Competition. New England Journal of Medicine, July 30, 1981:305:291-296)

The Minnesota Coalition on Health Care Costs, in its report issued in November 1981, noted that "Certificate of Need is a distinct barrier to market entry", the Coalition report states that "new innovations and alternative facilities should be permitted and encouraged."

The Citizens League, a Minneapolis, St. Paul based public interest and research organization, issued a report in September, 1981 which indicates that rising health care costs are attributable to market failure, and recommends that Certificate of Need be eliminated.

Dr. Vernon Sommerdorf in 1971, when he was a legislator, co-sponsored the original certificate of need legislation in Minnesota. At the time, he noted it had a strong intuitive appeal: only enough services would be provided so that costly duplication would be avoided. Unfortunately, this has not been the case. Dr. Sommerdorf, in testimony given in 1981 prior to the repeal of Minnesota's certificate of need law indicated:

"In a competitive health care system, consumers must have choices to make if they are to become cost-sensitive partners in the health care system. Certificate of Need tends to limit choices by reducing

excess capacity. Without excess capacity, there is no room for the growth of cost effective programs and providers, or for the demise of cost-ineffective programs and providers."

"After over 10 years in Minnesota and elsewhere in the nation, CON has not established a strong case for its effectiveness." (Minnesota Medicine, March 1982)

The Supreme Court of North Carolina (In the Matter of Certificate of Need for Aston Park Hospital, Inc. 282NC542, 193SE2d 729, 61ALR3d 268) held:

"Statutory provisions requiring issuance of a certificate of need before construction of hospital facilities was unconstitutional as a depriviation of liberty, even when attempted to be justified under the police power, when applied to a hospital seeking construction, with priviate funds and suitable materials, on private property suitably located, of a well-planned hospital, to be adequately equipped and staffed."

CONCLUSION

Based on the review of the research to date, studies have verified that CON has been unsuccessful in controlling health care costs. Administrative and compliance costs of CON even further increase health care costs. (Havighurst, 1973; Noll, 1975; Kinzer, 1977; Salkever 1978). These administrative and compliance costs of CON include costs resulting from additional institutional time devoted to planning, collection of data for use in CON applications, the need for legal assistance and higher constsruction costs resulting from delays due to the CON process.

RECOMMENDATION

Alaska's Certificate of Need (CON) law should be repealed.

Certificate of Need

HB 19

STAFF REPORT

TO

HOUSE HESS COMMITTEE

FEBRUARY 10,1983

F

Certificate

CONTENTS

- Memo from House HESS staff: Dave Palmer
- Memo from Senate HESS staff: Nancy Dietrich
- Itemization of funds subject to sanctions
- Itemization of FY82 payments from municipal revenue sharing
- Activity summary-DESS CON review
- Letter from Department of Health and Human Services Public Health Service regarding repeal of CON
- Memo summarizing the Arthur D. Little report

To: House HESS Committee
From: Dave Palmer
Date: February 10, 1983
Subject: HB 19, An act to repeal the Certificate of Need Program

The certificate of need program was established in 1974 by federal law (PL 93 641). It is intended to serve as a cost control aid and a planning review process. Through review of major capital expenditures, it is intended to serve as a check to frivolous or misdirected projects. It directs capital construction investment to be compatible with statewide health planning goals. The certificate of need was designed to prevent unnecessary duplication which results in underutilization and inflated costs in a cost based reimbursement system for medical payments.

While discussion of the Certificate of Need (CON) process can lead to esoteric analysis of health care, government, and social issues, I have identified four topics that I believe will be discussed by the committee and those testifying on either side of this issue:

1. Federal mandates
2. Effect on State revenue sharing programs
3. Effect on State medicaid programs
4. The private enterprise vs government regulation issue.

Federal Mandates

The CON process is required by Federal law. Failure to comply with the law carried a sanction that provided that the Federal government would withhold "any allotment, grant, loan and loan guarantee made to and each contract entered into with an individual or entity in such State... under this Act (Public Health Service Act), the Community Mental Health Centers Act, the Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment and Rehabilitation Act of 1970, and the Drug Abuse Office and Treatment Act of 1972."

The sanctions were to begin at a withholding of 25% of the entitlement and increase by 25% increments annually.

These sanctions have been lifted, temporarily at least, by a continuing resolution of Congress, which expires on September 30th of this year. Attached at the end of this paper is a letter itemizing those funds and programs that would be affected by the imposition of sanctions.

The Alaska Legislative Information Office in Washington, D.C. answered by inquiry about sanctions this way:

Question: What are the chances that the sanctions may be again suspended beyond September, 1983?

Answer: This is going to depend on what the 98th Congress chooses to do. The continuing resolution will stand unless Congress takes some action before the end of the fiscal year. If Congress does not act before June 30th of FY 84, the Dept. of Health and Human Services is powerless to impose the sanctions mandated by law and is waiting for some direction from Congress.

In response to a question about the reaction by the Department of Health and Human Services to Alaska's repeal of the CON program, the unofficial reply is: Alaska will still have to comply with some sort of federal regulations to receive health care funds and that starting from scratch (after repeal) might be much more difficult than trying to amend the existing program on CON. For instance, the Block Grant proposals from the 97th Congress included a CON requirement. The compromise bill by Senators Quayle and Kennedy (which was not accepted by the administration) included CON requirements. The Reagan administration favors repeal of CON, the Congress favors retention.

Regardless of the status of the sanctions, repeal of CON would probably mean loss of some federal health planning funds.

Effect on State Revenue Sharing Program

State aid through Title 29 revenue sharing funds for hospital entitlement grants, hospital capital construction, public roads, and volunteer fire departments outside the organized borough may be affected by repeal of the CON program. The reasoning is like this: If repeal of the CON removes a control on public health facility construction, other things being equal, one could expect an increase in construction. An increase in construction could mean more demand on the hospital entitlement and capital construction fund. Because all funds for the Title 29 topics listed above are allocated on a pro rata basis within the available appropriation, increasing the demand on one area decreases the funds available to all those entitled to funds.

Proponents for repeal explain that because the capital construction reimbursements are paid after financing and construction, the program is of little use to any but a few revenue producing facilities. I have attached the most current itemization of revenue sharing payments for health facilities and hospital construction aid.

Effect of State Medicaid

If the CON program does help contain health care costs by avoiding duplication and misdirected investments, it follows that repeal would have the opposite effect on health care costs. Because medicaid is a retrospective program, that is, payments are made after costs are incurred, an increase in health care cost will increase medicaid payments. Those arguing for retention of CON also point out that repeal could lead to overbuilding of facilities, and revenue for unused facilities must be generated from those services generating revenue. In short, costs subject to medicaid payments could increase.

There is a proposal by the Alaska State Hospital Association to develop a prospective rate structure for medicaid payments. This would allow for the establishment of approved rates by an independent commission. Discussion of the latitude of the commission for inclusion of economic depreciation, rate of return, and other costs associated with unused facilities would be relevant.

Private enterprise vs Government regulation

It is generally agreed that most health care facilities (especially in Alaska) do not fit within the free enterprise category. A free enterprise system operates when certain elements are present:

1. There exists a large number of buyers and sellers.
2. Consumers must bear the consequences of their decisions.
3. The seller must be able to leave or enter the marketplace freely.

With the exception of Anchorage, there are no Alaskan communities with more than one hospital. Choices for health care are limited.

Third party payments remove the consumer's responsibility for the financial consequences of their actions. There is little incentive to restrict demands on the system if someone else pays the bill. In 1981, only [illegible]2.1% of the health care users paid for their own treatment.

Health care is not a free entry marketplace. The CON review is only one of the restrictions to entry. There exists licensing standards, public funding processes, and licensing requirements for personnel...the physicians, nurses, and technicians. Because of the complexity of health care questions, consumers rely heavily on physicians. 70% of health care expenditures are influenced by physicians.

The question of private enterprise vs regulation is one that can be discussed over and over, but repeal or retention of the CON program will not address that issue.

CONCLUSIONS:

The certificate of need statute in Alaska in out of date. The limits are low, lower than those set by Federal law. Amendments could be proposed to address particular problems relating to the requirement for the replacement of existing equipment, replacement of like equipment, time limits for review and the like.

The purposes for which the CON procedures were enacted probably do not have much application in Alaska. Because of the large involvement by the State in the funding of hospitals, both for capital construction and operating facets, it can be argued that there exists sufficient programatic review. However, capital budget review and a detailed justification by a hospital administration in a CON process are completely different in scope and detail.

Several states, like Alaska, are currently out of compliance with the Federal requirements. Sanctions have never been imposed against a state, however, no state has repealed its CON program.

Repeal of the program will not reduce health care costs to the recipient of such care.

Repeal of the program may encourage expansion of existing facilities,

Repeal of the program will remove a state level review of health care facility development.

Repeal of the program will make health planning assistance for the Federal government difficult to obtain.

Repeal of the program will not remove Federal health planning requirements.

The current statutory requirements of the Alaskan CON program are obsolete.

alaska state hospital association

319 Seward St., Juneau, Alaska 99801 • (907) 586-1790

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Physician Member of the Board
Keith Brownsberger, M.D.
Anchorage

President
[illegible]nnis L. DeWitt
[illegible]eau

POLICY STATEMENT

CERTIFICATE OF NEED

Position: The Alaska State Hospital Association advocates the repeal of the certificate of need (CON) law, AS 18.07.

Rationale: The CON process has proven costly, wasteful, and unnecessary. The program has become excessively bureaucratic to the point that it undermines economic incentives throughout the decision-making process and so increases the cost of capital projects it takes valuable dollars from patient care. The certificate of need process also removes community control from local jurisdictions in respect to municipally-owned facilities and local advisory boards in respect to corporate ownership.

An alternative approach to state control would permit marketplace economics to control expansion and would rely on local decision-makers to make decisions for their own communities. We see a value in state government continuing its planning function with input from regional and local groups.

Note: This does not contemplate repeal of construction or licensure standards.

alaska state hospital association

JAN 27 '83

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Alaska State Hospital Association

Position Paper

Certificate of Need Repeal

The Certificate of Need program in Alaska (AS.07) should be repealed. It is both inequitable and unnecessary. Its basic presumption is that the Department of Health and Social Services can make better decisions for hospitals and nursing homes than can the facilities themselves.

Basic Issues

1. Equity

- While controlling non-state construction of skilled nursing facilities (SNF's) and intermediate care facilities (ICF's), the prgram exempts these beds constructed in Pioneers' Homes. Thus any determination of need based on the current program is flawed because forces external to the program can and have - in Anchorage, Juneau, and Ketchikan - altered the factual situation.

- Alaska Native Health Service and the Armed Forces facilities are also exempt from coverage. Their activities have a direct bearing on many other facilities in terms of both service area and referrals.

- Physician office construction and equipment purchase are also exempt.

The inequities are clearly illustrated in the Anchorage area: Providence Hospital, Humana Hospital, Nakoyia Health Care Center, Hope Cottages and the Alaska Treatment Center are included in the CON program while the Alaska Native Health Service Hospital, Elmendorf AFB Hospital, the Anchorage Pioneers's Home and the Diamond Emergency Center are not included. All of these facilities share the same basic service area.

2. Unnecessary

Market place economics and competition should be the determinant of capital expansion for health facilities. In Anchorage, the Municipal Health Commission as well as open board meetings provide the public input into a facility's planning process. In smaller communities the city council or borough assembly who own the facility provide the public input opportunity.

Alaska is a developing state of many isolated regions without any appeal for duplication of services or need to limit access to health care, which is the basic intent of the CON program.

3. Conformity

42 USC 300 m-(d) requires that states conform to the federal program or face a reduction of specified public health service funds.

- Conformity is not achievable without the inclusion of the Pioneers' Homes.

- There are 30 states, including New York and California as well as Alaska, which are not in conformity.

- The penalties have been deferred every year since passage. In December of 1982 they were deferred until October 1, 1983.

- The Reagan Administration is not supportive of continuing this program. Congress is working to create a state optional program without penalties. Thus the likelihood of imposition of penalties is remote at best and the across the board elimination of CON would not change Alaska's current status.

4. Other States

- Louisiana does not have a certificate of need law.

- According to the American Hospital Association, 30 states currently do not conform.

- At least seven states have termination clauses or specific sunset provisions.

5. Attachments

- Alaska State Hospital Association Policy Paper on Repeal of Certificate of Need

- Providence letter to Mayor Knowles explaining opposition to CON.

- U.S. Department of Health and Human Services letter to Dennis DeWitt discussing Alaska's non-conformity.

(Attachments cont.)

- Alaska Department of Administration letter to Representative Don Clocksin discussing Pioneers' Homes exemption, conformity problem, and potential for penalties.

- 42 USC 300m-(d)

- Alaska Department of Health and Social Services letter to Representative Mike Beirne indicating lack of compliance with federal program.

- Alaska State Medical Association Resolution calling for the repeal of certificate of need.

- Alaska State Hospital Association letter to Stevens on CON repeal.

- Governor Sheffield's response to the Association letter to Senator Stevens.

LAKE OTIS CLINIC, INC. P.O. BOX 4-1539 ANCHORAGE, ALASKA 99509
(907) 276-3166

THE LAKE OTIS COMMUNITY HOSPITAL

March 18, 1983

Representative Al Adams
Chairman of Finance Committee
Pouch V
Juneau, Alaska 99811

Re: HB 19
Repeal of Certificate of Need

Dear Representative Adams:

This Bill would permit Providence Hospital to "neuter" my hospital franchise. Neutering can be evil. I object to neutering. Please do not pass this Bill. If passed it not only would mean the end of our Lake Otis Hospital Project in Anchorage, but in addition all small hospitals would have to step aside and leave the field to the big corporations exclusively. This is not in the public interest.

The Certificate of Need law, in effect since 1977, does help to control hospital expansions and therefore "costs" to the patient, or whoever pays the bills including the State. The present law should be modified, however, to permit hospitals to spend up to One Million Dollars without a permit. But the law should require a permit whenever new beds are added.

In effect, in Alaska we have the "franchise" system. And it works well. The record is clear. All 50 states have this system under federal guidelines.

In 1977, Lake Otis was issued a Certificate of Need (the franchise) by the State in compliance with the new law. Shortly thereafter Providence Hospital and others initiated a series of legal maneuvers effectively creating a "legal cloud" on this particular Certificate of Need which blocked access to all financing "until such time as all litigation ceases".

Since the Certificate of Need was issued in 1977, five major lawsuits have been filed against us. To date, we have won three of these lawsuits. A fourth case is now awaiting decision. The fifth and last lawsuit has perhaps another year to go in Superior Court. This is the case filed by Providence Hospital more than three years ago. We won this case in the trial courts on Summary Judgment! Providence took it to the Supreme Court which at first concurred with the trial court, but then on petition from Providence agreed to send the case back to the trial court for review of a single point. We will win this case. It is a great world.

Representative Al Adams
Chairman of Finance Committee
March 18, 1983
Page 2

During these past five years, the big hospital corporations have maintained that there was no need for addition beds in the community. Now they claim there is a "crisis". In addition, now the big hospital corporations are asking you to repeal the CON law so that they may expand their hospital and serve the public which so desperately needs their beds now. What they obviously cannot win in court, and they can't, they now seek to obtain by "neutering" our franchise. This is not very nice at all.

We have proceeded on this project in good faith. Our Certified Public Accountants have testified in two separate courts that I have personally invested more than Two Million Dollars in this project. I estimate that an equal amount has been consumed by this project as provided by me and others over the years, exclusive of my time and my personal services. The State has repeatedly testified that our CON (franchise) is valid. The State is even a co-defendant with us in the Providence lawsuit. We just want to proceed with our project.

So, in closing, let me remind you that "neutering" can be a mortal sin. A person with a mortal sin on his soul is not admitted to Heaven. Please don't let Providence and the others commit that sin. Do not repeal Certificate of Need law.

Sincerely,

Your humble and devoted tax payer

Dr. Mike Beirne
President
Lake Otis Clinic, Inc.

MB/cm

Alaska State Legislature

Representative Milo Fritz
District 5
P.O. Box 158
Anchor Point, Alaska 99556
(907) 235-8366

While In Juneau
Pouch V
Juneau, Alaska 99811
(907) 465-4833

House of Representatives
MILO FRITZ

MEMORANDUM

TO: All Finance Committee Members

FROM: Representative Milo H. Fritz *MHF*

DATE: March 21, 1983

RE: House Bill 19, Repeal Certificate of Need

I have enclosed some basic information regarding the repeal of Certificate of Need. If you would like further information, please contact my office at 4833 or Room 114, Capital.

ds

Enclosures

Blue Cross
of Washington and Alaska

15700 Dayton Avenue North/P.O. Box 327
Seattle, Washington 98111
206/361-3000

February 4, 1983

POLICY STATEMENT

Blue Cross of Washington and Alaska supports the retention of Certificate of Need. That process should, however, be modified as follows:

1. The dollar threshold should be increased to $1,000,000 per application.

2. Modifications which are necessary to reduce health and safety hazards should be exempted.

3. The State Health Planning and Development Agency should become the sole health planning body for the State and should be charged with health planning for all Alaskans. A provision should be included allowing municipalities to establish local health councils to the State Health Planning and Development Agency, who may make recommendations on planning matters.

JHG:pf

TESTIMONY BEFORE HOUSE HESS COMMITTEE, HB 19

My name is Martin Tirador, and I am employed by Blue Cross of Washington and Alaska. I appreciate this opportunity to present these comments to the Committee.

Blue Cross of Washington and Alaska supports the retention of Certificate of Need. Certificate of Need is one method used to curtail the health care costs that are increasing at about four times the rate of other costs. Cost control is a vital part of our ability to provide affordable health care coverage to over 50,000 persons in Alaska. The addition of new beds and services can create new costs that may result in decreased service and increased premiums to groups and individual subscribers. The State of Massachusetts experience and the Arthur D. Little Company study have statistics that indicate that for every dollar spent in adding beds, the operational costs are thirty cents, about nineteen cents of which is a depreciation expense. This cost for beds is paid by the hospitalized patients in increased basic service charges. As an example, fifty beds constructed at a cost of $250,000 per bed provides a total construction cost of $12,500,000. Using the Massachusetts information, an average of thirty cents operational costs per one dollar of construction costs, $3,750,000 would be added to patient day charges annually over the useful life of the facility. These charges will increase the costs and increase the premium charges for coverage.

While Blue Cross supports the Certificate of Need program, we recognize this program must change to meet the changes in economy and society. To this goal, Blue Cross recommends the following:

1. Increase the Certificate of Need threshold from $150,000 to $1,000,000 for capital expenditures, $1,000,000 for major medical equipment purchases, and $1,000,000 for the establishment of new institutional health services. Expenses exceeding these new thresholds would require a Certificate of Need, except as exempt in recommendation number 2. Using this new threshold, most non-major purchases and modifications could be made without undergoing the review process, and many decisions can be based on patient need. Since it costs a facility less than one-half of one percent of the project costs to obtain a Certificate of Need, the cost can now be saved.

   Major expenses would still require a Certificate of Need. This provides an opportunity for input where large dollars are involved. The review will require

documentation of necessity and will exert control on runaway cost escalation.

2. Remove health, safety and regulation modifications from the Certificate of Need process. It would seem unnecessary that permission be obtained from one state agency to make necessary modifications required by another state agency.

3. Streamline the Certificate of Need review process. The present methodology appears burdensome and lends itself to as many as three review processes. One review would appear to be sufficient. We suggest the State Health Planning and Development Agency be the reviewing authority. The Certicat[of Need issuing authority should remain within the offices of the Commissioner of Health and Social Services.

Local government should have the option to establish local health advisory bodies to provide input to the decision-makers. These local planning bodies would be an input agency to the state health plan, as they are at this time.

In conclusion, Blue Cross of Washington and Alaska urges the State Legislature to retain the Certificate of Need program. Blue Cross feels this program, while appearing burdensome at times, is an avenue for the control of costs that are utimatel[borne by the hospitalized patient or the employer who provides his health care coverage. The Certificate of Need threshold should be increased to permit a higher level of autonomy by local health care providers. The review process should be made as simple as possible, while assuring that the applicant be accountable to the consumer for their major projects.

Thank you again for the opportunity to present this position to this Committee.

SECTIONAL ANALYSIS OF PROPOSED FINANCE CS FOR HB 19

Title: Title is changed to reflect addition of sections to the bill relating to state aid for health facilities.

Section 1: This is the authority for continuation of certificate of need (CON) until 1986. The section also makes two technical changes to present law. First, it substitutes "division of planning, policy, and program evaluation" for "office of planning and research". This change is necessary because of the Department's recent internal reorganization. The division of planning, policy and program evaluation is the proper office for administration of the certificate of need program, as well as the other health planning duties required by federal law as enumerated in the bill. Second, the new language corrects references to federal law with respect to health planning duties of the division.

Section 2: This is the authority for continuation of the division's health planning duties as enumerated in federal law without responsibility for CON review. This section would go into effect in 1986 when CON would be repealed if a bill to continue it is not introduced at that time.

Section 3: Subsection (a) states that a CON is required for construction or equipment purchase over $1 million, for alteration of bed capacity, and for addition or elimination of new services. (Current regulations require a CON for construction or equipment purchase over $150,000; current statute allows the department to provide this threshold through regulation.) Subsection (b) states that a CON is not required for replacement equipment. Subsection (c) provides that the legislature may not appropriate, nor may a person receive state funding for construction or equipment for which a CON is required before the CON is approved.

Section 4: This section describes the procedure for review of CONs. The division, and then the commissioner shall review all applications. Consultation with HSAs or municipal health commissions is allowable, but not mandatory, and approval of a CON does not have to be conditioned on approval by an HSA or municipal health commission. The entire review process must be completed within 90 days of submission of the completed application by the applicant.

Sections 5 - 11: These sections all make technical language changes to the CON statute to conform with the use of the term "division" to reflect the Department's recent reorganization.

Section 12: Provides that facilities who apply for financial assistance through the Alaska Medical Facilities Authority must meet state licensing requirements. The requirement that such facilities apply for and receive a CON is removed, however this

section does not go into effect until 1986 when CON will be sunsetted if legislation to continue it is not approved.

Section 13: This section caps revenue sharing for hospitals at $250,000 for a facility with ten or more acute care beds and at $50,000 for a facility with ten or less acute care beds. (Current statute provides for $1,000 per bed---not acute care bed--- or $250,000 and $50,000; it does not provide for maximum amounts of aid. Conceivably then, a hospital with 260 beds could get $260,000 if enough funding is appropriated.)

Section 14 - 19: These sections provide for a prospective payment system of reimbursement to health facilities for Medicaid and General Relief Medical recipients. Rates are currently established retrospectively through a process commonly called "cost settlement". Costs are estimated at the beginning of a fiscal year and an interim payment determined. At the end of the fiscal year, the total of interim payments made is compared to the allowable costs of the provider. The difference is either collected from or paid to the provider. "Cost settlement" does not provide any incentives to hold the line on staff, equipment, wage increases, and service expansion. In short, it does not provide any incentive for "cost containment".

Prospective payment, on the other hand, provides for establishment of payment rates prior to the fiscal year as a result of discussions between each facility and the state. Each facility must then operate and provide care at this predetermined rate for the entire fiscal year.

Section 14: Gives Medicaid Rate Commission the authority to institute prospective payment by regulation. Lists factors to be included when determining rates. States that underutilization because of "improvement or careless development of the facility" may be considered in rate determination.

Section 15: Within 120 days of the end of a facility's fiscal year, a financial performance report must be submitted to the commission. By September 30 of each year, the commission shall submit to the Governor a report summarizing prospective payments made during the current fiscal year and predicted rates for the next fiscal year. By regulation, the commission shall establish uniform accounting and financial reporting procedures for all facilities. Such procedures can be modified for facilities with less than 25 acute care beds in order to reduce operating costs of the facility. The section contains language requiring audits and inspections of facilities' records and applies the Administrative Procedures Act to the commission's activies.

Section 16: Defines "commission" and "health facility". A health facility includes a hospital, skilled nursing facility, intermediate care facility (ICF), an ICF for the mentally retarded, rehabilitation facility, inpatient psychiatric

facility, home health agency, rural health clinic, and outpatient surgical clinic.

Section 17: Establishes the Medicaid Rate Commission in DHSS as the commission charged with the responsibility for establishing prospective payment rates. The five members of the commission are a chief executive officer of a facility subject to prospective payment, the commissioner of DHSS or Administration, a physician not employed by the state, an accountant with relevant experience, and a consumer representative. Commissioners are appointed by the Governor and serve at his pleasure. Provides for term of membership, compensation, officers, meetings and quorum, employment of personnel. Provides that the commission's duty is to establish prospective payment rates.

Section 18: Provides that previous sections apply to rates paid under GRM as well as Medicaid.

Section 19: Provides authority to DHSS to establish an interim prospective payment system until the work of the commission is underway.

Section 20: Every three years, the legislature shall review CON and revenue sharing for construction of health facilities. Both statutes are "sunsetted" if legislation is not introduced to continue them.

Section 21: Provides for repeal of revenue sharing for construction of health facilities on July 1, 1986. Legislation must be introduced at that time to continue the program. However, any facility receiving aid on or before June 30, 1986 can continue to receive aid up to the 25% entitled to it in existing law.

Section 22: Repeals CON on July 1, 1986. Legislation must be introduced at that time to continue the program.

Section 23: Technical repealers.

Section 24: Provides that sections concerning the division's responsibilities, compliance with licensing requirements other than CON for assistance from the Alaska Medical Facilities Authority, the repeal of revenue sharing for health facility construction, and CON repealers take effect July 1, 1986.

Section 25: Provides that the rest of the bill takes effect immediately.

(LWC: 4/13/83)

By - Rep. Martin

AMENDMENT TO HB 19

After line 27, insert:

"Section 3 AS 29.90.010-29.90.030 is repealed.

Section 4. Any hospital or health facility currently receiving state aid for hospital and health facility construction shall receive such aid as it would have, had AS 29.90.010-29.90.030 not been repealed. However, no new applications for aid shall be received or processed after the effective date of this legislation."

Return to.

James D. Pister, M.D.
A Professional Corporation
SRA Box 939
Old Seward Highway
Anchorage, Alaska 99502
(907) ~~344-8516~~ 345-4480

11 April, 1983

Terry Martin
House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Representative Martin:

I would like to take this time to give you my views on changing or eliminating the Certificate of Need Law for Alaska. I suggest that you do not eliminate the law. If the amount of funding not subject to the Certificate of Need Law is raised I would recommend that it not be raised above $500,000.

I have considerable concern regarding the future of medicine in this state under the considerable influence of hospital corporations such as Providence Hospital and especially Humana. I believe that prices are already considerably above an appropriate level at both hospitals. Humana in particular, has raised prices in the x-ray department by almost 50% in a little over seven (7) months. I know for a fact the prices elsewhere in the hospital have also been raised substantially to a point where they are considered exhorbitant by many of us. You may be interested to know that at Humana Hospital for the same services in x-ray, an in-patient pays 15% more than an out-patient for an identical service. Humana in particular appears to be motivated by money. Although they pay a certain amount of lip service to other concerns, including patient well-being and so forth, virtually every concern is secondary to financial consideration.

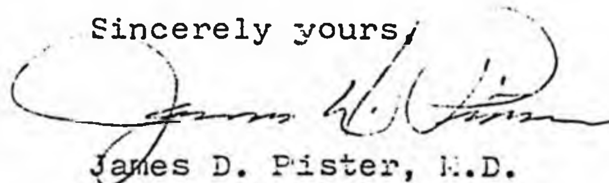
James D. Pister, M.D.
A Professional Corporation
SRA Box 939
Old Seward Highway
Anchorage, Alaska 99502
(907) ~~344-8516~~

Humana Hospital, and to some extent Providence Hospital also, has demonstrated in the past a willingness to attempt to limit the competition and force it out of the community if possible. Humana has a history elsewhere of buying out competitors. Humana also is well known to provide inexpensive loans or grants to new physicians for exchange for receiving that physician's patient referrals. I can elaborate further if requested.

For further enlightenment on this subject, please contact Representative Joe Hayes. I have sent him a video-tape which I recorded from the CBS National Network news a couple of weeks ago regarding hospital corporations. I think these short news broadcasts will shed further light on this matter. I apologize for the quality of the tape.

I appreciate your concern in this matter. Once again, I urge you not to change the Certificate of Need Law, or if it must be changed, to simply raise the ceiling on the amount not subject to the Certificate of Need Law and not to allow that limit to exceed $500,000.

Sincerely yours,



James D. Pister, M.D.

South Central
Health Planning and Development, Inc.
1135 West Eighth Avenue • Suite 1 • Anchorage, Alaska 99501
(907) 278-3631

April 11, 1983

Albert P. Adams
House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Representative Adams:

As you consider House Bill 19, an act repealing the Certificate of Need law we would hope that you would consider the following additional information.

Health care costs continue to rise at rates higher than other sectors of the economy. In the last federal fiscal year health care costs rose 11.4%, more than double the overall rate of inflation. Hospital costs rose 15.2%. The consumer price index for medical care for Anchorage rose 12.3% between January, 1981 and January, 1982. There would be no cost containment measures on the books if HB19 were to pass.

In addition, you should also be aware that while Alaska is considering the rather drastic action of suspending the Certificate of Need Program, other states are strenthening theirs. In addition, Congress has just finished deliberating and passed provisions within the Social Security bill which will have significant impact on the regulation of capital expenditures. The relevant parts of the final verson of the bill (as it was resolved in conference agreement) are attached. Generally they say:

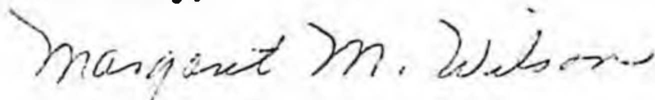
1) that there will be a form of prospective reimbursement adopted nationwide,
2) that Medicare will continue to reimburse facilities on a reasonable-cost basis until 1986,
3) that at that time Medicare payment related to new capital projects will be made only if a State has a capital expenditures review mechanism (1122) in place,
4) that the maximum threshold a State may use for determining which capital projects are subject to the Section 1122 review process would be increased from $100,000 to $600,000.

Alaska is not currently contracting with the Federal government to do Section 1122 reviews because they so closely parallel (duplicate) the Certificate of Need Review. If our Certificate of Need law is suspended or repealed and not replaced with 1122 right away, this could have the effect of creating a three year window on capital expenditures review. This might prove detrimental as there would be the incentive to "build it all now" by existing facilities and by outside facilities looking at Alaska as a new market.

We urge you to consider modifying the current law to raise minimum thresholds, tighten up time limits for decisions, such as the suggestions we sent you in the Alaska Health Coalition position paper.

We would be glad to discuss this further with you. Please don't hesitate to call me or Susan Callan of this agency.

Sincerely,



Margaret M. Wilson
Executive Director

MMW/ab

Enclosure

A M E N D M E N T

Offered in the HOUSE By Bettisworth

TO: SSHB 19

Page 1, line 7, before "and" insert:

"amending or repealing provisions relating to state aid for health facilities, Medicaid and general relief medical assistance;"

Page 1:

Delete all material following line 9 and insert in its place:

"Sec. 18.07.021. STATE HEALTH PLANNING AND DEVELOPMENT AGENCY. The <u>division of planning, policy, and program evaluation</u> [OFFICE OF PLANNING AND RESEARCH] in the department is the state health planning and development agency designated under <u>42 U.S.C. Sec. 300m(b)(3), (Sec. 3, P.L. 93-641)</u> [SEC. 1521(b)(3), P.L. 93-641]. The <u>division</u> [OFFICE] shall perform the functions enumerated under <u>42 U.S.C. Sec. 300m-2(a)(1) - (3), (a)(6) - (8), (b) and (c), (Sec. 3, P.L. 93-641)</u> [SEC. 1523,P.L. 93-641, ADMINISTER THE CERTIFICATE OF NEED PROGRAM OUTLINED IN AS 18.07.041 - 18.07.111, AND OTHER FUNCTIONS PRESCRIBED IN THIS CHAPTER].

* Sec. 2. AS 18.07.111 is amended by adding a new paragraph to read:

(13) "division" means the division of planning, policy, and program evaluation in the Department of Health and Social Services

* Sec. 3. AS 18.26.220 is repealed and reenacted to read:

Sec. 18.26.220. FACILITY COMPLIANCE WITH HEALTH AND SAFETY LAWS

AND LICENSING REQUIREMENTS. In order to receive financial assistance under this chapter, a medical facility shall comply with AS 18.20 and the licensing requirements of this chapter.

* Sec. 4. AS 29.89.030(a)(1) is repealed and reenacted to read:

(1) to a municipality that has the power to provide hospital facilities and services and that exercises that power, $250,000 per hospital for those hospitals with 10 or more acute care beds, and $50,000 per hospital for those hospitals with less than 10 acute care beds; money received under this paragraph may be used only for hospitals and shall be apportioned among qualifying hospitals as the municipality determines;

* Sec. 5. AS 47.07.070 is repealed and reenacted to read:

Sec. 47.07.070. PAYMENT TO HEALTH FACILITIES. (a) The commission shall determine prospectively the rate of payment to a health facility under this chapter and AS 47.25.120 - 47.25.300 based on a fair rate for reasonable costs incurred by the facility. The commission shall by regulation list the factors it considers in making its rate determinations under this section.

(b) In determining a rate of payment to a health facility under this section, the commission shall consider the proportionate share of the facility's financial requirements for patient care for

(1) costs of current operations, including salaries and wages; purchased services, supplies, insurance, leases, depreciation, taxes, interest expense, maintenance and other health facility operating expenses; and

(2) education, research, and appropriate capital

development.

(c) In determining a rate of payment to a health facility under this section, the commission may consider whether the rate of utilization of the facility has been reduced because of improvement or careless development of the facility.

* Sec. 6. AS 47.07 is amended by adding new sections to read:

Sec. 47.07.071. REPORTS BY HEALTH FACILITIES. Not later than 120 days after the end of each fiscal year of a health facility, the facility shall submit to the commission a report on the facility's financial performance during the fiscal year.

Sec. 47.07.072. REPORT BY THE COMMISSION. Not later than September 30 of each year, the commission shall submit to the governor a report on the prospective payments made under this chapter during the current fiscal year and an estimate of the prospective payments that will be made during the remainder of the current fiscal year and the next fiscal year. The report shall state the assumptions that are used as a basis for the estimates.

Sec. 47.07.073. UNIFORM ACCOUNTING, BUDGETING, AND FINANCIAL REPORTING. (a) The commission by regulation shall require a uniform system of accounting, budgeting, and financial reporting for health facilities receiving prospective payments under this chapter. The regulations shall provide for the reporting of revenues, expenses, assets, liabilities, and units of service. The commission shall specify the date the system becomes effective for each health facility.

(b) In adopting regulations under this section, the commission

shall consider

(1) accounting, budgeting, and financial reporting procedures used by health facilities;

(2) variations among health facilities in the types of health care services provided by health facilities;

(3) other factors the commission considers relevant, including the size and organizational structure of health facilities and the methods used by health facilities to obtain payments.

(c) The commission may waive or modify a requirement for accounting, budgeting, or financial reporting for a health facility if waiver or modification is

(1) necessary to avoid excessive costs to the facility; and

(2) consistent with the policies of this chapter.

(d) Notwithstanding other provisions of this section, the commission may, by regulation, modify the system of accounting, budgeting, and financial reporting required under this section for a health facility having less than 25 acute care beds in order to reduce the operating costs of that facility.

Sec. 47.07.074. AUDITS AND INSPECTIONS. As a condition of obtaining payment under AS 47.07.070, a health facility shall allow

(1) the department and the commission reasonable access to the financial records of medical assistance beneficiaries; and

(2) inspection of financial records by state and federal agencies to the extent required by federal law.

Sec. 47.07.075. APPLICATION OF ADMINISTRATIVE PROCEDURE ACT. Actions of the commission under AS 47.07 and AS 47.25.120 - 47.25.300

are subject to the provisions of the Administrative Procedure Act (AS 44.62).

* Sec. 7. AS 47.07.080 is amended by adding new paragraphs to read:

(6) "commission" means the Medicaid Rate Commission;

(7) "health facility" includes a hospital, skilled nursing facility, intermediate care facility, intermediate care facility for the mentally retarded, rehabilitation facility, inpatient psychiatric facility, home health agency, rural health clinic, and outpatient surgical clinic.

* Sec. 8. AS 47.07 is amended by adding new sections to read:

ARTICLE 2. MEDICAID RATE COMMISSION.

Sec. 47.07.110. MEDICAID RATE COMMISSION ESTABLISHED. The Medicaid Rate Commission is established in the Department of Health and Social Services.

Sec. 47.07.120. COMPOSITION OF COMMISSION. The commission consists of five members as follows:

(1) the chief executive officer of a health facility that is licensed by the state but not owned or operated by the state or federal government and that is subject to the budget review process under this chapter;

(2) the commissioner of administration, the commissioner of health and social services, or the appointed designee of either commissioner;

(3) a physician licensed to practice medicine in the state who is actively engaged in the practice of medicine and who is not employed by the state;

(4) a certified public accountant with relevant experience;

(5) a person representing consumers of health services who does not have a direct or indirect interest in an entity that provides health care services.

Sec. 47.07.130. APPOINTMENT OF MEMBERS. Members of the commission are appointed by the governor and serve at the pleasure of the governor.

Sec. 47.07.140. TERM OF MEMBERSHIP. The term of a member of the commission appointed under AS 47.07.120(1), (3), (4), or (5) is three years. A member may not be appointed to a successive term. The terms of the members shall be staggered. A member appointed to fill a vacancy serves for the unexpired term of the member. A term shall be measured from January 1 of the year in which the term of the vacant position begins, regardless of when the vacancy is filled.

Sec. 47.07.150. COMPENSATION. A member of the commission serves without compensation but is entitled to per diem and travel expenses authorized by law for boards and commissions under AS 39.20.180.

Sec. 47.07.160. OFFICERS. At the first meeting of each year, the commission shall elect a chair from among its members.

Sec. 47.07.170. MEETINGS AND QUORUM. The commission shall meet as often as is necessary to conduct its business. Three members of the commission constitute a quorum.

Sec. 47.07.180. DUTIES. The commission shall review proposed payment rates and budgets of health facilities and establish payment rates for health facilities under this chapter and AS 47.25.120 - 47.25.300.

Sec. 47.07.190. EMPLOYMENT OF PERSONNEL. The commission may employ and determine the salary of an executive director. With the approval of the commission, the executive director may select and employ additional staff. The commission shall be assisted by the officers or personnel of the department as the commissioner of health and social services shall direct. The executive director of the commission is in the exempt service under AS 39.25.

* Sec. 9. AS 47.25 is amended by adding a new section to read:

Sec. 47.25.195. PAYMENT TO HEALTH FACILITIES FOR TREATMENT OF NEEDY PERSONS. (a) The department may make payments to a health facility for the treatment of a needy person.

(b) A health facility receiving a payment under this chapter is subject to the requirements of AS 47.07.070 - 47.07.075.

(c) For purposes of this section, "health facility" includes a hospital, skilled nursing facility, intermediate care facility, intermediate care facility for the mentally retarded, rehabilitation facility, inpatient psychiatric facility, home health agency, rural health clinic, and outpatient surgical clinic.

* Sec. 10. INTERIM PROSPECTIVE PAYMENT SYSTEM. The department shall establish an interim system of prospective payments for health facilities under this Act for the period July 1, 1983 to June 30, 1984.

* Sec. 11. The sponsor of a hospital or health facility construction project who is receiving or entitled to receive state aid under AS 29.90 on the day preceding the effective date of this Act shall continue to receive state aid until the sponsor has received an amount which, combined with state matching money for construction of the hospital or health facility,

equals 25 percent of the total project cost. Money received for construction may not be used for any other purpose.

* Sec. 12. AS 18.07.031 - 18.07.101, 18.07.111(1) - (4), 18.07.111-(7) - (11); AS 29.90; AS 47.07.080(1) and AS 47.80.140(b) are repealed.

* Sec. 13. This Act takes effect immediately in accordance with AS 01.-10.070(c)."

Differences between Bettisworth amendment and Martin amendment.

On Sectional Analysis for CS for HB 19 by LWC 4/13/83, strike sections 1,3,4,20,23,24,25.

Modify Sections 5-11, 21, 22.

Effective differences:

TOPIC	Bettisworth	Martin
Certificate of Need AS 10.07	Repeal	Sunset review in 3 years Increases some thresholds Minor process change
Aid to Construction AS 29.90	Repeal	Sunsets in 3 years
Aid to Operations	Identical	Identical
Prospective Program for Medicaid	Identical	Identical

Bottisworth Amendments

SECTIONAL ANALYSIS OF ~~PROPOSED FINANCE CS~~ FOR HB 19

Title: Title is changed to reflect addition of sections to the bill relating to state aid for health facilities.

Section 1: This is the authority for continuation of the division's health planning duties as enumerated in federal law without responsibility for CON review.

Section 2: Makes technical language changes to the CON statute to conform with the use of the term "division" to reflect the Department's recent reorganization.

Section 3: Provides that facilities who apply for financial assistance through the Alaska Medical Facilities Authority must meet state licensing requirements. The requirement that such facilities apply for and receive a CON is removed.

Section 4: This section caps revenue sharing for hospitals at $250,000 for a facility with ten or more acute care beds and at $50,000 for a facility with ten or less acute care beds. (Current statute provides for $1,000 per bed---not acute care bed---or $250,000 and $50,000; it does not provide for maximum amounts of aid. Conceivabley then, a hospital with 260 beds could get $260,000 if enough funding is appropriated.)

Section 5-10: These sections provide for a prospective payment system of reimbursement to health facilities for Medicaid and General Relief Medical recipients. Rates are currently established retrospectively through a process commonly called "cost settlement". Costs are estimated at the beginning of a fiscal year and an interim payment determined. At the end of the fiscal year, the total of interim payments made is compared to the allowable costs of the provider. The difference is either collected from or paid to the provider. "Cost settlement" does not provide any incentives to hold the line on staff, equipment, wage increases, and service expansion. In short, it does not provide any incentive for "cost containment".

Prospective payment, on the other hand, provides for establishment of payment rates prior to the fiscal year as a result of discussions between each facility and the state. Each facility must then operate and provide care at this predetermined rate for the entire fiscal year.

Section 5: Gives Medicaid Rate Commission the authority to institute prospective payment by regulation. Lists factors to be included when determining rates. States that underutilization because of "improvement or careless development of the facility" may be considered in rate determination.

Section 6: Within 120 days of the end of a facility's fiscal year, a financial performance report must be submitted to the commission. By September 30 of each year, the commission shall submit to the Governor a report summarizing prospective payments made during the current fiscal year and predicted rates for the next fiscal year. By regulation, the commission shall establish uniform accounting and financial reporting procedures for all facilities. Such procedures can be modified for facilities with less than 25 acute care beds in order to reduce

operating costs of the facility. The section contains language requiring audits and inspections of facilities' records and applies the Administrative Procedures Act to the commission's activities.

Section 7: Defines "commission" and "health facility". A health facility includes a hospital, skilled nursing facility, intermediate care facility (ICF), an ICF for the mentally retarded, rehabilitation facility, inpatient psychiatric facility, home health agency, rural health clinic, and outpatient surgical clinic.

Section 8: Establishes the Medicaid Rate Commission in DHSS as the commission charged with the responsibility for establishing prospective payment rates. The five members of the commission are a chief executive officer of a facility subject to prospective payment, the commissioner of DHSS or Administration, a physician not employed by the state, an accountant with relevant experience, and a consumer representative. Commissioners are appointed by the Governor and serve at his pleasure. Provides for term of membership, conpensation, officers, meetings and quorum, employment of personnel. Provides that the commission's duty is to establish prospective payment rates.

Section 9: Provides that previous sections apply to rates paid under GRM as well as Medicaid.

Section 10: Provides authority to DHSS to establish an interim prospective payment system until the work of the commission is underway.

Section 11: Any facility receiving aid on or before the effective date of this bill can continue to receive aid up to the 25% entitled to it in existing law.

Section 12: Repeals CON and Aid to Construction (AS 29.90) contains technical repealers.

Section 13: Provides that the bill takes effect immediately.

Alaska State Legislature
House of Representatives
Al Adams
Chairman
Committee on Finance

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Official Business

March 25, 1983

MEMORANDUM

TO: House Finance Committee Members

FROM: Al Adams, Chair AA
House Finance Committee

SUBJ: Sectional Analysis of SS HB 19, an act repealing the certificate of need program

The certificate of need (CON) law requires that all nonfederal health care facilities apply for and receive a certificate of need from the state before making capital investments that will result in new construction, renovation, or provision of new services. A certificate of need is required, by regulation, for any capital expenditure of more than $150,000.

Section 1: Removes the certificate of need function from the responsibilities of the state health planning and development agency (SHPDA).

The Governor proposes in his FY 84 budget to incorporate SHPDA functions in the new Division of Planning, Policy and Evaluation. At present, the budget request includes CON review.

Section 2: States that if a medical facility wishes financial assistance from the Alaska Medical Facility Authority, it must comply with AS 18.20 which establishes the licensing and other regulatory requirements for health facilities in Alaska.

The Alaska Medical Facility Authority arranges mostly tax exempt bond sales to finance health facility construction.

Section 3: Repeals those portions of present law that require facilities to submit to the CON review process.

Section 4: Provides for an immediate effective date.

C O R R E C T I O N

Discard SSHB 19

and retain this corrected version.

Introduced: 1/24/83
Referred: Health, Education &
Social Services and Finance

BY FRITZ, HAYES, ZHAROFF, CATO, LINDAUER, SZYMANSKI, MCBRIDE AND BUSSELL

1 IN THE HOUSE

2 SPONSOR SUBSTITUTE FOR HOUSE BILL NO. 19

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 THIRTEENTH LEGISLATURE - FIRST SESSION

5 A BILL

6 For an Act entitled: "An Act repealing the certificate of need program;
7 and providing for an effective date."

8 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

9 * Section 1. AS 18.07.021 is amended to read:

10 Sec. 18.07.021. STATE HEALTH PLANNING AND DEVELOPMENT AGENCY.
11 The office of planning and research in the department is the state
12 health planning and development agency designated under 42 U.S.C. Sec.
13 300m(b)(3), (Sec. 3, P.L. 93-641) [SEC. 1521(b)(3), P.L. 93-641]. The
14 office shall perform the functions enumerated under 42 U.S.C. Sec.
15 300m-2(a)(1)-(3), (a)(6)-(8), (b) and (c), (Sec. 3, P.L. 93-641)
16 [SEC. 1523,P.L. 93-641, ADMINISTER THE CERTIFICATE OF NEED PROGRAM
17 OUTLINED IN AS 18.07.041 - 18.07.111,] and other functions prescribed
18 in this chapter.

19 * Sec. 2. AS 18.26.220 is repealed and reenacted to read:

20 Sec. 18.26.220. FACILITY COMPLIANCE WITH HEALTH AND SAFETY LAWS
21 AND LICENSING REQUIREMENTS. In order to receive financial assistance
22 under this chapter, a medical facility shall comply with AS 18.20 and
23 the licensing requirements of this chapter.

24 * Sec. 3. AS 18.07.031 - 18.07.101, 18.07.111(1) - (4), 18.07.111(7) -
25 (9), 18.07.111(11), and AS 47 80.140(b) are repealed.

26 * Sec. 4. This Act takes effect immediately in accordance with AS 01.-
27 10.070(c).