HB

19

(7)

COMMITTEE REPORT

HOUSE

FURTHER: FINANCE

1/24/83

Date: _____

Mr. Speaker:

The Committee on HESS has had SS HB 19

Ac 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)

[ ] replace with CS for _____ [ ] same title [ ] new title

and recommends _____

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

[ ] Zero Fiscal Note Attached

[ ] reports it back without recommendation

[ ] referred to the _____ Committee

MEMBERS SIGNING
DO PASS

M.W. Mike Do Pass

Mike Dawson

MEMBERS HAVING
OTHER RECOMMENDATIONS:

Mike Dawson, Do not Pass

(M) LO + FIZ

CHAIRMAN

Mat Tucker

H 60

POSITION PAPER/Department of Health & Social Services

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

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 Phone: 465-3038
Division: State Health Planning and Development Date: 2-14-83

Approved by Commissioner: Robt. London 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

CERTIFICATE OF NEED
HB 19

STAFF REPORT

TO

HOUSE HESS COMMITTEE

FEBRUARY 10, 1983

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-DHSS 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 a 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 32.1% 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 is 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.

SENATE HESS COMMITTEE

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 must ask itself if we can afford to give up the only control on health expenditures available to the state.

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF STATE HEALTH PLANNING & DEVELOPMENT

BILL SHEFFIELD, GOVERNOR

POUCH H 01A
JUNEAU, ALASKA 99811
PHONE: 465-3037

DOCUMENT NO. 83-35

February 2, 1983

FEB 7 1983

Dave Palmer
Legislative Assistant
Office of Representative Tischer
Pouch V
Juneau, Alaska 99811

Dear Mr. Palmer:

Attached per your request is a letter the Department received on March 22, 1982 from DHHS Region X outlining the project and formula grants received (presumably in federal fiscal year 1981) in Alaska which would be subject to the sanctions of Section 1521(d) of Title 15 of the U. S. Public Health Service Act.

Sincerely,

Phoebe A. Lindsey

Phoebe A. Lindsey
Director

Enclosure

DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service

Region X
M/S 859 Arcade Plaza Building
1321 Second Avenue
Seattle WA 98101

RECEIVED
MAR 22 1982
DSHFD

Ms. Phoebe Lindsey, Director
Division of State Health Planning & Development
Department of Health and Social Services
Pouch H 01A
Juneau, Alaska 99811

Dear Phoebe:

In response to your letter to Jack Whitney, a listing is provided below of the project and formula grants funded for Alaska, along with the dollar amount involved.

PROJECT GRANTS Federal	NUMBER	AMOUNT AWARDED
Health Systems Agencies	3	$ 980,836
State Health Planning & Development Agencies	1	$ 442,551
Immunization, Financial Assistance	1	$ 130,188
Direct Assistance		$ 38,853
Venereal Disease, Financial	1	$ 155,392
Direct		$ 72,229
Community Health Centers	1	$ 560,535
General Community Health	1	$ 120,000
Family Planning	2	$ 310,239
Maternal & Child Health R/B	1	$ 422,012
Crippled Children's Services R/B	2	$ 141,000
Community Mental Health; Initial Oper.	1	$ 787,229
TOTAL PROJECT GRANTS	14	$4,161,064
FORMULA GRANTS		
Alcohol Formula	1	$ 182,238
Health Incentive	1	$ 38,300
Maternal & Child Health A Funds	1	$ 364,000
B Funds	1	$ 70,000
Crippled Children's A Funds	1	$ 175,100
B Funds	1	$ 70,000
TOTAL FORMULA GRANTS	6	$ 899,638
TOTAL OF ALL GRANTS	20	$5,060,702

If you need clarification of the above or any further information, please let us know.

Sincerely,

Rebecca J. Dyer

Rebecca J. Dyer, Director
Office of Grants Management

cc: Jack Whitney

FY 1981 MUNICIPAL REVENUE SHARING ENTITLEMENTS (H2)

FEBRUARY 22, 1982
1982

TOTAL ENTITLEMENT = $55,707,600

KEY	COMMUNITY	PUBLIC ROAD MILES	ICE ROAD MILES	HOSPITAL ENTITLEMENT	HEALTH FACILITIES ENTITLEMENT	HOSPITAL CONST. AID
BOROUGHS AND SERVICE AREAS						
0010	ANCHORAGE A.W.	400.60	0.00	$463,885	$688,405	$5,483,870
0020	CITY S.A.	0.00	0.00	$0	$0	$0
0030	EAGLE RIVER	25.99	0.00	$0	$0	$0
0040	CHUGIAK	0.00	0.00	$0	$0	$0
0060	GIRDWOOD	10.54	0.00	$0	$0	$0
0070	GLEN ALPS	10.59	0.00	$0	$0	$0
0080	FIRE S.A.	0.00	0.00	$0	$0	$0
0090	ROADS & DRAINAGE	0.00	0.00	$0	$0	$0
0095	LIMITED ROAD S.A.	0.00	0.00	$0	$0	$0
0100	POLICE S.A.	0.00	0.00	$0	$0	$0
0110	PARKS & REC	0.00	0.00	$0	$0	$0
0120	P & R/CHUGIAK	0.00	0.00	$0	$0	$0
0130	SOLID WASTE S.A.	0.00	0.00	$0	$0	$0
0140	CHUGIAK/SOLID WASTE	0.00	0.00	$0	$0	$0
0150	BUILDING SAFETY	0.00	0.00	$0	$0	$0
0160	CITY SA ROADS & DRAINAGE	0.00	0.00	$0	$0	$0
0170	SERVICE AREA 35	0.00	0.00	$0	$0	$0
0175	UPPER O'MALLEY	14.60	0.00	$0	$0	$0
0180	PORT OF ANCH.	0.00	0.00	$0	$0	$0
0185	ROADS	58.16	0.00	$0	$0	$0
0190	AIRPORT S.A.	0.00	0.00	$0	$0	$0
0195	PUBLIC TRANSIT	0.00	0.00	$0	$0	$0
0200	PARKING S.A.	0.00	0.00	$0	$0	$0
0210	BRISTOL BAY BOROUGH	6.87	0.00	$0	$38,414	$0
0230	FAIRBANKS BOROUGH	93.60	0.00	$0	$0	$0
0240	ESTER F.P.	0.00	0.00	$0	$0	$0
0250	NORTH STAR F.P.	0.00	0.00	$0	$0	$0
0260	UNIVERSITY F.P.	0.00	0.00	$0	$0	$0
0270	HAINES BOROUGH	0.00	0.00	$0	$0	$0

FY 1981 MUNICIPAL REVENUE SHARING ENTITLEMENTS (#2) FEBRUARY 22, 1982

TOTAL ENTITLEMENT = $55,707,600

KEY	COMMUNITY	PUBLIC ROAD MILES	ICE ROAD MILES	HOSPITAL ENTITLEMENT	HEALTH FACILITIES ENTITLEMENT	HOSPITAL CONST. AID
0280	FIRE DISTRICT	0.00	0.00	$0	$0	$0
0290	JUNEAU BOROUGH A.W.	0.00	0.00	$231,942	$159,576	$33,217
0300	S.A. 1	14.23	0.00	$0	$0	$0
0310	S.A. 2	5.08	0.00	$0	$0	$0
0320	S.A. 3	38.67	0.00	$0	$0	$0
0330	S.A. 4	0.00	0.00	$0	$0	$0
0340	S.A. 5	0.00	0.00	$0	$0	$0
0350	S.A. 6	0.00	0.00	$0	$0	$0
0360	S.A. 7	0.00	0.00	$0	$0	$0
0370	S.A. 8	0.00	0.00	$0	$0	$0
0380	KENAI PENINSULA BOROUGH	2.79	0.00	$0	$0	$0
0385	CENTRAL PENINSULA HOSPITAL	0.00	0.00	$249,662	$0	$0
0390	NIKISKI F.P.	0.00	0.00	$0	$0	$0
0395	SOUTH PENINSULA HOSPITAL	0.00	0.00	$249,662	$0	$0
0400	NORTH KENAI REC.	0.00	0.00	$0	$0	$0
0410	BEAR CREEK F.P.	0.00	0.00	$0	$0	$0
0420	KETCHIKAN BOROUGH	0.00	0.00	$0	$0	$0
0430	SHORELINE S.A.	0.00	0.00	$0	$0	$0
0440	KODIAK ISLAND BOROUGH	0.00	0.00	$249,662	$125,830	$0
0450	FIRE DISTRICT I	0.00	0.00	$0	$0	$0
0455	SERVICE DISTRICT	0.00	0.00	$0	$0	$0
0460	ROAD DISTRICT	15.00	0.00	$0	$0	$0
0470	MAT-SU BOROUGH	0.00	0.00	$0	$0	$0
0480	WASILLA F.P.	0.00	0.00	$0	$0	$0
0490	BUTTE F.P.	0.00	0.00	$0	$0	$0
0500	GREATER PALMER F.P.	0.00	0.00	$0	$0	$0

FY 1981 MUNICIPAL REVENUE SHARING ENTITLEMENTS (#2) FEBRUARY 22, 1982

TOTAL ENTITLEMENT = $55,707,600

KEY	COMMUNITY	PUBLIC ROAD MILES	ICE ROAD MILES	HOSPITAL ENTITLEMENT	HEALTH FACILITIES ENTITLEMENT	HOSPITAL CONST. AID
0510	SUTTON F.P.	0.00	0.00	$0	$0	$0
0520	NON AREA-WIDE	0.00	0.00	$0	$0	$0
0525	TALKEETNA FLOOD S.A.	0.00	0.00	$0	$0	$0
0530	TALKEETNA F.P.	0.00	0.00	$0	$0	$0
0540	GARDEN TERRACE	0.00	0.00	$0	$0	$0
0541	MIDWAY	581.89	12.00	$0	$0	$0
0550	LAKES F.P.	0.00	0.00	$0	$0	$0
0560	NORTH SLOPE BOROUGH	54.47	0.00	$0	$82,700	$0
0570	SITKA BOROUGH	16.05	0.00	$240,640	$32,727	$0
FIRST CLASS CITIES						
1000	BARROW	0.00	0.00	$0	$0	$0
1010	CORDOVA	8.55	0.00	$268,751	$25,800	$0
1020	CRAIG	4.91	0.00	$0	$22,266	$0
1030	DILLINGHAM	7.77	0.00	$0	$0	$0
1040	FAIRBANKS	87.20	0.00	$268,751	$165,551	$1,181,859
1050	GALENA	5.58	0.00	$0	$10,337	$0
1060	HAINES	10.44	0.00	$0	$0	$0
1070	HOMER	11.70	0.00	$0	$15,973	$0
1080	HOONAH	4.00	0.00	$0	$0	$0
1090	HYDABURG	3.17	0.00	$0	$0	$0
1100	KAKE	5.17	0.00	$0	$0	$0
1110	KENAI	45.87	0.00	$0	$15,978	$0
1120	KETCHIKAN	16.60	0.00	$231,942	$37,110	$40,659
1140	KING COVE	3.10	0.00	$0	$9,603	$0
1150	KLAWOCK	1.69	0.00	$0	$7,422	$0
1160	KODIAK	14.68	0.00	$0	$0	$0
1170	NENANA	13.26	0.00	$0	$0	$0
1180	NOME	13.60	0.13	$323,049	$51,687	$0
1190	NORTH POLE	10.72	0.00	$0	$0	$0
1200	PALMER	19.36	0.00	$240,640	$0	$0
1210	PELICAN	1.10	0.00	$0	$7,989	$0
1220	PETERSBURG	9.48	0.00	$240,640	$23,101	$0
1230	SAND POINT	8.34	0.00	$0	$9,603	$0
1240	SAINT MARY'S	7.93	10.21	$0	$9,964	$0
1250	SELDOVIA	6.31	0.00	$0	$7,989	$0

FY 1981 MUNICIPAL REVENUE SHARING ENTITLEMENTS (#2) FEBRUARY 22, 1982

TOTAL ENTITLEMENT = $55,707,600

KEY	COMMUNITY	PUBLIC ROAD MILES	ICE ROAD MILES	HOSPITAL ENTITLEMENT	HEALTH FACILITIES ENTITLEMENT	HOSPITAL CONST. AID
1260	SEWARD	18.35	0.00	$249,662	$143,805	$0
1270	SKAGWAY	9.50	0.00	$0	$7,989	$0
1280	SOLDOTNA	24.78	0.00	$0	$0	$0
1290	UNALASKA	38.42	0.00	$0	$9,603	$0
1300	VALDEZ	15.80	0.00	$278,818	$8,922	$0
1330	WRANGELL	7.13	0.00	$240,640	$15,400	$0
1360	YAKUTAT	3.31	0.00	$0	$7,989	$0
SECOND CLASS CITIES						
5000	AKHIOK	4.00	0.00	$0	$0	$0
5010	AKIACHAK	1.59	9.00	$0	$9,964	$0
5020	AKIAK	0.00	0.00	$0	$9,964	$0
5030	AKOLMIUT	0.00	44.75	$0	$19,928	$0
5040	AKUTAN	0.00	0.00	$0	$0	$0
5050	ALAKANUK	4.00	8.00	$0	$9,964	$0
5060	ALEKNAGIK	0.00	0.00	$0	$9,603	$0
5070	ALLAKAKET	2.70	0.00	$0	$0	$0
5080	AMBLER	5.22	0.00	$0	$10,337	$0
5090	ANAKTUVUK PASS	0.00	0.00	$0	$0	$0
5100	ANDERSON	5.00	0.00	$0	$0	$0
5110	ANGOON	5.18	0.00	$0	$0	$0
5120	ANIAK	8.10	24.00	$0	$20,675	$0
5130	ANVIK	0.00	0.00	$0	$10,337	$0
5140	ATMAUTLUAK	0.00	0.00	$0	$9,964	$0
5150	BETHEL	10.85	48.00	$0	$132,026	$0
5160	BREVIG MISSION	0.00	0.00	$0	$10,337	$0
5170	BUCKLAND	0.00	0.00	$0	$0	$0
5180	CHEFORNAK	0.00	0.00	$0	$9,964	$0
5190	CHEVAK	0.50	0.00	$0	$9,964	$0
5200	CHUATHBALUK	4.00	6.00	$0	$10,337	$0
5210	CLARK'S POINT	0.00	0.00	$0	$9,603	$0
5220	DEERING	0.00	0.00	$0	$10,337	$0
5230	DELTA JUNCTION	10.88	0.00	$0	$8,600	$0
5240	DIOMEDE	0.00	0.00	$0	$0	$0

FY 1981 MUNICIPAL REVENUE SHARING ENTITLEMENTS (#2) FEBRUARY 22, 1982

TOTAL ENTITLEMENT = $55,707,600

KEY	COMMUNITY	PUBLIC ROAD MILES	ICE ROAD MILES	HOSPITAL ENTITLEMENT	HEALTH FACILITIES ENTITLEMENT	HOSPITAL CONST. AID
5250	EAGLE	2.39	0.00	$0	$0	$0
5260	EEK	0.00	0.00	$0	$0	$0
5270	EKWOK	0.00	0.00	$0	$0	$0
5280	ELIM	1.60	0.00	$0	$10,338	$0
5290	EMMONAK	3.41	7.50	$0	$9,964	$0
5300	FORT YUKON	13.50	0.00	$0	$0	$0
5310	FORTUNA LEDGE	5.00	0.00	$0	$9,964	$0
5320	GAMBELL	0.00	0.00	$0	$0	$0
5330	GOLOVIN	0.00	0.00	$0	$10,337	$0
5340	GOODNEWS BAY	0.00	0.00	$0	$0	$0
5350	GRAYLING	0.00	0.00	$0	$0	$0
5360	HOLY CROSS	4.00	0.00	$0	$10,337	$0
5370	HOOPER BAY	0.00	0.00	$0	$0	$0
5380	HOUSTON	30.75	0.00	$0	$0	$0
5390	HUGHES	0.00	0.00	$0	$0	$0
5400	HUSLIA	17.70	0.00	$0	$10,337	$0
5410	KACHEMAK	0.00	0.00	$0	$0	$0
5420	KAKTOVIK	0.00	0.00	$0	$0	$0
5430	KALTAG	0.00	0.00	$0	$0	$0
5440	KASAAN	0.00	0.00	$0	$7,422	$0
5460	KIANA	2.20	0.00	$0	$10,337	$0
5470	KIVALINA	0.00	0.00	$0	$0	$0
5480	KOBUK	0.00	0.00	$0	$0	$0
5490	KOTLIK	0.00	0.00	$0	$9,964	$0
5500	KOTZEBUE	15.50	3.50	$0	$0	$0
5510	KOYUK	1.79	0.00	$0	$10,337	$0
5520	KOYUKUK	1.00	0.00	$0	$10,337	$0
5530	KUPREANOF	0.00	0.00	$0	$0	$0
5540	KWETHLUK	0.00	0.00	$0	$0	$0
5550	LARSEN BAY	0.00	0.00	$0	$0	$0
5555	LOWER KALSKAG	3.86	40.00	$0	$10,337	$0
5560	MANOKOTAK	0.43	0.00	$0	$9,603	$0
5570	MCGRATH	10.95	0.00	$0	$10,337	$0
5580	MEKORYUK	0.00	0.00	$0	$9,964	$0
5590	MOUNTAIN VILLAGE	3.50	18.00	$0	$9,964	$0
5600	NAPAKIAK	2.48	0.00	$0	$9,964	$0

FY 1981 MUNICIPAL REVENUE SHARING ENTITLEMENTS (#2) FEBRUARY 22, 1982

TOTAL ENTITLEMENT = $55,707,600

KEY	COMMUNITY	PUBLIC ROAD MILES	ICE ROAD MILES	HOSPITAL ENTITLEMENT	HEALTH FACILITIES ENTITLEMENT	HOSPITA CONST. AI
3610	NAPASKIAK	0.00	0.00	$0	$9,964	$
3620	NEWHALEN	0.00	0.00	$0	$9,603	$
3630	NEW STUYAHOK	0.00	0.00	$0	$9,603	$
3640	NEWTOK	0.00	0.00	$0	$9,964	$
3650	NIGHTMUTE	0.00	0.00	$0	$9,964	$
3660	NIKOLAI	0.00	0.00	$0	$0	$
3670	NONDALTON	1.50	0.00	$0	$9,603	$
3680	NOORVIK	2.42	0.00	$0	$10,337	$
3690	NULATO	5.80	0.00	$0	$10,337	$
3700	NUIQSUT	0.00	0.00	$0	$0	$
3710	OLD HARBOR	4.45	0.00	$0	$0	$
3720	OUZINKIE	3.10	0.00	$0	$0	$
3730	PILOT STATION	2.00	0.00	$0	$0	$
3740	PLATINUM	0.00	0.00	$0	$0	$
3750	POINT HOPE	0.00	0.00	$0	$0	$
3760	PORT ALEXANDER	0.00	0.00	$0	$0	$
3770	PORT HEIDEN	26.60	0.00	$0	$9,603	$
3780	PORT LIONS	3.39	0.00	$0	$0	$
3790	QUINHAGAK	1.25	0.00	$0	$9,964	$
3800	RUBY	0.00	0.00	$0	$0	$
3810	RUSSIAN MISSION	0.00	0.00	$0	$0	$
3820	SAINT MICHAEL	0.00	0.00	$0	$10,337	$
3830	SAINT PAUL	37.50	0.00	$0	$0	$
3840	SAVOONGA	0.00	0.00	$0	$10,337	$
3850	SAXMAN	3.20	0.00	$0	$0	$
3860	SCAMMON BAY	1.25	0.00	$0	$0	$
3870	SELAWIK	0.00	0.00	$0	$0	$
3880	SHAGELUK	2.00	0.00	$0	$0	$
3890	SHAKTOOLIK	3.50	18.00	$0	$10,337	$
3900	SHELDON POINT	0.00	0.00	$0	$9,964	$
3910	SHISHMAREF	1.98	0.00	$0	$0	$
3920	SHUNGNAK	0.00	0.00	$0	$10,337	$
3930	STEBBINS	0.00	0.00	$0	$10,337	$
3940	TANANA	31.69	0.00	$0	$0	$
3950	TELLER	2.69	0.00	$0	$10,337	$
3980	TENAKEE SPRINGS	2.00	0.00	$0	$7,700	$

FY 1981 MUNICIPAL REVENUE SHARING ENTITLEMENTS (#2) FEBRUARY 22,. 1982

TOTAL ENTITLEMENT = $55,707,600

KEY	COMMUNITY	PUBLIC ROAD MILES	ICE ROAD MILES	HOSPITAL ENTITLEMENT	HEALTH FACILITIES ENTITLEMENT	HOSPITA CONST. AI
3990	TOGIAK	5.00	0.00	$0	$9,603	$
3000	TOKSOOK BAY	0.00	0.00	$0	$9,964	$
3010	TULUKSAK	9.50	43.00	$0	$9,964	$
3015	TUNUNAK	0.00	0.00	$0	$9,964	$
3020	UNALAKLEET	9.52	0.00	$0	$10,337	$
3030	UPPER KALSKAG	1.50	16.50	$0	$0	$
3040	WAINWRIGHT	0.00	0.00	$0	$0	$
3050	WALES	0.00	0.00	$0	$0	$
3060	WASILLA	45.14	0.00	$0	$15,400	$
3070	WHITE MOUNTAIN	1.52	0.00	$0	$9,603	$
3080	WHITTIER	6.00	0.00	$0	$0	$
3090	EXT FIRE AREAS	0.00	0.00	$0	$0	$61,81
3100	NATIVE VILLAGE COVT	0.00	0.00	$0	$0	$1,141,85
	TOTAL			$4,028,354	$2,476,985	$7,943,27

Activity Report
December 30, 1982
for Certificate of Need
Health Resources Development
State Health Planning and Development

RECEIVED
JAN 4 1983
DEHFD

A. CERTIFICATE OF NEED REVIEWS COMPLETED

1. Lake Otis Clinic, Anchorage -- "Grandfathered CON" for 125 general acute care hospital; (issued 7/27/77)

2. Sitka Community Hospital, Sitka -- Review status of "Grandfathered CON" for new facilty; (six-month extension issued 12/31/78)

3. Lake Otis Clinic, Anchorage -- Review of status of "Grandfathered CON" for new facility; (six-month extension issued 12/31/78)

4. Fairbanks Memorial Hospital, Fairbanks -- Purchase and installation of laboratory information system; (information in archives)

5. Fairbanks Memorial Hospital, Fairbanks -- Application to Medical Facility Authority for bond sale; (information in archives)

6. Alaska Hospital and Medical Center, Anchorage -- Provide 21 bed chemcial dependency unit; (information in archives)

7. Juneau Regional Rehabilitation Facility, Juneau -- Construction of a 16 bed drug abuse/detoxification and rehabilitation facility; $654,000. (issued 6/7/79)

8. Providence Hospital, Anchorage -- Purchase and instalation of a simulator for radiation therapy; $195,365. (issued 9/4/79)

9. Providence Hospital, Anchorage -- Purchase and installation of a G.E. flouricon system; $285,000. (issued 2/14/80)

10. Lake Otis Clinic, Anchorage -- Review to determine status of "Grandfathered C/N"; (Bonified certificate status continued 3/10/80)

11. Fairbanks Memorial Hospital, Fairbanks -- Remodel of labor, delivery, and nursery areas; $540,000. (issued 2/26/80)

12. Central Peninsula Hospital, Soldotna -- expansion and improvement of facility (phase one); $6,762,646. (issued 4/2/80)

13. Providence Hospital , Anchorage -- Purchase and installation of a linear accelerator; $1,785,000. (issued 5/15/80)

14. Valdez Community Hospital, Valdez -- Purchase and installation of replacement radiology room; $150,000. (issued 5/15/80)

15. Seward General Hospital, Seward -- several energy saving construction projects; $286,113. (issued 10/6/80)

16. Valley Hospital, Palmer -- Minimal expansion and remodeling of facility; $2,000,000. (issued 6/9/80)

17. South Peninsula Hospital, Homer -- expansion and improvement of facility; $6,472,300. (issued 10/28/80)

18. Faith Hospital, Glennallen -- Expansion of outpatient areas of facility; $700,000. (issued 11/3/80)

19. Providence Hospital, Anchorage -- "Grandfathered C/N" for 250 bed acute care facility; (issued 5/1/81)

20. Alaska Hospital and Medical Center, Anchorage -- "Grandfathered C/N" for 199 bed acute care facility; (issued 12/4/81)

21. Sitka Community Hospital, Sitka -- 1122 review of diagnostic ultrasound services; $79,320. (five year lease with option to purchase) (issued 11/5/80)

22. Providence Hospital, Anchorage -- Replacement of radiology room; $236,000. (issued 12/26/80)

23. Juneau Regional Rehabilitation Facility, Juneau -- Remodel facility to meet hospital standards; $250,000. (issued 2/21/81)

24. Central Peninsula Hospital, Soldotna -- Purchase and installation of radiographic and fluorscopic imaging system; $305,899. (issued 5/21/81)

25. Wrangell General Hospital, Wrangell -- Renovation and Expansion of facility; $6,870,000. (issued 7/13/81)

26. Providence Hospital, Anchorage -- Purchase of replacement radiology room; $230,000. (issued 7/20/81)

27. Providence Hospital, Anchorage -- Construction of hostel for outpatients and family of inpatients; $900,000. (issued 7/29/81)

28. Petersburg General Hospital, Petersburg -- Renovation and expansion of facility; $7,150,000. (issued 8/11/81)

29. Alaska Hospital and Medical Center, Anchorage -- Purchase adjacent professional office building for expansion of chemical dependancy unit and other hospital areas; $15,236,000. (issued 9/24/81)

30. Central Peninsula Hospital, Soldotna -- Expansion of surgery and other areas of facility (phase two); $5,849,000. (issued 11/10/81)

31. Family Centered Birth, Juneau -- Construction of a birthing center; Review terminated following a Department of Law Opinion regarding applicability of C/N statute to birthing centers; (review terminated 12/22/81)

32. Alaska Treatment Center, Anchorage -- Construction of a new free-standing inpatient rehabilitation facility; $11,400,000. (denied, 1/22/82)

33. Valley Hospital, Palmer -- Construction of a new hospital adjacent to existing facility; $10,570,000. (issued 2/19/82)

34. Cordova Hospital, Cordova -- Construction of a new hospital at a new site; $15,075,000. (issued 4/13/32)

35. Providence Hospital, Anchorage -- Purchase and installation of a laboratory computer; $440,000. (issued 4/23/82)

36. Petersburg General Hospital, Petersburg -- Modification of previously issued CON, increase in space and expenditure; $2,005,000. (issued 5/18/82)

37. Fairbanks Memorial Hospital, Fairbanks -- Construction of new 5 floor patient tower, increase in acute care beds; $26,200,000. (issued 6/2/82)

38. Humana Hospital, Anchorage - Application for temporary certificate for expansion of chemical dependency unit; $1,000,000. (denied 6/28/82)

39. Providence Hospital, Anchorage -- Purchase and install replacement hospital incinerator; $200,000. (issued 7/20/82)

40. Humana Hospital Alaska, Anchorage -- Purchase and install CT full body scanner to replace CT head scanner; $848,000. (issued 10/1/82)

41. Advanced Health Systems, Anchorage -- Construct new free-standing Raleigh Hills alcoholism treatment hospital; $3,700,000. (issued 11/16/82)

42. Charter Medical Corporation -- Construct new free-standing psychiatric and substance abuse hospital; $12,248,000. (issued 11/16/82)

43. Providence Hospital, Anchorage -- Purchase and install replacement CT full body scanner; $832,000. (issued 11/16/82)

44. Providence Hospital, Anchorage -- Purchase and install new digital fluorography system; $256,000. (issued 11/30/82)

B. CERTIFICATE OF NEED APPLICATIONS RECEIVED AND IN PROCESS OF REVIEW

1. Providence Hospital, Anchorage -- Purchase and install new hospital information system; $2,698,000.

2. Providence Hospital, Anchorage -- Construct new 160 bed patient tower, increase acute care beds, add inpatient rehabilitation program, expand ancillary departments; $79,754,000.

3. Surgery Center, Inc., Anchorage -- Construct new free-standing ambulatory surgery center to replace current facility; $2,698,000.

4. Humana Hospital Alaska, Anchorage -- Renovation and expansion of emergency department; $1,012,200.

5. Humana Hospital Alaska, Anchorage -- Construction of new patient tower adjacent to existing hospital, 73 bed increase in acute care beds, addition of 20 bed inpatient rehabilitation program; $20,000,000.

6. Lake Otis Hospital, Anchorage -- Hearing to determine whether CON should be revoked; cost of project not identified. Decision - pending.

C. ADDITIONAL LETTERS OF INTENT RECEIVED BUT NOT REVIEWED AS APPLICATIONS

1. Valley Hospital, Palmer -- Termination of skilled nursing services. No further action by VH. (LOI dated 12/13/79)

2. Metlakatla Indian Community, Metlakatla -- construction of long term care facility. $200,000. No further action by MIC. (LOI dated 12/26/79)

3. Lake Otis Clinic, Anchorage -- Construction of 265 bed acute care/chemical deependancy hospital. $7,000,000.+ No further action by LOC. (LOI dated 2/14/80)

4. Providence Hospital, Anchorage -- Construction of 132 bed addition and expansion of services. $25,400,000. No further action by Providence. (LOI dated 3/31/80)

5. Health Care Services - Alaska, Anchorage -- Sale of Nakoyia Health Care Center. $14,200,000. No further action by HCS. (LOI dated 6/6/80)

6. Alaska Kidney Foundation, Anchorage -- Construction of a new facility for Alaska Kidney Center. Capitalized five year lease = $200,000. No further action by AKC. (LOI dated 6/23/80)

7. Norton Sound Regional Hospital, Nome -- Provision of family services unit. No further action by NSRH. (LOI dated 9/25/80)

8. Kodiak Island Hospital, Kodiak -- Offering of diagnostic ultrasound services. Decision - diagnostic radiology is a part of radiology department and not a new service; therefore, is not subject to CON review. (LOI dated 10/14/80)

9. Alaska Hospital and Medical Center, Anchorage -- Addition of 21 beds to chemical dependancy unit. No further action by AHMC. (LOI dated 10/21/80)

10. Alaska Hospital and Medical Center, Anchorage -- Purchase of professional office building for facility expansion; $10,000,000. (LOI dated 12/28/80)

11. Ketchikan Genceral Hospital, Ketchikan -- Replacement of computer system. $103,000. Decision - not subject to CON review. (LOI datded 2/11/81)

12. Ketchikan General Hospital, Ketchikan -- provision of recompression chamber. $55,000. Decision - not subject to CON review. (LOI dated 7/21/81)

13. Akeela House, Anchorage -- new building for residential drug abuse therapy program. $460,000. Decision - not subject to CON review. (LOI dated 8/4/81)

14. Ketchikan General Hospital, Ketchikan -- Offering of diagnostic ultrasound services. $70,000. Decision - not subject to CON review. (LOI dated 8/19/81)

15. Providence Hospital, Anchorage -- Predevelopment application for large construction project; $4,000,000. (withdrawn 10/8/81)

16. Humana, Anchorage -- Purchase of Alaska Hospital and Medical Center by Humana. $65,000,000. Decision - not subject to CON review. (LOI dated 11/13/81)

17. Comprehensive Care Corporation, Anchorage - Establishment of a 50 bed alcoholism and chemical dependency hospital in Anchorage. Letter of intent still valid through 2/16/83, however letter received from applicant indicates that application was not expected to be submitted. (LOI dated 2/17/82)

18. Providence Hospital, Anchorage -- Offering of home health services; cost uncertain. Decision - subject to CON review. (LOI dated 1/19/92)

19. Kodiak Island Hospital, Kodiak - Purchase of gamma camera, $90,000. Decision - not subject to CON review. (LOI dated 2/10/82)

20. Humana Hospital, Anchorage - Relocation and expansion of chemical dependency unit, increase CDU from 21 beds to 36 beds; $1,000,000. Letter of intent withdrawn. (LOI dated 5/10/82)

21. Anchorage Community Mental Health, Anchorage - Establishment of residential transitional facility. Decision - not subject to CON review. (LOI dated 6/14/82)

22. Humana Hospital, Anchorage, Purchase of hospital data processing services; Decision - not subject to CON review. (LOI dated 10/11/82)

23. Penninsula Addiction Center, Inc., Soldotna - Establishment of new freestanding 12 to 24 bed substance abuse treatment facility; cost undetermined. Application anticipated. (LOI dated 5/14/82)

24. Bartlett Hospital, Juneau -- Construction of new patient tower, increase in acute care beds; $20,000,000. Application anticipated. (LOI dated 7/21/82)

25. Providence Hospital, Anchorage -- Purchase of new cardio-vascular imaging system; $820,000. Application anticipated. (LOI dated 10/1/82)

26. Providence Hospital, Anchorage - construction of employee child care center; $1,400,000. Decision - not subject to CON review. (LOI dated 10/14/82)

27. Sisters of Providence, Inc. Seattle - Purchase of Nakoyia Health. Care Center Applicability of certificiate of need requirement under review by Department of Law. (LOI dated 12/10/82)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Region X
M/S 403
2901 Third Avenue
Seattle, WA 98121

HESS

February 7, 1983

David R. Palmer
Alaska State Legislature
House of Representatives
Pouch V
State Capital
Juneau, Alaska 99811

Dear Mr. Palmer:

Although our Regional Office has not yet received a copy of House Bill 19 proposing to repeal the Alaska (AS18.07) Certificate of Need law, our recent telephone conversation provided sufficient information to reply to your January 28, 1983, letter to Mr. John D. Whitney.

Several issues are involved and although interrelated, for clarity sake ought to be considered separately, at least at first.

Section 1536 of P.L. 93-641 as amended does not, as suggested in your letter, deal with exemption of Certificate of Need requirements. In essence, it allows local Health Systems Agencies to be dropped, as a requirement of P.L. 641, and transfers their functions to the State. This includes HSA CON functions usually performed under section 122.310. Therefore, the effect of the 1536 request if granted to Alaska would be to close out Health Systems Agencies, while necessitating a State plan to accomplish the required local planning functions now accomplished by these planning bodies.

The National Health Planning and Resources Development Act of 1974, P.L. 93-641 as amended by P.L. 96-79 and P.L. 96-538, requires a State Certificate of Need program and specifies minimal requirements for this activity. These requirements are not currently being met by Alaska's CON program. Current law could be changed to gain compliance. The absence of CON enabling legislation, however, would clearly remove the possibility of compliance and prevent Full designation of the Alaska State Health Planning and Development Agency (SHPDA).

Without Full designation within specified time limits, P.L. 93-641 as amended, calls for termination of Federal support to the SHPDA and imposes certain sanctions on other Public Health Service dollars going into Alaska. The language of the Continuing Resolution passed in December 1982, however, specifically prohibits imposition of such penalties during FY 1983. Therefore, revocation of Alaska's AS 18.07 would have little impact for the remainder of FY 1983. Beyond FY 1983, the impact could be minor or drastic, depending on Congressional action and the continuance of a Federal planning act.

Potentially negative impact issue from revoking Alaska CON Statute might come from budget reductions in the upcoming SHPDA's grant application. Since approximately 30% of the SHPDA's activities have been allocated to CON, the proposed budget would probably be reduced proportionately if CON activities were no longer authorized.

During the telephone conversation you mentioned that you heard many States were considering termination of their CON program. I believe such information is not valid. Last week Mr. Whitney and I attended a week long meeting in Washington, D.C., with nine other Regional Offices and Headquarters staff. During this period, in addition to informal information exchange, each of the ten Regions reported on Planning and CON activities in the States on the basis of intelligence recently collected.

You may find several of our observations relevant to your current task:

1) Many States are---as is usual---revising their planning statute and rules to better meet their own environment and to make the State Planning less dependent on Federal support, or in anticipation of future block grant funding for Planning.

2) Several States that had requested and received 1536 designation, such as Alabama and Texas, apparently wish to regain their former planning status and reconstitute their Health Systems Agencies and local planning. (While a final program decision has not been made on this issue, the current perception is that once done, it probably cannot be undone under existing rules.)

3) Because the free-market elements do not yet exist in order to allow competition to be the major controlling factor for health care costs, most States intend to strengthen their CON and health facility rate review regulation mechanisms to cover the next few years. Highly populous States, such as New York, as can be noted by the recent report of the Health Care Capital Policy Advisory Committee" which is attached, see CON and rate review as critically important tools of planning and cost management. Other States, such as Washington, while having one of the nation's most effective programs, perceive CON and rate review as an essential but perhaps intermediate range solution to health costs management over the next few years.

On the telephone I mentioned a new and very thorough study by Arthur D. Little, Inc., that suggests CON and capital expenditure reviews are definitely cost-effective. I am including an October 1982 transition briefing memo that includes a summary of the findings of this report and some other facts you may find useful.

I hope you find this information responsive to your needs and I encourage you to call or write if we can be of further assistance.

Sincerely,

Edgar LeRoy Ross
Regional Program Consultant
for Regulatory Activities

Enclosure

cc: William R. Berry

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

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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.

Dave I would ask for this

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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JAN 31 1983

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January 26, 1983

H 555

The Honorable Mae Tischer
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 Tischer:

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 he 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

Alaska State Legislature

House of Representatives

Committee on

Health, Education & Social Services

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

January 28, 1983

John D. Whitney
Department of Health Resources Development
Public Health Service
1321 Second Ave.
Seattle, Wa. 98101

Dear Mr. Whitney:

I am the staff person assigned to develop background material for the House Committee for Health and Social Services in the Alaskan Legislature.

I am writing to solicit your comments on the attached House bill 19 that proposes to repeal the certificate of need process in Alaska. If this is done in conjunction with an application for exemption under §1536 of PL 93 641, would the effect be different, assuming the exemption is granted?

I know that this is not a new issue, just the names and faces have changed. This bill will be scheduled for a hearing soon. I will appreciate any help you can provide.

Sincerely,

David R. Palmer

Historical Note

References in Text. Subchapter XIV of this chapter, referred to in subsec. (b)(13), is classified to section 300o et seq. of this title.

1979 Amendment. Subsec. (b)(5). Pub.L. 96–79, § 122(b), inserted "and contain provisions to assure compliance with requests for information made by health systems agencies in accordance with section 300l–2(h) of this title" following "section 300n–1 of this title".

Subsec. (b)(6). Pub.L. 96–79, § 111(c), inserted in cl. (A), provision exempting from the public meeting requirement any part of a meeting in which it is likely that information respecting the performance or remuneration of an agency employee will be disclosed and such disclosure would constitute a clearly unwarranted invasion of privacy or that information relating to the agency's participation in a judicial proceeding will be disclosed, and in cl. (C), provision exempting from the public records requirement any records or data respecting the performance or remuneration of an employee the disclosure of which would constitute a clearly unwarranted invasion of privacy or records or data of the agency relating to its participation in a judicial proceeding.

Subsec. (b)(7)(A). Pub.L. 96–79, § 120(b), inserted "and for the coordination by the State Agency in the conduct of its activities with any entity of the State which reviews the rates or budgets of health care facilities in the State" following "health and health care".

Subsec. (b)(7)(C). Pub.L. 96–79, § 115(b)(3), added cl. (C).

Subsec. (b)(10). Pub.L. 96–79, § 101(b)(2), inserted provision requiring the State Agency to assemble and report to the Secretary data, other than data regularly collected by any entity of the Department of Health, Education, and Welfare, required by the Secretary to carry out his responsibilities under section 300k–1(e) of this title, including data on personnel, facilities, and other resources needed to meet State health plan goals.

Subsec. (b)(13). Pub.L. 96–79, §§ 117(b)(4), 123(c)(1)(A), substituted in provision preceding subpar. (A), "paragraph (4), (5), or (6)" for "paragraph (3), (4), (5), or (6)" and "or (g)" for "(g), or (h)", inserted in subpar. (A), "in a timely manner" following "be reviewed" and ", or, if there is no such State law" following "administrative agencies", and in cl. (B), "under subparagraph (A)" following "reviewing agency".

Subsec. (c). Pub.L. 96–79, § 123(e)(1), substituted "once every three years" for "once every year".

Change of Name. "Department of Health and Human Services" was substituted for "Department of Health, Education, and Welfare" in subsec. (b)(10) pursuant to section 509(b) of Pub.L. 96–88 which is classified to section 3508(b) of Title 20, Education.

Effective Date of 1979 Amendment. Amendment of subsec. (b)(13) by section 117(b)(4) of Pub.L. 96–79 effective on Oct. 4, 1979, except that if the Secretary of Health and Human Services determines that any amendment made by such section will require a State to change its laws before the State health planning and development agency designated for such State may perform its functions under section 300m–2(a)(4)(B) of this title, such amendment shall take effect in such State, if the State legislature is in a regular session on Dec. 17, 1980, and the legislature will be in session for at least 12 months from Dec. 17, 1980, 12 months from Dec. 17, 1980, or if the State legislature is in session on Dec. 17, 1980, but 12 months do not remain in such session after Dec. 17, 1980, or if the State legislature is not in session on Dec. 17, 1980, 12 months after the beginning of the first regular session of the legislature beginning after Dec. 17, 1980, see section 129(b)(2) of Pub.L. 96–79, set out as an Effective Date note under section 300m–6 of this title.

Amendment of subsec. (b)(5) and (7) by Pub.L. 96–79 effective one year after Oct. 4, 1979, see section 129(a) of Pub.L. 96–79, set out as an Effective Date of 1979 Amendment note under section 300l of this title.

Transfer of Functions. All functions vested by statute in the United States Civil Service Commission were transferred to the Director of the Office Personnel Management (except as otherwise specified) by Reorg Plan No. 2 of 1978, § 102, 43 F.R. 36037, 92 Stat. 3783, set out under section 1101 of Title 5, Government Organization and Employees, effective Jan. 1, 1979, as provided by section 1-102 of Ex.Ord.No.12107, Dec. 28, 1978, 44 F.R. 1055, set out under section 1101 of Title 5.

Health Systems Agencies, State Health Planning and Development Agencies, and Statewide Health Coordinating Councils; Organizational and Related Changes; Changes in Functions. Effective on or after Oct. 4, 1979, health systems agencies, State health planning and development agencies, and Statewide Health Coordinating Councils may make the organizational and related changes required by the amendments to this section by Pub.L. 96–79 and may act in accordance with the changes in their functions made by the amendments to this section by Pub.L. 96–79, see section 129(a)(2) and (3) of Pub.L. 96–79, set out as an Effective Date of 1979 Amendment [illegible] title.

Legislative History. For legislative and purpose of Pub.L. 93–641, see 1974 U.S. Code Cong. and Adm.News, p. 7842. See, also, Pub.L. 96–79, 1979 U.S.Code Cong. and Adm.News, p. 1306.

Library References

States ⇐4.10.

C.J.S. States § 24.

Notes of Decisions

1. Exhaustion of administrative remedies

Health systems agency's petition for judicial review of the state board of health's recommendation to the secretary that defendant hospital be reimbursed with federal funds for certain expenses related to a proposed expenditure was properly dismissed for petitioner's failure to exhaust its administrative remedies, since the review mechanism of this subchapter requires that health systems agency whose recommendation has been rejected by a state agency request a review by an agency of the state, since petitioner did not even allege that it made any request for such a review, and since it was entitled to a review, it was not shown that a request for review would have been futile. Southern Indiana Health Systems Agency, Inc. v. State Bd. of Health, Ind.App.1979, 391 N.E.2d 845.

§ 300m–2. State health planning and development functions

Performance by State agency of State designated under section 300m(b)(3) of this title

(a) Each State Agency of a State designated under section 300m(b)(3) of this title shall, except as authorized under subsection (b) of this section, perform within the State the following functions:

(1)(A) Conduct the health planning activities of the State and implement those parts of the State health plan (except as provided under section 300m–3(c)(2)(E) of this title) and the plans of the health systems agencies within the State which relate to the government of the State, and (B) determine the statewide health needs of the State, including the need for mental health services in the State, after providing reasonable opportunity for the submission of written recommendations respecting such needs by the State health authority, the State mental health authority, and other agencies of the State government, designated by the Governor for the purpose of making such recommendations, and after consulting with the Statewide Health Coordinating Council.

(2) Prepare and, review at least triennially, and revise as necessary a preliminary State health plan which shall be made up of the HSP's of the health systems agencies within the State. In carrying out its functions under this paragraph, the State Agency shall refer the HSP's to the State health authority, the State mental health authority, and other agencies of the State government (designated by the Governor to make the review prescribed by this sentence) to review the goals and related resource requirements of the HSP's and to make written recommendations to the State Agency respecting such goals and requirements. Such preliminary plan may, as found necessary by the State Agency,

contain such revisions of such HSP's to achieve their appropriate coordination or to deal more effectively with statewide health needs determined under paragraph (1)(B). Such preliminary plan shall be submitted to the Statewide Health Coordinating Council of the State for approval or disapproval and for use in developing the State health plan referred to in section 300m–3(c) of this title.

(3) Assist the Statewide Health Coordinating Council of the State in the performance of its functions generally.

(4)(A) Serve as the designated planning agency of the State for the purposes of section 1320a–1 of this title if the State has made an agreement pursuant to such section, and (B) administer a State certificate of need program which applies to the obligation of capital expenditures within the State and the offering within the State of new institutional health services and the acquisition of major medical equipment and which is consistent with standards established by the Secretary by regulation. A certificate of need program shall provide for procedures and penalties to enforce the requirements of the program. In performing its functions under this paragraph the State Agency shall consider recommendations made by health systems agencies under section 300*l*–2(f) of this title.

(5) After consideration of recommendations submitted by health systems agencies under section 300*l*–2(f) of this title respecting new institutional health services proposed to be offered within the State, make findings as to the need for such services.

(6) Review on a periodic basis (but not less often than every five years) at least those institutional and home health services which are offered in the State and with respect to which goals have been established in the State health plan and, after consideration of recommendations submitted by health systems agencies under section 300*l*–2(g) of this title respecting the appropriateness of such services, make public its findings. In making the appropriateness review required by this paragraph of a health service, the State Agency shall at least consider the need for the service, its accessibility and availability, financial viability, cost effectiveness, and the quality of service provided.

(7) Prepare an inventory of the health care facilities (other than Federal health care facilities) located in the State and evaluate on an ongoing basis the physical condition of such facilities. Such inventory and evaluations shall be reported to the health systems agencies designated for health service areas located (in whole or in part) in the State for purposes of the functions of the agency under section 300*l*–2(b) of this title.

(8) Provide technical assistance to individuals and public and private entities in obtaining and filling out the necessary forms for the development of projects and programs.

If in determining the statewide health needs under paragraph (1)(B) or in preparing or revising a preliminary State health plan under paragraph (2) the State Agency does not take an action proposed in a recommendation

submitted under the applicable paragraph, the State Agency shall when publishing such needs or health plan make available to the public a written statement of its reasons for not taking such action.

Performance by other State agencies

(b)(1) Any function described in subsection (a) of this section may be performed by another agency of the State government upon request of the Governor under an agreement with the State Agency satisfactory to the Secretary.

(2) The requirement of paragraph (4)(B) of subsection (a) of this section shall not apply to a State Agency of a State until the expiration of the first regular session of the legislature of such State which begins after January 4, 1975.

(3) A State Agency shall complete its findings with respect to the appropriateness of any existing institutional health service within one year after the date a health systems agency has made its recommendation under section 300*l*–2(g) of this title with respect to the appropriateness of the service.

Statement

(c) If a State Agency makes a decision in carrying out a function described in paragraph (4), (5), or (6) of subsection (a) of this section which is not consistent with the goals of the applicable HSP or the priorities of the applicable AIP, the State Agency shall submit to the appropriate health systems agency a detailed statement of the reasons for the inconsistency.

(July 1, 1944, c. 373, Title XV, § 1523, as added Jan. 4, 1975, Pub.L. 93–641, § 3, 88 Stat. 2246, and amended Aug. 1, 1977, Pub.L. 95–83, Title I, § 106(n), 91 Stat. 385; Oct. 4, 1979, Pub.L. 96–79, Title I, §§ 115(c)(1)(A)–(C), (i)(2), 117(b)(1), (2), 118(a)(2), (b)(2), 123(c)(2), (3), (e)(2), (g)(1), 93 Stat. 607, 608, 610, 618, 619, 621, 625–627; Oct. 7, 1980, Pub.L. 96–398, Title III, § 303, 94 Stat. 1588; Aug. 13, 1981, Pub.L. 97–35, Title IX, § 902(e)(1), 95 Stat. 560.)

Historical Note

1980 Amendment. Subsec. (a)(1)(B). Pub.L. 96–398 added provisions respecting applicability to the need for mental health services in the State.

1979 Amendment. Subsec. (a). Pub.L. 96–79, § 115(c)(1)(C), inserted following par. (8), provision requiring that if the State Agency, in determining the statewide health needs or in preparing or revising a preliminary State health plan, does not take an action proposed in a recommendation, the State Agency make available to the public a written statement of its reasons for not taking such action when publishing such needs or health plan.

Subsec. (a)(1). Pub.L. 96–79, § 115(c)(1)(A), redesignated existing provision as subpar. (A), and in subpar. (A) as so redesignated, substituted "except as provided under section 300m–3(c)(2)(E) of this title" for "under section 300m–3(c)(2) of this title", and added subpar. (B).

Subsec. (a)(2). Pub.L. 96–79, § 115(c)(1)(B), (i)(2), substituted "review at least triennially, and revise as necessary" for "review and revise as necessary (but at least annually)" and "statewide health needs determined under paragraph (1)(B)" for "statewide health needs" and inserted provision requiring the State Agency to refer the health systems plan to the State health authority, the State mental health authority, and other agencies of the State government to review the goals and related resource requirements and to make written recommendations to the State Agency respecting such goals and requirements.

Subsec. (a)(3). Pub.L. 96–79, § 123(c)(2) struck out "review of the State medical facilities plan required under section 300o–2 of this title, and in the" following "State in the".

MSG 83-00005437 PRTY 1 02/01/83 16:36:45 ORIG: LJ03 IN= 0001
FROM: DAVE PALMER TO: KIM
TARGET: LJ03 SUBJ: CERTIFICATE OF NEED..RETRY PAGE 0001

KIM..I FOUND THAT I SENT THE SECOND PAGE TWICE. I AM LEARNING THIS SPACE AGE STUFF SLOWLY. I WILL SEND THE FIRST PAGE NOW.

I AM TRYING TO GATHER INFORMATION CONCERNING THE CERTIFICATE OF NEED PROCESS THAT FINDS ITS ROOTS IN PL 93-641. THERE IS A BILL IN OUR COMMITTEE THAT PROPOSES TO REPEAL REFERENCE TO SEC. 1521 (B)(3) AND SEC. 1523 OF PL 93-641...THE CERTIFICATE OF NEED PROCESS. I AM TRYING TO DETERMINE THE IMPACT ON ALASKA IF THAT BILL IS PASSED.

SANCTIONS AGAINST STATES THAT DO NOT CONFORM TO THE FEDERAL LAW INCLUDE REDUCTION OF PUBLIC HEALTH SERVICE GRANTS AND CONTRACTS TO ANY ENTITY IN THE STATE BY 25% THE FIRST YEAR, THEN 50%,75%, AND 100% OVER THE NEXT THREE YEARS.

MY UNDERSTANDING IS THAT ALASKA HAS ALREADY BEEN PLACED ON "CONDITIONAL" STATUS DUE TO NON COMPLIANCE WITH PORTIONS OF THE CERTIFICATE OF NEED PROGRAM (PIONEER HOMES ARE NOT INCLUDED). I HAVE ASKED JOHN WHITNEY OF REGION X IN SEATTLE FOR HIS AGENCY'S REACTION TO A REPEAL OF THE CERTIFICATE OF NEED. IN PRACTICE, IT APPEARS THAT THE FEDERAL GOV'T HAS NOT INSTITUTED SANCTIONS, EVEN THOUGH STATES LIKE CALIFORNIA HAVE...CONT NEXT PAGE

MORE _ NXT MSG U/R/S _ PREV MSG U/R/S _ RESEND _ CANCEL _

MSG 83-00005437 PRTY 1 02/01/83 16:36:45 ORIG: LJ03 IN= 0001
FROM: DAVE PALMER TO: KIM
TARGET: LJ03 SUBJ: CERTIFICATE OF NEED..RETRY PAGE 0002

OUT OF COMPLIANCE FOR YEARS. IN FACT, SANCTIONS WERE SUSPENDED BY PL 97-377. A CONTINUING RESOLUTION SUSPENDS THOSE SANCTIONS THROUGH SEPTEMBER OF 1983. SPECIFIC QUESTIONS ARE ON OMNI 5332 AND 5404. I HOPE THIS OMNI CONFUSION HASN'T MADE THINGS IMPOSSIBLE FOR YOU TO DECIPHER. THANKS AGAIN. DAVE PALMER

BACK _ NXT MSG U/R/S _ PREV MSG U/R/S _ RESEND _ CANCEL _

MSG 83-00005332 PRTY IN= 0001
FROM: Dave Palmer TO: Kim
ACCT: kinney SUBJ: HB 19, certificate of need TYPE: PAGE 1

My questions, general and specific:F
1. What are the chances that the sanctions may again be suspendedF as in 97-377. In short, what does the mood of congress seem to be regardingF certificate of need (how's that for a wide open questions?).F
2. Can you find out what response the Health and Human ServicesF Dept. would have to a repeal of certificate of need here?F
3. Would an exemption via B1536 of PL 93Z641 for Alaska to theF health systems agency requirement do the same thing as a repeal of theF certificate of need? Authority is supposedly in an amendment to the F Omnibus Budget Reconciliation Act of 1981.F
4. If certificate of need were repealed, and sanctions invoked,F how much money would Alaska loose?F
F
I'll appreciate any help. Send answer to the LIO office in Juneau.F I am in rm. 112 at the capitol. The phone is 465Z3777. Thanks.

MORE
MSG326 MSG WITH THIS NUMBER ALREADY EXISTS

5404 p. 2

MSG1-5 to img

3391

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

Pouch Y, State Capitol
Juneau, Alaska 99811
(907) 465-3991

February 25, 1982

MEMORANDUM

TO: Representative Mike Beirne

FROM: Leslie Longenbaugh, Research Staff

RE: Health Care Planning Agencies
Research Request Number 82-32

Jens Zehbe of your staff asked that we provide information on moving to a "§1536 designation" in Alaska to replace the State's health systems agencies. Mr. Zehbe also asked that we provide a copy of the Ohio legislation that dissolved that state's health systems agencies in favor of the §1536 designation.

The §1536 designation derives from Section 1536 of PL 93-641, the National Health Planning and Resources Development Act of 1974. The Act required that governors designate health systems agencies in local health care service areas; these agencies assess the health care needs of their local populations and make recommendations regarding certificates of need, which must be obtained by providers who plan to make capital improvements costing more than $600,000 or purchase equipment at a cost of more than $400,000.[1] The State Health Planning and Development Agency (SHPDA) and Statewide Health Coordinating Council (SHCC), also required and partially funded under the Act, use the health systems agencies' recommendations in issuing certificates of need to health care providers.

The federal government provides funding for each health systems agency according to the size of the population served; states of small population, such as Alaska, receive a minimum level of funding for their health systems agencies. The states share in the cost of the PL 93-641 agencies.

Section 1536 exempts certain political bodies, such as Guam and Puerto Rico, from the requirement that they establish local health systems agencies in conjunction with their State Health Planning and Development Agencies and their Statewide Health Coordinating Councils. Also made exempt by §1536 were those states that had no health planning agencies at all prior to 1975.

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[1]These figures, $400,000 and $600,000, are the result of 1981 amendments; the original Act of 1974 specified that all improvements or purchases costing more than $150,000 required a certificate of need.

An amendment to the Omnibus Budget Reconciliation Act of 1981 allows states to apply to the Secretary of Health and Human Services for a §1536 designation (an exemption from the requirement that they provide health systems agencies) under two conditions: 1) any state could apply for an exemption, showing good cause, before November 1, 1981; and 2) a state with a population of less than 600,000 may apply for an exemption at any time. Alaska, with a population of just over 400,000, would be eligible to apply for the §1536 designation under the second of these conditions. States that move to a §1536 designation are eligible to receive for use in health care planning some of the federal funds that would have been allocated to the health systems agencies if the state were not exempt.

In the last year, the governors of Rhode Island and Hawaii have applied for and received exemptions on the grounds that their populations are under 600,000. The governors of five additional states with larger populations applied to Secretary Schweiker for §1536 designation before the November 1, 1981 deadline. The Secretary granted all five requests; Ohio, Nebraska, Missouri, Louisianna, and Alabama have taken the §1536 designation and are now dismantling their health systems agencies.

Ohio was the first state to apply for a §1536 designation under the conditions of the Omnibus Health Care Reconciliation Act of 1981. We spoke with Frankie Williamson of the Health Planning and Development Agency in Ohio's Department of Health,[2] who reported that in applying for the exemption, the governor of Ohio was responding to a political battle that had been raging for some time. Because they refused to issue a number of certificates of need to potential builders of hospitals, the state's ten health systems agencies were seen by some legislators and others as standing in the way of a source of employment. Ms. Williamson noted that the Ohio health systems agencies were somewhat more aggressive in the pursuit of their advisory function than their counterparts in most other states have been. When the state Department of Health issued certificates of need over their objections, the health systems agencies sometimes took the state to court, charging that the state health planning and development agency had been "arbitrary and capricious" in overriding the agencies' recommendations. For its part, the State of Ohio accused the health systems agencies of being "politically motivated" in their recommendations.

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[2]Frankie Williamson, Ohio Department of Health, Columbus; telephone: (614) 466-3543.

Because the National Health Planning and Resources Development Act gave responsibility for applying for and administering health care agency funds to governors rather than to legislatures, it was the executive branch in Ohio that moved to change that state's designation. The only legislation that was introduced concerning the move was enacted after the change in designation, to "clean up" the state statutes by deleting all mention of the official duties and privileges of the dissolved health systems agencies. This legislation was important in Ohio, because there was some question over whether the §1536 designation would actually dissolve the agencies if they were still included in the statutes. The legislation finally was enacted, after much debate, in late 1981. Because the bill did not actually enact the change to a §1536 designation but instead only deleted the health systems agencies from the statutes, and did not contain any language that would be instructive to you, we did not obtain a copy of the legislation.

In addition to amending the conditions of eligibility for the §1536 designation, Congress, at the request of President Reagan, in 1981 reduced substantially the level of federal funding for the state health care planning agencies that are required under PL 93-641. The President has been said to feel that health care costs can best be reduced through free market competition, achieved through deregulation of the industry. This philosophy was reflected in Ohio, according to Ms. Williamson, where the governor and legislature chose limited deregulation of health care over continued local planning. According to staff at the State Health Planning and Development Agency[3], the federal funding for Alaska's three health systems agencies has been reduced by almost 40%, to approximately $165,000 per agency; the Legislature has allocated $100,000 to each of the health systems agencies for the present fiscal year.

If we can be of further assistance to you, please call on us.

LL/bf

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[3]State Health Planning and Development Agency, Department of Health and Social Services, Juneau; telephone: 465-3038.

ments. Sole community providers would be eligible for exceptions or adjustments at the Secretary's discretion. Psychiatric, long term care, tuberculosis, and pediatric facilities would continue to receive cost-plus reimbursement while HHS works on separate payment plans for each group. The payment system would be phased in according to each hospital's fiscal year. HHS hopes to have the plan implemented for fiscal 1984, which begins on Oct. 1, 1983.

Despite Schweiker's enthusiasm for the DRG model, Congress is expected to take a careful look at the details of the plan. Madigan has not warmed to the concept and may prove to be a difficult problem for HHS. Waxman is expected to maneuver to gain some jurisdiction over such a bill even though it is a Medicare Part A proposal and therefore under the Ways & Means Committee's province. Reliable Capitol Hill sources say they believe Congress will spend the next year talking about prospective payment but do nothing until 1984 in time for the fiscal 1985 budget. Congress can rely on the cost controls instituted under TEFRA to continue to contain costs while this debate goes on.

* * *

STATUS REPORT

Health Planning Odyssey Continues

With the failure of the 97th Congress to pass a new health planning bill (HLeg. 12-22-82), the fate of that program remains in limbo. However, it is clear that despite Reagan Administration opposition, the planning program continues to have strong bipartisan Congressional support. New attempts by the Administration to eliminate or cripple the program are almost sure to fail. In fact, if anything at all happens in 1983, Congress is likely to pass a strengthening measure.

During the past two years, the Administration has made several legislative and regulatory attacks on the planning system. Health and Human Services Secretary Richard Schweiker and Office of Management and Budget director David Stockman brought with them to the Administration a dislike for the regulatory aspects of planning. Strong hospital industry influence on HHS and White House officials fueled the anti-planning fire.

In his first budget, President Reagan proposed a three-year phase-out of the planning program. Funding was to be cut in half in fiscal 1982 and more or less eliminated after fiscal 1983. At the same time, the Administration sought changes in planning's certificate of need laws and a diminution of the power of health systems agencies -- the local planning component.

Congress resisted the call for a phase-out but did agree to make substantive changes in the planning law. Certificate of need thresholds were increased to the following new levels: capital expenditures $600,000, major medical equipment $400,000, and new institutional health services $250,000. Congress also agreed to establish a new flexibility for states whereby a governor could ask HHS to allow that state to eliminate all HSAs and perform planning activities on a statewide basis. This power became known as the "1536 option" named for the section of the new bill pertaining to the flexibility. In the time since that bill became law, 11 states have taken the 1536 option. HHS is encouraging other states to join them.

The Administration was not satisfied with those changes and, in its fiscal 1983 budget proposal, provided only $2 million for planning activities. These funds were to be used to close offices of remaining planning agencies. Reagan officials hoped that they would have more luck with this proposal since the planning authority expired on Sept. 30, 1982. However, despite several attempts, Congress never agreed to a planning bill but continued to fund the program into fiscal 1983 through a continuing appropriations resolution.

The Administration might have had its way if not for the opposition of key House Republican health leader Rep. Edward Madigan (R-Ill.). Madigan, who holds the ranking Republican spot on the House Commerce Health Subcommittee, decided early in 1982 that some planning function is necessary in the multi-billion hospital industry. He began work with the National Council of Community Hospitals to develop an alternative planning program. The plan that Madigan arrived at would have repealed the current program but created a new planning block grant. CON thresholds would rise to $5 million for capital expenditures while leaving the other thresholds at their current levels. It would have allowed states the option of continuing local planning but provide no federal funding for it.

Madigan put forward a draft version of his bill for comment in the hospital and planning community and by fellow health policy makers in Congress. It received a cool welcome from all concerned but was not dismissed by any. Rep. Henry Waxman (D-Calif.), chairman of the Commerce Health Subcommittee, had introduced his own planning bill and was not immediately open to compromise with his Republican counterpart. Later, this lack of trust between the two men proved to be a key factor in the long delay that eventually led to the rejection of any planning bill.

With Waxman holding steady on the left, Madigan moved to the right to court conservative colleagues on the Health Subcommittee. In order to gain support from conservative Democrats Richard Shelby (D-Ala.) and Phil Gramm (D-Tex.), Madigan agreed to change his draft bill to significantly increase the CON thresholds. Now, he proposed a $10 million threshold for capital expenditures and $1 million for each of the remaining two categories.

By making these moves, Madigan picked up enough support to pass his bill in the Health Subcommittee. Waxman moved to stymie Madigan in the full committee but could not gain enough support to pass his own bill. When Madigan seemed almost sure to have the votes to get his bill approved in committee, Waxman agreed to compromise. The two men, along with Shelby, Gramm, Rep. John Dingell (D-Mich.), and James Broyhill (R-N.C.) fashioned a compromise that would have set CON thresholds at $5 million for capital expenditures, and $1 million each for medical equipment and health services. That bill later passed the House by a wide margin.

Meanwhile, in the Senate Human Resources Committee planning debate took many turns. Democrats on the panel backed an extension of planning while committee chairman Orrin Hatch (R-Utah) opposed the program. However, Republican moderate Lowell Weicker (Conn.) supported planning and developed a proposal that he offered as an amendment to a biomedical research bill. Weicker seemed to have the support of two Republican colleagues on the panel, Dan Quayle (R-Ind.) and Paula Hawkins (R-Fla.). Those two deserted Weicker at the last minute and his amendment was defeated. Quayle, under pressure from his Republican governor, pressed Hatch and Hawkins to develop some kind of planning proposal. The

three later introduced S.2720, a bill that would have extended planning for one year with no CON thresholds and no local planning. The skeleton bill was introduced but never considered by the Senate.

While Congress debated the merits of health planning legislation, the Administration continued its attempts to weaken the existing program. It placed sharp restrictions on the minimum staffing levels for HSAs. While the staffing requirements were on the federal books, they had been developed during a time when planning was a growing program. With the changes enacted by Congress in 1981, the staffing requirements were obsolete. Several HSAs were sent termination notices before Congress stepped in once again.

Behind the leadership of Senate Appropriations Labor-HHS Subcommittee chairman Harrison Schmitt (R-N.Mex.), Congress approved a restriction on HSA closing for understaffing. The language was added to a supplemental appropriations bill.

The final round of fighting over health planning came during the recently completed lame-duck session of the 97th Congress. Madigan, Waxman, Hatch, and others saw that the session was the last chance they would have to put together a compromise bipartisan planning measure. Working quietly behind the scenes, the three men agreed to a bill that would continue the program for two-and-one-half years, raise the CON thresholds to $1 million for capital expenditures and $500,000 for other costs, and provide for the repeal of the program on March 31, 1985. That bill cleared the House as part of a package including alcohol and drug abuse funding and was sent to the Senate for what was expected to be quick approval.

It was here that HHS Secretary Schweiker stepped in and gummed up the works (HLeg. 12-22-82). Schweiker insisted that Congressional Republicans would do better in the 98th Congress in obtaining repeal of the program. This argument seemed to fly in the face of common political belief that the GOP would have difficulty passing much of anything in the coming year because of Democratic gains in the House. Madigan argued that he felt Waxman would be able to steamroll him in committee and gain House passage of a liberal planning bill. Madigan added that Waxman is clever enough to attach such a bill to a popular legislative vehicle that would be difficult to block in the Senate. Schweiker, citing his 20 years of experience in Congress, stuck to his guns and blocked Senate approval of the bill.

Schweiker's actions seemed even more peculiar in light of the action taken by Congress on the continuing appropriations resolution. Congress not only funded planning at $64 million, but added language that blocks HHS from terminating HSAs for understaffing or because they have been on conditional status for more than 12 months. It also places a one-year restriction on the imposition of penalties on states without CON laws.

The results for planning agencies are almost all positive. Funding will continue at the same level as 1982. CON thresholds will remain at $600,000 for capital expenditures, $400,000 for major medical equipment, and $250,000 for institutional health services. HHS may well be unable to terminate any HSA durthe coming year. And Waxman and his fellow planning supporters will have a stronger hand in seeking a planning bill in 1983.

* * *

MSG 83-00005404 PRTY 1 [redacted]/01/83 15:47:18 ORIG: [redacted]40 IN= 0002
FROM: DAVE PALMER TO: KIM
TARGET: LJ40 SUBJ: CERTIFICATE OF NEED..PAGE 2 PAGE 0001

...SANCTIONS WERE SUSPENDED BY PL 97-377 THROUGH SEPT. 83.
MY QUESTIONS:

1. WHAT ARE THE CHANCES THAT THE SANCTIONS MAY ATAIN BE SUSPENDED? IN SHORT, WILL 97-377 BE CONTINUED BEYOND SEPTEMBER 1983?

2. CAN YOU FIND OUT WHAT RESPONSE THE HEALTH AND HUMAN SERVICES DEPARTMENT WOULD HAVE TO A REPEAL OF THE CERTIFICATE OF NEED HERE?

3. WOULD AN EXEMPTION VIA SUBSECTION 1536 OF PL 93-641 FOR ALASKA TO THE HEALTH SYSTEMS AGENCY REQUIREMENT DO THE SAME THING AS A REPEAL OF THE CERTIFICATE OF NEED? AUTHORITY IS SUPPOSEDLY IN AN AMENDMENT TO THE OMNIBUS BUDGET RECONCILIATION ACT OF 1981.

4. IF THE CERTIFICATE OF NEED PROCESS IS REPEALED, HOW MUCH MONEY DOES ALASKA LOOSE?

I HAD TROUBLE WITH OMNI, THIS IS MY FIRST TRY. REPLY TO LIO OFFICE IN JUNEAU. I AM IN RM. 112, PH 465-3777. HOPE THIS ALL GETS THERE. THANKS FOR ANY HELP.

NXT MSG U/R/S PREV MSG U/R/S RESEND CANCEL

2-4-83

Phone call from Jack Whitney, Ed Ross
206-442-0215
Public Health - send copy of SSHB19 - omitted from letter

1. State is on "conditional" status.
   Pioneer home exemption NOT as big an issue w PHS as w/ state hosp. assn.
   Notification, requirements, etc
2. Attempt by state to repeal CON does not change ~~State~~ Fed law. Requiring CON. Put state further out of compliance
3. Most states are strengthening CON process
4. Sanctions don't apply until October.
5. 1536 exemption is from public Health planning agencies. State must do same functions w/o fed money States that have taken the exemption can't get back out
6. Look at Arthur Little report - plaribe

¶LOOKUP ALL WHILE TOPIC IS "CERTIFICATE OF NEED". 15 ENTRIES WERE DETECTED 7 ARTICLES DETECTED 8 REPORTS DETECTED ¶SHOW ABSTRACTS

******* ARTICLES *******

TITLE: BOOK NOTES: 'HOSPITAL CERTIFICATE-OF-NEED CONTROLS.'
AUTHOR: AUTHOR UNLISTED.

PERIODICAL: STATE LEGISLATURES.
VOLUME INFORMATION: VOL. 5, NO. 5.
DATE 06/01/79

SCOPE
GE

ABSTRACT

THIS STUDY, CONDUCTED BY THE AMERICAN ENTERPRISE INSTITUTE, CONCLUDES THAT STATE LAWS INSTITUTING CERTIFICATE-OF-NEED PROGRAMS FOR HOSPITALS HAVE FAILED TO CONTROL RISING HOSPITAL COSTS.

NCSL IDENTIFICATION NUMBER: ART7900119
****

TITLE: CONTROLLING HEALTH CARE COSTS: STRATEGIES FROM THE STATES.
AUTHOR: HEREFORD, R.

PERIODICAL: STATE LEGISLATURES.
VOLUME INFORMATION: VOL. 6, NO. 3.
DATE 03/01/80

SCOPE
WI MD WA NJ PA NY MI FE

ABSTRACT

STATES APPEAR TO BE THE MOST APPROPORIATE LEVEL AT WHICH RISING HEALTH COSTS CAN BE CONTROLLED, SINCE STATES OFFER THE OPPORTUNITY FOR EXPERIMENTATION ON VARIOUS APPROACHES TO HEALTH CARE COST CONTROL. HOSPITAL COST CONTAINMENT PROGRAMS HAVE BEEN ENACTED IN 18 STATES, WITH PROGRMS REGULATING RATES AND CHARGES APPEARING TO BE SUCCESSFUL IN CONTROLLING HOSPITAL COST INCREASES. SEVERAL STATES HAVE ENACTED ALTERNATIVES TO INSTITUTIONAL CARE PROGRAMS DESIGNED TO PROVIDE NURSING-HOME LEVEL CARE TO PERSONS IN THEIR OWN HOME. OTHER STATES HAVE MOVED TO REDUCE THE OVERSUPPLY OF HOSPITAL BEDS AND PROVIDE EFFICIENT UTILIZATION OF AVAILABLE SERVICES.

NCSL IDENTIFICATION NUMBER: ART8000346
****

TITLE: THE MICHIGAN HOSPITAL BED REDUCTION ACT.
AUTHOR: PAUL-SHAHEEN, P.

PERIODICAL: STATE HEALTH NOTES.
VOLUME INFORMATION: VOL & # NOT AVAIL.
DATE 01/01/80

SCOPE
MI

ABSTRACT

IN 1978, THE MI LEGISLATURE ENACTED A LAW DESIGNED TO HELP SLOW THE STATE'S ESCALATING HEALTH CARE COSTS BY ESTABLISHING A PLANNING METHODOLOGY TO IDENTIFY AND REDUCE THE STATE'S EXCESS HOSPITAL CAPACITY. WHILE THE LEGISLATION, THE CONSTITUENCY THAT DEVELOPED IT AND THE PROCESS USED TO ACHIEVE IT ARE UNIQUE TO MI, THE LAW IS AN EXAMPLE OF ACTIONS THAT INDIVIDUAL STATES CAN INITIATE TO CONTROL RISING HEALTH CARE COSTS. IN THIS ARTICLE, A FORMER HEALTH CONSULTANT TO THE MI LEGISLATURE DESCRIBES THE COALITION THAT DEVELOPED THE LEGISLATION, THE KEY POINTS OF DEBATE IN ENACTING THE BILL, THE STEPS INVOLVED IN IMPLEMENTING THE ACT, AND FUTURE HURDLES TO THE PROGRAM'S SUCCESS.

NCSL IDENTIFICATION NUMBER: ART8000445
********** ----------

TITLE: NEW CERTIFICATE OF NEED LAWS IN IDAHO AND INDIANA.
AUTHOR: HEREFORD, R.

PERIODICAL: STATE HEALTH NOTES.
VOLUME INFORMATION: NUMBER 12.
DATE 06/01/80

SCOPE
CA CO CT GA HI ID IN KS KY LA MI MN MO OK NJ NY NH NM PA RI SD TN VA VT WA WI WV FE

ABSTRACT

THIS ARTICLE SUMMARIZES RECENT TRENDS IN STATE LEGISLATION IN THE AREA OF HEALTH. AMONG THE LEGISLATION DISCUSSED IN THIS ISSUE ARE NEW CERTIFICATE OF NEED LAWS IN ID AND IN, STATE REGULATION OF HEALTH INSURANCE, LAWS IN KS AND PA TO REDUCE THE NUMBER OF INSPECTIONS OF MEDICAL CARE FACILITITES REQUIRED FOR LICENSING THESE FACILITIES, LAWS REGARDING THE LICENSING OF MEDICAL PERSONNEL AND CHANGES IN LAWS RELATING TO NURSING HOMES. IT ALSO DISCUSSES A RECENT FE COURT DECISION THAT RULED THAT PERSONS OVER 65, NO MATTER HOW WEALTHY, COULD TRANSFER THEIR ASSETS TO SOMEONE ELSE AND BECOME IMMEDIATELY ELIGIBLE FOR MEDICAID.
CONT., BILL., BIBL., CASE., STAT. INCLUDED.

NCSL IDENTIFICATION NUMBER: ART8000462
********** ----------

TITLE: IN BRIEF: STATES HAVE EXTRA YEAR TO COMPLY WITH CON LAW.
AUTHOR: AUTHOR UNLISTED.

PERIODICAL: DATELINE WASHINGTON.
VOLUME INFORMATION: VOL. 5, NO. 20.
DATE 12/22/80

SCOPE
FE

ABSTRACT

LEGISLATION NOW AWAITING PRESIDENT CARTER'S SIGNATURE GIVES STATES A ONE-YEAR DEADLINE EXTENSION FOR COMPLIANCE WITH THE CERTIFICATE OF NEED (CON) REQUIREMENTS MANDATED BY THE HEALTH PLANNING AMENDMENTS OF 1979. THE EXTENSION, LONG SOUGHT BY NCSL, WAS INCLUDED IN THE CONFERENCE REPORT ON THE HEALTH SCIENCES PROMOTION ACT OF 1980. APPROVAL OF THE DEADLINE CHANGE PRECLUDES THE STATES' LOSS OF SUBSTANTIAL FE HEALTH FUNDS FOR NON-COMPLIANCE WITH FE CON LEGISLATION. NCSL CONTACT: KATHY BRENNAN WIGGINS, 202/624-5441.

NCSL IDENTIFICATION NUMBER: ART8100530
********** ----------

TITLE: HEALTH PLANNING.
AUTHOR: AUTHOR UNLISTED.

PERIODICAL: STATE HEALTH NOTES.
VOLUME INFORMATION: NO. 19.
DATE 06/01/81

SCOPE
FE

ABSTRACT

A FEW INITIATIVES ARE UNFOLDING AT THE STATE LEVEL IN RESPONSE TO THE PROPOSED WITHDRAWAL OF FE FUNDS. THIS BRIEF ARTICLE OUTLINES SOME EFFORTS IN THE STATES TO COPE WITH WHAT APPEARS TO BE A SUBSTANTIAL REDUCTION IN FE GOVT AID. THESE EFFORTS RANGE FROM INCREASED APPROPRIATIONS IN SOME STATES, CREATION OF SPECIAL STUDY TEAMS IN OTHER STATES, AND CREATION OF PUBLIC CORPORATIONS TO SERVE AS A SINGLE HEALTH SYSTEMS AGENCY IN ANOTHER STATE. BILL. INCLUDED.

NCSL IDENTIFICATION NUMBER: ART8101052
********** ----------

TITLE: CERTIFICATE OF NEED.
AUTHOR: AUTHOR UNLISTED.

PERIODICAL: STATE HEALTH NOTES.
VOLUME INFORMATION: NO. 19.
DATE 06/01/81 Rcd

SCOPE
AR AL MI FL NH NM ND SD TX MS HI TN UT VA WV WI WY FE

ABSTRACT

IN SPITE OF ADMINISTRATION EFFORTS TO WITHDRAW FEDERAL SUPPORT FOR HEALTH PLANNING AND REGULATION, MANY STATES ARE MOVING AHEAD TO BRING THEIR CERTIFICATE OF NEED STATUTES INTO CONFORMITY WITH 1979 AMENDMENTS TO THE NATIONAL HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT (PL 93-641). MOST STATES HAVE UNTIL THE END OF 1981 IN WHICH TO COMPLY WITH THE C.O.N. REQUIREMENTS OF THE 1979 AMENDMENTS. THIS ARTICLE DETAILS EFFORTS IN A NUMBER OF STATES TO MODIFY THEIR C.O.N. STATUTES. STAT.

NCSL IDENTIFICATION NUMBER: ART8101053
********** ----------

******* REPORTS *******

TITLE: PROCEDURES FOR THE ISSUANCE OF A CERTIFICATE OF NEED.
AUTHOR: MIDGET, D.

SOURCE
STATE AGENCY
OK LEGIS. COUNCIL.

PUBLISHED 03/15/78, 2 PAGES

SCOPE
OK FE

ABSTRACT

P.L. 93-641 REQUIRES THAT EACH STATE HEALTH PLANNING AND DEVELOPMENT AGENCY ADMINISTER A STATE CERTIFICATE OF NEED PROGRAM WHICH APPLIES TO PROPOSALS FOR NEW INSTITUTIONAL HEALTH SERVICES TO BE DEVELOPED WITHIN THE STATE. THE PROCEDURES PRESCRIBED BY THE OK HEALTH PLANNING COMMISSION AND THE OK HEALTH SYSTEMS AGENCY FOR OBTAINING A CERTIFICATE OF NEED ARE OUTLINED.

NCSL IDENTIFICATION NUMBER: RCH7802604
********** ----------

TITLE: CERTIFICATE OF NEED: ASSESSMENT OF CURRENT PROGRAMS AND POLICY ISSUES.
AUTHOR: HEANEY, C.

SOURCE
STATE AGENCY
WA WA UNIV.

PUBLISHED 03/13/78, 72 PAGES

SCOPE
50 FE

ABSTRACT

BACKGROUND INFORMATION AND HISTORY OF STATE CERTIFICATE OF NEED (CON) PROGRAMS IS SUPPLIED AS AN INTRODUCTION TO A COMPREHENSIVE ANALYSIS OF CON MAJOR AREAS OF DISCUSSION INCLUDE: (1)MINIMUM FEDERAL REQUIREMENTS FOR STATE CON PROGRAMS; (2)THE IMPACT OF CON (ON HEALTH CARE PLANNING, ACCESS, AND QUALITY); (3)CONSIDERATION OF CON BEYOND THE MINIMUM REQUIREMENTS. ILL., BIB., R&R., STAT. INCLUDED.

NCSL IDENTIFICATION NUMBER: RCH7802620

TITLE: CERTIFICATE OF NEED.
AUTHOR: GODFREY, B.

SOURCE
STATE AGENCY
LA LEGIS. COUNCIL.

PUBLISHED 04/16/79, 92 PAGES

SCOPE
LA FE GE

ABSTRACT

THE JOINT COMMITTEE ON HEALTH AND HUMAN RESOURCES DIRECTED ITS SUBCOMMITTEE ON HEALTH TO COMPLETE A PROJECT OF DEVELOPING A PROPOSED DRAFT OF CERTIFICATE OF NEED LEGISLATION BASED UPON PUBLIC LAW 93-641 AND THE RULES PROMULGATED AND ISSUED PURSUANT THERETO. THE DRAFT HAS THE MAIN OBJECTIVE OF MEETING THE MINIMUM REQUIREMENTS OF A CERTIFICATE OF NEED PROGRAM IN ACCORDANCE WITH PUBLIC LAW AND RULES. IT ADDRESSES THE MAJOR ELEMENTS OF A CERTIFICATE PROGRAM WHICH ARE (1)DEFINED SCOPE OF COVERAGE; (2)THRESHOLD FOR APPLICABILITY; (3)PLAN-BASED REVIEW; (4)DUE PROCESS MECHANISM; AND (5)SANCTIONS FOR NON-COMPLIANCE. CERTIFICATE OF NEED IS CLOSELY LINKED TO HEALTH PLANNING. STAT., R&R. INCLUDED.

NCSL IDENTIFICATION NUMBER: RCH7903624

TITLE: HOSPITAL COSTS IN CALIFORNIA.
AUTHOR: CHANDLER, D.

SOURCE
STATE AGENCY
CA ASSEM. OFC. OF RES.

PUBLISHED 11/01/79, 13 PAGES

SCOPE
CA FE

ABSTRACT

CURRENT GOVERNMENT POLICY REGARDING HOSPITALS IS FOUNDED ON THE THEORY THAT THE NATION HAS ENOUGH RESOURCES. THE NEW GOAL IS TO ACHIEVE MORE EQUITABLE DISTRIBUTION AND USE OF THESE RESOURCES THROUGH A MORE RATIONALE SYSTEM OF MEDICAL SERVICES ALLOCATION. BUT AN EXCESS SUPPLY OF HOSPITAL BEDS, INSTEAD OF CAUSING RATES TO FALL, LEADS TO A SMALLER PERCENTAGE OF OCCUPIED BEDS AMONG WHICH TO SPREAD THE HOSPITAL'S FIXED COSTS. THIS RESULTS IN HIGHER COSTS PER UNIT. INCLUDED IS A DICUSSION OF DEFICIENCIES WITH STATEWIDE HEALTH PLANNING AND PROBLEMS WITH CERTIFICATE OF NEED, HOSPITAL COST CONTAINMENT, MEDI-CAL COST CONTROL, AND GOVERNMENT REGULATION OF HOSPITALS.

NCSL IDENTIFICATION NUMBER: RCH8004110
********** ----------

TITLE: CERTIFICATE OF NEED.
AUTHOR: TRESIDDER, A.

SOURCE
STATE AGENCY
OR LEGIS. RESEARCH.

PUBLISHED 02/08/80, 6 PAGES

SCOPE
OR FE

ABSTRACT

CERTIFICATE OF NEED IS BASICALLY A METHOD TO PREVENT TH NSTRUCTION OR DEVELOPMENT OF UNNECESSARY AND INAPPROPRIATE HEALTH CARE FACILITIES AND SERVICES. OR LAW SPECIFIES THAT ANY PROJECT OR SERIES OF PROJECTS HAVING A CLINICAL HEALTH SERVICE RELATED LINKAGE, WHICH IN THE AGGREGATE EXCEEDS $150,000, CANNOT BE OFFERED OR DEVELOPED WITHOUT OBTAINING A CERTIFICATE OF NEED. ARGUMENTS FAVORING CERTIFICATE OF NEED INCLUDE THAT THE PROCEDURES CAN MODERATE COSTS, LESSEN DUPLICATION OF SERVICES AND FACILITIES, AND IMPROVE QUALITY AND ACCESSIBILITY OF HEALTH CARE SERVICES. OPPONENTS ARGUE THAT THE REGULATORY PROCESS RESULTS IN POLITICS ENTERING THE AREA OF HEALTH PLANNING. BIBL., INCLUDED.

NCSL IDENTIFICATION NUMBER: RCH8004346
********** ----------

TITLE: STATE REGULATION OF HEALTH MAINTENANCE ORGANIZATIONS.
AUTHOR: BELSKY, A.

SOURCE
STATE AGENCY
CT LEGIS. RESEARCH.

PUBLISHED 02/21/80, 3 PAGES

SCOPE
CT

ABSTRACT

HEALTH MAINTENANCE ORGANIZATIONS (HMOS) PROVIDE COMPREHENSIVE HEALTH CARE SERVICES IN RETURN FOR A FIXED PREPAYMENT RATHER THAN ON A FREE-FOR-SERVICE BASIS. AS A SPECIFIC TYPE OF NONPROFIT CORPORATION WITHOUT CAPITAL STOCK, HMOS ARE REGULATED BY THE INSURANCE COMMISSIONER. IN ADDITION, THEY ARE WITHIN THE JURISDICTION OF THE COMMISSION ON HOSPITAL AND HEALTH CARE'S CERTIFICATE OF NEED PROGRAM AND ARE CLASSIFIED AS 'CLINICS' FOR THE PURPOSE OF LICENSURE BY THE DEPT OF HEALTH SERVICES. SUMMARIZED ARE MAJOR STATUTORY PROVISIONS REGARDING CERTIFICATE OF NEED, INCORPORATION REQUIREMENTS, GOVERNANCE, FINANCIAL MATTERS, MINIMUM SERVICES, SUBSCRIBER AGREEMENTS AND PUBLIC HEALTH CODE LICENSURE STANDARDS.

NCSL IDENTIFICATION NUMBER: RCH8004438
********** ----------

TITLE: REPORT OF THE AD HOC COMMITTEE ON NURSING HOME UTILIZATION.
AUTHOR: AUTHOR UNLISTED.

SOURCE
STATE AGENCY
WI LEGIS. COUNCIL.

PUBLISHED 01/01/81, 32 PAGES

SCOPE
WI FE

ABSTRACT

ABOUT 60% OF NEARLY $1 BILLION SPENT THROUGH MEDICAL ASSISTANCE PROGRAMS GOES TO NURSING HOMES. IN WI 7.2% OF THE PERSONS OVER 65 LIVE IN NURSING HOMES, COMPARED WITH 5.5% NATIONALLY. COMMITTEE RECOMMENDATIONS AIMED AT SLOWING GROWTH OF NURSING HOMES BY ENCOURAGING COMMUNITY AND HOME CARE. THE COMMITTEE ADVISED A TWO-YEAR MORATORIUM ON ISSUING CERTIFICATES OF NEED FOR NEW NURSING HOME BEDS. A DRAMATIC INCREASE IN DEMAND FOR BEDS RESULTS FROM A CHANGE IN THE LAW THAT ALLOWS MENTAL PATIENTS TO BE REIMBURSED UNDER MEDICAL ASSISTANCE AS NURSING PATIENTS. THE COMMITTEE ADVISED USING HOSPITAL BEDS FOR SOME ELDERLY. BY SCREENING NURSING HOME ADMISSIONS, A TEAM COULD DIRECT SOME ELDERLY TO COMMUNITY CARE. BIBL.

NCSL IDENTIFICATION NUMBER: RCH8104934
********** ----------

TITLE: BACKGROUND MEMORANDUM ON NURSING HOME REGULATION AND NURSING HOME RATE STRUCTURES.
AUTHOR: AUTHOR UNLISTED.

SOURCE
STATE AGENCY
ND LEGIS. COUNCIL.

PUBLISHED 09/01/81, 6 PAGES

SCOPE
FE ND

ABSTRACT

A STUDY OF STATE REGULATION OF NURSING HOMES WAS REQUESTED BECAUSE OF A BELIEF THAT LARGE DIFFERENTIALS EXIST IN NURSING HOME CHARGES TO RESIDENTS WHO ARE ABLE TO PAY THEIR OWN COSTS AND THOSE RESIDENTS WHO ARE NOT. THIS REPORT CONTAINS FE AND STATE STATUTES AND REGULATIONS AND STATISTICAL DATA WITH REGARD TO NURSING HOMES IN ND. FE LAW PLACES SEVERAL REQUIREMENTS ON NURSING HOMES AS CONDITIONS OF OBTAINING FE MEDICAID FUNDS. ND REGULATES AND ADMINISTERS LONG-TERM CARE HOMES THROUGH 2 AGENCIES--THE STATE HEALTH DEPT. AND THE STATE SOCIAL SERVICE BOARD. ND LAW PROVIDES FOR THE ESTABLISHMENT OF NURSING HOMES BY A COUNTY. ILL., STAT. INCLUDED.

NCSL IDENTIFICATION NUMBER: RCH8205416

SEWARD GENERAL HOSPITAL
P.O. BOX 365
SEWARD ALASKA 99664
PHONE (907) 224-5205

January 26, 1983

JAN 31 1983

Representative Bette Cato
Alaska State Legislature
State Capitol
Pouch V
Juneau, Alaska 99811

Dear Bette:

From our point of view at Seward General Hospital, prompt passage of House Bill No. 19 repealing the State Certificate of Need program is needed immediately.

This hospital wants to and needs to offer long term care to the patients of this community under the "Swing-Bed Program" passed by Congress. To do so we must go through the Certificate of Need process because the Department of Health and Social Services has not issued a blanket Certificate of Need for this level of care. The Certificate of Need process takes 90 to 120 days to complete and the expense runs as much as $4,500.00.

I submit to you that those dollars could be better spent in patient care rather than paper work to justify a program that all agree needs to be implemented without further delay.

Thank you for your attention to this matter.

Yours truly,

C. Keith Campbell, Administrator

CKC:ecb

cc: Dennis L. DeWitt, Ak. Hosp. Asso.

Bette:
Thanks for introducing this Bill. I would like to invite you to a party at the home of Jim Burns in Juneau on Feb 3rd. Dinner at Tidewards if possible. I'll confirm by phone.

northern alaska health resources association, inc.

FEB 9 1983

February 03, 1983

The Honorable Bette Cato
Alaska State Legislature
Pouch V (MS 3100)
Juneau, Alaska 99811

Dear Representative Cato:

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

529 5th avenue, suite 8 fairbanks, alaska 99701 telephone (907) 456-2553

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 effectiveness 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.

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

Alaska State Legislature

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House of Representatives

COMMITTEES

CHAIRMAN
HOUSE TRANSPORTATION

MEMBER
COALITION POLICY COMMITTEE
HOUSE HEALTH EDUCATION
AND
SOCIAL SERVICES

M E M O R A N D U M

TO: Dave Palmer

FM: Edie Russel

RE: HB 19

DT: February 14, 1983

For your information, I've attached the correspondence received by Representative Cato, to date, concerning the proposed repeal of the State Certificate of Need program.

Unless you indicate otherwise, I'll continue to do so.

Municipal Revenue Sharing

Hospital entitlement $1,000/bed or $250,000 or $50,000/hospital

1981 - $14,620,000

Hospital Construction 25% Reimbursement

1981 = $6,000,000

Public Roads $2500/mile

~~Native Villages $25,000 each~~

Volunteer fire depts in unorganized borough

10.00 /per capita

CMS - Betty - H/E

STATE HEALTH NOTES

In This Issue

- Certificate of Need
- Health Planning
- Emergency Medical Services
- Health Insurance

Number 19
June 1981

Certificate of Need

In spite of Administration efforts to withdraw federal support for health planning and regulation, many States are moving ahead to bring their certificate of need (CON) statutes into conformity with 1979 amendments to the National Health Planning and Resources Development Act (PL 93-641). Most States have until the end of 1981 in which to comply with the CON requirements of the 1979 Amendments. Federal law stipulates that if a State CON program is found out of compliance with the federal requirements, the State will face a sizeable reduction in the amount of federal health funds it receives.

During 1980, thirteen states took action to bring their CON statutes into compliance, despite the fact that federal regulations implementing the 1979 Amendments were not issued until late in the year.

In 1981 eleven other States (**ARKANSAS, MISSISSIPPI, NEW HAMPSHIRE, NEW MEXICO, NORTH DAKOTA, SOUTH DAKOTA, TEXAS, UTAH, TENNESSEE, WEST VIRGINIA** and **WYOMING**) adopted comprehensive CON legislation. All of these laws, however, must await a determination by the Secretary of HHS to assure they meet federal specifications. So far only one state--**HAWAII**--has been judged to be in full compliance with the 1979 Amendments.

Further CON action is possible in fourteen other States where legislation has been introduced but no final action taken as of yet. A total of twelve States, however, have either refused to act or are unlikely to take action this year, thereby bringing themselves into direct conflict with federal law.

Of the States which enacted CON legislation in 1981, several referenced the federal requirements as the catalyst for their action. **ARKANSAS** and **ALABAMA**, however, have both adopted language which effectively repeals their state CON statutes in the event the Health Planning Act (PL 93-641) is not reauthorized or is repealed. The **ALABAMA** law (H 826) sets the effective date for repeal on the last day of the regular session of the legislature following the repeal of PL 93-641; the **ARKANSAS** statute makes the repeal coincidental with the repeal of the federal law. **TEXAS** amended its earlier law making CON review applicable only to those facilities and services required as a minimum by federal law.

In adopting some amendments to its CON legislation, **UTAH** reaffirmed its previous policy in support of competition. **UTAH's** law--known as the Pro-Competitive Certificate of Need Act--states that one primary objective is to increase competition and improve market conditions. The law directs that among the criteria the agencies must consider for conducting CON reviews is "the relationship of the proposed project to the existing health care system of the area in which the project is proposed to be provided, including the effect of the proposed facility or service on the maintenance of competitive conditions in the local market." The law further directs the administering agencies to consider the effectiveness of competition and consumer choice in protecting the public interest.

In other CON actions, **VIRGINIA** (HB 1452) adopted a one-year moratorium on the issuance of any certificates of need for the construction of any new nursing

homes or an increase in the bed capacity of any existing nursing homes. **MISSISSIPPI** (HB 427) extended its existing moratorium on certificates of need for nursing homes for one additional year. **WISCONSIN** is considering (AB 66) a two-year moratorium on granting certificates for both hospitals and nursing homes.

FLORIDA amended (SB 459) its CON statute giving the department extended authority to enforce statements of intent expressed by applicants which the department relied on in making a decision to issue the certificate of need.

Health Planning

On the health planning front, a few initiatives are unfolding at the state level in response to the proposed withdrawal of federal support. Bills (A 6962, S 4876) in the NEW YORK legislature would provide an additional $400,000 in state funds to health systems agencies to continue to perform state-mandated health planning functions. A resolution (HCR 5026) adopted by the **KANSAS** legislature directs the SHCC to study the future of health planning activities in the State, emphasizing the need to find ways to maintain planning activities in relevant areas and to protect the interests of local communities.

A new **FLORIDA** law (SB 459) mandates the creation of a special task force drawing from the SHCC and the Hospital Cost Containment Board to make recommendations to the legislature on important state health policy concerns. Among its specific charges, the task force is to make recommendations on alternative organizational models and funding sources for any necessary health planning or regulation programs in the State in the absence of federal requirements.

A recent telephone survey by iHPP of various state officials revealed very little optimism for the survival of local health systems agencies in the event federal financial support is withdrawn. With the exception of a few places where local business and labor coalitions or Blue Cross-Blue Shield associations have indicated a willingness to support local health planning, most state officials contacted felt that neither public nor private support would be forthcoming for their continuation. Significantly, many of the same officials expressed the view that, even if the Federal Health Planning law is repealed, their state would probably retain some degree of certificate-of-need authority, as well as some health planning functions at the state level.

In other health planning action, a new **UTAH** law (SB 15) creates a public benefit corporation to serve as the single State Health Systems Agency. In addition to its planning and development functions, the corporation is charged with fostering competition and encouraging innovations in the financing and delivery systems for health services in order to promote economic behavior by consumers and providers.

A **WEST VIRGINIA** bill (HB 1787) would authorize the SHPDA to develop and implement a plan in cooperation with participating health facilities for the merger and sharing of services for which competition will not appropriately allocate supply. The bill also would provide antitrust immunity to those facilities complying with the SHPDA's plan. A **CALIFORNIA** bill (AB 1263) would require the SHPDA to develop a plan for the regionalization of certain tertiary health care services.

Health Planning and Antitrust

In a major decision affecting health planning, the U.S. Supreme Court ruled that actions taken by providers under the general authority of the Health Planning Act are not necessarily immune from federal antitrust laws. In a specific case, the Court refused to extend immunity from antitrust to Blue Cross of Kansas City for its refusal to enter into a reimbursement contract with a hospital because the hospital failed to obtain approval from the local HSA before beginning construction (National Gerimedical Hospital and Gerontology Center v. Blue Cross of Kansas City). Blue Cross contended that its action was pursuant to the local HSA plan and was furthering the purposes of the National Health Planning Act. The Court, however, rejected the argument that the Health Planning Act immunizes all private conduct undertaken in response to the health planning process. The decision suggests that immunity from antitrust should be granted only in cases where Congress has explicitly indicated its preference. And, in the Court's opinion, "There is no reason to believe that Congress specifically contemplated 'enforcement' of advisory decisions of an HSA

by private insurance providers, let alone relied on such action to put 'teeth' into the noncompulsory local planning process."

Emergency Medical Services

Emergency medical services has been the focus of considerable legislative attention in the states this year. Both **UTAH** and **VERMONT** enacted comprehensive EMS statutes, covering a range of issues such as licensure and training of personnel, maximum rates for services, minimum standards for equipment and data collection. A comprehensive EMS bill (SB 159) is under consideration in the **MICHIGAN** legislature.

A **MINNESOTA** bill (SF 1428) emphasizes the creation of regional emergency medical service districts as the best strategy for maintaining a coordinated emergency medical services system in the State.

HAWAII is considering amending its EMS statute to increase the physician composition of the EMS Advisory Council from four to five and to require that at least two of the five physicians be engaged in the full-time practice of emergency medicine and be board eligible or board certified by the American Board of Emergency Medicine. **ARIZONA** amended its law transferring administrative authority for EMS from the Department of Public Safety to the Department of Health Services, while **VIRGINIA** amended its statute to establish a statewide air medical evacuation system.

Several States have concentrated their legislative efforts on assuring proper training programs for EMS personnel and setting standards for the provision of emergency services. **HAWAII's** amended statute (HB 733) requires that basic life support and advanced life support training programs be based on a medical model.

A recently adopted **TEXAS** bill (SB 874) and a **LOUISIANA** proposal (SB 617) would require ambulances to be staffed by two persons, thus bringing these states into compliance with federal basic life support requirements.

NEVADA's new law (SB 147) permits the activities of intermediate emergency medical technicians. Intermediate technicians are authorized to perform certain procedures and administer certain drugs so long as they are under the direct supervision of a physician or a registered nurse supervised by a physician or are in direct communication with a physician or a registered nurse supervised by a physician.

A **PENNSYLVANIA** bill (HB 1139) would provide for the recertification of emergency medical technicians every three years, while another measure (SB 603) would set out licensure requirements to operate an ambulance service and minimum standards for personnel and equipment required on ambulances. The Senate bill, for example, would require that three years after the effective date of the act all ambulances be staffed by at least two persons, one of whom must be an emergency medical technician. The bill also would direct the Department of Health to provide tuition-free emergency medical technician courses to train adequate numbers of such personnel.

Three different bills dealing with immunity from civil damages for persons providing emergency medical services (commonly referred to as Good Samaritan laws) were introduced in **LOUISIANA**. Two relate to emergency medical technicians (HB 938 and SB 695); the other covers firemen and policemen as well as certified members of ambulance or rescue squads (HB 1302).

A **WISCONSIN** bill would extend the reach of the state's Good Samaritan law by allowing ambulance drivers to assist licensed EMS personnel without being licensed themselves. This protects them from civil liability under the Good Samaritan act when they handle sick, injured or disabled persons (SB 282). **VERMONT's** new EMS statute (SB 61) limits the civil liability of volunteer personnel.

Two states, **HAWAII** and **ALASKA**, are debating legislation which would assure emergency medical services for indigents. Under SB 1275, **HAWAII** would earmark all payments for services collected by the department to finance emergency care for indigents. HB 1130 in **LOUISIANA** would require any hospital offering emergency room services and receiving financial assistance (direct or indirect) from the State to provide emergency medical services free from discrimination or without regard to ability to pay.

Finally, a **NEW YORK** bill (S 4043) would mandate group health insurance policies which cover physician services to include coverage for emergency medical services provided in physicians' offices.

Health Insurance

Public Employees—A **FLORIDA** bill (SB 327) would require that at least two group health plan options be offered to public employees. Each option must provide financial incentives to participants not to overutilize benefits. Specifically, one option would allow participants who did not file a claim in a calendar year to receive reduced premium rates in the following year. A second option would permit participants to accumulate those portions of a policy deductible not used in a calendar year and be awarded the accumulated amount upon termination from the group. A **NEVADA** law (AB 301) gives public employees the option upon retirement to cancel or continue their group insurance or medical and hospital service coverage. If a retiree elects to continue coverage, he or she must assume the portion of the premium costs for the coverage continued which the governing body does not pay on behalf of retired employees.

Cost Containment—A **WEST VIRGINIA** bill (HB 1518) would require a demonstrated "good faith effort" to control costs on the part of all accident and health insurers before the insurer could increase its rates or lessen its benefits or coverage. The bill defines a good faith effort as a vigorous attempt by the insurer through a combination of education, persuasion, and financial incentives and disincentives to control costs and to encourage health care providers to also control costs by 1) eliminating duplicative or unnecessary services or facilities; 2) promoting alternative forms of care; 3) engaging in such experiments as incentive reimbursement and utilization review; 4) encouraging consumer involvement; and 5) promoting sound management practices by health care providers. A **NEW YORK** bill (A 4154) would require health insurance plans filing for rate changes to submit an economic impact statement indicating the effect of such increased rate on the elderly, the handicapped, the unemployed and on persons living on marginal fixed incomes.

Conversion—A new **GEORGIA** law (HB 124) provides conversion privileges under private health insurance for insured surviving or former spouses. The law prohibits individual policies which provide coverage to the spouse of the insured from terminating the coverage of the spouse solely as a result of a break in the marriage, except by reason of death or divorce. All policies must contain provisions to permit the spouse, upon the death of the insured or a divorce, to obtain a nongroup policy similar to the coverage contained in the earlier policy. Similarly, an **OREGON** bill (SB 484) would permit divorced or widowed spouses to obtain nongroup health insurance coverage when previously covered under the former spouse's group policy.

Medicaid Survey

IHPP recently completed a fifty state survey of current Medicaid cost containment strategies. The survey identifies all legislative and executive proposals affecting services, eligibility and reimbursement, as well as strategies for improving the administration and management of the program. A brief summary of the survey indicates that over one half of the States have proposed some degree of benefit reduction, from limits on the number of covered hospital days to the elimination of some or all optional services. Twenty-one States have proposed either increases in current copayments on some optional services or new copayment requirements on optional services. Almost half of the States are considering significant changes in provider reimbursement, from decreasing or freezing physician payment levels to restructuring nursing home reimbursement methodologies. Most significant, 14 States are proposing significant changes in their eligibility standards. Such proposals range from more restrictive criteria for the medically needy to eliminating 18 to 21 year old students to eliminating coverage altogether for the medically needy and the AFDC-U populations.

The IHPP survey is current through mid-May 1981. Copies can be obtained by sending $3.00 to IHPP.

Publications and Reports

• A publication entitled, Role of State and Local Governments in Relation to Personal Health Services, is now available from the American Public Health Association for $4.00 a copy. The volume, a collection of presentations made at a symposium in 1980, examines the involvement of state and local governments in the financing, organizing and delivery of health care services.

•The final report of the Primary Care Task Force in **NEW YORK** has been released. The Task Force was commissioned by Governor Carey to make recommendations on how the State's primary health care policy can be improved. Among the Task Force's major recommendations are: the establishment of a Primary Care Development Program to promote new primary and ambulatory care service delivery locations and to support placement of primary care personnel in medically underserved areas; changes in state aid for medical training and establishment of reimbursement incentives to stimulate primary care training; and a "fast track" review of new types of certificate-of-need applications designed to provide primary care services in shortage areas.

• The **CALIFORNIA** Department of Health Services recently released a report entitled, "Benefits and Costs of the Family Planning Program." The report suggests that by using formal family planning services, a woman of childbearing age reduces her annual probability of pregnancy by 21 percent. Findings indicate that for Family Planning Program clients in California, the State saves an average of $5.10 for each dollar spent on family planning services; for Medi-Cal beneficiaries the State saves an average of $77.00 for each dollar spent.

• The Office of Research, Demonstrations and Statistics, HCFA, HHS, recently released a briefing paper entitled, "HMO's: Issues and Alternatives for Medicare and Medicaid." The paper provides a comprehensive overview of the major issues and alternatives which need to be addressed if public payer involvement with HMOs is to expand. The report focuses on current legislative barriers to HMO enrollment, reimbursement problems, benefits and liabilities, marketing strategies, and quality assurance. To order, request HCFA Pub. No. 03107.

• A recent report by the General Accounting Office (GAO) supports greater state legislative involvement in the federal grant process. The report, entitled "Federal Assistance System Should Be Changed To Permit Greater Involvement By State Legislatures," reviews some of the more important ways the federal grant process has discouraged legislative participation. The report concludes with a recommendation that Congress should ensure that "grant provisions assigning responsibilities to state executive officials not be construed as limiting or negating the powers of state legislatures under state law to appropriate federal funds, to designate state agencies, and to review state plans and grant applications."

• A GAO report concluded that, while the maximum allowable cost (MAC) resulted in savings under state operated Medicaid outpatient drug programs, the savings could have been even more substantial if (1) the states had implemented the limits in a more timely manner; (2) HHS had systematically updated the limits; and (3) HHS had encouraged states to implement or expand their own MAC programs.

State Health Highlights

• **NEBRASKA** has adopted legislation (LB 379) which significantly expands the scope of nursing practice. The new law addresses the state's problem of geographic maldistribution of health care services by encouraging and enabling registered professional nurses to perform in expanded roles in nursing, such as, nurse-practitioner and nurse-anesthetist.

• The **NEW YORK** Department of Health has released an information kit which explains in detail the rights and responsibilities of employers and employees under the State's new "Right to Know" law. The "Right to Know" law requires employers to notify employees what information is available concerning the toxic effects of chemical substances; to provide all requested information; and to provide education and training to employees in the safe and proper handling of such substances.

• A **MONTANA** law (Chapter 432, 1981) waives the state licensure inspection requirement for hospitals that are accredited by the Joint Commission on Accreditation of Hospitals and for clinical laboratories that are accredited by the College of American Pathologists.

• A new agreement between the **PENNSYLVANIA** Departments of Health and Insurance and Pennsylvania Blue Shield would establish a new selection process to guarantee greater consumer representation on the Blue Shield Board of Directors. The new agreement, said to be a national trend setter for nonprofit health care insurance organizations, seeks to balance the Board's structure between providers and consumers.

• The **CONNECTICUT** Department of Health Services unveiled a plan for a proposed new rating system designed to rank individual nursing homes according to certain quality-of-care standards.

• The **NEW YORK** legislature adopted legislation (S 5672, A 7137) expanding the State's Insurance law to require insurance carriers to furnish information on coverage of Medicaid recipients to the Department of Social Services, or to the local districts, upon their request.

• State health agencies spent nearly $1.2 billion in FY 80 for maternal and child health programs, according to National Public Health Program Reporting System (NPHPRS) data. Such expenditures represented the largest portion of personal health expenditures by state health agencies in FY 80.

• SB 413 in **PENNSYLVANIA**, if enacted, would preclude the implementation of any proposed closing of any state hospital or any substantial reduction in staff or patients without the approval of certain legislative committees within the General Assembly. Both the Senate Public Health and Welfare Committee and the House Health and Welfare Committee must approve the closing or staff and patient reductions before the Department could take action.

• A **FLORIDA** statute (SB 459) charges the SHCC, in consultation with the SHPDA and the local HSAs, with submitting recommendations to the legislature by October 1, 1981, regarding how federal health block grant monies should be allocated.

• A U.S. District Court ruled that **ALABAMA** is not obligated to pay all coinsurance, deductibles and other cost-sharing charges for dual eligibles under the buy-in agreement on those Medicare Part B benefits which are not covered under Medicaid. (For example, speech therapy, podiatry services, chiropractic services). Moreover, the Court declared that if the State opts to provide less than the full amount of Medicare Part B cost-sharing charges, the State is not required to file an amended state plan. The State is, however, obligated to assure that the portion of the cost-sharing charges it meets must be reasonably related to the recipient's income and resources.

• The Supreme Court of **MONTANA** has recently upheld the constitutionality of its state Medical Malpractice Panel Act. The 1977 statute had been challenged on the grounds that Montana's Medical Malpractice Panels violates an individual's right to a jury trial, access to the courts, and due process (Linder vs. Smith, Murray, and the Montana Medical Association, June 10, 1981).

• A new **GEORGIA** law directs the Department of Human Resources to establish minimum standards for certifying family violence shelters. These facilities would serve as temporary receiving shelters for the admission of any persons who were subjected to family violence (HB 203).

STATE HEALTH NOTES

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State Health Notes is jointly published several times a year with grant support from the Office of Research, Demonstrations and Statistics (ORDS), Health Care Financing Administration, DHHS, (HCFA Grants 18-P-97 321/3-03 and 18-P-97 062/8-03).

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February 14, 1983

The Honorable Milo Fritz
The Honorable Mae Tischer
Co-Chairman
Health, Education and Social Services Committee
State Capitol
Juneau, Alaska 99811

Dear Representatives Fritz and Tischer:

It is my understanding that your committee will be considering H.B. 19, An Act Repealing the Certificate of Need Program, at a hearing to be held on Friday, February 18, 1983. While it is not possible for me to attend in person, I would appreciate your reviewing the enclosed statement in opposition to this bill and entering it into the hearing record.

On behalf of the Ætna Life Insurance Company, I thank you for considering our comments.

Sincerely,

JEB/jem

Enclosure

STATEMENT OF

ÆTNA LIFE INSURANCE COMPANY

IN OPPOSITION TO

H.B. 19

As a major writer of commercial health insurance, the Ætna Life Insurance Company has for years been deeply concerned about health care cost increases and has consistently supported viable health planning programs. We strongly oppose H.B. 19, An Act Repealing the Certificate of Need Program. We believe that enactment of this legislation would represent a large step backward in Alaska's effort to realize an efficient and effective health care delivery system.

Health planning is one of the elements in the armamentarium of programs that are necessary to help in the reduction of the escalation of health costs and to ensure that the health care delivery system of the future is one that has been rationally and systematically planned.

We feel that it is most important that there be a mechanism in place for participation in the planning and development of health programs to improve the distribution of health services, ensuring that services are available to those citizens who need them, while restricting the investment in unnecessary facilities and services.

An important portion of a viable health planning program is state certificate of need legislation. We find it is essential to have such legislation in order that the necessity of capital expenditures can be determined, because of the two-pronged effect on the growth of health care costs. In the short run, the purchase, installation, and financing of expenditures increases annual health care expenditures. In the long run, operation and maintenance of capital expenditures continue to add to health care costs, to increased use of highly skilled labor (for maintenance and operation) and non-labor inputs (i.e., energy, supplies, etc.).

It has been estimated that every dollar of capital investment adds an additional 50¢ to annual operating cost. An important element in today's economy, which has had a dramatic effect on health care costs related to capital expenditures, is the interest rate now being charged on the finance debt. Efforts must be made to ensure that all capital expenditures made today are necessary and consistent with the goals of Alaska's Health Systems Plan and necessity for such expenditures.

Alaska's Certificate of Need Program is an important tool for implementation of the area health plan. We urge that this program be continued.

1) WHAT ARE THE CHANCES THAT THE SANCTIONS MAY BE AGAIN SUSPENED BEYOND SEPT. 1983?

THIS QUESTION 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, THE DEPARTMENT WILL HAVE TO AT LEAST FUND STATES THROUGH THE FIRST QUARTER OF FY84. H.H.S. IS POWERLESS TO IMPOSE THE SANCTIONS MANDATED BY LAW AND IS WAITING FOR SOME DIRECTION FROM CONGRESS.

2) WHAT RESPONSE WOULD THE DEPARTMENT OF HEALTH & HUMAN SERVICES HAVE TO A REPEAL OF THE CERTIFICATE OF NEED HERE?

OFFICIALLY I AM TOLD THAT THE DEPARTMENT CANNOT FORMULATE A RESPONSE UNTIL A REPEAL BILL IS ACTUALLY PASSED. UNOFFICIALLY, I WAS TOLD BY ONE PERSON THAT ALASKA WILL STILL HAVE TO COMPLY WITH SOME SORT OF FEDERAL REGS TO RECEIVE HEALTH CARE FUNDS AND THAT STARTING FROM SCRATCH (AFTER A REPEAL) MIGHT BE MUCH MORE DIFFICULT THAT TRYING TO AMEND THE EXISTING PROGRAM ON CERTIFICATE OF NEED. FOR INSTANCE, THE BLOCK GRANT PROPOSALS FROM THE 97TH CONGRESS ALL HAD CERTIFICATE OF NEED REQUIREMENTS. THE COMPROMISE BILL BY SENATORS QUAYLE, & KENNEDY (WHICH THE ADMINISTRATION WAS NOT WILLING TO ACCEPT IN THE 97TH CONGRESS) HAD CERTIFICATE OF NEED PROGRAM REQUIREMENTS ALSO.

3) WOULD A 1536 EXEMPTION DO THE SAME THING AS A REPEAL OF THE C.O.N.?

IT WOULD NOT. THERE IS NO CONNECTION. THE 1536 SECTION IS AN ORGANIZATIONAL OPTION WHICH THE GOVERNOR HAS TO CONTINUE OR NOT TO CONTINUE THE (3) STATE SYSTEM AGENCIES. IF ALASKA WANTS THE 1536 EXEMPTION, THE GOVERNOR WOULD HAVE TO APPLY FOR IT. THE CERTIFICATE OF NEED IS A STATUTORY PROVISION WHICH HAS PENALTIES FOR NON-COMPLIANCE ALTHOUGH THEY ARE NOT BEING EXERCISED.

4) IF THE CERTIFICATE OF NEED PROCESS IS REPEALED, HOW MUCH $ WOULD AK. LOSE?

NONE AT THE MOMENT. THE DEPARTMENT DOES NOT HAVE ANY ALTERNATIVE OTHER THAN TO CONTINUE AS THINGS ARE NOW UNTIL CONGRESS CLARIFIES THE ISSUE.

**** BROWSE FILE IN BILL ORDER ****

BILL NUMBER	STATUTE	ACTION
HB 19	18.07.021	AMENDED
HB 19	18.07.031	REPEALED
HB 19	18.07.041	REPEALED
HB 19	18.07.041	REFERENCE
HB 19	18.07.051	REPEALED
HB 19	18.07.051	REFERENCE
HB 19	18.07.061	REPEALED
HB 19	18.07.061	REFERENCE
HB 19	18.07.071	REFERENCE
HB 19	18.07.081	REPEALED
HB 19	18.07.081	REFERENCE
HB 19	18.07.091	REPEALED
HB 19	18.07.091	REFERENCE
HB 19	18.07.101	REPEALED
HB 19	18.07.101	REFERENCE
HB 19	18.07.111	REPEALED
HB 19	18.07.111	REFERENCE
HB 19	18.26.071	REPEALED
HB 19	18.26.220	REPL&REIN

SELECT A BILL NUMBER AND HIT ENTER BILL NUMBER *B 19 STATUTE 1826220

RETURN TO MAIN MENU ?

2/23
HEARING

2/23 Fbks Tom Mingen Administrator Fairbanks Memorial

1) Duplication of services
2) Cost to prepare CON
   5 people @ 60 days work
   hired organization $24,000 to review need projections
3) Public input: Lay Boards citizens
   Board of directors
4) Increased costs if CON repealed -
   N/A in Alaska
   construction costs hold up - 1%/mo inflation
   CON process difficult to time review to construction season.
5) Denied only 1 - no savings
   "No major proposal waiting in the wings".
6) Medicaid - population no increase significantly
   in medicaid # benefits increased

⇒ Increasing limits of CON threshold not addressing problem.

? # $ Retired in Fed & State 60% State grant process funds capital construction.
   Funds

Anchorage

DR. BEIRNE FAVOR modification of law
CHANGE threshold 750,000 to 1,000,000
1) MONITOR hospital, since STATE FUNDS constitute MAJOR investments.

Art Willman - SITKA President SE AK Health System
Agency - Rob. Health Service
LAW NEEDS work, don't REPEAL
opportunity REGIONAL & local groups. to REVIEW
Limits too low - 1,000,000 - 1.5M
COSTLY PROCESS $100,000?

Martin Tirador BLUE CROSS
RETAIN CON REPEAL could affect ability to provide coverage (100 of CAPital < 30K, IN operation Need to change law:
Limit to $1,000,000 min CAP EXPEND & MAJOR, equip REMOVE items from CON REVIEW / items subject to review & REGULATION. STREAMLINE process. ONE AGENCY - SHPDA in DHSS to review.
WRITTEN REMARKS? - YES

TRURAN

Dorothy Truman - Fairbanks - citizen
supports CON. Recommend changes
Work for commission on handicapped

Dennis Dewitt Nursing homes & Hospitals

- MEDICAID - CON NO RELATIONSHIP
  Agency can only stop projects

- HB112 is option to CON
  Cost of health care NOT relevant to Cost of care

Susan Callan HSA planner
Priority system for cap like CON
Public process, testimony
Local boards have vested interest in hospitals they work for. Raise limit to $750,000 or to 1 million & tie to inflation

HSA - Anchorage
Peggy Wilson - CON work gets done anyway.
public involvement - hundreds of people - testimony on controversial issues increases. Overall health planning

STATE planning - Regional plans

AK: 409.00/day 262.00/WASH 245.00/USA Aug.

UTILIZATION MORE AVAILABLE = MORE USE

John Pugh Support repeal - ... but look at AREAS that INCREASE HEALTH CARE COSTS:

Medicaid: Hospital construction & HEALTH CARE ARE RELATED. STUDY COMMITTEE ON RATE setting

Capital Budget 36.6 million for const or renovation in budget.

Reserve Sharing AS 29.90 Capital Rev. Sh. Reimbursement 25%

Capital Review HB 112 if CON REPEALED, then some REVIEW is REQUIRED to look at feasibility - STATE AS BANKER, NEED fiduciary RESPONSIBILITY, REVIEW

1. What Review exists if CON REPEALED?
   CAP REVIEW by gov.

2. Q-

Implied in position paper - need process to review construction costs

Repeal ~~or~~ in conjunction w/ review

P. Gould - capital pork barrel - cap. review not based on reason. Is CRNA relevant to review?

Why repeal CON? by Governor - marketplace economy will work in Anchorage.

PRELIMINARY STATEMENT OF FISCAL IMPACT

+165

Bill No: Senate Bill 85 Date on Bill: 1/27/83
Title: An Act repealing the certificate of need program;and providing for an effective date
Sponsor: Senators Faiks, P. Fischer, and Pettyjohn
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 Phone: 465-3038
Division: State Health Planning and Development Date: 2-14-83

Approved by Commissioner: Date: 2/16/83
Department: Health and Social Services Date:

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

SPONSOR: House Hess Committee

SUBJECT: HB 19 - Certificate of Need Repeal

MAILING ADDRESS: Info. Invitational only

zip

PHONE: 3777 CONTACT: Dave Palmer

SITES PARTICIPATING: ~~Anchorage~~ Juneau VC

TAKEN BY: Gail 2/18

T/C DATE/DAY: Wed

TIME: 1-3 pm Pacific
11-~~1~~2:00 pm Alaska
10-12 ~~Noon~~ Bering

T/C DURATION: 2 hour.

ALL ALASKAN	Anchorage	Dillingham	Juneau *	Mat-Su	Sitka
	Barrow	Fairbanks	Ketchikan	Nome	Seward
WASHINGTON DC	Bethel	Haines	Kodiak	*Petersburg	Soldotna (Kenai)
	Delta Junction	Homer	Kotzebue	Sand Point	Valdez
Sen. Stevens					*Wrangell
Sen. Murkowski					
Congressman Young					

SPECIAL OFF-NET* LOCATIONS/PHONE NUMBERS

Susan Callon	To testify
278-3631	From Anchorage
	c/o office

Chairing Site/Person *JNU - Rep Fahrenkamp *

Signature of Sponsor/Contact Person

2/18/83
Date

-------- TELECONFERENCE OFFICE USE ONLY --------

MODERATOR NOTES

Special backup, publicty or technical considerations.

Juneau Room Location
H. Hess Committee Room
112 schedule 12:20 pm
to 3:00 pm

POST TELECONFERENCE NOTES

SITE/LOCATION: _____

LOCAL MODERATOR: _____

T/C Started: _____

T/C Ended: _____

Was T/C Recorded? _____

Was T/C Broadcast on RADIO or TV?

(If yes, what stations?) _____

TESTIFIED/PARTICIPATED: _____

UNABLE TO TESTIFY: _____

OBSERVORS: _____

TOTAL #: _____

BILLING INFORMATION

Billing Address: _____

_____
zip

Phone
Charges To: _____
(area code) (phone number)

CATEGORY: Legislative ___ Non-Legislative ___

AMOUNT PAYABLE: _____

ALASKA

STATE LEGISLATURE

MEMORANDUM

Art Willman

Sitka 966-8333

1 pm Sitka L.I.O.

Chuck Kalbern

Art Wilman &

Sitka 966-8333

PRES. SE H.S.A.

Alb Health Hearth Service



HB 19 2/21

GOVERNOR'S POSITION TODAY PER EMIL:

1) FAVORS REPEAL
2) WANTS TO REMOVE STATE 25% CONSTRUCTION Reimbursement - give outright GRANTS IN PLACE of CON
3) Not strong support but will SIGN bill if PASSED.

HB19 2-25-83

Clocksin

HEALTH CARE - NOT FREE MKT

1) CONSUMER NOT RESPONSIBLE for COSTS
   3rd PARTY PAYS
2) - SUPPLY induced demand 80-70% physician's influence
3) high cost of technology
4) lack of information - choices AVAILABLE to patient

Non competitive - non profit - public funds

ROLE of CON

1) REPEAL of laws - sunset - NOT REPEALED
2) COST of CON. $250,000 for FY84
   COST to hospitals - have them support costs?

STUDIES - Arthur Little - 6 STATE REVIEW - DOCUMENTS
   SAVINGS due to CON
   - MASSachusetts - ROEMER?

IN ALASKA = NOT applicable only Anchorage
   Proposal presented - Altered by CON process - benefit
   in SMALL RURAL AREAS too.

IN Anchorage: HUMANA, Providence calculated beds in 1995 - 575 to 606. If both Approved = 692 - 85-90 beds extra

   HUMANA: NO ~~hospital~~ public $ 30% REVENUE of addition - comes from Gov't programs.

   COST COMPARISONS

Providence	250 beds	$ 186,000,000	223 47	376,000	Per bed
Hum	200 "	$ 56,000,000	161 63	150,000	Per bed

clocksin

Medical care FY 80 81 82 $153,000,000
health care covered by programs covered by CON.
ENTITLEMENT 23
Rev Operat. 36
7.5
Medicaid GRM, corrections operating funds
COST TO CONSTRUCT – related to COST to operate

Amend:
INCREASE: threshold to $600,000
~~$750,000~~ or more
400,000
Exempt: Replacement equipment
Non medical construction
Remodeling due to code conformance
STREAMline process
1) Simplify application for smaller projects
2) deadline on commissions time to approve
3) Review whether HSA's are necessary
4) ~~Prospective Rate~~ Setting commission
eliminate full reimbursement w/o careful
Review
5) tie capital const $ to C.O.N.

Supply induces demand - Roemer effect NOT VALID
WESTERN OS patient day AK - 600/1000

occupancy Rate on WEST COAST less than EAST COAST
Dentistry; ultrasound
New Mexico
"ASSN supports planning process"
ERROR factor 16% ± for Humana & Providence

DAVIS — PROV - Humana - difference between two - ?
"
HB 112
FED $ lost if CON ? 25%

OCCUPANCY RATE - Humana
Providence 95%

P. Groll — DATA from CON for Cordova made justification for expansion of hospital easier.

Mild - EQUIPMENT VERY EXPENSIVE + MAKES COST A different.

- DELAY in CON limits ACCESS to HEALTH CARE

ALAN BLUME

GOV-

1. Public REVIEW?
2. Statewide planning & coordination H. SH
3.

Humana & Providence - CON REPEAL

ALAN BLUME 2/23

1) Marketplace ECONOMICS

John Pugh

1) Fritz - Reconsider - mention to you.
2) CAP other Aspects of CAPital construction
3) - Prospective R System +
   ANHS - Medicaid

Comprehensive health care cost containment

Would NOT oppose Amendment or omnibus
bill to ~~[illegible]~~

alaska state hospital association

NORTHERN CARE

Published by the
Alaska State Hospital Association

Vol. 6 April 1985 No. 4

DATES TO REMEMBER

April 20 - 23, 1985
Medical Technology Association
of Alaska Annual Meeting
Sheraton Hotel, Anchorage

April 24 - 27, 1985
AWH Convention
Anaheim, California

April 25 - 26, 1985
Rehabilitation Workshop
Cordova Community Hospital

May 8 - 14
National Hospital Week
National Nursing Home Week

May 19-21, 1985
Alaska Medical Records Assn.
Anchorage Hilton

August 29 - 30, 1985
ACHA Seminar: Staff Evaluation
Anchorage, Alaska

September 18 - 21, 1985
ASHA Annual Meeting
Valdez, Alaska

CON REPEAL STUMBLES

On Monday, April 18, the House Finance Committee reported out a committee substitute for House Bill 19, formerly the certificate of need repeal. At the first hearing on March 25, Chairman Al Adams, (D) Kotzebue, referred HB 19 to a subcommittee of Terry Martin, (R) Anchorage, John Lindauer, (R) Anchorage, and Jim Duncan, (D) Juneau. The subcommittee, on the votes of Martin and Duncan, reported back a proposal which would sunset certificate of need and aid to construction revenue sharing on July 1, 1986, increase the threshold on new equipment and some construction to $1 million, retain CON review on any new beds or new services, caps operational revenue sharing at its current level and creates a prospective payment system for Medicaid and General Relief Medical.

Representative Bob Bettisworth, (R) College, twice offered Association sponsored amendments which would have repealed certificate of need. Both times the amendments failed. Voting with the Association for repeal were Representatives Bettisworth, Lindauer, Joe Flood, (R) Anchorage, and Jerry Ward, (R) Anchorage. Voting against the Association were Reprsentatives Adams, Martin, Duncan, Ben Grussendorf, (D) Sitka, Sam Pestinger, (R) Anchorage, and Fred Zharoff, (D) Kodiak.

A floor fight looms on the horizon over the certificate of need issue. The Association will seek to have the Bettisworth amendments added to the Finance Committee Substitute for House Bill 19 or failing that defeat House Bill 19 on the floor of the House. Without the immediate repeal of certificate of need, there is no obligation to maintain a commitment to the other parts of the bill. According to Association President Dennis DeWitt, "Legislative compromises are supposed to contain quid pro quo's to achieve some satisfaction for all participants. Currently, the Finance Committee Substitute for House Bill 19 has all the quids but the Finance Committee took away the pro quo for the Association. We, unfortunately, have no option but to carry on a floor fight to insert an amendment to repeal certificate of need and be prepared to defeat the bill entirely if we fail to amend it."

CAPITAL BUDGET BLEAK

In early April Governor Sheffield released his revised capital budget which failed to receive rave reviews. For health facilities the picture was extremely bleak. While Fairbanks Memorial Hospital received $3.4 million and Valley Hospital in Palmer received $1 million in the supplemental appropriation bill which emerged from the legislature to complete their projects, there was little in the way of commitment to new projects. In the revised budget Cordova Hospital was listed for a $2 million grant towards its $15 million project but Wrangell's $9 million project received no mention. The Association will continue to work with legislative leadership in an attempt to augment the appropriations to hospitals.

FEDS PASS PROSPECTIVE PAYMENT

On March 24 Congress passed and sent to the President a massive overhaul of the Social Security System, including a new payment process for the Medicare system. In doing so, Congress accomplished in six weeks what would have taken the better part of two years under normal circumstances.

The new Medicare Prospective Payment system will be based on Diagnostic Related Groupings (DRG) which were developed at Yale University to create an effective framework to monitor the quality of care and perform as a utilization review tool in hospitals. In 1976 the state of New Jersey began a prospective payment system based on DRG's which now has effectively been spread nation wide for hospital inpatient services under Medicare. It does not include outpatient, psychiatric, or skilled nursing services.

The measure passed by Congress (HR 1900) creates a three year phase-in period moving from the current system based on 223 limitations through a phase of nine regional urban and rural rates to national urban and rural rates. During the three year phase-in period payments will be a blend of hospital specific average Medicare costs per discharge and a combination of national and regional payment rates based on DRG's. In the fourth year payments will be based totally on national urban and rural DRG based rates.

Capital costs are passed through until October 1, 1986. In the interim, Congress must determine how to pay capital costs and if it wishes to differentiate between capital costs incurred before and after March 1, 1983. If Congress fails to act on the capital cost question by October 1, 1986 states will be mandated to perform a review of all capital expenditures over $600,000 under Section 1122. The return on equity is reduced one third and appears to be eliminated on October 1, 1986.

Sole community providers will be subject to a blended rate which is 75% hospital specific, 25% combination of regional and national DRG based payments with a further adjustment by the secretary of HHS to fully pay the costs involved if the hospital's Medicare volume changes more than 5% one year to the next. This cost adjustment would be in effect for only three years. The fourth year sole community providers would be paid as other providers under the DRG system.

The measure included language which provides a special cost of living adjustment for both Alaska and Hawaii. Also of significance to Alaska is a one year suspension of the TEFRA provision which requires a single rate for hospital based and free-standing nursing homes.

JAMBOREE WRAP-UP

Long term care facilities in Alaska reported approximately $11,000.00 in contributions to the Alaska chapters of the Diabetes and Heart Associations as a result of Rock N' Roll Jamborees sponsored by nusing homes around the state. This money raised by nursing home residents, staff and volunteers will go to benefit public education, research and community service projects of these worthwhile charities, both in local areas and on the national level.

The marathon fundraiser traditionally features individuals rocking in rocking chairs and rolling in wheelchairs for donations pledged to them by members of the community. Each nursing home in Alaska, through their resident councils, elected to add to or "dress-up" the original idea of rocking and rolling. 1983 Jamboree activities in our state included a raffle for roundtrip airfare Outside, bake sales, quessing contests, costumes, and the election of Jamboree royalty. Entertainment for the rock n' rollers ranged from belly dancing and bagpipes to a dog sled demonstration. Residents sold (and ate) chili dinners, homemade pies and sweetbreads and the ever-popular Big Mac. We recieved one report of a long term care resident who swam to benefit charity.

The Jamboree was organized by the American Health Care Association in 1977 and has become one of the most popular events in the history of nursing homes.

NATIONAL NURSING HOME WEEK

Governor Bill Sheffield has set aside May 8 - 14, 1983 as the special week this year to honor nursing homes and their residents. The theme "Memories Were Made To Be Shared" emphasizes the fact that nursing home residents have contributed much to the history of our state and have many personal memories to share about the early life of Alaska. Many of our convalescing aged and chronically ill friends and relatives need contact with the community. Members of the Alaska State Hospital Association are sponsoring many activities during the week of May 8 - 14 to ensure that this important contact is reinforced. The primary focal point is the nursing home resident and National Nursing Home Week is a good time to visit the facility in your community and share with a friend.

NORTON SOUND HOSPITAL AWARDED RURAL GRANT

A proposal entitled "Audiology Measures for Reduction of Student and Employee Absenteeism", submitted by Jane Sabes, administrator of the Norton Sound Regional Hospital, was selected as one of the winners of the Association of Western Hopitals' Rural Health Care/Business Alliance Grant Award Program. The Nome hospital will receive $24,500.00 for audiometry testing equipment to provide screening for early detection of hearing problems. Sabes cites ear infections among workers and school-aged children as a major health problem experienced in the Arctic enviroment.

Funding for the project is provided through a grant to AWH from the W.K. Kellogg Foundation. The overall goal of the Rural Health Care/Business Alliance Program is to build a supportive relationship between rural health care providers and local business leaders for the mutual benefit of the community. David Jeppson, president of AWH, noted that "competition was keen and we believe the top proposals represent important contributions to the field of rural health care".

NATIONAL HOSPITAL WEEK MAY 8 - 14

May 8 - 14 has been designated by President Reagan as National Hospital Week. The theme for the week, "We Treat You Like Family" reminds us that hospitals in Alaska are like family to the communities they serve. A caring attitude characterizes our hospitals, often situated in isolated areas where indeed, they provide a primary health care resource. The Alaska State Hospital Association urges members and friends to participate in local activities planned to increase community awareness of the services provided by dedicated and skilled professionals who offer compassionate help in the hospital.

WESTERN NETWORK INST. FOR NURSE EXECUTIVES

The Western Network for Education in Health Administration has announced the second annual Western Network Institute for Nurse Executives to be held at the University of California, Berkeley, from July 23 - 30, 1983.

This is an intensive residential program designed for nurses who hold managment positions in hospitals and long term care facilities. Its core curriculum includes the Art of Nurse Management, Strategic Planning and Marketing, Financial Management and Advanced Managerial Strategies and Tactics.

According to the Institute's news release, "the curriculum will be presented in a problem-oriented format focusing on the application of theory to pratice."

A fee of $2,150 covers tuition, course materials, housing and meals. A 10% reduction of the fee will be granted when participants submit a completed application by May 1. For applications or further information, contact Catherine Robinson, Western Network for Education in Health Administration, School of Public Health, Warren Hall, University of California, Berkeley, CA 94720 (415) 642-1627.

EXAMS FOR CLINICAL LAB TECHS

The Health & Human Services' (HHS) Proficiency Examination for Clinical Laboratory Technologists will be held October 7, 1983 in Fairbanks and Anchorage. The exact locations have not yet been determined. Applications for the exam may be obtained from the Division of State Health Planning & Development, Health Facilities Certification & Licensing in the Frontier Building, 36th and C Streets, Anchorage, Room 508 or by writing the same at 3601 C Street, Pouch 6333, Anchorage, 99502-0333, phone: (907) 561-4350. A $35. fee must accompany the application.

The examination will be conducted by Professional Examination Services, 475 Riverside Drive, New York, New York 10115 and the applications must be submitted to them before June 30, 1983.

FELLOWSHIP SITE AT BRISTOL BAY HOSPITAL

The Bristol Bay Area Hospital at Dillingham has been selected by the Association of Western Hospitals as one of two sites for the 1983 Kellogg Rural Post-Graduate Fellowship Program. The other site selected is Delta County Memorial Hospital in Delta, Colorado.

The fellowship program provides rural hospitals an opportunity to obtain management assistance from a well-trained individual who has expressed interest in rural health and who is evaluating alternatives for placement in the field. John Dumbolton, administrator of the Bristol Bay hospital, will participate with AWH in the selection of an exceptional hospital/health graduate to assume a staff management position in the Dillingham hospital for one year beginning September, 1983. Dumbolton and the Kellogg Fellow will develop specific objectives and one or more special projects achievable within the year period of the fellowship.

Funding for the project is provided through a Kellogg Foundation grant, the AWH Educational & Research Foundation and the participating hospital. AWH advises they received 13 excellent site applications from throughout the western states. "We feel that both facilities ultimately selected offer a unique and valuable fellowship experience focusing on rural health concerns," the announcement stated.

AWH: 53RD ANNUAL CONVENTION

Industry professionals from hospitals, hospital associations, and other health care organizations from throughout the West will be meeting at the 1983 Association of Western Hospitals annual convention in Anaheim, California, April 24-27.

"Essentials for Excellence: New Directions in Health Care" is the theme of the 52rd annual convention and participants will be able to explore new directions in health care through a wide variety of educational programs. The 74 Western Instructional Conferences (WICs) offer an opportunity for in-depth examination of a broad range of health care issues including financial management, education and training, fund development, marketing, information systems, reimbursement, organizational models, planning and ambulatory care.

The $25. general registration fee admits participants to the opening and closing general assemblies and two special sessions, as well as the exhibit floor. Additional fees of $45., $65. and $100. cover the cost of attending WICs. Convention registration catalogs and additional information may be obtained by contacting the Association of Western Hospitals, 850 Market Street, CA 94102, (415) 421-8810.

THIS N' THAT

Humana Hospital Alaska has elected its medical staff officers. They are Richard Curtis, president; Robert Bosveld, president-elect; Leo Morresey, vice president; David Anderson, secretary-treasurer; Thomas J. Harrison, member-at-large; and John D. Frost, immediate past president.

Jane Sabes, administrator of Norton Sound Regional Hospital, has been recommended to the Board of Governors of the American College of Hospital Administration as a 1983 Nominee.

A sale of attic treasures was held mid-March to benefit the Wrangell Hospital Auxiliary. Proceeds from the sale will go toward the purchase of Resusic-Annes, used in teaching cardio-pulmonary resuscitation (CPR).

Three members of the Providence Hospital Auxiliary were nominated to receive the Volunteer of the Year Award according to Shirley Shaggs, volunteer manager for Providence. Nominated were Cleo Schoen, Billie Church, and Irene Durrant. The award will be presented at the annual awards luncheon on May 3rd.

The new intensive care unit at Central Peninsula General Hospital in Soldotna, opened on March 14. According to administrator Mike Lockwood, this is the first area of the $5.7 million construction project to be opened. The four-room intensive care unit will have complete monitoring capabilities including three telemetry monitoring units which will double the present hospital capabilities for the critically ill. The ICU will be manned 24 hours a day by specially trained nurses.

NORTHERN CARE

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alaska state hospital association

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Juneau, Alaska 99801
(907) 586-1790

D

BULK RATE
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The Honorable Mae Tischer
State House of Representatives
Pouch V
Juneau, AK 99811

Sources of $ to hospitals

25% CAPITAL CONST. REIMBURSEMENT

250,000 or 2500/bed operating grant

Capital budget appropriations

Tax free bonding capability via Alaska Medical Facility Authority

30-42% hospital REVENUES ARE from government (STATE & FEDERAL) funds

STATE MEDICAID from 2 million in 1972 to 70 million today.

Alaska State Legislature

House of Representatives

MAR 1 1983

Pouch V
State Capitol
Juneau, Alaska 99811

Official Business

cc to all committee members

MEMORANDUM

TO: Rep. Milo Fritz, Co-Chairman
Rep. Mae Tischer, Co-Chairwoman
House Health and Social Services Committee

FROM: Rep. Jack Fuller, Chairman
House Rules Committee

DATE: March 1, 1983

RE: House Bill 19 - Certificate of Need

Attached for your files and information is back-up information relating to House Bill 19.

The Norton Sound Health Corporation has offered recommendations for consideration to the proposed legislation.

Thank you.

FEB 28 1983

NORTON SOUND
HEALTH CORPORATION

P.O. BOX 966
NOME, ALASKA 99762
(907) 443-5411

February 24, 1983

Representative Jack Fuller
Pouch V
Juneau, Alaska 99811

Dear Jack:

HOUSE BILL 19 - CERTIFICATE OF NEED

OPINION-

ADVANTAGES TO CON

There are distinct advantages to the CON process if those working within the division are truly dedicated to their objective of supplying adequate health care for the area.

(1) The state dept of health planning can gather and supply data relevant for planning to hospitals lacking time and expertise for such essential information prior to a proposed building or equipment acquisition.

(2) In the review process, CON requires and assists hospitals in the formidable steps so necessary but not infrequently overlooked or ignored - public input, avoiding duplicity of services....

DISADVANTAGES TO CON

(1) Public Health Service (federal) hospitals are exempt. ALL health care facilities should be required to participate - or none.

(2) Current lengthy process.

(3) Planning should be for the sake of planning - not tied to funding levels. If improper planning and building (or equipment acquisition) the institution will eventually find the funding not meeting expense.

While the battle wages between the State Hospital Assn and Blue Cross, between Humana and Providence Hospitals of Anchorage I must still maintain that the CON advantages outweigh the disadvantages WITH the following modifications:

(1) Demand the state health planning office to streamline the CON review process-currently lengthy and costly. The entire process should be fashioned after an employee grievance system-three steps, brief periods of time in which to respond back to the employee.

(2) Begin to accept the fact that in this day of Medicare, Medicaid, IHS and even private philanthropic dollar reductions responsible health care providers would be fiscally foolish to act in any other than a judicious way - not adding one additional service, bed, staff, or squre foot that would be "unprofitable" - even to a non-profit establishment. This is where I agree with the President that free enterprise will rule if allowed.

(3) The state health planning agency should establish a long range goal to develop expertise and assistance "in the field" in health planning - assuming more an advocate or assistant rather than an adversary role.

(4) Require ALL hospitals - federal, state, private, etc - to participate in the CON process.

There are my opinions in a nutshell. My prayers are with you that heaven will assist you in this and all your deliberations to cut through subjective opinions and see only what would be best for the people, the state, the country.

Cordially,

Jane Sabes
NORTON SOUND REGIONAL HOSPITAL
Hospital Administrator

ne

PS I'd love to view the legislative process, especially on a health issue. How does one go about that? A response from your secretary will suffice. Thank you.

2-25-83 9:40 AM

MAE-MED:

ENTITLEMENTS OUTSTANDING AS of JULY 1, 1983
(FY84) 25% HOSPITAL REIMBURSEMENT

FAIRBANKS MEMORIAL	1,215,281	1 YR REMAINING
JUNEAU DETOX FACILITY	75,059	3 YRS REMAINING
KENAI - CENTRAL PEN. HOSPITAL	2,167,338	4 YRS REMAINING
	# 3,457,678	

Proposed Amendment to SSHB 19

By Dem. H

Section 4 AS 29.90.010 - 29.90.030 is Repealed

Section 5. Those hospitals or health facilities which are currently receiving funds pursuant to ~~sections~~ AS 29.90.010-29.90.030 shall continue To receive construction AID as Though AS 29.90 were not repealed until its entitlement is satisfied. No new applications shall be received a processed after the effective date of this legislation

Mike Maher
Corrections
Mary Hess

The proposal to ~~establish~~ change the division of corrections within DHSS to ~~a~~ departmental status is one that is supported by the governor's office, correctional professionals and the Health Education and Social Services Committee.

Dealing with the correctional crisis is one of the governor's ~~prime~~ primary objectives for this session, and as responsible legislators, it should be ours too. Knowledge of the crisis — the overcrowding, the mismanagement, the poor conditions, the lack of rehabilitation and the rest ~~are all too well~~ is common. The Clearycase, as you know too well, brings the problem to rest in the laps of both the legislature and the executive departments.

As pointed out by the Governor's task force on Corrections, cooperation between the three branches of government is necessary to solve the problem.

Fortunately, the problem can be solved with proper administration, budgeting, and organization. Correction of the problems identified by the ~~previous~~ task force, begins with proper management. The ~~best~~ solution is to develop a Department of Corrections and establish a Commissioner in charge of that Department who can build a management team dedicated to the solution of Alaska's

Alaska Health Coalition

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Fairbanks, Alaska 99701
(907) 456-2553

FEB 23 1983

February 17, 1983

The Honorable Bill Sheffield
Governor, State of Alaska
Pouch A
Juneau, Alaska 99811

Dear Governor Sheffield:

We were dismayed to discover that funding for Alaska'a three Health Systems Agencies (HSAs) was not included in your FY84 budget.

During your campaign, you responded very positively to our "Health Issues Questionnaire." We were greatly encouraged to learn that you strongly supported a formal mechanism for citizen participation in State health program decisionmaking and that you felt that HSAs were an appropriate avenue for that involvement. You answered the questionnaire by saying that you support raising State funding for each HSA "to at least $300,000 to maintain citizen involvement in health care decisions at the local level."

Because of recent Congressional action, each HSA in Alaska will receive $100,000 from the U.S. Department of Health and Human Services in FY84. This is a 63% decrease from FY82. Therefore it is critical that HSAs receive $200,000 in State support to prevent their demise.

I would suggest to you that HSAs have provided the only real means for public involvement in health care decisionmaking at the State, regional, and local levels. HSAs enable effective citizen participation in grant and Certificate of Need reviews, in planning, and in resource ddvelopment. Because of this input, the State has been able to direct its resources to areas of greatest need in efficient and effective ways. Also, the State has been able to avoid unnecessary duplication and to prevent unneeded service expansion, resulting in savings of several million dollars in the last six years. In addition, HSAs provide technical assistance to communities and organizations in ways that improve service effectiveness and continuity of care and promote development of new, needed services and facilities.

The publication I have enclosed, "Public Involvement in Health Care Decisions" summarizes the activities of the three Alaska HSAs. It also describes the important services which would be lost to the public if HSAs do not receive adequate State support. I hope you will take the time to familiarize yourself with the many significant accomplishments

Coalition Members

J. B. Carnahan, Fairbanks; Joseph Cladouhos, Juneau;
Charles Kaltenbach, Dr. P.H., Fairbanks; Steve Lesko, Anchorage;
John Manning, Ketchikan; Lillie McCarvey, Anchorage; Art Willman, Sitka; Margaret Wilson, Anchorage

that HSAs have made in the health care system of Alaska. The Alaska Health Coalition believes the Health Systems Agencies have earned a place within the health care system in this State and we urge your support for their continued operation.

Sincerely,

Charles M. Kaltenbach

Charles M. Kaltenbach, Dr. P.H.
Chairman

CMK:flr

cc: Robert London Smith, Ph.D.
Commissioner, DHSS
Senate HESS Committee
Senate Finance Committee
House Hess Committee
House Finance Committee
Alaska Health Coalition
The Honorable Don Clocksin





Public Involvement in Health Care Decisions



At Risk

Alaska's three Health Systems Agencies, funded by State and Federal dollars since 1976, will cease to exist unless funds are restored to the State budget or appropriated by the Legislature this session.

WITHOUT HEALTH SYSTEMS AGENCIES AT THE REGIONAL LEVEL THERE WILL BE:

* NO opportunity for public discussion at the regional level of the impact of health care programming and funding decisions.
* NO public participation in deciding the future of local health care services. (Decisions will be made in Juneau.)
* NO technical assistance for agencies, organizations, and communities from a non-aligned organization with experienced staff.
* NO regional efforts to promote health.
* NO regional coordination to focus on health-related issues of mutual concern.
* NO independent assessments in the public interest of issues related to health care cost containment.
* NO regional source of information related to health status measurement, health service utilization, health-care quality issues, and health care costs.

THERE WILL BE DUPLICATION OF DATA COLLECTION AND ANALYSIS, RESEARCH, SYSTEMS MANAGEMENT ACTIVITIES, AND PROGRAM DEVELOPMENT.

THERE WILL BE UNNECESSARY EXPANSION OF SERVICES AT EXCESSIVE COSTS TO THE TAXPAYER.

Our Past and Present

Three Health Systems Agencies (HSAs) serve the State of Alaska.

The **Northern Alaska Health Resources Association** serves the North Slope and Fairbanks North Star Boroughs and the areas encompassed by the Arctic Slope, Doyon, and NANA Native regional corporations.

South Central Health Planning and Development serves the Municipality of Anchorage and the areas covered by the Bering Straits, Calista, Bristol Bay, Aleutians, Kodiak, Copper River, North Pacific Rim, and Cook Inlet Native regional corporations.

The **Southeast Alaska Health Systems Agency** serves the Southeastern panhandle.

These HSAs were established by Public Law 93-641 in 1974 to plan for the rational development of health care resources within their regions by providing staff to governing boards composed of a representative cross-section of providers and consumers of health care services. As was the case in other states, the State of Alaska provided funds to supplement the federal grant awards and, consequently, has enjoyed an efficient and mutually beneficial relationship between State officials and planners and their local constituents.

The legal responsibilities of the HSAs are as follows:

A. To improve the health of residents of the health service areas.
B. To increase the accessibility (including overcoming geographic, architectural, and transportation barriers), acceptability, continuity, and quality of health services.
C. To restrain increases in the cost of providing health care.
D. To prevent unnecessary duplication of health care resources.
E. To preserve and improve advantageous competition in the health service area.

These responsibilities are carried out through the development of a long-range health plan and a short-range action plan; reviews of various federal and State grant applications; community assistance with needs assessments, evaluations and plan implementation; and technical assistance to agencies and organizations. These functions are closely coordinated with the respective State agencies which build and expand on our local and regional activities to construct appropriate State-level plans, studies, and policies.

While all this is accomplished on a regular basis by each of the three HSAs, each agency has also recognized the need to tailor its particular work program to the unique requirements and circumstances of its individual health service area.

These activities have helped to:

- **Improve the health status of Alaskans.**
- **Contain the costs of health care.**
- **Improve access to needed health services.**
- **Involve the public in decision-making about the current and future health care delivery system for their communities.**
- **Tailor health service and facility development to the unique needs of each community.**

Our Future

Decreasing support at the Federal level has given Alaska's HSAs a chance to reassess our activities and to discard irrelevant federal requirements. We now have more opportunity to meld our activities to the health systems needs of the regions and communities of Alaska.

The three HSAs have formed the Alaska Health Coalition to encourage responsible participation by the State in health planning and decisionmaking and to support those activities which are vital to the health of Alaska's citizens. The essential program areas are:

COMMUNITY ASSISTANCE

Regional health resources organizations should be available to assist communities and citizen groups in defining health problems in their communities and in identifying solutions to those problems, through:

A. Organizing key individuals for action.
B. Gathering ideas and opinions on identified issues.
C. Analyzing problems and assisting in the development of local strategies for their amelioration.
D. Assisting communities in the implementation of identified strategies.
E. Providing assistance to individuals and organizations in the preparation of funding applications, program development, and evaluation.

HEALTH PROMOTION

Because many of the health problems in the state are related to lifestyle and individual behavior, the resource organizations will seek to improve the health status of Alaskans, by:

A. Determining the prevention and health promotion needs of the regions.
B. Assisting existing programs to improve their effectiveness through coordination and cooperation with other programs.
C. Providing a forum for prevention and health promotion interests.
D. Developing new prevention and health promotion programs to meet the special health needs of Alaskans.

REGIONAL ADVOCACY

To allocate limited resources in a rational and equitable manner, it is necessary to examine individual community needs in relation to the needs of the region and the state as a whole. A framework for providing and communicating this perspective will be accomplished by:

A. Maintaining a regional and local capability to provide current, accurate, health-related data for planning and program development
B. Providing a forum for local grant applications and proposals for new institutional health services and facilities.
C. Providing the Legislature and the Department of Health and Social Services with regional perspectives on health-related issues.
D. Assisting State, local and regional organizations and the Government by conducting research on health-related issues.

HSAs are the forum through which citizens influence the development of health-related services for Alaska. As arenas for participatory democracy, HSAs assist communities, agencies, and individuals to define needs and achieve goals for health resource development. As regional advocates, HSAs bring the concerns of local residents to the attention of the Alaska Legislature and State government. As agents for improving the health of the people, HSAs direct their energies to health promotion and disease prevention, aiming toward increases in the overall health status of the population. **These activities are essential to the continuation of community self-determination in the area of health service development.**

Some of Our Recent Activities

COMMUNITY ASSISTANCE

- SCHPD* assisted the Kenaitze Tribe to establish a clinic.
- NAHRA** helped to establish a patient hostel in Fairbanks.
- SCHPD supported the development of Hospice in Anchorage and Home Health Care, Inc., of Anchorage.
- NAHRA supported development of the Arctic Alliance for People, an association of human service providers in the Interior.
- SCHPD administered a contract for safety week fairs in Sand Point and King Cove.
- NAHRA analyzed the effectiveness and efficiency of Fairbanks Rehabilitation Association's respite care programs.
- SCHPD explored the issues surrounding provision of health care to non-Natives in Bethel.
- SEAHSA*** developed information and assessed the impact of government funding cuts in Ketchikan.
- SEAHSA assessed alternatives for program design and funding sources in Ketchikan.
- NAHRA, SCHPD, and SEAHSA conducted numerous service-specific needs assessments.
- SCHPD trained the Yukon-Kuskokwim Health Corporation Board and staff on health planning, assessment, and management issues.
- NAHRA, SCHPD, and SEAHSA conducted a survey of primary care clinics in rural areas on behalf of DHSS.
- SEAHSA and SCHPD assisted Kake and the Mat-Su Borough to develop community health plans.
- SCHPD provided technical assistance to the Whittier Health Committee.
- NAHRA assessed alcoholism treatment services in Fairbanks and alcohol counselor training in the northern region.

HEALTH PROMOTION

- NAHRA and SEAHSA funded six community-based health education programs.
- SEAHSA developed a boating safety curriculum for grades 7-12.
- SCHPD sponsored a "Health Promotion at the Workplace" conference, with 120 participants.
- SCHPD established a Tel-Med service in Anchorage, with plans to expand to other parts of Alaska.
- NAHRA implemented Alcohol Awareness Week in the Greater Fairbanks area.
- SCHPD developed a resource guide for community health fairs.
- NAHRA published a Health Promotion Resource Directory.
- NAHRA, SCHPD, and SEAHSA wrote a manual for communities to use in establishing health education in their schools.
- NAHRA, SCHPD, and SEAHSA assisted with numerous community health fairs.
- SCHPD established an ongoing Health Promotion at the Workplace working group.
- NAHRA and SCHPD organized child passenger safety groups in Fairbanks and Anchorage.
- NAHRA, SCHPD, and SEAHSA provided information and assistance to various school districts on health education curricula development.
- SCHPD participated in the organization, planning, and leadership of workshops at the Alaska Native Health Board Health Conference.
- NAHRA and SCHPD developed health education legislation.

REGIONAL ADVOCACY

- NAHRA, SCHPD, and SEAHSA developed documents, through public involvement, which identify health problems and health service delivery concerns and propose solutions.
- NAHRA, SCHPD, and SEAHSA provided regional data and evaluation comments for use in the State Health Plan and the Maternal and Child Health Plan.
- NAHRA, SCHPD, and SEAHSA reviewed and commented on proposals for State and federal funding for programs such as mental health, alcohol, and drug abuse (on request of the funding authority).
- NAHRA, SCHPD, and SEAHSA reviewed major capital expenditures by facilities under the Alaska Certificate of Need program, including:
  - Free-standing birthing center in Juneau.
  - Changes in Petersburg Hospital.
  - Re-financing of Alaska Hospital.
  - Expansion of Central Peninsula General Hospital.
  - Replacement of Valley Hospital, Palmer.
  - Replacement and improvement of computer tomography equipment at Alaska Hospital.
  - Free-standing inpatient rehabilitation facility by Alaska Treatment Center.
  - Replacement of Cordova Hospital.
  - Mini-computer system for clinical

lab at Providence Hospital, Anchorage.

- Digital fluoroscopy at Providence Hospital, Anchorage.
- Development of an 80-bed substance abuse/psychiatric facility by Charter Medical Corporation.
- Development of a substance abuse facility by Advanced Health Systems.
- Replacement and expansion of an ambulatory surgery center in Anchorage.
- Expansion of Humana Hospital emergency department.
- Installation of a hospital information system at Providence Hospital, Anchorage.
- Expansion of Fairbanks Memorial Hospital.

* SCHPD — South Central Health Planning and Development, Anchorage
** NAHRA — Northern Alaska Health Resources Association, Fairbanks
*** SEAHSA — Southeast Alaska Health Systems Agency, Ketchikan

HESS —7

What is South Central Health Planning and Development, Inc.(SCHPD)? South Central Health Planning and Development, Inc., like the other two Health Systems Agencies in Alaska, is a non-profit corporation run by a volunteer board of directors established for the purpose of improving the health of residents, increasing the accessibility, acceptability, continuity and quality of health services provided to the population, restraining increases in the cost of providing health services, and preventing unnecessary duplication of health services.

SCHPD serves the 270,000 residents of south central and western Alaska. The service area encompases eight of the twelve Native regional corporation areas: Norton Sound, Yukon-Kuskokwim, Kodiak, Bristol Bay, Copper River, Cook Inlet, North Pacific Rim, Aleutian/Pribilof Islands. The Municipality of Anchorage is designated as a ninth subarea in the total service area.

While all the residents of the area are affected by the decisions of the agency, SCHPD works most closely with: 1) health care providers, including physicians, nurses, representatives from the 16 hospitals in our area, staff from the 8 non-profit health corporations in the area, directors of mental health and alcohol/drug abuse programs, Indian Health Service representatives (on health care cost and health promotion at the workplace issues), community residents who desire technical assistance for the development of proposals for new health services, Boards of health programs who desire training on effective functioning, and others.

The volunteer Board members of SCHPD with help from the staff they hire, provide a process for public involvement in the decisions as to how public money is to be spent in health care. With an ever increasing portion of public (State and Federal) dollars being spent on health services through Medicare, Medicaid, revenue-sharing, mental health and alcoholism programs, risk reduction grants, direct appropriations for capital expenditures (to name a few) public input into the form and organization of those services becomes even more critical.

The public involvement process as implemented by SCHPD has meant:

- -continual coordination with providers and consumers on health care delivery issues in the development of planning documents, on committees and task forces, public meetings;
- -publication, at least annually, of short-range plans listing high priority areas of concern in south central and western Alaska;
- -publication and distribution of periodically updated long-range plan that analyzes health problems and establishes a framework for development of health services by size of community;
- -public review of any Certificate of Need proposals (the only opportunity for the public to review and comment on any analysis of proposals submitted);
- -provision of data to communities, elected officials, health care providers to justify and/or evaluate health care expenditures;
- -public meetings in communities, technical assistance to communities;
- -other involvement in health issues, such as sponsorship and organization of a Health Promotion at the Worksite conference attended by over 200 participants.

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

February 16, 1983

FEB 18 1983

Mae Tischer
House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Representative Tischer:

The Executive Committee of South Central Health Planning and Development, Inc., met on February 14 to consider our future as a regional health planning agency. In order to continue our activities beyond May 31, 1983, the end of our grant year, we need to have some assurance of funding from the State. We are asking that an amount of $200,000 for each of the three Health Systems Agencies be reinstated in the budget.

As we understand it, your subcommittee is now in the process of reviewing the DHSS budget. Alaskan Health Systems Agencies, established in 1976, have received Federal and State grants each year of our operation. Commissioner Beirne told us HSAs were not included in the proposed budget this year for two reasons. First, the Division of Corrections was consuming an increasing portion of the Department's resources. Since then, the new administration has proposed changes in the organization with respect to Corrections services. Second, at the time the budget was drafted, there was no indication Federal money was going to be available. However, Congress has since passed a continuing resolution providing for funding of HSAs at last year's levels.

Continuation of Federal funding at last year's levels means a basic grant of $100,000 plus $15,000 in match (at 30¢ on the dollar for the $50,000 State grant). The chart on the next page shows grant amounts received for the last six years. In addition to the $200,977 in Federal and State money received this last fiscal year, we had approximately $40,000 in carry-over. Therefore, a $200,000 grant from the State would mean a reduction in funding from FY 1980, 1981, 1982 levels. It would mean a slight increase from the latest year. During the past year all staff (except one) are working on a half-time basis due to the budget cuts.

Amount	Federal	State	Total
FY 1983	150,977	50,000	200,977
FY 1982	298,377	100,000	398,377
FY 1981	353,310	100,000	453,310
FY 1980	234,902	125,000	359,902
FY 1979	175,000	125,000	300,000
FY 1978	175,000	125,000	300,000

We urge you to rectify the error made by the Department in excluding funding for the three organizations that provide a forum for public involvement in health care decisions. (See attached page for brief summary of our responsibilities.)

If you have any questions about our organization do not hesitate to call me or the President of the Board, Lillie McGarvey.

Sincerely,

Margaret M. Wilson

Margaret M. Wilson
Executive Director

MMW/ab

Enclosure

In This Issue
- Governors' Health Messages
- The FY 1984 Health Budget

STATE HEALTH NOTES

Number 32
January 1983

Intergovernmental Health Policy Project, George Washington University, Washington, DC 20037

Governors' Health Messages

The governors' state of the state and inaugural messages not surprisingly concentrated on the state of their separate economies. Controlling state budgets is clearly the dominant priority among the states' chief executives. Among the states, deficits for the remainder of their fiscal years are estimated at $1.6 billion in **CALIFORNIA**, $530 million in **NEW YORK**, $260 million in **WISCONSIN**, $164 million in **PENNSYLVANIA**, $150 million in **NEW JERSEY**, and the list continues. Governor Nigh of **OKLAHOMA** reported that a revenue shortfall has occurred for the first time in the state's history.

A recent survey by the National Conference of State Legislatures shows that 19 states are incurring deficits for the current fiscal year and another 13 are operating on very slim margins between revenues and expenditures.

Interestingly, very few governors singled out their Medicaid programs for major reductions or constraints in order to help bring their budgets into balance. Most apparently are reasonably satisfied with the initiatives their states have taken over the past year or two to control the rates of growth in their Medicaid budgets.

GEORGIA'S new Governor Harris specifically pointed to the need for new efforts in Medicaid fraud and abuse control, improved claims review and recovery of overpayments, and a careful study of various alternative reimbursement structures under Medicaid. **NEW YORK** Governor Cuomo intends to recommend a Medicaid Reform Program, which will include major financial and programmatic restructuring. The plan, according to the governor, will enable the state to institute appropriate cost controls, improve access to health care, and strengthen the state's oversight capability through audits and utilization review.

Two governors—Rockefeller of **WEST VIRGINIA** and Lamm of **COLORADO**—made specific references to the need for the regulation of hospital costs. Governor Rockefeller singled out a tripling in state expenditures for public employee health insurance benefits since 1976 as a key reason for his support for a hospital rate setting commission. Governor Lamm referred to the unemployment rate plus increased federal cost containment efforts as reasons for expanding state cost containment measures. In addition to rate regulation, the governor urged the legislature to consider competitive bidding by providers for Medicaid contracts and insurance reform packages.

Acknowledging that hospital costs in **NEVADA** are the highest in the nation—41 percent higher than the national average —Governor Bryan called for several cost containment strategies, e.g., performing day surgery where appropriate and shortening hospital stays. The governor also intends to submit legislation to require understandable billing procedures to reduce the chances of patients being billed for services not received.

Governors Lamm, Anaya (**NEW MEXICO**) and Garrahy (**RHODE ISLAND**) used their inaugural addresses to reconfirm their support for strong certificate of need (CON) legislation. Governor Lamm declared that the state's CON program had saved almost $38 million in health costs over a three-year period, while Governor Garrahy pointed to $42 million in savings to his state over the past decade. Governor Lamm also urged the legislature to consider a limitation on the total yearly amount of capital expenditures made by hospitals.

LESLIE LONGENBAUGH
RESEARCH STAFF

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

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see next pg., too

Governor Cuomo took the opportunity to announce he was ordering a one-year moratorium on the issuance of any new certificates of need. During the one-year moratorium, the Department of Health, in cooperation with other state agencies, is directed to design a new capital budgeting process for hospitals, nursing homes and clinics. The new process is designed to provide the state with the ability to analyze relative need among projects, as well as specific elements in the proposals.

The governors made very little mention of moving away from regulatory strategies and in the direction of containing costs through greater competition. **ARIZONA's** Governor Babbitt was a major exception, however. The governor mentioned the state's repeal of certificate of need legislation in 1982 and deregulation of nursing homes as examples of the state's contribution to removing artificial subsidies in the health care delivery industry. The governor identified three new initiatives he will support on behalf of furthering competition: 1) requiring health care institutions to participate in a uniform billing and discharge data reporting program; 2) prohibiting tax exempt bond issuing bodies from providing tax exempt financing for health care institutions which maintain overall occupancy rates below 85 percent; and 3) creating programs which encourage state employees to be more sensitive about costs in choosing between health care options.

With regard to the state's employee health insurance program, the governor will seek legislative action to establish an employee rebate program for employees selecting lower cost health care insurance plans and to require contracting indemnity insurers to offer plans with varied copayment levels.

Prevention ranked high on the priority list of the governors of **ALASKA, ARIZONA, NEW MEXICO** and **RHODE ISLAND.** Governor Garrahy identified the need to reassess health insurance coverage with a goal of emphasizing coverage for less costly preventive care. Governor Babbitt will seek legislative action to develop health promotion and education programs for state employees and to require contracting indemnity insurers to allow payments for preventive health measures.

The need for expanded alcoholism services received a fair amount of attention. Governor Cuomo will support legislation mandating private health insurance coverage for alcohol treatment. Governor Rockefeller called for an increase in the state tax on alcoholic beverages and a dedication of the revenues to alcohol treatment programs. And Governor Anaya identified alcoholism prevention and services among the top priorities of his administration.

Improving mental health services was a key priority of the governors of **INDIANA, NEW HAMPSHIRE, NEW YORK** and **NORTH DAKOTA.**

A commitment to expanding home and community-based services for the elderly was mentioned by the governors in **NEW MEXICO, MARYLAND, NEW JERSEY,** and **NEW YORK.**

Governor Rockefeller and **MINNESOTA** Governor Perpich spoke of the need to restore medical benefits that had recently been cut. Rockefeller requested a revision in the state's corporate income tax to provide additional revenues for restoring some cuts and financing the federal match to receive federal funds under the primary care health block grant.

Governor Matheson of **UTAH** called for state assumption of the county medically indigent program.

The FY 1984 Health Budget

President Reagan's Fiscal Year 1984 budget proposes a number of far reaching reforms in the financing of health care. Most of the reforms concentrate on the Medicare program, with very little attention given to Medicaid. The major ingredients of the President's Health Care Incentives Reform plan are: 1) extending Medicare coverage for catastrophic illness; 2) restructuring beneficiary cost-sharing under Medicare; 3) establishing a prospective rate structure for hospitals under Medicare; 4) limiting the current tax subsidy of higher cost private health insurance plans; and 5) establishing a voluntary voucher program to permit Medicare beneficiaries to enroll in private health plans.

To underscore the need for substantial reforms in health care financing, the Administration points to some alarming statistics. In 1982, health care costs went up almost three times the national inflation rate. The cost of health insurance rose 15.9 percent in 1982, the biggest increase ever. Over the last five years, Medicare

costs have increased at an average annual rate of 19 percent. And in 1983, Medicare and Medicaid will spend as much *every month* as they did during the entire year of 1966, their first full year of operation.

According to the Administration's restructuring initiative, Medicare beneficiaries will continue to pay a deductible equal to one day of hospital care, but a copayment equal to 8 percent of the deductible will be required for each day of hospital care from the 2nd through the 15th day. From the 16th through the 60th day the copayment will be reduced to 5 percent of the deductible (currently, no cost-sharing is required from the 2nd through the 60th day). After the 60th day, beneficiaries would face no further financial obligation for hospital costs for the remainder of the year.

With respect to reimbursement reform, the budget assumes the implementation of a prospective payment system on a per-case basis, adjusted by diagnosis and patient characteristics. The diagnosis-related group (DRG) classification system would serve as the basis for the case adjustments.

Under the Administration's proposed Voluntary Voucher program, beneficiaries will enjoy the option of receiving services through a private health benefits plan, rather than through the Medicare system. If a beneficiary selects alternative coverage, the government would pay an amount equal to 95 percent of the per person costs under the Medicare program.

At the heart of the Administration's Incentives Reform plan is a proposal to limit the current tax subsidy of higher priced health insurance plans. If the plan is adopted, tax-free treatment of employer contributions to employee benefits would be limited to $175 a month for family coverage or $70 a month for individual coverage. According to the Administration's estimates, about 30 percent of those with employment-based health coverage currently receive employer contributions above those limits. An additional $2.3 billion in tax revenue is anticipated in FY 84 as a result of this initiative.

The Administration projects that, if Congress accepts its reform proposals, Medicare payments will reach $63 billion in 1984—13.2 percent higher than the current estimate for 1983. The Administration claims, however, that the rate of increase would be 16.3 percent absent its legislative proposals.

Other significant initiatives in the FY 84 budget affecting Medicare include: freezing physician reimbursement for one year; modifying the rate of increase in Part B premiums; indexing the Part B deductible to the Medicare Economic Index; eliminating mandatory utilization review by hospitals and skilled nursing facilities; and authorizing DHHS to employ competitive purchasing procedures for the procurement of laboratory services, durable medical equipment and other medical supplies for beneficiaries.

The FY 84 budget is marked by the absence of any significant new reform proposals for the Medicaid program. The budget recommends an extension of the reductions in federal payments to states for Medicaid (as originally provided in the 1981 Reconciliation Act) by 3 percent beginning in 1985 and continuing indefinitely. A state could, however, offset the reductions if it managed to contain its expenditures below specified limits. The budget also includes a recommendation to require states to impose nominal copayments on the categorically and medically needy for physician, clinic, and hospital inpatient and outpatient service. Finally, the budget contains a provision which would require applicants, as a condition of eligibility, to assign their health insurance rights to the state Medicaid agency.

Once again, the Administration's budget contains no request for health planning activities, which is in keeping with its policy to eliminate federal involvement in health planning at state and local levels.

The FY 84 budget contains a request for $1.357 billion to fund the four health block grants (Preventive Health at $85 million; Alcohol, Drug Abuse and Mental Health at $439 million; Primary Care at $460 million; and Maternal and Child Health at $373 million). The Administration intends to submit legislation to include three additional programs in the Primary Care block grant: Migrant Health Services, Black Lung Clinics, and Family Planning. The budget further proposes to consolidate the administration of the block grants within the Office of the Assistant Secretary for Health.

Reports and Publications

A new study commissioned for the Federal Trade Commission details the trends in the evolution of three separate kinds of health care services: retail dentistry, freestanding emergency care centers, and freestanding surgery centers. The study provides a descriptive overview of the three types of services and identifies various factors impeding their growth. It provides some answers to four broad questions: 1) How does the growth of entrepreneurial medical/dental services vary across states because of differences in licensing requirements? 2) How do reimbursement practices of commercial insurers and of medical and dental service plans impact on the growth of these entities? 3) How are these services being marketed and to what types of consumers? 4) Is there any evidence of competitive responses by traditional health care providers? Copies of the report, entitled *Entrepreneurial Trends in Health Care Delivery: The Development of Retail Dentistry and Freestanding Ambulatory Services*, are available free on a limited basis. Request document number IH-83 from Michael Pollard, Room 272, FTC, Washington, DC 20580.

The Institute for Health Planning recently published several monographs which should be of interest to health policymakers. The publications include: *State Health Care Cost Containment: A Review of Strategies* ($9.00); *Health Care Vouchering and Competition* ($8.00); *A New Era for State Health Planning* ($8.00); *Issues in Health Block Grant Funding* ($7.00); *Bidding for Long Term Care Patients* ($8.00); and *Altering Incentives in Health Care Delivery* ($6.00). To order copies write to: IHP, 702 North Blackhawk Avenue, Madison, WI 53705.

State Health Highlights

• A **NEW YORK** bill (S 737, A 817) would amend the state's Medicaid law to require programs to provide recipients with the means to make a fully informed and independent choice from among licensed health and mental health providers.

• A **COLORADO** bill (HB 1184) would prohibit hospitals from denying or limiting staff privileges or the use of hospital facilities to any health care provider licensed to perform surgery, or from discriminating against such providers on any basis other than training, experience, or demonstrated competence in their field of practice.

• A **NEW MEXICO** bill (HB 20) would require any health care practitioner advertising services to the public to state in the advertisement his name, address, telephone number, and the designation of the profession in which he is licensed to practice.

• **NORTH CAROLINA** recently decided to replace Blue Cross-Blue Shield coverage for state employees with a self-insurance plan. The new plan provides for a $100 deductible with 5 percent employee coinsurance up to $2,000, and full coverage thereafter. The plan also removes limits from hospital and physician reimbursement, which had been frozen for over a year.

• **CALIFORNIA** enacted legislation (AB 2346, Chapter 1304) permitting physician assistants to form professional corporations and to render professional services in the name of a corporation. The law also allows registered nurses to be shareholders in a physician assistants' corporation, and physician assistants to be shareholders in a nursing corporation.

STATE HEALTH NOTES

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State Health Notes is jointly published several times a year with grant support from the Office of Research and Demonstrations (ORD), Health Care Financing Administration, DHHS (HCFA Grants 18-P-98 148/3-01 and 18-P-97 062/8-83).

innovations

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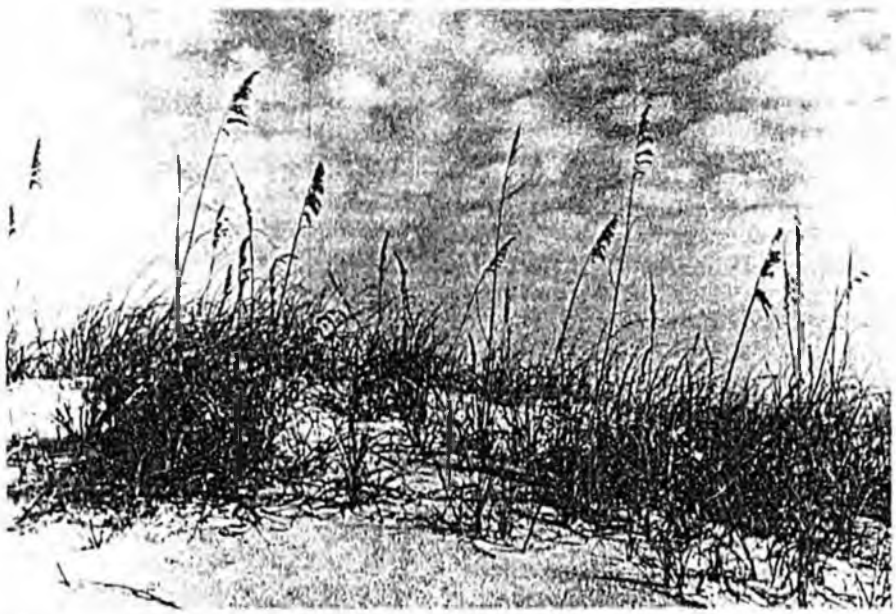
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Contact: Elton J. Gissendanner, Dept. of Natural Resources, Tallahassee (904) 488-1555.



Florida is protecting its beaches and sand dunes.

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Contact: Tom Konrad, Dept. of HRS, Tallahassee (904) 488-8673.

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1) If CERTIFICATE of NEED is REPEALED and HSA funding is cut, ~~what~~ how will STATEwide health planning be implemented.

2) What CONTROL ON health CARE COSTS EXISTS if CON is REPEALED?

3) If prospective RATE setting is proposed, why should it not be included in AN omnibus bill that links CON REPEAL with PRP?

4) ~~Hospital ASSOCIATIONS and STATES~~
NATIONwide trend is toward STRENGTHENING CON REVIEWS - Hospital ASSN's generally support it.

5) What benefit to public by repeal? Loose public INPUT at local level. Loose STATEwide planning perspective at STATE level. Loose Federal health planning $ and MAY loose up to 5 million IN FEDERAL $ for programs. What's the benefit to weigh against that?

What benefits accrue to the public if CON is repealed? The HSA's recommendation will have no authority to support it, the statewide planning perspective will be lost. Alaska may loose up to 5 million dollares in Federal funds and will loose 30% of the Federal Health Planning funds. What is the benefit to public? Health care costs reduced?

2. Will Hospital Assn support an omnibus package that includes repeal of CON with prospective rate program, repeal of 25% Capital reimbursement, in short, a comprehensive health care cost containment package?

3. If CON is unworkable as it is, why not amend it, or work out problems instead of throwing the whole program out?

Law Department
151 Farmington Avenue
Hartford, CT 06156

James E. Brown
Counsel
Government Relations
(203) 273-0343

February 14, 1983

Senator Joe Josephson, Chairman
Health, Education and Social Services Committee
State Capitol
Juneau, Alaska 99811

Dear Senator Josephson:

It is my understanding that your committee will be considering S. B. 85, An Act Repealing the Certificate of Need Program, at a hearing to be held on Wednesday, February 16, 1983. While it is not possible for me to attend in person, I would appreciate your reviewing the enclosed statement in opposition to this bill and entering it into the hearing record.

On behalf of the Ætna Life Insurance Company, I thank you for considering our comments.

Sincerely,

JEB/jem

Enclosure

RECEIVED
FEB 17 1983
Josephson

STATEMENT OF

ÆTNA LIFE INSURANCE COMPANY

IN OPPOSITION TO

S.B. 85

As a major writer of commercial health insurance, the Ætna Life Insurance Company has for years been deeply concerned about health care cost increases and has consistently supported viable health planning programs. We strongly oppose S.B. 85, An Act Repealing the Certificate of Need Program. We believe that enactment of this legislation would represent a large step backward in Alaska's effort to realize an efficient and effective health care delivery system.

Health planning is one of the elements in the armamentarium of programs that are necessary to help in the reduction of the escalation of health costs and to ensure that the health care delivery system of the future is one that has been rationally and systematically planned.

We feel that it is most important that there be a mechanism in place for participation in the planning and development of health programs to improve the distribution of health services, ensuring that services are available to those citizens who need them, while restricting the investment in unnecessary facilities and services.

An important portion of a viable health planning program is state certificate of need legislation. We find it is essential to have such legislation in order that the necessity of capital expenditures can be determined, because of the two-pronged effect on the growth of health care costs. In the short run, the purchase, installation, and financing of expenditures increases annual health care expenditures. In the long run, operation and maintenance of capital expenditures continue to add to health care costs, to increased use of highly skilled labor (for maintenance and operation) and non-labor inputs (i.e., energy, supplies, etc.).

It has been estimated that every dollar of capital investment adds an additional 50¢ to annual operating cost. An important element in today's economy, which has had a dramatic effect on health care costs related to capital expenditures, is the interest rate now being charged on the finance debt. Efforts must be made to ensure that all capital expenditures made today are necessary and consistent with the goals of Alaska's Health Systems Plan and necessity for such expenditures.

Alaska's Certificate of Need Program is an important tool for implementation of the area health plan. We urge that this program be continued.

innovations

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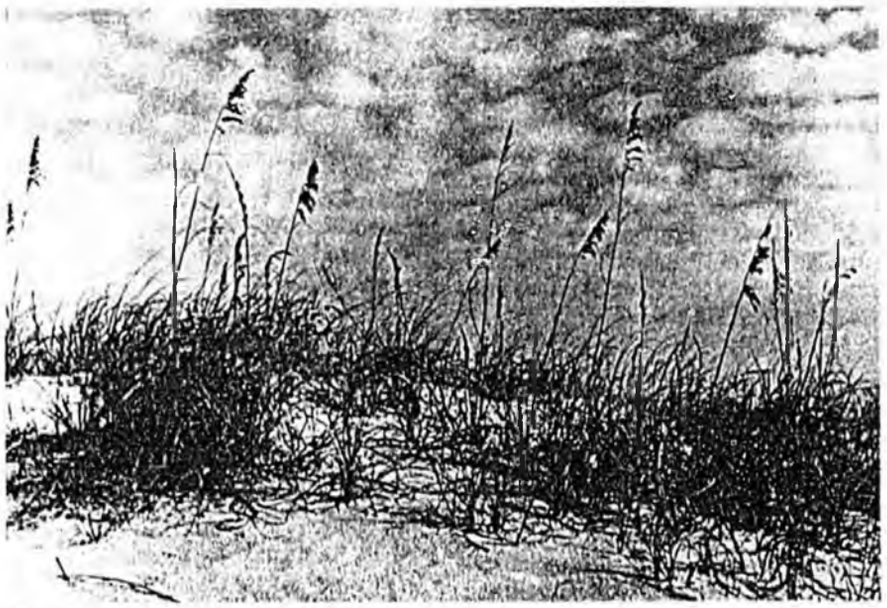
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In This Issue
Governors' Health Messages
The FY 1984 Health Budget

STATE HEALTH NOTES

Number 32
January 1983

Intergovernmental Health Policy Project, George Washington University
Washington, DC 20037

Governors' Health Messages

The governors' state of the state and inaugural messages not surprisingly concentrated on the state of their separate economies. Controlling state budgets is clearly the dominant priority among the states' chief executives. Among the states, deficits for the remainder of their fiscal years are estimated at $1.6 billion in **CALIFORNIA**, $530 million in **NEW YORK**, $266 million in **WISCONSIN**, $164 million in **PENNSYLVANIA**, $150 million in **NEW JERSEY**, and the list continues. Governor Nigh of **OKLAHOMA** reported that a revenue shortfall has occurred for the first time in the state's history.

A recent survey by the National Conference of State Legislatures shows that 19 states are incurring deficits for the current fiscal year and another 13 are operating on very slim margins between revenues and expenditures.

Interestingly, very few governors singled out their Medicaid programs for major reductions or constraints in order to help bring their budgets into balance. Most apparently are reasonably satisfied with the initiatives their states have taken over the past year or two to control the rates of growth in their Medicaid budgets.

GEORGIA's new Governor Harris specifically pointed to the need for new efforts in Medicaid fraud and abuse control, improved claims review and recovery of overpayments, and a careful study of various alternative reimbursement structures under Medicaid. **NEW YORK** Governor Cuomo intends to recommend a Medicaid Reform Program, which will include major financial and programmatic restructuring. The plan, according to the governor, will enable the state to institute appropriate cost controls, improve access to health care, and strengthen the state's oversight capability through audits and utilization review.

Two governors—Rockefeller of **WEST VIRGINIA** and Lamm of **COLORADO**—made specific references to the need for the regulation of hospital costs. Governor Rockefeller singled out a tripling in state expenditures for public employee health insurance benefits since 1976 as a key reason for his support for a hospital rate setting commission. Governor Lamm referred to the unemployment rate plus increased federal cost containment efforts as reasons for expanding state cost containment measures. In addition to rate regulation, the governor urged the legislature to consider competitive bidding by providers for Medicaid contracts and insurance reform packages.

Acknowledging that hospital costs in **NEVADA** are the highest in the nation—41 percent higher than the national average —Governor Bryan called for several cost containment strategies, e.g., performing day surgery where appropriate and shortening hospital stays. The governor also intends to submit legislation to require understandable billing procedures to reduce the chances of patients being billed for services not received.

Governors Lamm, Anaya **(NEW MEXICO)** and Garrahy **(RHODE ISLAND)** used their inaugural addresses to reconfirm their support for strong certificate of need (CON) legislation. Governor Lamm declared that the state's CON program had saved almost $38 million in health costs over a three-year period, while Governor Garrahy pointed to $42 million in savings to his state over the past decade. Governor Lamm also urged the legislature to consider a limitation on the total yearly amount of capital expenditures made by hospitals.

see next pg., too

Governor Cuomo took the opportunity to announce he was ordering a one-year moratorium on the issuance of any new certificates of need. During the one-year moratorium, the Department of Health, in cooperation with other state agencies, is directed to design a new capital budgeting process for hospitals, nursing homes and clinics. The new process is designed to provide the state with the ability to analyze relative need among projects, as well as specific elements in the proposals.

The governors made very little mention of moving away from regulatory strategies and in the direction of containing costs through greater competition. **ARIZONA's** Governor Babbitt was a major exception, however. The governor mentioned the state's repeal of certificate of need legislation in 1982 and deregulation of nursing homes as examples of the state's contribution to removing artificial subsidies in the health care delivery industry. The governor identified three new initiatives he will support on behalf of furthering competition: 1) requiring health care institutions to participate in a uniform billing and discharge data reporting program; 2) prohibiting tax exempt bond issuing bodies from providing tax exempt financing for health care institutions which maintain overall occupancy rates below 85 percent; and 3) creating programs which encourage state employees to be more sensitive about costs in choosing between health care options.

With regard to the state's employee health insurance program, the governor will seek legislative action to establish an employee rebate program for employees selecting lower cost health care insurance plans and to require contracting indemnity insurers to offer plans with varied copayment levels.

Prevention ranked high on the priority list of the governors of **ALASKA, ARIZONA, NEW MEXICO** and **RHODE ISLAND.** Governor Garrahy identified the need to reassess health insurance coverage with a goal of emphasizing coverage for less costly preventive care. Governor Babbitt will seek legislative action to develop health promotion and education programs for state employees and to require contracting indemnity insurers to allow payments for preventive health measures.

The need for expanded alcoholism services received a fair amount of attention. Governor Cuomo will support legislation mandating private health insurance coverage for alcohol treatment. Governor Rockefeller called for an increase in the state tax on alcoholic beverages and a dedication of the revenues to alcohol treatment programs. And Governor Anaya identified alcoholism prevention and services among the top priorities of his administration.

Improving mental health services was a key priority of the governors of **INDIANA, NEW HAMPSHIRE, NEW YORK** and **NORTH DAKOTA.**

A commitment to expanding home and community-based services for the elderly was mentioned by the governors in **NEW MEXICO, MARYLAND, NEW JERSEY,** and **NEW YORK.**

Governor Rockefeller and **MINNESOTA** Governor Perpich spoke of the need to restore medical benefits that had recently been cut. Rockefeller requested a revision in the state's corporate income tax to provide additional revenues for restoring some cuts and financing the federal match to receive federal funds under the primary care health block grant.

Governor Matheson of **UTAH** called for state assumption of the county medically indigent program.

The FY 1984 Health Budget

President Reagan's Fiscal Year 1984 budget proposes a number of far reaching reforms in the financing of health care. Most of the reforms concentrate on the Medicare program, with very little attention given to Medicaid. The major ingredients of the President's Health Care Incentives Reform plan are: 1) extending Medicare coverage for catastrophic illness; 2) restructuring beneficiary cost-sharing under Medicare; 3) establishing a prospective rate structure for hospitals under Medicare; 4) limiting the current tax subsidy of higher cost private health insurance plans; and 5) establishing a voluntary voucher program to permit Medicare beneficiaries to enroll in private health plans.

To underscore the need for substantial reforms in health care financing, the Administration points to some alarming statistics. In 1982, health care costs went up almost three times the national inflation rate. The cost of health insurance rose 15.9 percent in 1982, the biggest increase ever. Over the last five years, Medicare

costs have increased at an average annual rate of 19 percent. And in 1983, Medicare and Medicaid will spend as much *every month* as they did during the entire year of 1966, their first full year of operation.

According to the Administration's restructuring initiative, Medicare beneficiaries will continue to pay a deductible equal to one day of hospital care, but a copayment equal to 8 percent of the deductible will be required for each day of hospital care from the 2nd through the 15th day. From the 16th through the 60th day the copayment will be reduced to 5 percent of the deductible (currently, no cost-sharing is required from the 2nd through the 60th day). After the 60th day, beneficiaries would face no further financial obligation for hospital costs for the remainder of the year.

With respect to reimbursement reform, the budget assumes the implementation of a prospective payment system on a per-case basis, adjusted by diagnosis and patient characteristics. The diagnosis-related group (DRG) classification system would serve as the basis for the case adjustments.

Under the Administration's proposed Voluntary Voucher program, beneficiaries will enjoy the option of receiving services through a private health benefits plan, rather than through the Medicare system. If a beneficiary selects alternative coverage, the government would pay an amount equal to 95 percent of the per person costs under the Medicare program.

At the heart of the Administration's Incentives Reform plan is a proposal to limit the current tax subsidy of higher priced health insurance plans. If the plan is adopted, tax-free treatment of employer contributions to employee benefits would be limited to $175 a month for family coverage or $70 a month for individual coverage. According to the Administration's estimates, about 30 percent of those with employment-based health coverage currently receive employer contributions above those limits. An additional $2.3 billion in tax revenue is anticipated in FY 84 as a result of this initiative.

The Administration projects that, if Congress accepts its reform proposals, Medicare payments will reach $63 billion in 1984—13.2 percent higher than the current estimate for 1983. The Administration claims, however, that the rate of increase would be 16.3 percent absent its legislative proposals.

Other significant initiatives in the FY 84 budget affecting Medicare include: freezing physician reimbursement for one year; modifying the rate of increase in Part B premiums; indexing the Part B deductible to the Medicare Economic Index; eliminating mandatory utilization review by hospitals and skilled nursing facilities; and authorizing DHHS to employ competitive purchasing procedures for the procurement of laboratory services, durable medical equipment and other medical supplies for beneficiaries.

The FY 84 budget is marked by the absence of any significant new reform proposals for the Medicaid program. The budget recommends an extension of the reductions in federal payments to states for Medicaid (as originally provided in the 1981 Reconciliation Act) by 3 percent beginning in 1985 and continuing indefinitely. A state could, however, offset the reductions if it managed to contain its expenditures below specified limits. The budget also includes a recommendation to require states to impose nominal copayments on the categorically and medically needy for physician, clinic, and hospital inpatient and outpatient service. Finally, the budget contains a provision which would require applicants, as a condition of eligibility, to assign their health insurance rights to the state Medicaid agency.

Once again, the Administration's budget contains no request for health planning activities, which is in keeping with its policy to eliminate federal involvement in health planning at state and local levels.

The FY 84 budget contains a request for $1.357 billion to fund the four health block grants (Preventive Health at $85 million; Alcohol, Drug Abuse and Mental Health at $439 million; Primary Care at $460 million; and Maternal and Child Health at $373 million). The Administration intends to submit legislation to include three additional programs in the Primary Care block grant: Migrant Health Services, Black Lung Clinics, and Family Planning. The budget further proposes to consolidate the administration of the block grants within the Office of the Assistant Secretary for Health.

Reports and Publications

A new study commissioned for the Federal Trade Commission details the trends in the evolution of three separate kinds of health care services: retail dentistry, freestanding emergency care centers, and freestanding surgery centers. The study provides a descriptive overview of the three types of services and identifies various factors impeding their growth. It provides some answers to four broad questions: 1) How does the growth of entrepreneurial medical/dental services vary across states because of differences in licensing requirements? 2) How do reimbursement practices of commercial insurers and of medical and dental service plans impact on the growth of these entities? 3) How are these services being marketed and to what types of consumers? 4) Is there any evidence of competitive responses by traditional health care providers? Copies of the report, entitled *Entrepreneurial Trends in Health Care Delivery: The Development of Retail Dentistry and Freestanding Ambulatory Services,* are available free on a limited basis. Request document number IH-83 from Michael Pollard, Room 272, FTC, Washington, DC 20580.

The Institute for Health Planning recently published several monographs which should be of interest to health policymakers. The publications include: *State Health Care Cost Containment: A Review of Strategies* ($9.00); *Health Care Vouchering and Competition* ($8.00); *A New Era for State Health Planning* ($8.00); *Issues in Health Block Grant Funding* ($7.00); *Bidding for Long Term Care Patients* ($8.00); and *Altering Incentives in Health Cure Delivery* ($6.00). To order copies write to: IHP, 702 North Blackhawk Avenue, Madison, WI 53705.

State Health Highlights

• A **NEW YORK** bill (S 737, A 817) would amend the state's Medicaid law to require programs to provide recipients with the means to make a fully informed and independent choice from among licensed health and mental health providers.

• A **COLORADO** bill (HB 1184) would prohibit hospitals from denying or limiting staff privileges or the use of hospital facilities to any health care provider licensed to perform surgery, or from discriminating against such providers on any basis other than training, experience, or demonstrated competence in their field of practice.

• A **NEW MEXICO** bill (HB 20) would require any health care practitioner advertising services to the public to state in the advertisement his name, address, telephone number, and the designation of the profession in which he is licensed to practice.

• **NORTH CAROLINA** recently decided to replace Blue Cross-Blue Shield coverage for state employees with a self-insurance plan. The new plan provides for a $100 deductible with 5 percent employee coinsurance up to $2,000, and full coverage thereafter. The plan also removes limits from hospital and physician reimbursement, which had been frozen for over a year.

• **CALIFORNIA** enacted legislation (AB 2346, Chapter 1304) permitting physician assistants to form professional corporations and to render professional services in the name of a corporation. The law also allows registered nurses to be shareholders in a physician assistants' corporation, and physician assistants to be shareholders in a nursing corporation.

STATE HEALTH NOTES

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HOSPITAL GROUP WANTS PATIENT FEES IN MEDICARE PAY PLAN

While determined to see Congress pass a prospective payments system, the American Hospital Assn. wants Congress to make some significant changes in HHS' proposed plan. The group's major concern is to have the plan allow hospitals to charge Medicare patients a fee above what Medicare will pay for hospitalization. AHA Vice President Jack Owen urged members at the group's annual meeting to press Congress to give the go-ahead to such payments by Medicare beneficiaries.

The group also will lobby Congress to base the pay plan on each hospital's cost per diagnosis group, rather than use national average costs as proposed by HHS. The association claims this will not raise total costs for Medicare, merely allocate funds more accurately.

AHA also hopes legislators will exempt some small and rural hospitals from the plan. Another area of worry is that the HHS secretary will be the one to decide the actual dollar figure on which payment for each diagnosis will be based (WHCL, Jan. 7, page 1). The non-profit hospital group wants an independent panel of economists to decide this. Owen also urged AHA members to lobby for health planning programs that are locally-run, rather than federally controlled.

CAPITAL COSTS CURBED BY HEALTH PLANNING PROGRAMS

Proponents of the highly criticized health planning program will note with satisfaction a study for the Health Resources Administration which found that certificate-of-need programs have succeeded in curbing increased capital costs. The program in particular averted capital expenditures for acute care services and facilities, said the study(*) prepared by Arthur D. Little, Inc. Health planning programs were studied in six states: N.J., Iowa, Colo., Va., S.C., Wash.

Projects were blocked because they did not meet objectives set forth in state and health systems plans. Review of programs before applications were submitted meant that some programs were stopped early on. Iowa's program of a presubmission conference between the applicant and local health planning staff on the need for a project eliminated the expense of preparation and review for projects which were immediately rejected.

Decisions on certificate-of-need were made on the basis of specific objectives, standards for programs and need estimates. The latter included the volume and utilization of existing and proposed health services. The issue of financial feasibility came into most decisions, particularly at the state level. The effect of new capital spending on operating costs and patient charges was evaluated.

More than two-thirds of the acute care capital expenditures approved were for renovation/replacement and/or conversion of existing capacity. This may be related to the fact that while standards exist for adding acute care capacity, there are no guidelines for renovation and replacement of such services. Many of the new or additional services approved were equipment. Nearly half of N.J.'s new/additional capacity was equipment.

Certificate-of-need programs are especially effective when integrated with state cost containment plans such as rate setting, the study said. It also recommended better standards for long-term care and renovation of acute care facilities.

(*) - Document used in an article is available from our affiliated *Regulatory Watchdog Service* (202) 47[illegible]

POSITION PAPER/Department of Health & Social Services

Position Paper

on

Senate Bill 85

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

Senate Bill 85 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 Senate Bill 85 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

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

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: 2/16/83

Approved by: for John R. Smith

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

Date: 2/16/83

Bill No: Senate Bill 85 Date on Bill: 1/27/83
Title: An Act repealing the certificate of need program;and providing for an effective date
Sponsor: Senators Faiks, P. Fischer, and Pettyjohn
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 Phone: 465-3038
Division: State Health Planning and Development Date: 2-14-83

Approved by Commissioner: John R. Bragg Date: 2/16/83
Department: Health and Social Services Date:

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

Central Peninsula General Hospital

P. O. Box 1268
SOLDOTNA, ALASKA 99669

OPERATED BY
LUTHERAN HOSPITALS AND HOMES SOCIETY
FARGO, NORTH DAKOTA 58102

February 14, 1983

The Honorable Mae Tischer
Alaska State House of Representatives
State Capitol
Pouch V
Juneau. Alaska 99811

FEB 18 1983

Subject: House Bill #19

Dear Representative Tischer:

Central Peninsula General Hospital, along with the other hospitals of the Alaska State Hospital Association, would encourage the earliest possible passage of Senate Bill #85.

It is a premise of this organization that the Certificate of Need process is both cumbersome and ineffective in a state such as Alaska. The original purpose was developed to help contain health care costs by discouraging over-building of hospital beds. The State's major health care problem is not over-bedding, but the continuing lack of accessibility to health care programs and facilities due to the rural nature of our state.

I would encourage our legislators to promote the health care agencies in the planning and providing for better health care, and not tying up their time with the fruitless Certificate of Need process.

Please find attached a copy of a letter from the Central Peninsula General Hospital Service Area Board to the Kenai Peninsula Borough Assembly in support of the repeal of the Certificate of Need process.

Again, passage of this legislation at the earliest time is available.

Thank you for your consideration.

Sincerely yours,

Michael J. Lockwood,
Administrator

MJL/pt

enc. (1) Resolution of the Central Peninsula General Hospital Service Area Board for Repeal of the C.O.N.

Central Peninsula General Hospital

P. O. Box 1268
SOLDOTNA, ALASKA 99669

OPERATED BY
LUTHERAN HOSPITALS AND HOMES SOCIETY
FARGO, NORTH DAKOTA 58102

February 11, 1983

Kenai Peninsula Borough Assembly

At its regular meeting on February 10, 1983, the Service Area Board of the Central Peninsula General Hospital unanimously endorsed Resolution 83-13 "Urging the Alaska Congressional Delegation to work for Repeal of 42 USC 300 M (D) and Urging the State to subsequently repeal AS18.07 03L-111 which provides for a Certificate of Need program for the Construction, Alteration of Bed Capacity, or Addition or Elimination of a Category of Health Services of a Health Care Facility.

To this end the Service Area Board also endorses House Bill 19 and Senate Bill 85, 2 bills that have been introduced in the 1983 Alaska State Legislature.

Copies of this endorsement have been sent to Senators Stevens, Murkowski and to Congressman Young as well as the Alaska State Legislators.

Robert F. Jensen

ROBERT F. JENSEN
Chairman
Service Area Board

alaska state hospital association

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

REPRESENTING ACUTE, LONG TERM AND OUTPATIENT FACILITIES

Chairman of the Board
Ronald A. Pavellas
Humana Hospital Alaska
Anchorage

Chairman-Elect
Mark Hawkins
Sitka Community Hospital
Sitka

Immediate Past Chairman
Tom Mingen
Fairbanks Memorial Hospital
Fairbanks

Secretary/Treasurer
Edward Zeine
Cordova Community Hospital
Cordova

Delegate to the American Hospital Association
Al M. Camosso
Providence Hospital
Anchorage

Alternate Delegate to the American Hospital Assoc.
Michael Lockwood
Central Peninsula Hospital
Soldotna

Delegate to the American Health Care Association
Jack Buck
St. Ann's Nursing Home
Juneau

Alternate Delegate to the American Health Care Association
Emma G. Ivy
Wrangell General Hospital
Wrangell

Delegate to the Association of Western Hospitals
Michael Herring
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Homer

Alternate Delegate to the Association of Western Hospitals
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Physician Member of the Board
Keith Brownsberger, M.D.
Anchorage

President
Dennis L. DeWitt
Juneau

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 Denni[illegible]t 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.

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Anchorage

President
Dennis L. DeWitt
Juneau

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.

#1

bcc Dennis Nesbett

PROVIDENCE
HOSPITAL

3200 PROVIDENCE DRIVE - POUCH 6604
ANCHORAGE, ALASKA 99502
PHONE: (907) 276-4511

SISTERS OF
PROVIDENCE

SERVING IN THE WEST SINCE 1856

December 27, 1982

Mayor Tony Knowles
Municipality of Anchorage
Pouch 6-650
Anchorage, Alaska 99502

Dear Mayor Knowles:

Thank you for the opportunity on December 13 to share Providence's plans and some of our concerns with you.

One point came up during our discussion regarding Certificate of Need (CON). I would like to elaborate for you in more detail why the health care providers in Alaska oppose CON and have so strongly supported its repeal.

As you know, the CON law was passed in this and most other states as a requisite to receive Federal funds. The major impetus for the law were:

1. Excess hospital beds in many large cities, and
2. 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 desired throughout the country. The law is cumbersome, wasteful and, in fact, costly.

The lack of "success" is especially true in Alaska for some basic reasons:

1. The process which the law sets in place is cumbersome and wasteful. The institution must:
   - submit a letter of intent at least 60 days prior to an application (for no apparent reason);
   - submit an elaborate, repetitive application (most are well over 100 pages). There are 12 separate "criteria" which must be addressed in any application;
   - wait to be declared complete (minimum 20 days; several of our applications were delayed months);
   - then go through a 90-day review process--with three or four public meetings.

2. The costs of CON to the institution are enormous to prepare this cumbersome document (at least 35 copies) and submit to the minimum 110-day process. There are also the institutional costs of delaying implementation and watching the price of a piece of equipment or construction project increase several percent points with inflation.

   The cost to the public is also great in the state, regional and local staff needed to coordinate the program, prepare staff analyses and hold public meetings.

3. The dollar limit for what must be reviewed has been ridiculously low--$150,000. The federal law has allowed that limit to be raised to $400,000 and $600,000 although the Alaska legislature failed in its last session to raise the limits. Some states have raised the limit to $1 million or more. To have a limit of $150,000 or even $600,000 when the hospital's annual operating budget is $75,000,000 (such as Providence's) is overkill.

   In just 1982 alone, Providence has prepared 6 CON applications, including two equipment replacements (for a CT Scanner and a Cath Lab), a $250,000 computer enhancement for an x-ray machine and most absurd, a $167,000 replacement incinerator (25 years old, replacement required by State and EPA codes!). The State did not give final approval on the incinerator until the 90th day.

4. The law itself is overkill in Alaska. Designed for areas of heavy population, excess hospital beds and competition, the law does not work for Alaska for several reasons:

   - The law only covers private facilities--not public health, nor state owned (API or Pioneer Homes), nor military.

   - Alaska has only one city with more than one hospital and only three private ("eligible") hospitals of over 100 beds.

5. The law is reactive to existing decision making processes. Most hospitals in the State already have local public review and approval designed in their own budget review processes. Many hospitals are owned by municipalities, and all have governing or advisory boards of local citizens. These citizens should have control of the expansion and budgetary decisions of their own institutions. Several other layers are unnecessary. Hospitals and their boards are capable of making sound financial and program decisions.

As the attached Policy Statement of the Alaska State Hospital Association (ASHA) notes, we are supportive of state and local planning for the health care needs. The process should be positive and proactive-- encouraging institutions to respond to needs in the community rather than reactive, cumbersome and negative.

We encourage the city to support the ASHA position on repealing the state CON law. Your own Municipal Health Commission is a strong local planning body which helps identify health needs and encourages solutions. It also serves to review public expenditures in health. Those roles are appropriate. It should be freed from the cumbersome CON review.

Thank you for giving me the opportunity to share our concerns with you.

Best wishes for a prosperous 1983.

Sincerely,

Al M. Camosso
Administrator

Enclosure

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Region X
M/S 829 Arcade Plaza Building
1321 Second Avenue
Seattle WA 98101

June 22, 1982

Re: 10P 550016
Alaska SHPDA

Dennis L. DeWitt
President
Alaska State Hospital Association
319 Seward Street
Juneau, Alaska 99801

Dear Mr. DeWitt:

Your letter dated June 11, 1982, requested information about Region X's intentions as a result of the failure of the Alaska Legislature to pass amendments proposed to bring the State Certificate of Need program into compliance with the Federal planning law, as amended. Our course of action is quite clear. We will continue to fullfill our mandated responsibilities guided by actions and time frames specified in the law.

Under the existing provisions of Title XV of the Public Health Service Act, as amended, current law requires (in order to be fully designated) that a SHPDA must meet all requirements for full designation, including that of having a complying Certificate of Need program.

If a SHPDA is not eligible for full designation by a certain date (which for Alaska is January 19, 1983) the Department must invoke the statutory penalty of reducing most Public Health Service grants and contracts to any entity in the State by 25% the first year, 50%, 75%, and 100% over the next three years. Amendments contained in PL 97-35 extended the date by which a State must have a fully designated SHPDA to avoid imposition of the penalty. However, PL 97-35 also amended Section 1521(b)(2)(B) by specifying that a conditional designation agreement could not extend beyond a State's penalty date.

Fully designated SHPDAs (such as Alaska) which do not have complying CON programs but continue to meet other requirements, will be returned to conditional designation. As noted above, PL 97-35 prohibits the conditional designation of any SHPDA from extending beyond its penalty date. Any SHPDA which remains conditionally designated on its penalty date must be terminated. Therefore, we will send a termination notice to any conditionally designated SHPDA 90-days prior to its penalty date, if it still has not demonstrated that it has a complying CON program.

The enclosed copy of a letter to Commissioner Beirne, from the Regional Health Administrator, further emphasizes the critical nature of having a complying CON program in Alaska.

Also the enclosed copy of a 1981 letter addressed to Mr. Ivan Lawner, Esq. concerning Pioneer Homes Certificate of Need review issues, reflects our unchanged position.

I hope the facts in this letter provide the detail of information required to understand the situation. Please call or write, should you need further assistance.

Sincerely,

John D. Whitney
Director
Department of Health
Resources Development
Region X

Enclosures (2)

DEPARTMENT OF HEALTH. EDUCATION. AND WELFARE

829

JUN 21 1982

Re: IOP 550016
Alaska SHPDA

Helen D. Beirne, Ph.D.
Commissioner
Department of Health and
Social Services
Pouch H 01
Juneau, Alaska 99811

Dear Dr. Beirne:

The State of Alaska's Department of Health and Social Services full designation agreement with the Department of Health and Human Services is being extended for three months, until September 30, 1982. As you know, because Alaska's Certificate of Need Program does not comply with Federal requirements, it is necessary that the SHPDA be returned to conditional designation. As required by statute, this 90-day extension of your current designation is being given to allow you to request and prepare for a hearing, if you should want one. Letters from the Bureau of Health Planning to you and to the Governor will further explain this process.

The following conditions are to be considered a part of the extended full designation agreement:

1. If the Agency is unable to retain full designation after September 30, 1982, it will be returned to conditional designation for the period October 1, 1982 to June 30, 1983.

2. The designation of the Agency will automatically terminate when the Agency reaches its penalty date, if the Agency still has not achieved full designation.

You may at any time prior to your penalty date (1-19-83, per PPM 82-12) submit documentation which you believe contains evidence that the State's CON program complies with the minimum Federal requirements, or a certification by the State's Attorney General, attesting to the program's complian

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Please sign both copies of this letter, indicating your acceptance of this extension with conditions. Return one copy to this office. As soon as we receive the signed copy, we will issue a Notice of Grant Award for the extended designation period.

Sincerely,

Dorothy H. Mann, M.P.H.
Regional Health Administrator
Region X

Helen D. Deirne, Ph.D.
Commissioner
Alaska Department of Health

Date

DHRD:ROSS:vw:6/21/82

DEPARTMENT OF HEALTH & HUMAN SERVICES

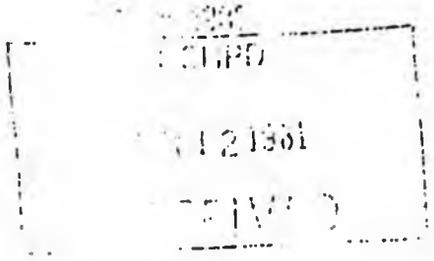
Public Health Service

Pioneer Homes
Lynns Room

Region X
M/S 829 Arcade Plaza Building
1321 Second Avenue
Seattle WA 98101

Re: 10P 550007-05

Mr. Ivan Lawner, Esq.
Hellen & Partnow
524 G Street
Suite 710
Anchorage, Alaska 99501



Dear Mr. Lawner:

This is to respond to your recent letter concerning Certificate-of-Need review of a skilled nursing facility addition to the Pioneer Home in Anchorage. In that correspondence you raised two issues: the need for clarification of our 1978 letter to Howard Gabriel regarding C/N coverage of Pioneer Homes, and the compliance of the Alaska C/N program with federal standards. These matters will be addressed separately.

1. In our September 11, 1978 letter to Howard Gabriel, Director of the Southeast Alaska HSA, we were assuming that Pioneer Homes were only residential or domiciliary care facilities; there was no understanding that inpatient skilled nursing care was provided in these institutions. Given this understanding of the nature and services of Pioneer Homes at that time we were correct in concluding that they would not be included in the federal definition of "health care facilities" which would require coverage under Certificate-of-Need programs. If indeed skilled nursing services are provided in these institutions, they would be considered "health care facilities" as defined by our C/N regulations. The 1978 letter did not consider a Pioneer Home to be such a facility.

2. We have reviewed the Alaska C/N statute and implementing regulations to determine whether Pioneer Homes would be included in the definition of a health care facility. We found that:

   a. The Alaska C/N statute defines a "health care facility" as:

      A private, municipal. . . hospital, psychiatric hospital, turberculosis hospital, skilled nursing facility. . . . (Sec. 18.07.111(7)).

   b. The Alaska C/N regulations, in turn, define "health care facility" as:

      Any of those listed in AS 18.07.111, as defined, where appropriate, in 42 CFR 123.401 (adopted 1/21/77). (7AAC07.130)

c. The State's C/N statute and regulations, taken together and including the cross reference to 42 CFR 123.401, would provide coverage of a distinct part of an institution and would, therefore, meet the federal definition of a skilled nursing facilities, i.e., an institution or a distinct part of an institution which is primarily engaged in providing inpatient skilled nursing care and related services for patients who require medical or nursing care . . . . (42 CFR 123.401)

From the above points, it would appear that the Alaska C/N program adequately defines "heath care facility" and "skilled nursing facility." It is the responsibility of the state to follow its own C/N statute and regulations. If there is an on-going and sustained pattern of not following their statute and regulations, we would certainly assess the state's overall C/N program and then take appropriate action.

Please call us should you have further questions.

Sincerely yours,

John D. Whitney, Director
Division of Health Resources
Development PHS, Region X

cc: Ron Hammett, Director, SCHPD
Howard Gabriel, Director, SEAHSA

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPARTMENT OF ADMINISTRATION

OFFICE OF THE COMMISSIONER

POUCH C
JUNEAU, ALASKA 99811

465-2200

May 29, 1981

Honorable Donald E. Clocksin
Chairman, Health, Education and
Social Services
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Representative Clocksin:

This is in response to your request to put in writing my verbal testimony before your committee on CSSB 225. I will try and confine my remarks to the major issues.

Administration's position is that the Legislature has always implicitly exempted Pioneers' Homes from the certificate of need program. The Senate has concurred with this position as evidenced by CSSB 225. We are asking that the House members be afforded the same opportunity to express their will as the Senate.

There appears to be some confusion existing with the recent State Supreme Court decision of South Central Health Planning and Development, Inc. vs the Department of Administration, on certificate of need. At issue was whether or not the Legislature exempted Pioneers' Homes from certificate of need. The court found that there is no language in State statutes which can reasonably be read as exempting skilled nursing facilities from the certificate of need process when they are contained in Pioneers' Homes. Consequently, whether or not the Legislature intended to exempt Pioneers' Homes now becomes moot. The Legislature's intent can now be established only through the legislative process of amending existing law to allow this exemption.

There has been a substantial amount of discussion centering around the need for proper planning so that health facilities in Alaska are not overbuilt. This is an admirable and worthy objective, and I can assure you that this Department supports health facility planning. However, the existing system under the certificate of need program is fraught with inequities and frustrations; further, it does not represent a comprehensive planning effort.

2-89LH

There are three providers of health facilities; the federal government, the State government, and the "private sector." However, the federal health facilities don't come under the certificate of need program, and in most states this wouldn't pose any problem. The military contingent in California, for instance, would represent a small portion of the state's total population and as such would not greatly impact the planning process for certificate of need. In Alaska, the opposite is true. The federal government is a major provider of health care and facilities. Roughly one-fourth of the state's population are eligible to use federal health facilities (military base, Public Health, Indian Health, etc.). This has a devasting effect on trying to logically plan for state and "private sector" health facilities when a critical component is missing.

In addition, if we look closely at the "private sector" we see that it is not truly private. A substantial portion of the revenues of private nursing homes and health facilities originate through state and federal programs. State and federal rules, regulations, requirements, and laws, guide and govern, in minute detail, the construction and operation of private health facilities. This includes the proper ratios of professional staff to patients, the type of equipment allowed, size of hallways, reporting procedures, and many others. In effect, the "private sector" is part of the "public sector." Consequently, the charge that the State, through the establishment of Pioneers' Homes, is unfairly competing with the private sector is a fallacious argument.

There has also been considerable discussion on the impact of granting Pioneers' Homes an exemption from certificate of need as it relates to federal programs. Mr. Vern Perry, Director of the Division of Pioneers' Benefits spoke with Mr. Jim Egan, Regional Project Officer of the Office of Health Planning, Region X, U. S. Department of Health, Education and Welfare, on Wednesday May 27, regarding the certificate of need program.

QUESTION: What effect would there be on the State of Alaska if Pioneers' Homes were exempted from the certificate of need program?

ANSWER: It would have no effect on medicare, medicaid, AFDC or Indian Health Service. It could only affect categorical programs such as alcoholism, EMS, Neighborhood Health Clinics, Mental Health Clinics, Day Care, etc.

QUESTION: Would the federal government actually discontinue such programs as alcoholism and mental health if Pioneers' Homes were exempted from the certificate of need program?

ANSWER: No! Absolutely not. In his opinion, under the new administration, there would be no federal sanctions whatsoever in health care programs, especially since the responsibility for this is being turned over to the states.

Further, discussions were held with the States of California and Washington regarding their certificate of need programs. In California, Mr. Ken Umbach (916/323-6955) of the Office of Statewide Health Planning and Development was contacted. He stated that California has been out of conformance with the federal certificate of need program since 1969. Their latest date for coming into conformance is October. He stated that if they did not meet the deadline that the feds would probably extend it. Mr. Jim Bettridge of Washington Health Care Facilities Authority (206/753-6185) indicated that the feds were withdrawing total support from the certificate of need program by 1983.

These conversations indicate that:

i. The federal government is not inclined to impose sanctions on a State for nonconformance with the certificate of need program;

ii. There are states which are nonconforming, and have been nonconforming for a number of years, on which federal sanctions have not been imposed; and

iii. The federal government is withdrawing total support for the certificate of need program by 1983. If the state wants to continue a planning process for health facility development it will have to provide for the process by using General Funds monies. Based on the aforementioned problems, now would be the appropriate time to revise this planning process to make it more meaningful.

Finally, a compromise position has been mentioned in which the new nursing wing at the Anchorage Pioneers' Home and the new Pioneers' Home in Ketchikan would be totally grandfathered into law and not made subject to certificate of need. This compromise does not address a truly complex problem.

The Fairbanks Pioneers' Home presently is serving twelve skilled nursing beds in unlicensed beds. Unless a certificate of need is issued which allows licensing of these beds, these twelve pioneers would have to be discharged.

The Fairbanks and Palmer Pioneers' Homes are full to capacity with skilled nursing patients at the present time. If we are to accommodate anticipated need in the near future, additional skilled nursing facilities will have to be constructed within the next few years. This expansion would be impossible unless a certificate of need is issued.

The Department of Health and Social Services, in recent licensing inspections, has advised a significant number of residents in the ambulatory sections of all the Pioneers' Homes should be designated intermediate care patients. Intermediate care requires both a certificate of need and a significant increase in staffing, installation of call buttons or other signalling devices, and closer attention to patients when taking medications, etc. The number of patients which might be considered in need of intermediate care are: thirty at Sitka, twenty at Fairbanks, twenty at Palmer and forty at Anchorage (in the new wing).

Funding to provide intermediate care was not included in the FY 82 operating budget. Although a dollar figure is not available at the present time, a significant increase will be necessary if we must comply with the certificate of need program. Passage of SB 225 would eliminate this situation.

In summary:

1. Administration believes the Legislature had always intended to exclude Pioneers' Homes from certificate of need;

2. The certificate of need process is not appropriate for Alaska;

3. There needs to be planning for health care facilities and a more responsive process needs to be developed;

4. Grandfathering the nursing wing at Anchorage and the new Pioneers' Home at Ketchikan will not solve the complex problems existing at the Fairbanks, Palmer, and Sitka Pioneers' Home; and,

5. Passage of CSSB 225 will eliminate the potential for pain and suffering by allowing Pioneers' Homes residents to remain in their home.

If I can be of any further assistance to you or your committee, please give me a call.

Sincerely,

Frederick B. Muller

Frederick B. Muller
Deputy Commissioner for
Personnel Management

FBM/mjc
cc: Honorable Charles Parr
Honorable Robert Ziegler
Honorable Jalmar Kerttula
Honorable Patrick Rodey
Pioneers' Homes Advisory Board
Dennis Dewitt, Executive Director
Alaska State Hospital Association

accordance with subsection (b)(2), or (b)(3) of this section (as the Secretary determines appropriate), enter into another agreement with the Governor for the designation of a State Agency.

Failure to designate State Agency within specified period; reduction in allotment, grant, loan, loan guarantee, or contract

(d)(1) If an agreement under subsection (b)(3) of this section for the designation of a State Agency for a State is not in effect upon the expiration of—

(A) the fourth fiscal year which begins after 1975; or

(B)(i) if the legislature of the State is in a regular session on December 17, 1980 and the legislature will be in session for at least twelve months from such date, twenty-four months from such date, or

(ii) if the legislature of the State is in session on December 17, 1980, but twelve months do not remain in such session after such date or if the legislature of the State is not in session on such date, twenty-four months after the beginning of the first regular session of the legislature beginning after such date,

whichever occurs later, the Secretary shall take the action prescribed by paragraph (2).

(2) If upon the expiration of the period applicable under paragraph (1) an agreement is not in effect for the designation of a State Agency for a State, the Secretary shall until such an agreement is in effect take the following action:

(A) During the first twelve months after the date of the expiration of the applicable period, the Secretary shall reduce by 25 percent the amount of each allotment, grant, loan, and loan guarantee made to and each contract entered into with an individual or entity in such State during such period under this chapter or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970.

(B) During the second twelve months after such expiration date, the Secretary shall reduce by 50 percent the amount of each such allotment, grant, loan, loan guarantee, and contract.

(C) During the third twelve months after such expiration date, the Secretary shall reduce by 75 percent the amount of each such allotment, grant, loan, loan guarantee, and contract.

(D) After the expiration of thirty-six months after such expiration date, the Secretary may not make or enter into any such allotment, grant, loan, loan guarantee, or contract.

(July 1, 1944, c. 373, Title XV, § 1521, as added Jan. 4, 1975, Pub.L. 93–641, § 3, 88 Stat. 2242, and amended Aug. 1, 1977, Pub.L. 95–83, Title I, § 106(*l*), (m), 91 Stat. 385; Dec. 19, 1977, Pub.L. 95–215, § 6(b), 91 Stat. 1507; July 16, 1979, Pub. L. 96–33, 93 Stat. 86; Oct. 4, 1979, Pub.L. 96–79, Title I, § 123(a), (b)(1)(A), (2), (d), (f), (g)(2), 93 Stat. 624–627; Oct. 17, 1979, Pub.L. 96–88, Title V, § 509(b), 93 Stat. 695; Dec. 17, 1980, Pub.L. 96–538, Title III, § 303(b), 94 Stat. 3190; Aug. 13, 1981, Pub.L. 97–35, Title IX, §§ 902(g)(5), 936(b), 95 Stat. 561, 572.)

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

POUCH H 01
JUNEAU, ALASKA 99811
PHONE: 465-3030

May 10, 1982

The Honorable Mike Beirne
Chairman
House HESS Committee
Alaska State House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Rep..sentative Beirne:

I am enclosing a Program Policy Notice we recently received from the Bureau of Health Planning in the U. S. Department of Health and Human Services. This Notice emphasizes that states which do not have State Health Planning and Development Agencies which fully comply with federal requirements will lose federal support for health planning efforts and will also lose most federal Public Health Service dollars. Alaska currently receives some $5 million annually in such federal funds. Our lack of compliance would result in one quarter of these funds being withheld for four years until certain federal public health service funds are no longer available to Alaska.

We appreciate the hearing you conducted on House Bill 195. We believe this bill, with the amendments we offered, would bring our State Health Planning and Development Agency into full compliance with federal requirements. Your assistance in helping to move this legislation would be very much appreciated.

We appreciate your assistance and support in this matter.

Sincerely,

Helen D. Beirne

Helen D. Beirne
Commissioner

Enclosure

cc: Phoebe A. Lindsey

F38LH

ALASKA STATE MEDICAL ASSOCIATION
4107 Laurel Street • Suite 1 • Anchorage, Alaska 99504 • (907) 277-6891



ADOPTED BY THE ALASKA STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES AT ITS ANNUAL MEETING IN FAIRBANKS, ALASKA JUNE 3, 1982

RESOLUTION NO. 82-23

SUBJECT: Certificate of Need

WHEREAS, the certificate of need process has increased the cost of health care rather than reduced it; and

WHEREAS, the certificate of need process has wreaked havoc upon the orderly development of hospitals in Alaska, therefore

BE IT RESOLVED, the Alaska State Medical Association urges and encourages the Legislature to repeal the certificate of need law.

DISTRIBUTION: Legislature
Alaska State Hospital Association
Press

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
Dennis L. DeWitt
Juneau

November 4, 1982

The Honorable Ted Stevens
United States Senate
Washington, D.C. 20510

Similar letter sent to:
Senator Murkowski and
Congressman Young

Dear Senator Stevens:

As you are well aware the State of Alaska is not in conformity with the National Health Planning and Development Act and without federal action in 1982 faces penalties in grant monies under the Public Health Service Act and the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970. To avoid this penalty it is imperative that Congress repeal 42 U.S.C. 300m-(d) (copy attached).

This Association as well as the Alaska State Medical Association (resolutions attached) are opposed to the continuation of the state Certificate of Need law. Both are committed to its repeal in 1983. Repeal of 42 U.S.C. 300m-(d) will greatly assist our efforts.

We have communicated our support for various measures considered by this Congress to restructure the federal law. It appears however, that a full reform may be a consideration which must be left to the next Congress. If that is so, it is imperative that you secure repeal of 42 U.S.C. 300m-(d) before the current Congress adjourns in December.

All of those concerned with this issue including Congressman Waxman, the National Governors Conference, the American Hospital Association, etc., agree on removing sanctions against states which do not conform to the federal program. The notion of further delay of the sanctions does not assist anyone, it simply prevents states such as Alaska from dealing with its own law on anything beyond a temporary basis.

For these reasons we urge you to secure the repeal of 42 U.S.C. 300m-(d). This will permit the legislature of the State of Alaska to deal with its law in whatever manner it deems appropriate. Further, we urge that this repeal be secured prior to the adjournment of the 97th Congress.

Sincerely,

Dennis L. DeWitt
President

DLD:lf
cc: Friday Mailing
Alaska State Medical Society
Governer Jay Hammond
Governer Elect Sheffield
Lt. Governer Terry Miller
Lt. Governer Elect McAlpine
American Hospital Association - Lynn Hart
Federation of American Hospitals

BILL SHEFFIELD, GOVERNOR

STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

December 22, 1982

Mr. Dennis L. DeWitt
President
Alaska State Hospital Association
319 Seward Street
Juneau, Alaska 99801

Dear Mr. DeWitt:

Thank you for sending me a copy of your letter to Senator Stevens regarding the state Certificate of Need law.

As you know, I am in agreement with you in your opposition to this law. Please keep me posted as to what I can do to change the law in Alaska.

Best regards.

Sincerely,

Bill Sheffield
Governor

Blue Cross
of Washington and Alaska

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

FEB 18 1983

February 14, 1983

Representative Mae Tischer
Alaska State Legislature
Pouch V (MS 3100)
Juneau, Alaska 99811

Dear Representative Tischer:

I appreciated having the opportunity to discuss with you the legislative proposals which you are addressing in this session and which are of concern to Blue Cross of Washington and Alaska. Martin Tirador will be keeping in close contact with you on these and other issues.

We are continuing to develop information which supports our position for the modification of the certificate of need law. Other organizations such as the Health I[redacted] Much of this information will be presented to the Health Education and Social Services Committee in the hearing on HB 19.

I particularly appreciated the chance to visit with you. I would hope that you will call on either Martin Tirador or me if you feel we can provide you with information on any issue you are considering in the legislative process.

Sincerely,

Joan Gaumer

Joan Gaumer, Director
Government Relations

JHG:pf

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

northern alaska health resources association, inc.

FEB 9 1983

February 03, 1983

The Honorable Mae Tischer
Alaska State Legislature
Pouch V (MS 3100)
Juneau, Alaska 99811

Dear Representative Tischer:

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

529 5th avenue, suite 8 fairbanks, alaska 99701 telephone (907) 456-2553

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 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.

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.

FEB 18 1983

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

David, all these type comments need to be made part of the testimony. Please put with our file

February 15, 1983

Dear Alaska Legislator:

The Executive Committee of South Central Health Planning and Development, Inc., yesterday met to discuss the proposed Certificate of Need repeal bill. The Committee asked me to convey to you our support for the attached position paper developed by the Alaska Health Coalition.

The [redacted]

If you have questions on this issue, you might contact Executive Director, Peggy Wilson.

Sincerely,

Margaret McClure Wilson

Margaret M. Wilson
Executive Director

MMW/ab

Alaska Health Coalition

529 5th Avenue, Suite 8
Fairbanks, Alaska 99701
(907) 456-2553

February 11, 1983

TO: Members of the Alaska Legislature

Proposed legislation (HB 19 and SB 85) would repeal Alaska Statute 18.07.031-18.07.111, better known as the Alaska Certificate of Need (CON) law. These bills reflect the position of the Alaska Hospital Association, whose member institutions are subject to the provisions of the CON process. The attached paper, developed by the Alaska Health Coalition, was written to provide legislators and the public with a series of alternatives to consider during discussion of these important bills. The paper summarizes the provisions of the CON law, discusses several of the problems which have been identified with the current process, and reviews the effectiveness of the CON program, both nationally and within Alaska. In addition, a list of recommendations is provided for consideration in revising the current CON law.

The Alaska Health Coalition is a group of interested citizens with memberships from the three Alaska Health Systems Agencies and the Statewide Health Coordinating Council. The primary purposes of the Coalition are to review the need for health planning, development, and promotion activities and to develop goals, describe functions, and recommend structures to achieve optimal health for the citizens of the state. Therefore, we believe that the subject of public review of capital expenditures as currently provided for in the Certificate of Need law is an important issue which deserves a reasonable, objective discussion. We present this paper for the purpose of initiating this discussion.

For additional information, please contact any of the following organizations: Northern Alaska Health Resources Association, Fairbanks (456-2553); South Central Health Planning and Development, Anchorage (278-3631); or, Southeast Alaska Health Systems Agency, Ketchikan (225-9681).

Best regards,

Charles M. Kaltenbach

Charles M. Kaltenbach, Dr. P.H.
Chairman

CMK:sem

Enclosure

Coalition Members

J. B. Carnahan, Fairbanks; Joseph Clarkson, Juneau;
Charles Kaltenbach, Dr. P.H., Fairbanks; Steve Lesko, Anchorage;
John Manning, Ketchikan; Lillie McCarvey, Anchorage; Art Wilson, Sitka; Margaret Wilson, Anchorage

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.[6]

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, an effective market for health care services does not exist in most communities. Competition exists but it is rarely price competition; indeed the nature of current competition based on scope of services, amenities, and convenience is to encourage price increasing 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. (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 taxpayers).

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.[3]

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.

[redacted]

1. [redacted] to at least:

[redacted]

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. [redacted]

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

6. [redacted] the CON process.

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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.

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

The Governor designated a State Health Planning and Development Agency (SHPDA) as a unit of State government. The SHPDA has the responsibility to conduct the health planning activities of the State, including preparation and implementation of the State Health Plan, and to provide coordination of the HSAs. The SHPDA also supports the function of the Statewide Health Coordinating Council and is responsible for administration of the Certificate of Need program. In Alaska, the SHPDA resides within the Department of Health and Social Services. It currently occupies division-level status.

STATEWIDE HEALTH COORDINATING COUNCIL

The Alaska Statewide Health Coordinating Council (SHCC) is the third entity involved in the State health planning network. The SHCC is a group of citizens appointed by the Governor who oversee the health planning activities within the State. Specifically, they have responsibility for preparation of the State Health Plan. The State Health Plan forms the basis upon which Certificate of Need applications are reviewed. Both the SHPDA and SHCC are supported with a mix of Federal and State funds.

STATEMENT OF

ÆTNA LIFE INSURANCE COMPANY

IN OPPOSITION TO

H.B. 19

As a major writer of commercial health insurance, the Ætna Life Insurance Company has for years been deeply concerned about health care cost increases and has consistently supported viable health planning programs. We strongly oppose H.B. 19, An Act Repealing the Certificate of Need Program. We believe that enactment of this legislation would represent a large step backward in Alaska's effort to realize an efficient and effective health care delivery system.

Health planning is one of the elements in the armamentarium of programs that are necessary to help in the reduction of the escalation of health costs and to ensure that the health care delivery system of the future is one that has been rationally and systematically planned.

We feel that it is most important that there be a mechanism in place for participation in the planning and development of health programs to improve the distribution of health services, ensuring that services are available to those citizens who need them, while restricting the investment in unnecessary facilities and services.

An important portion of a viable health planning program is state certificate of need legislation. We find it is essential to have such legislation in order that the necessity of capital expenditures can be determined, because of the two-pronged effect on the growth of health care costs. In the short run, the purchase, installation, and financing of expenditures increases annual health care expenditures. In the long run, operation and maintenance of capital expenditures continue to add to health care costs, to increased use of highly skilled labor (for maintenance and operation) and non-labor inputs (i.e., energy, supplies, etc.).

It has been estimated that every dollar of capital investment adds an additional 50¢ to annual operating cost. An important element in today's economy, which has had a dramatic effect on health care costs related to capital expenditures, is the interest rate now being charged on the finance debt. Efforts must be made to ensure that all capital expenditures made today are necessary and consistent with the goals of Alaska's Health Systems Plan and necessity for such expenditures.

Alaska's Certificate of Need Program is an important tool for implementation of the area health plan. We urge that this program be continued.

FEB 16 1983

CERTIFICATE OF NEED:

REVISION OR REPEAL

Prepared in
the
Public Interest
by
the

ALASKA HEALTH COALITION
February, 1983

Alaska Health Coalition

529 5th Avenue, Suite S
Fairbanks, Alaska 99701
(907) 456-2553

February 11, 1983

FEB 15 [illegible]

TO: Members of the Alaska Legislature

Proposed legislation (HB 19 and SB 85) would repeal Alaska Statute 18.07.031-18.07.111, better known as the Alaska Certificate of Need (CON) law. These bills reflect the position of the Alaska Hospital Association, whose member institutions are subject to the provisions of the CON process. The attached paper, developed by the Alaska Health Coalition, was written to provide legislators and the public with a series of alternatives to consider during discussion of these important bills. The paper summarizes the provisions of the CON law, discusses several of the problems which have been identified with the current process, and reviews the effectiveness of the CON program, both nationally and within Alaska. In addition, a list of recommendations is provided for consideration in revising the current CON law.

The Alaska Health Coalition is a group of interested citizens with memberships from the three Alaska Health Systems Agencies and the Statewide Health Coordinating Council. The primary purposes of the Coalition are to review the need for health planning, development, and promotion activities and to develop goals, describe functions, and recommend structures to achieve optimal health for the citizens of the state. Therefore, we believe that the subject of public review of capital expenditures as currently provided for in the Certificate of Need law is an important issue which deserves a reasonable, objective discussion. We present this paper for the purpose of initiating this discussion.

For additional information, please contact any of the following organizations: Northern Alaska Health Resources Association, Fairbanks (456-2553); South Central Health Planning and Development, Anchorage (278-3631); or, Southeast Alaska Health Systems Agency, Ketchikan (225-9681).

Best regards,

Chas M. Kaltenbach

Charles M. Kaltenbach, Dr. P.H.
Chairman

CMK:sem

Enclosure

Coalition Members

J. B. Carnahan, Fairbanks; Joseph Cladouhos, Juneau;
Charles Kaltenbach, Dr. P.H., Fairbanks; Steve Lesko, Anchorage;
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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, an effective market for health care services does not exist in most communities. Competition exists but it is rarely price competition; indeed the nature of current competition based on scope of services, amenities, and convenience is to encourage price increasing 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 taxpayers).

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.[8]

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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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.

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

The Governor designated a State Health Planning and Development Agency (SHPDA) as a unit of State government. The SHPDA has the responsibility to conduct the health planning activities of the State, including preparation and implementation of the State Health Plan, and to provide coordination of the HSAs. The SHPDA also supports the function of the Statewide Health Coordinating Council and is responsible for administration of the Certificate of Need program. In Alaska, the SHPDA resides within the Department of Health and Social Services. It currently occupies division-level status.

STATEWIDE HEALTH COORDINATING COUNCIL

The Alaska Statewide Health Coordinating Council (SHCC) is the third entity involved in the State health planning network. The SHCC is a group of citizens appointed by the Governor who oversee the health planning activities within the State. Specifically, they have responsibility for preparation of the State Health Plan. The State Health Plan forms the basis upon which Certificate of Need applications are reviewed. Both the SHPDA and SHCC are supported with a mix of Federal and State funds.

Phoebe Lindsey

1122 PROGRAM

CERTIF ON NEED 18.07.111 (7)

hospitals, licensed, care facilities

PROCESS:

60 days from letter of intent to Application date

0-60 DAYS Application

15 DAYS - Dept Determines APP is OK

90 DAYS - TO MAKE RECOMMENDATION to COMMISSIONER

APPEAL

REQUEST for HEARING

PL 97-377 CONTINUING RESOLUTION through Sept 83

- 93-641 HEALTH PLANNING ENABLING LAW

If current 97-377 is REPLACED then FED MAY REQUIRE inspections, etc

1) Medicaid FED & STATE SUPPORT- 60 million

REPEAL OPENS option

PER DAY RATE to different facilities based on operating EXPENSES

PROSPECTIVE not Retrospective Reimbursement system

2) Revenue Sharing 25% cost of non profit capital construction

HOSPITALS —

Operating expenses - $250,000 to each non prof. Hospital

Nursing homes get $2000 per bed

TRACK RECORD

Dave Williams 305 Assembly Bldg.

└ heads staff

INSURANCE companies support CERT. of NEED

HEALTH INSURANCE CORP of America favors cert of need

HB 19

1/21

BLUE CROSS COBBLEST —

QUESTIONS
- tie to STATE AID
- COST of SERVICE if EXTRA BEDS
- Why ~~RE~~ SET PRIORITY for HEALTH CARE FACILITIES if REGIONAL CERT. of NEED. Bette Cato may into 6.11 setting up PRIORITY

SEARCH
ALL

SELECT
ALL CHAPTER EQ 18.07

Summary:

PL 93-641 is FED. ENABLING ~~STEP~~ Authority RE: HEALTH PLANNING

PL 97-377 is A CONTINUING RESOLUTION effective through Sept 83. The "1122" PROGRAM 1122 SEC of Soc. Sec. Act REQUIRES SOME SORT of CERT. of NEED ANALYSIS - that is not REQUIRED under current temporary law.

Until Sept 83, REPEAL of CERT of NEED would have NO other Federally mandated counterpart. ~~IF~~ FEDERAL action could supercede the REPEAL. All 50 STATES have "CON" PROCESS.

1) Reimbursements for Medicaid ± 60 million

All CERTIFIED FACILITIES ARE ELIGIBLE for REIMBURSEMENT REPEAL could MEAN MORE OPTIONS. PER DAY REIMBURSEMENT VARIES with individual facility

Change to PROSPECTIVE, NOT REIMBURSEMENT method might help

2) State Rev. Sharing funds available for 25% cost of CAPITAL CONSTRUCTION - more facilities built, greater demand

- Why Hospital Assn support for this bill? Acts as controlling factor to competition.

THE CERTIFICATE of NEED

1. OUTLINE BASIC PROCESS - FED MANDATE, STATE LAW
   STATE AGENCY. ATTACH CON ACTIVITY REPORT
   CURRENT THRESHOLD LIMITS 7AAC 07.010 - $150,000 CAP 600,000 EQUIP. 400,000
2. SUMMARIZE VIEWPOINTS
   A. REPEAL - UNNECESSARY CONTROL ~~FOR~~ ON AN ENTERPRISE. MOST FACILITIES COVERED BY CON
      REQUIRE PUBLIC FUNDS - ALLOCATION & BUDGET REVIEW
   B. A FREE ENTERPRISE
      B. B ESPECIALLY NOT SUITED FOR RURAL AK
      C. C SANCTIONS NOT IN EFFECT. TIME TO ACT IF SANCTIONS ARE IMPOSED
      D. D CHANGE IN RETROSPECTIVE TO PROSPECTIVE FEE
      E. E SCHEDULE FOR MEDICAID WOULD ~~BE~~ PROVIDE RATE REVIEW
   C. RECURRENT THRESHOLD LIMITS UNREALISTICALLY LOW.
2. B. MAINTAIN OR AMEND
   1. REQ'D BY FED LAW
   2. MANDATES COULD MEAN LOSS OF $
   3. PROVIDES PLANNING ON STATEWIDE BASIS
   4. RESTRICTS FRIVOLOUS EXPENDITURES
   5. FREE ENTERPRISE DOESN'T EXIST IN HEALTH CARE

Repeal will have effects on 4 major four topics:

4 issues appear prominently when considering Repeal of Certificate of Need:

1. ~~Effect~~ Demand on State Revenue Sharing funds
2. Effect on State Medicaid payments
3. Free Enterprise vs. Regulation
4. Federal mandates and potential loss of funds.

Tierney, et al

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 planning review process. It acts as a check to frivolous or misdirected projects. It directs capital (construction) investment to be compatible with the goals and policies of the reviewing agency. The certificate of need was designed to avoid unnecessary duplication which results in underutilization and inflated costs in a cost based reimbursement system.

- Sanctions "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."

  Sanctions begin at 25% and continue annually in 25% increments.

1979 Amendments to Health Planning 96-79

7 AAC 07.010 PL - 93-641

Senate Advisory Catalogue Library
CARD # 000262
Category HEALTH
Auth AMER HOSPITAL ASSN
Pubs 1981

CARD # 000549
AMER HOSP ASSN
APPROPRIATENESS REVIEW of Health Care Services

7 AAC 07.010 - SETS level of construction amount REQ CON at $150,000.

FED LAW allows CAP imp $600,000
EQUIP 400,000

Federal Mandates

The 1974 law, 93-641 established the requirement for states to develop the certificate of need review. The law was amended by 96-79 in 1979. The sanctions imposed against states for non compliance with the CON (certificate of need) process have been temporarily lifted by P.L. 97-377, which expires September 30, 1983. So, until Sept 30, 1983, a repeal of CON would impose no threat of loss of federal funds. Federal funds that are subject to sanction action IF the sanctions are allowed total just over 5 million dollars. See letter of Rebecca Dyer attached.

Attach $ letter

The most recent word from the Legislative information office in Wash D.C. is that the continuing resolution (that suspends sanctions) will stand unless congress takes action before the end of the fiscal year. If congress does not act before June 30th, the Dept. will have to fund at least the first quarter of FY84. The Dept of H.H.S. is waiting for congressional direction. Repeal of CON would probably result in loss of some planning review regardless of sanctions.

Attach 1 & 2 from Omnicom

Alaska, and several other states are out of compliance now and have been placed on "conditional" status by D.H.H.S. Should sanctions be imposed, the state is given notice that funds may be withheld.

STATE REVENUE SHARING to MUNICIPALITIES

Don't GRIFFIN

STATE AID through Title 29 REVENUE SHARING ~~GRANTS~~ FUNDS ~~ARE~~ FOR HOSPITAL ENTITLEMENT GRANTS, & HOSPITAL CAPITAL CONSTRUCTION, PUBLIC ROADS, AND VOLUNTEER FIRE DEPTS IN THE UNORGANIZED BOROUGH ARE ISSUED by PRORATING THE TOTAL REQUESTS ~~by the amounts~~ within the ALLOCATIONS.

ASK GINNY

If REPEAL on CERTIFICATE of NEED MEANS AN INCREASE in CAPITAL CONSTRUCTION, AND, therefore, AN INCREASE in demand for STATE AID, THERE will be A REDUCED AMOUNT of funds AVAILABLE to individual RECIPIENTS for those CATEGORIES listed — ~~hospital~~ GRANTS, PUBLIC ROADS, VOLUNTEER FIRE DEPARTMENT.

ATTACH FY81,82 ENTITLEMENTS C&RA

5437

Public Health Service in Seattle for his AGENCY's Retention to a Repeal of the certificate of NEED. IN PRACTICE, it APPEARS that the Federal government has not instituted SANCTIONS - EVEN though STATES (like CALIFORNIA) have been out of compliance for YEARS. IN FACT, SANCTIONS WERE SUSPENDED by PL 97-377. A continuing RESOLUTION suspends SANCTIONS Through September 1983.

My QUESTIONS for you - GENERAL ONES which you MAY not be able to address EASILY and then SPECIFIC ONES:

1) What ARE the CHANCES that the SANCTIONS MAY AGAIN BE SUSPENDED AS in 97-377? - MOOD of CONGRESS?

2) CAN you find out what ~~the~~ response the Health and Human Services Dept would have to a Repeal of certificate of need process here?

3) Would AN EXEMPTION (§1536 of PL 93-641) for ALASKA to the ~~the~~ HEALTH SYSTEMS ~~AGENCY~~ AGENCY REQUIREMENT do the SAME thing AS Repeal of C/N PROCESS? (FOUND IN AN AMENDMENT to the Omnibus Budget RECONCILIATION Act of 1981).

4) If C/N were REPEALED and SANCTIONS WERE INVOKED, how much Federal money would ALASKA loose.

FY 1981 MUNICIPAL REVENUE SHARING ENTITLEMENTS (#2) april 27, 1981

TOTAL ENTITLEMENT = $51,900,000 14,6200,000 6 million

KEY	COMMUNITY	PUBLIC ROAD MILES	ICE ROAD MILES	HOSPITAL ENTITLEMENT	HEALTH FACILITIES ENTITLEMENT	HOSPIT CONST. A
BOROUGHS AND SERVICE AREAS						4,885,65
0010	ANCHORAGE A.W.	0.00	0.00	$423,674	$355,886	$4,885,6
0020	CITY S.A.	0.00	0.00	$0	$0	
0030	EAGLE RIVER	0.00	0.00	$0	$0	
0040	CHUGIAK	0.00	0.00	$0	$0	
0060	GIRDWOOD	0.00	0.00	$0	$0	
0070	GLEN ALPS	0.00	0.00	$0	$0	
0080	FIRE S.A.	0.00	0.00	$0	$0	
0090	ROADS & DRAINAGE	402.95	0.00	$0	$0	
0100	POLICE S.A.	0.00	0.00	$0	$0	
0110	PARKS & REC	0.00	0.00	$0	$0	
0120	P & R/CHUGIAK	0.00	0.00	$0	$0	
0130	SOLID WASTE S.A.	0.00	0.00	$0	$0	
0140	CHUGIAK/SOLID WASTE	0.00	0.00	$0	$0	
0150	BUILDING SAFETY	0.00	0.00	$0	$0	
0160	SPECIAL ASSESSMENT	0.00	0.00	$0	$0	
0170	SERVICE AREA 35	63.37	0.00	$0	$0	
0180	PORT OF ANCH.	0.00	0.00	$0	$0	
0190	AIRPORT S.A.	0.00	0.00	$0	$0	
0200	PARKING S.A.	0.00	0.00	$0	$0	
0210	BRISTOL BAY BOROUGH	0.00	0.00	$0	$0	
0220	SOUTH NAKNEK S.A.	4.42	0.00	$0	$0	
0230	FAIRBANKS BOROUGH	74.31	0.00	$0	$0	
0240	ESTER F.P.	0.00	0.00	$0	$0	
0250	NORTH STAR F.P.	0.00	0.00	$0	$0	
0260	UNIVERSITY F.P.	0.00	0.00	$0	$0	
0270	HAINES BOROUGH	0.00	0.00	$0	$0	
0280	FIRE DISTRICT	0.00	0.00	$0	$0	

FY 1981 MUNICIPAL REVENUE SHARING ENTITLEMENTS (#2) april 27, 1981

TOTAL ENTITLEMENT = $51,900,000

KEY	COMMUNITY	PUBLIC ROAD MILES	ICE ROAD MILES	HOSPITAL ENTITLEMENT	HEALTH FACILITIES ENTITLEMENT	HOSPIT CONST. A
0290	JUNEAU BOROUGH A.W.	0.00	0.00	$74,766	$89,719	
0300	S.A. 1	14.23	0.00	$0	$0	
0310	S.A. 2	4.84	0.00	$0	$0	
0320	S.A. 3	38.17	0.00	$0	$0	
0330	S.A. 4	0.00	0.00	$0	$0	
0340	S.A. 5	0.00	0.00	$0	$0	
0350	S.A. 6	0.00	0.00	$0	$0	
0360	S.A. 7	0.00	0.00	$0	$0	
0370	S.A. 8	0.00	0.00	$0	$0	
0380	KENAI PENINSULA BOROUGH	2.79	0.00	$160,956	$0	
0390	NIKISKI F.P.	0.00	0.00	$0	$0	
0400	NORTH KENAI REC.	0.00	0.00	$0	$0	
0410	BEAR CREEK F.P.	0.00	0.00	$0	$0	
0420	KETCHIKAN BOROUGH	0.00	0.00	$0	$0	
0430	SHOREL INE S.A.	0.00	0.00	$0	$0	
0440	KODIAK ISLAND BOROUGH	0.00	0.00	$80,478	$67,601	
0450	FIRE DISTRICT I	0.00	0.00	$0	$0	
0460	ROAD DISTRICT	15.00	0.00	$0	$0	
0470	MAT-SU BOROUGH	286.12	0.00	$0	$0	
0480	WASILLA F.P.	0.00	0.00	$0	$0	
0490	BUTTE F.P.	0.00	0.00	$0	$0	
0500	GREATER PALMER F.P.	0.00	0.00	$0	$0	
0510	SUTTON F.P.	0.00	0.00	$0	$0	
0520	NON AREA-WIDE	0.00	0.00	$0	$0	
0525	TALKETNA FLOOD S.A.	0.00	0.00	$0	$0	
0530	TALKEETNA F.P.	0.00	0.00	$0	$0	
0540	GARDEN TERRACE	0.00	0.00	$0	$0	

0550 LAKES F.P.	0.00	0.00	$0	$0	

FY 1981 MUNICIPAL REVENUE SHARING ENTITLEMENTS (#2) april 27, 1981

TOTAL ENTITLEMENT = $51,900,000

KEY	COMMUNITY	PUBLIC ROAD MILES	ICE ROAD MILES	HOSPITAL ENTITLEMENT	HEALTH FACILITIES ENTITLEMENT	HOSPI CONST.
0560	NORTH SLOPE BOROUGH	51.94	0.00	$0	$38,876	
0570	SITKA BOROUGH	16.05	0.00	$77,569	$16,548	
	FIRST CLASS CITIES					
1000	BARROW	0.00	0.00	$0	$0	
1010	CORDOVA	8.30	0.00	$86,631	$13,861	
1020	CRAIG	4.50	0.00	$0	$3,987	
1030	DILLINGHAM	6.81	0.00	$0	$0	390,934
1040	FAIRBANKS	87.20	0.00	$179,038	$90,096	$1,380,9
1050	GALENA	5.58	0.00	$0	$5,553	
1060	HAINES	10.44	0.00	$0	$0	
1070	HOMER	10.63	0.00	$0	$8,584	
1080	HOONAH	4.00	0.00	$0	$0	
1090	HYDABURG	3.17	0.00	$0	$3,987	
1100	KAKE	5.17	0.00	$0	$0	
1110	KENAI	45.12	0.00	$0	$8,584	261,2
1120	KETCHIKAN	16.60	0.00	$91,713	$19,937	$261,2
1140	KING COVE	0.00	0.00	$0	$5,159	
1150	KLAWOCK	1.69	0.00	$0	$3,987	
1160	KODIAK	14.68	0.00	$0	$0	
1170	NENANA	11.28	0.00	$0	$0	
1180	NOME	13.45	0.13	$104,134	$11,107	
1190	NORTH POLE	10.72	0.00	$0	$0	
1200	PALMER	19.36	0.00	$77,569	$0	
1210	PELICAN	1.10	0.00	$0	$4,292	
1220	PETERSBURG	9.48	0.00	$77,569	$8,274	
1230	SAND POINT	8.34	0.00	$0	$5,159	
1240	SAINT MARY'S	7.93	10.21	$0	$5,353	
1250	SELDOVIA	6.48	0.00	$0	$4,292	
1260	SEWARD	18.35	0.00	$80,478	$77,259	
1270	SKAGWAY	9.50	0.00	$0	$4,292	
1280	SOLDOTNA	24.78	0.00	$0	$0	
1290	UNALASKA	38.42	0.00	$0	$5,159	

1320 ZONE II	0.00	0.00	$0	$0

FY 1981 MUNICIPAL REVENUE SHARING ENTITLEMENTS (#2) april 27, 1981

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KEY	COMMUNITY	PUBLIC ROAD MILES	ICE ROAD MILES	HOSPITAL ENTITLEMENT	HEALTH FACILITIES ENTITLEMENT	HOSPIT CONST. A
1330	WRANGELL	7.04	0.00	$77,569	$4,137	
1340	ZONE II	0.00	0.00	$0	$0	
1350	ZONE IV	0.00	0.00	$0	$0	
1360	YAKUTAT	3.31	0.00	$0	$4,292	
SECOND CLASS CITIES						
5000	AKHIOK	0.00	0.00	$0	$0	
5010	AKIACHAK	2.00	11.00	$0	$0	
5020	AKIAK	0.00	0.00	$0	$5,353	
5030	AKOLMIUT	0.00	44.75	$0	$10,706	
5040	AKUTAN	0.00	0.00	$0	$0	
5050	ALAKANUK	4.00	4.00	$0	$5,353	
5060	ALEKNAGIK	0.00	1.50	$0	$5,159	
5070	ALLAKAKET	0.00	0.00	$0	$5,553	
5080	AMBLER	5.22	0.00	$0	$5,553	
5090	ANAKTUVUK PASS	0.00	0.00	$0	$0	
5100	ANDERSON	5.00	0.00	$0	$0	
5110	ANGOON	5.18	0.00	$0	$4,137	
5120	ANIAK	8.00	24.00	$0	$11,107	
5130	ANVIK	1.50	0.00	$0	$0	
5140	ATMAUTLUAK	0.00	15.00	$0	$5,353	
5150	BETHEL	10.85	48.00	$0	$66,915	
5160	BREVIG MISSION	0.00	0.00	$0	$5,553	
5170	BUCKLAND	0.00	0.00	$0	$0	
5180	CHEFORNAK	0.00	0.00	$0	$5,353	
5190	CHEVAK	0.50	00	$0	$5,353	
5200	CHUATHBALUK	4.00	00	$0	$5,553	
5210	CLARK'S POINT	0.00	00	$0	$5,159	
5220	DEERING	0.00	0.00	$0	$5,553	
5230	DELTA JUNCTION	10.88	0.00	$0	$4,620	
5240	DIOMEDE	0.00	0.00	$0	$0	

KEY	COMMUNITY	PUBLIC ROAD MILES	ICE ROAD MILES	HOSPITAL ENTITLEMENT	HEALTH FACILITIES ENTITLEMENT	HOSPI CONST.
5300	FORT YUKON	16.48	0.00	$0	$0	
5310	FORTUNA LEDGE	5.00	0.00	$0	$5,353	
5320	GAMBELL	0.00	0.00	$0	$0	
5330	GOLOVIN	0.00	0.00	$0	$5,553	
5340	GOODNEWS BAY	0.00	0.00	$0	$0	
5350	GRAYLING	0.00	0.00	$0	$0	
5360	HOLY CROSS	4.00	0.00	$0	$5,553	
5370	HOOPER BAY	0.00	0.00	$0	$0	
5380	HOUSTON	30.75	0.00	$0	$0	
5390	HUGHES	5.00	0.00	$0	$0	
5400	HUSLIA	17.70	0.00	$0	$5,553	
5410	KACHEMAK	0.00	0.00	$0	$0	
5420	KAKTOVIK	0.00	0.00	$0	$0	
5430	KALTAG	2.00	0.00	$0	$0	
5440	KASAAN	0.00	0.00	$0	$0	
5460	KIANA	0.00	0.00	$0	$0	
5470	KIVALINA	0.00	0.00	$0	$0	
5480	KOBUK	4.00	0.00	$0	$0	
5490	KOTLIK	0.00	0.00	$0	$5,353	
5500	KOTZEBUE	15.52	3.50	$0	$0	
5510	KOYUK	0.00	0.00	$0	$0	
5520	KOYUKUK	1.50	0.00	$0	$5,553	
5530	KUPREANOF	0.00	0.00	$0	$0	
5540	KWETHLUK	0.00	0.00	$0	$5,353	
5550	LARSEN BAY	0.00	0.00	$0	$0	
5555	LOWER KALSKAG	2.60	40.00	$0	$5,553	
5560	MANOKOTAK	0.43	0.00	$0	$5,159	
5570	MCGRATH	10.95	0.00	$0	$5,553	
5580	MEKORYUK	0.00	0.00	$0	$5,353	
5590	MOUNTAIN VILLAGE	0.00	0.00	$0	$0	
5600	NAPAKIAK	2.48	0.00	$0	$5,353	
5610	NAPASKIAK	0.00	0.00	$0	$5,353	
5620	NEWHALEN	0.00	0.00	$0	$5,159	
5630	NEW STUYAHOK	0.00	0.00	$0	$5,159	
5640	NEWTOK	0.00	0.00	$0	$5,353	
5650	NIGHTMUTE	1.00	0.00	$0	$5,353	

FY 1981 MUNICIPAL REVENUE SHARING ENTITLEMENTS (#2) april 27, 1981

TOTAL ENTITLEMENT = $51,900,000

KEY	COMMUNITY	PUBLIC ROAD MILES	ICE ROAD MILES	HOSPITAL ENTITLEMENT	HEALTH FACILITIES ENTITLEMENT	HOSPIT CONST. A
5660	NIKOLAI	0.00	0.00	$0	$0	
5670	NONDALTON	1.80	0.00	$0	$0	
5680	NOORVIK	2.20	0.00	$0	$5,553	
5690	NULATO	4.80	0.00	$0	$5,553	
5700	NUIGSUT	0.00	0.00	$0	$0	
5710	OLD HARBOR	4.45	0.00	$0	$0	
5720	OUZINKIE	0.00	0.00	$0	$0	
5730	PILOT STATION	2.00	0.00	$0	$0	
5740	PLATINUM	0.00	0.00	$0	$0	
5750	POINT HOPE	0.00	0.00	$0	$0	
5760	PORT ALEXANDER	0.00	0.00	$0	$0	
5770	PORT HEIDEN	26.60	0.00	$0	$5,159	
5780	PORT LIONS	2.44	0.00	$0	$0	
5790	QUINHAGAK	1.25	0.00	$0	$5,353	
5800	RUBY	0.00	0.00	$0	$0	
5810	RUSSIAN MISSION	0.00	0.00	$0	$5,353	
5820	SAINT MICHAEL	0.00	0.00	$0	$5,553	
5830	SAINT PAUL	37.50	0.00	$0	$0	
5840	SAVOONGA	0.00	0.00	$0	$0	
5850	SAXMAN	2.90	0.00	$0	$0	
5860	SCAMMON BAY	1.25	0.00	$0	$5,353	
5870	SELAWIK	0.00	0.00	$0	$0	
5880	SHAGELUK	0.00	0.00	$0	$0	
5890	SHAKTOOLIK	3.50	18.00	$0	$5,553	
5900	SHELDON POINT	0.00	0.00	$0	$5,353	
5910	SHISHMAREF	0.00	0.00	$0	$0	
5920	SHUNGNAK	0.00	0.00	$0	$5,553	
5930	STEBBINS	0.00	0.00	$0	$5,553	
5940	TANANA	29.35	0.00	$0	$0	
5950	TELLER	2.69	0.00	$0	$5,553	
5980	TENAKEE SPRINGS	2.00	0.00	$0	$0	
5990	TOGIAK	5.00	0.00	$0	$5,159	
6000	TOKSOOK BAY	0.00	0.00	$0	$5,353	
6010	TULUKSAK	9.50	18.00	$0	$5,353	
6015	TUNUNAK	0.00	0.00	$0	$0	
6020	UNALAKLEET	9.22	0.00	$0	$5,553	

6020 DNALAKLEET 9.22 0.00 $0 $5,553

FY 1981 MUNICIPAL REVENUE SHARING ENTITLEMENTS (#2) april 27, 1981

TOTAL ENTITLEMENT = $51,900,000

KEY	COMMUNITY	PUBLIC ROAD MILES	ICE ROAD MILES	HOSPITAL ENTITLEMENT	HEALTH FACILITIES ENTITLEMENT	HOSPI CONST.
6030	UPPER KALSKAG	1.50	1.50	$0	$0	
6040	WAINWRIGHT	0.00	0.00	$0	$0	
6050	WALES	0.00	0.00	$0	$0	
6060	WASILLA	44.96	0.00	$0	$4,137	
6070	WHITE MOUNTAIN	0.00	0.00	$0	$0	
6080	WHITTIER	10.50	0.00	$0	$4,620	~~74,357~~
6090	EXT FIRE AREAS	0.00	0.00	$0	$0	~~$74,~~
6100	NATIVE VILLAGE GOVT	0.00	0.00	$0	$0	~~$1,~~470,
	TOTAL			$1,682,026	$1,241,800	~~$8,~~072,5

1,470,402

8,072,574

NV6= $24,574 ea.

SUMMARY OF MAJOR CHANGES IN

THE NATIONAL HEALTH PLANNING AND RESOURCES DEVELOPMENT PROGRAM

FROM ENACTMENT OF THE HEALTH PLANNING AND RESOURCES DEVELOPMENT AMENDMENTS

OF 1979 (Public Law 96-79) ON OCTOBER 4, 1979

The Health Planning and Resources Development Amendments of 1979 amend Titles XV and XVI of the Public Health Service Act and extend for 3 years the health planning program begun by P.L. 93-641 enacted on January 4, 1975. The amendments authorize appropriations of $267 million in fiscal 1980, $354 million in 1981 and $416 million in 1982, a total of $1.04 billion.

Title XV (National Health Planning and Development) is administered by the Bureau of Health Planning, Health Resources Administration, and Title XVI (Health Resources Development) by the Bureau of Health Facilities, HRA. The Administration is one of the six agencies of the Public Health Service of the U.S. Department of Health, Education, and Welfare. The two bureaus are located at 3700 East-West Highway, Hyattsville, Maryland 20782.

Contacts:

Title XV, Bureau of Health Planning, Frances Dearman (301) 436-6110
Title XVI, Bureau of Health Facilities, Dorothy Bailey, (301) 436-8988

October 11, 1979

TITLE XV NATIONAL HEALTH PLANNING AND DEVELOPMENT

ADMINISTERED BY BUREAU OF HEALTH PLANNING

National Guidelines for Health Planning (Section 1501)

The Department of Health, Education, and Welfare (HEW) must annually review the goals and standards of the National Guidelines for Health Planning as well as the plans of the Health Systems Agencies (HSA) and State Health Planning and Development Agencies (SHPDA) and on the basis of the findings, revise the National Guidelines. The HSAs, SHPDAs and Statewide Health Coordinating Councils (SHCC) must be consulted at least 45 days prior to their issuance or revision. Relying on data HSAs and SHPDAs must supply, HEW may collect and make public data on whether the health care delivery systems are changing to meet the standards and goals in the Guidelines and the resources required to meet the goals.

The standards promulgated as part of the National Guidelines must reflect the unique circumstances and needs of medically underserved populations including isolated rural communities.

National Health Priorities, National Council (Section 1502)

The list of National Health Priorities is lengthened from 11 to 17, more emphasis is placed on cost containment and a new section is added on the role of competition in the allocation of health services. New priorities concern:

--identification and discontinuance of unneeded or duplicate services and facilities;

--cost containment through technology, more appropriate use of resources and increased efficiency;

--deinstitutionalization of improperly placed mental patients and improved care for the institutionalized;

--emphasis on outpatient mental health care;

--promotion of health prevention and treatment including emotional and psychological components of care; and

--development and use of cost-saving technology.

Also added as a priotity is strengthening of competition where it can appropriately advance quality assurance, cost effectiveness and access to care.

Council: The National Council on Health Planning and Development is expanded from 15 to 20 members. The number of nonprovider members is increased from 5 to 8 and the representation of urban and rural medically underserved populations is required. At least one hospital representative is required. The Assistant Secretary of Agriculture for Rural Development is added as a nonvoting, ex-officio member.

Health Service Areas (Section 1511)

Procedures for review and revision of health service area boundaries are changed. A review can be initiated by HEW, a Governor or HSA. The boundaries may be revised if HEW finds they no longer meet the requirements of the law or that the proposed boundaries meet them more appropriately. Within one year of enactment of the amendments, HEW must publish regulations listing criteria for revisions.

The Commonwealth of Puerto Rico is added to the jurisdictions where the State agency, under Section 1536, may perform the functions of the HSA.

Health Systems Agency Governing Body (Section 1512)

The amendments provide that the governing board of a public HSA must appoint the members of its governing body for health planning. Under the amendments the governing board of a public HSA rather than the separate governing body for health planning is responsible for personnel policies and budget unless it specifically delegates the responsibility.

Consumer members of an HSA governing board no longer are required to have been consumers for 12 months prior to appointment. The language requiring them to be "broadly representative" of the composition of the area's population has been deleted. The new language requires consumers to be "broadly representative of the health service area" and to include representatives of the principal social, economic, linguistic, handicapped and racial populations and of geographic areas of the health service area.

Providers can now serve on HSA governing bodies where they live or where they work. The proportion of direct providers among the provider minority is increased from one-third to one-half and at least one direct provider must be engaged in the administration of a hospital.

Governmental representatives other than elected officials must be appointees of units of general purpose local government.

The proportion of nonmetropolitan representation must be "at least equal to the nonmetropolitan proportion of the population of the area." Persons knowledgeable about mental health must be included on the governing body.

A consumer majority is required for all subcommittees or advisory bodies appointed by an HSA governing board or executive committee.

A new section requires broad participation in governing body selection by residents of the area served. The process developed by each agency must prohibit selection of more than one-half of the members by the governing body itself. The same requirements apply to subarea council selection if the subarea council selects one or more members of the governing body.

If a governing body has more than 30 members, the required size of its executive committee is changed from "not more than 25" to "not less than 10 nor more than 30."

A new section requires each HSA to have a program of technical support of governing body members, executive committee members and members of entities appointed by these groups. At least one staff person is to be responsible for providing information and technical assistance to governing body members particularly consumers. Minimum areas of staff expertise are expanded to include financial and economic analysis, prevention of disease and other health matters, and development and use of health and mental health resources.

A new subsection deals with conflict of interest for members of governing bodies, executive committees or other HSA entities. They are prohibited from voting on matters involving any individual or entity with which a member has had "any substantial ownership, employment, medical staff, fiduciary, contractual, creditor or consultative relationship" currently or in the preceding 12 months. Written disclosure and public announcement of conflicts are required at meetings during which actions are taken.

Revised language absolves an HSA from liability for damage when a governing body member or employee acts within the scope of his duty with reasonable care and without malice.

Provisions are changed to allow closed meetings and records when the board determines that discussions about an employee's performance or salary would constitute an unwarranted invasion of personal privacy. Meetings also may be closed when information relating to a judicial proceeding involving the agency might be disclosed.

HSA governing body membership must now include individuals who are knowledgeable about mental health services (including substance abuse).

Health Systems Plan, Annual Implementation Plan, PUFF, (Section 1513)

Lobbying: New language prohibits an HSA from hiring a lobbyist.

Health Systems Plan and Annual Implementation Plan: The review and revision of the Health Systems Plan are changed from an annual to a triennial process, allowing more time for implementation. An HSA must establish the Health Systems Plan in a format determined by the SHCC in consultation with the State agency and HSAs. The description of a "healthful environment" is to be "primarily with regard to health care equipment and to health services provided by health care institutions, health care facilities and other providers of health care and other health resources."

The Health Systems Plan must include goals for the delivery of mental health services.

The goals of the Health Systems Plan are to be responsive to statewide needs but no longer are required to be consistent with the National Guidelines. The plan must describe the institutional health services needed to provide for the well-being of persons in the area and must also describe the number and type of resources needed to meet the plan goals plus the extent to which new facilities need to be constructed or existing ones need modernization, discontinuance or conversion.

The procedural requirements for the Health Systems Plan also apply to the establishment, review and amendment of the Annual Implementation Plan.

Coordination: Examples of other regional planning bodies with which an HSA must coordinate activities are agencies concerned with aging, alcohol abuse, drug abuse and mental health. Coordination is required with rate review bodies.

New language describes coordination among HSAs within a Standard Metropolitan Statistical Area and requires HEW to issue regulations for sharing of HSA data with Indian Tribes.

Proposed Uses of Federal Funds: A number of changes are made in the review of Proposed Uses of Federal Funds (PUFF). Direct funding of entities other than State government is usually subject to HSA review while direct funding to State government is reviewed only if its impact on health resources occurs solely in the Agency's health service area. Federal funds made available by a State to a third party are now reviewable not only under the allotment programs but also under grants or contracts to State government.

An attempt is made to clarify HSA review of research and training funding. Training funds would be reviewed only if they made a significant change in health services available in the health service area. Research funds would be reviewable only if they would change significantly the delivery of health services or the distribution of available health resources in the area.

In the case of Federal funds made available by a State to a third party, a Governor must allow 60 days for HSA review. If the Governor decides to make funds available despite a negative HSA finding, the HSA and SHPDA must be provided with a detailed statement of the reasons.

Appropriateness: The requirement for review of appropriateness of "all institutional health services" is narrowed to "at least" those institutional and home health services for which goals have been set in the State Health Plan. In an appropriateness review, the minimum considerations are "accessibility and availability, financial viability, cost effectiveness, and quality of service provided."

Hospital Charges: To aid consumers in making informed choices, a new provision requires each HSA to collect annually on forms developed with the State the charges for the State's 25 most frequently used hospital services. The charges must include average rates for private and semiprivate rooms. The information must be made available in easily understandable form for public inspection and copying.

Designation of Health Systems Agencies (Section 1515)

The maximum duration of a full designation agreement is extended from 12 months to 36 months. HEW may terminate the agreement with a nonperforming HSA but must first consult with the Governor and the SHCC; give notice of intent to terminate, listing steps that could be taken to comply; provide an opportunity for a hearing; and consult with the National Council.

HEW may return a nonperforming HSA to conditionally designated status for not more than 12 months if the agency is given notice and an opportunity for a hearing. Before renewing a full designation agreement, HEW must provide the State agency with an opportunity to comment on the HSA's performance and to recommend whether or not the HSA should be renewed as well as stating any conditions the State agency believes should be attached to the renewal.

In terminating an HSA, HEW may choose to continue its operation until a new designation agreement is in effect. It must provide the terminating agency an opportunity to settle its affairs.

HSA Planning Grants (Section 1516)

The amendments provide for carryover of grant funds for one more year beyond that in which they are made available. The funding formula is changed in several respects. The maximum base grant is the lesser of $0.60 per capita or $3,750,000. The minimum base grant is a sliding scale of $225,000 for fiscal 1980; $245,000 for fiscal 1981; and $260,000 for a succeeding year.

HEW is authorized to retain an amount not to exceed 5 percent of the appropriation to supplement grants to meet extraordinary expenses, such as those related to bi-State status, large underserved populations and large geographic areas or to assist an agency in improving its performance as a result of the development and implementation of innovative planning mechanisms. The grant amount may be reduced if not needed by the Agency.

Non-Federal funds may be matched by: (1) an amount equal to the non-Federal funds (2) $200,000 or (3) $0.25 per capita, whichever is less.

State Agency Designation (Section 1521)

The period of conditional designation may be extended beyond 36 months if HEW finds the State agency is making "a good faith effort" to comply with its required functions.

The penalties for a State failing to have its agency qualify for full designation have been extensively revised and the effective dates changed. During the first year of noncompliance, HEW will withhold 25 percent of Federal funds. The percentage rises to 50 percent in the second year, and 75 percent in the third with a complete cutoff in the fourth year.

September 30, 1980, is the earliest date for compliance but the deadline will be later for many States depending on when their legislatures meet.

The period of a full designation agreement is extended from 12 to 36 months. If HEW decides to terminate a State agency agreement, the Department must consult with the SHCC; notify the agency, explaining the decision and listing corrective actions required; provide an opportunity for a hearing; and consult with the National Council.

Before renewing a State agency designation agreement, HEW must provide each HSA and the SHCC with an opportunity to comment and recommend renewal or nonrenewal. If it is not performing satisfactorily, a State agency may be returned to conditionally designated status for up to 12 months.

State Health Planning and Development Functions (Section 1523)

A new function, the determination of statewide health needs, is given to the State agency. In developing these needs, the agency is to consult with the SHCC and to solicit written recommendations from the State health authority, the State mental health authority and other agencies designated by the Governor.

The development of the preliminary State Health Plan and review of the Health Systems Plan is changed from an annual to a triennial process. In reviewing Health Systems Plans, the State agency is required to make them available to

the State health authority, the State mental health authority and other State agencies specified by the Governor. It also is to solicit written recommendations concerning the goals and resource requirements in Health Systems Plans.

As another new function, the State agency must prepare an inventory of health care facilities, evaluate their physical condition and report the results to HSAs for their use. The requirement for a separate State Medical Facilities Plan is deleted.

Statewide Health Coordinating Council (Section 1524)

HSA representation required on the SHCC will vary with the number of HSAs in the State. If there are ten or fewer HSAs, each is entitled to two representatives. If there are more than ten, each is entitled to one representative. Each HSA is to submit to the Governor a list of at least twice as many representatives as it is entitled to. In the case of bi-State HSAs, representation on the SHCC will be based on the proportion that the population of the bi-State area living in the State bears to the population of the largest health service area in the State, with a minimum of one representative assured.

Not less than one-half the providers on the SHCC must be direct providers. If there are rural and urban medically underserved populations in a State, they must be represented on the SHCC. The Governor is given the option of selecting, with legislative advice and consent, the chairman of the SHCC from among its members. If the Governor does not act, the SHCC can select its own chairman.

The SHCC is given responsibility for establishing in consultation with the HSAs and the State agency, a uniform format for the Health Systems Plan. It also reviews and coordinates the Health Systems Plans triennially and the Annual Implementation Plans annually. The State Health Plan also is prepared triennially. It must include a description of the institutional health services needed in the State, describe the number and type of resources available and those in need of modernization, closure and conversion.

New language seeks to integrate mental health, alcohol and drug abuse into the State health planning process and requires the health plans in these areas to be consistent with the State Health Plan.

As approved by the SHCC, the State Health Plan does not become effective until it is approved by the Governor. The Governor can disapprove the plan only if he determines it does not effectively meet the statement of health needs as developed by the State agency.

In a change in the review of uses of Federal funds function, the SHCC is given authority to review and recommend approval or disapproval of applications for certain Federal health funds submitted by the State government which is carried out in more than one health service area. If the SHCC recommends disapproval of a plan or application, HEW, after finding that the proposed use is not in conformity with the State Health Plan, may not make funds available. The Governor must be allowed 30 days to submit a revised plan or application that conforms with the State Health Plan.

The SHCC is extended the same immunity from damages as the HSA board and placed under the same conflict of interest requirements.

Grants for State Health Planning and Development (Section 1525)

Amendments permit one year carryover of grant funds.

Grants for Rate Regulation (Section 1526)

New language removes the limitation on the number of rate regulation demonstration grants to States, allows entities of State government other than the State agency to administer the rate regulation program, and allows rate regulation grant funds to remain available for one fiscal year after that in which they are awarded.

Certificate of Need (Section 1527)

A new section broadens and further defines certificate of need programs. Certificate of need decisions must be consistent with the State Health Plan except for emergency situations. In reviewing applications, a SHPDA must make its determination before major equipment is purchased, institutional health services are offered or capital expenditures obligated.

The amendments limit the type of conditions that can be placed on awarding a certificate of need. States are prohibited from attaching any condition not related to criteria in the law or in State or Federal regulations in force before the amendments took effect.

A State agency is authorized to withdraw a certificate of need if the applicant is not adhering to its timetable or making a good faith effort.

Each certificate must specify the maximum amount of money that can be spent on an approved project.

HMOs: Health maintenance organizations (as defined in this section or as qualified under Section 1310 of the Public Health Service Act) are exempt from certificate of need requirements under specified conditions. The State may not require a certificate of need for the offering of an inpatient health service, the acquisition of major equipment, or obligation of capital expenditures by health maintenance organizations if:

--the HMO meets the definition under this law;

--the HMO (or a combination of HMOs) has an enrollment of at least 50,000 individuals;

--the facility in which the service will be provided is reasonably accessible to members; and

--at least 75 percent of the patients who can be reasonably expected to receive the service will be individuals enrolled with the HMO (or combination of HMOs).

Certificate of need applications from other health maintenance organizations must be approved if the State agency finds that approval is required to meet the needs of enrollees and the health maintenance organization cannot obtain these services or facilities within the area in a manner consistent with the health maintenance organization concept.

The establishment of and the outpatient facilities and services of an health maintenance organization are exempt from certificate of need review in any case.

Safety Hazards, Licensure, Accreditation: Automatic approval is required of any certificate of need application to comply with building and safety codes, State licensure standards or Medicare/Medicaid certification unless the SHPDA finds the facilities or services are unneeded or inconsistent with the State Health Plan.

Simple Acquisitions: Special treatment also is provided for simple acquisitions of health facilities or major medical equipment for noninstitutional uses. In both cases, a notice stating intent to acquire and expected uses must be filed with the SHPDA 30 days before contracts are signed. These acquisitions are exempt from certificate of need coverage unless notice is not given or the State agency finds that the acquisition will provide inappropriate bed capacity or services.

Definitions of "capital expenditure" and "major medical equipment" are added. "Major medical equipment" excludes the equipment of independent clinical labs. Congress wanted to make clear that this provision is a minimum requirement of an acceptable certificate of need program, and that a State is permitted to cover medical equipment acquired for use in other than inpatient settings, which costs less than $150,000, or which is acquired by a clinical laboratory. Although States would be prohibited from changing their law to go beyond the minimum requirements after September 30, 1982, no State which had imposed additional requirements before that date would be required to alter those requirements.

Definitions (Section 1531)

"Indirect provider" is no longer a separate category but included under "direct providers." This term is broadened to include persons who: have a fiduciary interest in health care delivery, research, health manpower instruction and drug production; receive directly or through their spouse more than 20 percent of their gross income from health care; or are members of the immediate families of persons in these categories. An individual will not be considered a provider solely because of membership on the governing board of a health care institution or drug or equipment producer.

The definition of "institutional health services" is altered to include services which are provided through designated facilities and those to be defined in HEW regulations and which entail an annual operating cost of at least $75,000. The $75,000 figure may be adjusted upward after 12 months at the discretion of a State to reflect inflation.

Criteria and Procedures for Reviews (Section 1532)

Extensive statutory requirements relating to review procedures are added. They include requirements for administrative and judicial reviews, timely notification and those related to failure to complete review in a timely manner.

"Batched review" of all similar certificate of need applications is required at both the State agency and HSA level at least twice a year. Batching enables planning agencies to review simultaneously applications proposing similar services and to evaluate them on the basis of relative need.

Factors to be considered in the development of criteria for review are expanded to include: the effects of the service on the needs for clinical training in the area; the access that health profession schools will have to services for teaching; and the accessibility of the services to all residents of the service area. Other factors include the efficiency and appropriateness of the use of existing services and facilities, and quality of care provided by the applicant in the past.

TITLE XVI HEALTH RESOURCES DEVELOPMENT

ADMINISTERED BY THE BUREAU OF HEALTH FACILITIES

State Allotments and State Medical Facilities Plans

In amending Title XVI, Congress targeted resources to meet special needs ranging from excess inpatient hospital capacity to the unmet primary care needs of the urban and rural poor. These needs are defined by conditions, not by State or other geographic boundary lines. Thus, Congress repealed the allotment grants to States which originally existed in Title XVI to aid facilities construction. Congress also repealed the requirement for a separate, HEW-approved State Medical Facilities Plan. Previously, the State Medical Facilities Plan existed as a framework which had to be approved before allotments could be made for facility construction and aid. In the amendments, Congress intends to integrate facilities planning as part of the State Health Plan produced by each State's SHCC.

Loan and Loan Guarantee Program (Sections 1601-2)

Congress centralized the loan and loan guarantee program by requiring that all applications under this program be submitted directly to HEW for approval. Direct loans, previously limited to public facilities, have been expanded to nonprofit private facilities. Loan guarantees, limited before to nonprofit private facilities, may now go to public entities as well.

Authority for loans and loan guarantees had been limited to projects for: (1) modernization; (2) construction of new outpatient medical facilities; (3) construction of new inpatient medical facilities in areas where population growth has been recent and substantial; and (4) conversion projects. Now loan and loan guarantees are also authorized for: (1) projects which will discontinue unneeded hospital services or facilities, and (2) modernization projects which before had been eligible only for special project grant money to correct safety hazards and avoid noncompliance with licensure or accreditation standards.

Interest Subsidy: HEW may now pay up to one-half the net effective interest rate on guaranteed loans for projects located in poverty areas. Formerly this subsidy was limited to three percent and was not targeted to any special need areas.

Default Authority: Under the previous law, HEW did not have authority to act on behalf of loan or loan guarantee projects which were in danger of default. Default funds were limited to actual default procedures. The amended law permits HEW to spend money on technical and consultative assistance to prevent such defaults. In addition to taking title to assets used to secure loans HEW may now take "any other actions needed" to protect the government's interests.

Project Grants For Construction Modernization (Section 1610)

The amended law allows facilities to apply for loan and loan guarantees for construction to correct safety hazards or to avoid licensure or accreditation noncompliance. The law also now allows private nonprofit facilities to apply for grant aid. Formerly only public facilities were eligible. To be eligible, however, the private nonprofits must serve the same patient population as would public facilities (i.e., the same proportion of patients unable to pay for services) and, further, must show that without a grant there would be a disruption of health care services to low income individuals.

New Project Grants: Congress addressed the special needs of medically underserved areas by establishing a new grant program. The grants would be available to public or private nonprofit facilities for construction of outpatient facilities or conversion of inpatient to outpatient or long-term care facilities in underserved areas.

Funds for this program are authorized starting in fiscal 1981.

Discontinuance and Conversion (Sections 1641-2)

A new program of grants for voluntary discontinuance and conversion of unneeded hospital services is authorized effective April 1, 1980. Congress intended it to be a demonstration program to help combat the escalating cost of inpatient hospital care. It also is intended to strengthen health care delivery through conversion of hospital capacity to less expensive and more appropriate services.

Grants may be awarded for liquidation of debt in case of closure; planning, development and delivery of another service in case of conversion; termination pay and retraining and re-employment costs for displaced hospital personnel.

Applications for grants must be reviewed by the local HSA, which recommends approval or disapproval, and forwarded to the State agency which reviews and makes its recommendation to HEW. The HSAs and SHPDAs are to determine the need for discontinuance or conversion of a service or facility and give special attention to needs and access patterns of poverty populations. HEW may not override a State agency recommendation for disapproval but may disapprove a recommendation for discontinuance or conversion if it determines the project would not reduce health care costs.

The Department of Labor must review applications and certify that any proposed project protects the rights and vested interests of affected employees of the hospital.

Grants also are authorized to SHPDAs to assist in the reduction of excess hospital capacity. Funds are authorized to assist State agencies in: identifying excess hospital capacity; developing programs to reduce excess capacity to lower health care costs; developing means to overcome barriers to reduction of excess capacity; and carrying out programs to decertify nonappropriate facilities serving densely populated areas and for poverty area outpatient services.

Enforcement of Assurances: The amendments reinforce the intent of Congress that facilities adhere to the uncompensated care and community service parts of the law. Facilities which received Federal aid under either Title VI (Hill-Burton) or XVI were required to give assurances that they would provide a certain amount of uncompensated care to those unable to pay and to provide care without discrimination to community residents. The obligations apply to more than 5,000 hospitals, nursing homes and other medical facilities.

Periodic reports by facilities of compliance with the law are required under the amendments.

AUTHORIZATIONS FOR APPROPRIATIONS ($ MILLIONS)

HEALTH PLANNING AND RESOURCES DEVELOPMENT AMENDMENTS OF 1979

	FY 1980	FY 1981	FY 1982
HSA Planning Grants (Sec. 1516)	$150	$165	$185
State Agency Grants (Sec. 1525)	35	40	45
Technical Assistance/Health Planning Centers (Sec. 1534)	6	8	10
Rate Reviews (Sec. 1526)	6	6	6
Area Development Funds (Sec. 1640)	-	20	30
Facilities Project Grants (Sec. 1610)	40	50	50
Outpatient Facilities (Sec. 1610)	-	15	15
Closure/Conversion Grants (Sec. 1643-44)	30	50	75
TOTALS	$267	$354	$416

HEALTH PLANNING AND DEVELOPMENT BUDGET HISTORY

FY 1978-80

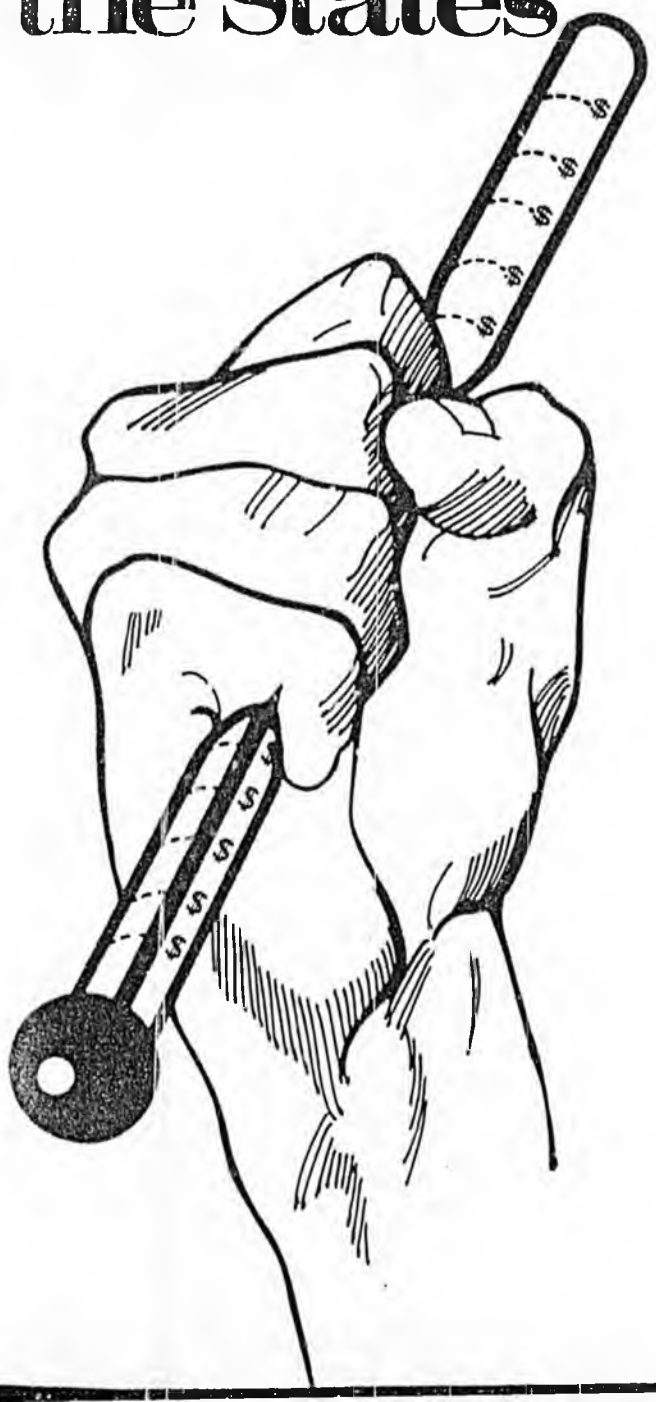
(Millions)

	Appropriations		
	1978	1979	1980
HSA Planning Grants (Sec. 1511)	107.0	107.0	124.7
State Agency Grants (Sec. 1525)	29.5	29.5	32.0
Technical Assistance/Health Planning Centers (Sec. 1534)	6.5	6.5	1.0
Rate Reviews (Sec. 1526)	2.0	2.0	-
Area Development Funds (Sec. 1640)	-	-	-
Facilities Project Grants (Sec. 1625)	-	-	-
Outpatient Facilities (Sec. 1625)	-	-	-
Closure/Conversion Grants (Sec. 1644 & 1643)	-	-	30.0

Russ Hereford

Controlling Health Care Costs: Strategies from the States

With Congress divided over how—and whether—to address the rising cost of health care, states have taken the lead in fashioning solutions.



The defeat of President Carter's hospital cost containment legislation in the House of Representatives underscores the difficult task facing those who seek to curb the high rate of inflation in health care. It also reemphasizes the key role which states must continue to play in the nation's health cost crisis. The role is not a new one for the states; in fact, they have taken the lead in developing solutions to the problem.

Although the health care cost problem has not disappeared (during the 12 months ending last March, the nation's health expenditures rose 13.3 percent to 198.6 billion dollars), actions undertaken in some states appear to have had a major impact on health expenditures. For example, in the eight states that would have been exempted from federal controls under the Administration's bill—because they were already operating mandatory hospital cost containment programs—1978 hospital expenses per admission increased at a rate less than three-fourths that of the other 42 states.

Why States?

States appear to be the most appropriate level at which rising health costs can be controlled. State legislators and state government are affected by rising health costs in a variety of ways. As purchasers of health care for the needy through Medicaid, states (and, in nine states, local government) contributed over $8 billion to this joint federal-state program in 1978. States spent another $1 billion for the poor who are not eligible for Medicaid and for benefits not covered by federal matching funds. In addition, state governments are major employers who contribute to the cost of health insurance premiums for their employees. The growing burden placed on constituents to finance the increased cost of health programs leaves legislators with the unpleasant dilemma of either raising taxes to cover increased costs or reducing services to keep health costs within budget.

Having responsibility for the state's economic environment, legislators face demands from both industry and labor. Businesses express concern over their ability to remain competitive and still generate sufficient profits for future capital investment in the face of the growing costs of health benefits for their workers. At the same time, workers are increasingly frustrated as they forego real increases in their standard of living, or improvements in health benefit coverage, merely to maintain their current level of benefits.

State level control of health care costs should be encouraged for a number of reasons. The protection of

public health has traditionally been within the recognized police powers of the states. (It is interesting to note that the U.S. Department of Health, Education and Welfare was not established until 1953.) As financiers and regulators of health care, and through the delivery of public health services, state government has a long history of involvement in health activities.

"States have responded to the problem with a number of innovative programs. Some particularly interesting ones are in the fields of hospital cost containment, alternatives to institutional care, and health planning."

States are in the best position to view the operation of health programs within the context of statewide priorities and resources. The ability to consider the unique features of a particular state, especially its health care delivery system, when designing a cost containment program best assures that the legitimate concerns of all interested parties will be addressed.

It is at the state level that many health-related programs are regulated. The complementary nature of these activities can give extra clout to cost containment efforts: Certificate of need programs are operated by the states; states administer the Medicaid program; health care providers, such as physicians, nurses, and hospitals, are licensed by state government; the insurance industry is regulated at the state level. Through coordination of these and other regulatory programs, a comprehensive, system-wide cost containment approach can be implemented.

At the same time, states offer the opportunity for experimentation on various approaches to health care cost control. Cost containment is a new art, not an established science. States have the opportunity to develop and implement innovative approaches to health care cost containment which may later be adopted by other states or the federal government.



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Finally, given their major financial stake as a health care financing agency, states have a vested interest in seeing that cost containment programs work.

State Responses

States have responded to the problem of rapidly rising health care costs with a number of innovative programs. Some particularly interesting approaches are in the fields of hospital cost containment, alternatives to institutional care, and health planning.

Hospital Cost Containment Programs: Eighteen states have enacted some type of legislation designed to control hospital costs. These programs vary widely in scope, structure and procedure, from simple disclosure statutes to programs requiring state review and approval of hospital rates and charges.

The programs regulating rates and charges appear to have been quite successful in controlling hospital cost increases. For example, the effectiveness of the mandatory state programs was recognized by the Carter Administration when it chose to exempt them from federal controls under the Administration's proposed cost containment bill.

State rate review programs have one major feature in common. They revise one of the inflationary incentives built into the hospital payment system: retrospective reimbursement. Under the Medicare and Medicaid programs in most states, and under many Blue Cross plans, hospitals are paid after the fact on the basis of costs incurred in treating a patient. This retrospective, cost-plus system contains no incentives to hospitals for cost control. In reality, the incentive is to increase costs, since higher costs will result in increased hospital revenue. Even unnecessary services will lead to additional income.

To counter this inflationary incentive, state rate-setting programs determine ahead of time the rates which hospitals may charge. Under such a prospective reimbursement system, hospitals know in advance the amount of money they will receive for treating patients. In effect this requires hospitals to hold their costs within a predetermined budget, and instills an element of financial management into hospital operations.

Maryland established one such program in 1971. After an initial developmental period, the Maryland Health Services Cost Review Commission began setting rates in 1974. In 1977, HEW's Health Care Financing Administration, on an experimental basis, agreed to permit the Maryland Commission to set rates for the Medicare program—an agreement that made Maryland the first state agency in the country to set rates for all payers. More recently, Medicare waivers have also been granted for experimental programs in Washington, New Jersey and western Pennsylvania. Senate Majority Leader Rosalie Abrams played a key role in the enactment of the legislation and continues to be pleased with the law. According to Senator Abrams, "The commission has demonstrated its effectiveness in containing the rise in hospital costs in Maryland, where the rate of

increase is certainly more rational than in the rest of the country. It is not state rate review alone, however, that is achieving this effect. One essential ingredient of the legislation was a requirement that a uniform accounting system be adopted. This has forced hospitals to examine their own budgets and has made them more cost conscious."

While a state body sets rates in Maryland, Wisconsin has vested rate review authority in a 20 member committee composed of representatives of the State, the Wisconsin Hospital Association, and Blue Cross of Wisconsin. The



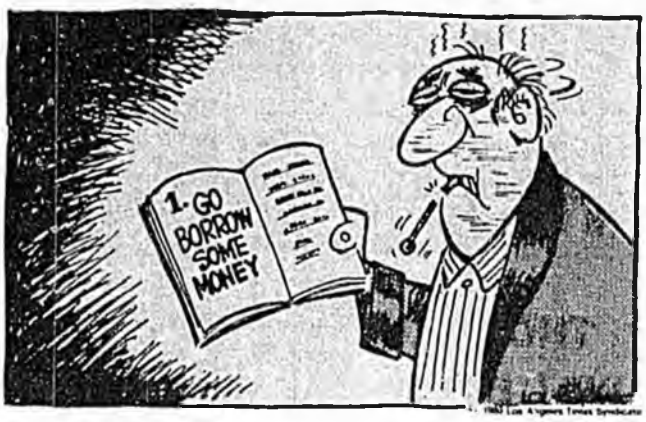
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methodology for rate setting was developed by the Department of Health and Social Services, but actual analysis is performed by Blue Cross. Representative Joseph Czerwinski, Chairman of the Assembly Health and Services Committee reports that, "The rate review process appears to be working well, although we are still only in the developmental stage." Representative Czerwinski agrees with Senator Abrams that hospitals have become more cost conscious since the program began. "We do have to be satisfied that any one making a decision on hospital costs —a hospital administrator talking to a dietary expert or to a physician who wants a CAT scanner—is thinking about the fact that he will have to go before a rate review committee, and justify that position in public," Czerwinski says. "That exercise makes hospital administrators much more conscious of the cost implications of their decisions."

Alternatives to Institutional Care: While much attention nationally has been focused on controlling hospital costs, an even more serious problem for the states is long-term care. This segment now takes the largest portion of the average state's Medicaid budget—39 percent, or over $7 billion nationally.

It appears that long-term care will continue to be a major financial burden on state governments. The size of the nation's elderly population will continue to grow. It is estimated that by the year 2015, almost 40 million people will be over 65 versus 24 million in 1978. And it appears that relief will not be forthcoming should a national health insurance plan be enacted: No national health insurance proposal now under consideration in Congress would reduce the states' role in financing long-term care. A number of the proposals would place additional funding responsibilities on state government.

One cannot consider alternatives to institutional care as a purely fiscal issue. Few people disagree that patients are happier when they are able to remain at home with family or friends rather than be placed in a nursing home. Unfortunately, the long-term care funding programs—primarily Medicaid—are heavily biased towards expensive insitutions rather than at-home care. At the same time, community-based delivery systems are lacking or woefully inadequate in many places. Several states, however, have initiated actions to rectify this situation.



One such effort has recently been undertaken in New York through the enactment of the "Nursing Home without Walls" program in 1977. The author of the legislation establishing the program, Senate Health Committee Chairman Tarky Lombardi, Jr., explains, "This program is designed to provide nursing-home level care to persons in their own home. We expect it to have several benefits: We should find happier patients recovering more rapidly under a managed, coordinated program of care provided at home. This program will also obviate the need for construction of more long term care facilities. It should free acute hospital beds for sicker patients, or permit the closing of excess hospital beds that had been filled with patients who need nursing home—not acute hospital—care. We have found that almost 4,000 Medicaid beneficiaries are in our hospitals awaiting long term care placement at an average monthly cost in excess of $6,000. We have been able to serve patients under the Nursing Home without Walls program for an average of $785 per month." Senator Lombardi is also quick to emphasize that the program has an important quality of life aspect. "As just one example, one of the persons served under this program is a 93-year-old woman with a heart condition who is able to stay home and supervise her 72-year-old mentally retarded daughter."

Health Planning: An oversupply of hospital beds and inefficient utilization of available services have also been major contributors to health inflation. The problem is not a small one. The Department of Health, Education and Welfare has estimated that approximately 130,000 hospital beds could be eliminated without affecting quality of care. An analysis of health costs in Michigan determined that over 16 percent of the state's bed supply was surplus.

Excessive supply contributes to high costs in at least two major ways. First, empty beds are expensive to maintain. Although the exact cost has never been determined, estimates place it between 50 and 75 percent of the cost of a full bed. Second, given the expense of maintaining an empty bed, physicians and hospitals are encouraged to fill empty beds in order to generate revenue. This can result in unnecessary admissions and excessive stays in the hospital.

"Obviously, the interest of state legislators in health care issues extends beyond cost containment. Other unmet needs are readily apparent . . . Resolution of these problems, however, is intimately related to cost containment. Few public officials will look favorably at efforts to expand government's financial stake in the health care delivery system until they rest assured that the high rate of inflation in that system is under control."

To deal with the problem of oversupply of beds and services, and to prevent future unnecessary construction, New York enacted legislation in 1964 to establish the nation's first certificate of need program. Certificate of need is a mechanism to require prior state approval of hospital capital expenditures and construction; the primary determining factor in the approval process is the need for a proposed new service or facility. By the early 1970's, more than half of the state legislatures had enacted laws establishing a certificate of need program. Ten years after New York's action, the federal government adopted the concept in the National Health Planning and Resources Development Act, requiring that states must have an approved certificate of need program in order to be eligible for federal funds under such programs as the Public Health Service Act.

Some states, however, have gone beyond a simple certificate of need program. In 1978, Michigan enacted legislation establishing a mechanism for reducing that state's surplus of hospital beds. The legislation, which grew out of a joint public/private cost containment coalition, identifies health service areas with surplus beds. The local Health Systems Agency is responsible for developing a hospital specific plan for closing the excess beds. After the state has approved the HSA's bed reduction plan, the State Department of Public Health is prohibited from issuing a certificate of need inconsistent with the bed reduction plan, or to a facility out of conformity with the plan. Michigan hopes to eliminate 3,800 excess beds during the first five years of the law.

In addition to controlling the supply of hospitals and institutions, certificate of need provides a mechanism for assuring that expensive new technologies, such as kidney dialysis or open heart surgery, are distributed according to need. An example of a high cost technology that has recently been introduuced is computerized axial tomography, or CAT scanning. This process represents a tremendous advance in medical diagnostic capability; it is so significant that its inventors were awarded the 1979 Nobel Prize for Medicine. While virtually every hospital might like its own CAT scanner, and every patient might like to have one in the the local hospital, the machine costs between one-half and three-quarters of a million dollars. In addition a CAT scan is not administered to most hospital patients. The high price of such a technology and its relatively restricted use dictate that if it is to operate in a cost effective manner, the supply should be limited and distributed on the basis of the public need for the service. Accordingly, a certificate of need program might require that the equipment perform at least 2,000 CAT scans annually in order to be approved.

Wisconsin has gone even further. As Representative Czerwinski said, "Certificate of need is reactive only to new development. In Wisconsin, we thought it important to look at existing services and institutions available to our citizens. So along with certificate of need, Wisconsin has the ability to decertify existing services which do not meet minimum usage criteria in such areas as heart catheterization, radiation therapy, chemo-dialysis, renal transplants, high risk maternal and neonatal care, and computer tomography." In order to permit the effective and planned reduction of services without placing an institution in extreme financial hardship, the Wisconsin Rate Review Committee "has the ability to negotiate with the hospital to increase its daily rate to amortize the costs of deleting that service. While this may raise short run costs, in the long run it should prove cost effective."

Obviously, the health interests of state legislators extend beyond cost containment. Even in the relatively narrow field of health financing other unmet needs are readily apparent: expanded access to care for rural residents; protection against the catastrophic costs of a major illness; and funding health services for the poor not covered under existing programs are among the other urgent concerns. Resolution of these problems, however, is intricately related to cost containment. Few public officials will favorably view efforts to further expand government's financial stake in the health care delivery system until they rest assured that the high rate of inflation in that system is under control. Accordingly, it appears that cost containment will retain its place at the top of the nation's health agenda.

Russ Hereford is director of the Health Care Cost Containment project of the National Conference of State Legislators.

Chapter 88. Municipal Tax Resource Equalization.

Section

10. State equalization of tax resources for local government services
15. Determination of population
20. Determination of millage rate equivalent
25. Reports
30. Limitation on computation and use of payments
35. Tax equalization account
40. Administration
45. Definitions

Effective date of chapter. — Section 17, ch. 155, SLA 1980, provides that §§ 1 — 12 of the act take effect on the first day of the fiscal year for which $33,400,000 or more is appropriated and allowed by the governor for distribution to municipalities and other recipients under the provisions of §§ 1 — 12 of this act or on July 1, 1983, whichever is earlier. A total of $33,500,000 was appropriated for the programs for the fiscal year beginning July 1, 1980. The appropriations were made in §§ 51 and 52, ch. 120, SLA 1980, and § 6, ch. 165, SLA 1980.

Editor's note. — Section 1, ch. 155, SLA 1980, effective on the same day as this chapter, provides: "It is the purpose of sec. 2 of this act [this chapter] to (1) improve the revenue raising and distribution system for the benefit of residents of home rule and general law municipalities by providing for more equitable allocation of financial resources among municipalities to improve their fiscal capacities; and (2) assure that no municipality suffers impoverishment of necessary public services, relative to other municipalities, because of the chance location of taxable wealth in the state."

Section 12, ch. 155, SLA 1980, effective on the same day as this chapter, provides: "(a) Notwithstanding other provisions of secs. 1 — 11 of this act, (1) a municipality may not receive less than $25,000 plus an area cost-of-living differential during the first fiscal year in which this act is effective; and (2) a municipality which would receive under AS 29.88, added by sec. 2 of this act, less than 125 percent of the amount which it received for the last fiscal year under AS 43.18.010 — 43.18.045, repealed by sec. 11 of this act, is, for each of the first five fiscal years during which secs. 1 — 10 of this act are effective, entitled to receive an amount equal to 125 percent of the amount which it received for the last fiscal year under the former provisions of AS 43.18.010 — 43.18.045 in accordance with those provisions. (b) For the first five fiscal years during which secs. 1 — 10 of this act are effective, in order to pay the amounts required by (a) of this section, the allocations made by the Department of Community and Regional Affairs to the accounts established in AS 29.88.035, AS 29.89.080, and AS 29.90.020 shall be prorated by an amount which reduces the allocation to each account in equal proportion, and the prorated amounts shall be allocated to these accounts. (c) For the first five fiscal years during which secs. 1 — 10 of this act are effective, payment of an entitlement to a borough under AS 29.88 may be made to a borough only if the borough assembly agrees to allocate to each borough service area in the borough at least the amount of money that the service area received during the last fiscal year under the former provisions of AS 43.18.010 — 43.18.045, in accordance with those provisions."

Sec. 29.88.010. State equalization of tax resources for local government services. (a) During each fiscal year the department shall compute an equalization entitlement for local government services provided by a taxing unit.

(b) The equalization entitlement computed for a taxing unit is based on the population, relative ability to generate revenue, and local tax burden of the taxing unit and is determined by the application of the

formula

Entitlement = P x R

where P = population, and

R = millage rate equivalent, determined by dividing the sum of the locally generated revenue of the taxing unit by one-tenth of one percent (0.1) of the full and true value of assessed property of the taxing unit determined under AS 29.88.020(d); however, the property value used under this subsection may not be less than 15 percent of the statewide average per capita full and true assessed property value.

(c) For purposes of this section, locally generated revenue

(1) includes

(A) the actual revenue derived from the levy and collection of local taxes in the taxing unit for local government services during the preceding fiscal year of the taxing unit;

(B) motor vehicle payments received by the municipality during the preceding fiscal year under AS 28.10.431;

(C) revenue from fees, rentals, leases, penalties, licenses or permits received during the preceding fiscal year by the municipality for a function or service over which it has control, including revenues derived from parks and recreation services, mass transit, offstreet parking, and garbage and solid waste disposal services;

(D) special assessments received during the preceding fiscal year; and

(E) payments received by a municipality from a utility which are in place of taxes levied and collected by the municipality;

(2) excludes

(A) revenue derived from the levy and collection of municipal taxes and appropriated for the operating expenses and debt service of utilities;

(B) revenue from interest earned on investments and from the sale and lease of land or equipment; and

(C) all other revenue from whatever service derived. (§ 2 ch 155 SLA 1980)

Sec. 29.88.015. Determination of population. (a) For purposes of this chapter, the population of a taxing unit shall be determined annually by the latest figures of the United States Bureau of the Census or other population data which, in the judgment of the department, is reliable.

(b) The population of the taxing unit includes the population of any military reservation which is a part of the taxing unit. (§ 2 ch 155 SLA 1980)

Sec. 29.88.020. Determination of millage rate equivalent. (a) The department may require a municipality to return a certification, signed by the municipal treasurer or manager and the mayor, which provides an estimate of the locally generated revenue received by the municipality during the preceding fiscal year.

(b) By October 15 of each year, the department shall make an initial determination of the millage rate equivalent of each taxing unit to be used for computing and distributing equalization entitlements for the current fiscal year under this chapter. The department shall base the initial determination on the estimates in the certification returned by a municipality under (a) of this section.

(c) As early as possible, but not later than December 15 of each year, the department shall make a final determination of the millage rate equivalent of each taxing unit to use to compute and distribute equalization entitlements under this chapter. The department shall base the determination on audits, financial statements and other financial reports prepared and submitted by a municipality. The department shall adjust the locally generated revenue reported by a municipality to exclude the municipal revenue claimed by the municipality which does not qualify for inclusion in or recognition as locally generated revenue for local government purposes under AS 29.88.010(c)(1). The adjustment shall be made by deducting from total revenue claimed by the municipality the amount of the department's estimate of revenue which is not recognized for local government purposes.

(d) The full and true assessed property value shall be determined by the department in the manner provided for the computation of state aid to education under AS 14.17.140. When the determination of locally generated revenue includes revenue of a utility received under AS 29.88.010(c)(1)(E), the full and true assessed property value shall include the computed assessed value of the utility, determined by dividing the amount of the payment in place of taxes made by the utility by the millage rate which would apply to the utility if the utility were subject to levy and collection of taxes under AS 29.53.

(e) In addition to the computation for municipalities which levy and collect a property tax, the department shall determine an estimated full and true assessed property value under (d) of this section for

(1) each municipality which is a school district and which does not levy and collect a property tax;

(2) each second class city with a population of 750 or more persons; however, a computation is not required under this paragraph more often than once during a period of three successive calendar years; and

(3) all other second class cities, by determining the average per capita full and true assessed property value of all cities having a population of less than 750 persons in which an assessment has been completed by a municipality or for which a determination is not made under (1) or (2) of this subsection.

(f) The department shall annually compute a statewide average per capita full and true assessed property value. (§ 2 ch 155 SLA 1980)

Sec. 29.88.025. Reports. A payment of an equalization entitlement may not be made to a municipality under this chapter until the municipality has submitted its certificate of estimated revenue and its financial report to the department for the fiscal year preceding the year for which the equalization entitlement is sought, together with a budget for the municipality's current fiscal year. The financial report shall include a listing of general revenue collected from taxes levied and assessed by the municipality and any other revenue which, in the opinion of the municipal officials, is eligible for inclusion in computations of the locally generated revenue of the taxing unit. (§ 2 ch 155 SLA 1980)

Sec. 29.88.030. Limitation on computation and use of payments. (a) An equalization entitlement generated by the general tax levy of a taxing unit may be used only for authorized expenditures of that taxing unit, but up to 15 percent of the payment of an equalization entitlement generated by areawide revenue of a municipality may be used by the municipality for areawide or nonareawide purposes at the discretion of its assembly or council.

(b) An equalization entitlement determined with reference to revenue other than revenue obtained from the levy and collection of taxes may be used for areawide or nonareawide purposes, at the discretion of the assembly or council. (§ 2 ch 155 SLA 1980)

Sec. 29.88.035. Tax equalization account. The tax equalization account is established. Money to carry out the provisions of this chapter shall be allocated by the department to the account. The amount allocated to the account shall be fully distributed by the department as payments to municipalities to fulfill each municipality's share authorized under AS 29.88.010. The amount allocated to the account shall be distributed by the department pro rata among eligible municipalities. (§ 2 ch 155 SLA 1980)

Sec. 29.88.040. Administration. (a) The department may adopt regulations necessary to implement this chapter. The regulations shall include, among other provisions,

(1) procedures and filing dates for submitting certification and financial reports;

(2) procedures for obtaining information required to compute and determine the municipality's millage rate equivalent; and

(3) procedures by which the department shall notify a municipality in writing of the reasons for a proposed disallowance or adjustment of any factor bearing upon the determination of the municipality's entitlement and by which the municipality will be provided reasonable time in which to respond or to challenge the department's determination.

(b) The department shall make reasonable efforts to advise and assist municipalities in collecting information and completing reports necessary for the determination of entitlements under this chapter.

(c) The department shall, by regulation, classify for inclusion or exclusion as a component of a municipality's millage rate equivalent under AS 29.88.010 any tax revenue appropriated for a utility not included in the definition set out in AS 29.88.045(4). (§ 2 ch 155 SLA 1980)

Sec. 29.88.045. Definitions. In this chapter

(1) "department" means the Department of Community and Regional Affairs;

(2) "municipality" means a city, borough or unified municipality incorporated under the laws of the state;

(3) "taxing unit" means a municipality and

(A) in a borough or unified municipality, a service area or the entire area outside cities;

(B) in a city, a differential tax zone;

(4) "utilities" means electricity, water, sewer, gas, heat, or telephone services, and refuse and garbage collection services. (§ 2 ch 155 SLA 1980)

Chapter 89. State Aid for Miscellaneous Municipal Purposes.

Section

10. Revenue sharing payable
20. State aid to municipalities for roads
30. State aid to municipalities and other eligible recipients for health facilities and hospitals
40. State aid to volunteer fire departments in the unorganized borough
50. State aid to Native village governments
60. Population determination
70. Area cost-of-living differential
80. Miscellaneous services account
90. Regulations
100. Definitions

Effective date of chapter. — Section 17, ch. 155, SLA 1980 provides that §§ 1 — 12 of the act take effect on the first day of the fiscal year for which $33,400,000 or more is appropriated and allowed by the governor for distribution to municipalities and other recipients under the provisions of §§ 1 — 12 of this act or on July 1, 1983, whichever is earlier. A total of $33,500,000 was appropriated for the programs for the fiscal year beginning July 1, 1980. The appropriations were made in §§ 51 and 52, ch. 120, SLA 1980, and § 6, ch. 165, SLA 1980.

Editor's note. — Section 12, ch. 155, SLA 1980, effective on the same day as this chapter, provides: "(a) Notwithstanding other provisions of secs. 1 — 11 of this act, (1) a municipality may not receive less than $25,000 plus an area cost-of-living differential during the first fiscal year in which this act is effective; and (2) a municipality which would receive under AS 29.88, added by sec. 2 of this act, less than 125 percent of the amount which it received for the last fiscal year under AS 43.18.010 — 43.18.045, repealed by sec. 11 of this act, is, for each of the first five fiscal years during which secs. 1 — 10 of this act are effective, entitled to receive an amount equal to 125 percent of the amount which it received for the last fiscal year under the former provisions of AS 43.18.010 — 43.18.045 in accordance with those provisions. (b) For the first five fiscal years during which secs. 1 — 10 of this act are effective, in order to pay the amounts required by (a) of this section, the allocations made by the Department of Community and Regional Affairs to the accounts established in AS 29.88.035, AS 29.89.080, and AS 29.90.020 shall be prorated by an amount which reduces the allocation to each account in equal proportion, and the prorated amounts shall be allocated to these accounts. (c) For the first five fiscal years during which secs. 1 — 10 of this act are effective, payment of an entitlement to a borough under AS 29.88 may be made to a borough only if the borough assembly agrees to allocate to each borough service area in the borough at least the amount of money that the service area received during the last fiscal year under the former provisions of AS 43.18.010 — 43.18.045, in accordance with those provisions."

Sec. 29.89.010. Revenue sharing payable. In addition to the equalization entitlements paid under AS 29.88, during each fiscal year the department shall pay aid

(1) to a municipality or other eligible recipient which has the power to provide the services described in AS 29.89.020 — 29.89.040 and exercises the power in the manner required by this chapter;

(2) to a Native village government under AS 29.89.050. (§ 3 ch 155 SLA 1980)

Sec. 29.89.020. State aid to municipalities for roads. (a) The department shall pay to a municipality which has power to provide for road maintenance and exercises that power, $2,500 a mile for each mile of road, street or highway maintained by the local government, excluding (1) the official state highway system, (2) roads, streets or highways not dedicated to public use, (3) roads, streets or highways maintained under the local service road program (AS 19.30.111 —

19.30.251), and (4) alleyways, in accordance with regulations adopted by the Department of Transportation and Public Facilities. A payment may not be made under this subsection for maintenance of a road which is not used by automotive equipment.

(b) A frozen waterway and a connection from an inhabited area to a waterway which may be safely used for public transportation by automotive equipment and is so used during a portion of a year is eligible for a payment of $1,500 per mile if the waterway and connection are maintained during the period of use by a municipality or combination of municipalities. The department, after consultation with the Department of Transportation and Public Facilities, shall determine which waterways and connections qualify and, where the waterways or connections lie outside the corporate limits of a municipality, which municipalities shall receive the payments under this subsection, unless the municipalities involved have agreed in writing to a particular distribution. (§ 3 ch 155 SLA 1980)

Sec. 29.89.030. State aid to municipalities and other eligible recipients for health facilities and hospitals. (a) The department shall pay

(1) to a municipality which has the power to provide hospital facilities and services and which exercises that power, $1,000 per bed for each bed actually used for patient care, limited to the number of beds provided for in the construction design of the hospital, or $250,000 a hospital for those hospitals with 10 or more beds, or $50,000 a hospital for those hospitals with less than 10 beds, as the municipality may elect; money received under this paragraph may be used only for hospitals and shall be apportioned among qualifying hospitals as the municipality determines;

(2) on the basis set out in (1) of this subsection to a municipality for a nonprofit hospital not operated by a municipality if the municipality first certifies to the department that the nonprofit hospital is in compliance with all standards for hospitals which have been adopted by the municipality; money may not be paid on behalf of a nonprofit hospital without this certification; payments to the municipality shall be transferred to the nonprofit hospital in accordance with the basis by which the payment was generated by the hospital, and shall be applied to the annual cost of operation and maintenance of the hospital or for the provision of health care service at the hospital as the directors of the hospital determine;

(3) to a municipality in which a health facility is operated, $2,000 per bed for each bed actually used for patient care, limited to the number of beds provided for in the construction design of the health facility, or $8,000 per health facility as the municipality determines.

(b) A hospital may not receive payment under both (a)(1) and (a)(2) of this section.

(c) Money received by a municipality under (a)(3) of this section shall be used for expenses of health services or operation and maintenance of health facilities as the municipality determines.

(d) Before money may be distributed under this section, the commissioner of health and social services shall certify to the commissioner of community and regional affairs that any accumulation of assets by nonprofit corporations or other recipients under this section is dedicated irrevocably to a public purpose. (§ 3 ch 155 SLA 1980; am §§ 1, 2 ch 103 SLA 1981)

Cross reference. — As to state aid for hospital construction, see AS 29.90.

Editor's note. — As to reports by Department of Health and Social Services and Department of Community and Regional Affairs and commissioner of health and social services, see § 14, ch. 155, SLA 1980, effective July 1, 1980, in the 1980 Temporary and Special Acts and Resolves.

Sec. 29.89.040. State aid to volunteer fire departments in the unorganized borough. (a) The department shall pay to a volunteer fire department registered with the state fire marshal and serving an area not in an organized borough or city a sum for protection purposes equal to $10 per capita for the population served by the department, as determined by the state fire marshal.

(b) A grant shall be made under (a) of this section to facilitate the organization of a volunteer fire department in an area not in an organized borough or city, upon application of the proposed fire protection group to the state fire marshal and upon approval of applications according to standards of organization and service prescribed by regulations adopted by the state fire marshal. (§ 3 ch 155 SLA 1980)

Sec. 29.89.050. State aid to Native village governments. The state shall pay $25,000 to a Native village government for a village which is not incorporated as a city under this title. In this section, "Native village government" means

(1) a local governing body organized by authority of the Act of Congress of June 18, 1934 (25 U.S.C. § 476); or

(2) a traditional village council or, if there is no traditional village council, the paramount chief or other governing body of a Native village which meets the requirements of the Alaska Native Claims Settlement Act (43 U.S.C. §§ 1601 — 1628). (§ 3 ch 155 SLA 1980)

Sec. 29.89.060. Population determination. For purposes of this chapter, population shall be determined by the latest figures of the United States Bureau of the Census or other reliable population data, including but not limited to public school enrollment figures, public utility connection, registered voters or certified employment payrolls. (§ 3 ch 155 SLA 1980)

Sec. 29.89.070. Area cost-of-living differential. (a) Payments to a municipality or other eligible recipient under AS 29.89.020 — 29.89.030 shall reflect area cost-of-living differentials. Payments shall be based upon the sum of per capita, per mile and per bed or facility grants due each municipality or other recipient multiplied by the appropriate area cost-of-living differential. The area cost-of-living differential for each recipient shall be determined annually by election district under the provisions of AS 39.27.030. Application of the area cost-of-living differential may not result in distribution of an amount less than the amount of the payment determined without application of this section.

(b) The election districts used to establish area cost-of-living differentials under (a) of this section are those designated by the proclamation of reapportionment and redistricting of December 7, 1961, and retained for the house of representatives by proclamation of the governor September 3, 1965. (§ 3 ch 155 SLA 1980)

Sec. 29.89.080. Miscellaneous services account. The miscellaneous services account is established. Money to carry out the provisions of this chapter shall be allocated by the department to the account in accordance with AS 29.95.010. If amounts in the account are insufficient to pay each municipality's or other recipient's share authorized under this chapter, the amounts which are available shall be distributed pro rata among eligible municipalities and other recipients. (§ 3 ch 155 SLA 1980)

Sec. 29.89.090. Regulations. The department shall adopt regulations necessary to carry out the purposes of this chapter. The regulations shall include minimum standards required to qualify a municipality or other recipient for payments for each service. The department may require a municipality or other recipient to submit a performance report adequate to demonstrate to the department that a service for which payment is requested under this chapter was performed by the municipality or other recipient and meets minimum standards of service prescribed by regulation. (§ 3 ch 155 SLA 1980)

Sec. 29.89.100. Definitions. In this chapter

(1) "department" means the Department of Community and Regional Affairs;

(2) "health facility"

(A) means a facility which is licensed, when required, by the state under AS 18.20.010 — 18.20.130 and which is owned or operated or both by a municipality or by a nonprofit corporation or other nonprofit sponsor;

(B) includes a public health center, maternity home, community mental health center, facility for the mentally or physically handicapped, nursing home or convalescent center;

(C) excludes a facility operated or wholly supported by the state or the federal government;

(3) "hospital" means a licensed hospital determined by the Department of Health and Social Services to be a general hospital; the term excludes a facility operated or wholly supported by the state or the federal government. (§ 3 ch 155 SLA 1980)

Chapter 90. State Aid for Hospital Construction.

Section

10. State aid for hospital construction
20. Hospital construction assistance account
30. Definitions

Cross reference. — As to state aid to municipalities and other eligible recipients for health facilities and hospitals, see AS 29.89.030.

Effective date of chapter. — Section 17, ch. 155, SLA 1980, provides that §§ 1 — 12 of the act take effect on the first day of the fiscal year for which $33,400,000 or more is appropriated and allowed by the governor for distribution to municipalities and other recipients under the provisions of §§ 1 — 12 of this act or on July 1, 1983, whichever is earlier. A total of $33,500,000 was appropriated for the programs for the fiscal year beginning July 1, 1980. The appropriations were made in §§ 51 and 52, ch. 120, SLA 1980, and § 6, ch. 165, SLA 1980.

Editor's note. — Section 12, ch. 155, SLA 1980, effective on the same day as this chapter, provides: "(a) Notwithstanding other provisions of secs. 1 — 11 of this act, (1) a municipality may not receive less than $25,000 plus an area cost-of-living differential during the first fiscal year in which this act is effective; and (2) a municipality which would receive under AS 29.88, added by sec. 2 of this act, less than 125 percent of the amount which it received for the last fiscal year under AS 43.18.010 — 43.18.045, repealed by sec. 11 of this act, is, for each of the first five fiscal years during which secs. 1 — 10 of this act are effective, entitled to receive an amount equal to 125 percent of the amount which it received for the last fiscal year under the former provisions of AS 43.18.010 — 43.18.045 in accordance with those provisions. (b) For the first five fiscal years during which secs. 1 — 10 of this act are effective, in order to pay the amounts required by (a) of this section, the allocations made by the Department of Community and Regional Affairs to the accounts established in AS 29.88.035, AS 29.89.080, and AS 29.90.020 shall be prorated by an amount which reduces the allocation to each account in equal proportion, and the prorated amounts shall be allocated to these accounts. (c) For the first five fiscal years during which secs. 1 — 10 of this act are effective, payment of an entitlement to a borough under AS 29.88 may be made to a borough only if the borough assembly agrees to allocate to each borough service area in the borough at least the amount of money that the service area received during the last fiscal year under the former provisions of AS 43.18.010 — 43.18.045, in accordance with those provisions."

As to reports by Department of Health and Social Services and Department of Community and Regional Affairs and commissioner of health and social services, see § 14, ch. 155, SLA 1980, in the 1980 Temporary and Special Acts and Resolves.

Sec. 29.90.010. State aid for hospital and health facility construction. If construction of a hospital began after January 1, 1968, or if construction of a health facility began after January 1, and before July 1, 1980, and state matching aid for construction approved for payment to the municipality or other hospital or health facility sponsor constitutes less than 25 percent of the total project cost, the department shall pay to the municipality or other hospital or health facility sponsor each fiscal year $2,500 a bed for the maximum number of beds provided for in the construction design of the hospital or health facility or five percent of the total project cost, whichever is greater. State aid provided for in this section shall continue until the municipality or other hospital or health facility 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. (§ 4 ch 155 SLA 1980; am § 3 ch 103 SLA 1981)

Sec. 29.90.020. Hospital and health facility construction assistance account. The hospital and health facility construction assistance account is established. Money to carry out the provisions of this chapter shall be allocated by the department to the account in accordance with AS 29.95.010. If amounts in the account are insufficient to pay each recipient's share authorized under this chapter, the amounts which are available shall be distributed pro rata among eligible recipients. (§ 4 ch 155 SLA 1980; am § 4 ch 103 SLA 1981)

Sec. 29.90.030. Definitions. In this chapter

(1) "department" means the Department of Community and Regional Affairs;

(2) "hospital" means a licensed hospital determined by the Department of Health and Social Services to be a general hospital; the term excludes a facility operated or wholly supported by the state or the federal government;

(3) "total project cost" means

(A) costs directly related to the project; and

(B) the total of all costs of financing and carrying out the project, including but not limited to,

(i) the costs of all necessary studies, surveys, plans and specifications, architectural, engineering or other special services, acquisition of real property, site preparation and development, purchase, construction, reconstruction and improvement of real property, and the acquisition of machinery and equipment as may be necessary in connection with the project;

(ii) an allocable portion of the administrative and operating expenses of the municipality or other hospital sponsor;

(iii) the cost of financing the project, including interest on bonds issued to finance the project; and

(iv) the cost of other items, including any indemnity and surety bonds and premiums on insurance, legal fees, fees and expenses of trustees, depositaries, financial advisors, and paying agents for the bonds issued as the issuer considers necessary.

(4) "health facility"

(A) means a facility that is licensed, when required, by the state under AS 18.20.010 - 18.20.130 and that is owned or operated or both by a municipality or by a nonprofit corporation or other nonprofit sponsor;

(B) includes a public health center, maternity home, community mental health center, facility for the mentally or physically handicapped, nursing home, or convalescent center;

(C) excludes a facility operated or wholly supported by the state or the federal government.

(§ 4 ch 155 SLA 1980; am § 5 ch 103 SLA 1981)

Chapter 95. Administration of Municipal Financial Assistance Programs.

Section

10. Allocation and distribution
20. Qualification for minimum payment
30. Proration of payments

Effective date of chapter. — Section 17, ch. 155, SLA 1980, provides that §§ 1 — 12 of the act take effect on the first day of the fiscal year for which $33,400,000 or more is appropriated and allowed by the governor for distribution to municipalities and other recipients under the provisions of §§ 1 — 12 of this act or on July 1, 1983, whichever is earlier. A total of $33,500,000 was appropriated for the programs for the fiscal year beginning July 1, 1980. The appropriations were made in §§ 51 and 52, ch. 120, SLA 1980, and § 6, ch. 165, SLA 1980.

Editor's note. — Section 12, ch. 155, SLA 1980, effective on the same day as this chapter, provides: "(a) Notwithstanding other provisions of secs. 1 — 11 of this act, (1) a municipality may not receive less than $25,000 plus an area cost-of-living differential during the first fiscal year in which this act is effective; and (2) a municipality which would receive under AS 29.88, added by sec. 2 of this act, less than 125 percent of the amount which it received for the last fiscal year under AS 43.18.010 — 43.18.045, repealed by sec. 11 of this act, is, for each of the first five fiscal years during which secs. 1 — 10 of this act are effective, entitled to receive an amount equal to 125 percent of the amount which it received for the last fiscal year under the former provisions of AS 43.18.010 — 43.18.045 in accordance with those provisions. (b) For the first five fiscal years during which secs. 1 — 10 of this act are effective, in order to pay the amounts required by (a) of this section, the allocations made by the Department of Community and Regional Affairs to the accounts established in AS 29.88.035, AS 29.89.080, and AS 29.90.020 shall be prorated by an amount which reduces the allocation to each account in equal proportion, and the prorated amounts shall be allocated to these accounts. (c) For the first five fiscal years during which secs. 1 — 10 of this act are effective, payment of an entitlement to a borough under AS 29.88 may be made to a borough only if the borough assembly agrees to allocate to each borough service area in the borough at least the amount of money that the service area received during the last fiscal year under the former provisions of AS 43.18.010 — 43.18.045, in accordance with those provisions."

Sec. 29.95.010. Allocation and distribution. (a) Each year, the Department of Community and Regional Affairs shall allocate money appropriated to the accounts established in AS 29.88, AS 29.89, and AS 29.90 in the amounts determined by the legislature.

(b) Money in the miscellaneous services account established in AS 29.89.080 which exceeds the amount required to fully fund distributions authorized by AS 29.89 shall be reallocated to the tax equalization account established in AS 29.88.035 and distributed according to the provisions of AS 29.88.

(c) Money in the hospital construction assistance account established in AS 29.90.020 which exceeds the amount required to fully

fund distributions authorized by AS 29.90 shall be reallocated to the tax equalization account established in AS 29.88.035 and distributed according to the provisions of AS 29.88. (§ 5 ch 155 SLA 1980)

Sec. 29.95.020. Qualification for minimum payment. (a) A municipality qualifying for an entitlement under AS 29.88 or AS 29.89 shall receive a minimum payment of $25,000 plus an area cost-of-living differential for each fiscal year if:

(1) the municipality has conducted a regular election under AS 29.28.010 — 29.28.050 during the fiscal year preceding the year for which payment of an entitlement is authorized by AS 29.88 or AS 29.89 and has reported the results of the election to the commissioner of the Department of Community and Regional Affairs;

(2) regular council meetings are held in the municipality in accordance with the requirements of AS 29.23.210 during the fiscal year preceding the year for which payment of an entitlement is authorized by AS 29.88 or AS 29.89 and a record of the proceedings is maintained;

(3) a municipal budget has been adopted for the fiscal year during which payment of an entitlement is authorized by AS 29.88 or AS 29.89 and an audit or financial statement for the preceding fiscal year has been prepared and furnished to the Department of Community and Regional Affairs in accordance with AS 29.23.560(a); and

(4) local ordinances adopted by the governing body of the municipality have been codified in accordance with AS 29.48.180.

(b) The area cost-of-living differential payable to each municipality under this section shall be determined annually by election district under the provisions of AS 39.27.030. Except as provided in AS 29.95.030, application of the area cost-of-living differential may not result in a payment which is less than the minimum payment determined under (a) of this section. For purposes of this subsection, the election districts used are those designated by the proclamation of reapportionment and redistricting of December 7, 1961, and retained for the house of representatives by proclamation of the governor September 3, 1965.

(c) The Department of Community and Regional Affairs shall pay to each municipality eligible to receive a minimum payment under this section an amount equal to the difference between the minimum payment determined under (a) and (b) of this section and the sum of the amounts payable for the same fiscal year under AS 29.88 and AS 29.89.

(d) A payment under this section may be prorated and reduced under AS 29.95.030.

(e) Payments under this section shall be made from the money allocated to the tax equalization account established in AS 29.88.035. (§ 5 ch 155 SLA 1980)

Sec. 29.95.030. Proration of payments. (a) Payments under AS 29.95.020 and AS 29.88 shall equal the amount allocated to the tax equalization account (AS 29.88.035), adjusted in accordance with AS 29.95.010.

(b) Adjustments of payments shall be determined by prorating amounts payable under AS 29.95.020 and amounts payable under AS 29.88 by a factor which, when applied, reduces all payments in equal proportion so that payments under AS 29.95.020 and payments under AS 29.88 equal the amount allocated to the tax equalization account established in AS 29.88.035. (§ 5 ch 155 SLA 1980)

LEGISLATIVE CHANGES AFFECTING STATE CERTIFICATE OF NEED PROGRAMS

This list summarizes the changes made by the National Health Planning and Resources Development Amendments of 1979 to the requirements for acceptable State Certificate of Need programs. The amendments are grouped according to changes in procedures, in coverage, in criteria, and in definitions. Following the summary of each change are citations for the conference report, the Health Planning Act, and the page in the conference report on which the complete text of the change may be found.

Prepared by Division of Regulatory Activities
Bureau of Health Planning

October 1979

CHANGE IN PROCEDURES

Applications must be submitted according to a timetable established by the reviewing agency. Reviews must be undertaken in a timely fashion, and similar types of applications must be considered in relation to each other, but no less often than twice a year. (Section 116(e) amends 1532(b)(13)(A), see page 24.)

Written notification of the beginning of a review and notification of review status must be made in a "timely" manner. Agencies are required to maintain a mailing list of persons requesting to be notified of reviews. (Section 116(d)(1)(A)&(B) amends 1532(b)(1)&(7), page 22.)

If an agency requests additional information the applicant must be given 15 days to provide the information. (Section 116(d)(2) amends 1532(b)(2), page 22.)

Agencies must establish procedures to assure that only necessary information is requested in an application, and that all "essential" information is accessible to the general public. (Section 116(i)(1)&(2) amends 1532(b), page 25.)

The State Agency must specify a time period for approving or disapproving an application, and for granting an exemption. If additional information is requested of an applicant, the applicant may request that the review period be extended by 15 days. (Section 116(d)(3) amends 1532(b)(12)(C), page 23.)

The following requirements apply to hearings held before the State Agency and before an HSA to which the State Agency has delegated the authority to hold a hearing: Any person may be represented by counsel and may submit arguments and evidence. Any person directly affected may question persons who make factual allegations. A record of the hearing must be maintained. (Section 116(d)(3) amends 1532(b)(12)(A), page 22.)

A State's decision to approve, disapprove, or withdraw a certificate of need must be based solely on a review by the State conducted in accordance with adopted procedures and criteria, and on the record of administrative proceedings. A State's decision to approve or disapprove an exemption is based solely on the record established in administrative proceedings. (Section 116(d)(3) amends 1532(b)(12)(B), page 23.)

An HSA which includes a portion of a single standard metropolitan statistical area will review criteria used for project reviews and certificate of need decisions which affect the area. (Section 121(b) amends 1513(d), page 35.)

Upon the request of any person directly affected, a decision to approve, disapprove, or withdraw a certificate of need must be <u>administratively</u> reviewed under an appeals mechanism consistent with State law governing the practices and procedures of administrative agencies. (Section 116(d)(3) amends 1532(b)(12)(D), page 23.)

After an administrative review, any person adversely affected by a decision may seek judicial review. The Court must affirm the State's decision unless it is found to be "arbitrary, capricious, or not made in compliance with applicable law." (Section 116(d)(3) amends 1532(b)(12)(E), page 23.)

An HSA must be permitted a "timely" appeal. The decision of the reviewing agency must be considered the decision of the State Agency. (Section 117(b)(4) amends 1522(b)(13), page 31.)

A notice of intent is required before any person arranges to acquire an existing health care facility, or arranges to acquire major medical equipment which will not be owned by or located in a health care facility. (Section 117(a) adds 1527(d)(2) and (e)(2), page 29.)

Once a hearing has commenced, ex parte contacts are prohibited between applicants or opponents and any person in the State Agency who exercises responsibility in granting, denying, or withdrawing certificates of need. (Section 116(d)(3) amends 1532(b)(12)(F), page 24.)

If no decision is made within the required time, the applicant may bring an action in the appropriate State Court to require the State Agency to make a decision. (Section 116(d)(3) amends 1532(b)(12)(C)(ii), page 23.)

A governing body member is prohibited from voting on any application in which the member has a conflict of interests. (Section 113(a) amends 1512(b)(3)(F), page 17.)

The State Agency must consider the recommendation of the HSA to approve, disapprove, or withdraw a certificate of need. (Section 117(a) adds 1527(g), page 30.)

The State Agency must monitor the progress of the holder of a certificate in meeting the timetable specified in the application. The State Agency may withdraw a certificate of need if it determines that the holder is not making a good faith effort to meet the timetable. (Section 117(a) adds 1527(a)(3), page 26.)

A certificate of need may only be issued by the State Agency, and must, except in emergency circumstances which pose a threat to public health, be consistent with the State health plan. (Section 117(a) adds 1527(a)(5), page 26.)

When a State issues a certificate of need it must specify a maximum capital expenditure which may be obligated under the certificate. The State program will prescribe the nature of further review if the capital expenditure maximum is exceeded. (Section 117(a) adds 1527(a)(4), page 26.)

HSAs and State Agencies must coordinate the development of procedures and criteria. (Section 116(c) amends 1532(a), page 22.)

Any criterion used to review an application or any condition attached to a certificate of need must be directly related to criteria at section 1532(c), criteria in Federal regulation prior to the date of enactment, or criteria in State regulation. The Secretary may not require the inclusion of criteria other than those at section 1532(c) or those in regulation prior to the date of enactment. (Section 117(a) adds 1527(a)(2), page 25.)

A certificate of need program must provide procedures and penalties to enforce the requirements of the program. (Section 117(b)(2) amends 1523(a)(4), page 30.)

CHANGES IN COVERAGE

A certificate of need program must provide for the review and determination of need for capital expenditures, major medical equipment, and institutional health services. (Section 117(a) adds 1527(a)(1), page 25.)

A certificate of need may not be required for 1) the offering of an inpatient institutional health service 2) the acquisition of major medical equipment for the provision of an inpatient institutional health service or 3) the obligation of a capital expenditure for the provision of an institutional health service by 1) an HMO, 2) combinations of HMOs, 3) health care facilities controlled directly or indirectly by HMOs, or 4) facilities leased by HMOs, if exemption requirements are met. (Section 117(a) adds 1527(b)(1), page 26.)

An HMO or health care facility which meets the requirements must apply for and receive an exemption from coverage. (Section 117(a) adds 1527(b)(2), page 26.)

A certificate of need is required when any major medical equipment or facilities acquired under an exemption are sold, unless the purchaser is an exempted organization. (Section 117(a) adds 1527(b)(3), page 27.)

HMOs and HMO health care facilities may be subject to certificate of need review only to the extent that they are not exempt under the conditions at section 1527(b)(1), and then only for the offering of inpatient institutional health services, the acquisition of major medical equipment, and the obligation of capital expenditures. (Section 117(a) adds section 1527(b)(4), page 28.)

A State Agency must approve an application from an HMO or HMO facility if the Agency finds that the approval is required to meet the needs of enrolled members and new members reasonably expected to enroll, and is required to offer health services in a reasonable and cost effective manner. (Section 117(a) adds 1527(b)(5), page 28.)

A certificate of need must be approved for capital expenditures required to eliminate safety hazards, to comply with State licensure standards, or to comply with accreditation standards required to receive certain reimbursements or payments, unless the State Agency finds that the facility is not needed or the expenditure is not consistent with the State health plan. (Section 117(a) adds 1527(c), page 28.)

A certificate of need is required for the acquisition of a health care facility by any person if a notice of intent is not submitted or if the State Agency finds within 30 days that the acquisition will result in a change of service or bed capacity. (Section 117(a) adds 1527(d)(1), page 29.)

A certificate of need is required for the acquisition of major medical equipment by any person if a notice of intent is not submitted or if the State Agency finds within 30 days that the equipment will be used to provide service to inpatients. A State may require additional coverage of major medical equipment; however, after September 30, 1982, a State may not change its program to include additional requirements. (Section 117(a) adds 1527(e)(1)(A), page 29.)

CHANGES IN COVERAGE

Donations, leases and transfers for less than fair market value (if the fair market value is greater than the capital expenditure threshold) of major medical equipment are subject to review if the acquisition would be subject to review under 1527(e)(1)(A). (Section 117(a) adds 1527(e)(3), page 30.)

Applications from osteopathic and allopathic facilities must be considered on the basis of the needs of osteopathic and allopathic physicians and patients. (Section 117(a) adds 1527(f), page 30.)

CHANGES IN CRITERIA

The State Health plan is added to those plans which must be considered. (Section 116(b)(3) amends 1532(c)(1), page 22.)

Additional criteria concerning the availability of resources and funds, the effect on health professional training programs, alternative uses of the resources involved, and accessibility of the proposed service. (Section 116(f)(3) amends 1532(c)(6), page 24.)

Additional criteria concerning the effects of construction projects on costs and charges, the efficiency and appropriateness of existing services, and the quality of existing services. (Sections 116(g)(1) & (2) amend 1532(c)(6) and add 1532(c)(13) & (14), page 25.)

Adds a consideration of the factors which affect the effect of competition on the supply of the proposed service, and a consideration of improvements or innovations in the financing and delivery of services which foster competition and promote quality and cost effectiveness. (Section 103(c) adds 1532(c)(11) & (12), page 5.)

The criterion on the special needs and circumstances of HMOs is amended to include all HMOs. (Section 117(b)(5) amends 1532(c)(8), page 32.)

DEFINITIONS

"Capital expenditure" is defined as an expenditure which exceeds the minimum, substantially changes the bed capacity, or substantially changes the services of a health care facility. States may adjust the capital expenditure threshold to reflect changes in an index maintained or developed by the Department of Commerce and designated by the Secretary by regulation for purposes of making such adjustments. (Section 117(b)(3) adds 1531(6), page 30.)

"Major medical equipment" means equipment which provides medical and other health services, and which costs in excess of $150,000. (Section 117(b)(3) adds 1531(7), page 31.)

"HMO" is defined as a qualified HMO under section 1310(d), or an organization which satisfies the requirements in existing regulations. (Section 117(b)(3) adds 1531(8), page 31.)

"Institutional health service" is defined as a health service which is provided through the specified facilities, and which entails an annual operating cost of $75,000 (or a figure adjusted as specified by the Secretary by regulation.) (Section 126(a)(1) adds 1531(5), page 40.)

National Conference of State Legislatures

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Speaker, New Hampsh
House of Representati

Executive Director
Earl S. Mackey

MEMORANDUM

TO: Interested Legislators and Staff

FROM: Kay Miller, NCSL Health Planning Project Director

SUBJECT: 1979 Congressional Health Planning Amendments (P.L. 96-79): Implications for State Certificate of Need Programs

DATE: December 27, 1979

NCSL Health Planning Project

The National Conference of State Legislatures, through a contract with HEW's Bureau of Health Planning, has a Health Planning Project designed to collect information on state certificate of need (CON) legislation. As part of the project, NCSL is providing interested legislators and staff with information on federal developments which have ramifications for their state certificate of need programs.

NCSL has completed a series of four regional seminars for legislators and their staff which focused in part on the recent amendments to the Health Planning Act and the impact those amendments have on certificates of need. The materials included in this packet are intended to supplement the information provided at the seminars and to give those who did not attend the basic information necessary to understand the implications of the recent amendments.

Finally, the NCSL project can make available necessary technical assistance to state legislatures attempting to develop certificate of need legislation to reflect new changes. Questions regarding the project or requests for technical assistance should be directed to: Kay Miller, Project Director, Health Planning Project, NCSL, Denver, CO 80202 (303) 623-6600.

1979 Amendments to the Health Planning Law

The National Health Planning and Resources Development Act of 1974, P.L. 93-641, established a new nationwide network of health planning agencies. It also mandated that each state establish and administer a certificate of need (CON) program. Certificate of need is basically a method to prevent the construction and other development of unnecessary and inappropriate health care facilities and services. These programs were regarded by many as the regulatory mechanism necessary to give teeth to the planning process.

The Congressional amendments, signed into law October 4, 1979, to the 1974 Act have certain implications for state certificate of need programs. Depending on the latitude which a state's statute permits the state health planning agency in developing a certificate of need program, a legislature may be required to amend (or enact, in a few cases) its CON statute to reflect the significant changes in the federal legislation.

Several examples of the changes in the recent Congressional amendments which may require changes in the state laws are:

I. Health maintenance organizations (HMOs) meeting certain specified criteria outlined in federal law (Section 117 (a), page 26 of the Conference Report, adds 1527 (6)) may not be required to obtain a certificate of need for: 1) the offering of an in-patient institutional health service 2) the acquisition of major medical equipment for the provision of an inpatient institutional health service or 3) the obligation of a capital expenditure for the provision of an institutional health service.

II. A certificate of need is required for the acquisition of major medical equipment by any person if a notice of intent is not submitted or if the state agency finds within 30 days that the equipment will be used to provide service to inpatients. A state may require additional coverage of major medical equipment; however, after September 30, 1982, a state may not change its program to include additional requirements (Section 117 (a) of the Conference Report adds 1527 (e) (1) (A) on page 29.)

There are numerous other changes which may require state statutory changes if state law does not grant liberal rulemaking authority to the state agency. Each state will need to review its legislation in light of the new amendments to determine what legislative action will be necessary to comply. The NCSL Health Planning Project can assist in making this determination and reviewing proposed amendments for compliance.

Timetable for Compliance

Section 123 of the Conference Report, page 38, amends subsection (d) of section 1521 to establish the dates when a state agency must have a final designation agreement is a satisfactory CON program which may require legislation to implement, the dates are tied to legislative sessions. Basically, the amendments state: 1) if the legislature of the state was in session on the date of enactment of the 1979 health planning amendments (October 4, 1979) and will continue to be in session 12 months, the state agency must be fully designated 12 months from that date; 2) if the legislature of a state was in session on the date of enactment but 12 months do not remain in that session, or if the legislature was not in session on the date of enactment, the state agency of that state must be fully designated 12 months after the beginning of the first regular session of the legislature beginning after that date.

NCSL has provided the HEW's Bureau of Health Planning with 1979 adjournment information and 1980 session information on all 50 states. Legislators and staff with questions regarding when their state must have a fully designated State Health Planning & Development Agency should contact their regional office of HEW. If the Regional Office is unable to give a definite answer, contact NCSL, which will obtain a judgment from the Bureau of Health Planning.

Penalties for Failure to have a Fully Designated State Agency

The 1979 amendments also make changes in the penalties that will be imposed on states which do not have final designation agreements in effect on the dates outlined above. These penalties also appear in Section 123 of the Conference Report, page 38, in the amendments to subsection 1521 (d) (2). Basically, the sanctions that HEW must impose

on any state failing to have a fully designated state agency by the required date would involve 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 & Alcoholism Prevention Treatment and Rehabilitation Act of 1970 and the Drug Abuse Office & Treatment Act of 1972."

If a final designation agreement is not in effect during the first year after the applicable expiration date, the Secretary of HEW must reduce the above mentioned funds by 25 percent; in the third year by 75 percent; and all funds under these acts are to be withheld after three years have elapsed.

The penalties in the new amendments are more stringent and comprehensive than those contained in the original Health Planning Act, P.L. 93-641, Section 1521 (d). The new amendments add funds under the Drug Abuse Office & Treatment Act of 1972 to the list of sanctions. More importantly, the amendments include all funds under the stated acts, not just those for "the development, expansion and support of health resources" as stated in the original act.

NCSL requested the Bureau of Health Planning to compute for each state the total dollars involved if the penalties were imposed. They have done this based on FY 1978 figures. States should be able to obtain these dollar figures through their regional HEW office of by contacting NCSL directly.

Federal Regulations Pursuant to the New Amendments

Federal law requires HEW to promulgate rules and regulations to implement the new amendments within six months of enactment. The Bureau of Health Planning intends to publish a Notice of Proposed Rulemaking (NPRM) in the Federal Register in mid-January, 1980. The NPRM will outline the issues on which further regulatory guidance is necessary. Interested parties will be given a period of time, probably sixty days, to review and comment on these issues before the final regulations are published in April, 1980.

NCSL will insure that everyone receiving this mailing will also receive the January NPRM. Legislative response to the proposed rules can be addressed directly to DHEW or channeled through NCSL. The Human Resources Committee of NCSL's State Federal Assembly will be actively involved in the review of the regulations and would appreciate receiving at least copies of the comments or concerns of state legislators and their staffs.

SFA Resolution Supporting a Timetable Extention for States

During the NCSL seminars on the health planning amendments, it became apparent that the timetable for compliance with the new amendments presents a hardship on those states which will have to amend CON statutes in the 1980 legislative sessions. Many states have to enact legislation even before the final federal regulations are published in April.

In response to this problem, the State-Federal Assembly of NCSL, the body which gives policy guidance to the organization in areas of state-federal relations, adopted the enclosed policy resolution at its December 7, 1979 meeting. The resolution urges

passage of an amendment to the recent Congressional amendments (P.L. 96-79) which would give states until the close of the first regular session after the promulgation of the HEW regulations to enact complying CON legislation.

Because Congress was near recess at the time of passage of the SFA resolution, it was impossible to find a Congressional sponsor for such an amendment before the holiday recess. However, efforts will continue to find a sponsor as soon as Congress reconvenes in January.

For additional information regarding the status of this amendment, contact: Dick Merritt, Human Resources Staff Director, NCSL Washington, (202) 624=5413.

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Certificate-of-Need—No Panacea but Not without Merit

JOHN T. TIERNEY, WILLIAM J. WATERS, and WILLIAM H. ROSENBERG

WITH the current Administration in Washington promoting competition, the certificate-of-need (CON) program is experiencing critical scrutiny. The National Health Planning and Resources Development Act of 1974, Public Law 93–641, required all states to establish certificate-of-need programs to control major hospital and nursing home construction, renovation, and development proposals. However, many states had certificate-of-need programs long before Public Law 93–641 was enacted, and many are likely to maintain certificate-of-need programs for many years to come.

An extensive literature has developed over the past few years regarding the effectiveness of certificate-of-need (1). While the empirical evidence is mixed, the current academic perspective appears to be largely negative on certificate-of-need. Evidently, certificate-of-need has enjoyed some success in restraining the number of hospital beds, but many researchers indicate that certificate-of-need has not been greatly successful in controlling health care costs. Apparently, in those areas where beds have been controlled, hospitals have shifted investment to service-intensifying expenditures. Many analyses point out the fact that a high percentage of all certificate-of-need applications are approved. However, most certificate-of-need analyses give little attention to three of its most important features: *deterrence*, *guidance*, and *institutional planning*.

The very existence of certificate-of-need acts as a deterrent to frivolous or obviously misdirected projects. Few institutions are likely to expend the time, energy, and money to traverse the complex certificate-of-need process for a project that cannot withstand the test of public scrutiny. This is a powerful deterrent to unnecessary and inappropriate development in the health care industry.

The deterrent effect appears to be working in Rhode Island where the physician supply has been expanding more rapidly than the acute hospital bed supply. In the absence of certificate-of-need, one would have expected the hospital bed supply to expand in accordance with an expanding supply of practicing physicians. From 1956 to 1971, the number of licensed physicians in Rhode Island increased by 49%, and the number of community hospital beds during the period 1958 to 1973 (assuming a two-year lag period) increased by 31%. That is, for every new physician, .63 beds were added. After certificate-of-need was operational in Rhode Island, that is, from 1971 to 1980, the number of licensed physicians in Rhode Island increased by 13%, but during the period 1973 to 1980, the community hospital bed supply actually decreased by 2.3%. Had the trend of the previous fifteen years continued after certificate-of-need, Rhode Island would have 300 more hospital beds today (see Table 1).

TABLE 1

Hospital Bed[1] and Physician Supply[2] in Rhode Island, 1956–1980

Resource	*1956*	*1958*	*1971*[3]	*1973*	*1980*
PHYSICIAN SUPPLY					
Number	1264		1889		2100
Rate per 100,000 population	152		197		226
HOSPITAL BED SUPPLY					
Number		2707		3550	3420
Rate per 1,000 population		3.2		3.7	3.6
Beds per physician[4]		2.1		1.9	1.5

[1] Short-term, acute, community hospital beds. Source: AHA Annual Survey.
[2] Licensed physicians. Source: Division of Professional Regulation, RIDH.
[3] Rhode Island certificate-of-need program was instituted in 1968 but did not become fully operational until around 1971.
[4] Beds in year X ÷ physicians in year X–2. For 1978, the number of licensed physicians was 2238.

Further, one cannot minimize the potential of certificate-of-need in terms of guiding institutional actions. While certificate-of-need may not have had the effect of reducing overall hospital investment, it may very well have had a positive impact on the types of investments which hospitals have been making. Certainly, the desire on the part of hospitals for success-

ful certificate-of-need applications would tend to guide them into areas which are compatible with the goals and policy positions of certificate-of-need bodies and agencies. For example, the certificate-of-need program in Rhode Island has promoted a number of important policies: the utilization of tax-exempt bonds where appropriate, the pursuit of community fund drives as a source of financing capital expenditures, the employment of debt/equity ratio limitations to moderate community debt burden, the use of insolvency insurance as a substitute for large capital reserves for developing health maintenance organizations (HMOs), and the gradual and thoughtful introduction of CAT scanners. The appropriate funneling of provider activity is an obviously critical but largely unevaluated area of certificate-of-need impact.

Thirdly, certificate-of-need tends to promote better institutional planning. This is especially true in states where hospitals are required to submit annual long- and short-range plans as part of the certificate-of-need process. This is the case in Rhode Island. In Rhode Island, institutional plans serve as the notices-of-intent for certificate-of-need purposes. That is, no certificate-of-need proposals will be accepted unless they have previously appeared in the institution's documented plan for the future. Informal reports seem to indicate that hospitals themselves agree that certificate-of-need requirements have encouraged them to upgrade their institutional planning processes. In addition, the Rhode Island experience indicates that the certificate-of-need process can promote greater inter-institutional planning. In fact, over the last ten years the certificate-of-need process in Rhode Island has encouraged or required significant increases in inter-institutional planning affecting nine hospitals, almost half the hospitals in the nation's smallest state.

Thus existing empirical evaluations of certificate-of-need do not tell the whole story. There may be certain beneficial aspects of certificate-of-need which are difficult to measure. In fact, effective institutional/system planning encouraged by a credible certificate-of-need process should result in very few certificate-of-need denials. In this context, happiness in certificate-of-need is saying yes. That is, effective, upfront planning and dialogue between the institutional and systemwide levels should minimize the number of certificate-of-need denials. In any event, controlling total health expenditures is not the only policy objective of certificate-of-need. In fact, certificate-of-need by itself is not well suited to controlling total health expenditures. Nevertheless, certificate-of-need can be an effective mechanism for restraining health care costs, affecting the supply of health care resources,

and guiding health policy and planning at both the institutional and system levels. Therefore, certificate-of-need programs should not be abandoned without careful consideration of all the foreclosed opportunities which abandonment implies.

Finally, certificate-of-need would be a more effective cost-control device if there were a capital expenditure limit associated with the certificate-of-need process. As things stand now, there are no financial boundaries conditioning the number of certificate-of-need proposals which can be approved in a given time-frame. This is unrealistic and cripples the cost-control potential of the certificate-of-need process. No industry can afford to operate forever without some form of capital budget. Certificate-of-need capital limits would not only serve to restrain costs, they would also induce a healthy priority-setting process within certificate-of-need. Perhaps we should direct our energies toward improving the certificate-of-need process rather than dismantling it.

In conclusion, certificate-of-need was designed to avoid unnecessary duplication which results in underutilization and inflated costs in a largely cost-based reimbursement system. From this perspective, certificate-of-need has been successful in Rhode Island and elsewhere. Rhode Island's high overall community hospital occupancy rate (85.6%) and the absence of patently wasteful developments attest to this. At the same time, it is recognized in Rhode Island and elsewhere that effective overall cost control also requires use of a combination of other mechanisms such as prospective reimbursement, utilization review, consumer choice, and health maintenance organization (HMO) development.

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Original Article on Health Economics

THE SOCIAL CONSEQUENCES OF FREE TRADE IN HEALTH CARE: A PUBLIC HEALTH RESPONSE TO ORTHODOX ECONOMICS

Milton I. Roemer and John E. Roemer

In recent years, difficulties in U.S. health services have been ascribed to excessive government intervention and regulation; high costs and other problems would be solved, it is argued, by "return to the free market and competition." Examination of the past operations of free trade and competition in health care, however, shows that in this market not one of at least five conditions necessary for effective competition exists. Numerous adjustments made by society reflect strikingly the problems caused by these market deficiencies (such as seriously inadequate information or the presence of major social "externalities"). Furthermore, even these adjustments—such as medical ethics or health insurance—have generated serious secondary problems. Many types of waste and social inequity also persist, in spite of all the attempts to compensate for market failure. In effect, the so-called free market in health care has survived only because of the extensive regulations and other actions taken to patch it up. Abandoning these adjustments would further aggravate current problems. Only replacement of free trade by systematic social planning could hope to achieve a health care system that allocates resources and distributes services both efficiently and equitably.

In recent years it has become increasingly fashionable to attribute the many serious problems of the American health care system to "excessive government regulation." It is argued that a deliberate return to the classical entrepreneurial model of free trade and competition would solve or greatly reduce our problems of spiraling health care costs and inaccessibility of needed services. From this viewpoint, there follow many political actions to minimize the entire role of government—with respect to both regulation and planning—and to enhance the private sector in health care (1). Under the Reagan Administration, such strategies have become explicitly dominant.

INTRODUCTION: THE BASIC ISSUE

The question of whether free trade with competition, or social planning with regulation, is the most effective mechanism for governance of the health care system, has very complex ramifications. Comprehensive analysis of these issues would require a lengthy book. In this paper, we shall offer only an introductory statement of our

This paper is based on an address on "Competition in the Health Care System" presented by Dr. Milton I. Roemer to the Third Annual Michigan Statewide Health Planning Conference, held in Detroit on May 21, 1980.

International Journal of Health Services, Volume 12, Number 1, 1982

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argument that a policy of greater free trade and lesser public regulation of health services would not reduce but would increase the problems of the U.S. health care system.

We contend that the current health care systems in the United States and other capitalist nations have survived to the present day only because they have been continuously modified by planning and regulation. Without those modifications, the effects of free market dynamics in the health care sector would have been so disastrous, so unacceptable politically, that these systems would have collapsed long ago, and been replaced by completely planned and regulated health care systems. In order to solve the still persistent health care problems—involving costs, accessibility, quality, and other features—America requires not greater free trade and competition, but rather much more planning and regulation.

The virtues of free trade and competition have long been acclaimed in the modern, parliamentary, and capitalist world. From early childhood, we become so deeply convinced of the wisdom of free competition as the best incentive for diligence—in the classroom, on the athletic field, everywhere—that in later life it becomes naturally accepted as the obvious path to sound social policy.

As well summarized by Anne Somers (2, p. 468), in the wind-up of a 1977 national conference of economists on Competition in the Health Care Sector:

> Competition is generally the most desirable method of quality control, price-setting, and resource allocation. In theory, at least, the consumer has the final say, while producers or providers compete for his favor in terms of quality as well as price, thus maximizing the incentive to efficiency.

Continuing with her statement of this ideal, Professor Somers states further:

> Interference by Government or any other third party in the consumer-provider relationship is non-existent or minimal. . . . Even in the health care economy, with all its idiosyncrasies, my philosophical bias is in the same direction.

Most Americans probably share this notion of the virtues of free trade and competition in all sectors of society, including the health field; the basic trouble, many think, is that the concept has not really been fairly tested. Some regard "government interference" as the major obstruction. While most would acknowledge problems caused by monopolistic producers (i.e. health care providers) and by the non-sophistication of consumers (i.e. patients), these characteristics of the health care industry are viewed as only minor disturbances that do not nullify the basic soundness of a free market policy—perhaps modified in small ways.

Examining the actual dynamics and experience of free trade and competition in the health care systems of the United States and other countries, however, one becomes increasingly skeptical of the whole idea. With respect to a goal of social justice, one finds not only the inadequacy of the free competition model for governing the complex processes of a modern health economy, but even its ultimate perversity. In countless ways, free trade and competition have operated and still operate to thwart the attainment of social justice in the health sector. Regulation, controls, and numerous other instruments of public policy have been necessary to overcome or neutralize the harmful social consequences of unbridled competition. These "interventions" have been gradually replacing free competition with a strategy that may be epitomized in the phrase "systematic social planning."

It is relevant to recall the origins of the concept of free trade and the theoretical rationale of competition as its regulatory mechanism. After this, some of the major consequences of this mechanism in the health sector can be better understood.

ORIGINS OF FREE TRADE AND COMPETITION

Theoretical formulation of the principles of free enterprise—with competition, its regulator—as the best path to a just and efficient social order, we all know, came from a Scottish economist, Adam Smith. His classic *Inquiry Into the Nature and Causes of the Wealth of Nations* was published in 1776, the same year, interestingly, that another kind of freedom was formulated by American revolutionaries in their *Declaration of Independence*. In light of the restrictions of free trade and various other vestiges of feudalism, one can well appreciate how principles of *laissez-faire* economics and unfettered competition were a great step forward at the time.

In spite of his eloquent call for a free market, Adam Smith recognized the need, even in the 18th century, for a certain amount of government regulation. He saw this as necessary to prevent monopolies, and he accepted tariffs (trade barriers) as justified to protect young industries in a nation. This was *before* the Industrial Revolution was far along, with its urban slums, sweat shops, 12-14 hour workdays, and child labor. As against monarchistic and feudal despotism, economic and political freedom seemed a far preferable general policy.

Adam Smith's 1776 model was also formulated before the great flowering of science in the 19th century. The monarchy and the church were being rejected as the guides to truth and justice, but science had not yet acquired the stature to replace them. Electricity, bacteriology, and other instruments to achieve control over nature for the sake of human welfare were to come later. Likewise, rational or scientific social planning, by which societies could be effectively controlled for the sake of human welfare, were also to come later. Labor laws, public health legislation, and social security were products of the 19th century (3).

Thus, the notion of letting each individual be free to pursue his own self-interest seemed a sounder path to social justice than royal or religious dogma. Unreasonable or improper outcomes of this freedom would be averted, or at least minimized, by the "invisible hand" of competition in a free market. The scientific method had not yet won recognition as a better strategy. It has been the development of science, and its application both to nature and to society, that makes possible the replacement of competition by systematic social planning, particularly to meet essential needs such as health care.

Before reporting some of the health consequences of free enterprise and competition in the last two centuries or so, the relationship between free trade (*laissez-faire*) and competitive market dynamics should be clarified. These considerations are, of course, not limited to the health sector.

FREE TRADE MARKET STRUCTURES

Free trade is the umbrella concept encompassing many types of market mechanisms which may arise as each individual pursues his own self-interest, unrestrained by regulation from any source, such as the state. A competitive market is one structure

which, under certain circumstances, may emerge in a *laissez-faire* environment. Other economic structures may also emerge, as often occurs in the health sector.

Thus, as schematized in Figure 1, at least four market structures may evolve under free trade capitalism. *Monopoly* or oligopoly can result if one or a few of the competing producers beat out the others in the competitive struggle. As noted later, this often occurs in the health sector when technology can yield huge economies of scale, so that many atomized producers cannot remain viable. A second possible outcome is long-term *contractual arrangements*, as when producers and consumers decide to handle their transactions through a "health maintenance organization." The third and fourth outcomes in Figure 1 require elaboration.

The process of competition under free trade may also yield a more complex dynamics. Before reaching an outcome of competitive equilibrium, the market typically passes through a stage we describe as *turbulent competitive disequilibrium*. In this stage, consumers are shopping around (usually with very limited information) and providers are offering diverse sorts and qualities of product at various prices. The idealized description of the free market assumes this period of disequilibrium to be transient, leading rapidly to *competitive equilibrium*, in which the faulty products are eliminated from the market. Due, however, to the nature of the doctor-patient relationship, seriously inadequate consumer information, and other features of the health sector discussed below, the period of turbulent competitive disequilibrium is typically protracted. Competitive equilibrium is probably the rarest outcome of free trade dynamics in the health sector. But even if such an equilibrium is attained, it may be inefficient, as well as inequitable, in the allocation of health resources (hence the representation in Figure 1 of two types of competitive equilibrium).

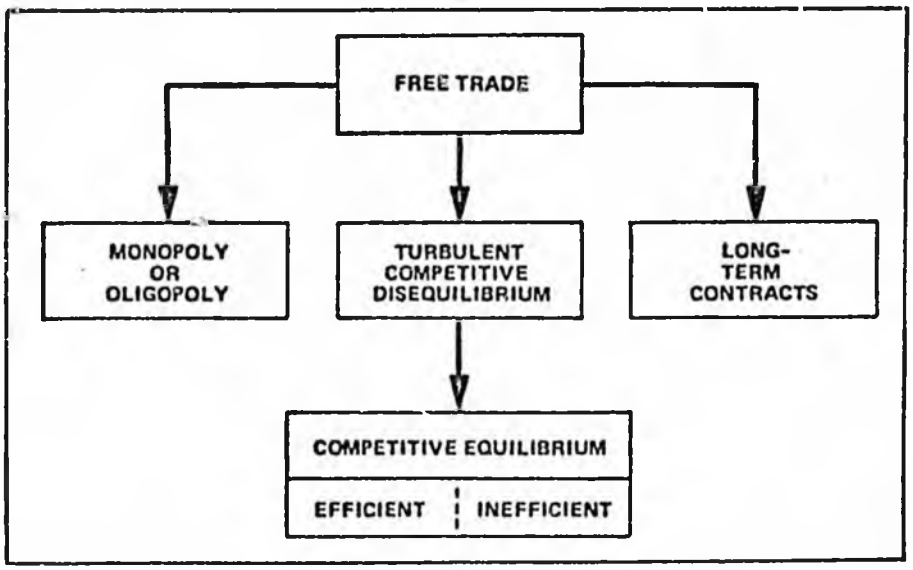


Figure 1. Free trade dynamics: some alternative outcomes.

The frequent outcomes of monopoly/oligopoly or turbulent competitive disequilibrium, unless averted by regulation, may be very deleterious to consumers. Occasionally the outcome of a free market is a long-term contract, which can be beneficial for consumers (although, as we shall see, even such contracts may require substantial regulation to protect consumers). In a sense, systematic social planning aims to extend this contracting phenomenon to a universal one, under specified conditions.

To understand why the invisible hand of Adam Smith's free trade seldom leads to a balanced market structure, with its famous property for efficient allocation of resources, one may identify at least five necessary conditions for achievement of that outcome (4):

1. *Many buyers and sellers freely interacting.* If there are few sellers, as often characterizes the health sector, competition can barely operate.
2. *No substantial economies of scale.* If such economies are possible, a competitive solution is not efficient. It is often more efficient to have one large producer (a "natural monopoly") than many small ones. Price and quality, however, must then be regulated to protect consumers, in place of competition.
3. *Low transaction costs.* If arranging the purchase of a commodity or service is, itself, a complex transaction, then the use of the market can be very costly and inefficient. The commonest solution in industry is the firm, which avoids these costs by internal planning and authority. The hospital is an obvious analogue.
4. *Adequate information.* If buyers are to exercise reasonable choices in a market of competing sellers, they must have knowledge about the product being sold. Advertising is intended theoretically to enlighten consumers on the merits of various competing products (although it has been found necessary to regulate to reduce biased or misleading information). Without clear and reliable information, how can "consumer sovereignty" be exercised to lead to selections of the "best" product?
5. *Absence of externalities.* A transaction entails "externalities" if people beyond the buyer and seller are directly affected by it. (With significant externalities, even pure competitive markets are seldom efficient.) Immunization is an obvious example; if one person is not immunized, many others may be harmed. Even if all the other conditions necessary for a competitive equilibrium hold, with significant externalities it will not be efficient.

These five conditions are not the only ones necessary for static efficiency of a competitive market, but they are sufficient to show the inapplicability of the concept to the health sector. On the other hand, free competition is often heralded for its *dynamic* efficiency, in leading to technological innovation. Adam Smith's invisible hand, some argue, is more important in this dynamic sense—that is, competition as the mother of invention, the stimulus to technological innovations and advances. However valid this may have been in the past, how true is it today? By far, the lion's share of scientific research is funded by government and philanthropy, not by competing entrepreneurs. In 1978, private industry supported 28 percent of the cost of health-related research, compared to 72 percent from government and philanthropy (5). The contribution to *basic* scientific knowledge from entrepreneurial research is doubtless smaller than 28 percent.

Before proceeding to empirical facts on free competition in the health sector, another word is necessary on the process schematized in Figure 1. By what mechanism does laissez-faire dynamics lead to competitive market equilibrium? In theory, with many buyers and sellers, those with a poor product or too high a price lose out and disappear. Competition supposedly weeds out the inferior sellers, until only those with an optimal combination of price and quality (for the consumer) remain. No one claims any harmonious efficiency during this period of disequilibrium, but it is commonly assumed to lead rapidly to efficient competitive equilibrium.

We have noted five conditions necessary for that outcome; if any one of these is absent, an efficient market equilibrium will not be reached. Instead, the injurious instability will persist, monopoly will emerge, a long-term contract may result, or an inefficient equilibrium may occur which misallocates health resources (each with its own persistent problems, as discussed below). Even if an efficient competitive equilibrium is attained, social equity still cannot be assured.

What, in fact, are the workings of free trade and competition in the medical market? To what extent do the operations of the market result either in the long run or the short run, in "quality control, price-setting, and resource allocation" that is "desirable" or optimal for achieving the best results for the individual and for society? What is the empirical evidence on the consequences of the free trade and competition model in the health sector?

The harmful effects of a social or socioeconomic idea can be reflected in two ways: first, by identification of actions taken by society to reduce those effects, and second, by recognition of problems that persist and have not yet been fully corrected. Below we offer evidence of the first type: adjustments found necessary to compensate for the ill effects of the free market over the past century.

ADJUSTMENTS FOR THE ILL EFFECTS OF FREE TRADE AND COMPETITION

One might offer scores of examples of social programs launched to intervene in the free market, insofar as its normal operations have yielded significant social problems. Many of these problems are perceived as failures to achieve social justice, or more specifically equitable response to the personal health needs of people. Some of the problems, as we will see, relate to economic waste; still others involve explicit harm to people.

Exposition of these social adjustments may be offered in accordance with the five conditions necessary for the effective operation of a free competitive market, as explained earlier.

The Need for Many Buyers and Sellers Freely Interacting

The ordinary medical care process is hardly conducive to comparative shopping by patients among many sellers of medical care. An essential requirement for effective doctor-patient relationships is long-term continuity in the linkage of the patient with a particular doctor; the very act of consulting another physician jeopardizes this relationship. Yet the initial choice of a doctor is often based on happenstances such as geographic location or a chance recommendation.

Little has been done deliberately to assure free interaction of many buyers and sellers of primary health care. An unplanned or spontaneous social adjustment, however, has been the great expansion of hospital "emergency" services, in response to the difficulties of patient access to ordinary primary care (6). In effect, the spiraling utilization of hospital emergency departments for non-urgent primary care has been an adjustment to the lack of adequate numbers of primary care doctors in American communities.

Perhaps a more deliberate adjustment to the sparsity of sellers of primary medical care has been the U.S. movement of the 1960s and 1970s to train substitutes for the general practitioner, in the form of physician assistants and nurse practitioners. It is noteworthy that other affluent nations with adequate supplies of generalists have not employed such a strategy (7). Many types of federally subsidized community health centers in poverty areas have been another American adjustment.

With respect to secondary care, specifically surgical operations, intervention to permit comparisons between sellers has been deliberate. Health insurance plans have introduced procedures for "second surgical opinions"—not to determine the lowest price bid, but to permit the patient to decide whether the surgery is truly necessary in the first place (8). Yet even this process has been opposed by medical societies as "interference in the doctor-patient relationship."

No Substantial Economies of Scale

The social adjustments induced by the clear existence of economies of scale and the associated "natural monopolies" have been numerous.

After discovery of the Salk vaccine against poliomyelitis, the restricted licensing of a few large pharmaceutical firms to produce the vaccine was done in obvious recognition of the economies, as well as quality controls, in such restriction of competition. The same policy is pursued with respect to production of all vaccines in many capitalist countries, not to mention the socialist countries.

In organized health care settings, the irrationality of the competitive free market model has long been evident. Hospitals, for example, continue to make exclusive contracts with radiologists and pathologists, even though this bars competition in these specialties (9). Without such contracts, hospital care would be less efficient and even more expensive than it is. The same basic concept of structured "closed staff" hospitals has been found to promote efficiency and quality for *all* specialty services in general hospitals throughout most of the industrialized world (capitalist and socialist) (10).

In normal comprehensive health planning, the implementation of "certificate of need" legislation to authorize new hospital construction is an obvious recognition of the value of restricting competition due to the benefits of natural monopoly (11). Quite aside from the wastefulness of superfluous hospital beds generating unjustified utilization (see below), multiple small facilities in a community are more costly and less effective than a larger integrated facility. Similar policies govern the authorization of new pharmacies in an area, even in an entrepreneurial nation like Belgium (12).

Low Transaction Costs

The bewildering complexities of the medical care system have induced all sorts of adjustments to the high costs of the whole transaction process.

Group medical practice is one such adjustment (13). Over the last 40 years it has grown rapidly, as an adjustment to the complexities caused for the patient by specialization in medicine, and in spite of its reduction of competition. Thus, a reduced choice of specialists is traded off for the benefits of professional teamwork and greater convenience for the patient. The elaborate integrated mechanism of the general hospital is also, of course, an adjustment to the economic and logistical monstrosity that would result if each of the hospital's hundreds of services were to be sold as a separate market transaction.

The operations of virtually all programs of organized health care delivery are further demonstrations of the high cost and inefficiencies of multiple separate transactions. This may be illustrated by governmental health programs from the magnitude of the Veterans Administration 175-hospital network down to a Health Department prenatal clinic in one small town.

Consider the transaction costs involved in the rehabilitation of a patient with a serious disability. His needs for physician services, drugs, hospitalization, physical and occupational therapy, perhaps prosthetic appliances, occupational retraining, job placement, and much more are bewildering. The process is so complex that highly directive vocational rehabilitation programs have had to be organized in all states, under which "vocational rehabilitation counsellors" cut through the complexities and make decisions for the patient, rejecting the competitive process with its high transaction costs.

Adequate Information

The deficiencies of information available to the consumer are perhaps the most widespread obstacles to the efficient operation of a free health care market. A catalog of all the social adjustments stimulated to cope with this problem would be very lengthy, indeed, and only a few can be cited.

Free competition gave rise to countless numbers and types of unqualified practitioners, particularly with the growth of cities in 19th-century Europe and America. How could the average consumer be expected to distinguish the knowledgeable physician from the imposter? Licensure in medicine (and later other professions) was the solution adopted throughout the world, even though it clearly reduced competition (14). Such restriction of the free market was preferable to the tragic consequences of treatment by charlatans.

But even licensure has been an imperfect solution in the United States, as state legislatures, clinging to free market concepts, have licensed chiropractors in almost every state; this is not merely to treat vertebral disorders (for which there may be limited justification), but to handle every type of disease (15). Moreover, medical licensure laws have been widely misused, to protect the "competitive position" of existing practitioners rather than to safeguard consumers. Yet no state has been willing to risk the disasters that might follow from revoking licensure legislation. Instead, licensure boards are being reconstituted to include consumers as spokesmen for the public interest (16).

Some have looked upon professional licensure and similar forms of regulation as a strategy for prohibiting innovation that might be sound. They point to the long history of opposition to new ideas by orthodox medicine—opposition to smallpox

vaccination, to the infectious cause of "childbed fever," and even to the pasteurization of milk (17). The negative American attitudes today about the use of trained midwives for normal obstetrical deliveries or of New Zealand-type "dental nurses" for the care of children are put in the same class. But the latter types of health personnel are, in fact, productively used in dozens of countries. Their non-acceptance in the United States is not caused by regulation but by the political effectiveness of the medical and dental professions in suppressing competition. When and if public pressures are mounted to change the licensure laws, these reasonable types of health personnel will be licensed in the United States, as they are elsewhere.

The countless tragedies from misinformation—often deliberately false claims—about drugs make a long and distressing saga. In the United States at the end of the 19th century, the unfettered free market was particularly adventurist; among other things, drugs were manufactured, labelled, and sold with complete abandon. The result was enormous deception of people by grossly false claims on packaged medications, with resultant waste of millions of dollars and doubtless thousands of lives. In response, the U.S. Congress passed the first Food and Drug Control Act in 1906, greatly restricting the free market in drug production and sales. It took additional tragedies in 1939 (scores of infant deaths from a lethal "elixir" of sulfanilamide) and in 1962 (hundreds of limbless babies born to mothers taking "thalidomide") to bring further tightening of drug control legislation against the abuses of competitive free enterprise in the U.S. pharmaceutical industry (18).

The workings of hospitals have long been far too complex to be evaluated by the average patient, even by the average community physician. Many facilities lacked proper laboratories, surgical equipment, or nursing staffs, but how was the outsider to know? In response, non-governmental action was taken first in 1919; this evolved into the Joint Commission on Accreditation of Hospitals in 1952 (19). Thus, information about hospitals is provided to potential users (or buyers of hospital service) through an emblem of approval, in spite of this indirect interference with free competition for the patient's patronage. Even so, an emblem of quality may not protect the consumer, since the hospital is ordinarily chosen not by him but by the doctor—who may (and often does) have his own reasons for selecting a non-accredited facility.

Absence of Externalities

In the health sector, externalities abound with particular force. Each person's health status affects the health and welfare of everyone else. As a practical matter, therefore, nations at all stages of capitalist development have taken actions to assure the distribution of health care quite outside the mechanism of a free competitive market. One may not always appreciate the abandonment of *laissez-faire* dynamics that these actions constitute.

The rise of insurance for health care—first voluntary, later mandatory—was an early response to recognition of the societal importance of assured medical care at times of need. In the 19th century, as medical care became a market commodity (available only from charitable sources for the very poor and destitute), mutual insurance societies grew up in Europe to pay doctor bills for low-wage workers. Eventually in the 1880s, Germany enacted a law mandating "sickness insurance" for low-wage workers, and launching the concept of social security. Both the private and public forms of health

care insurance spread to many other countries (20). Not until 1965 did the United States enact any social insurance for general medical care, limiting it to the aged. Mandatory or social insurance constitutes a major adjustment to the problems of the free market ideology (21). To a lesser extent, the same is true of voluntary health insurance. By spreading sickness risks over many people and over periods of time, the constraints of price on individual demand, when sickness strikes, are greatly reduced; the degree, of course, depends on the nature of copayments, deductibles, and other "cost-sharing" requirements that may be imposed (22). Prevention of insurance "abuse" by either patient or doctor—the so-called "moral hazard" of insurance—engenders all sorts of surveillance and policing in any insurance program. With all their weaknesses and faults, which are many, both voluntary health insurance and Medicare for the aged mollify the worst effects of the classical market mechanism in the distribution of medical care (albeit through introduction of another market for insurance).

To provide medical care for the poor—for those without even the low but stable incomes adequate for insurance—other adjustments have long been made. General revenue support of the U.S. Medicaid program is only the latest in a long saga of social measures to finance needed medical care that poor people were unable to purchase in the free market (23). Parliamentary governments could ignore the brutalities of a market price for all care of the sick only at the risk of deaths in the street, mass rebellion, and social revolution. Compromising the free medical market, with tax-supported health care for the poor, was a much more prudent solution taken throughout the world, if only to maintain social order. The introduction of social security under Bismarck was not designed to extend democratic rights and liberties, but rather to weaken the rising socialist movement among European workers (24).

The entire field of preventive medicine and public health has developed out of recognition of the crucial "externality" that each person's health care affects the well-being of all others. This has long been obvious for immunizations and other measures of communicable disease control; compulsory vaccinations, isolation, and quarantine have been implemented for centuries. Although less obvious, the same principle applies to health education on behavior to reduce the risk of chronic noncommunicable disease. We need not fall into the trap of blaming the victim for his "life style" in recognizing the importance of social measures (e.g. bans on cigarette advertising) to discourage harmful habits (25). Such social measures must operate not only outside the arena of free trade, but even as a frontal assault upon it.

These specific adjustments to the ill effects of a free market in the health sector may constitute enough empirical evidence of its grave inadequacies as a means for reasonable allocation of resources in society. All five of the conditions necessary for the market to serve as an efficient distributive mechanism are seriously lacking.

But the ill effects of free trade and competition in the health sector are shown in other ways. Returning to the process modeled in Figure 1, one must recognize the development of monopoly/oligopoly on the one hand, and semi-market contractual arrangements on the other—channels of development that do not even lead theoretically to competitive market equilibrium.

OTHER OUTCOMES OF FREE TRADE IN HEALTH CARE

The obstructive and anti-social rise of monopoly in the health sector has occurred again and again. Actions taken in response to this problem have led, in turn, to injurious secondary effects.

The U.S. pharmaceutical industry has engaged repeatedly in collusive price-fixing in restraint of trade. Convictions, such as that achieved for pegging the price of antibiotics to yield superprofits to several major firms after World War II, were widely publicized (26). But such exposure of monopolistic practices is probably only the iceberg seen above the water. Is it not significant that the U.S. pharmaceutical industry has long had the highest rate of profit of any type of enterprise (27)—higher than the steel industry or the manufacture of computers?

Medical societies have long used "ethics" as a constraint against development of innovative patterns of medical care delivery. Their strategy has been essentially monopolistic. Agreements among producers to stifle innovation sabotaged the ability of competition to regulate the whole free enterprise system.

There were other more subtle ways, however, that private physicans could block the development of competitive new patterns of health care delivery, designed to give consumers a better deal. Consumer cooperatives getting their medical care through group practice clinics constituted one such pattern; doctors in these clinics could be barred from admitting their patients to community hospitals, dominated by private solo practitioners. Exactly such a tactic was used by the Medical Society of the District of Columbia, along with the American Medical Association, in an attempt to destroy the Group Health Association of Washington, D.C., in the 1930s. It took legal action in the courts to stop this assault on competition from new health care ideas, resulting in the 1943 conviction of the AMA for "criminal conspiracy in restraint of trade." (28) In spite of this watershed decision, medical societies continue to apply social ostracism and other subtle strategies against physicians who would deviate from the status quo of private fee-for-service medical practice.

The development of long-term contractual arrangements under free trade in the health sector has taken several forms. While constituting partial departures from conventional market arrangements, each of these mechanisms has generated secondary problems, which in turn require regulatory controls.

Recognition of broadly accessible health care as sound social policy led to the rise of health insurance—first voluntary and then mandatory—as discussed earlier. Insurance overcame the obstacles to accessibility erected by market prices for medical care; but, in the absence of regulation, it generated much unnecessary service to enhance the earnings of doctors and hospitals.

In reaction to this abuse—that is, a serious flaw in the very mechanism (health insurance) designed to adjust for the inequities caused by the free market—numerous corrective adjustments have become necessary. In most countries official fee-schedules for medical services have been established, freezing price competition, and in the U.S. Medicare program various constraints have been put on the determination of "reasonable, customary, and prevailing" doctor fees. Under 1972 law, PSROs (professional standards review organizations) were set up throughout the nation to monitor the propriety of all services in hospitals financed by both Medicare and Medicaid (29).

It has also been found necessary to establish a federal Office of Fraud and Abuse, to cope with professional misconduct. Thus, socially planned insurance, organized to assure accessibility to health care, generates secondary problems, unless the economic freedom of vendors is regulated.

Health maintenance organizations (HMOs) are the most recent striking expression of a diversion to long-term contractual arrangements, in response to free market problems. The HMO is basically a strategy for complete removal from the orbit of the market of a population of patients and health care providers. Buyers and sellers make an agreement, a fixed-price contract, for future delivery (usually for one year) of needed medical care. This mechanism has been found to be so effective in controlling the cost escalations of the free medical market, that in 1973 federal legislation was enacted to promote it (30). The growth of HMOs has been slower than some had hoped; the reasons are many, but a major one is doubtless the opposition of private medical entrepreneurs precisely because the HMO constitutes such a departure from free market dynamics. It greatly modifies the profit incentives to maximize sales. Moreover, the HMO is regarded as an incursion on physician freedom and a first step in a broader assault on the medical market.

At the same time, HMOs have not been an unmixed blessing; they have given rise to new forms of abuse. In the early 1970s, to reduce medical care expenditures for the poor, California and certain other states actively encouraged the establishment of HMOs for Medicaid-eligibles. But these "prepaid health plans" (PHPs) were allowed to operate without any official standards; as a result dozens of unscrupulous organizations were formed, giving seriously deficient services (31). With fixed monthly payments from the state government assured, the PHPs gave grossly inadequate ambulatory as well as hospital care; an indigent patient would have to be at death's door before he was admitted to a hospital. It took widely publicized evidence of scandalous medical neglect or fiscal abuses to lead to new state regulation of these Medicaid HMOs. Only after this corrective action were the corrupt HMOs eliminated (32).

Others have spoken glowingly of the HMO as the crucial strategy for achieving the benefits of free competition in the U.S. health care system (33). The fundamental merit of the HMO concept is, in fact, its modification of the usual profit motive of maximizing the sale of medical services, toward an opposite motive of minimizing services—presumably through "maintenance of health." But the dynamic is far more complicated than this, and the potential for abuse is enormous, as shown in the California experience.

The allegedly effective competition among several HMOs in one midwest metropolitan area has been widely acclaimed (34). Its replication elsewhere or, indeed, its continued integrity in Minneapolis may be reasonably expected only if cautious state regulation and painstaking consumer education prevent the abuses experienced in California in the 1970s. (It is relevant that Minnesota's current statutory regulation of HMOs is especially rigorous.) Regulatory safeguards would be needed against still other potential abuses in "selection of risks" or "preferential pricing," which have long caused inequities in the commercial insurance industry (35). Whether the burden of public regulation necessary to assure equity and efficiency—under a system of HMOs competing with each other and also with other health insurance programs—would be less than under a wholly planned health care system, is very doubtful.

UNSOLVED PROBLEMS OF THE FREE MARKET

Beyond all the evidence of free market failure, reflected by the many adjustments stimulated in response, there are a host of persistent problems on which little action has been taken or the attempted corrections have been ineffective. Only some of the most prominent of these unsolved problems need be briefly noted:

High and endlessly rising costs of medical care are probably the most prominent unsolved problem in the whole contemporary health sector (36). Several of the adjustments just reviewed have been directed to cost controls, but expenditures continue to mount. Some traditional economists argue that the regulatory constraints on competition are the *cause* of cost escalations–as though the many inherent obstacles to a free competitive market in health services, reviewed above, did not exist. The numerous imperfections of the competitive process in the health sector have not been sufficiently corrected by regulation, on the one hand, nor replaced by systematic planning, on the other. Prospective global budgeting of hospital operation, for example (not to be confused with prospective *per diem* reimbursement), is not implementable in the current pluralistic American health economy. It is these realities of halfway regulation, combined with halfway competition, that yield inflation of health care costs.

While professional licensure has eliminated the worst chicanery from the medical care market, it has not gone far enough. Disciplinary actions taken against even grossly incompetent doctors are notoriously weak. The beginnings of mandatory continuing education, enforced by requirements for periodic relicensure of pharmacists, physicians, nurses, and others in a few states, point up the need for great extension of such policies (37).

Excessive medical, and particularly surgical, specialization in America has led to many difficulties, most prominently a serious shortage of primary care doctors. Under the Health Professions Educational Assistance Act of 1976, training grants have been designed to favor residencies in primary fields of medicine. Much more is needed, however, to assure the appropriate access of everyone to a continuing and reliable source of primary health care (38).

Geographic maldistribution of physicians and other health personnel–causing serious handicaps for rural populations–is a problem plaguing the health care system of every capitalist nation. While many factors account for this problem, the operation of the free market is important among them; most rural people are relatively poor and lack the purchasing power for proper medical care. Many countries have coped with this by scrapping market mechanisms, and requiring a period of rural service from all new medical graduates. Norway has its highly developed "district doctor" system, and the United States has its modest "National Health Service Corps." (39) Far more powerful measures are needed, if this major inequity of the free medical market is to be corrected.

Permeating the American free market in health services is the paradoxical problem of "supply creating demand"–fundamentally because the seller (doctor) rather than the buyer (patient) makes most of the decisions on the health services to be obtained and paid for (40). The problem has been most conspicuous with respect to hospitalization and its spiraling costs, and yet one wonders why it took until the late 1950s to recognize the dynamics.

As the rise of U.S. hospital costs accelerated in the 1950s, attention became focused on possible "overutilization." It was charged that, because insurance had eliminated the constraints of price, patients were "abusing" it and consuming more hospital days than needed. One would have thought patients could check into a hospital, as into a hotel. Studies at Cornell's Institute of Hospital Administration, however, showed that—with almost any ratio of hospital beds in a community, high or low—doctors managed to keep those beds filled at about the same occupancy level (41). As a result, New York State enacted in 1964 the first "certificate of need" law to control hospital bed supply. Soon many other states did the same, and federal law in 1974 made such regulation virtually nationwide (11). What a strange commentary on the operations of the free market model of supply, demand, competition, and price! Excess supply did not bring down the price, but caused greater overall expenditures.

Indeed, excess hospital beds have resulted not only in higher rates of patient-day utilization, but even higher costs per day, as competing hospitals acquire superfluous technology in order to attract doctors. How can more CT (computerized tomography) scanners be justified in Los Angeles County (some 65 units for a population of 7,000,000) than in all of Great Britain (population of 55,000,000) where the machine was invented? (42). The low point in hospital enticements to doctors may have been reached in May 1980, when evidence was disclosed that a supposedly prestigious institution, with low bed occupancy, was operating a "call girl service" for doctors, to induce them to admit patients (43). Legal prosecution, of course, was necessary. With respect to CT scanners or excess hospital beds, planning agency decisions—hardly distinguishable from regulation—are necessary to control the extravagances of the free market in hospital care. Not many states, however, have been as forthright as Michigan, in passing legislation to deliberately reduce excess hospital capacity (44).

Evidence that supply creates demand has now accumulated for every component of the health care industry, not only for the use of hospital beds (45). Surgeons create "demand" for surgical operations, the benefits of which are far from established (46). In Canada, the in-migration of foreign medical graduates was stopped a few years ago when it was learned that each new physician meant an expenditure of some $300,000 —about 40 percent for his own gross income and 60 percent for the hospital and other secondary services that he generated. Similarly, a steady increase in the U.S. doctor-population ratio has led not to any decline in prices, but to a rise in aggregate expenditures.

Partial or half-way planning leaves many problems unsolved. Thus collectivized financing along with entrepreneurial delivery of service creates enormous problems in surveillance of quality and expenditures. For reasons explored earlier, insurance, taxation, and other third-party sources of finance have been mobilized everywhere to help achieve health care equity. At the same time, everyone agrees that third-party payment inevitably dulls or eliminates both the doctor's and the patient's sensitivity to price. Such social financing, nevertheless, is quite properly designed to facilitate the seeking of health service in the first place. Thus, for the lion's share of total health care costs now supported by third parties, the free market has already been largely abandoned (47). Yet, monitoring medical care fee claims under third-party financing programs is enormously difficult and seldom effective.

Within the field of health insurance, insofar as competition operates among carriers,

its effects have promoted inequity. The commercial insurance practice of "experience-rating"–decreasing premiums for the young and healthy, and increasing them for the aged and disabled–has forced the non-profit insurance plans to follow suit or lose their enrollment (48). The only solution to this perverse dynamics would be a system of universal social financing, within a framework of either enormously regulated competition or systematic social planning.

Zealous devotion to concepts of the free market and competition has led to the rejection of "ethical" bans on medical advertising (49). The importance of consumer accessibility to complete objective information is one thing; freedom of advertising is another. Even with the utmost scientific effort, evaluation of either the "process" or "outcome" of health services is extremely difficult to carry out, let alone to report lucidly. Take note of the limited impact of the U.S. Federal Trade Commission on the advertising of so-called "ethical drugs"–as revealed each month in the highly authoritative *Medical Letter on Drugs and Therapeutics*–in spite of the relatively broad powers vested in government by the Food, Drug, and Cosmetic Act. Objective information should be broadcast by government or some neutral body, not by parties obviously trying to sell their own particular products. Are we to welcome to the health care industry the skillful distortions with which advertising has glamorized cigarette smoking, liquor consumption, and other garden paths to disease and death?

Inadequate consumer information persists in plaguing a free market health care model, despite the most earnest efforts to ameliorate it through education. To the extent that a patient may have an impact on the doctor's decisions, he must be inordinately knowledgeable. Even if he or she is, it is rare for the patient to prevail over the judgment of the doctor. Not many patients are as sophisticated as Norman Cousins who, aided by a physician of exceptional humility, cured himself of an incurable disease (50). For every Mr. Cousins, there are thousands of other patients whose non-compliance with their doctor's prescription of anti-hypertensive drugs, for example, leads to fatal strokes.

The problems arising from the complexity of medical information, beyond the understanding of the vast majority of consumers, can be tragic. The choice of a faulty product (e.g. an incompetent doctor) may be prolonged disability or death. Rapid technological change creates new information requirements almost daily. If new drugs could freely enter the market each week, there could be endless human tragedy and waste as consumers tested each product. (Regulation, of course, has been necessary to bar this.) Even after a product has been purchased and consumed, how can the consumer judge its value? Health outcomes depend on many environmental, genetic, and other factors outside of medical care.

Market mechanisms may achieve reasonable distribution of some luxury goods and services, such as fancy clothing or night-club entertainment, but they cannot be expected to work soundly for health care. Regarding services accounting for 80-90 percent of health care costs, decisions in the last analysis are made by the doctor, not the patient. How can one expect *consumer* preferences to govern the flow of products in the medical market (51)?

Finally, one need only take note of the magnitude of "unfinished business" faced by the nation's 212 local health planning agencies, to recognize the enormity of health deficiencies remaining in the free market of health care. It has not been excessive regulation, but the consequences of the free market that led to establishment of Health Systems Agencies as mechanisms to cope with excess general hospital beds,

health care cost-containment, emergency medical services, environmental health protection, perinatal intensive care, and rehabilitation services—to name only some of the problems recently identified in the planning of one local HSA (52).

Health planning (national and local) constitutes, after all, a series of interventions in the free market of health care, designed to correct its many failures.

IN CONCLUSION—SYSTEMATIC SOCIAL PLANNING OF THE HEALTH SECTOR

We trust this is enough of a recitation of the failures, distortions, wastages, and human inequities of the free market in health care to clarify our reasons for rejecting it, and preferring a strategy of *systematic social planning.* The failures of a free market in health care to achieve effective allocation of resources for meeting the needs of populations have been gigantic. Some entrepreneurial voices even reject as "naive" the very concept of *needs*, and wish only to consider "effective demand" in a market. Yet, the market has not been completely abandoned in capitalist nations, only because countless corrective measures have kept patching it up.

Entitlement to health care, unlike most other goods and services, has come to be recognized throughout the world as a "universal human right." (53) The rationale is both humane and pragmatic. To implement its distribution, one cannot be satisfied with a free market mechanism that treats health care fundamentally as a commodity to be produced for profit and sold. A pig trough philosophy of access has been rejected. The incompatibilities between these two concepts of health care—as a commodity for sale versus a basic right—are overwhelming.

In broad terms, an agenda for a systematically planned health care system is not difficult to summarize: (a) universal population coverage; (b) comprehensive services, based solely on need; (c) emphasis on prevention through integration with treatment; (d) health personnel trained at public expense to serve in coordinated teams; (e) health facilities public and regionalized; (f) quality regulated through built-in organizational structure (rather than external surveillance); and (g) fully collectivized financing (54). In a word, a planned social system would replace the vagaries of the competitive medical market. Consumer choice would not disappear (e.g. for Doctor A rather than Doctor B), but it would be constrained by conditions under which one person's choice does not thwart reasonable response to another person's need.

The way of science, which matured only after the days of Adam Smith, has far more effective strategies to offer, both along the biological and the social dimensions of health care. Health services can be effectively distributed not by the tools of price or non-price competition, not on the basis of personal affluence, geographical location, social position, educational sophistication, or any other of the features on which free market dynamics depend. The production and distribution of health services can be based on their scientifically demonstrated value and on the differential needs of each human being (55).

The strategies required to construct a soundly planned health care system are not simple, nor free from the possibilities of error. Each of the above seven attributes of such a system requires vast information and sophisticated judgment in the arena of

both economics and politics. If one prefers an option of modifying the free market, however, the requirements for regulatory intervention are no less—if efficiency and social justice are to be attained. Programs of this sort, formulated by Alain Enthoven (33) and others, would require elaborate administration and constant regulation. These complex issues and options must be discussed, but the issue before us is the past and present medical markets. We believe it can be demonstrated that deliberate and systematic social planning of the health services can be more effective, less subject to the evils of corruption and inequity, than the most judiciously regulated model of the free competitive market. The lessons of history on the perverse social consequences of the pursuit of individual self-interest in the health sector are abundant. The human and social benefits of rational scientific health planning are demonstrable throughout the modern world.

In this paper, we have addressed the ascending wave of opinion in the United States that current difficulties in the health sector arise from "too much" regulation, and that the path to efficiency and justice lies in uninhibited competition and free trade. An objective assessment of past experience, we believe, points to a path in exactly the opposite direction.

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DOCUMENT NO. 83-44

February 1, 1983

Dave Palmer
Legislative Assistant
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Juneau, Alaska 99811

Dear Mr. Palmer:

Enclosed, per your request, are several publications on the topic of certificate of need. These include:

- A Study of Intermediate Outcomes of the CON Review Process - a final report by the Arthud D. Little Co.
- "Certificate-of-Need - No Panacea but Not Without Merit" by William H. Rosenberg
- "The Social Consequences of Free Trade in Health Care: A Public Response to Orthodox Economics" by Milton I. Roemer and John E. Roemer
- Regulating Hospital Capital Investment: The Experience in Massachusetts - an NCHSR publication

Our library and files contain many other materials and reports which you are welcome to review at your convenience.

When I receive a final copy of the "Briefing Paper on Certificate of Need" which is being prepared by the ALPHA Center, I will be happy to send you a copy.

Please let me know if we can be of further assistance.

Sincerely,

Phoebe A Lindsey

Phoebe A. Lindsey
Director

Enclosures (4)

Regulating Hospital Capital Investment: The Experience in Massachusetts

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Abstract

This study examines hospital capital investment among Massachusetts short-term general voluntary hospitals between 1967 and 1976, and assesses the impact of Certificate of Need (CON) regulation. A profile of capital expenditures for fiscal years 1967-1976 was developed from Massachusetts Rate Setting Commission data for 26 sample hospitals, stratified by teaching status and Boston versus non-Boston location. Case studies were conducted in nine sample hospitals to explore the determinants and consequences of major capital projects undertaken by the institution. Enormous capital expansion took place from 1967-76. Hospitals in areas of rapid population growth significantly increased their bed size; other hospitals replaced or modernized inpatient facilities, and expanded ambulatory care capacity. All hospitals significantly expanded their ancillary service capacity. With respect to the impact of CON regulation, the evidence revealed that by 1976 and beyond, CON review had reduced all dimensions of project scale and cost by as much as two-thirds of [illegible] proposed

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Broadly speaking, certificate of need laws are grounded on the assumption that a primary reason for spiralling health care costs lies in the existence of duplicative and inappropriate facilities and services. To avoid perpetuating this problem, it is necessary to curtail the construction of new facilities and the provision of new services unless they can be shown to be needed. The rationale for certificate of need is compelling. However, there are many who doubt that the substitution of a regulatory mechanism for an admittedly imperfect market mechanism will improve the situation. On the other hand, it is the failure of the market system, embodied in the so-called "Roemer effect" which posits that the existence of hospital beds creates a demand for them, that certificate of need programs are designed to correct. How well these programs work is still an open question.

This report presents a summary of Ph.D. dissertation research supported by the National Center for Health Services Research. The study examines in detail hospital capital investment undertaken by Massachusetts short term general hospitals between 1967 and 1976. Patterns of capital expansion are compared for teaching versus nonteaching, and for Boston versus nonBoston hospitals, and special emphasis is placed upon assessing the impact of certificate of need legislation. It is hoped that this report will contribute to our understanding of the regulatory process and the reactions of those who are involved.

Gerald Rosenthal, Ph.D.

March 1981

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During the past decade the rapid and continuing increase in the costs of medical care has emerged as a major health policy issue at all levels of government. Leading the health care cost spiral has been the acute care hospital sector; expenditures for hospital services constitute the largest portion of total health care spending, 40 percent in recent years, account for more than half of the government share, and since the enactment of Medicare and Medicaid in 1965 have risen almost twice as fast as outlays for other categories of medical care.[1] Most efforts to curb the increase in health care costs have therefore been focused on acute care hospitals.

Analyses by several different investigators have now established that approximately half of the total increase in hospital costs since 1960 has been attributable simply to inflation – that is, to the increase in the wages and prices in the hospital sector that would have been required simply to produce the same level of service over time. The remainder of the increase, however, stems from the inexorable growth in the sophistication of labor and non-labor inputs required to produce the ever more complex services that now comprise a hospital admission or "patient day".[2,3] Capital expansion – the construction of new facilities, the addition of new beds and services, and the investment in new "equipment-embodied technology" – has long been recognized as one of the major vehicles through which the intensity of hospital care is increased. As a result, the creation of mechanisms to limit capital investment by hospitals, and particularly the enactment of Certificate of Need (CON) regulation, have received early and continuing prominence in state and federal government strategies to contain rising health care costs.[4]

Despite the importance of hospital capital expansion and of Certificate of Need, neither the factors influencing hospital capital investment nor the impacts of CON upon them have been examined in detail. Not even the actual composition and patterns of hospital capital expenditures over time have been de-

termined because the sources of readily available data are too aggregated to reveal any but the most obvious changes in total beds and total investment. Yet an understanding of the nature and determinants of hospital capital expansion is essential to the evaluation of the impacts of current regulatory mechanisms and to the design of more effective strategies to shape future investment.

This study was conducted to fill some of the gaps in current knowledge about hospital investment behavior and its response to regulation. Previous investigations either examined hospital capital expansion or attempted to evaluate the process and outcome of Certificate of Need. By contrast, this study employed a design that combined an in-depth analysis of the amount and composition of capital investment across the whole voluntary hospital industry in one state, both before and after the introduction of CON regulation, with an examination of the implementation of the CON program itself and of the changes in the nature of hospital investment resulting from the presence of CON. Study findings, therefore, offer insights into the dynamics of hospital capital expansion and the impacts of CON that previous work could not provide.

The study focused on short-term general non-government nonprofit (i.e. voluntary) hospitals in Massachusetts over the period Fiscal Years 1967-76, five years prior to the enactment of CON regulation in the Commonwealth on November 15, 1971, and five years following CON implementation, and addressed the following major sets of questions:

- Is there a basic pattern of investment followed by all hospitals or by certain categories of hospitals, such as teaching versus nonteaching institutions? In particular, how frequently does investment in beds occur and is there a relationship between investment in beds and investment in ancillary services?

- What are the incentives, opportunities, and constraints that have governed a hospital's choice of investment projects? Have these determinants varied by type of hospital and/or time period?

- How much of hospital capital expenditure falls under the aegis of CON review and what, therefore, is the potential of this mechanism to limit future capital expenditure?

- What is the lag between the introduction of CON regulation and the time that capital expenditures reviewed by CON first appear in a hospital's asset base? When, therefore, can CON impacts be appropriately examined using "ultimate" outcome

measures focused on the amount and composition of hospital investment? What measures of more "intermediate" outcomes can be used to evaluate CON performance in the interim?

- How have the Certificate of Need program, the prospective reimbursement programs of the Rate Setting Commission, and the broader planning efforts under P.L. 93-641 affected hospital investment behavior in Massachusetts? What changes in current regulatory policies and procedures might establish more binding constraints on hospital capital expansion?

TABLE 1: Sample composition and its determination using optimal allocation

Stratum	Stratum size (N_h)	Stratum standard deviation [1] (in Thousands) (s_h)	Sample size (n_h)
Major teaching	10		5
Boston	7	$7,100	3
Non Boston	3	6,200	2
Lesser teaching	7		4
Boston	5	8,900	3
Non Boston	2	6,700	1
Limited teaching	5		2
Non Boston	5	6,800	2
Nonteaching	73		15
Boston	18		4
≤ 100 Beds	6	130	2
> 100 Beds	12	1,240	2
Non Boston	55		11
≤ 100 Beds	14	1,600	2
101-200 Beds	18	1,900	2
> 200 Beds	23	5,900	7
Total	95		26

[1] Standard deviation of Certificate-of-Need approved capital expenditures 1972-76 as estimated from Massachusetts Determination of Need Program Information System

Optimal Allocation Formula (with equal cost of sampling for each stratum):

$$n_h = \frac{n N_h s_h}{\sum_{l=1}^{L} N_h s_h}$$

n = total sample size
n_h = sample size in the hth stratum
N_h = population in the hth stratum
s_h = standard deviation in the hth stratum

From public information available in the files of the Commonwealth of Massachusetts Rate Setting Commission, data were collected on the annual capital expenditures over the period FY 1967-76 made by each sample hospital in total and in the following categories: land, "plant" (including building, building improvements, and fixed equipment), and major movable equipment (MME). Data on asset values at historical cost and accumulated depreciation were also collected for Fiscal Years 1966, 1971 and 1976.

For all "projects" that involved total expenditures of $100 thousand or more (current dollars), the introduction of a major new ancillary service, or the addition of 4 or more beds, information was then obtained on the specific changes in hospital facilities and services that resulted from these investments: number and types of beds added or renovated, number of square feet added or renovated, ancillary service changes, etc. Data from the Rate Setting Commission, the Massachusetts Department of Public Health, the Massachusetts Determination of Need Program (as Certificate of Need is officially known in Massachusetts), and the sample hospital itself were combined to provide the necessary

Methodology

This study was designed to combine a statistically valid quantitative examination of capital investment among Massachusetts voluntary hospitals with a more qualitative case-study investigation of the factors that shaped the amount and composition of this investment. The design was developed because the combination of quantitative and qualitative analyses could yield complementary insights into hospital capital investment and the impact of Certificate of Need upon it that neither approach alone could provide. The quantitative analyses could offer a basic profile on the amount and composition of capital expenditure over time and on variations in the pattern of investment among hospitals of different teaching status and geographic location. Against this background, case-study analysis of selected institutions and specific investment projects could then offer information on the motivations underlying a hospital's capital program, the decision-making process surrounding capital expansion, and the consequences resulting from it. The conduct of case studies could also provide an opportunity to explore perceptions of CON and its effects held by individuals involved with hospitals in a variety of different capacities.

Development of the capital expenditure profile

The 95 short-term general voluntary hospitals in Massachusetts were stratified by Boston versus non-Boston location (with "Boston" defined by the boundaries of Health Services Area 4) and by teaching status: major teaching, lesser teaching, limited teaching, and nonteaching. Nonteaching hospitals were further stratified by bed size into those with 100 or fewer beds, 101 to 200 beds, and more than 200 beds. All teaching hospitals had at least 200 beds and therefore did not have to be further classified according to total bed complement. A random sample of 26 hospitals was then selected, using the technique of optimal allocation to determine the number of institutions to be drawn from each cell (Table 1).

detail. For projects approved by the Determination of Need Program, information was also obtained on changes in design, scope, and estimated cost that resulted from the process of CON review.

Data on the amount of capital expenditures, in total and for "plant" and MME considered separately, were used to examine general differences in capital investment by teaching status, geographic location, and time period. Because hospital accounting conventions recognize a capital expenditure only at the time the asset is first put into service, a hospital's capital expenditure profile is quite "lumpy" if examined on an annual basis. Therefore, total and average annual expenditures over the "pre-CON" period of 1967-71 versus the "post-CON" period 1972-76 were analyzed instead. In order to eliminate the effects of the considerable inflation in capital costs that occurred during the study period, all expenditures were converted to constant 1967 dollars using deflators derived from two indices employed by the Rate Setting Commission (RSC) to determine price-level depreciation: the Marshall and Stevens Class B Eastern Index for plant and an index for major movable equipment developed specifically for Massachusetts hospitals by American Appraisal Company at the request of the RSC.

Within the basic "picture" of hospital capital investment established by the expenditure data, "project" data were then used to determine more specifically the nature and composition of investment. Eight project categories were defined, and particular attention was focused on exploring variations across time and hospital type for "major bed projects" (i.e. new buildings or wings constructed by hospitals that included at least 20 inpatient beds), projects devoted to ancillary services and/or ambulatory care, and projects devoted to research. These project categories proved most important in institutional development strategy over the study period for all types of hospitals examined.

Conduct of case studies

Case studies were designed to elicit information on the course of institutional development among different types of Massachusetts voluntary hospitals by using a specific capital project or group of projects completed by an institution to focus discussion. This approach was chosen to assure that the same set of decisions and outcomes would be discussed with different "actors" in a hospital and to allow interviews to probe concrete details surrounding an actual capital investment as well as more general issues of

institutional development. All but 3 of the 26 sample institutions had either completed major capital projects during the study period or had submitted applications for such projects for CON review during this time and, therefore, were considered candidates for case-study. Ultimately, 9 institutions were selected representing the range of teaching status both in Boston and the rest of Massachusetts. In each case-study hospital, extensive interviews were conducted with the director or associate director, the chief financial officer or one of his principal assistants, a senior member of the board of trustees, the current or past president of the medical staff, and either the Chief of Radiology or Chief of Pathology. Selected other members of a hospital's administration, board, and medical staff who had played particularly important roles in the institution's development and who were identified during the course of discussion with the hospital director were interviewed as well. In order to gain some insight into the development of the three sample institutions that had made only limited capital investments during the study period, the director or associate director of two of these hospitals was interviewed as well.

Extensive interviews were also conducted with various members of the staff of the Massachusetts Department of Public Health to obtain information on the structure, function, and evolution over time of the Determination of Need Program and with staff of the Rate Setting Commission to clarify details of the prospective reimbursement system the Commission is developing for Massachusetts hospitals.

Findings

Both the capital expenditure analyses and case study findings revealed that Massachusetts voluntary hospitals experienced dramatic changes in the scale and scope of their operations during the period under study. Further, an appreciation of these changes and the forces underlying them proved essential to correctly interpreting the effects of Certificate of Need regulation upon hospital expansion. Therefore, the basic patterns of investment that have been characteristic of different types of Massachusetts hospitals are first summarized before the presentation of findings on the potential and actual impacts of CON.

Capital investment among Massachusetts voluntary hospitals

The period 1967-76 was one of enormous capital expansion among voluntary hospitals in Massachusetts. Net total capital asset values per bed of total complement at least doubled for all categories of institutions. Yet, average total bed complements increased by no more than 20 percent among any type of hospital (except nonteaching institutions with less than 100 beds) and actually declined slightly among nonBoston major teaching hospitals and among limited teaching hospitals. Major teaching hospitals in Boston led all other types of institutions in total capital investment, spending on average $23 million per hospital (constant 1967 dollars), $60 thousand per bed of total complement. Lesser teaching hospitals, both in Boston and elsewhere in the Commonwealth, showed the greatest change in asset values over the study period, increasing their net total capital assets almost 400 percent through average capital expenditures per hospital of $14 million (constant 1967 dollars), $44 thousand per bed. Nonteaching hospitals, on average, spent $4 million per institution, $25 thousand per bed.

Despite this universal expansionary behavior, the pattern of capital expenditures during the "pre-Certificate of Need" period 1967-71 versus the "post-CON" period 1972-76 proved distinctly

different as a function of hospital teaching status and bed size (Table 2). Among major, lesser, and limited teaching hospitals and hospitals with greater than 200 beds in general, total capital expenditures during 1972-76 in constant 1967 dollars were, on average, almost twice those during 1967-71; among nonteaching institutions, particularly those with fewer than 200 beds located outside of Boston, these patterns were reversed and expenditures "pre-CON" exceeded those "post-CON" by at least two-fold. When expenditures for physical plant versus major movable equipment were examined separately, those for plant exhibited the same patterns across time found for total expenditures. By contrast, expenditures for major movable equipment, the category most readily identified with hospital investment in "technology", were essentially constant across time, except among lesser teaching hospitals which showed a two-fold increase during 1972-76.

These patterns in total and plant expenditures, apparently associated with the presence of CON regulation, proved instead to be a function primarily of the completion dates of "major bed projects" and the synchrony in the construction of such facilities among similar hospitals (Table 3). Thus, the higher expenditures in 1972-76 among various categories of teaching hospitals largely resulted from the fact that these hospitals completed their major bed projects in 1972 or later. The higher expenditures in the "pre-CON" era among nonteaching hospitals arose because most of these institutions completed their major bed projects during 1967-71.

Differences in the completion dates of major bed projects reflected during the study period were found to have been present throughout the years since the conclusion of World War II. On average, Massachusetts voluntary hospitals constructed new inpatient facilities once every 14 years during this time. In general, construction peaked at different times for different types of institutions, largely as a function of particular environmental influences such as the ready availability of Hill-Burton funding to community hospitals during the early 1950's and the impact on teaching hospitals of the Medicare regulations requiring the replacement of ward care with semi-private accommodations.

Among virtually all types of Massachusetts hospitals, almost half of total capital expenditures during the entire study period was devoted to major bed projects, and case studies revealed that the 25 such projects completed by sample institutions played the pivotal roles in hospital development strategy and response to

TABLE 2: Average capital expenditures per hospital 1967-71 and 1972-76 by teaching status and geographic location—5-year sums, constant 1967 dollars in thousands

	Total		Total/Bed		Plant		Plant/Bed		MME		MME/Bed	
	1967-71	1972-76	1967-71	1972-76	1967-71	1972-76	1967-71	1972-76	1967-71	1972-76	1967-71	1972-76
Major teaching	$6,624	$11,833	$18.2	$28.8	$3,898	$8,006	$10.6	$19.2	$2,558	$3,231	$7.0	$8.1
Boston	8,425	14,766	24.1	37.3	5,048	9,856	14.4	24.7	3,203	4,140	9.2	10.6
Non Boston	2,420	4,987	4.6	9.0	1,215	3,687	2.3	6.3	1,053	1,110	2.0	2.3
Lesser teaching	4,831	9,448	14.7	28.9	3,553	6,788	10.7	20.8	987	1,721	3.0	5.2
Boston	4,024	9,834	13.4	30.9	2,756	6,770	9.2	21.4	885	1,789	2.9	5.5
Non Boston	6,847	8,484	18.2	23.9	5,546	6,835	14.7	19.3	1,209	1,552	3.3	4.3
Limited teaching	2,758	3,383	9.2	10.8	1,991	1,799	6.7	5.7	730	960	2.4	3.1
Nonteaching	2,513	1,688	15.8	9.4	2,068	1,078	13.0	5.8	416	455	2.6	2.5
Boston	2,236	1,314	13.8	10.4	1,758	824	11.1	7.6	437	442	2.5	2.5
< 100 Beds	747	1,493	11.6	19.0	662	1,334	10.2	16.9	86	143	1.4	1.9
> 100 Beds	2,980	1,224	14.9	6.1	2,306	568	11.5	3.0	612	593	3.1	2.9
Non Boston	2,604	1,810	16.5	9.1	2,170	1,161	13.6	5.2	410	460	2.7	2.5
< 100 Beds	1,229	357	15.5	3.9	1,029	62	12.6	0.7	200	144	2.9	1.7
101-200 Beds	3,980	1,551	26.1	9.8	3,522	814	22.7	4.5	419	516	3.0	3.2
> 200 Beds	2,364	2,897	9.5	11.8	1,807	2,099	7.1	8.6	530	609	2.3	2.5
All hospitals	$3,129	$3,273	$15.6	$13.0	$2,366	$2,266	$12.2	$ 8.3	$ 700	$ 867	$3.1	$3.3
Statistically Significant Differences [1]	p < .01	TEACH	None		None		None		TEACH TEACH × LOCATION		TEACH TEACH × LOCATION	
	p < .05	None	TIME × LOCATION × BED SIZE		TEACH		TIME × LOCATION × BED SIZE		LOCATION BED SIZE		LOCATION	

[1] Four Way Analysis of Variance by Time Period (TIME), Teaching Status (TEACH), Geographic Location (LOCATION), and BED SIZE.

TABLE 3: Total capital expenditures (in constant 1967 dollars) "Pre-CON" 1967–71 versus "Post-CON" 1972–76 among sample hospitals and fraction of total attributable to major bed projects

Hospital category	Total capital expenditures (in millions) "Pre-CON" 1967–71	"Post-CON" 1972–76	Fraction of total attributable to major bed projects 1967–71	1972–76
Major teaching	$18.1	$32.4	0	.50
Lesser teaching	9.3	18.1	.57	.49
Limited teaching	3.8	4.6	0	.29
Nonteaching	50.2	33.7	.76	.38
All hospitals	$81.4	$88.8	.54	.44

changing market conditions. For all categories of voluntary hospitals, both before and after the introduction of CON, these projects provided the opportunity to greatly expand ancillary service "capacity" necessitated by rapid technological change and growing numbers of physicians entering practice with specialty and subspecialty training. Among nonteaching hospitals, in particular, the increase in the sophistication of the institution's product that resulted from the ancillary service expansion accompanying major bed project completion in the late 1960's represented a significant change in the hospital's capability to diagnose and manage complicated medical problems. Such projects provided the opportunity to introduce intensive care units, to inaugurate high-technology ancillary services, such as radiation therapy, and to greatly expand the scope of basic ancillary services such as radiology and laboratory. As a result, the necessity for community hospitals to transfer difficult cases to teaching centers was considerably diminished and a marked change in the structure of the hospital services market occurred.

With the decrease in referrals from community hospitals, teaching centers had to turn increasingly to their surrounding neighborhoods as a source of patients and redefined their mission to include provision of the full range of medical services as well as tertiary care. The major bed projects completed by major and lesser teaching hospitals were, therefore, largely motivated by the necessity to create the commanding institutional presence and to expand the primary care services considered essential to competing successfully for patients. The implementation of Medicare and Medicaid contributed greatly to the success of these efforts by providing third-party coverage to potential patient populations that previously had lacked the financial means to seek care in the private sector. While teaching hospitals also used such projects to marginally increase total bed complement, only non-

teaching hospitals in areas of rapid population growth significantly increased their bed size during the study period. The 25 major bed projects completed by sample hospitals resulted in the construction of more than 2200 new beds, but almost two-thirds of these beds replaced existing old ones. Hence, total bed complement increased by less than 800 beds.

Because most hospitals experienced only minimal increases in their total bed complements but greatly expanded the size and value of their physical plant, their resource "intensity" per bed increased considerably. The increased intensity, however, was found both prior to and following the introduction of Certificate of Need and simply reflected that fact that by the late 1960's and beyond, the provision of "state of the art" ancillary services and ambulatory care had become as necessary a part of a hospital's basic "capacity" as the hospital bed itself. A hospital lacking such services could not fill its beds because it could attract neither the necessary medical staff nor the requisite patient population.

During the study period, all types of voluntary hospitals constructed new inpatient facilities. Major and lesser teaching hospitals in addition significantly expanded their facilities devoted exclusively to ancillary services and research as these institutions enlarged their teaching and research commitments in response to greatly increased medical school enrollments and federal support for medical education and research.

While much of hospital capital investment during the study period was motivated by the desire of hospital decisionmakers to be responsive to the increased technological sophistication of current and potential staff physicians, decisions on the timing and scope of major investments were still primarily the province of hospital administrators and trustees. Except in teaching hospitals where major chiefs of service, such as the Chief of Medicine, played particularly influential roles in shaping institutional development, staff physicians were not the primary influences determining the amount or composition of a hospital's capital investment.

During the late 1960's and early 1970's, because third-party reimbursement assumed most of both the capital and operating costs associated with such investment, hospitals were largely unconstrained in their ability to expand. Some limited constraint on the overall scale and cost of major construction, however, was imposed for most hospitals by concerns over maintaining per-diem rates roughly comparable to those of other institutions in their market. Hospitals, therefore, had to exercise some caution

in the amount of debt they assumed. By the mid-1970's, the presence of the Determination of Need Program and charge control policies of the Rate Setting Commission, coupled with more restrictive reimbursement policies introduced by Medicare, began to introduce some further constraints, though not before most hospitals in Massachusetts had at least inaugurated if not completed capital expansion on a truly massive scale.

The extent of Certificate of Need coverage

During the period 1967 - 76, on average three-fourths or more of a hospital's total capital expenditures either were or would have been subject to CON review (Table 4). Of the expenditures devoted specifically to an institution's inpatient facilities, 80 percent or more would have or did require CON approval; by contrast, only 37 percent of hospital expenditures for major movable equipment either did or would have come under the aegis of CON.

Basically, all construction of new facilities and all projects involving the introduction or modernization of high-technology

TABLE 4: Average fraction of capital expenditures per hospital that either was or would have been subject to Certificate-of-Need review 1967–1976

	Total	*Plant*	*Major movable equipment*
Major teaching	.60	.73	.28
Boston	.66	.81	.28
	(.21)	(.10)	(.24)
Non Boston	.48	.54	.27
	(.39)	(.45)	(.06)
Lesser teaching	.83	.91	.46
Boston	.81	.88	.35
	(.04)	(.08)	(.31)
Non Boston	.89	.98	.46
Limited Teaching	.67	.86	.15
	(.14)	(.03)	(.13)
Nonteaching	.76	.85	.40
Boston	.73	.84	.44
≤200 Beds	.80	.85	.55
	(.17)	(.07)	(.24)
>200 Beds	.70	.87	.35
Non Boston	.76	.85	.39
≤200 Beds	.84	.93	.42
	(.06)	(.05)	(.19)
>200 Beds	.66	.74	.34
	(.33)	(.35)	(.22)
All hospitals	.74	.84	.37

( ) = standard deviation

specialized ancillary services fell under the authority of CON. Thus, all of the investments that have served as key elements in a hospital's strategy to make major changes in institutional image and/or product are subject to regulatory control, and Certificate of Need, therefore, has at least the theoretical potential to have a considerable influence on the direction of a hospital's future development. The minor renovations to existing facilities and purchase of major movable equipment associated with hospital investment in basic ancillary services, however, for the most part fall outside of the boundaries of CON authority, and whenever possible, at least in recent years, many hospitals have "packaged" even those few investments that should have been submitted for review in ways that avoided the CON ceiling. Thus, CON regulation has not been an effective mechanism for controlling this component of hospital capital investment and other approaches have more potential for limiting the amount of routine "technological investment".

The accomplishments and limitations of Certificate of Need regulation in Massachusetts

Previous investigators have commonly used "ultimate" outcome measures, such as the change in total hospital capital investment or investment per bed, to evaluate the effects of CON.[5,6,7] The patterns of hospital investment revealed by this study suggest, however, that such measures are not appropriate at least for several years following the introduction of regulation. The majority of hospital capital expenditures are attributable to infrequent large-scale "major bed projects" that have been built in different periods by hospitals of similar size and teaching status. At least in Massachusetts, the introduction of Certificate of Need regulation coincided with the conclusion of the peak of construction among small nonteaching hospitals and the beginning of the construction peak among teaching hospitals and large hospitals in general. Hence, differences in total capital expenditures across time display a spurious association with the introduction of CON that, in fact, was not related to the presence of regulation. Further, because all projects actually under construction when CON regulation began were exempt from review and because the construction of a major new facility takes several years, less than one-[illegible] of the expenditures actually made by sample hospitals during the "post-CON" period had in fact been reviewed by the program (Table 5). During the first two years "post-CON", virtually

TABLE 5: Average fraction of total capital expenditures per hospital falling under aegis of CON in 1972-76, 1972-73 and 1974-76 compared with average fraction actually approved by CON during each period

	Fraction of expenditures falling under aegis of CON 1972-76*	Fraction actually CON-approved 1972-76	Fraction of expenditures falling under aegis of CON 1972-73	Fraction actually CON-approved 1972-73	Fraction of expenditures falling under aegis of CON 1974-7*	Fraction actually CON-approved 1974-76
Major teaching.....	.66	.27	.70	.01	.56	.44
Boston	.71	.28	.75	.01	.57	.37
	(.21)	(.45)	(.24)	(.02)	(.27)	(.44)
Non Boston	.56	.25	.57	0	.54	.54
	(.46)	(.15)	(.46)		(.44)	(.44)
Lesser teaching.....	.81	.40	.78	.11	.57	.53
Boston	.78	.26	.77	.14	.41	.41
	(.14)	(.61)	(.30)	(.25)	(.32)	(.32)
Non Boston	.87	.74	.80	0	.89	.89
Limited teaching....	.52	.42	.02	.02	.61	.50
	(.38)	(.24)	(.02)	(.02)	(.38)	(.23)
Nonteaching	.53	.29	.32	.01	.43	.31
Boston	.52	.27	.39	0	.50	.24
≤200 Beds...	.72	.22	.58	0	.61	.24
	(.15)	(.37)	(.52)	0	(.13)	(.40)
> 200 Beds...	.15	.15	0	0	.23	.23
Non Boston . ..	.53	.30	.30	.01	.41	.34
≤200 Beds...	.51	.34	.22	0	.47	.38
	(.35)	(.40)	(.44)		(.37)	(.07)
>200 Beds ...	.53	.24	.40	.01	.33	.31
	(.40)	(.38)	(.50)	(.03)	(.43)	(.44)
All Hospitals	.57	.31	.38	.02	.46	.38

*Fraction of Expenditures that according to CON Regulations would be subject to review, including both expenditures that actually were reviewed and those that would have been if they had not been initiated prior to enactment of the CON statute in November, 1971.
( ) = Standard deviation

none of the capital expenditures made by hospitals had been subjected to review. By 1974 and beyond, almost all expenditures that fell under the aegis of CON had in fact been reviewed and approved by the program. Nonetheless, during the 1974 - 76 period, the great majority of the expenditures that had been reviewed were attributable to projects approved during the first year of CON operation when the program lacked the rigorous review procedures and standards that characterized the function of the "mature" Certificate of Need process in 1976 and beyond (Table 6).

For these reasons, an ultimate outcome assessment was concluded to be inappropriate during the 1972 - 76 interval for which relevant data were available. Instead, this study evaluated CON effects using two measures of "intermediate" outcome: first, changes in project scope and design that resulted from the process of review, differentiating those achieved during the Program's "early" phase 1972 - 74 versus its "mature" period post-

TABLE 6: Amount and fraction of CON-approved expenditures in millions (current dollars) made during 1974-76 attributable to projects approved during 1972, by hospital teaching status

	Total expenditures 1974-76 that had been CON-approved	Amount of 1974-76 CON-approved total approved in 1972	Fraction of 1974-76 total approved in 1972
Major teaching	$31.3	$26.7	.85
Lesser teaching	17.5	13.4	.77
Limited teaching	6.5	2.2	.33
Nonteaching	23.5	16.8	.72
All hospitals	$76.8	$59.0	.75

1975, and second, changes in internal hospital investment strategy and interhospital relationships attributable to the presence of Certificate of Need.

Over the period 1972 to 76, only 9 percent of projects submitted to CON review by sample hospitals were denied certificates of need, and even many of these projects were eventually approved in modified form. However, as other investigators have also noted, a program's denial rate merely reflects the degree to which the review process permits negotiation over project details before a final decision is rendered.[8] The CON process in Massachusetts involves considerable interaction between program staff and applicant hospitals in the course of project evaluation. Consequently, despite the low project denial rate, one fourth of all projects ultimately approved by the CON program were either significantly modified as a result of CON review or were approved only with attached conditions that required some change in existing hospital operations. The projects of all types of hospitals, including those of the major teaching institutions in Boston, experienced such modifications.

Throughout its existence, the CON program devoted its most careful analysis to projects involving acute care beds. During the early years of regulation, CON review concentrated on reducing the increase in a hospital's total bed complement that would result from the construction of a major bed project. The final CON-approved form of a project virtually always either included fewer new beds than an applicant had proposed or required that existing underutilized inpatient services, such as obstetrics or pediatrics, be closed as a condition of approval for the proposed project. During this phase of CON program operation, however, projects were usually approved at the total cost proposed by the applicant hospital, and the final costs of many completed facili-

ties often exceeded even these generous budgets by several million dollars before the Rate Setting Commission in 1975 became aware of the problem and helped to institute more rigorous financial analysis and control in the CON review process.

By late 1975, the scope of CON review had been expanded beyond a consideration of the number of beds proposed to include a critical analysis of every aspect of a project. Over the next three years, the CON Program began to develop the detailed standards and criteria required to evaluate "need" for various ancillary services and ambulatory care components as well as for acute care beds and established a basis for examining many dimensions of a project's scale and cost. During this mature phase of CON analysis, the final approved form of some projects was reduced by as much as two-thirds of that originally proposed, and in several instances the process of CON review and approval was able to eliminate several million dollars in proposed expenditures. Case-study interviews revealed that hospitals had not specifically "padded" proposed projects in order to provide opportunities for cuts by the CON Program, and these reductions therefore represent true savings attributable to the presence of regulation. No group of hospitals has been immune to such careful scrutiny, and even cherished projects of influential teaching hospitals were considerably diminished in scope and cost.

During both its early and mature stages, the Certificate of Need Program in Massachusetts also achieved considerable success in preventing the duplication of high-technology specialized ancillary services. In particular, for several years CON severely restricted the diffusion of CT scanners by approving only one scanner per HSA region outside of Boston until criteria for the appropriate use of CT scanning had been established and the technological development of the necessary equipment sufficiently stabilized to limit the high cost of rapid obsolescence. The CON Program was also able to reduce already existing redundancy in services such as radiation therapy by denying applications for new equipment submitted by hospitals lacking sufficient utilization to justify continuation and modernization of the service. In its mature form, the Massachusetts Determination of Need Program has also markedly changed the whole hospital investment "environment", in the view of all hospital decisionmakers. The construction of new facilities and the introduction or modernization of specialized ancillary services that have played so prominent a role in institutional development strategy are no longer the sole province of the individual hospital. Instead, the details of such projects must now be carefully negotiated with

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other institutions in the hospital's market area and with the Health Systems Agency and the CON staff. As a result, internally hospitals have been forced to evaluate their appropriate roles and mission much more carefully and to develop more systematic and precise plans for capital expansion and replacement. Externally, interactions and interrelationships among hospitals have been greatly increased; hospital councils in many areas of Massachusetts have now become the arenas in which hospitals are attempting to develop the cooperative relationships that will diminish some of the pressures for product competition by allowing one institution to become the center for renal dialysis, another for obstetrics, a third for CT scanning, and so forth. These are negotiations of considerable delicacy because each hospital views its services as highly interdependent. Therefore, only the presence of external constraints imposed by CON, planning in general, and the emerging prospective reimbursement systems of the Rate Setting Commission has forced hospitals to alter the natural tendencies to maintain or acquire specialized services and facilities evidenced by hospital investment during the early years of the study period.

Nonetheless, Certificate of Need has not established a binding constraint on hospital capital expenditure. The CON process achieves only limited control over the acquisition of major movable equipment because the majority of such expenditures fall below CON review limits and hospitals have been successful in "unbundling" even some projects that should have been reviewed to circumvent the CON process. While CON reduced the scale of new construction, it has not prevented the addition of new physical capacity because the program now has no overall basis upon which to evaluate "need" for new replacement construction. Further, while CON has developed standards for acute-care beds that now permit precise calculation of the number of beds a hospital requires, the guidelines for the ancillary services and ambulatory care that now comprise such a major component of hospital capital expansion are much less specific. Finally, even mature CON analysis is based upon standards that define optimal efficient hospital practice on a service-by-service basis. Certificate of Need regulation provides no means of establishing an overall limit to the amount of resources an individual hospital or hospitals in general "should" commit to capital investment. Even the presence of a mature CON program, therefore, does not force an institution to choose among "necessary" projects for which expenditures can be justified on the basis of current or projected demand.

Implications and recommendations

These findings have significant implications for the conduct of future evaluations of regulatory impacts, for the ongoing operation of the Massachusetts Determination of Need Program and the prospective reimbursement system of the Rate Setting Commission, and for the use of "competitive" versus regulatory strategies in the effort to contain rising medical care costs.

Implications for the design of future evaluations of regulation

From the perspective of future evaluations of regulatory impacts, three particularly important lessons emerge from this study. First, regulation is imposed upon already existing patterns of behavior that in a realm such as capital investment with its long lags in planning and implementation are not likely to show an instantaneous response to a changed environment. Unless an effort is first made to understand these underlying patterns, one risks serious misinterpretation of the results generated by evaluation. Second, the implementation of regulation is an extremely complex process. The mobilization of requisite staff and the development of defensible procedures necessary to establish a rigorous and effective program take *years*, not months, even in the presence of strong political commitment to the importance of the effort. Therefore, it is simply unrealistic to expect that the effects of program action will begin to appear immediately after its enactment, especially if measures of ultimate outcome are used to determine these effects. Essential as it is to evaluate the impacts of the numerous government interventions that have been introduced in recent years, it is also important to be realistic in establishing a time frame within which results can be expected. Otherwise, one risks concluding that a program has been ineffective or worse, has been counterproductive when, in fact, it is simply too early to determine what its actual effects have been. Finally, much as measures of ultimate impact are eventually the ones that provide the true test of regulatory accomplishments, it is important to develop and use more intermediate measures of program

performance until final outcomes do begin to appear. Intermediate outcome measures are currently held in lower esteem than measures of ultimate outcome and usually require more detailed and costly data collection. Nonetheless, measures of intermediate outcome, such as those employed in this study, are the only ones that can provide the kind of interim assessment of program strengths and weaknesses necessary to improve regulatory performance.

Proposed modifications in current regulatory procedures

As judged on these intermediate outcome measures, the Determination of Need Program in Massachusetts has clearly been successful in creating an external mechanism that can assure the "necessity" of the investments being pursued by hospitals and limit the wasteful duplication of some facilities and services that previously accompanied each hospital's pursuit of its own individual interests. At present, however, the CON process in Massachusetts (and elsewhere in the country as well) is based on standards of absolute need and does not provide a means for allocating limited resources. Under present procedures, tradeoffs are not required, either among the worthy projects of a single institution or among those of the various hospitals serving a particular population. Hence, Certificate of Need does not now constrain capital investment in total and can therefore make only a limited contribution to the ultimate objective of restraining further increases in the consumption of real resources by the hospital sector.

The principal strategy now being advocated to impose a binding constraint on hospital capital expenditure is the introduction of a total expenditure "cap", either at the national level as Title II of President Carter's 1977 Hospital Cost Containment legislation proposed or in selected states, as New York for example, has considered. The crucial issues of how a fixed expenditure ceiling should be allocated across health services areas and how criteria could be developed to permit the approval of specific hospital capital projects within this "budget", however, have not been addressed in any detail. Given the difficult and time-consuming process that the development of defensible standards even for the review of individual projects proved to be in Massachusetts, it is hard to imagine how the necessary criteria for allocation of a fixed budget could be generated.

The patterns of hospital investment revealed by this study suggest, however, that a less comprehensive and therefore potential-

ly more feasible approach directed at the level of the individual hospital might be taken to more effectively constrain hospital capital expenditure in total. Such an approach would combine the development of a specific capital budget for each hospital to limit routine annual investment in major movable equipment and minor plant renovation with the establishment of more stringent criteria to guide evaluation for less frequent capacity and service expansion projects. The following specific modifications in current Certificate of Need and rate setting procedures are proposed as the first steps toward establishing more stringent limits on the amount of capital expenditure by Massachusetts hospitals:

- An annual budget for major movable equipment should be developed for each hospital on the basis of size, teaching status, and other relevant characteristics and not tied simply to the institution's own current MME asset value. The budget should be established through the Rate Setting Commission's prospective reimbursement system and once full payer participation in this system is secured, hospitals should be permitted to spend their budgets as they wish, submitting only projects involving high-technology ancillary services or new construction for CON review. Such a change would free the CON staff from reviewing projects that rarely have been modified significantly by the CON process, eliminate current incentives for hospitals to try to subvert CON review for these types of expenditures, and provide more time for the analysis of the types of projects that are the major vehicles used by hospitals to achieve significant changes in product and image.

- As part of the development of Health Systems Plans and the State Health Plan, criteria should be formulated to specify the grounds justifying replacement of existing facilities. In addition, more precise guidelines must be developed regarding expansion of facilities for ancillary services and ambulatory care. Such criteria and guidelines are essential to support more rigorous review of proposals for future major construction and hopefully would better enable Certificate of Need to counteract the environmental factors that stimulated and facilitated the enormous expansion in hospital physical plant since the mid-1960's.

- The Rate Setting Commission should reinstate its efforts to replace the current provision of historical cost depreciation with a "capital allowance" for each hospital that would include the costs of principal on current indebtedness and provide funding for future capital replacement and, if necessary, expansion. The de-

velopment of such an allowance was initially intended to be one important component of the prospective reimbursement system being established for Massachusetts hospitals. Recently, the Commission has retrenched from this position, feeling that it lacks sufficient information on capital formation to make a compelling argument for changing current reimbursement policies. The vital role that this and earlier studies have shown such policies to play in contributing to hospital capital expansion suggests that a capital allowance is an important component of an effective prospective reimbursement system and should be developed as initially planned.

The role of "competition" versus regulation in limiting increasing medical costs.

In recent years, numerous voices have been raised against the failings of "command and control" regulation, and more "market-oriented" solutions have been advocated as a better means of overcoming the problems to which regulation has been addressed.[9] In the health care sector, the development of health maintenance organizations (HMO's) is the most prominent of the "competitive" strategies now being promoted.[10] Because the financial viability of an HMO depends upon careful control of the costs of hospital care rendered its enrollees, HMO's are sensitive to the price of hospital services in a way that individuals with comprehensive insurance coverage are not. Hence, if HMO's gain wide acceptance, hospitals may be forced to compete on the basis of price as well as product.

Nonetheless, it must be appreciated that at present HMO's still cover a small fraction of the population, that most physicians still are in fee-for-service private practice, and that the number of physicians is still increasing. It is widely recognized that physician utilization of hospital services is a major contributor to the total level of hospital costs and that the increasing number of physicians therefore has ominous implications for future increases in the cost of hospital care and indeed of medical care in general. The findings of this study have demonstrated, however, that while hospitals have expanded service and facility "capacity" in response to the "needs" of current and potential medical staff, the major decisions involving the timing and scale of expansion reside with hospital administrators and trustees. Therefore, capital expenditure and rate regulation designed to constrain the future options of hospital decisionmakers has the potential to exert considerable influence on physician behavior as well. Hence, the

continuation and indeed strengthening of existing hospital regulation offers an important instrument for limiting the future cost impacts of the growth in the supply of physicians.

Given the nature of the health services "market", therefore, the fostering of "competition" and the further refinement of regulation should be viewed not as alternative strategies but rather as complementary mechanisms to introduce some economic discipline into a sector that has largely operated without it.

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15. Supplementary Notes			

16. Abstracts

This study examines hospital capital investment among Massachusetts short-term general voluntary hospitals between 1967 and 1976, and assesses the impact of Certificate of Need (CON) regulation. A profile of capital expenditures for fiscal years 1967 - 1976 was developed from Massachusetts Rate Setting Commission data for 26 sample hospitals, stratified by teaching status and Boston versus non-Boston location. Case studies were conducted in nine sample hospitals to explore the determinants and consequences of major capital projects undertaken by the institution. Enormous capital expansion took place from 1967-76. Hospitals in areas of rapid population growth significantly increased their bed size; other hospitals replaced or modernized inpatient facilities, and expanded ambulatory care capacity. All hospitals significantly expanded their ancillary service capacity. With respect to the impact of CON regulation, the evidence revealed that by 1976 and beyond, CON review had reduced all dimensions of project scale and cost by as much as two-thirds of that originally proposed.

17. Key Words and Document Analysis. 17a. Descriptors

NCHSR publication of research findings does not necessarily represent approval or official endorsement by the National Center for Health Services Research or the U.S. Department of Health and Human Services.

Marianne Miller, NCHSR Project Officer, 301/436-8943

17b. Identifiers/Open-Ended Terms

Health services research
Regulating hospital capital investment
Impact of certificate of need regulation

17c. COSATI Field Group

18. Availability Statement	19. Security Class (This Report)	21. No. of Pages
Releasable to the public. Available from National Technical Information Service, Springfield, VA 22161 (Tel.: AC 703/487-4650)	UNCLASSIFIED	30
	20. Security Class (This Page) UNCLASSIFIED	22. Price

FORM NTIS-35 (REV. 10-73) ENDORSED BY ANSI AND UNESCO THIS FORM MAY BE REPRODUCED USCOMM-DC 8265-P74

U S GOVERNMENT PRINTING OFFICE 1981 – 341-787:105

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF PUBLIC ASSISTANCE
FY84 BRIEFING PAPER

I. GENERAL INTRODUCTION

The Division of Public Assistance (DPA) is responsible for administration of ten programs:

- Aid to Families With Dependent Children (AFDC)
- Old Age Assistance (OAA)
- Aid to the Disabled (APD)
- Aid to the Blind (ABL)
- Food Stamps
- General Relief
- General Relief Medical
- Catastrophic Illness
- Medicaid
- Energy Assistance

Several of these programs are funded wholly or in part with federal funds. These programs include AFDC (50% Federal), Food Stamps (95% Federal), Medicaid (48% Federal) and Energy Assistance (100% Federal). Food Stamp funding is not contained in the State budget. The remaining programs are funded entirely from state general funds. Along with the presence of federal money in these four programs comes a complete set of federal rules and procedures governing conditions of eligibility for benefits as well as rules for overall program operation.

The Division conducts business through a mixture of private vendor contracts and state staffed facilities. Most activities still administered by state staff are prohibited by federal law from transfer to the private sector. At present the Division has state staffed client service offices in (21) locations:

SOUTHEAST	SOUTHCENTRAL	NORTHERN	SOUTHWEST
Juneau	Anchorage	Fairbanks	Nome
Sitka	Valdez	Galena	Unalakleet
Ketchikan	Dillingham	Ft. Yukon	Bethel
Wrangell	Kodiak	Kotzebue	Aniak
Petersburg	Kenai		
	Wasilla		
	Palmer		
	Homer		

The Division also contracts for application-taking assistance in Barrow with the North Slope Borough and in Kotzebue through a similar arrangement with Maniilaq Association. Total Division staff authorized for FY83 is 299 positions.

In addition to these state and contractor operated client service offices, the Division has paid agents in approximately 165 additional communities around the State, bringing the total number of communities having local Division representation to approximately 185 locations.

The Division will serve approximately 25,000 families monthly during FY84. Since a large number of these families will access more than one of the Division's programs, the above numbers do not represent an unduplicated count of families to be served. A conservative estimate would place the unduplicated count of families who will receive aid during FY83 at 20,000 families consisting of approximately 45,000 persons, or roughly 11% of the State's population. One out of ten Alaskans will, by these estimates, seek some type of cash, food, medical, or energy assistance from the Division in FY84.

II. ADVISORY COMMITTEES

The Division also does business with four advisory committees. These include the Medical Care Advisory Committee, the Catastrophic Illness Committee, the Corrective Action Committee, and the Energy Assistance Committee.

1. The Medical Care Advisory Committee: Comprised of persons appointed by the Commissioner who provide policy and program guidance for the administration of the Medicaid and General Relief Medical programs.

2. The Catastrophic Illness Committee: A three member body appointed by the Governor who provide the Commissioner with policy guidance in the operation of the Catastrophic Illness Program, which is a sub-program of General Relief Medical.

3. The Corrective Action Committee: Comprised entirely of Division employees and is chaired by the Division Director. The Corrective Action Committee meets to review error data compiled by the Quality Control Section as well as from other surveillance sources, and develops appropriate corrective action to reduce the occurrence of these errors.

4. The Energy Assistance Committee: Appointed by the Commissioner to evaluate the Division's energy assistance plan.

III. DIVISION BUDGET OVERVIEW

The Division's FY84 total budget request is $164.6 million plus $24.0 million in Food Stamps benefits for a total of $188.7 million ($89.9 million SGF).$15.2 million or 8% finances the administrative activities of the Division. The remaining $173.0 million flows directly to needy Alaskans as cash ($60.9 million), food stamps ($24.0 million), medical care ($81.7 million), or energy assistance ($6.7 million). A comparison of Division administrative and program budgets between FY83 and FY84 is as follows:

Budget Category	FY83	FY84 Request
Human Services N.W.	$ 179.3	$ 179.3
Administration	14173.5	15183.1
Cash Assistance	56384.8	60851.5
Food Stamps	26500.0	24000.0
Medical Assistance	74355.9	81720.0
Energy Assistance	7208.6	6747.5
PFD Hold Harmless	12866.5	-0-
TOTALS	$191668.6	$188681.4

IV. QUALIFYING LEVELS FOR ALASKA'S PUBLIC ASSISTANCE PROGRAMS

The following table displays the FY83 income qualifying limits for the Division's programs compared to the poverty level. AFDC and APA benefits for FY84 will be approximately 6% higher.

Programs	1 Person	2 Persons	3 Persons	4 Persons	Based On Gross Or Net Income
FOODSTAMPS	636	844	1052	1260	Gross
AFDC	-	546	614	682	Net
AGED, BLIND AND DISABLED	546	802			Net
GENERAL RELIEF	300	400	500	600	Gross
ENERGY PROGRAM	851	1113	1375	1637	Gross
OMB POVERTY LEVEL	489	649	809	969	Gross

V. DIVISION PROGRESS REPORT

The Division was faced with serious problems from a number of quarters. These included:

- The AFDC payment error rate was at 30%.
- Decision timeframes for new applicants exceeded the federal standard of 30 days routinely, and in some offices reached 60 days or longer.
- The computer system which supported the client service offices and authorized monthly benefits was developed in 1968 and was near collapse.
- The state run medical payment system was taking up to 6 months to pay medical providers for medical services received by public assistance recipients.
- Recipient failure to report information to the agency was contributing to a mushrooming overpayment problem with inadequate field staff to impose tighter surveillance of recipients' financial circumstances.

The Division set out in 1979 to remedy these problems. The goals were:

- to reduce the level of overpayments to recipients and concurrently the high error rates,
- to place the agency on a solid legal footing through introduction of regulations and statute revisions,
- to upgrade the data processing capabilities supporting client service offices,
- to reimburse the medical community in a more timely and cost efficient manner by transferring the medical payment system to the private sector, and
- to accomplish this with as little harm to truly needy Alaskans as possible.

The Division accomplished these goals as evidenced by the following milestones:

- The Division successfully transferred the processing of medical claims to the private sector. Complete transfer was completed in August 1982. The present five year contract provides for processing of medical claims through 1987. The contract calls for a 20 day processing standard at one third the cost of the previous Department operated system.

- The Division is nearing implementation of its new data processing support for client service offices. This new eligibility system will integrate all ten of the Division's programs into a single data base. The system will permit on-line eligibility determination and benefit issuance from the central computer from any Division office by late 1983 and further improve client service.

- State regulations and policy manuals for each program have been adopted.

- Decision timeframes on new applications of 30 days or less have been maintained in all programs.

- AFDC, Medicaid and Foodstamp error rates are much improved.

- Major program reforms were implemented in AFDC and Food Stamps during 1982. Monthly reporting of financial circumstances, introduction of prior month budgeting, and requiring home visits have reduced error rates and caseloads.

VI. DIVISION CONCERNS FOR 1983

1. Error Rates

Improved quality in AFDC, Medicaid and Foodstamp eligibility determinations remains a top priority of the Division. To date federal expectations in each of these programs have been met or corrective action plans (CAP) been negotiated to achieve reductions. The Division entered a new penalty period in October 1982 that brings with it the following payment error rate expectations for the next 12 months:

Program	Current Error Rate	Required Error Rate
AFDC	11%	4%
Food Stamps	23%	21%
Medicaid	1%	5%

An important factor in the error rate calculation is that all client caused errors, such as failure to report information, are counted against the State when assessing its error rate.

2. AMPS Performance Improvement

The new Alaska Medical Payments System (AMPS) must continue to be improved to foster a better relationship between the medical community and low income Alaskans needing medical care.

3. Eligibility Information System (EIS)

The detailed design of this new automated eligibility system has been completed. This new system will reduce much of the risk of agency caused error in the eligibility determination process, and greatly improve service timeframes to Alaskans around the State.

4. Food Stamp Mail Issuance Losses

A new federal rule has been established setting a mail loss limit of .5%.

Under federal rules Alaska has the option of sending households an Authorization To Purchase (ATP) card which can be exchanged for food stamps at a client-service office or U.S. Post Office, or the State can mail households their food stamps directly.

The Division currently mails food stamps directly to all recipients monthly except those residing in Anchorage. Anchorage residents are issued an ATP which is exchanged for food stamps at the Post Office. Alaska has periodically experienced a high loss level with the direct mailing of food stamps. Fairbanks residents were removed from direct mail for a period of time for this reason but are now back on direct mail. Because of the rural nature of many addresses, mail losses have at times exceeded 1%. This loss rate must be watched routinely to avoid State repayment of any loss amounts that exceed .5%. Backup delivery methods have been designed in the event that direct mail creates losses above the .5% level. These backup measures should be deployed if needed.

5. Food Stamp Rural Allotment

Alaska must push for implementation of a rural Food Stamp allotment. Since 1973 the State has been lobbying the U.S. Department of Agriculture (USDA) and the U.S. Congress for a higher food stamp allotment for rural Alaska. The State has demonstrated repeatedly that rural food costs exceed urban costs by 40% or better. Congress gave USDA the authority to create the 2nd standard in Alaska in 1981. USDA has failed to implement this law thus far even though the State defined the geographic areas to be affected.

6. HB174 Implementation

During the 1982 Session the Legislature passed HB174 which provided for an increase of approximately $50 monthly to most AFDC families but no funds were appropriated. This increase was to be in addition to the 7.4% annual cost-of-living increase also given AFDC families on July 1. The purpose of HB174 was to close the gap between the payment levels for two adults receiving APA and two individuals on AFDC. In view of this, Governor Hammond advised the legislative leadership that HB174 would be implemented within available funds. The Division has concluded that funds are available to implement HB174 safely effective January 1, 1983. The Division has published regulations proposing to do this. In excess of $2 million has been included in the FY84 AFDC request in anticipation of this increase in AFDC grant levels. A final decision is pending whether to effect this increase in FY83, or to wait until FY84, or to forego the increase altogether if funds for FY84 are determined not available in view of the constitutional spending limit.

7. Medical Budget Projections

The Department has perpetually had problems predicting spending levels in this category. While projection models for administrative and cash assistance budgets generally were reliable, prediction of medical costs were not. Most states have a problem similar to Alaska's. Several changes will improve the Division's ability to predict the medical costs for a fiscal year and to remain solvent in times of trouble:

(A) Shift Medicaid and GR Medical expenditure accrual from "month of service" to "month of billing". Under the present system a fiscal year is nearly over before the Division can safely predict its outcome.

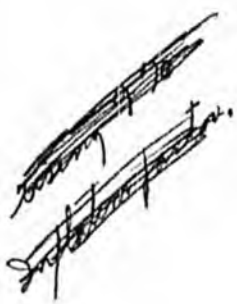
(B) Consider adoption of uniform cost reporting and prospective reimbursement for hospitals and nursing homes. Hospital and nursing home expenditures comprise 54% of the medical budget.

(C) Consider new Medicaid regulation requiring all non-emergency hospital admissions be reported to the Department in advance. In its simplest form this requirement would generate needed information to permit total program liabilities to be more closely watched.

8. Strategy to Contain Escalating Medical Costs

In any period, total spending is always a function of the number of recipients, the volume of services used, and 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% annually in Alaska.



This situation will be further complicated in FY84 and later years in light of Congress' actions to reduce Medicaid funding to all States (TEFRA changes). Alaska is facing a 4 to 5 million dollar shortfall in FY84 because of these federal changes. Absent additional funding to replace these lost federal/State revenues, critical decisions need to be made to bring program spending in line with available federal/State resources.

This decision process must arrive at an equitable balance between persons eligible, covered services and unit price for services received, particularly hospitals and nursing homes. All of these choices are largely controlled by the Alaska Legislature. This decision process will also cause the State to more precisely define its health care policy for all areas of Alaska, particularly in rural areas where the delivery of health care cannot be accomplished as competitively in large urban areas with more than one hospital.

9. General Relief Program Review

This state funded program is not meeting the emergency subsistence needs of employable Alaskans. Strict income requirements and a demonstrated need (such as an eviction notice) must be met. If eligible, a maximum monthly payment of $80 per person is allowed by state statute. The Division makes these payments to landlords and utility companies to ensure only critical subsistence needs are met. Participation in this program has declined, even though the BIA General Assistance program was terminated. An analysis of this program is critically needed to determine if changes in qualifying conditions and benefit levels are appropriate. No changes have been made in the qualifying limits since 1978, and the $80 payment limit since 1957.

10. Catastrophic Illness Program

This program was funded at $2.1 million for FY83 but has requests totalling $8-10 million. Any individual with unpaid medical bills of $1000 may apply. The Catastrophic Illness Committee determines the eligibility formula and may adjust it as frequently as necessary to stay within available funding. Under the current formula, the FY83 program is already out of funds. A complete review of this program is also in order.

11. Work Programs

Considerable debate continues as to the type of work programs that should be imposed on Alaska public assistance recipients, if any. Options range from merely registering for employment to requiring every able-bodied recipient to perform some type of public service employment. Because of Alaska's conservative set of public assistance programs, and the lack of two parent, unemployed households on assistance in this State, the Division has recommended that a mandatory public service program not be adopted in Alaska. Rather, the Division has recommended an emphasis towards job search and job training with built-in program disincentives for recipients who refuse to cooperate. The following elements are essential to a meaningful program in Alaska within an acceptable administrative cost:

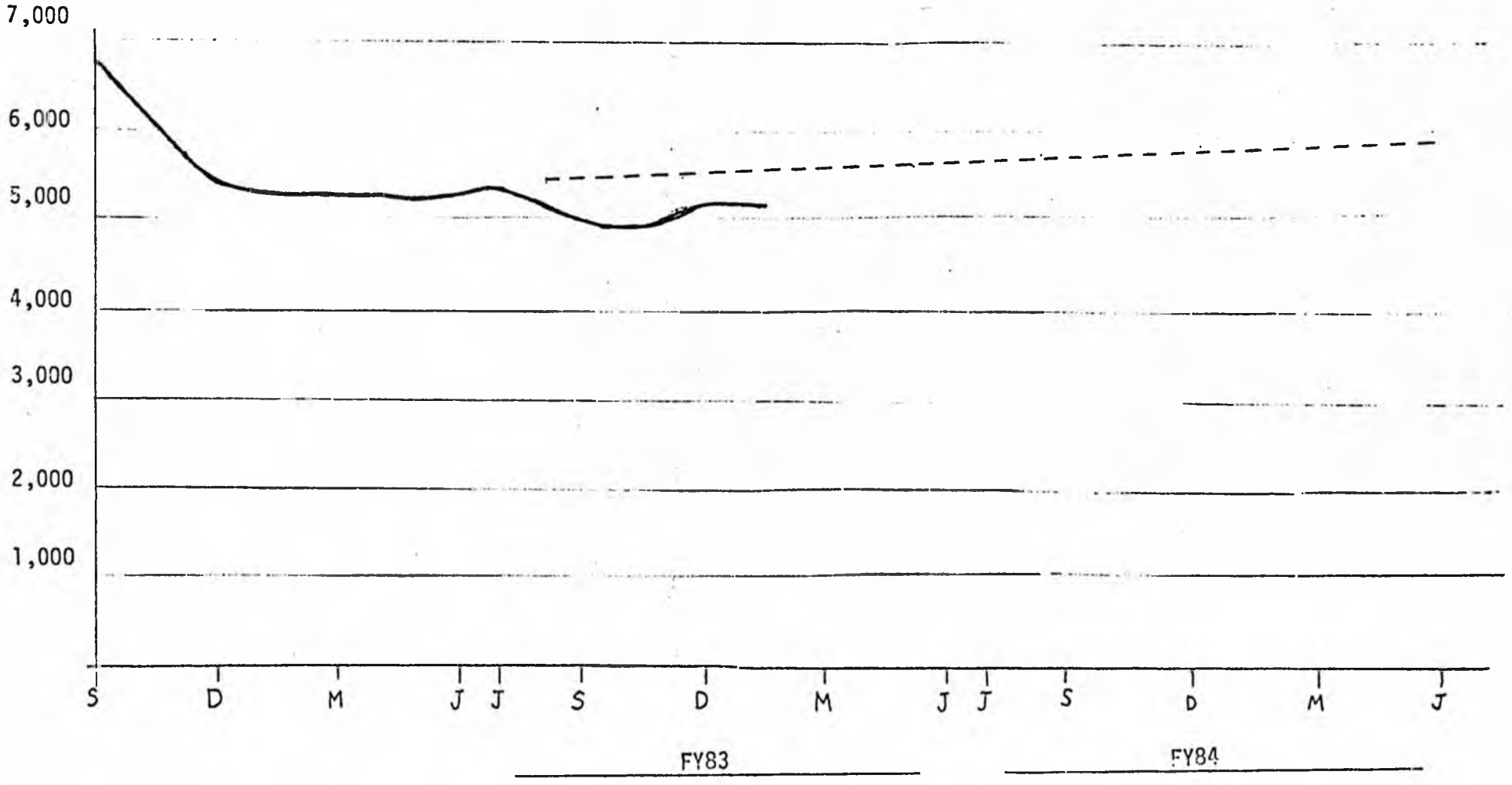
(a) Focus on high availability jobs
(b) Constructive not punitive in nature (Rules out CWEP)
(c) Establish client motivation through AFDC program disincentives for those who do not cooperate
(d) Prepare client to compete with non-welfare job applicants
    - Resume preparation
    - Effective job search skills
    - Develop a marketable skill through training or education
        ** typing
        ** key punching
        ** general clerical
        ** day care
    - Effective job interview skills
    - Agency follow-up on unsuccessful interviews to determine why
    - Client preparation to leave AFDC/Medicaid once employed
(e) Coordination with State and private job placement agencies
(f) Contracts for OJT leading to permanent position with private agencies

(g) Minimal surveillance burdens on agency - low state staff needs
(h) Coordination with day care agencies/homes for school age kids
(i) Recipient workshops - allow successful recipients to enlighten and encourage others
(j) Fair good cause system for clients who do not cooperate
(k) Pilot project experience

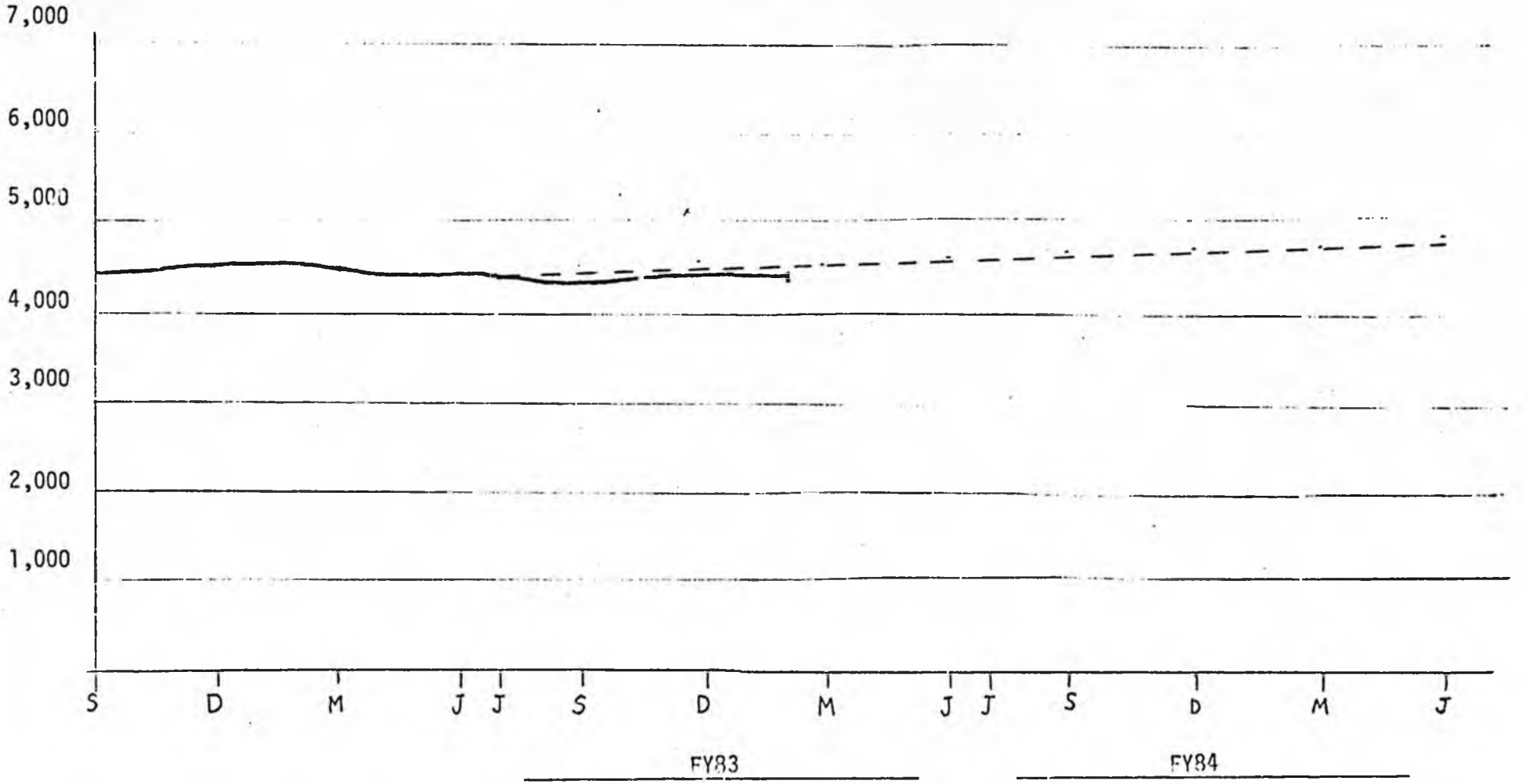
12. APA Federalization

The State is in a position to consider federal administration of its aged, blind and disabled programs. Although these three programs were federalized in 1974, Alaska and a number of other states continued to operate their programs because the uniform national payment was below that previously received by recipients in these states. As a result, there is a great deal of duplicate administrative effort, conflicting information and other problems which could be avoided if the State part of the program were federalized as well. The Division commissioned an analysis of this issue. The final report will be available by March 1, 1983 at which time the Department will consider the merits of complete federalization from both an administrative and program perspective and then make a recommendation to the Governor.

AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC)
Caseload analysis Sept. 1981 thru June 1984



ADULT PUBLIC ASSISTANCE PROGRAMS
Caseload analysis Sept. 1981 thru June 1984



ADULT PUBLIC ASSISTANCE (APA) :

OLD AGE ASSISTANCE (OAA)
AID to the BLIND (ABL)
AID to the DISABLED(APD)

——— APA ACTUAL CASELOAD Sept. 1981 thru Feb. 1983

----- APA PROJECTED CASELOAD FY83 and FY84

Division of Public Assistance

FY84 Contracts/RSA

BRU	Component	Contract	FY84 Amount
PA Admin	Admin	Dept. of Law	$ 51.4
PA Admin	Admin	AMPS	736.2
PA Admin	Admin	AMPS Reports	43.4
PA Admin	Admin	TPL Collections	40.0
PA Admin	Elig Det	Fee Agents	149.7
PA Admin	Elig Det	Loomis	207.7
PA Admin	Elig Det	North Slope	81.7
PA Admin	Elig Det	U.S. Post Office	139.0

	FY83 Projected Without SB817	FY83 FCC With SB 817	FY83 Base Revised 10/1/82	FY84 Factor	FY84 Request	% Increase FY84 vs FY83 FCC
Medicaid	$48,923.5	$64,924.5	$61,933.4	12.7%	$69,809.8	7.5%
GR Medical	$14,625.8	$7,931.4	$10,392.8	14.6%	$11,910.2	50.2%
Total	$63,549.3	$72,855.9	$72,326.2	13.0%	$81,720.2	12.2%
(State)	(37,232.0)	(36,413.8)	(37,320.1)	14.2%	(42,604.8)	17.0%
(Federal)	(26,317.3)	(36,442.1)	(35,006.5)	11.7%	(39,115.2)	7.3%

Comments

Estimated costs of medical care for FY83 if SB 817 had not been passed by the 1982 Alaska Legislature. SB 817 moved all low-income children into the Medicaid Program out of GR Medical, among other changes.

Revised FY83 estimate taking SB 817 into account. Several key assumptions made:
1. $1.5 million would be later added to $7.9 million GRM from Federal Budget Impact Fund.
2. Prescription drugs would be paid out of Medicaid, not GRM.
3. SB 817 would be implemented on 7/1/82 for 12 month cost savings.
4. Adult medical care would be provided under GRM for persons not eligible for AFDC, OAA, ABL or EPD. If funding fell short, services would be reduced.

Latest FY83 estimate showing full costs of Medicaid and GRM. Assumptions include:
1. $1.5 Federal impact money assumed part of $10.3 GRN base.
2. Drugs moved back into GRM ($1 million).
3. SB 817 implemented 10/1/82 not 7/1/82.
Based on these assumptions the total FY83 medical cost expected exceed authorized State funding by $906.3 if the federal impact funds are not made available.

Factors vary by type of medical service in Medicaid and GRM. These factors are a composite for Medicaid and GRM.

Estimate of medical costs for FY84 with following assumptions:
1. Medical care costs will increase at 9%.
2. Caseloads and therefore persons covered will increase at 6%.
3. No limits will be applied to rate of increase in hospital or long term care rates.

The Department seriously questions the forecast of a 9% increase in medical costs for FY84. Preliminary information from the hospital association indicates their facilities are expecting increases in costs ranging from 12% to 16%.

23 CONTINUED 2

AGENCY Health and Social Services

PROGRAM Public Health

BRU Medical Assistance BRU

COMPONENT

Revised Date

FY 84

001305

01 11543(7.021-23

FDIJ

- STATE REVENUE SHARING
  25% CAPITAL CONSTRUCTION
  $20,000 OPERATIONS

- MEDICAID

- 3rd PARTY PAYMENTS

- BLUE CROSS JOAN GAUMER, MARTIN TIRADOR

- AETNA

CURRENT BUDGET

* DOCUMENT= 1 OF 1 PAGE = 25 OF 36

MENTAL HEALTH ADVISORY COUNCIL AND LAND BOARD

APPROPRIATION ALLOCATIONS	APPROPRIATION ITEMS	APPROPRIATION FUND SOURCES GENERAL FUND	OTHER FUNDS
16,200			

SPECIAL PROJECTS AND GRANTS (3 POSITIONS)

APPROPRIATION ALLOCATIONS	APPROPRIATION ITEMS	APPROPRIATION FUND SOURCES GENERAL FUND	OTHER FUNDS
427,300			

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

APPROPRIATION ALLOCATIONS	APPROPRIATION ITEMS	APPROPRIATION FUND SOURCES GENERAL FUND	OTHER FUNDS
	711,700	461,300	250,400

HEALTH PLANNING & DEVELOPMENT (10 POSITIONS)

APPROPRIATION ALLOCATIONS	APPROPRIATION ITEMS	APPROPRIATION FUND SOURCES GENERAL FUND	OTHER FUNDS
	525,300	260,900	264,400

CERTIFICATION & LICENSING (6 POSITIONS)

APPROPRIATION ALLOCATIONS	APPROPRIATION ITEMS	APPROPRIATION FUND SOURCES GENERAL FUND	OTHER FUNDS
327,800			

* DOCUMENT= 1 OF 1 PAGE = 26 OF 36

ADMINISTRATION (4 POSITIONS)

APPROPRIATION ALLOCATIONS	APPROPRIATION ITEMS	APPROPRIATION FUND SOURCES GENERAL FUND	OTHER FUNDS
169,700			

HEALTH PLANNING COMMITTEE (1 POSITION)

APPROPRIATION ALLOCATIONS	APPROPRIATION ITEMS	APPROPRIATION FUND SOURCES GENERAL FUND	OTHER FUNDS
64,200			

HEALTH SYSTEMS AGENCY GRANTS

APPROPRIATION ALLOCATIONS	APPROPRIATION ITEMS	APPROPRIATION FUND SOURCES GENERAL FUND	OTHER FUNDS
150,000			

COMMISSIONER'S OFFICE

APPROPRIATION ALLOCATIONS	APPROPRIATION ITEMS	APPROPRIATION FUND SOURCES GENERAL FUND	OTHER FUNDS
	860,300	860,300	

COMMISSIONER'S OFFICE (11 POSITIONS)

APPROPRIATION ALLOCATIONS	APPROPRIATION ITEMS	APPROPRIATION FUND SOURCES GENERAL FUND	OTHER FUNDS
860,300			

GAO STUDY - competitive strategy

CON - Restricts competition

MEDICAL MARKETPLACE

with KEY ELEMENTS. MARKET PLACE will OPERATE EFFECTIVELY. KEY ELEMENTS ARE:

1. A LARGE NUMBER of buyers AND sellers
2. CONSUMERS must bear CONSEQUENCES of bad DECISIONS
3. SELLER MUST be able to LEAVE OR ENTER the MARKET FREELY

Differences from ECONOMIC model in MEDICAL MARKETPLACE

1) THIRD PARTY PAYMENTS REMOVE CONSUMER'S RESPONSIBILITY for FISCAL effect of their ACTIONS. IN 1981 only 32.1% of HEALTH CARE USERS paid for their own treatment
2) BECAUSE of COMPLEXITY of HEALTH CARE, CONSUMERS are NOT AWARE of CONSEQUENCES OR OPTIONS re: HEALTH CARE. 70% of HEALTH CARE EXPENDITURES are INFLUENCED by PHYSICIANS.
3) # of PROVIDERS is SMALL in SOME MARKETPLACES i.e. RURAL AREAS - ALASKA IN GENERAL
4) RESTRICTIONS to entry into MKTPLCE - licensing of NURSES; PHYSICIANS, FACILITIES VIA CON, possibly by STATE FUNDING.

TABLE 1 - good on competition.

JAN 31 1983

PROVIDENCE HOSPITAL

SISTERS OF PROVIDENCE

SERVING IN THE WEST SINCE 1856

3200 PROVIDENCE DRIVE - POUCH 6604
ANCHORAGE, ALASKA 99502
PHONE: (907) 276-4511

January 26, 1983

The Honorable Bette Cato
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 Cato:

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

1982-CURRENT

145.83 [Repealed, 1979 c 323 s 16]

145.831 [Repealed, 1979 c 323 s 16]

NOT REPEALED - DAVE

MINNESOTA CERTIFICATE OF NEED ACT

145.832 PURPOSE; CITATION.

Subdivision 1. The legislature finds that the unnecessary construction or modification of health care facilities increases the cost of care and threatens the financial ability of the public to obtain necessary medical services. The purposes of sections 145.832 to 145.845 are to promote comprehensive health planning; to assist in providing the highest quality of health care at the lowest possible cost; to avoid unnecessary duplication by ensuring that only those health care facilities and services which are needed will be developed; and to provide an orderly method of resolving questions concerning the necessity of construction or modification of health care facilities.

It is the policy of sections 145.832 to 145.845 that decisions regarding the construction or modification of health care facilities should be based on the maximum possible participation on the local level by consumers of health care and elected officials, as well as the providers directly concerned.

Subd. 2. Sections 145.832 to 145.845 may be cited as "The Minnesota Certificate of Need Act."

History: *1979 c 323 s 1*

NOTE: This section is repealed by Laws 1982, Chapter 614, Section 12 effective March 15, 1984. See Laws 1982, Chapter 614, Section 13.

145.833 DEFINITIONS.

Subdivision 1. As used in sections 145.832 to 145.845, unless the context otherwise requires, the terms defined in this section have the meaning ascribed to them.

Subd. 2. "Health care facility" means any facility licensed under sections 144.50 to 144.56, or any nursing home licensed under sections 144A.02 to 144A.11; but does not include any facility licensed under sections 245.781 to 245.813 or 252.28, unless the facility is a vendor of medical care under section 256B.02, subdivision 7, and is certified as any type of intermediate care facility or skilled nursing facility or is operated by the commissioner of public welfare as a state hospital. "Health care facility" also includes any facility in which services are provided primarily for the treatment of kidney diseases.

Subd. 3. "Health services" means all clinically related services, diagnostic, treatment or rehabilitative, that are cost centers utilized by a health care facility for its accounting purposes. The cost center shall conform to definitions of cost centers recognized by generally accepted accounting principles and shall conform to the cost center definitions utilized in reports of the facility, or organization to any other state agency or program. The cost centers include alcohol, drug abuse and mental health services.

Subd. 4. "Predevelopment activity" means any activity by or on behalf of a health care facility or any person which occurs in preparation for the offering or development of a new institutional health service if the predevelopment activity would require an expenditure in excess of $150,000 or if the predevelopment activity involves any arrangement or commitment for financing the offering or development of a new institutional health service.

Subd. 5. "Construction or modification" means:

(a) Any erection, building, alteration, reconstruction, modernization, improvement, extension, lease or other acquisition, or any purchase, lease or other

COMMITTEE REPORT

HOUSE

FURTHER:

Date: _____

Mr. Speaker:

The Committee on _____ has had _____

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)

[ ] replace with CS for _____ [ ] same title [ ] new title

and recommends _____

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

[ ] reports it back without recommendation

[ ] referred to the _____ Committee

MEMBERS SIGNING DO PASS

MEMBERS HAVING OTHER RECOMMENDATIONS:

Mike Davis Do not Pass

CHAIRMAN

H 60

SOURCES OF HOSPITAL FUNDING

Ak statue: 25% construction cost reimbursement AS 29.90.010

$250,000 or $2500 per bed operating grant

Capital budget process through legislature funds major construction.

Tax free bonding capability via Alaska Medical Facility Authority provides access to lower rates on bonds.

Approximately 30 to 42% of hospital revenues are from state and federal funds.

State medicaid has risen from a 2 million dollar program in 1972 to 70 million dollar program today.

2-25-83 9:40 AM

MAE-MICO:

ENTITLEMENTS OUTSTANDING AS of JULY 1, 1983
(FY84) 25% Hospital REIMBURSEMENT

FAIRBANKS MEMORIAL	1,215,281	1 YR REMAINING
JUNEAU DETOX FACILITY	75,059	3 YRS REMAINING
KENAI - CENTRAL PEN. HOSPITAL	2,167,338	4 YRS REMAINING
#	3,457,678	

Proposed Amendment to SSAB 19

By Dem. H

Section 4 AS 29.90.010 - 29.90.030 is Repealed

Section 5. Those hospitals or health facilities which are currently receiving funds pursuant to ~~sections~~ AS 29.90.010-29.90.030 shall continue To receive construction AID AS Though AS 29.90 were not repealed until its entitlement is satisfied. No new applications shall be received a processed after the effective date of this legislation

Dorothy Turnbaw - Fbks citizen
Speaks against repeal:

Dennis DeWitt - Pres Ak St. Hosp. Assn
Supports the repeal:
will reduce Consumer costs
Medicaid
Cost of care containment has not occurred

Susan Callan - Health System Agency
Speaks for repeal: raise thresh. to Fed. Regs.
+ tie it to inflation

Peggy Wilson - Staff to Health Resources System Agency.
Speaks against repeal:
Ak Rev. cost 409
St of Wash - 262

John (Penn) Pruah / Phebe Findsay - D.H.S.S.
Supports Repeal: must look at the following in Retrospective
1. Medicaid.
2. C.O.N.
3. Health Care Cost
4. Capital Budget - tighter review process.
5. Revenue Sharing - Capital projects
all requests for funding goes thru C+R A.
Repeal should be in Conjunct with
review Capital process.

1. Re-Completion
2.

Elaine Sitka – Art Wilman

Bonnie Observer – Ketchikan – John Manning (SE. Ak Health agency)

Barbara Arch – Susan Callan Health systems agency
Peggy Wilson

Tom Meniger – FBks Memorial Hospital administrator
speaks for repeal: expensive, cumbersome, delays construction which is expensive daily, short building season, public input by Hospital boards. State has not saved $. Medicaid population # hasn't increased. The # of requests + services have increased

Question: Banker.
60% State $

Dr Bierne:
Speaks against Repeal:
Wants modification (major) upward to $1 mil of $ + thru amendment.

Art Wilman – SE. AK. Health Systems agency
Speaks against Repeal: agrees w/ Bierne
the law + regs are to cumbersome but gives some control by citizens. Threshold to $1.5 mil.

Al Swiadon – Blue Cross
Speaks against repeal: will increase care costs, recommends capital thresh to $1 mil.
Remove some juris. by State agencies.
streamline process, use of local health committees,
one agency to make recommendations to Grantor i.e Planning + Develop.

Rep Clarkson – Speaks against

no cost controls
- not a free market
- Consumer indifference
- high cost of Technology.
- Lack of info in the consumer info

now state has repealed – only sunset Provisions

Cost to State – $250,000 FY84

Lack for documentation from witnesses on "Costs" of CON.

Studies show 2/3's in savings w/ CON.

Anch – projected need Bed capacity 575 beds to 606 beds

692 total if CON approved w/ Humana + Providence

Waste of Taxpay $

Humana – " will build w/out taxpay funds

but 30% revenue rec'd from Bed occupancy.

Medicare etc

Per bed
$196 mil Providence – 250 added Beds 186 mil $206
$150 thou Humana – 200 ad. beds 50 mil $161

$ Medical Care in State – $ 15B mil paid under CON

22 mil = 25% Construction re-imburse

7.5 mil – Operating

Medicaid, Corrections, etc

Proposed Substitute:

Increase Threshold to Fed law or above

$ 400 thou – Equip

$ 600 thou – Construction

Exempt – any replacement of Equipment

Non-Medical equip + Construction

Any purchase or expense to meet fire + other codes

1. Simplify + streamline CON
2. Impose deadline Commissioner decision
3. Do the health care input adequate

Establish a rate review Council - Tough
Type Tie appropriate w/ approval.

Dennis DeWitt -

719 Beds established

~~Consultant~~

Mr Davis - Providence occupancy 80% overall

Consultant -
beds filled

HOUSE HESS
COMMITTEE MEETING
AGENDA

DATE: February 25, 1983

TIME: 1:00 pm

I. Call Meeting to Order

A. Note Committee Members Present

B. Welcome Those Observing

C. Remind those wishing to testify to sign up, and those giving testimony to speak up and state their names.

II. Announce Legislation Under Consideration:

SSHB 19 An act repealing the certificate of need program.

Other notes or reminders:
Announce / Ask Committee about Confirmation Hearings

Monday, February 28, 1983

HCR 17	Relating to the state medal for heroism.
HJR 27/ SJR 11am	Relating to health care delivery to non-Native dependents by the U.S. Public Health Service.
HB 117	An act relating to sexual abuse of a minor.
HB 127	An act to increase punishment for sexual assault in the first degree.
HB 128	An act raising penalties for promoting child prostitution.

MAE —

FEB 16 1983

CERTIFICATE OF NEED:

REVISION OR REPEAL

Prepared in
the
Public Interest
by
the

ALASKA HEALTH COALITION
February, 1983

Alaska Health Coalition

529 5th Avenue, Suite 8
Fairbanks, Alaska 99701
(907) 456-2553

February 11, 1983

FEB 16 1983

TO: Members of the Alaska Legislature

Proposed legislation (HB 19 and SB 85) would repeal Alaska Statute 18.07.031-18.07.111, better known as the Alaska Certificate of Need (CON) law. These bills reflect the position of the Alaska Hospital Association, whose member institutions are subject to the provisions of the CON process. The attached paper, developed by the Alaska Health Coalition, was written to provide legislators and the public with a series of alternatives to consider during discussion of these important bills. The paper summarizes the provisions of the CON law, discusses several of the problems which have been identified with the current process, and reviews the effectiveness of the CON program, both nationally and within Alaska. In addition, a list of recommendations is provided for consideration in revising the current CON law.

The Alaska Health Coalition is a group of interested citizens with memberships from the three Alaska Health Systems Agencies and the Statewide Health Coordinating Council. The primary purposes of the Coalition are to review the need for health planning, development, and promotion activities and to develop goals, describe functions, and recommend structures to achieve optimal health for the citizens of the state. Therefore, we believe that the subject of public review of capital expenditures as currently provided for in the Certificate of Need law is an important issue which deserves a reasonable, objective discussion. We present this paper for the purpose of initiating this discussion.

For additional information, please contact any of the following organizations: Northern Alaska Health Resources Association, Fairbanks (456-2553); South Central Health Planning and Development, Anchorage (278-3631); or, Southeast Alaska Health Systems Agency, Ketchikan (225-9681).

Best regards,

Chas M. Kaltenbach

Charles M. Kaltenbach, Dr. P.H.
Chairman

CMK:sem

Enclosure

Coalition Members

J. B. Carnahan, Fairbanks; Joseph Cladouhos, Juneau;
Charles Kaltenbach, Dr. P.H., Fairbanks; Steve Lesko, Anchorage;
John Manning, Ketchikan; Lillie McGarvey, Anchorage; Art Willman, Sitka; Margaret Wilson, Anchorage

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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, an effective market for health care services does not exist in most communities. Competition exists but it is rarely price competition; indeed the nature of current competition based on scope of services, amenities, and convenience is to encourage price increasing 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 taxpayers).

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.[8]

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.

REFERENCES CITED

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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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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.

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

The Governor designated a State Health Planning and Development Agency (SHPDA) as a unit of State government. The SHPDA has the responsibility to conduct the health planning activities of the State, including preparation and implementation of the State Health Plan, and to provide coordination of the HSAs. The SHPDA also supports the function of the Statewide Health Coordinating Council and is responsible for administration of the Certificate of Need program. In Alaska, the SHPDA resides within the Department of Health and Social Services. It currently occupies division-level status.

STATEWIDE HEALTH COORDINATING COUNCIL

The Alaska Statewide Health Coordinating Council (SHCC) is the third entity involved in the State health planning network. The SHCC is a group of citizens appointed by the Governor who oversee the health planning activities within the State. Specifically, they have responsibility for preparation of the State Health Plan. The State Health Plan forms the basis upon which Certificate of Need applications are reviewed. Both the SHPDA and SHCC are supported with a mix of Federal and State funds.

POSITION PAPER/Department of Health & Social Services

Tischer

Position Paper

on

Senate Bill 85 & HB 19

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

Senate Bill 85 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 Senate Bill 85 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

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

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: 2/16/83

Approved by: for John R. Smith

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

Date: 2/16/83

Bill No: Senate Bill 85 Date on Bill: 1/27/83
Title: An Act repealing the certificate of need program;and providing for an effective date
Sponsor: Senators Faiks, P. Fischer, and Pettyjohn
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 Phone: 465-3038
Division: State Health Planning and Development Date: 2-14-83

Approved by Commissioner: Jack R. Fry Date: 2/16/83
Department: Health and Social Services Date:

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

Central Peninsula General Hospital

P. O. Box 1268
SOLDOTNA, ALASKA 99669

OPERATED BY
LUTHERAN HOSPITALS AND HOMES SOCIETY
FARGO, NORTH DAKOTA 58102

February 14, 1983

The Honorable Mae Tischer
Alaska State House of Representatives
State Capitol
Pouch V
Juneau, Alaska 99811

FEB 18 1983

Subject: House Bill #19

Dear Representative Tischer:

Central Peninsula General Hospital, along with the other hospitals of the Alaska State Hospital Association, would encourage the earliest possible passage of Senate Bill #85.

It is a premise of this organization that the Certificate of Need process is both cumbersome and ineffective in a state such as Alaska. The original purpose was developed to help contain health care costs by discouraging over-building of hospital beds. The State's major health care problem is not over-bedding, but the continuing lack of accessibility to health care programs and facilities due to the rural nature of our state.

I would encourage our legislators to promote the health care agencies in the planning and providing for better health care, and not tying up their time with the fruitless Certificate of Need process.

Please find attached a copy of a letter from the Central Peninsula General Hospital Service Area Board to the Kenai Peninsula Borough Assembly in support of the repeal of the Certificate of Need process.

Again, passage of this legislation at the earliest time is available.

Thank you for your consideration.

Sincerely yours,

Michael J. Lockwood,
Administrator

MJL/pt

enc. (1) Resolution of the Central Peninsula General Hospital Service Area Board for Repeal of the C.O.N.

Central Peninsula General Hospital

P. O. Box 1268
SOLDOTNA, ALASKA 99669

OPERATED BY
LUTHERAN HOSPITALS AND HOMES SOCIETY
FARGO, NORTH DAKOTA 58102

February 11, 1983

Kenai Peninsula Borough Assembly

At its regular meeting on February 10, 1983, the Service Area Board of the Central Peninsula General Hospital unanimously endorsed Resolution 83-13 "Urging the Alaska Congressional Delegation to work for Repeal of 42 USC 300 M (D) and Urging the State to subsequently repeal AS18.07 03L-111 which provides for a Certificate of Need program for the Construction, Alteration of Bed Capacity, or Addition or Elimination of a Category of Health Services of a Health Care Facility.

To this end the Service Area Board also endorses House Bill 19 and Senate Bill 85, 2 bills that have been introduced in the 1983 Alaska State Legislature.

Copies of this endorsement have been sent to Senators Stevens, Murkowski and to Congressman Young as well as the Alaska State Legislators.

Robert F. Jensen

ROBERT F. JENSEN
Chairman
Service Area Board

alaska state hospital association

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

REPRESENTING ACUTE, LONG TERM AND OUTPATIENT FACILITIES

Chairman of the Board
Ronald A. Pavellas
Humana Hospital Alaska
Anchorage

Chairman-Elect
Mark Hawkins
Sitka Community Hospital
Sitka

Immediate Past Chairman
Tom Mingen
Fairbanks Memorial Hospital
Fairbanks

Secretary/Treasurer
Edward Zeine
Cordova Community Hospital
Cordova

Delegate to the American Hospital Association
Al M. Camosso
Providence Hospital
Anchorage

Alternate Delegate to the American Hospital Assoc.
Michael Lockwood
Central Peninsula Hospital
Soldotna

Delegate to the American Health Care Association
Jack Buck
St. Ann's Nursing Home
Juneau

Alternate Delegate to the American Health Care Association
Emma G. Ivy
Wrangell General Hospital
Wrangell

Delegate to the Association of Western Hospitals
Michael Herring
South Peninsula Hospital
Homer

Alternate Delegate to the Association of Western Hospitals
Daniel Van Wieringen
Kodiak Island Hospital
Kodiak

Trustee Delegate to the American Hospital Assoc.
Moe Kadish
Trustee, Providence Hospital
Anchorage

Alternate Trustee Delegate to American Hospital Association
Robert Jensen
Central Peninsula Hospital
Soldotna

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

President
Dennis L. DeWitt
Juneau

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.

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to American Hospital
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Central Peninsula Hospital
Soldotna

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

President
Dennis L. DeWitt
Juneau

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.

#1

DEC Zoning Meeting

PROVIDENCE HOSPITAL

SISTERS OF PROVIDENCE

SERVING IN THE WEST SINCE 1856

3200 PROVIDENCE DRIVE - POUCH 6604
ANCHORAGE, ALASKA 99502
PHONE: (907) 276-4511

December 27, 1982

Mayor Tony Knowles
Municipality of Anchorage
Pouch 6-650
Anchorage, Alaska 99502

Dear Mayor Knowles:

Thank you for the opportunity on December 13 to share Providence's plans and some of our concerns with you.

One point came up during our discussion regarding Certificate of Need (CON). I would like to elaborate for you in more detail why the health care providers in Alaska oppose CON and have so strongly supported its repeal.

As you know, the CON law was passed in this and most other states as a requisite to receive Federal funds. The major impetus for the law were:

1. Excess hospital beds in many large cities, and
2. 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 desired throughout the country. The law is cumbersome, wasteful and, in fact, costly.

The lack of "success" is especially true in Alaska for some basic reasons:

1. The process which the law sets in place is cumbersome and wasteful. The institution must:
   - submit a letter of intent at least 60 days prior to an application (for no apparent reason);
   - submit an elaborate, repetitive application (most are well over 100 pages). There are 12 separate "criteria" which must be addressed in any application;
   - wait to be declared complete (minimum 20 days; several of our applications were delayed months);
   - then go through a 90-day review process--with three or four public meetings.

2. The costs of CON to the institution are enormous to prepare this cumbersome document (at least 35 copies) and submit to the minimum 110-day process. There are also the institutional costs of delaying implementation and watching the price of a piece of equipment or construction project increase several percent points with inflation.

   The cost to the public is also great in the state, regional and local staff needed to coordinate the program, prepare staff analyses and hold public meetings.

3. The dollar limit for what must be reviewed has been ridiculously low--$150,000. The federal law has allowed that limit to be raised to $400,000 and $600,000 although the Alaska legislature failed in its last session to raise the limits. Some states have raised the limit to $1 million or more. To have a limit of $150,000 or even $600,000 when the hospital's annual operating budget is $75,000,000 (such as Providence's) is overkill.

   In just 1982 alone, Providence has prepared 6 CON applications, including two equipment replacements (for a CT Scanner and a Cath Lab), a $250,000 computer enhancement for an x-ray machine and most absurd, a $167,000 replacement incinerator (25 years old, replacement required by State and EPA codes!). The State did not give final approval on the incinerator until the 90th day.

4. The law itself is overkill in Alaska. Designed for areas of heavy population, excess hospital beds and competition, the law does not work for Alaska for several reasons:

   - The law only covers private facilities--not public health, nor state owned (API or Pioneer Homes), nor military.

   - Alaska has only one city with more than one hospital and only three private ("eligible") hospitals of over 100 beds.

5. The law is reactive to existing decision making processes. Most hospitals in the State already have local public review and approval designed in their own budget review processes. Many hospitals are owned by municipalities, and all have governing or advisory boards of local citizens. These citizens should have control of the expansion and budgetary decisions of their own institutions. Several other layers are unnecessary. Hospitals and their boards are capable of making sound financial and program decisions.

As the attached Policy Statement of the Alaska State Hospital Association (ASHA) notes, we are supportive of state and local planning for the health care needs. The process should be positive and proactive-- encouraging institutions to respond to needs in the community rather than reactive, cumbersome and negative.

We encourage the city to support the ASHA position on repealing the state CON law. Your own Municipal Health Commission is a strong local planning body which helps identify health needs and encourages solutions. It also serves to review public expenditures in health. Those roles are appropriate. It should be freed from the cumbersome CON review.

Thank you for giving me the opportunity to share our concerns with you.

Best wishes for a prosperous 1983.

Sincerely,

Al M. Camosso
Administrator

Enclosure

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Region X
M/S 829 Arcade Plaza Building
1321 Second Avenue
Seattle WA 98101

June 22, 1982

Re: 10P 550016
Alaska SHPDA

Dennis L. DeWitt
President
Alaska State Hospital Association
319 Seward Street
Juneau, Alaska 99801

Dear Mr. DeWitt:

Your letter dated June 11, 1982, requested information about Region X's intentions as a result of the failure of the Alaska Legislature to pass amendments proposed to bring the State Certificate of Need program into compliance with the Federal planning law, as amended. Our course of action is quite clear. We will continue to fullfill our mandated responsibilities guided by actions and time frames specified in the law.

Under the existing provisions of Title XV of the Public Health Service Act, as amended, current law requires (in order to be fully designated) that a SHPDA must meet all requirements for full designation, including that of having a complying Certificate of Need program.

If a SHPDA is not eligible for full designation by a certain date (which for Alaska is January 19, 1983) the Department must invoke the statutory penalty of reducing most Public Health Service grants and contracts to any entity in the State by 25% the first year, 50%, 75%, and 100% over the next three years. Amendments contained in PL 97-35 extended the date by which a State must have a fully designated SHPDA to avoid imposition of the penalty. However, PL 97-35 also amended Section 1521(b)(2)(B) by specifying that a conditional designation agreement could not extend beyond a State's penalty date.

Fully designated SHPDAs (such as Alaska) which do not have complying CON programs but continue to meet other requirements, will be returned to conditional designation. As noted above, PL 97-35 prohibits the conditional designation of any SHPDA from extending beyond its penalty date. Any SHPDA which remains conditionally designated on its penalty date must be terminated. Therefore, we will send a termination notice to any conditionally designated SHPDA 90-days prior to its penalty date, if it still has not demonstrated that it has a complying CON program.

The enclosed copy of a letter to Commissioner Beirne, from the Regional Health Administrator, further emphasizes the critical nature of having a complying CON program in Alaska.

Also the enclosed copy of a 1981 letter addressed to Mr. Ivan Lawner, Esq. concerning Pioneer Homes Certificate of Need review issues, reflects our unchanged position.

I hope the facts in this letter provide the detail of information required to understand the situation. Please call or write, should you need further assistance.

Sincerely,

John D. Whitney
Director
Department of Health
Resources Development
Region X

Enclosures (2)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

829

JUN 21 1982

Re: IOP 550016
Alaska SHPDA

Helen D. Beirne, Ph.D.
Commissioner
Department of Health and
Social Services
Pouch H 01
Juneau, Alaska 99811

Dear Dr. Beirne:

The State of Alaska's Department of Health and Social Services full designation agreement with the Department of Health and Human Services is being extended for three months, until September 30, 1982. As you know, because Alaska's Certificate of Need Program does not comply with Federal requirements, it is necessary that the SHPDA be returned to conditional designation. As required by statute, this 90-day extension of your current designation is being given to allow you to request and prepare for a hearing, if you should want one. Letters from the Bureau of Health Planning to you and to the Governor will further explain this process.

The following conditions are to be considered a part of the extended full designation agreement:

1. If the Agency is unable to retain full designation after September 30, 1982, it will be returned to conditional designation for the period October 1, 1982 to June 30, 1983.

2. The designation of the Agency will automatically terminate when the Agency reaches its penalty date, if the Agency still has not achieved full designation.

You may at any time prior to your penalty date (1-19-83, per PPM 82-12) submit documentation which you believe contains evidence that the State's CON program complies with the minimum Federal requirements, or a certification by the State's Attorney General, attesting to the program's complian

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Please sign both copies of this letter, indicating your acceptance of this extension with conditions. Return one copy to this office. As soon as we receive the signed copy, we will issue a Notice of Grant Award for the extended designation period.

Sincerely,

Dorothy H. Mann, M.P.H.
Regional Health Administrator
Region X

Helen D. Cairne, Ph.D.
Commissioner
Alaska Department of Health

Date

DHRD:ROSS:vw:6/21/82

DEPARTMENT OF HEALTH & HUMAN SERVICES

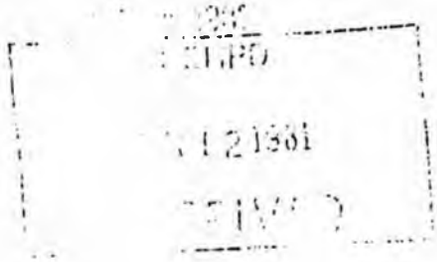
Public Health Service

Pioneer Homes
Lynns Room

Region X
M/S 829 Arcade Plaza Building
1321 Second Avenue
Seattle WA 98101

Re: IOP 550007-05

Mr. Ivan Lawner, Esq.
Hellen & Partnow
524 G Street
Suite 710
Anchorage, Alaska 99501



Dear Mr. Lawner:

This is to respond to your recent letter concerning Certificate-of-Need review of a skilled nursing facility addition to the Pioneer Home in Anchorage. In that correspondence you raised two issues: the need for clarification of our 1978 letter to Howard Gabriel regarding C/N coverage of Pioneer Homes, and the compliance of the Alaska C/N program with federal standards. These matters will be addressed separately.

1. In our September 11, 1978 letter to Howard Gabriel, Director of the Southeast Alaska HSA, we were assuming that Pioneer Homes were only residential or domiciliary care facilities; there was no understanding that inpatient skilled nursing care was provided in these institutions. Given this understanding of the nature and services of Pioneer Homes at that time we were correct in concluding that they would not be included in the federal definition of "health care facilities" which would require coverage under Certificate-of-Need programs. If indeed skilled nursing services are provided in these institutions, they would be considered "health care facilities" as defined by our C/N regulations. The 1978 letter did not consider a Pioneer Home to be such a facility.

2. We have reviewed the Alaska C/N statute and implementing regulations to determine whether Pioneer Homes would be included in the definition of a health care facility. We found that:

   a. The Alaska C/N statute defines a "health care facility" as:

      A private, municipal. . . hospital, psychiatric hospital, turberculosis hospital, skilled nursing facility. . . . (Sec. 18.07.111(7)).

   b. The Alaska C/N regulations, in turn, define "health care facility" as:

      Any of those listed in AS 18.07.111, as defined, where appropriate, in 42 CFR 123.401 (adopted 1/21/77). (7AAC07.130)

c. The State's C/N statute and regulations, taken together and including the cross reference to 42 CFR 123.401, would provide coverage of a distinct part of an institution and would, therefore, meet the federal definition of a skilled nursing facilities, i.e., an institution or a distinct part of an institution which is primarily engaged in providing inpatient skilled nursing care and related services for patients who require medical or nursing care . . . . (42 CFR 123.401)

From the above points, it would appear that the Alaska C/N program adequately defines "heath care facility" and "skilled nursing facility." It is the responsibility of the state to follow its own C/N statute and regulations. If there is an on-going and sustained pattern of not following their statute and regulations, we would certainly assess the state's overall C/N program and then take appropriate action.

Please call us should you have further questions.

Sincerely yours,

John D. Whitney, Director
Division of Health Resources
Development PHS, Region X

cc: Ron Hammett, Director, SCHPD
Howard Gabriel, Director, SEAHSA

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPARTMENT OF ADMINISTRATION

OFFICE OF THE COMMISSIONER

POUCH C
JUNEAU, ALASKA 99811

465-2200

May 29, 1981

Honorable Donald E. Clocksin
Chairman, Health, Education and
Social Services
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Representative Clocksin:

This is in response to your request to put in writing my verbal testimony before your committee on CSSB 225. I will try and confine my remarks to the major issues.

Administration's position is that the Legislature has always implicitly exempted Pioneers' Homes from the certificate of need program. The Senate has concurred with this position as evidenced by CSSB 225. We are asking that the House members be afforded the same opportunity to express their will as the Senate.

There appears to be some confusion existing with the recent State Supreme Court decision of South Central Health Planning and Development, Inc. vs the Department of Administration, on certificate of need. At issue was whether or not the Legislature exempted Pioneers' Homes from certificate of need. The court found that there is no language in State statutes which can reasonably be read as exempting skilled nursing facilities from the certificate of need process when they are contained in Pioneers' Homes. Consequently, whether or not the Legislature intended to exempt Pioneers' Homes now becomes moot. The Legislature's intent can now be established only through the legislative process of amending existing law to allow this exemption.

There has been a substantial amount of discussion centering around the need for proper planning so that health facilities in Alaska are not overbuilt. This is an admirable and worthy objective, and I can assure you that this Department supports health facility planning. However, the existing system under the certificate of need program is fraught with inequities and frustrations; further, it does not represent a comprehensive planning effort.

C-89LH

There are three providers of health facilities; the federal government, the State government, and the "private sector." However, the federal health facilities don't come under the certificate of need program, and in most states this wouldn't pose any problem. The military contingent in California, for instance, would represent a small portion of the state's total population and as such would not greatly impact the planning process for certificate of need. In Alaska, the opposite is true. The federal government is a major provider of health care and facilities. Roughly one-fourth of the state's population are eligible to use federal health facilities (military base, Public Health, Indian Health, etc.). This has a devasting effect on trying to logically plan for state and "private sector" health facilities when a critical component is missing.

In addition, if we look closely at the "private sector" we see that it is not truly private. A substantial portion of the revenues of private nursing homes and health facilities originate through state and federal programs. State and federal rules, regulations, requirements, and laws, guide and govern, in minute detail, the construction and operation of private health facilities. This includes the proper ratios of professional staff to patients, the type of equipment allowed, size of hallways, reporting procedures, and many others. In effect, the "private sector" is part of the "public sector." Consequently, the charge that the State, through the establishment of Pioneers' Homes, is unfairly competing with the private sector is a fallacious argument.

There has also been considerable discussion on the impact of granting Pioneers' Homes an exemption from certificate of need as it relates to federal programs. Mr. Vern Perry, Director of the Division of Pioneers' Benefits spoke with Mr. Jim Egan, Regional Project Officer of the Office of Health Planning, Region X, U. S. Department of Health, Education and Welfare, on Wednesday May 27, regarding the certificate of need program.

QUESTION: What effect would there be on the State of Alaska if Pioneers' Homes were exempted from the certificate of need program?

ANSWER: It would have no effect on medicare, medicaid, AFDC or Indian Health Service. It could only affect categorical programs such as alcoholism, EMS, Neighborhood Health Clinics, Mental Health Clinics, Day Care, etc.

QUESTION: Would the federal government actually discontinue such programs as alcoholism and mental health if Pioneers' Homes were exempted from the certificate of need program?

ANSWER: No! Absolutely not. In his opinion, under the new administration, there would be no federal sanctions whatsoever in health care programs, especially since the responsibility for this is being turned over to the states.

Further, discussions were held with the States of California and Washington regarding their certificate of need programs. In California, Mr. Ken Umbach (916/323-6955) of the Office of Statewide Health Planning and Development was contacted. He stated that California has been out of conformance with the federal certificate of need program since 1969. Their latest date for coming into conformance is October. He stated that if they did not meet the deadline that the feds would probably extend it. Mr. Jim Bettridge of Washington Health Care Facilities Authority (206/753-6185) indicated that the feds were withdrawing total support from the certificate of need program by 1983.

These conversations indicate that:

i. The federal government is not inclined to impose sanctions on a State for nonconformance with the certificate of need program;

ii. There are states which are nonconforming, and have been nonconforming for a number of years, on which federal sanctions have not been imposed; and

iii. The federal government is withdrawing total support for the certificate of need program by 1983. If the state wants to continue a planning process for health facility development it will have to provide for the process by using General Funds monies. Based on the aforementioned problems, now would be the appropriate time to revise this planning process to make it more meaningful.

Finally, a compromise position has been mentioned in which the new nursing wing at the Anchorage Pioneers' Home and the new Pioneers' Home in Ketchikan would be totally grandfathered into law and not made subject to certificate of need. This compromise does not address a truly complex problem.

The Fairbanks Pioneers' Home presently is serving twelve skilled nursing beds in unlicensed beds. Unless a certificate of need is issued which allows licensing of these beds, these twelve pioneers would have to be discharged.

The Fairbanks and Palmer Pioneers' Homes are full to capacity with skilled nursing patients at the present time. If we are to accommodate anticipated need in the near future, additional skilled nursing facilities will have to be constructed within the next few years. This expansion would be impossible unless a certificate of need is issued.

The Department of Health and Social Services, in recent licensing inspections, has advised a significant number of residents in the ambulatory sections of all the Pioneers' Homes should be designated intermediate care patients. Intermediate care requires both a certificate of need and a significant increase in staffing, installation of call buttons or other signalling devices, and closer attention to patients when taking medications, etc. The number of patients which might be considered in need of intermediate care are: thirty at Sitka, twenty at Fairbanks, twenty at Palmer and forty at Anchorage (in the new wing).

Funding to provide intermediate care was not included in the FY 82 operating budget. Although a dollar figure is not available at the present time, a significant increase will be necessary if we must comply with the certificate of need program. Passage of SB 225 would eliminate this situation.

In summary:

1. Administration believes the Legislature had always intended to exclude Pioneers' Homes from certificate of need;

2. The certificate of need process is not appropriate for Alaska;

3. There needs to be planning for health care facilities and a more responsive process needs to be developed;

4. Grandfathering the nursing wing at Anchorage and the new Pioneers' Home at Ketchikan will not solve the complex problems existing at the Fairbanks, Palmer, and Sitka Pioneers' Home; and,

5. Passage of CSSB 225 will eliminate the potential for pain and suffering by allowing Pioneers' Homes residents to remain in their home.

If I can be of any further assistance to you or your committee, please give me a call.

Sincerely,

Frederick B. Muller

Frederick B. Muller
Deputy Commissioner for
Personnel Management

FBM/mjc
cc: Honorable Charles Parr
Honorable Robert Ziegler
Honorable Jalmar Kerttula
Honorable Patrick Rodey
Pioneers' Homes Advisory Board
Dennis Dewitt, Executive Director
Alaska State Hospital Association

accordance with subsection (b)(2), or (b)(3) of this section (as the Secretary determines appropriate), enter into another agreement with the Governor for the designation of a State Agency.

Failure to designate State Agency within specified period; reduction in allotment, grant, loan, loan guarantee, or contract

(d)(1) If an agreement under subsection (b)(3) of this section for the designation of a State Agency for a State is not in effect upon the expiration of—

(A) the fourth fiscal year which begins after 1975; or

(B)(i) if the legislature of the State is in a regular session on December 17, 1980 and the legislature will be in session for at least twelve months from such date, twenty-four months from such date, or

(ii) if the legislature of the State is in session on December 17, 1980, but twelve months do not remain in such session after such date or if the legislature of the State is not in session on such date, twenty-four months after the beginning of the first regular session of the legislature beginning after such date,

whichever occurs later, the Secretary shall take the action prescribed by paragraph (2).

(2) If upon the expiration of the period applicable under paragraph (1) an agreement is not in effect for the designation of a State Agency for a State, the Secretary shall until such an agreement is in effect take the following action:

(A) During the first twelve months after the date of the expiration of the applicable period, the Secretary shall reduce by 25 percent the amount of each allotment, grant, loan, and loan guarantee made to and each contract entered into with an individual or entity in such State during such period under this chapter or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970.

(B) During the second twelve months after such expiration date, the Secretary shall reduce by 50 percent the amount of each such allotment, grant, loan, loan guarantee, and contract.

(C) During the third twelve months after such expiration date, the Secretary shall reduce by 75 percent the amount of each such allotment, grant, loan, loan guarantee, and contract.

(D) After the expiration of thirty-six months after such expiration date, the Secretary may not make or enter into any such allotment, grant, loan, loan guarantee, or contract.

(July 1, 1944, c. 373, Title XV, § 1521, as added Jan. 4, 1975, Pub.L. 93–641, § 3, 88 Stat. 2242, and amended Aug. 1, 1977, Pub.L. 95–83, Title I, § 106(*l*), (m), 91 Stat. 385; Dec. 19, 1977, Pub.L. 95–215, § 6(b), 91 Stat. 1507; July 16, 1979, Pub. L. 96–33, 93 Stat. 86; Oct. 4, 1979, Pub.L. 96–79, Title I, § 123(a), (b)(1)(A), (2), (d), (f), (g)(2), 93 Stat. 624–627; Oct. 17, 1979, Pub.L. 96–88, Title V, § 509(b), 93 Stat. 695; Dec. 17, 1980, Pub.L. 96–538, Title III, § 303(b), 94 Stat. 3190; Aug. 13, 1981, Pub.L. 97–35, Title IX, §§ 902(g)(5), 936(b), 95 Stat. 561, 572.)

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

POUCH H 01
JUNEAU, ALASKA 99811
PHONE: 465-3030

May 10, 1982

The Honorable Mike Beirne
Chairman
House HESS Committee
Alaska State House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Rep. .sentative Beirne:

I am enclosing a Program Policy Notice we recently received from the Bureau of Health Planning in the U. S. Department of Health and Human Services. This Notice emphasizes that states which do not have State Health Planning and Development Agencies which fully comply with federal requirements will lose federal support for health planning efforts and will also lose most federal Public Health Service dollars. Alaska currently receives some $5 million annually in such federal funds. Our lack of compliance would result in one quarter of these funds being withheld for four years until certain federal public health service funds are no longer available to Alaska.

We appreciate the hearing you conducted on House Bill 195. We believe this bill, with the amendments we offered, would bring our State Health Planning and Development Agency into full compliance with federal requirements. Your assistance in helping to move this legislation would be very much appreciated.

We appreciate your assistance and support in this matter.

Sincerely,

Helen D. Beirne

Helen D. Beirne
Commissioner

Enclosure

cc: Phoebe A. Lindsey

HF38LH

ALASKA STATE MEDICAL ASSOCIATION
4107 Laurel Street • Suite 1 • Anchorage, Alaska 99504 • (907) 277-6891



ADOPTED BY THE ALASKA STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES AT ITS ANNUAL MEETING IN FAIRBANKS, ALASKA JUNE 8, 1982

RESOLUTION NO. 82-23

SUBJECT: Certificate of Need

WHEREAS, the certificate of need process has increased the cost of health care rather than reduced it; and

WHEREAS, the certificate of need process has wreaked havoc upon the orderly development of hospitals in Alaska, therefore

BE IT RESOLVED, the Alaska State Medical Association urges and encourages the Legislature to repeal the certificate of need law.

DISTRIBUTION: Legislature
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Press

alaska
state
hospital
association

319 Seward St., Juneau, Alaska 99801 • (907) 586-1790
REPRESENTING ACUTE, LONG TERM AND OUTPATIENT FACILITIES

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Moe Kadish
Trustee, Providence Hospital
Anchorage

Alternate Trustee Delegate to American Hospital Association
Robert Jansen
Central Peninsula Hospital
Soldotna

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

President
Dennis L. DeWitt
Juneau

November 4, 1982

The Honorable Ted Stevens
United States Senate
Washington, D.C. 20510

Similar letter sent to:
Senator Murkowski and
Congressman Young

Dear Senator Stevens:

As you are well aware the State of Alaska is not in conformity with the National Health Planning and Development Act and without federal action in 1982 faces penalties in grant monies under the Public Health Service Act and the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970. To avoid this penalty it is imperative that Congress repeal 42 U.S.C. 300m-(d) (copy attached).

This Association as well as the Alaska State Medical Association (resolutions attached) are opposed to the continuation of the state Certificate of Need law. Both are committed to its repeal in 1983. Repeal of 42 U.S.C. 300m-(d) will greatly assist our efforts.

We have communicated our support for various measures considered by this Congress to restructure the federal law. It appears however, that a full reform may be a consideration which must be left to the next Congress. If that is so, it is imperative that you secure repeal of 42 U.S.C. 300m-(d) before the current Congress adjourns in December.

All of those concerned with this issue including Congressman Waxman, the National Governors Conference, the American Hospital Association, etc., agree on removing sanctions against states which do not conform to the federal program. The notion of further delay of the sanctions does not assist anyone, it simply prevents states such as Alaska from dealing with its own law on anything beyond a temporary basis.

For these reasons we urge you to secure the repeal of 42 U.S.C. 300m-(d). This will permit the legislature of the State of Alaska to deal with its law in whatever manner it deems appropriate. Further, we urge that this repeal be secured prior to the adjournment of the 97th Congress.

Sincerely,

Dennis L. DeWitt
President

DLD:lf
cc: Friday Mailing
Alaska State Medical Society
Governer Jay Hammond
Governer Elect Sheffield
Lt. Governer Terry Miller
Lt. Governer Elect McAlpine
American Hospital Association - Lynn Hart
Federation of American Hospitals

BILL SHEFFIELD, GOVERNOR

STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

December 22, 1982

Mr. Dennis L. DeWitt
President
Alaska State Hospital Association
319 Seward Street
Juneau, Alaska 99801

Dear Mr. DeWitt:

Thank you for sending me a copy of your letter to Senator Stevens regarding the state Certificate of Need law.

As you know, I am in agreement with you in your opposition to this law. Please keep me posted as to what I can do to change the law in Alaska.

Best regards.

Sincerely,

Bill Sheffield
Governor

Blue Cross
of Washington and Alaska

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

FEB 18 1983

February 14, 1983

Representative Mae Tischer
Alaska State Legislature
Pouch V (MS 3100)
Juneau, Alaska 99811

Dear Representative Tischer:

I appreciated having the opportunity to discuss with you the legislative proposals which you are addressing in this session and which are of concern to Blue Cross of Washington and Alaska. Martin Tirador will be keeping in close contact with you on these and other issues.

We are continuing to develop information which supports our position for the modification of the certificate of need law. Other organizations such as [redacted] Much of this information will be presented to the Health Education and Social Services Committee in the hearing on HB 19.

I particularly appreciated the chance to visit with you. I would hope that you will call on either Martin Tirador or me if you feel we can provide you with information on any issue you are considering in the legislative process.

Sincerely,

Joan Gaumer

Joan Gaumer, Director
Government Relations

JHG:pf

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

northern alaska health resources association, inc.

FEB 9 1983

February 03, 1983

The Honorable Mae Tischer
Alaska State Legislature
Pouch V (MS 3100)
Juneau, Alaska 99811

Dear Representative Tischer:

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

529 5th avenue, suite 8 fairbanks, alaska 99701 telephone (907) 456-2553

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 effectiveness 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.

FEB 18 1983

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

David, all these papers need to be made part of the testimony. Please put into our file

February 15, 1983

Dear Alaska Legislator:

The Executive Committee of South Central Health Planning and Development, Inc., yesterday met to discuss the proposed Certificate of Need repeal bill. The Committee asked me to convey to you our support for the attached position paper developed by the Alaska Health Coalition.

[redacted]

If you have questions on this issue, you might contact Executive Director, Peggy Wilson.

Sincerely,

Margaret McClure Wilson

Margaret M. Wilson
Executive Director

MMW/ab

Alaska Health Coalition

529 5th Avenue, Suite 8
Fairbanks, Alaska 99701
(907) 456-2553

February 11, 1983

TO: Members of the Alaska Legislature

Proposed legislation (HB 19 and SB 85) would repeal Alaska Statute 18.07.031-18.07.111, better known as the Alaska Certificate of Need (CON) law. These bills reflect the position of the Alaska Hospital Association, whose member institutions are subject to the provisions of the CON process. The attached paper, developed by the Alaska Health Coalition, was written to provide legislators and the public with a series of alternatives to consider during discussion of these important bills. The paper summarizes the provisions of the CON law, discusses several of the problems which have been identified with the current process, and reviews the effectiveness of the CON program, both nationally and within Alaska. In addition, a list of recommendations is provided for consideration in revising the current CON law.

The Alaska Health Coalition is a group of interested citizens with memberships from the three Alaska Health Systems Agencies and the Statewide Health Coordinating Council. The primary purposes of the Coalition are to review the need for health planning, development, and promotion activities and to develop goals, describe functions, and recommend structures to achieve optimal health for the citizens of the state. Therefore, we believe that the subject of public review of capital expenditures as currently provided for in the Certificate of Need law is an important issue which deserves a reasonable, objective discussion. We present this paper for the purpose of initiating this discussion.

For additional information, please contact any of the following organizations: Northern Alaska Health Resources Association, Fairbanks (456-2553); South Central Health Planning and Development, Anchorage (278-3631); or, Southeast Alaska Health Systems Agency, Ketchikan (225-9681).

Best regards,

Charles M. Kaltenbach, Dr. P.H.
Chairman

CMK:sem

Enclosure

Coalition Members

J. B. Carnahan, Fairbanks; Joseph [illegible], Juneau;
Charles Kaltenbach, Dr. P.H., Fairbanks; Steve [illegible], Anchorage,
John Manning, Ketchikan; Lillie McGarvey, Anchorage; Art Williams, Sitka; Margaret Wilson, Anchorage

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.[6]

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, an effective market for health care services does not exist in most communities. Competition exists but it is rarely price competition; indeed the nature of current competition based on scope of services, amenities, and convenience is to encourage price increasing 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 taxpayers).

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.[8]

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.

[redacted]

1. [redacted]

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. [redacted]

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

6. [redacted]

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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.

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

The Governor designated a State Health Planning and Development Agency (SHPDA) as a unit of State government. The SHPDA has the responsibility to conduct the health planning activities of the State, including preparation and implementation of the State Health Plan, and to provide coordination of the HSAs. The SHPDA also supports the function of the Statewide Health Coordinating Council and is responsible for administration of the Certificate of Need program. In Alaska, the SHPDA resides within the Department of Health and Social Services. It currently occupies division-level status.

STATEWIDE HEALTH COORDINATING COUNCIL

The Alaska Statewide Health Coordinating Council (SHCC) is the third entity involved in the State health planning network. The SHCC is a group of citizens appointed by the Governor who oversee the health planning activities within the State. Specifically, they have responsibility for preparation of the State Health Plan. The State Health Plan forms the basis upon which Certificate of Need applications are reviewed. Both the SHPDA and SHCC are supported with a mix of Federal and State funds.

STATEMENT OF

ÆTNA LIFE INSURANCE COMPANY

IN OPPOSITION TO

H.B. 19

As a major writer of commercial health insurance, the Ætna Life Insurance Company has for years been deeply concerned about health care cost increases and has consistently supported viable health planning programs. We strongly oppose H.B. 19, An Act Repealing the Certificate of Need Program. We believe that enactment of this legislation would represent a large step backward in Alaska's effort to realize an efficient and effective health care delivery system.

Health planning is one of the elements in the armamentarium of programs that are necessary to help in the reduction of the escalation of health costs and to ensure that the health care delivery system of the future is one that has been rationally and systematically planned.

We feel that it is most important that there be a mechanism in place for participation in the planning and development of health programs to improve the distribution of health services, ensuring that services are available to those citizens who need them, while restricting the investment in unnecessary facilities and services.

An important portion of a viable health planning program is state certificate of need legislation. We find it is essential to have such legislation in order that the necessity of capital expenditures can be determined, because of the two-pronged effect on the growth of health care costs. In the short run, the purchase, installation, and financing of expenditures increases annual health care expenditures. In the long run, operation and maintenance of capital expenditures continue to add to health care costs, to increased use of highly skilled labor (for maintenance and operation) and non-labor inputs (i.e., energy, supplies, etc.).

It has been estimated that every dollar of capital investment adds an additional 50¢ to annual operating cost. An important element in today's economy, which has had a dramatic effect on health care costs related to capital expenditures, is the interest rate now being charged on the finance debt. Efforts must be made to ensure that all capital expenditures made today are necessary and consistent with the goals of Alaska's Health Systems Plan and necessity for such expenditures.

Alaska's Certificate of Need Program is an important tool for implementation of the area health plan. We urge that this program be continued.

Alaska Health Coalition

529 5th Avenue, Suite 8
Fairbanks, Alaska 99701
(907) 456-2553

February 11, 1983

FEB 16 1983

TO: Members of the Alaska Legislature

Proposed legislation (HB 19 and SB 85) would repeal Alaska Statute 18.07.031-18.07.111, better known as the Alaska Certificate of Need (CON) law. These bills reflect the position of the Alaska Hospital Association, whose member institutions are subject to the provisions of the CON process. The attached paper, developed by the Alaska Health Coalition, was written to provide legislators and the public with a series of alternatives to consider during discussion of these important bills. The paper summarizes the provisions of the CON law, discusses several of the problems which have been identified with the current process, and reviews the effectiveness of the CON program, both nationally and within Alaska. In addition, a list of recommendations is provided for consideration in revising the current CON law.

The Alaska Health Coalition is a group of interested citizens with memberships from the three Alaska Health Systems Agencies and the Statewide Health Coordinating Council. The primary purposes of the Coalition are to review the need for health planning, development, and promotion activities and to develop goals, describe functions, and recommend structures to achieve optimal health for the citizens of the state. Therefore, we believe that the subject of public review of capital expenditures as currently provided for in the Certificate of Need law is an important issue which deserves a reasonable, objective discussion. We present this paper for the purpose of initiating this discussion.

For additional information, please contact any of the following organizations: Northern Alaska Health Resources Association, Fairbanks (456-2553); South Central Health Planning and Development, Anchorage (278-3631); or, Southeast Alaska Health Systems Agency, Ketchikan (225-9681).

Best regards,

Chas M. Kaltenbach

Charles M. Kaltenbach, Dr. P.H.
Chairman

CMK:sem

Enclosure

Coalition Members

J. B. Carnahan, Fairbanks; Joseph Cladoukos, Juneau;
Charles Kaltenbach, Dr. P.H., Fairbanks; Steve Lesko, Anchorage;
John Manning, Ketchikan; Lillie McGarvey, Anchorage; Art Willman, Sitka; Margaret Wilson, Anchorage

northern alaska health resources association, inc.

FEB 9 1983

February 03, 1983

The Honorable Mae Tischer
Alaska State Legislature
Pouch V (MS 3100)
Juneau, Alaska 99811

Dear Representative Tischer:

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

529 5th avenue, suite 8 fairbanks, alaska 99701 telephone (907) 456-2553

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 effectiveness 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.

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CHIEF COUNSEL AND STAFF DIRECTOR

U.S. House of Representatives
Committee on Energy and Commerce
Room 2125, Rayburn House Office Building
Washington, D.C. 20515

February 2, 1983

Pierre Howard, Chairman
Senate Human Resources Committee
The State Senate
Atlanta, Georgia 30334

Dear Senator Howard:

Thank you for your letter concerning the consideration of Certificate of Need legislation by the Georgia Senate.

I can appreciate your interest in CON legislation. It is clear that without a strong health planning program, hospital and nursing home expansion will wildly inflate State and private, as well as Federal, health care payments. I suspect that Georgia, and Georgia's employers and employees, can ill afford to waste their resources on unnecessary or over-priced health services.

I am pleased to report to you that there is a firm Federal commitment to support a health planning system throughout the nation. A bill to extend Federal assistance to State and local health planning agencies was passed by the House of Representatives last year by a vote of 302 to 14. Although it was not possible to work out an agreement with the Senate in this regard at the end of the 97th Congress, the program was extended through FY 1983 by the Continuing Resolution.

As the 98th congress begins its work, I am sure that health planning legislation will again be on the agenda. While it is not possible to predict what the exact result of the legislative process will be, I think it is reasonable to assume:

1. The Federal government will continue to provide substantial funds to the States and local agencies to support health planning activities; and

2. In order to be elgible to receive such funds, States and local agencies will have to meet certain standards of organization and operation necessary to ensure their effectiveness.

3. States will be required to conduct a certificate of need program which covers hospital and nursing homes and otherwise complies with Federal law.

In this context, I would suggest that the prudent course for Georgia, or any other State, at this time is to maintain the current program without any major change. This will insure that both State and local agencies remain eligible for Federal support this year under the FY 1983 Continuing Resolution. It will also mean that, once all of the details of the Federal legislation are settled, Georgia can, in a single step, make changes in its CON program with a clear understanding of what its effect on eligibility for Federal support may be. If Georgia revises its CON program this year, further revisions, even contradictory changes, may be necessary next year or the year after.

With specific regard to the provisions of SB 121, I can report that they are not consistent with the current requirements of the Federal statute. I cannot guess whether these provisions will or will not be consistent with that legislation that will be developed this year. I can point out, by way of example, that the legislation endorsed by the House last year did include detailed requirements for State CON programs and that the provisions of SB 121 are not consistent with all of the provisions of that bill.

Again, I appreciate your interest in the future of the health planning program. As a Federal-State partnership, planning can only be successful with the understanding and support of State officials throughout the nation.

My best regards to you and your colleagues in the Georgia Senate.

Sincerely,

HENRY A. WAXMAN
Chairman, Subcommittee on
Health and the Environment

HAW/bbg

Blue Cross
of Washington and Alaska

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

FEB 18 1983

February 14, 1983

Representative Mae Tischer
Alaska State Legislature
Pouch V (MS 3100)
Juneau, Alaska 99811

Dear Representative Tischer:

I appreciated having the opportunity to discuss with you the legislative proposals which you are addressing in this session and which are of concern to Blue Cross of Washington and Alaska. Martin Tirador will be keeping in close contact with you on these and other issues.

We are continuing to develop information which supports our position for the modification of the certificate of need law. Other organizations such as the Health Insurance Association of America and the American Health Planning Association have also researched the subject and have documented the necessity to retain CON if costs are to be contained in the health delivery system. Much of this information will be presented to the Health Education and Social Services Committee in the hearing on HB 19.

I particularly appreciated the chance to visit with you. I would hope that you will call on either Martin Tirador or me if you feel we can provide you with information on any issue you are considering in the legislative process.

Sincerely,

Joan Gaumer

Joan Gaumer, Director
Government Relations

JHG:pf

MAE -

New Mexico, Arizona, Minnesota, Colorado have sunset provisions that provide for Cert. of Need laws to expire on future dates - like ALASKA's sunset on topics like PAROLE Board, Psyclological examinos board, etc. REPEAL has NOT been passed by any legislature of FOR. CON.

DAVE

Alaska State Legislature

Representative Mae Tischer
District 11
3305 Oregon Drive
Anchorage, Alaska 99503

While In Juneau
Pouch V
Juneau, Alaska 99811
(907) 465-3759

House of Representatives

MAE TISCHER

15 March 1983

Dr. Mike Beirne
President, Lake Otis Clinic
P. O. Box 4-1539
Anchorage, AK. 99509

Dear Mike:

Thank you for your March 2 update regarding CON. The Bill has passed out of my committee but has a long way to go before final passage, as you know. Presently in House Finance, I will copy your attachments and personally present them to the Finance Committee for their perusal. Many of the points in the February 23, 5-page letter to Commissioner Smith are pertinent facts for deliberation.

Sincerely,

Representative Mae Tischer
District 11



MAR 7 1983

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

THE LAKE OTIS COMMUNITY HOSPITAL

file in my HESS CON file

March 2, 1983

The Honorable Mae Tischer
Alaska State House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Representative Tischer:

I know you are in the process of reviewing the Certificate of Need (CON) law. And, you are probably aware of the latest developments regarding the applications for CONs by Providence and Humana Hospitals.

Therefore, the attached materials are simply for your review. Should you have any questions, please let me know.

Sincerely,

mike

Dr. Mike Beirne
President
Lake Otis Clinic

MB/nc

attachments

mae -
Please don't repeal that law!
modify it - CON million
threshold, but keep the law.
me. Only thing you need a
CON for is new beds. Thanks.
- mike

LOA

LAW OFFICES OF
DAVIS, WRIGHT, TODD, RIESE & JONES
510 L STREET
SUITE 405
ANCHORAGE, ALASKA 99501
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1050 THOMAS JEFFERSON STREET N.W.
WASHINGTON, D. C. 20007
(202) 965-6484
TELECOPIER: (202) 342-1522

PLEASE REPLY TO ANCHORAGE OFFICE

February 23, 1983

The Honorable Robert L. Smith
Commissioner
Department of Health and Social Services
Pouch H 01
Juneau, AK 99811

Re: In the Matter of the Revocation of the Certificate of Need for Lake Otis Hospital

Dear Commissioner Smith:

Thank you for your letter of January 31, 1983 regarding the status of the above-referenced administrative proceeding. We am writing to you today on behalf of our client, Lake Otis Clinic, Inc., because of recent developments we believe should be brought to your attention. Counsel for petitioner, South Central Health Planning and Development, Inc. ("South Central") has been provided with a copy of this letter and its attachments so he may respond to the letter if he wishes.

As you are no doubt well aware, the principal issues in this case are whether there are grounds for revoking Lake Otis Clinic's certificate of need, and if so, whether the certificate should or should not be revoked. The revocation proceeding was filed and prosecuted by South Central, the regional health systems agency which acts in an advisory capacity to DHSS. Since 1977, South Central has opposed the certificate of need issued to Lake Otis Clinic by DHSS essentially on the grounds (1) that the certificate was never submitted to South Central's review and recommendations and (2) that there is no need for the 125 acute care hospital beds Lake Otis Hospital would put into operation in Anchorage. The Anchorage Municipal Health Commission ("MHC") has taken a similar position. It filed a lawsuit challenging Lake Otis' certificate of need in 1979 which was dismissed late that year. South Central filed the instant administrative action in 1980. Lake Otis has consistently taken the position that it is

CB 2/24/83

not required to submit its hospital proposal to review by South Central and MHC since its certificate was "grandfathered" and that there was or would be need for the additional 125 acute care beds when they are constructed.

Disturbing recent developments indicate that South Central and MHC may be radically altering their position on bed need in Anchorage, after having effectively embroiled Lake Otis' certificate of need in litigation since mid-1979. Providence Hospital has filed an application for a certificate of need authorizing it to undertake a $97 million construction project to increase its bed capacity from 250 to 410 beds. Humana Alaska Hospital also has filed an application for a certificate of need authorizing it to spend $21.5 million to add 93 beds to its 199 bed hospital. The two proposals together would add 243 new hospital beds in Anchorage, slightly less than twice as many beds authorized under the Lake Otis Clinic certificate of need.

Based on the firm position taken by South Central and MHC in opposition to the Lake Otis certificate of need over the last several years and those agencies' current bed-need projections for Anchorage, an impartial observer could reasonably anticipate rejection of the Providence and Humana applications on lack-of-need grounds. For example, in September, 1977 the Municipal Health Commission formally came out in opposition to the Lake Otis certificate of need under a resolution which states:

> The Municipal Health Commission recommends to the regional health systems agency, Mayor Sullivan, and the Municipal Assembly that there be a moritorium on the construcion of civilian non-native acute care hospital beds within the Municipality of Anchorage for a five-year period or until civilian population reaches 270,000, whichever is sooner.

Exhibits R-55 and R-68, Lake Otis Revocation Proceedings (copy attached). Shortly thereafter, South Central's board of directors adopted a similar resolution finding "need for no additional civilian non-native accute care beds for the Municipality of Anchorage," and opposing the Lake Otis certificate of need. Exhibit R-56, id. (copy attached). Based upon these and other exhibits and testimony in the Lake Otis

revocation proceedings, Hearing Officer Joan Katz concluded that neither agency would have found any need for Lake Otis' 125 hospital beds had the project been submitted for review. Hearing Officer Katz expressly found:

> Beirne's refusal to submit to agency review was predicated on a realistic assessment that the agencies would not find bed need sufficient to support LOC's respective applications. (Emphasis added.)

Proposed Decision of Joan M. Katz, Ultimate Findings of Fact at page 32 (June 25, 1982). Beirne, of course, is Dr. Michael F. Beirne, president of Lake Otis Clinic, Inc.

South Central and MHC have both adopted health systems plans, as required by their enabling statutes, which are consistent with their position that there is essentially no need for additional hospital beds in Anchorage. The Municipality of Anchorage Health Systems Plan (1982-84), attached hereto as Exhibit B, projects total acute care bed-need at 480 in 1985 and 511 in 1990 as against the 449 beds currently licensed and in operation. The addition of Lake Otis' 125 beds would, according to that plan, exceed projected bed need until 1995. Similarly, the South Central bed need projection for Anchorage, Exhibit C (copy attached), projects "high" bed needs of 481 and 513 in 1985 and 1990 respectively. Although we understand that one or both of these health plans have been revised upwards slightly this year, neither revision projects additional bed needs beyond the 125 beds authorized for Lake Otis Clinic.

In these circumstances, it is anomalous that the joint South Central/MHC project review committee assigned to review the Providence and Humana expansion applications has recommended approval of not one, but both hospital applications! The February 13, 1983 Anchorage Times article attached hereto as Exhibit A describes the action taken by the project review committee. The committee apparently has abandoned the MHC moritorium on construction of additional hospital beds "until civilian population [of Anchorage] reaches 270,000." It also has abandoned the health systems plans which - even disregarding Lake Otis' 125 beds - show no need for the number of beds proposed by Providence and Humana Hospitals until some time between 1995 and the year 2000, or later. According to the newspaper article, which our client believes

accurately reflects the actions taken by the committee, justification for approval of both applications is predicated on projections of bed need in 1995, some twelve years in the future, and the committee's "instinctive" or "gut" feeling that the 1995 projections are too low. If these recommendations are adopted by MHC and South Central in their February 23 and March 5, 1983 hearings, the agencies will have taken a position completely inconsistent with their long-running opposition to construction of the Lake Otis Hospital.

These developments have a direct impact on the case pending before you. Lake Otis Clinic believes that it has demonstrated good cause for not having completed its hospital project. Even assuming for the sake of argument that good cause were not shown, revocation of its certificate is permissive, not mandatory, under AS 18.07.081(d). Whether revocation is justified depends upon a careful weighing of equitable considerations such as Lake Otis' investment in and desire to complete its project and the public's interest in containing hospital cost escalations through prevention of unnecessary construction and equipment acquisitions. We believe it would be fundamentally unfair for the Department to revoke Lake Otis' certificate of need in the present circumstances. If South Central adopts the project review committee's recommendations, it will have effectively swung one hundred and eighty degrees from a position that there is no need for Lake Otis' 125 acute care beds to a position supporting the construction of 243 beds. The irony of South Central's revocation petition is that if it is granted by DHSS, Lake Otis's 125-bed certificate would be eliminated at precisely the same time the two major Anchorage hospitals are aggressively moving ahead with their own expansion plans which will have a substantially greater impact on bed availability than Lake Otis' project. In fairness, South Central cannot have it both ways: either there is no need for additional beds in Anchorage and all expansion applications should be resisted or there is need and Lake Otis should be permitted a reasonable time free of debilitating litigation against its certificate of need to complete construction of its hospital. The inequities inherent in these recent developments are clear.

We respectfully request that you consider the recent and pending actions by South Central and MHC in connection with the

Providence and Humana applications in rendering your final decision regarding the Lake Otis Clinic certificate of need. Thank you.

Very truly yours,

DAVIS, WRIGHT, TODD, RIESE & JONES

Parry Grover

PEG:lt
Attachments
cc: Lake Otis Clinic, Inc.
Peter Partnow, Esq.
0297G

2/24/83

ALASKA'S LARGEST NEWSPAPER

SUNDAY FINAL

The Anchorage Times

SUNDAY, FEBRUARY 28, 1988

Committee approves hospital plans

by Cary Virtue
Times Writer

A "hesitant" health committee voted 12 times — and did some flip-flopping — but decided Saturday that both Providence and Humana Alaska hospitals should be allowed to expand.

It will now be up to other review commissions, and ultimately the state health commissioner, to make the tough decision on which gets to expand, and by how much, by April 4.

The 13-member joint subcommittee of the state Health Systems Agency and the Anchorage Municipal Health Commission met for 10 hours at the Municipal Assembly Building before making the final decision. The vote was 8-5 in favor of the two hospitals' expansion requests.

But immediately after the favorable vote, the committee debated whether to overturn that decision. After three more votes, and almost two hours of discussion, the committee decided to stick with its original expansion approval.

The committee's next review hearing, which was to be held Saturday, has been canceled.

Committee chairman Pete Gallagher said the committee was "hesitant" about making up its mind. And, commissioner Don Bantz said the committee was "shirking its responsibility" by approving both proposals.

But a majority of the committee members disagreed, basing their approval vote on three major assumptions:

- An "instinctive" and "gut" feeling that adopted city and state tables showing a total need of 616 beds for 1995 was too low. It took three votes to decide that Anchorage may need 630 beds, with an error of plus or minus 100 beds.
- Dr. Mike Bierne's proposed 125-bed Lake Otis hospital expansion project, which already has a certificate of need to expand, won't be built. Bierne's project has been tied up in a lawsuit involving Lake Otis and Providence Hospital since 1977.
- That neither Providence or Humana would open new beds or hire additional staff and equipment for either expansion projects unless the need developed.

Humana wants to spend $21.5 million to create 93 new beds (for a total of 292) by building a 71,345 square-foot, five-story hopsital tower by 1995.

Providence proposes spending $97 million to increase its bed capacity from 250 licensed beds to 410 beds. The project involves remodeling about 84,000 square feet, and building a five-story, 186,000-square-foot hospital tower by 1996.

Voting in favor of both expansions were commissioners Margia-

See Hospitals, page A-4

Exhibit A

Calhoun, and Larry Korn.

"We recognize the need for two strong hospitals in the community and the need for additional beds," Wolfe said. She said she did not believe the two hospital would staff the new expansion unless there was a need.

Also, Wolfe said she suggested

thought the committee's approval of both projects was "fine."

"But I'm not going to hold my breath because we ave three more hurdles," Pavelias said.

Other hearings are scheduled for:

- **Feb. 23:** Both hospital expansions will be presented before the full Municipal Health Commission starting at 5:30 p.m., at the sixth floor conference room of the HIll Building, 632 W. Sixth Ave.
- **March 5:** Recommendation by full board of Health Systems Agency following a 9 a.m. hearing at the Municipal Assembly Chambers, 3500 E. Tudor Road.

Anchorage Health Systems Plan (1982-84)

TABLE 4.42

PROJECTED ACUTE CARE BED NEED FOR ANCHORAGE, 1985 - 2000

	1985	1990	1995	2000
Civilian Non-Native Population	188,668	201,779	225,364	262,724
° Women 14-44 (27%)	50,940	54,480	60,848	70,935
° 13 yrs & Under (25.1%)	47,355	50,646	56,566	65,943
° 14 & Over (74.9%)	141,312	151,132	168,797	196,780
Medical/Surgical				
° Anch Use Rate 491/1000				
° Anch Use 76.2%				
° Occupancy 85%				
° Beds Needed	294	314	351	409
° Licensed Beds Existing	290			
Pediatrics				
° Anch Use Rate 134/1000				
° Anch Use 78.2%				
° Occupancy 65%				
° Beds Needed	35	37	41	48
° Licensed Beds Existing	32			
Obstetrics				
° Anch Use Rate 266/1000				
° Anch Use 90.1%				
° Occupancy 75%				
° Beds Needed	47	50	56	66
° Licensed Beds Existing	41			
Psychiatrics				
° Anch Use Rate 24/1000				
° Anch Use 83.1%				
° Occupancy 85%				
° Beds Needed	13	14	16	19
° Licensed Beds Existing	15			
Subtotal Beds Needed**:	389	415	464	542
° Plus Thermal (50)% (11 existing)	10	11	12	14
° Plus ICU/CCU (60%) (38 existing)	44	46	52	60
° Plus CPU (75%) (22 existing)	37	39	44	51
TOTAL BEDS NEEDED	480	511	572	667
° Licensed Beds Existing	449			
° Bed's C/N'd, not built	125			

Exhibit B

South Central Health Planning & Development, Inc.

Health Systems Plan 1982-1986

7. Summary of Anchorage Community Hospital Bed Need

The table below summarizes the high and low estimates of civilian non-Native acute care need for Anchorage for 1985 and 1990.

TABLE VIII-34

Range of Projected Acute Care Bed Need
Anchorage, 1985-1990

Type	Licensed	1985 Low	1985 High	1990 Low	1990 High
Medical/Surgical	290	247	294	281	314
ICU/CCU	38	39	46	44	49
PCU	22	30	36	34	38
Pediatric	32	29	35	33	37
Obstetric	41	40	47	45	50
Psychiatric	15	12	13	13	14
Thermal	11	9	10	10	10
TOTAL	449*	406#	481#	460#	513#

* Lake Otis Hospital, Inc. holds Certificate of Need for 125 additional beds. #Also neonatal intensive care: 1985 - 30 beds, 1990 - 36 beds (20 available).

The chart below indicates the year by which additional beds will have to be in place by service. Since projections were estimated using 1985 and 1990 as benchmarks, in some cases beds would be needed earlier.

TABLE VIII-35

Estimated Year by Which Anchorage Will Need
Additional Beds®, By Type

	1985 Low	1985 High	1990 Low	1990 High
Medical/Surgical		*		*
ICU/CCU	*	*	*	*
PCU	*	*	*	*
Pediatric		*	*	*
Obstetric		*	*	*
Neonatal Intensive Care	*		*	

® Depending on low versus high range population estimates

D. Summary Statistics as Compared to National Guidelines for General Acute Care Beds

In response to the rising costs of hospital care, the Federal government adopted a set of resource standards in 1978 called "National Guidelines for Health Planning", most of which relate to inpatient acute care facilities.

Exhibit C

Municipality of Anchorage

MEMORANDUM

DATE: September 15, 1977

TO: South Central Health Planning and Development, Inc.

FROM: Municipal Health Commission

SUBJECT: Revised Acute Care Hospital Bed Need Projections

The Municipality of Anchorage is currently experiencing what is termed as an "overbedding" situation for acute care. This situation arose from the following:

(a) Simultaneous completion of two construction projects for new hospital beds;

(b) Exceeding of approved number of beds (according to the State facilities plan) in construction of one new facility;

(c) Impacts of peer review which is keeping down the average length of inpatient stays;

(d) Availability of beds in outlying areas which draws away potential patients from Anchorage.

At present, neither civilian non-native hospital is operating with all beds opened and staffed. Both facilities are experiencing major difficulties in recruiting and hiring nursing personnel. After one year of overbedding, the bed need situation has stabilized as follows:

Utilization Rate = 600 inpatient days/1,000 population
Average Length of Stay = 4.8 days

Bed need projections for the civilian non-native population for 1977 through 1985 are as follows:

	Total Available Beds	Licensed Beds	Open Beds	Occupancy Rates (Open Beds)
Alaska Hospital	202	154	132	73%
Providence Hospital	250 (268)	250	232	74%
	452 (470)	404	354	73.8%

Exhibit R-55

M 9-29-77

Bed Need Projections:

Year	Civilian Non-Native Population	Occupancy Rate	Number of Beds
1977	156,825	85%	303
1982	208,728	85%	403
1985	255,524	85%	494
1989	298,116	85%	577

Additionally, with 577 beds in 1978, the following would occur at 600 inpatient days per 1,000 population.

Year	Civilian Non-Native Population	Occupancy Rate	Number of of Beds
1978	170,893	48%	577

By 1982, unless the utilization dramatically increases or the average length of stay increases, we will achieve less than 75% occupancy with existing beds, using 452 beds as baseline (with 470, occupancy would be at 72%). The consequences of not reaching 85% occupancy for "overbedding" are as follows:

(a) high room rates to offset costs of plant maintenance;

(b) incentive for non-necessary hospitalization and increased length of stay;

(c) higher tax support for subsidized patients;

(d) dis-incentive for use of low cost and outpatient alternatives to hospital care (i.e., outpatient surgery).

The addition of 125 acute beds to an already "overbedded" market will serve to exaggerate the present cost increases and inappropriate use of inpatient beds. The Municipal Health Commission, and its predecessor, the Anchorage Health Planning Council, has gone on record as opposing additional acute bed construction for reasons of cost effectiveness. This position is supported by the South Central Health Systems Agency which has endorsed a policy of non-approval of beds exceeding four per 1,000 total population. Present statistics (including Elmendorf and A.N.S. hospitals) shows 4.6 beds per 1,000 population in 1977 existing in Anchorage. The number of acceptable beds per 1,000 population will decrease to three per 1,000 population by 1985, according to the areawide health systems plan.

There is some cross utilization of civilian non-native facilities by the native and military population.

The total native population in Anchorage is stabilized at 4%. At that figure (6,273 in 1977), utilizing the Alaska Native Medical Center utilization rate (1,400 inpatient/1,000), total anticipated native inpatient days in 1977 would equal 8,680. ANMC has 170 beds with a potential number of inpatient days of 62,050.

The military hospital has 200 beds with a total number of potential inpatient days of 73,000. There are 27,242 military and dependents. Using the Elmendorf utilization rate of 1,100/1,000 population, the total number of inpatient days which would be generated by our local military and dependent population is 29,920.

There is some utilization of Anchorage civilian non-native hospitals by non-Anchorage residents. The primary use appears to be in the categories of sophisticated tertiary care, not available in smaller communities. The construction of additional small facilities in outlying regions will decrease the use of Anchorage facilities for other levels of care not requiring high levels of technology. Patient origin studies which are available, combined with new construction and utilization trends, indicate a probable use of a maximum of 5% of the available inpatient beds by non-Anchorage residents.

Finally, there is still significant use of facilities outside Alaska by Anchorage residents for certain types of specialized care. While this utilization may be more related to tradition than need, it is a factor which serves to reduce utilization of Anchorage facilities.

The following motion was carried unanimously by the Municipal Health Commission at a special meeting held September 14, 1977:

THE MUNICIPAL HEALTH COMMISSION RECOMMENDS TO THE REGIONAL HEALTH SYSTEMS AGENCY, MAYOR SULLIVAN, AND THE MUNICIPAL ASSEMBLY THAT THERE BE A MORATORIUM ON THE CONSTRUCTION OF CIVILIAN NON-NATIVE ACUTE CARE HOSPITAL BEDS WITHIN THE MUNICIPALITY OF ANCHORAGE FOR A 5 YEAR PERIOD OR UNTIL CIVILIAN POPULATION REACHES 270,000, WHICHEVER IS SOONER.

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



cc Sv Tichelk

P. 3

M E M O R A N D U M

To: SCHPD Board of Directors and Interested Others

From: SCHPD Staff

Subject: Information Update #19

Date: September 23, 1977

I. The major conference planned for Unalaska in early November is beginning to take shape. The first day will deal mostly with fisheries related issues and other economic and resource problems. The second day will address the social, health, education and physical needs of the Aleutian/Pribilof region (water, police, fire, etc.) It is anticipated that about 100 people will attend the conference, about 45 of whom will be State and Federal officials. The lack of hotel facilities in Unalaska will allow participants to "discover" Alaska via the good offices of the high school gymnasium and their own sleeping bags. Coordinator for the conference is Hillary Hilscher, at the Aleutian/Pribilof Island Association. South Central Health Planning and Development, Inc. has been given responsibility for conducting the health portion of the second day's proceedings.

II. Update welcomes Dr. Tom Neiswander back to Alaska after several years outside. Dr.Neiswander was the first Alaska Coordinator for the National Heal ervice Corporation; he was instrumental in establishing the clinic op tions at Yakutat, Galena, and Unalaska. He is currently in charge of outpatient services at Alaska Native Medical Center, in Anchorage.

III...Speaking of which, Cook Inlet Association has unveiled plans to assume responsibility for a large portion of the outpatient services at ANMC. They came into a $600,000 windfall, and seem to have struck an accord with the IHS on the matter.

IV...Speaking of which, Update congratulates Mr. Jake Lestenkoff on his new job with Cook Inlet Native Association as Executive Assistant. Jake is a Pribilof Islander, recently involved with APIA in planning the Unalaska Conference. Jake reports that he will continue to have some involvement with that effort, while he assumes his new duties.

V...Speaking of which, Update congratulates Mr. Dan Hertsgaard on his

Exhibit R-56

new job with Aleutian/Pribilof Island Association as their Health Department Director.

VI. Update welcomes Mr. Bob Ogden back as Administrator of Valley Hospital in Palmer. Bob tried Utah for a while, but couldn't stay away from Alaska.

VII. Robert Clark, Director of Bristol Bay Area Health Corporation and a member of the SCHPD, Inc. Board, reports he still has need for workers in the Dillingham area. He needs a controller, a planner, and a village coordinator.

VIII. The Bristol Bay Area Health Corporation Board of Directors at their recent meeting passed several resolutions:

....for more housing in the area, the lack of which is hindering recruitment of qualified health and regional corporation personnel.

....opposing RCA Alaska's proposed 87% rate hike.

....asking the legislature and the Governor to provide funds for EMS services at least to the level provided in FY 1976 as a minimum.

....asking Rural Cap to reassign an Alcoholism counselor to 32 villages of Bristol Bay.

....asking IHS cooperation in providing needed data in the development of Tribal-Specific Plans that are now required.

....supporting Representative Anderson's bill which would increase Community Health Aide salaries.

....supporting a bill that would widen, lengthen and improve the lights on airplane landing strips, in the interest of impoving EMS capabilities of rural Alaskan airports.

IX. South Central Health Planning and Development, Inc. held it's regular meeting September 16 and 17 in Anchorage, with the following major results:

The Board approved the Health Systems Plan (HSP) as amended, including most of the 151 separate suggestions for changes and additions. The Plan now goes to the State Health Planning and Development Agency (SHPDA) for their review.

Dr. Dave Johnson, Regional Health Officer for DHEW, Region X, spoke at some length with Board members regarding the regulatory role of HSAs.

The Annual Report of SCHPD, Inc. was discussed in it's draft format, and the Executive Committee will approve the final report in about two weeks, allowing for further input by Board members.

Two persons from Yukon-Kuskokwim subarea have been voted to fill vacancies on the SCHPD, Inc. Board. They are: Pat Shea, a provider from Bethel, and Peter Black, a consumer from Alakanuk.

Three persons from the Anchorage subarea have been elected to fill vacancies on the SCHPD, Inc. Board. They are: Gari Andreini, a provider, and Jerry Ward and Elizabeth Jacks, both Consumers.

The SCHPD, Inc. Board voted to approve meetings between the SCHPD Nominating Committee and the Anchorage Subarea Advisory Councils, Operations Committee for purposes of discussing common goals and problems.

Diddy Hitchins, of the SCHPD, Inc. Board, has been named Coordinator of Social Services Planning to the Capitol Site Planning Commission.

The following motion was approved by the SCHPD, Inc. Board of Directors: "Based upon statistical demonstration of the lack of clear and evident need as supported by the SCHPD, Inc. Health Systems Plan, the Health Systems Agency shall publicize it's Plan contents with emphasis on the need for no additional civilian non-Native acute care beds for the Municipality of Anchorage. The Health Systems Agency shall oppose the irresponsible and possibly illegal Certificate of Need for Lake Otis Hospital and publicize these two efforts to Blue Cross, the State and others who have funding authority".

X. Mr. Jerry Madden has been retained by the Department of Policy Development and Planning in the Office of the Governor, to complete a study of housing in Alaska. The emphasis will be upon rural areas and will include concerns for environmental health. The first draft of goals and objectives will be available in mid November.

XI. On the 4th, 5th, and 6th of October, the 25th Annual Convention of the Alaska State Hospital Association, Inc. and the 5th Annual meeting of the Alaska Hospital Research and Education Foundation, Inc. will be held in Wrangell, Alaska. The theme will be: THE SECRET TO SUCCESS IS CONSISTENCY OF PURPOSE.

XII. Mr. Roy Haney, President of the Idaho HSA, will be visiting SCHPD, Inc., September 28th, to study our ways of doing business.

XIII. Public Information and Education Council of the Municipal Health Commission has been studying the Adolescent Sexuality Conference held in May, and is presently involved in reviewing the health curriculum of the Anchorage School District.

XIII. The Anchorage Health Service Plan is in it's final completion stages and will go to public hearing in October and November.

XV. The Behavioral Health Advisory Council of the Municipal Health Commission, in studying the Governor's Legislative Alcoholism Package, has been meeting with members of the Legislature. Most recently they met with Senator Colletta and discussed the philosophy of the Interim Alcoholism Committee in their review of the Governor's bills. In an effort to understand how extra revenue would be utilized the Council has also invited Mr. Robert Cole, Director of the State Office on Alcoholism.

XVI. The Human Resources Planning Division of the Municipal Planning Department has recently completed the Human Resources Study.

The study includes the results of a community needs assessment of a random sample of 500 Anchorage residents, reflecting attitudes and participation rates in relation to leisure, health and social services.

XVII. An Annual meeting of all HSAs, SHPDAs and SHCCs in Region X will be held October 19, 20, 21. The exact agenda is not known yet.

XVIII. A Rural health Seminar for staffs and board members of regional health entities is being hosted by Norton Sound Health Corporation in Nome, October 11, 12, 13.

XVIIII. Hearings on National Health Insurance will be held in Anchorage October 12 and 13.

XX. There will be a meeting of the Alaska Public Health Association September 28, 7:30 p.m. on the 5th floor in the Conference Room of the old Community Hospital building at 825 L. Street, Anchorage.

XXI. The next SCHPD, Inc. Annual Board of Directors Meeting will be in Anchorage on December 2 and 3. The location will be announced at a later date.

/ab

Municipality of Anchorage

POUCH 6-650
ANCHORAGE, ALASKA 99502
(907) 274-2525

GEORGE M. SULLIVAN, MAYOR

MUNICIPAL HEALTH COMMISSION

December 15, 1977

Dr. Helen Beirne
Commissioner
Dept. of Health and Social Services
Pouch H-01
Juneau, Ak 99811

Subject: Hospital Bed Construction in Anchorage

Dear Commissioner Beirne:

The Anchorage Municipal Health Commission was created by Municipal Ordinance AO 255-76 in February, 1977. The Commission is the designated subarea council for Anchorage to the regional health systems agency, South Central Health Planning and Development, Inc. The duties and function of the Commission in This capacity are to advise the HSA concerning local subarea health resource allocation, improvement in availability, accessibility, acceptability of health services, to contain costs and to promote the quality and continuity of health care.

Recently the Municipal Health Commission unanimously passed the following motion: "THAT THE MUNICIPAL HEALTH COMMISSION RECOMMEND TO THE REGIONAL HEALTH SYSTEMS AGENCY, MAYOR SULLIVAN AND THE MUNICIPAL ASSEMBLY THAT THERE BE A MORATORIUM ON THE CONSTRUCTION OF CIVILIAN, NON-NATIVE, ACUTE CARE HOSPITAL BEDS WITHIN THE MUNICIPALITY OF ANCHORAGE FOR A FIVE YEAR PERIOD, OR UNTIL THE CIVILIAN POPULATION REACHES 270,000, WHICHEVER IS SOONER".

This request was forwarded to the regional health systems agency and the Commission bed need projections were reviewed by their Board of Directors. The result of their review was approval of the following motion:

"BASED UPON STATISTICAL DEMONSTRATION OF LACK OF CLEAR AND EVIDENT NEED AS SUPPORTED BY THE SCHPD HEALTH SYSTEMS PLAN, THE HEALTH SYSTEMS AGENCY SHALL PUBLICIZE ITS PLAN CONTENTS WITH EMPHASIS ON THE NEED FOR NO ADDITIONAL CIVILIAN, NON-NATIVE ACUTE CARE BEDS FOR THE MUNICIPALITY OF ANCHORAGE. THE HEALTH SYSTEMS AGENCY SHALL OPPOSE THE IRRESPONSIBLE AND POSSIBLY ILLEGAL CERTIFICATE OF NEED FOR LAKE OTIS HOSPITAL AND PUBLICIZE THESE EFFORTS TO BLUE CROSS, THE STATE, AND OTHERS WHO HAVE FUNDING AUTHORITY."

Enclosed is a copy of the draft Anchorage Health Services Plan, and excerpts from the South Central Health Planning and Development, Inc. Health Systems Plan, in which bed need projections are contained, and upon which these motions were based.

Exhibit R-68

Blue Cross of Washington and Alaska, a major health insurance provider in Alaska, has stated that they support the health systems agency and Commission's position concerning a moratorium on construction of hospital beds. A copy of their letter is also enclosed.

At this time I respectfully request that the State of Alaska accept the recommendations of the Anchorage subarea council and regional health systems agency on this matter and incorporate these conclusions into the State Facilities Plan as soon as possible.

If you have any questions, please contact Noreen Pedrick, Manager, Human Resources Planning Division, telephone number 264-4261.

Sincerely,

Bonnie L. McGee

Bonnie McGee, Chairman
Municipal Health Commission

cc: D. Sharon Osborne
Office of Planning and Research

Lowell Schwartz
Office of Planning and Research

Ron Hammett
South Central Health Planning and Development, Inc.

PROVIDENCE
HOSPITAL

3200 PROVIDENCE DRIVE - POUCH 6604
ANCHORAGE, ALASKA 99502
PHONE: (907) 276-4511

SISTERS OF
PROVIDENCE

SERVING IN THE WEST SINCE 1856

March 4, 1983

mt

The Honorable Mae Tischer
House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Representative Tischer:

Thank you for taking the time to meet with us on our recent visit to Juneau. I know how pressing your time is, with constituent requests, keeping pace with legislation and going to committee meetings. The time you gave us was appreciated.

We hope the information we discussed regarding the certificate of need repeal was informative for you, and that with an amendment, also repealing the construction revenue sharing monies (Title 29.90.010-030), and consideration for passing HB 112 or a like bill in the Senate, that the concerns you may have had are now answered. Should you have any further questions, please feel free to contact us at any time.

Al Camosso, administrator, and I want to assure you that should you need any resource material regarding health care information, we will do everything we can to provide it for you.

Sincerely,

Christopher Beardsley
Director of Public Relations
& Governmental Affairs

P.S. Notice you passed bills out of committee with a "do pass." Great!

Alaska State Legislature

Representative Mae Tischer
District 11
3305 Oregon Drive
Anchorage, Alaska 99503

While In Juneau
Pouch V
Juneau, Alaska 99811
(907) 465-3759

Mae
HESS

House of Representatives

MAE TISCHER

March 19, 1983

George S. Rhyneer, M.D.
3300 Providence Drive
Anchorage, Alaska 99504

Dear Dr. Rhyneer,

Thank you for your March 16, 1983 letter regarding the Certificate of Need law. I too support the repeal of the Certificate of Need process.

House Bill 39, which repeals the Certificate of Need law, was passed out of the Health, Education and Social Services Committee, which I co-chair, with my affirmative vote. The bill now rests in Finance Committee.

Sincerely,

Mae Tischer

Rep. Mae Tischer
District 11

MT/dp

3300 PROVIDENCE DRIVE
ANCHORAGE, ALASKA 99504

Cardiology

James A. Baldauf M.D.
George S. Rhyneer M.D.
Leo B. Bustad M.D.

Telephone
(907) 279-8577

Internal Medicine
Gilbert P. Blankinship M.D.

March 16, 1983

Representative Mae Tischer
Pouch V
Juneau, Alaska 99811

Dear Representative Tischer:

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.

alaska state hospital association

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

REPRESENTING ACUTE, LONG TERM AND OUTPATIENT FACILITIES

Chairman of the Board
Ronald A. Pavellas
Humana Hospital Alaska
Anchorage

Chairman-Elect
Mark Hawkins
Sitka Community Hospital
Sitka

Immediate Past Chairman
Tom Mingon
Fairbanks Memorial Hospital
Fairbanks

Secretary/Treasurer
Edward Zeino
Cordova Community Hospital
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Delegate to the American Hospital Association
Al M. Camosso
Providence Hospital
Anchorage

Alternate Delegate to the American Hospital Assoc.
Michael Lockwood
Central Peninsula Hospital
Soldotna

Delegate to the American Health Care Association
Jack Buck
St. Ann's Nursing Home
Juneau

Alternate Delegate to the American Health Care Association
Emma G. Ivy
Wrangell General Hospital
Wrangell

Delegate to the Association of Western Hospitals
Michael Herring
South Peninsula Hospital
Homer

Alternate Delegate to the Association of Western Hospitals
Daniel Van Wieringen
Kodiak Island Hospital
Kodiak

Trustee Delegate to the American Hospital Assoc.
Moe Kadish
Trustee, Providence Hospital
Anchorage

Alternate Trustee Delegate to American Hospital Association
Robert Jenson
Central Peninsula Hospital
Soldotna

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

President
Dennis L. DeWitt
Juneau

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.

alaska state hospital association

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

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Robert Jensen
Central Peninsula Hospital
Soldotna

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

President
Dennis L. DeWitt
Juneau

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.

#1 Dec Dennis Kelly

PROVIDENCE
HOSPITAL

3200 PROVIDENCE DRIVE - POUCH 6604
ANCHORAGE, ALASKA 99502
PHONE: (907) 276-4511

SISTERS OF
PROVIDENCE

SERVING IN THE WEST SINCE 1856

December 27, 1982

Mayor Tony Knowles
Municipality of Anchorage
Pouch 6-650
Anchorage, Alaska 99502

Dear Mayor Knowles:

Thank you for the opportunity on December 13 to share Providence's plans and some of our concerns with you.

One point came up during our discussion regarding Certificate of Need (CON). I would like to elaborate for you in more detail why the health care providers in Alaska oppose CON and have so strongly supported its repeal.

As you know, the CON law was passed in this and most other states as a requisite to receive Federal funds. The major impetus for the law were:

1. Excess hospital beds in many large cities, and
2. 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 desired throughout the country. The law is cumbersome, wasteful and, in fact, costly.

The lack of "success" is especially true in Alaska for some basic reasons:

1. The process which the law sets in place is cumbersome and wasteful. The institution must:
   - submit a letter of intent at least 60 days prior to an application (for no apparent reason);
   - submit an elaborate, repetitive application (most are well over 100 pages). There are 12 separate "criteria" which must be addressed in any application;
   - wait to be declared complete (minimum 20 days; several of our applications were delayed months);
   - then go through a 90-day review process--with three or four public meetings.

MEMBERS OF THE SISTERS OF PROVIDENCE CORPORATION—ALASKA: PROVIDENCE HOSPITAL, ANCHORAGE—WASHINGTON: PROVIDENCE MEDICAL CENTER, SEATTLE—THE DePAUL RETIREMENT RESIDENCE AND MOUNT ST. VINCENT NURSING CENTER, SEATTLE—PROVIDENCE HOSPITAL, EVERETT—ST. PETER HOSPITAL, OLYMPIA—ST. ELIZABETH HOSPITAL, YAKIMA—OREGON: PROVIDENCE HOSPITAL, MEDFORD—PROVIDENCE MEDICAL CENTER, PORTLAND—PROVIDENCE CHILD CENTER, PORTLAND—ST. VINCENT HOSPITAL AND MEDICAL CENTER, PORTLAND—CALIFORNIA: PROVIDENCE HOSPITAL, OAKLAND—PROVIDENCE HIGH SCHOOL, BURBANK—SAINT JOSEPH MEDICAL CENTER, BURBANK

2. The costs of CON to the institution are enormous to prepare this cumbersome document (at least 35 copies) and submit to the minimum 110-day process. There are also the institutional costs of delaying implementation and watching the price of a piece of equipment or construction project increase several percent points with inflation.

   The cost to the public is also great in the state, regional and local staff needed to coordinate the program, prepare staff analyses and hold public meetings.

3. The dollar limit for what must be reviewed has been ridiculously low--$150,000. The federal law has allowed that limit to be raised to $400,000 and $600,000 although the Alaska legislature failed in its last session to raise the limits. Some states have raised the limit to $1 million or more. To have a limit of $150,000 or even $600,000 when the hospital's annual operating budget is $75,000,000 (such as Providence's) is overkill.

   In just 1982 alone, Providence has prepared 6 CON applications, including two equipment replacements (for a CT Scanner and a Cath Lab), a $250,000 computer enhancement for an x-ray machine and most absurd, a $167,000 replacement incinerator (25 years old, replacement required by State and EPA codes!). The State did not give final approval on the incinerator until the 90th day.

4. The law itself is overkill in Alaska. Designed for areas of heavy population, excess hospital beds and competition, the law does not work for Alaska for several reasons:

   - The law only covers private facilities--not public health, nor state owned (API or Pioneer Homes), nor military.

   - Alaska has only one city with more than one hospital and only three private ("eligible") hospitals of over 100 beds.

5. The law is reactive to existing decision making processes. Most hospitals in the State already have local public review and approval designed in their own budget review processes. Many hospitals are owned by municipalities, and all have governing or advisory boards of local citizens. These citizens should have control of the expansion and budgetary decisions of their own institutions. Several other layers are unnecessary. Hospitals and their boards are capable of making sound financial and program decisions.

As the attached Policy Statement of the Alaska State Hospital Association (ASHA) notes, we are supportive of state and local planning for the health care needs. The process should be positive and proactive-- encouraging institutions to respond to needs in the community rather than reactive, cumbersome and negative.

We encourage the city to support the ASHA position on repealing the state CON law. Your own Municipal Health Commission is a strong local planning body which helps identify health needs and encourages solutions. It also serves to review public expenditures in health. Those roles are appropriate. It should be freed from the cumbersome CON review.

Thank you for giving me the opportunity to share our concerns with you.

Best wishes for a prosperous 1983.

Sincerely,

Al M. Camosso
Administrator

Enclosure

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Region X
M/S 829 Arcade Plaza Building
1321 Second Avenue
Seattle WA 98101

June 22, 1982

Re: 10P 550016
Alaska SHPDA

Dennis L. DeWitt
President
Alaska State Hospital Association
319 Seward Street
Juneau, Alaska 99801

Dear Mr. DeWitt:

Your letter dated June 11, 1982, requested information about Region X's intentions as a result of the failure of the Alaska Legislature to pass amendments proposed to bring the State Certificate of Need program into compliance with the Federal planning law, as amended. Our course of action is quite clear. We will continue to fullfill our mandated responsibilities guided by actions and time frames specified in the law.

Under the existing provisions of Title XV of the Public Health Service Act, as amended, current law requires (in order to be fully designated) that a SHPDA must meet all requirements for full designation, including that of having a complying Certificate of Need program.

If a SHPDA is not eligible for full designation by a certain date (which for Alaska is January 19, 1983) the Department must invoke the statutory penalty of reducing most Public Health Service grants and contracts to any entity in the State by 25% the first year, 50%, 75%, and 100% over the next three years. Amendments contained in PL 97-35 extended the date by which a State must have a fully designated SHPDA to avoid imposition of the penalty. However, PL 97-35 also amended Section 1521(b)(2)(B) by specifying that a conditional designation agreement could not extend beyond a State's penalty date.

Fully designated SHPDAs (such as Alaska) which do not have complying CON programs but continue to meet other requirements, will be returned to conditional designation. As noted above, P 97-35 prohibits the conditional designation of any SHPDA from extending beyond its penalty date. Any SHPDA which remains conditionally designated on its penalty date must be terminated. Therefore, we will send a termination notice to any conditionally designated SHPDA 90-days prior to its penalty date, if it still has not demonstrated that it has a complying CON program.

The enclosed copy of a letter to Commissioner Beirne, from the Regional Health Administrator, further emphasizes the critical nature of having a complying CON program in Alaska.

Also the enclosed copy of a 1981 letter addressed to Mr. Ivan Lawner, Esq. concerning Pioneer Homes Certificate of Need review issues, reflects our unchanged position.

I hope the facts in this letter provide the detail of information required to understand the situation. Please call or write, should you need further assistance.

Sincerely,

John D. Whitney
Director
Department of Health
Resources Development
Region X

Enclosures (2)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

829

JUN 21 1982

Re: IOP 550016
Alaska SHPDA

Helen D. Beirne, Ph.D.
Commissioner
Department of Health and
Social Services
Pouch H 01
Juneau, Alaska 99811

Dear Dr. Beirne:

The State of Alaska's Department of Health and Social Services full designation agreement with the Department of Health and Human Services is being extended for three months, until September 30, 1982. As you know, because Alaska's Certificate of Need Program does not comply with Federal requirements, it is necessary that the SHPDA be returned to conditional designation. As required by statute, this 90-day extension of your current designation is being given to allow you to request and prepare for a hearing, if you should want one. Letters from the Bureau of Health Planning to you and to the Governor will further explain this process.

The following conditions are to be considered a part of the extended full designation agreement:

1. If the Agency is unable to retain full designation after September 30, 1982, it will be returned to conditional designation for the period October 1, 1982 to June 30, 1983.

2. The designation of the Agency will automatically terminate when the Agency reaches its penalty date, if the Agency still has not achieved full designation.

You may at any time prior to your penalty date (1-19-83, per PPM 82-12) submit documentation which you believe contains evidence that the State's CON program complies with the minimum Federal requirements, or a certification by the State's Attorney General, attesting to the program's compliance

Please sign both copies of this letter, indicating your acceptance of this extension with conditions. Return one copy to this office. As soon as we receive the signed copy, we will issue a Notice of Grant Award for the extended designation period.

Sincerely,

Dorothy H. Mann, M.P.H.
Regional Health Administrator
Region X

Helen D. Deirne, Ph.D.
Commissioner
Alaska Department of Health

Date

DHRD:ROSS:vw:6/21/82

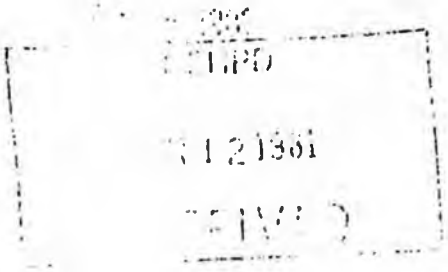
DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Pioneer Homes
Lynns Room

Region X
M/S 829 Arcade Plaza Building
1321 Second Avenue
Seattle WA 98101

Re: 10P 550007-05



Mr. Ivan Lawner, Esq.
Hellen & Partnow
524 G Street
Suite 710
Anchorage, Alaska 99501

Dear Mr. Lawner:

This is to respond to your recent letter concerning Certificate-of-Need review of a skilled nursing facility addition to the Pioneer Home in Anchorage. In that correspondence you raised two issues: the need for clarification of our 1978 letter to Howard Gabriel regarding C/N coverage of Pioneer Homes, and the compliance of the Alaska C/N program with federal standards. These matters will be addressed separately.

1. In our September 11, 1978 letter to Howard Gabriel, Director of the Southeast Alaska HSA, we were assuming that Pioneer Homes were only residential or domiciliary care facilities; there was no understanding that inpatient skilled nursing care was provided in these institutions. Given this understanding of the nature and services of Pioneer Homes at that time we were correct in concluding that they would not be included in the federal definition of "health care facilities" which would require coverage under Certificate-of-Need programs. If indeed skilled nursing services are provided in these institutions, they would be considered "health care facilities" as defined by our C/N regulations. The 1978 letter did not consider a Pioneer Home to be such a facility.

2. We have reviewed the Alaska C/N statute and implementing regulations to determine whether Pioneer Homes would be included in the definition of a health care facility. We found that:

   a. The Alaska C/N statute defines a "health care facility" as:

      A private, municipal. . . hospital, psychiatric hospital, turberculosis hospital, skilled nursing facility. . . . (Sec. 18.07.111(7)).

   b. The Alaska C/N regulations, in turn, define "health care facility" as:

      Any of those listed in AS 18.07.111, as defined, where appropriate, in 42 CFR 123.401 (adopted 1/21/77). (7AAC07.130)

c. The State's C/N statute and regulations, taken together and including the cross reference to 42 CFR 123.401, would provide coverage of a distinct part of an institution and would, therefore, meet the federal definition of a skilled nursing facilities, i.e., an institution or a distinct part of an institution which is primarily engaged in providing inpatient skilled nursing care and related services for patients who require medical or nursing care . . . . (42 CFR 123.401)

From the above points, it would appear that the Alaska C/N program adequately defines "heath care facility" and "skilled nursing facility." It is the responsibility of the state to follow its own C/N statute and regulations. If there is an on-going and sustained pattern of not following their statute and regulations, we would certainly assess the state's overall C/N program and then take appropriate action.

Please call us should you have further questions.

Sincerely yours,

John D. Whitney, Director
Division of Health Resources
Development PHS, Region X

cc: Ron Hammett, Director, SCHPD
Howard Gabriel, Director, SEAHSA

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPARTMENT OF ADMINISTRATION

OFFICE OF THE COMMISSIONER

POUCH C
JUNEAU, ALASKA 99811

465-2200

May 29, 1981

Honorable Donald E. Clocksin
Chairman, Health, Education and
Social Services
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Representative Clocksin:

This is in response to your request to put in writing my verbal testimony before your committee on CSSB 225. I will try and confine my remarks to the major issues.

Administration's position is that the Legislature has always implicitly exempted Pioneers' Homes from the certificate of need program. The Senate has concurred with this position as evidenced by CSSB 225. We are asking that the House members be afforded the same opportunity to express their will as the Senate.

There appears to be some confusion existing with the recent State Supreme Court decision of South Central Health Planning and Development, Inc. vs the Department of Administration, on certificate of need. At issue was whether or not the Legislature exempted Pioneers' Homes from certificate of need. The court found that there is no language in State statutes which can reasonably be read as exempting skilled nursing facilities from the certificate of need process when they are contained in Pioneers' Homes. Consequently, whether or not the Legislature intended to exempt Pioneers' Homes now becomes moot. The Legislature's intent can now be established only through the legislative process of amending existing law to allow this exemption.

There has been a substantial amount of discussion centering around the need for proper planning so that health facilities in Alaska are not overbuilt. This is an admirable and worthy objective, and I can assure you that this Department supports health facility planning. However, the existing system under the certificate of need program is fraught with inequities and frustrations; further, it does not represent a comprehensive planning effort.

2-89LH

There are three providers of health facilities; the federal government, the State government, and the "private sector." However, the federal health facilities don't come under the certificate of need program, and in most states this wouldn't pose any problem. The military contingent in California, for instance, would represent a small portion of the state's total population and as such would not greatly impact the planning process for certificate of need. In Alaska, the opposite is true. The federal government is a major provider of health care and facilities. Roughly one-fourth of the state's population are eligible to use federal health facilities (military base, Public Health, Indian Health, etc.). This has a devasting effect on trying to logically plan for state and "private sector" health facilities when a critical component is missing.

In addition, if we look closely at the "private sector" we see that it is not truly private. A substantial portion of the revenues of private nursing homes and health facilities originate through state and federal programs. State and federal rules, regulations, requirements, and laws, guide and govern, in minute detail, the construction and operation of private health facilities. This includes the proper ratios of professional staff to patients, the type of equipment allowed, size of hallways, reporting procedures, and many others. In effect, the "private sector" is part of the "public sector." Consequently, the charge that the State, through the establishment of Pioneers' Homes, is unfairly competing with the private sector is a fallacious argument.

There has also been considerable discussion on the impact of granting Pioneers' Homes an exemption from certificate of need as it relates to federal programs. Mr. Vern Perry, Director of the Division of Pioneers' Benefits spoke with Mr. Jim Egan, Regional Project Officer of the Office of Health Planning, Region X, U. S. Department of Health, Education and Welfare, on Wednesday May 27, regarding the certificate of need program.

QUESTION: What effect would there be on the State of Alaska if Pioneers' Homes were exempted from the certificate of need program?

ANSWER: It would have no effect on medicare, medicaid, AFDC or Indian Health Service. It could only affect categorical programs such as alcoholism, EMS, Neighborhood Health Clinics, Mental Health Clinics, Day Care, etc.

QUESTION: Would the federal government actually discontinue such programs as alcoholism and mental health if Pioneers' Homes were exempted from the certificate of need program?

ANSWER: No! Absolutely not. In his opinion, under the new administration, there would be no federal sanctions whatsoever in health care programs, especially since the responsibility for this is being turned over to the states.

Further, discussions were held with the States of California and Washington regarding their certificate of need programs. In California, Mr. Ken Umbach (916/323-6955) of the Office of Statewide Health Planning and Development was contacted. He stated that California has been out of conformance with the federal certificate of need program since 1969. Their latest date for coming into conformance is October. He stated that if they did not meet the deadline that the feds would probably extend it. Mr. Jim Bettridge of Washington Health Care Facilities Authority (206/753-6185) indicated that the feds were withdrawing total support from the certificate of need program by 1983.

These conversations indicate that:

i. The federal government is not inclined to impose sanctions on a State for nonconformance with the certificate of need program;

ii. There are states which are nonconforming, and have been nonconforming for a number of years, on which federal sanctions have not been imposed; and

iii. The federal government is withdrawing total support for the certificate of need program by 1983. If the state wants to continue a planning process for health facility development it will have to provide for the process by using General Funds monies. Based on the aforementioned problems, now would be the appropriate time to revise this planning process to make it more meaningful.

Finally, a compromise position has been mentioned in which the new nursing wing at the Anchorage Pioneers' Home and the new Pioneers' Home in Ketchikan would be totally grandfathered into law and not made subject to certificate of need. This compromise does not address a truly complex problem.

The Fairbanks Pioneers' Home presently is serving twelve skilled nursing beds in unlicensed beds. Unless a certificate of need is issued which allows licensing of these beds, these twelve pioneers would have to be discharged.

The Fairbanks and Palmer Pioneers' Homes are full to capacity with skilled nursing patients at the present time. If we are to accommodate anticipated need in the near future, additional skilled nursing facilities will have to be constructed within the next few years. This expansion would be impossible unless a certificate of need is issued.

The Department of Health and Social Services, in recent licensing inspections, has advised a significant number of residents in the ambulatory sections of all the Pioneers' Homes should be designated intermediate care patients. Intermediate care requires both a certificate of need and a significant increase in staffing, installation of call buttons or other signalling devices, and closer attention to patients when taking medications, etc. The number of patients which might be considered in need of intermediate care are: thirty at Sitka, twenty at Fairbanks, twenty at Palmer and forty at Anchorage (in the new wing).

Funding to provide intermediate care was not included in the FY 82 operating budget. Although a dollar figure is not available at the present time, a significant increase will be necessary if we must comply with the certificate of need program. Passage of SB 225 would eliminate this situation.

In summary:

1. Administration believes the Legislature had always intended to exclude Pioneers' Homes from certificate of need;

2. The certificate of need process is not appropriate for Alaska;

3. There needs to be planning for health care facilities and a more responsive process needs to be developed;

4. Grandfathering the nursing wing at Anchorage and the new Pioneers' Home at Ketchikan will not solve the complex problems existing at the Fairbanks, Palmer, and Sitka Pioneers' Home; and,

5. Passage of CSSB 225 will eliminate the potential for pain and suffering by allowing Pioneers' Homes residents to remain in their home.

If I can be of any further assistance to you or your committee, please give me a call.

Sincerely,

Frederick B. Muller
Deputy Commissioner for
Personnel Management

FBM/mjc
cc: Honorable Charles Parr
Honorable Robert Ziegler
Honorable Jalmar Kerttula
Honorable Patrick Rodey
Pioneers' Homes Advisory Board
Dennis Dewitt, Executive Director
Alaska State Hospital Association

accordance with subsection (b)(2), or (b)(3) of this section (as the Secretary determines appropriate), enter into another agreement with the Governor for the designation of a State Agency.

Failure to designate State Agency within specified period; reduction in allotment, grant, loan, loan guarantee, or contract

(d)(1) If an agreement under subsection (b)(3) of this section for the designation of a State Agency for a State is not in effect upon the expiration of—

(A) the fourth fiscal year which begins after 1975; or

(B)(i) if the legislature of the State is in a regular session on December 17, 1980 and the legislature will be in session for at least twelve months from such date, twenty-four months from such date, or

(ii) if the legislature of the State is in session on December 17, 1980, but twelve months do not remain in such session after such date or if the legislature of the State is not in session on such date, twenty-four months after the beginning of the first regular session of the legislature beginning after such date,

whichever occurs later, the Secretary shall take the action prescribed by paragraph (2).

(2) If upon the expiration of the period applicable under paragraph (1) an agreement is not in effect for the designation of a State Agency for a State, the Secretary shall until such an agreement is in effect take the following action:

(A) During the first twelve months after the date of the expiration of the applicable period, the Secretary shall reduce by 25 percent the amount of each allotment, grant, loan, and loan guarantee made to and each contract entered into with an individual or entity in such State during such period under this chapter or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970.

(B) During the second twelve months after such expiration date, the Secretary shall reduce by 50 percent the amount of each such allotment, grant, loan, loan guarantee, and contract.

(C) During the third twelve months after such expiration date, the Secretary shall reduce by 75 percent the amount of each such allotment, grant, loan, loan guarantee, and contract.

(D) After the expiration of thirty-six months after such expiration date, the Secretary may not make or enter into any such allotment, grant, loan, loan guarantee, or contract.

(July 1, 1944, c. 373, Title XV, § 1521, as added Jan. 4, 1975, Pub.L. 93-641, § 3, 88 Stat. 2242, and amended Aug. 1, 1977, Pub.L. 95-83, Title I, § 106(*l*), (m), 91 Stat. 385; Dec. 19, 1977, Pub.L. 95-215, § 6(b), 91 Stat. 1507; July 16, 1979, Pub. L. 96-33, 93 Stat. 86; Oct. 4, 1979, Pub.L. 96-79, Title I, § 123(a), (b)(1)(A), (2), (d), (f), (g)(2), 93 Stat. 624-627; Oct. 17, 1979, Pub.L. 96-88, Title V, § 509(b), 93 Stat. 695; Dec. 17, 1980, Pub.L. 96-538, Title III, § 303(b), 94 Stat. 3190; Aug. 13, 1981, Pub.L. 97-35, Title IX, §§ 902(g)(5), 936(b), 95 Stat. 561, 572.)

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

POUCH H 01
JUNEAU, ALASKA 99811
PHONE: 465-3030

May 10, 1982

The Honorable Mike Beirne
Chairman
House HESS Committee
Alaska State House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Representative Beirne:

I am enclosing a Program Policy Notice we recently received from the Bureau of Health Planning in the U. S. Department of Health and Human Services. This Notice emphasizes that states which do not have State Health Planning and Development Agencies which fully comply with federal requirements will lose federal support for health planning efforts and will also lose most federal Public Health Service dollars. Alaska currently receives some $5 million annually in such federal funds. Our lack of compliance would result in one quarter of these funds being withheld for four years until certain federal public health service funds are no longer available to Alaska.

We appreciate the hearing you conducted on House Bill 195. We believe this bill, with the amendments we offered, would bring our State Health Planning and Development Agency into full compliance with federal requirements. Your assistance in helping to move this legislation would be very much appreciated.

We appreciate your assistance and support in this matter.

Sincerely,

Helen D. Beirne

Helen D. Beirne
Commissioner

Enclosure

cc: Phoebe A. Lindsey

P38LH

alaska
state
hospital
association

319 Seward St., Juneau, Alaska 99801 • (907) 586-1790
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Central Peninsula Hospital
Soldotna

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

President
Dennis L. DeWitt
Juneau

November 4, 1982

The Honorable Ted Stevens
United States Senate
Washington, D.C. 20510

Similar letter sent to:
Senator Murkowski and
Congressman Young

Dear Senator Stevens:

As you are well aware the State of Alaska is not in conformity with the National Health Planning and Development Act and without federal action in 1982 faces penalties in grant monies under the Public Health Service Act and the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970. To avoid this penalty it is imperative that Congress repeal 42 U.S.C. 300m-(d) (copy attached).

This Association as well as the Alaska State Medical Association (resolutions attached) are opposed to the continuation of the state Certificate of Need law. Both are committed to its repeal in 1983. Repeal of 42 U.S.C. 300m-(d) will greatly assist our efforts.

We have communicated our support for various measures considered by this Congress to restructure the federal law. It appears however, that a full reform may be a consideration which must be left to the next Congress. If that is so, it is imperative that you secure repeal of 42 U.S.C. 300m-(d) before the current Congress adjourns in December.

All of those concerned with this issue including Congressman Waxman, the National Governors Conference, the American Hospital Association, etc., agree on removing sanctions against states which do not conform to the federal program. The notion of further delay of the sanctions does not assist anyone, it simply prevents states such as Alaska from dealing with its own law on anything beyond a temporary basis.

For these reasons we urge you to secure the repeal of 42 U.S.C. 300m-(d). This will permit the legislature of the State of Alaska to deal with its law in whatever manner it deems appropriate. Further, we urge that this repeal be secured prior to the adjournment of the 97th Congress.

Sincerely,

Dennis L. DeWitt
President

DLD:lf
cc: Friday Mailing
Alaska State Medical Society
Governer Jay Hammond
Governer Elect Sheffield
Lt. Governer Terry Miller
Lt. Governer Elect McAlpine
American Hospital Association - Lynn Hart
Federation of American Hospitals

· BILL SHEFFIELD, GOVERNOR

STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

December 22, 1982

Mr. Dennis L. DeWitt
President
Alaska State Hospital Association
319 Seward Street
Juneau, Alaska 99801

Dear Mr. DeWitt:

Thank you for sending me a copy of your letter to Senator Stevens regarding the state Certificate of Need law.

As you know, I am in agreement with you in your opposition to this law. Please keep me posted as to what I can do to change the law in Alaska.

Best regards.

Sincerely,

Bill Sheffield
Governor

ALASKA STATE MEDICAL ASSOCIATION
4107 Laurel Street • Suite 1 • Anchorage, Alaska 99504 • (907) 277-6891



ADOPTED BY THE ALASKA STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES AT ITS ANNUAL MEETING IN FAIRBANKS, ALASKA JUNE 8, 1982

RESOLUTION NO. 82-23

SUBJECT: Certificate of Need

WHEREAS, the certificate of need process has increased the cost of health care rather than reduced it; and

WHEREAS, the certificate of need process has wreaked havoc upon the orderly development of hospitals in Alaska, therefore

BE IT RESOLVED, the Alaska State Medical Association urges and encourages the Legislature to repeal the certificate of need law.

DISTRIBUTION: Legislature
Alaska State Hospital Association
Press