SB

85

CS FOR SB 85 (HESS) - SECTIONAL ANALYSIS

SECTION 1. FINDINGS AND DECLARATION OF POLICY

*THAT THERE ARE PROBLEMS WITH THE CERTIFICATE OF NEED PROGRAM AS IT EXISTS.
*THAT THE LEGISLATURE FINDS UNCERTAINTY ON THE FEDERAL LEVEL CONCERNING THE PROGRAM, AND THEREFORE SUSPENDS IT.
*THAT THE RETROSPECTIVE METHOD OF PAYMENT TO HEALTH FACILITIES IS INADEQUATE, AND THAT THE LEGISLATURE INTENDS TO CHANGE TO A PROSPECTIVE METHOD OF PAYMENT.

SECTION 2. THIS SECTION CONCERNING THE CERTIFICATE OF NEED PROGRAM WILL GO INTO EFFECT IN FOUR YEARS (SECTION 16) FOLLOWING THE SUSPENSION.

SECTION 3. AMENDS THE STATE HEALTH PLANNING LAW

SECTION 4. REANCTMENT OF SECTION REMOVES REFERENCE TO THE CERTIFICATE OF NEED PROGRAM. THIS SECTION WILL BE LAW DURING THE TIME OF SUSPENSION.

SECTION 5. THIS SECTION (CURRENT LAW) WILL BE LAW WHEN SUSPENSION PERIOD IS OVER, AND TAKES EFFECT FOUR YEARS FROM THE EFFECTIVE DATE OF THIS BILL.

SECTION 6. LIMITS REVENUE SHARING FOR HOSPITALS TO HOSPITALS WITH 50 OR LESS ACUTE CARE BEDS.

SECTION 7. INTENT IS TO GIVE THE MEDICAL RATE COMMISSION SOME AUTHORITY IN RATE SETTING FOR OVERBUILT OR OVERBEDDED FACILITIES.

SECTION 8. EACH HEALTH FACILITY IS REQUIRED TO SUBMIT A FINANCIAL REPORT TO THE MEDICAL RATE COMMISSION BY 120 DAYS AFTER THE END OF THEIR FISCAL YEAR.

THE COMMISSION WILL SUBMIT A REPORT TO THE GOVERNOR BY SEPTEMBER 30 OF EACH YEAR ON PERSPECTIVE PAYMENTS MADE AND AN ESTIMATE OF CURRENT AND SUBSEQUENT YEAR'S PROSPECTIVE PAYMENTS.

A UNIFORM BUDGETING AND ACCOUNTING SYSTEM WILL BE ESTABLISHED BY THE COMMISSION BY REGULATION, TAKING INTO CONSIDERATION CURRENT SYSTEMS, DIFFERENCES IN FACILITIES AND THEIR SERVICES.

THE COMMISSION HAS THE POWER TO WAIVE OR MODIFY A REQUIREMENT IN ACCOUNTING ON A CASE BY CASE BASIS.

AUDITS ARE REQUIRED, AND HEALTH FACILITIES SHALL ALLOW REASONABLE ACCESS TO FINANCIAL RECORDS BY THE COMMISSION, THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES AND ANY FEDERAL AGENCIES REQUIRED BY LAW.

ACTIONS OF THE COMMISSION ARE SUBJECT TO THE ADMINISTRATIVE PROCEDURES ACT.

SECTION 9. DEFINITIONS

SECTION 10. CREATION OF THE MEDICAL RATE COMMISSION WITHIN THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES.

LISTS THE FIVE MEMBERS TO BE APPOINTED BY THE GOVERNOR FOR THREE YEAR STAGGERED TERMS.

COMPENSATION FOR BOARD MEMBERS IS TRAVEL AND PERDIEM.

BOARD MEMBERS WILL SELECT A CHAIR AT THEIR FIRST YEARLY MEETING.

THE COMMISSION MEETS AS OFTEN AS NECESSARY, AND THREE MEMBERS CONSTITUTES A QUORUM.

DUTIES OF THE COMMISSION IS TO REVIEW AND ESTABLISH RATES PAID TO HEALTH FACILITIES FOR MEDICAID AND GENERAL RELIEF PROGRAMS.

THE COMMISSION MAY EMPLOY AN EXECUTIVE DIRECTOR WHO MAY HIRE ADDITIONAL STAFF AT THE APPROVAL OF THE COMMISSION. PERSONNEL OF THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES WILL PROVIDE STAFF ASSISTANCE TO THE COMMISSION.

SECTION 11. GIVES THE DEPARTMENT AUTHORITY TO ESTABLISH A PROSPECTIVE PAYMENT SYSTEM FOR THE GENERAL RELIEF ASSISTANCE PROGRAM TO HEALTH FACILITIES.

SECTION 12. GIVES THE DEPARTMENT THE AUTHORITY TO SET INTERIM PAYMENT RATES WHILE THE COMMISSION IS COMING ON LINE.

SECTION 13. GUARANTEES THAT FUNDING PREVIOUSLY AWARDED THROUGH AS 29.90 WILL CONTINUE. (HOSPITAL CONSTRUCTION FUNDS).

SECTION 14. SUSPENDS THE CERTIFICATE OF NEED PROGRAM FOR FOUR YEARS.

SECTION 15. REPEALS THE HOSPITAL CONSTRUCTION FUND(AS 29.90) AND THE RETROSPECTIVE PAYMENT METHOD OF COST SETTLEMENT.

SECTION 16. REENACTS THE CERTIFICATE OF NEED PROGRAM IN FOUR YEARS FROM THE EFFECTIVE DATE OF THE BILL.

SECTION 17. EFFECTIVE DATE.

PLEASE NOTE: THE FOLLOWING PAGES WERE TREATED AS A UNIT IN THE ORIGINAL DOCUMENT

Sheffield Response to

HEALTH ISSUES QUESTIONNAIRE

Please circle the symbol that most closely corresponds to your opinion. If you wish, add any comments in the blank provided.

Strongly Support | Support | Oppose | Strongly Oppose

(SS) S O SO A formal mechanism should exist for citizen involvement in State health program decision-making.

Comment see Comment No. 1, attached

Governed by volunteer boards made up of health care providers as well as a "consumer" majority, the three Health Systems Agencies (HSAs) in Alaska have provided a process for citizen involvement in health care decisions. The HSAs operate with both Federal and State financial support. Federal support, previously at up to $500,000. and currently approximately $125,000., constituted 75% of each HSA's funding in the past. State support was $125,000. in FY 1976-77 and $100,000. in FY 1978-81. The most recent allocation reduced the subsequent annual authorized amount by 50% to $50,000. The Federal government has proposed eliminating support for Health Systems Agencies after the current fiscal year. Indicate your feelings about the following statements.

SS (S) O SO The State should increase the current level of State support to each agency to at least $300,000. to maintain citizen involvement in health decisions at the local level.

SS S (O) SO The State should continue support at the authorized level of $100,000. to maintain citizen involvement in health decisions at the local level.

SS S (O) SO The State should provide no support.

Comment see Comment No. 2, attached .

A program administered by the State requires that health care providers apply for a Certificate of Need prior to any capital expenditures in excess of $150,000. and/or any change in licensed bed capacity of 10 beds or 10 percent. Indicate your feelings about the alternative suggestions below.

SS S (O) SO The Certificate of Need program should continue as presently designed with review, public comment, and analysis at the regional level and the final decision at the Commissioner level.

SS (S) O SO The Certificate of Need program should continue with an increase in levels to at least $600,000.

SS S O (SO) The role of regional Health Systems Agencies should be eliminated, leaving the review, analysis, and final decision with the Commissioner of Health and Social Services.

Comment see Comment No. 3, attached

A number of groups have indicated support for health education in the schools as a way to prevent some of the major health problems in Alaska. Indicate your feelings about the following proposals.

(SS) S O SO Schools should have health education programs.

SS (S) O SO Comprehensive health education should address the range of health problems in Alaska including sessions on alcohol and drug abuse, mental health, sex education, and values clarification.

SS S (O) SO The Legislature should require comprehensive health education in all Alaskan schools.

SS (S) O SO The Legislature, while not requiring health education, should provide financial assistance and other incentives to school districts to encourage development of school health education programs.

Comment see Comment No. 4, attached

Strongly Support / Support / Oppose / Strongly Oppose

Alcohol abuse is widely recognized as a problem in Alaska. In addition to prevention and treatment programs, legislative changes have been proposed.

Indicate your feelings about the following legislative changes:

SS S O (SO) Increase the sales tax on alcohol.

SS S O (SO) Reduce the bar hours statewide (e.g., require closure for a minimum of 6 hours/day).

SS S (O) SO Raise the drinking age to 21 years.

SS S (O) SO Restrict alcohol advertising.

SS (S) O SO Implement more stringent penalties for driving while intoxicated/operating a motor vehicle while intoxicated.

SS (S) O SO Continue and/or increase State funding of treatment programs.

SS (S) O SO Continue and/or increase State support for prevention programs.

Comment see Comment No. 5, attached

Traditionally the State has provided prevention and public health services in all parts of Alaska leaving the provision of direct health care services to the private sector and the Federal government. The Federal government is cutting back on direct services offered. Due to the isolation of many areas of the State, it has not been economically feasible for the private sector to provide direct health care services in all areas. Indicate your opinion about the idea

SS S * O SO that the State should financially support direct health care services in those areas that are medically underserved.

Comment see Comment No. 6, attached

In the past legislative session, a bill was introduced proposing a comprehensive health insurance plan which would allow a choice of coverage for residents on a cost-sharing basis based on ability to pay. Indicate your feelings about some

SS S * O SO form of state-supported comprehensive health insurance.

Comment see Comment No. 7, attached

Name Bill Sheffield

Comment No. 1

- A formal mechanism should exist for citizen involvement in the expenditure of public funds for health program expenditures.

- Health outlays in recent years have been increasing at a greater rate than in other areas.

- The Federal and State outlays for health are increasing rapidly.

- Since substantial and increasing public monies provided by tax revenues are involved, citizen involvement in public program decision making is of increasing importance.

- The present formal mechanism for accomplishing citizen involvement could be open to changes and improvement based on careful analysis of past and present arrangements and potential new arrangements.

Comment No. 2

- Based on statutory and regulatory changes which are finally made, if any, in Federal and State laws related to State health planning efforts, including the health systems agencies, adequate financial support from the State and Federal level should be made available.

- An integral relation exists between a State Certificate of Need Program and outlays for health planning.

- Should the Certificate of Need Program on the Federal or State level, or both, be repealed, the financial outlays for the health systems agencies would be affected substantially as well, if not eliminated.

- A $100,000 authorized support level for each health systems agency will not be sufficient to have an effective planning staff capacity. Should only $100,000 be available for each agency, one of two developments would be indicated:

  1. Close the activity for three health systems agencies; or

  2. Combine the funds available into a single health systems agency with amended, limited functions and powers.

Comment No. 3

- It is my understanding that the Certificate of Need Programs on both Federal and State levels are faced with a measure of uncertainty.

- If the Certificate of Need Program is repealed by the State of Alaska, an appropriate program relating to planning of health services and facilities will be required based on the substantial public interest issues involved.

- While I oppose the continuation of the Certificate of Need Program "as presently designed", I could support an amended Certificate of Need Program within the State under two conditions:

  1. That no substantial multi-million dollar Federal penalty become applicable to Alaska due to the absence of a Certificate of Need Program; or

  2. The revised or amended Certificate of Need Program could remove some of the burdensome provisions as related to the health facilities under a simplified and more efficient application and review process.

Comment No. 4

My views are expressed generally in line with the markings in the questionnaire under health education.

Comment No. 5

- Consideration should be given to a uniform "development of maturity" age for Alaskans which would take into account responsibilities related to voting age, military service age, and drinking age.

- To assume that a young person can exercise adequately some of the privileges and responsibilities of military service, voting for officials and using alcoholic beverages at different ages, I find problematical. However, substantial discussion and public input should be required before making changes in such important activities related to youth.

Comment No. 6

- It is understood that the private health sector may not under present arrangements be able to provide direct health services in all areas. This is especially the case in unusually remote locations and very small communities.

- The State should encourage wherever possible the providing of direct health services by the private sector, understanding that the Federal government has provided, and doubtless will continue to provide, a substantial level of direct health services in the rural regions.

- The State should not consider the automatic assumption of those direct health services which have been or may be terminated by the Federal government.

- The State should take all reasonable measures to work with the Federal government and insist that the Federal government continue an adequate level of direct health services which has been its historic responsibility and current responsibility under the applicable Federal statutes, programs, and policies.

Comment No. 7

- While I favor strongly the adequate and reasonable access to health services on behalf of every Alaskan, I am not convinced that a "comprehensive health insurance plan" with certain other provisions would be the best plan for the following reasons:

  1. Health insurance for tens of thousands of Alaskans is a program based upon negotiated labor agreements between hundreds of employers, employees, and their respective unions.

     The State should not take action to disrupt that part of the insurance arrangements which have worked exceedingly well, except for the growing costs.

  2. The Federal government has certain levels of responsibility for approximately 60,000 Alaskan Natives with an annual outlay of more than $100,000,000 for program services alone, excluding capital expenditures. Any program of comprehensive health insurance,

Comment No. 7 (cont'd)

in order to be equitable, must include all Alaskans. The implication of a State-sponsored comprehensive health insurance program must be considered only in relation to the Indian Health Service Program.

3. I strongly support the concept of cost sharing, co-payment, and deductible plans since such have been demonstrated to reduce over-utilization and abuse of both public and private and other health care insurance programs. If such arrangements are adopted, they should be fair, reasonable, and equitable and related to broad categories of ability to pay.

- With a population of approximately 450,000 in Alaska, a recent research study indicated that only 29,000 Alaskans (estimated) do not now have either private or public coverage. Any reasonable State program should probably focus on the uncovered populations. To do otherwise would be to displace program and financial responsibilities and result in shifting to the State financial responsibility not now assumed.

- The best plan for improving health coverage and financing should focus on improvement to Medicaid, General Relief Medical, and Catastrophic Illness Programs, including the possibility of creation of a high risk pool for persons who are not low income but cannot afford coverage of any kind, because they are unemployed, part-time employed, or too ill.

- While, for the above reasons, I oppose a comprehensive health insurance plan per se, any plan which would meet some of the more important objectives outlined above without creating counter-productive elements as indicated above would meet with my great interest and open mind.

* * *

WJS/jes

- dental, vision, and hearing care;
- prescription drugs; and
- alcoholism treatment.

The elderly population covered only by Medicare faces the risk of high out-of-pocket medical expenses. Similarly, many persons covered by private plans must make significant out-of-pocket payments to receive their benefits. The supposedly comprehensive Native health care benefits are quite limited in certain instances due to the AANHS budget constraints.

B.5. Expenditures and Expenditure Trends

The total health care bill in Alaska was $480 million in 1979; approximately 14% of that amount was paid by state and local governments, 31% by the federal government, and 55% by the private sector. About 64% of the state and federal share was used to provide direct services, and the other 36% was used to pay for various public health programs. About 63% of the private sector share was paid directly by consumers for out-of-pocket expenses and health insurance premiums, and 37% was paid by employers for health insurance premiums (See Figure I-1 in Volume I).

The total cost of health care has been rising dramatically in Alaska. Population increases and decreases in the relative price of medical care account for some of this, but the largest part is due simply to general inflation. Health care expenditures could reach $1 billion by 1990 if inflation continues at current rates.

C. OPTIONS FOR STATE ACTION

Weaknesses in the health care system determined during the survey of Alaska health care resources and financing were used to identify the types of options the state of Alaska could consider to improve the comprehensiveness and accessibility of health care. The principal barriers which reduce the accessibility of health care among the Alaska population, and specific actions that the state could consider for eliminating these barriers and improving

Summary of Private and Public Health Care Coverage in Alaska

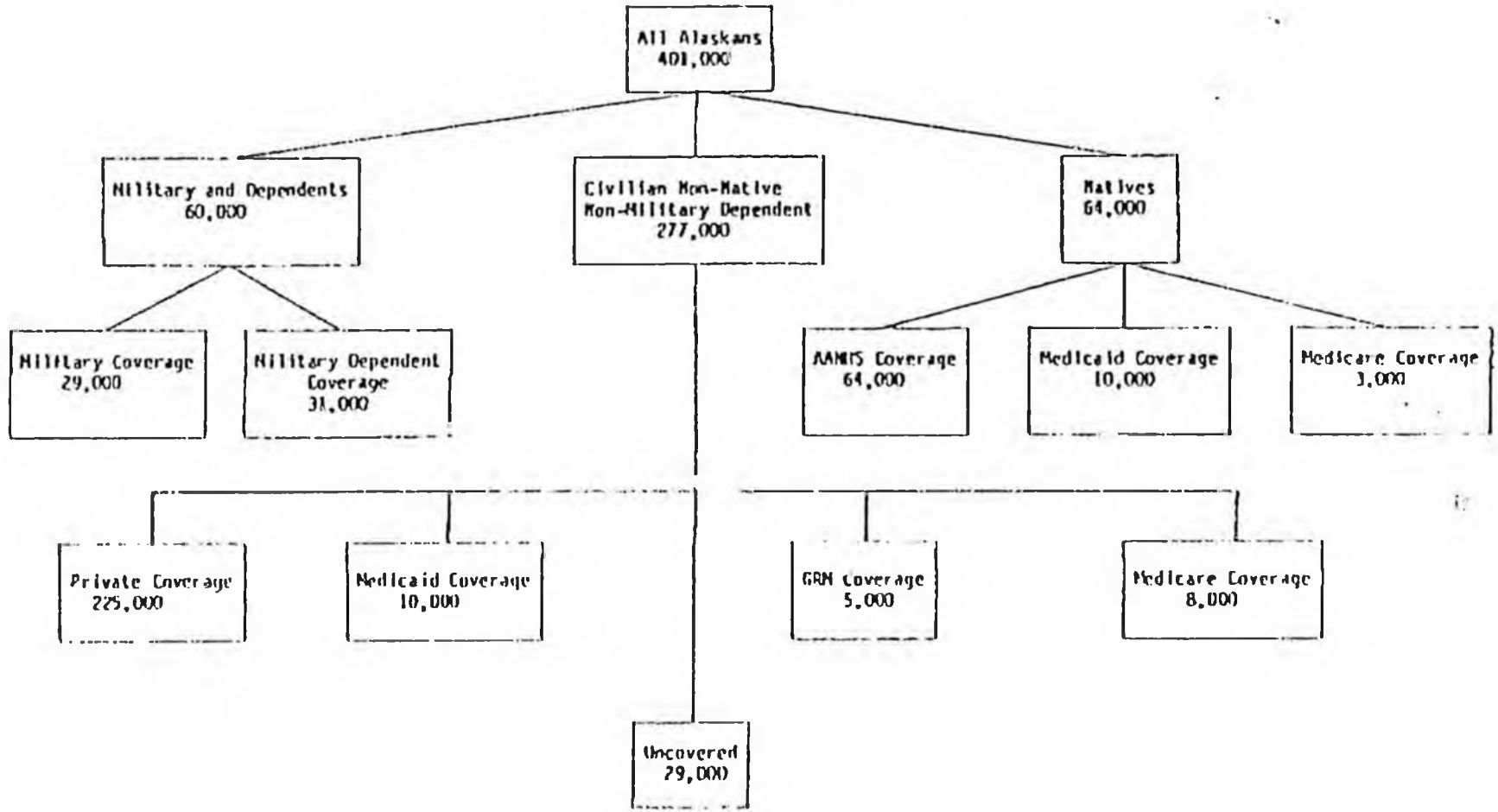

Figure 1.

Battelle Report —
F.A.C.T. — March, 1982

PLEASE NOTE: THE PRECEDING PAGES WERE TREATED AS A UNIT IN THE ORIGINAL DOCUMENT.

FY 1981 MUNICIPAL REVENUE SHARING ENTITLEMENTS (112) FEBRUARY 22, 198

TOTAL ENTITLEMENT = $55,707,600

KEY	COMMUNITY	PUBLIC ROAD MILES	ICE ROAD MILES	HOSPITAL ENTITLEMENT	HEALTH FACILITIES ENTITLEMENT	HOSPITA CONST. A
BOROUGHS AND SERVICE AREAS						
0010	ANCHORAGE A.W.	400.60	0.00	$463,825	$688,405	$5,483,87
0020	CITY S.A.	0.00	0.00	$0	$0	$
0030	EAGLE RIVER	25.39	0.00	$0	$0	$
0040	CHUGIAK	0.00	0.00	$0	$0	$
0060	GIRDWOOD	10.54	0.00	$0	$0	$
0070	GLEN ALPS	10.59	0.00	$0	$0	$
0080	FIRE S.A.	0.00	0.00	$0	$0	$
0090	ROADS & DRAINAGE	0.00	0.00	$0	$0	$
0095	LIMITED ROAD S.A.	0.00	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	CITY SA ROADS & DRAINAGE	0.00	0.00	$0	$0	$
0170	SERVICE AREA 55	0.00	0.00	$0	$0	$
0175	UPPER O'MALLEY	14.60	0.00	$0	$0	$
0180	PORT OF ANCH.	0.00	0.00	$0	$0	$
0185	ROADS	58.16	0.00	$0	$0	$
0190	AIRPORT S.A.	0.00	0.00	$0	$0	$
0195	PUBLIC TRANSIT	0.00	0.00	$0	$0	$
0200	PARKING S.A.	0.00	0.00	$0	$0	$
0210	BRISTOL BAY BOROUGH	6.87	0.00	$0	$38,414	$
0230	FAIRBANKS BOROUGH	93.60	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	$

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. AI
0230	FIRE DISTRICT	0.00	0.00	$0	$0	$0
0290	JUNEAU BOROUGH A.W.	0.00	0.00	$231,942	$159,576	$33,21
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 1	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

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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	$1,181,855
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	$15,978	$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 (H2) FEBRUARY 22, 198

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KEY	COMMUNITY	PUBLIC ROAD MILES	ICE ROAD MILES	HOSPITAL ENTITLEMENT	HEALTH FACILITIES ENTITLEMENT	HOSPITA CONST. A
1260	S WARD	18.35	0.00	$249,662	$143,805	$
1270	SKAGWAY	9.50	0.00	$0	$7,989	$
1280	SOLDOTNA	24.78	0.00	$0	$0	$
1290	UNALASKA	38.42	0.00	$0	$9,603	$
1300	VALDEZ	15.80	0.00	$278,818	$8,922	$
1330	WRANGELL	7.13	0.00	$240,640	$15,400	$
1360	YAKUTAT	3.31	0.00	$0	$7,989	$
SECOND CLASS CITIES						
5000	AKHIOK	4.00	0.00	$0	$0	$
5010	AKIACHAK	1.59	9.00	$0	$9,964	$
5020	AKIAK	0.00	0.00	$0	$9,964	$
5030	AKOLMIUT	0.00	44.75	$0	$19,928	$
5040	AKUTAN	0.00	0.00	$0	$0	$
5050	ALAKANUK	4.00	8.00	$0	$9,964	$
5060	ALEKNAGIK	0.00	0.00	$0	$9,603	$
5070	ALLAKAKET	2.70	0.00	$0	$0	$
5080	AMBLER	5.22	0.00	$0	$10,337	$
5090	ANAKTUVUK PASS	0.00	0.00	$0	$0	$
5100	ANDERSON	5.00	0.00	$0	$0	$
5110	ANGOON	5.18	0.00	$0	$0	$
5120	ANIAK	8.10	24.00	$0	$20,675	$
5130	ANVIK	0.00	0.00	$0	$10,337	$
5140	ATMAUTLUAK	0.00	0.00	$0	$9,964	$
5150	BETHEL	10.85	48.00	$0	$13 ,026	$
5160	BREVIG MISSION	0.00	0.00	$0	$,	$
5170	BUCKLAND	0.00	0.00	$0	$0	$
5180	CHEFORNAK	0.00	0.00	$0	$9,964	$
5190	CHEVAK	0.50	0.00	$0	$9,964	$
5200	CHUATHBALUK	4.00	6.00	$0	$10,337	$
5210	CLARK'S POINT	0.00	0.00	$0	$9,603	$
5220	DEERING	0.00	0.00	$0	$10,337	$
5230	DELTA JUNCTION	10.88	0.00	$0	$8,600	$
5240	DIOMEDE	0.00	0.00	$0	$0	$

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KEY	COMMUNITY	PUBLIC ROAD MILES	ICE ROAD MILES	HOSPITAL ENTITLEMENT	HEALTH FACILITIES ENTITLEMENT	HOSPITAL CONST. AI
6250	EAGLE	2.39	0.00	$0	$0	$
6260	EEK	0.00	0.00	$0	$0	$
6270	EKWOK	0.00	0.00	$0	$0	$
6280	ELIM	1.60	0.00	$0	$10,338	$
6290	EMMONAK	3.41	7.50	$0	$9,964	$
6300	FORT YUKON	13.50	0.00	$0	$0	$
6310	FORTUNA LEDGE	5.00	0.00	$0	$9,964	$
6320	GAMBELL	0.00	0.00	$0	$0	$
6330	GOLOVIN	0.00	0.00	$0	$10,337	$
6340	GOODNEWS BAY	0.00	0.00	$0	$0	$
6350	GRAYLING	0.00	0.00	$0	$0	$
6360	HOLY CROSS	4.00	0.00	$0	$10,337	$
6370	HOOPER BAY	0.00	0.00	$0	$0	$
6380	HOUSTON	30.75	0.00	$0	$0	$
6390	HUGHES	0.00	0.00	$0	$0	$
6400	HUSLIA	17.70	0.00	$0	$10,337	$
6410	KACHEMAK	0.00	0.00	$0	$0	$
6420	KAKTOVIK	0.00	0.00	$0	$0	$
6430	KALTAG	0.00	0.00	$0	$0	$
6440	KASAAN	0.00	0.00	$0	$7,422	$
6460	KIANA	2.20	0.00	$0	$10,337	$
6470	KIVALINA	0.00	0.00	$0	$0	$
6480	KOBUK	0.00	0.00	$0	$0	$
6490	KOTLIK	0.00	0.00	$0	$9,964	$
6500	KOTZEBUE	15.50	3.50	$0	$0	$
6510	KOYUK	1.79	0.00	$0	$10,337	$
6520	KOYUKUK	1.00	0.00	$0	$10,337	$
6530	LUPREANOF	0.00	0.00	$0	$0	$
6540	KWETHLUK	0.00	0.00	$0	$0	$
6550	LARSEN BAY	0.00	0.00	$0	$0	$
6555	LOWER KALSKAG	3.86	40.00	$0	$10,337	$
6560	MANOKOTAK	0.43	0.00	$0	$9,603	$
6570	MCGRATH	10.95	0.00	$0	$10,337	$
6580	MEKORYUK	0.00	0.00	$0	$9,964	$
6590	MOUNTAIN VILLAGE	3.50	18.00	$0	$9,964	$
6600	NAPAKIAK	2.48	0.00	$0	$9,9 4	$

FY 1981 MUNICIPAL REVENUE SHARING ENTITLEMENTS (H2) FEBRUARY 22, 198

TOTAL ENTITLEMENT = $55,707,600

KEY	COMMUNITY	PUBLIC ROAD MILES	ICE ROAD MILES	HOSPITAL ENTITLEMENT	HEALTH FACILITIES ENTITLEMENT	HOSPIT CONST. A
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 (H2) FEBRUARY 22, 1982

TOTAL ENTITLEMENT = $55,707,600

KEY	COMMUNITY	PUBLIC ROAD MILES	ICE ROAD MILES	HOSPITAL ENTITLEMENT	HEALTH FACILITIES ENTITLEMENT	HOSPITA CONST. AI
BOROUGHS AND SERVICE AREAS						
0010	ANCHORAGE A.W.	400.60	0.00	$463,885	$688,405	$5,483,87
0020	CITY S.A.	0.00	0.00	$0	$0	$
0030	EAGLE RIVER	25.99	0.00	$0	$0	$
0040	CHUGIAK	0.00	0.00	$0	$0	$
0060	GIRDWOOD	10.74	0.00	$0	$0	$
0070	GLEN ALPS	10.59	0.00	$0	$0	$
0080	FIRE S.A.	0.00	0.00	$0	$0	$
0090	ROADS & DRAINAGE	0.00	0.00	$0	$0	$
0095	LIMITED ROAD S.A.	0.00	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	CITY SA ROADS & DRAINAGE	0.00	0.00	$0	$0	$
0170	SERVICE AREA 35	0.00	0.00	$0	$0	$
0175	UPPER O'MALLEY	14.60	0.00	$0	$0	$
0180	PORT OF ANCH.	0.00	0.00	$0	$0	$
0185	ROADS	58.16	0.00	$0	$0	$
0190	AIRPORT S.A.	0.00	0.00	$0	$0	$
0195	PUBLIC TRANSIT	0.00	0.00	$0	$0	$
0200	PARKING S.A.	0.00	0.00	$0	$0	$
0210	BRISTOL BAY BOROUGH	6.87	0.00	$0	$38,414	$
0230	FAIRBANKS BOROUGH	93.60	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	$

DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service

Region X
M/S 239 Arcade Plaza Building
1321 Second Avenue
Seattle WA 98101

RECEIVED
MAR 22 1982
DSHPD

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	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

PLEASE NOTE: THE FOLLOWING PAGES WERE TREATED AS A UNIT IN THE ORIGINAL DOCUMENT

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
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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
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Kodiak

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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 his 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

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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.

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

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

ALASKA STATE MEDICAL ASSOCIATION
707 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

#1

Dec Dennis Knowles

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, 1992

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 presperous 1983.

Sincerely,

Al M. Camosso
Administrator

Enclosure

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.

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 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

P38LH

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

alaska
state
hospital
association

319 Seward St., Juneau, Alaska 99801 • (907) 586-1790
REPRESENTING ACUTE, LONG TERM AND OUTPATIENT FACILITIES

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Ronald A. Pavelias
Humana Hospital Alaska
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Alternate Delegate to the Association of Western Hospitals
Daniel Van Wieringen
Kodiak Island Hospital
Kodiak

Trustee Delegate to the American Hospital Assoc.
Moe Radich
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

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

PLEASE NOTE: THE PRECEDING PAGES WERE TREATED AS A UNIT IN THE ORIGINAL DOCUMENT.

PROVIDENCE
HOSPITAL

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

SISTERS OF
PROVIDENCE

SERVING IN THE WEST SINCE 1856

March 22, 1983

The Honorable Donald Clocksin
House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Representative Clocksin:

We read with interest your article on hospital expansion in the March 14 issue of the Anchorage Daily News.

Several issues and statistics were addressed in the article. There were some significant errors. Evidently, we have failed to let you know all the facts about Project 90 and we would like to clear up some of the errors and misconceptions, especially as the legislature proceeds to consider a number of health care issues. Attached is a fact sheet which highlights some of the most important points.

We would encourage you to come and visit us sometime soon when you are in Anchorage. It would be a pleasure to discuss your concerns, share our plans, show you the crowded conditions at the hospital and explore the needs we foresee in the years to come.

Please contact me or Chris Beardsley at any time; we will set up a tour and meeting time. Thank you for your consideration of these comments.

Sincerely,

Al M. Camosso
Administrator

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

PROJECT 90 UPDATE FACT SHEET
IN RESPONSE TO THE HONORABLE DONALD CLOCKSIN'S
LETTER OF MARCH 14, 1983, IN THE ANCHORAGE DAILY NEWS

1. Providence's expansion, Project 90, is a totally integrated program to keep pace with the growing demands of Alaskans for highly specialized hospital care provided by this major referral center.

   As a prudent and responsible institution and community asset, Providence would only open and staff the patient care beds and units as needed. However, some of those units are needed right now. The hospital is so full that we are experiencing inverse efficiency and tremendous patient and community disruption. For example, elective surgery is often cancelled because there are no beds. Patients are transferred from room to room to accommodate emergencies of more critical patients.

2. The Providence and Humana projects are very different. One project (Humana) is primarily adding beds, the other (Providence) includes significant expansion to the ancillary departments, laboratory, surgery, radiology, etc.

   The most accurate way to compare construction costs of projects is to compare the cost per square foot, not cost per bed. Project 90 would add 270,000 new and remodeled square feet. Humana would add 86,525 square feet.

   Cost estimates done by an independent Alaskan contractor familiar with projects of this size, estimated Project 90 to cost $286 per square foot (in 1984 dollars). This estimate is below our Certificate of Need estimates of $296 per square foot.

   To further put these figures in context, these 1984 estimates were compared with two recent health facility projects. Using 1980 dollars, the extended care facility at the Anchorage Pioneer Home had projected costs of $250 per square foot. The Anchorage Neighborhood Health Center, a project far less complicated or sophisticated than a medical referral center, had projected costs of $210 per square foot.

3. Providence Hospital has a policy of funding depreciation and earning an amount for growth and development. These funds, funded depreciation and growth and development, are used to replace and add equipment and facilities and to introduce new technology to enable the hospital to continue to render effective and efficient services in accordance with the needs of the community and state on a solvent basis. These funds have been invested prudently and earned interest. The total of these funds is a community asset. Providence has accumulated $20 million, not $55 million, in the past several years which will become the equity in financing Project 90 and will help keep rate increases to patients at a reasonable level.

4. Projections which include the use of $46 million of State funds for building Project 90 need to be revised as they are now dated.

   Although current law (29.90) established eligibility for hospitals to receive State construction revenue sharing funds after completion of a project, Providence Hospital did not include any amount of that construction aid in the projected rates (charges to the patient). These rates include debt financing cost independent of State aid. If funds were received, they would be used to retire debt, therefore reducing operating expense and lowering the charges to the public.

   Since submitting the Certificate of Need application in July, 1982, Providence and the State Hospital Association have urged repeal or suspension of the Certificate of Need law and we also have recommended repeal or suspension of the Alaska Statute 29.90, construction revenue sharing program.

5. The average per diem rate increase from 1979 through 1982 has been 11.4%, well below the 18% quoted in March 14 letter. Rate increases between 1983 and 1990, including Project 90 costs, are projected to average less than 9% per year (see the Certificate of Need Application Section VII, Statistics and Ratios).

6. If both hospitals build, the total number of civilian, non-Native beds in Anchorage would be 692, including 40 rehabilitation beds. There would only be an "excess" of 83 beds over the 606 beds estimated by the HSA, not 170 as stated in the March 14 letter. That 692 is, in fact, below the 3.5 beds per thousand population maximum allowed by the State Health Plan.

7. Providence and Humana Hospitals have just gone through the entire Certificate of Need process so strongly advocated by some. This process included over 30 hours of public meetings and hearings, involving a Project Review Committee, Anchorage Municipal Health Commission and the HSA Board. At the end of that extensive process, these bodies either could not or did not answer the many complex questions posed or they concluded that both projects should be approved.

In conclusion, to put the Alaskan situation in a national context, Alaska is ranked last of all 50 states in the increases in hospital expenses, both by per capita and by patient admissions, according to the annual survey of hospitals conducted by the American Hospital Association. Alaska also has the shortest length of stay in a hospital and the fewest beds per capita of any state.

The National Center for Health Services Research has recently completed an economic study of the relationship of hospital operating costs to capital investments. Results show that operating costs lag behind investment, so that the full operating cost increase is not realized until after the first year that a new capital asset is completed or brought on-line. The average annual gain in operating costs is 22¢ for each dollar of capital investment, about 12¢ of which stems from increased non-labor costs resulting from expanded hospital purchases of supplies, services, and energy. Rising labor costs account for the remainder and they are due to increased hospital employment made possible by new capital expenditures. ~~There also is a difference according to type of investment: a dollar spent on equipment will generate greater future operating~~ The report concludes that each dollar invested in capital improvement over a 10-year period will result in average additional operating costs with a present value of $1.84. This $1.84 figure does not include depreciation or debt service and is a quick means of estimating the annual operating costs related to a capital expenditure.

Using the $1.84 figure to estimate the annual operating cost for the two Anchorage projects provides estimates of annual operating cost increases of $147,000,000 for Humana Hospital and $341,533,000 for Providence Hospital.

Providence (projected ~~construction~~ costs allocated by program as a percentage of total cost

		Construction	Operating
Medicaid	8%	14,849,280	
Medicare	9%	16,705,440	
Commercial Ins.	59%	109,513,440	
Blue Cross	16%	29,698,560	
Kaiser	2%	3,712,320	
Aetna	2%	3,712,320	
Other	4%	7,424,640	
	100%	185,616,000	

		Const. Humana	Operating
Medicaid	6%	3,356,320	
CHAMPUS	3.5%	1,959,020	
Medicare	9%	5,027,460	
Medicaid	1.2%	671,[illegible]	
Commercial Ins.	39.1%	21,[illegible]	
Blue Cross	14.7%	7,236,0[illegible]	
Aetna	8.5%	4,921,[illegible]	
Champus	18%	447,77[illegible]	
Other	17.5%	9,7[illegible]	
	100.1%		

Total 55,972,[illegible]

alaska state hospital association

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

REPRESENTING ACUTE, LONG TERM AND OU ATIENT FACILITIES

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Humana Hospital Alaska
Anchorage

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Sitka Community Hospital
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Fairbanks

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Cordova Community Hospital
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Central Peninsula Hospital
Soldotna

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

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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 Jonsen
Central Peninsula Hospital
Soldotna

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

President
Dennis L. DeWitt
Juneau

RECEIVED

MAR 2 8 1983

March 28, 1983

Josephson,

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

Subject: Senate Bill 85.

Dear Governor Sheffield:

I have reviewed the Committee Substitute for SB85 with the Executive Committee of the Alaska State Hospital Association and can inform you of our support for this Committee Substitute. This omnibus legislation addresses Certificate of Need, prospective payment for Medicaid and GRM, and revenue sharing in a manner acceptable to us on the whole.

While this bill does not repeal Certificate of Need, we are confident that the experience gained over the next 7 years will prove the point we have been making as to its uselessness. The prospective payment portion embodies an independent commission approach, basic principles of reimbursement, and a fair appeals mechanism. The suspension of Capital Revenue Sharing for 7 years is consistent with our committment that CON and Capital Revenue Sharing should be dealt with on the same basis. Capping operational revenue sharing at $250,000 per facility is in our judgement appropriate in the context of this bill.

While this measure does not accomplish totally our desire, we believe it merits your support as well as ours. This will, over the long run, accomplish our mutual goal of improving health care delivery with sensitivity to both cost and quality. The Alaska State Hospital Association respectfully requests your support for CSSB85(HESS).

Sincerely,

Dennis L. DeWitt
President

DLD:hb

cc: Senator Joe Josephson
Larry Crawford
Allen Blume

Health, Education and
Social Services Committee

Official Business

Alaska State Legislature

Senate

Pouch V
State Capitol
Juneau, Alaska 99811
465-4907
465-4908

January 21, 1983

re: Certificate of Need

Mr. Ronald A. Pavellas
Executive Director
Humana Hospital Alaska
2801 DeBarr Road
Anchorage, Alaska
99508

Dear Ron:

Thank you for sharing with me a copy of your letter of the 19th to Governor Sheffield. I read your letter with interest.

Truth to tell, I was unaware that the Task Force had apparently not been supported of the abolition of the Certificate of Need.

As you know, Dr. Fritz has sponsored legislation in the House. You can be sure that the Senate Committee on Health, Education and Social Services will attempt to give the fullest consideration to his proposal, or a Senate bill to the same effect.

Best wishes.

Sincerely,

Joe P. Josephson

January 19, 1983

Governor Bill Sheffield
State Capitol Building
Juneau, AK 99811

Dear Governor Sheffield:

I served on your Transition Task Force on Human Services, representing The Alaska State Hospital Association.

Upon reading the final published report, I was dismayed to see the recommendation regarding the State's "Certificate of Need" law.

I wish to be on record personally, professionally, and as a representative of The Alaska State Hospital Association that I am in complete disagreement with the recommendation (#6).

My input to the Task Force's work was clear: I was in favor of completely eliminating the "Certificate of Need" law, statutes and administrative machinery. I did not see the final draft of the recommendation and, therefore, did not vote on it. It is not my recommendation.

I did enjoy assisting in your transition to power, and have the highest respect for the people with whom I worked on the Task Force. I just need to make my position clear on this one issue.

Sincerely,

Ronald A. Pavellas

Ronald A. Pavellas
Executive Director

RAP:jb
cc: Dennis DeWitt, President, Alaska State Hospital Assn.
Robert Smith, Commissioner of Health & Social Services
Mae Tisher, Chairman, House H & SS Committee
Joe Josephson, Chairman, Senate H & SS Committee
Ilene Sackett

As has been previously noted, even though the promotion of competitve pricing may have great merit, no acceptable transistion plan has as yet been identified. When and if an acceptable plan is identified, several years may be required to implement the necessary changes. Health care care economists conservatively estimate the implementation period to be 10-20 years. Competition in the health care field presently exists in a very different form from that of competitive pricing in the general economy. The present competition in health care relates primarily to the ability of a health facility to attract physicians and to secure a greater share of the health care market.

This type of competition does not promote cost containment, but in the absence of the Certificate of Need program can be expected to sharply increase the cost of health care in Alaska. The cost of any constructed health care beds, whether utilized or not, will be considered in determining the rates to be charged for hospital services.

In the more rural areas of the state, recognition of "construction competition" is perhaps more difficult to identify, but nevertheless does exist. The 1982 Inventory and Evaluation of rural Alaskan health care facilities identified many deficiencies in existing rural health facilites which will require new construction and/or renovation. As the rural facilities are planning for this new construction, a trend is developing among those plans toward construction of replacement or renovated facilities which make it possible to offer more specialized services within the community. The proposed Cordova facility, for example, is planned to provide a capability to offer a justifiably higher level care, thereby, obviating the present need to travel to Anchorage for some specialized services. Since Anchorage facilities have been available to provide specialized services to the residents of Cordova it can be said that the proposed construction is in competition with the Anchorage facilities for the offering of those specialized services.

Some of the rural hospitals are assessing the possiblity of becoming regional referral centers for certain specialized services. Most communities believe it is desirable to have as many specialized services available locally as is practical. In order to make the provision of specialized services feasible, a rural facility will find it necessary to secure patients needing the specialized services emanationed from beyond its present service area.

Another facet of construction competition is the race for State funding. One of the responsibilites of the Health Resources Development Section of the Division of State Health Planning and Development has been to produce a six-year construction plan for rural health facilities which includes a rational plan for state financial assistance for the construction of hospitals, nursing homes, and intermediate care facilities. Competition for State funding of health facilities construction has been evident since the 1960s and has steadily increased in following years.

PLEASE NOTE: THE FOLLOWING PAGES WERE TREATED AS A UNIT IN THE ORIGINAL DOCUMENT

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.

Alaska State Legislature RECEIVED FEB 15 1983

SENATOR
DON BENNETT
P.O. BOX 2801
FAIRBANKS, ALASKA 99707

Senate

LEGISLATIVE ADDRESS
POUCH V - STATE CAPITOL
JUNEAU, ALASKA 99811

February 11, 1983

J.B. Carnahan
President, Northern Alaska Health Resources Association, Inc.
529 5th Avenue, Suite 6
Fairbanks, Alaska 99701

Dear Mr. Carnahan:

Thank you for your letter concerning legislation that would repeal the requirement for a certificate of need for health facilities.

SB 85, the Senate version of this legislation, is now before the Committee on Health, Education and Social Services and has a further referral to the Committee on Community and Regional Affairs. HB 19, the comparable House bill, is before the HESS Committee right now.

In the past I have observed major problems and delays associated with certificate of need procedures, however, I do agree with your assessment that some form of review process is preferable to a Laissez faire policy.

I appreciate knowing of your opinion on this issue and hope you will feel free to contact me on matters of importance to you.

Best Regards,

Senator Don Bennett

DB/jrk

RECEIVED FEB 16 1983

Alaska State Legislature

House of Representatives

Office of The Majority Leader

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

February 14, 1983

Mr. J.B. Carnahan, President
Northern Alaska Health Resources
Association, Inc.
529 Fifth Avenue, Suite 8
Fairbanks, Alaska 99701

Dear Mr. Carnahan:

Thank you very much for your very interesting and informative letter of February 3, regarding House Bill 19 and its proposed repeal of the requirements for certificates of need (CON) for health care facilities.

I am generally in agreement with each major point you raised. I also feel that the repeal of the CON requirement would result in overbuilding and a significant increase in the cost of medical care. There is presently a struggle between major hospitals in Anchorage over who gets a CON for major expansion. If no CON was required, probably both would do so; resulting in an excess of beds and a commensurate increase in costs per bed. I also share your concern over the exorbitant rise in the cost of medical care in general -- costs that I cannot explain by considering inflation, staffing, and plant/equipment costs, etc.

In short, I agree with your proposal to retain the CON program with revisions as necessary; e.g. to exempt non-clinical capital expenditures and to change threshold figures to reflect more realistic costs. I am sure we will have expert testimony to determine whether the levels you proposed are the most realistic.

Again, thanks for your excellent letter and you may be assured of my support. Your comments are always welcome.

Very truly yours,

Ramona

Ramona L. Barnes
House Majority Leader

RLB:jl

Alaska State Legislature

House of Representatives

Rep. Mike Davis

Pouch V
State Capitol
Juneau, Alaska 99811

Official Business

February 9, 1983

Mr. J.B. Carnahan, President
Northern Alaska Health Resources Asso., Inc.
529 5th Ave., Suite 8
Fairbanks, AK 99701

Dear Mr. Carnahan,

Thank you very much for your recent correspondence regarding HB 19 and the Certificate of Need process. I am very supportive of the position that it is more favorable to amend the current law rather than repeal it. It is information of the type you sent that helps make for a more persuasive argument.

I am currently researching this issue , and will do all I can to insure the best possible outcome regarding the CON law. I would also appreciate hearing from you if you can provide additional information.

Again, thank you for contacting me. Please continue to keep me informed of your concerns.

Sincerely,

Mike

Rep. Mike Davis

md/kh

Alaska State Legislature

House of Representatives

John J. Liska

Official Business

While in Session
Pouch V
Juneau, Alaska 99811
(907) 465-3733

Home - District 15
P.O. Box 421
Eagle River, Alaska 99577
(907) 688-2526

February 11, 1983

J. B. Carnahan
President
Northern Alaska Health Resources Association, Inc.
529 5th Avenue, Suite 8
Fairbanks, Alaska 99701

Dear J. B. Carnahan,

Thank you for your in depth letter of Feburary 3, 1983, regarding House Bill 19, "An Act repealing the certificate of need program; and providing for an effective date."

The information you supplied will be very useful when we consider the Bill. It is always good to hear how the industry feels about proposed changes in the laws that will affect them.

Sincerely,

John J. Liska
Representative - District 15

JJL/le

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

February 11, 1983

J.B. Carnahan, President
Northern Alaska Health Resources Assoc., Inc.
529 5th Avenue, Suite 8
Fairbanks, Alaska 99701

Dear Mr. Carnahan,

Thank you for your letter of February 3, 1983. Your comments are interesting and appropriate arguements on the future of CON in Alaska.

On Friday, February 18, 1983, the House Health, Education & Social Services Committee will hold its first public hearing on HB 19. As co-chairman of House HESS, I will introduce your written comments during the hearing. They will be considered pertinent testimony of record.

I appreciate your comments. Please feel free to contact me again regarding this issue and other concerns you may have.

Sincerely,

Mae Tischer

Rep. Mae Tischer
District 11

MT/hb

RECEIVED FEB 16 1983

Alaska State Legislature

REPRESENTATIVE
BARBARA LACHER
PO BOX 478
PALMER, ALASKA 99645
(907) 376-4215

WHILE IN JUNEAU
POUCH V
JUNEAU, ALASKA 99811
(907) 465-4894

House of Representatives

February 14, 1983

J.B. Carnahan
Northern Alaska Health Resources Institute
529 5th Avenue, Suite 8
Fairbanks, Alaska 99701

Dear Mr. Carnahan:

Thank you for taking the time to outline your position on HB19, an act repealing the certificate of need program.

I will continue to study both sides of this issue so that I can be properly informed when casting me vote.

I would be more than happy to read any additional information you could provide me.

Sincerely,

Barbara Lacher
Representative
District 16

RECEIVED FEB 18 1983

REP. JOHN G. (JACK) FULLER

DISTRICT 23

NOME
SAVOONGA
SCAMMON BAY
SHAKTOOLIK
SHELDON'S POINT
SHISHMAREF
STEBBINS
ST MICHAEL
TELLER
UNALAKLEET
WALES
WHITE MOUNTAIN

CHAIRMAN, RULES COMMITTEE

MEMBER
FINANCE COMMITTEE
POLICY COMMITTEE
COMMITTEE ON COMMITTEES
REAA BUDGET OVERSIGHT COMMITTEE
BLUE RIBBON COMMISSION ON PERSONNEL

Alaska House of Representatives

February 16, 1983

J. B. Carnahan, President
Northern Alaska Health Resources
Association, Inc.
529 5th Avenue, Suite 8
Fairbanks, Alaska 99701

Dear J. B. :

Thank you for your letter concerning House Bill 19 - An Act repealing the certificate of need program.

A hearing has been scheduled on this bill for February 24-25. I have taken the liberty of forwarding your letter on to the House Health and Social Services Committee for their review and consideration.

I will certainly take your views into consideration when we begin work on this bill when it is brought to the House for debate.

Again, thank you for sharing your comments with me.

Sincerely,

Jack

Rep. Jack Fuller
District 23

HOME
P.O. BOX 689
NOME, ALASKA 99762
907-443-2568

WHILE IN JUNEAU
POUCH V
JUNEAU, ALASKA 99811
(907) 465-3789
465-3764 465-3765

RECEIVED FEB 15 1983

Alaska State Legislature

REPRESENTATIVE
BETTE CATO
DISTRICT 5
BOX 775
VALDEZ, ALASKA 99686
(907) 835-4568

WHILE IN JUNEAU
POUCH V
JUNEAU, ALASKA 99811
(907) 465-4859

House of Representatives

COMMITTEES

CHAIRMAN
HOUSE TRANSPORTATION

MEMBER
COALITION POLICY COMMITTEE
HOUSE HEALTH EDUCATION AND SOCIAL SERVICES

February 14, 1983

J.B. Carnahan, President
Northern Alaska Health Resources
Association, Inc.
529 5th Avenue, Suite 8
Fairbanks, Alaska 99701

Dear J.B.:

Thank you for writing to me about HB 19 which proposes to repeal the State Certificate of Need program. Your letter provided me with some very good recommendations for improving the program without actually eliminating it, and for this reason I have forwarded a copy of the Chairmen of the House Health and Social Services Committee.

As you may know, I am a co-sponsor of HB 19. However, when the HESS committee addresses this bill, February 18th being the first date for a hearing, I will consider very closely all the information submitted.

Thank you, once again, for writing.

Sincerely,

Bette

Bette Cato
Alaska State Representative
District 6

BC:jm

RECEIVED FEB 16 1983

Alaska State Legislature

House of Representatives

Al Adams
Chairman
Committee on Finance

WHILE IN SESSION
Pouch V
State Capitol
Juneau, Alaska 99811
(907) 465-3706

OUT OF SESSION
P.O. Box 333
Kotzebue, Alaska 99752
(907) 442-3320

1024 W. 6th
Anchorage, Alaska 99501
(907) 274-0615

Official Business

February 14, 1983

J.B. Carnahan
President
Northern Alaska Health Resources Assn., Inc.
529 5th Avenue, Suite 8
Fairbanks, Alaska 99701

Dear Mr. Carnahan:

I have received your letter regarding repeal of the certificate of need statute. At this time, I do not support repeal. However, I agree with you that some revisions are needed and I have directed my staff to look into the matter further. In this light, your letter was particularly useful because of its many suggestions for revision of the statute. You will be hearing from my staff about your suggestions if HB 19 or SB 85 reach the House Finance Committee.

Thank you for your input.

Sincerely,

Al Adams, Chair
House Finance Committee

AA:lc

NINETY-EIGHTH CONGRESS

JOHN D. DINGELL, MICH., CHAIRMAN

JAMES H. SCHEUER, N.Y.
RICHARD L. OTTINGER, N.Y.
HENRY A. WAXMAN, CALIF.
TIMOTHY E. WIRTH, COLO.
PHILIP R. SHARP, IND.
JAMES J. FLORIO, N.J.
EDWARD J. MARKEY, MASS.
THOMAS A. LUKEN, OHIO
DOUG WALGREN, PA.
ALBERT GORE, JR., TENN.
BARBARA A. MIKULSKI, MD.
AL SWIFT, WASH.
MICKEY LELAND, TEX.
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W. J. "BILLY" TAUZIN, LA.
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DAN COATS, IND.
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JACK FIELDS, TEX.
MICHAEL G. OXLEY, OHIO
HOWARD C. NIELSON, UTAH

FRANK M. POTTER, JR.
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

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 wh.' 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 article is available from our affiliated *Regulatory Watchdog Service* (202) 47[illegible]

Central Peninsula General Hospital

P. O. Box 1268
SOLDOTNA, ALASKA 99669

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

February 15, 1983

RECEIVED
FEB 22 1983
Josephson,

Senator Joe Josephson
Alaska State Senate
State Capitol
Pouch V
Juneau, Alaska 99811

Subject: Senate Bill #85

Dear Senator Josephson:

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 desirable.

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

PLEASE NOTE: THE PRECEDING PAGES WERE TREATED AS A UNIT IN THE ORIGINAL DOCUMENT.

P.O. Box 72
Glennallen, Alaska 99588
March 5, 1983

MAR 0 1983
Humana Hospital Alaska

Mr. Ronald A. Pavellas
Executive Director
Humana Hospital
2801 DeBarr Road
Anchorage, Alaska 99501

Dear Mr. Pavellas:

As a former member of the SCHPD Board of Directors I want to express my profound praise to you and your staff for the most professional way in which you conducted yourselves during the recent reviewing process for the Humana expansion.

I sincerely regret that an efficient process does not exist by which a hospital may proceed to expand and deliver health services to its community.

Unfortunately, the CON process is expensive, exhaustive, quite repetitive and evidently not very beneficial to either the consumer or the provider.

Personally, I want to express to you and your staff my best wishes as you continue to walk through the process of the CON. In the present form NO ONE WINS!

Just a few minutes ago I submitted my resignation to the SCHPD Board of Directors for the CON process is a real deterent for effective health planning. I am speaking as a private consumer who indeed is interested in EFFECTIVE health planning. The CON is not one of those marked EFFECTIVE!

I thoroughly enjoy receipt of the Humana bulletins but since I am no longer on the SCHPD Board you may desire to take my name off your list.

Thanks again for your professional attitude. It has been a real enjoyable experience to have met and talked with you and some members of your staff.

Sincerely,
Maxwell L. Fancher
Former SCHPD Board member

Attachment: Letter of resignation to SCHPD

March 5, 1983
P.O. Box 72
Glennallen, Alaska 99588

Lillie McGarvey, President
Southcentral Health Planning & Development Board
1135 West Eighth
Anchorage, Alaska 99501

Dear Lillie:

Please accept this letter as my formal notice of resignation as a Board Member of SCHPD, to be effective the date of this letter.

This past work session confirmed for me the decision I have made.

To the SCHPD Staff I want to offer my most hearty thanks for the superb work and advise you have provided.

To the other Commissioners on the Board I want to say I have really enjoyed the opportunity of meeting you and discovering what is transpiring in other parts of the region.

To the many who have come before the SCHPD to present a project I would say you have been indeed most professional.

The CON process is my reason for resigning. Three specific incidents have been provided me for reaction. First, was the process through which Faith Hospital had to go in order to develop LOCALLY the ability to expand the outpatient segment of the hospital. Unfortunately, the costs for the CON process were heavy for Faith Hospital.

Secondly, the two projects we reviewed relating to Alcohol treatment programs for Anchorage increased my frustration level.

Finally, this past weekend we were in a "catch 22" process in the review of Humana and Providence. Because the Project Review Committee had not priortized the projects or reviewedthem in such a light, the Commissioners were somewhat bound to be "lost in the system".

Never have so many spent so much time in planning with such poor results. I was highly embarassed to see we had painted ourselves into such a predicament. I agree that indeed the CON process is a real franchise with perhaps not the best outcome for the delivery of health services.

To me, the CON process is far from being a cost effective process. As a consumer I believe it must be reviewed in terms of health planning. To merely revise it may make no difference to anyone. Yes, we do need planning but it must stem from the Health Commissioner and permeate all phases of the health planning process. If the SCHPD is to advise then a new structure is needed. I am reminded of the blind leading the blind.

Tonight, as I submit this letter I am positive my action is correct and I trust that those who have the time will be able to create order out of this present chaos. For me, the time is too short to be part of the process. I have other interests which are more important and need my attention.

I hate paralysis for it leads to immobility. The current CON process is laden with a type of paralysis which is not consistent with health planning.

Lillie, my sincere thanks to you and the other Board members who are eager to promote health planning in this region. I have come to appreciate health facilities and programs in a new viewpoint since I have had the opportunity of being part of the Board.

Sincerely,

Maxwell L. Fancher

Maxwell L. Fancher, Consumer

cc: Copper River Native Association
Commissioner Robert Smith
Peggy Wilson, Ex Director SCHPD
Senator Jalmar Kerttula
Senator Pappy Moss
Representative Dick Schultz

Alaska State Legislature
Senate

OFFICIAL BUSINESS

RULES COMMITTEE

March 14, 1983

JAN FAIKS
POUCH V
JUNEAU, ALASKA 99811
(907) 465-3770

RECEIVED
MAR 14 1983
Josephson,

MEMORANDUM

To: Senator Josephson

From: Senator Faiks

Subject: Millett Keller Letter

Attached is a copy of a letter I received from Millett Keller dealing with Certificate of Need and other related issues. He expresses my own views on this topic very well. As a good Republican, I strongly support the free enterprise system and a hospital's right to proceed with needed improvements without jumping through a series of hoops positioned by the government.

I urge you to please schedule SB 85 for a final hearing. I would ask that you do whatever is necessary to move the bill out of the HESS Committee as expeditiously as possible.

Attachment (letter)

RECEIVED
MAR 14 1983
Josephson,

Millett Keller Company

921 West 6th Avenue
Anchorage, Alaska 99501
(907) 279-8441

February 24, 1983

The Honorable Jan Faiks
Alaska State Senate
Pouch V (MS3100)
Juneau, AK 99811

Dear Jan:

The purpose of this letter is to pass on some thoughts regarding the certificate of need process that Humana and Providence are currently going through. I understand that you are reviewing the statutes that created this process.

During the last two weeks, I have attended two of the "process review meetings" and witnessed the public bodies fulfilling the requirements of the law. For those who truly believe that the government is smarter than the marketplace, these meetings are a dream come true.

Watching the commission's activities provided, in microcosm, a case study in why the government, despite its noble intentions, acts counter to the best interests of the consumer. The outcome that is desired by the government will be arrived at; the only problem is adjusting the facts to allow the outcome results to be rationalized. A society that relies on this process precludes the "Freedom to Choose" mechanism of the private sector and thereby penalizes consumers by creating artificial inefficiencies in capital investment and less productive operations.

In the case of the Health Commission, the facts of the matter are that if both Providence and Humana proceed, all rational forecasts indicate a significant surplus of beds in the near term (1986-1990), with the excess inventory eventually being worked down by the late 1990's. Even after reconfirming the assumptions used in forecasting population increase and per capita bed needs, the basic forecast of bed needs has not changed during the last nine months.

However, the dynamics of both Health Commission meetings is that they want to approve both hospital proposals because they don't want to have to choose sides.

Therefore, knowing they were recommending a plan which would result in an excess of beds in the near term, the commissions spent most of their time trying to adjust the bed need forecast. This takes on comical proportions when one recognizes that the whole certificate of need process openly and knowingly defies the fundamental dynamics of the marketplace and as such is antithetical to a sound decision making process.

It seems to me that if a hospital institution is willing to forego the use of any public funds, it ought to be able to proceed on the basis of its own judgments about the marketplace. We usually refer to this "unusual" technique as "free enterprise". Therefore, I would recommend that the certificate of need process be exposed for what it is, namely an affront to the consumer.

However, it is equally important that medical institutions recognize that if they seek to utilize state funds in their construction process, they must be subject to some amount of state review and certification. The major difference between the two proposals is, of course, that the Humana proposal involves 100% private funding whereas the Providence proposal is relying on a significant amount (at least $40 million) of state funds. It seems to me that the incentive should be provided to Providence to allow them to avoid the certificate of need process by avoiding the use of state funds.

In the Providence presentation this week, they indicated that their construction plans can go ahead without any state funding. Given that acknowledgment it seems to me that the certificate of need law should be changed to reflect the removal of constraints on institutions who are willing to develop their facilities with no state or federal funds. It would seem appropriate that the government should not become involved in funding or certification as long as private investment can do the job. (Didn't Abraham Lincoln have some recommendations in this regard?) Anchorage is very fortunate to have two strong hospitals which both have the ability and financial strength to improve their plant and equipment without help from the government.

Sincerely,

Millett Keller

MK:lw

CS FOR SB 85 (HESS) - SECTIONAL ANALYSIS

SECTION 1. FINDINGS AND DECLARATION OF POLICY

*THAT THERE ARE PROBLEMS WITH THE CERTIFICATE OF NEED PROGRAM AS IT EXISTS.
*THAT THE LEGISLATURE FINDS UNCERTAINTY ON THE FEDERAL LEVEL CONCERNING THE PROGRAM, AND THEREFORE SUSPENDS IT.
*THAT THE RETROSPECTIVE METHOD OF PAYMENT TO HEALTH FACILITIES IS INADEQUATE, AND THAT THE LEGISLATURE INTENDS TO CHANGE TO A PROSPECTIVE METHOD OF PAYMENT.

SECTION 2. THIS SECTION CONCERNING THE CERTIFICATE OF NEED PROGRAM WILL GO INTO EFFECT IN FOUR YEARS (SECTION 16) FOLLOWING THE SUSPENSION.

SECTION 3. AMENDS THE STATE HEALTH PLANNING LAW

SECTION 4. REANCTMENT OF SECTION REMOVES REFERENCE TO THE CERTIFICATE OF NEED PROGRAM. THIS SECTION WILL BE LAW DURING THE TIME OF SUSPENSION.

SECTION 5. THIS SECTION (CURRENT LAW) WILL BE LAW WHEN SUSPENSION PERIOD IS OVER, AND TAKES EFFECT FOUR YEARS FROM THE EFFECTIVE DATE OF THIS BILL.

SECTION 6. LIMITS REVENUE SHARING FOR HOSPITALS TO HOSPITALS WITH 50 OR LESS ACUTE CARE BEDS.

SECTION 7. INTENT IS TO GIVE THE MEDICAL RATE COMMISSION SOME AUTHORITY IN RATE SETTING FOR OVERBUILT OR OVERBEDDED FACILITIES.

SECTION 8. EACH HEALTH FACILITY IS REQUIRED TO SUBMIT A FINANCIAL REPORT TO THE MEDICAL RATE COMMISSION BY 120 DAYS AFTER THE END OF THEIR FISCAL YEAR.

THE COMMISSION WILL SUBMIT A REPORT TO THE GOVERNOR BY SEPTEMBER 30 OF EACH YEAR ON PERSPECTIVE PAYMENTS MADE AND AN ESTIMATE OF CURRENT AND SUBSEQUENT YEAR'S PROSPECTIVE PAYMENTS.

A UNIFORM BUDGETING AND ACCOUNTING SYSTEM WILL BE ESTABLISHED BY THE COMMISSION BY REGULATION, TAKING INTO CONSIDERATION CURRENT SYSTEMS, DIFFERENCES IN FACILITIES AND THEIR SERVICES.

THE COMMISSION HAS THE POWER TO WAIVE OR MODIFY A REQUIREMENT IN ACCOUNTING ON A CASE BY CASE BASIS.

AUDITS ARE REQUIRED, AND HEALTH FACILITIES SHALL ALLOW REASONABLE ACCESS TO FINANCIAL RECORDS BY THE COMMISSION, THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES AND ANY FEDERAL AGENCIES REQUIRED BY LAW.

ACTIONS OF THE COMMISSION ARE SUBJECT TO THE ADMINISTRATIVE PROCEDURES ACT.

SECTIONAL ANALYSIS OF CS FOR SB 85(HESS) 3-17-83

SECTION 1	FINDINGS AND POLICY (SAME)
SECTION 2	LAW TO BE IN EFFECT DURING CERTIFICATE OF NEED SUSPENSION(SAME)
SECTION 3	CERTIFICATE OF NEED STATUTE TO BE RETURNED TO EFFECT AFTER SUSPENSION PERIOD(SAME)
SECTION 4	FACILITY COMPLIANCE STATUTE TO BE IN EFFECT DURING PERIOD OF SUSPENSION(SAME)
SECTION 5	FACILITY COMPLIANCE LAW TO BE IN EFFECT AFTER PERIOD OF SUSPENSION(SAME)
SECTION 6	CAPS MUNICIPAL REVENUE SHARING FOR HOSPITALS AT A MAXIMUM AMOUNT OF $250,000 FOR ALL FACILITIES WITH 10 OR MORE ACUTE CARE BEDS.
SECTION 7	LINE 23 ADDED THE WORD "PROSPECTIVELY" TO THE CURRENT LANGUAGE, SLIGHT SENTENCE RESTRUCTURING. (b) LINES 28, page 3-lines 1-8, page 4 ADDED GENERALLY ACCEPTED ACCOUNTING PRINCIPLES REQUESTED BY HOSPITAL ASSOCIATION. THE DEPARTMENT ALREADY PAYS A PORTION OF THESE EXPENSES IN MEDICAID REIMBURSEMENT AS REQUIRED BY FEDERAL LAW. (c) PAGE 4, LINES 3-11 RESTRUCTURE OF PREVIOUS SUBSECTION CHANGING THE CONCEPT OF OCCUPANCY TO UTILIZATION, AND NOT RESTRICTING THE SECTION TO THE PERIOD OF SUSPENSION.
SECTION 8	SUBSECTION (d) THE ONLY NEW ADDITION, ALLOWING THE COMMISSION, BY REGULATION, TO MAKE EXCEPTIONS IN THE ACCOUNTING METHODS FOR SMALL FACILITIES OF LESS THAN 25 ACUTE CARE BEDS.
SECTION 9	ADDED "INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED" TO THE DEFINITION OF HEALTH FACILITY.
SECTION 10	CHANGED COMMISSION NAME FROM "MEDICAL " TO "MEDICAID"
SECTION 11	ADDED "INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED" TO THE DEFINITION OF HEALTH FACILITY.
SECTION 13	NO CHANGE
SECTIONS 14-16	CHANGED SUSPENSION FROM 4 TO 7 YEARS, AND SUSPENDED AS 29.90 RATHER THAN REPEAL(HOSPITAL CONSTRUCTION FUNDING)

NEW MEXICO STATUTES 1978

ANNOTATED

Chapter 24: Health and Safety

Pamphlet 44: 24-1-1 through 24-15A-6

1981 REPLACEMENT PAMPHLET

Pamphlet 44 includes laws enacted through the First Regular Session and First Special Session of the Thirty-Fifth Legislature (1981) and annotations through 623 P.2d 1209, 447 U.S. 529, 638 F.2d 1234, 505 F. Supp. 1123, 88 F.R.D. 367 and 1980 Op. Att'y Gen. No. 80-40.

Repealed effective 7/1/83

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(3) the making available without cost to any person unable to afford the services of a physician, tests to diagnose sickle cell trait and sickle cell anemia.

History: 1953 Comp., § 12-3-45, enacted by Laws 1973, ch. 300, § 1; 1977, ch. 253, § 25.

Cross-references. — As to education and testing relating to phenylketonuria, see 24-1-6 NMSA 1978.

Effective dates. — Laws 1973, ch. 300, § 3, makes the act effective on July 1, 1973.

Appropriations. — Laws 1973, ch. 300, § 2 appropriates $15,000 from the general fund to the former health and social services department for the sixty-second fiscal year for carrying out the provisions of the act.

ARTICLE 3A

Certificates of Need for New Health Services

Sec.

24-3A-1. (Effective until July 1, 1983) Short title.
24-3A-1. (Repealed effective July 1, 1983.)
24-3A-2. (Effective until July 1, 1983) Purpose.
24-3A-2. (Repealed effective July 1, 1983.)
24-3A-3. (Effective until July 1, 1983) Applicability.
24-3A-3. (Repealed effective July 1, 1983.)
24-3A-4. (Effective until July 1, 1983) Definitions.
24-3A-4. (Repealed effective July 1, 1983.)
24-3A-5. (Effective until July 1, 1983) Duties.
24-3A-5. (Repealed effective July 1, 1983.)
24-3A-6. (Effective until July 1, 1983) Certificate of need; requirement.
24-3A-6. (Repealed effective July 1, 1983.)
24-3A-7. (Effective until July 1, 1983) Criteria for agency review.
24-3A-7. (Repealed effective July 1, 1983.)
24-3A-8. (Effective until July 1, 1983) Agency review of applications.
24-3A-8. (Repealed effective July 1, 1983.)
24-3A-9. (Effective until July 1, 1983) Duration of certificate of need; withdrawal.
24-3A-9. (Repealed effective July 1, 1983.)
24-3A-10. (Effective until July 1, 1983) Review; appeal.
24-3A-10. (Repealed effective July 1, 1983.)
24-3A-11. (Effective until July 1, 1983) Joint reviews.
24-3A-11. (Repealed effective July 1, 1983).
24-3A-12. (Effective until July 1, 1983) Required approvals; expedited review.
24-3A-12. (Repealed effective July 1, 1983.)
24-3A-13. (Effective until July 1, 1983) Health facility license; revocation.
24-3A-13. (Repealed effective July 1, 1983.)

(Effective until July 1, 1983)

24-3A-1. Short title.

The provisions of this act [24-3A-1 to 24-3A-13 NMSA 1978] may be cited as the "Certificate of Need Act."

History: 1978 Comp., § 24-3A-1, enacted by Laws 1978, ch. 104, § 1.

(Effective July 1, 1983)

24-3A-1. Repealed.

Repeals. — Laws 1981, ch. 300, § 9, repeals 24-3A-1 NMSA 1978, being the Certificate of Need Act short title, effective July 1, 1983.

(Effective until July 1, 1983)

24-3A-2. Purpose.

It is the purpose of the Certificate of Need Act [24-3A-1 to 24-3A-13 NMSA 1978] to conserve limited health resources, to contain and reduce health care costs by minimizing the duplication and fragmentation of health care facilities resources, to explore alternative methods of health care delivery and to assure provision of health services not currently available or insufficiently provided within the state

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offenses relating to controlled substances, or an attempt or conspiracy to commit any ~~such offense or said~~ of these offenses, as punishable under sections 609.185, 609.19, 609.195, 609.20, 609.225, 609.245, 609.25, 609.291, 609.321 to 609.324, 609.42, 609.48, 609.485, subdivision 4, clause (1), 609.52, 609.53, 609.54, 609.58, 609.625, 609.63, 609.76, 609.825, and chapter 152.

Sec. 7. Repealer.

Minnesota Statutes 1980, Section 609.53, Subdivision 2; and Minnesota Statutes 1981 Supplement, Section 609.53, Subdivision 2a, are repealed.

Sec. 8. Effective date.

Sections 1 to 5 are effective August 1, 1982 and apply to all crimes committed on or after that date. Section 6 is effective May 1, 1982, and applies to warrants issued on or after that date. Section 7 is effective August 1, 1982.

Approved March 23, 1982.

HEALTH CARE SYSTEM

CHAPTER 614

H.F.No. 1799

An Act relating to health; allowing certain nursing homes and hospitals to share an administrator; providing for evaluation of certain changes in certificate of need review; requiring certain price information to be reported and disseminated; requiring monitoring; amending the thresholds of review; providing for additional waivers; requiring reports; amending Minnesota Statutes 1980, Sections 144A.04, Subdivision 5; 145.833, Subdivision 5; 145.835, Subdivisions 3 and 4; Minnesota Statutes 1981 Supplement, Sections 250.05, Subdivision 4; 447.45, Subdivision 1; and 474.03; proposing new law coded in Minnesota Statutes, Chapter 144; repealing Minnesota Statutes 1980, Sections 145.832 to 145.845, as amended; and Minnesota Statutes 1981 Supplement, Sections 62D.22, Subdivision 6; 145.834; and 145.845.

Be it enacted by the Legislature of the State of Minnesota:

Section 1. Purpose.

The legislature finds that Minnesota has had certificate of need review since 1971 and that there is a need to evaluate the requirements of this law, the effect of the law on the current health care delivery system, and the effect of repeal of the law on the cost and quality of health care in

Minnesota. The legislature further finds that the public may benefit from certain changes in the health care system but that supporting documentation, data, and information are lacking. It is the intent of the legislature that the Minnesota certificate of need act not be repealed prior to full consideration of the effects of such an action on the issue of cost for health care services. Alternative cost containment measures should be in place and documentation available that those measures will benefit the public interest and encourage the benefits of a price-competitive health care system for the citizens of Minnesota. It is the intent of the legislature that voluntary efforts to disseminate certain price information be encouraged and that mandatory efforts be undertaken only if voluntary efforts do not make satisfactory progress.

Sec. 2.

144.705. Collection, analysis and dissemination of diagnostic and price information

Subdivision 1. Price reporting. The commissioner of health shall encourage hospitals and professionals regulated by the health related licensing boards as defined in section 214.01, subdivision 2, or by the commissioner of health pursuant to section 214.13, to publish prices for procedures and services that are representative of the diagnoses and conditions for which citizens of this state seek treatment.

Subd. 2. **Hospital reports.** The commissioner of health may periodically establish a list of illnesses, injuries and medical conditions which is representative of the diagnoses for which the citizens of the state are hospitalized. The commissioner shall select illnesses, injuries, and conditions for inclusion in this list in a manner so as to adequately differentiate among patient characteristics which may influence the consumption of resources during treatment, such as the age of patients, patients' need for surgery, the presence of secondary diagnoses and medical complications. The establishment of this list shall not be subject to the provisions of sections 15.0412 to 15.0417. The commissioner may add to or delete from this list. For each of these illnesses, injuries and medical conditions, every hospital with a licensed capacity equal to or greater than 100 beds shall, within 120 days of the close of its fiscal year, report to the commissioner the following information for that fiscal year:

(a) the number of patients discharged;

(b) the shortest and longest lengths of patient stay in the hospital, the mean length of stay, and the respective lengths of stay at the 25th, 50th and 75th percentiles of the total range of lengths of stay;

(c) the lowest and highest prices for hospital services, the mean price, and the respective prices at the 25th, 50th and 75th percentiles of the total range of prices;

(d) a separation of the mean price into mean component prices, where applicable, for routine room and board, special care unit room and board, nursery services, delivery room use, operating room use, anesthesia services, pharmacy services, laboratory services, radiology services, supplies and other services; and

(c) any additional or alternative information relating to prices that is specified in rules promulgated by the commissioner pursuant to this section. At the time it reports the information required to be reported by this subdivision, each hospital may also report any additional information that it believes to be relevant to the purposes of section 144.705.

Subd. 3. **Health provider reports.** For each health profession regulated by the health-related licensing boards as defined in section 214.01, subdivision 2, or by the commissioner of health pursuant to section 214.13, the commissioner of health shall periodically establish a list of procedures and services which are representative of the diagnoses and conditions for which citizens of the state seek treatment. The establishment of this list shall not be subject to the provisions of section 15.0412 to 15.0417. For each of these procedures and services, every regulated health care provider engaged in the private practice of his profession within the state shall post in a public area the established prices or provide a notice of the availability of the established prices of the procedures or services. The commissioner may request to receive a copy of these prices.

Subd. 4. **Source of information.** The information described in subdivision 2 may be directly compiled and submitted to the commissioner by the hospital, or in the interests of efficiency and at the hospital's option, the information may be submitted through any entity which collects or compiles all or portions of the information for several hospitals or providers. When information is furnished through such an entity, the commissioner shall pay the entity what he determines to be a reasonable fee for the costs of organizing and providing the information in the form called for by this section.

Subd. 5. **Samples.** The commissioner may, in the interests of efficiency, permit a hospital to submit the information described in subdivision 2 in the form of statistically valid samples of the patients discharged from the hospital during the fiscal year.

Subd. 6. **Fostering price competition.** The commissioner shall analyze the information provided under this section and shall disseminate the information and analyses so as to foster the development of price competition among hospitals required by subdivision 2 to make reports to the commissioner. Prior to initial dissemination of any hospital-specific information, the commissioner shall give the hospital opportunity for review and comment. In the initial dissemination of hospital-specific information the commissioner shall publish a summary of the hospital's comments, together with notice of a means of contacting a person designated by the hospital to provide further information.

Subd. 7. **Rules.** The commissioner may promulgate such rules pursuant to chapter 15 as are necessary to implement the provisions of this section.

Sec. 3. Minnesota Statutes 1980, Section 144A.04, Subdivision 5, is amended to read:

Subd. 5. Except as otherwise provided by this subdivision, a nursing home must have a full time licensed nursing home administrator serving the

facility. In any nursing home of less than 25 beds, the director of nursing services may also serve as the licensed nursing home administrator. Two nursing homes having a total of 100 beds or less and located within 50 miles of each other may share the services of a licensed administrator if the administrator divides his full time work week between the two facilities in proportion to the number of beds in each facility. Every nursing home shall have a person-in-charge on the premises at all times in the absence of the licensed administrator. The name of the person in charge must be posted in a conspicuous place in the facility. The commissioner of health shall by rule promulgate minimum education and experience requirements for persons-in-charge, and may promulgate rules specifying the times of day during which a licensed administrator must be on the nursing home's premises. A nursing home may employ as its administrator the ~~registered~~ administrator of a hospital licensed pursuant to sections 144.50 to 144.56 if the individual is licensed as a nursing home administrator pursuant to section 144A.20 and the nursing home and hospital have a combined total of 150 beds or less, ~~are under the same governing body~~ and are located within ~~one-half~~ one mile of each other. A nursing home which is located in a facility licensed as a hospital pursuant to sections 144.50 to 144.56, may employ as its administrator the ~~registered~~ administrator of the hospital if the individual meets minimum education and long term care experience criteria set by rule of the commissioner of health.

Sec. 4. Minnesota Statutes 1980, Section 145.833, Subdivision 5, is amended to read:

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 acquisition of diagnostic or therapeutic equipment, by or on behalf of a health care facility which:

(1) Requires, or would require if purchased, a total capital expenditure, under generally accepted accounting principles, in excess of ~~$150,000 and which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance~~ $600,000; or

(2) Changes the bed capacity of a health care facility in a manner which increases the total number of beds, or distributes beds among various categories, or relocates beds from one physical facility or site to another, by more than ten beds or more than ten percent of the licensed bed capacity, whichever is less, over a two year period;

(b) ~~Any expansion or extension of the scope or type of existing health services rendered by a health care facility if expansions or extensions of the scope or type of existing health services requires a capital expenditure in excess of $50,000 during any continuous 12 month period for that service;~~

(c) The establishment of a new health care facility or any predevelopment activity by or on behalf of a health care facility which may result in a proposal reviewable according to sections 145.832 to 145.845;

~~(d)~~(c) Any establishment of a new institutional health service, excluding home health services, by a health care facility which is to be offered in or through a health care facility and which was not offered on a regular basis in or through that facility within the 12 month period prior to the time when that service is intended to be offered; ~~and~~

~~(e)~~(d) The purchase, lease or other acquisition of diagnostic or therapeutic equipment by a licensed medical doctor, a group of licensed medical doctors, or a professional corporation of licensed medical doctors organized pursuant to chapter 319A, which requires, or would require if purchased, a capital expenditure in excess of ~~$150,000~~ $400,000 for any one item of equipment and is determined by the state commissioner of health to be designed to circumvent the provisions of sections 145.832 to 145.845; and

(e) The purchase, lease or other acquisition of diagnostic or therapeutic equipment by, or on behalf of, a health care facility which requires, or would require if purchased, a total capital expenditure in excess of $400,000 for any one item of equipment.

Sec. 5. Minnesota Statutes 1980, Section 145.835, Subdivision 3, is amended to read:

Subd. 3. **Physicians; notice of acquisition of equipment.** A licensed medical doctor, a group of licensed medical doctors, or a professional corporation of licensed medical doctors organized pursuant to chapter 319A, proposing to purchase, lease or otherwise acquire one or more items of diagnostic or therapeutic equipment which require a capital expenditure in excess of ~~$150,000~~ $400,000 shall, prior to purchasing or acquiring the equipment, notify the health systems agency and the commissioner of health of the proposed acquisition or purchase.

The commissioner of health shall within 30 days of receipt of the notice determine whether or not the proposed acquisition or purchase is designed to circumvent the provisions of sections 145.832 to 145.845. A hearing shall be held if requested by the applicant or the health systems agency. The commissioner of health shall notify the applicant and the health systems agency in writing of its determination. If the commissioner of health determines that the proposed acquisition or purchase is not designed to circumvent the provisions of sections 145.832 to 145.845, no certificate of need shall be required of the applicant. If the commissioner of health determines that the proposed acquisition or purchase is designed to circumvent the provisions of sections 145.832 to 145.845, the applicant must obtain a certificate of need.

Sec. 6. Minnesota Statutes 1980, Section 145.835, Subdivision 4, is amended to read:

Subd. 4. **Waivers.** A proposed construction or modification may be granted a waiver from the requirements of section 145.834 by the commissioner of health if, based on the recommendation of the health systems agency, the commissioner determines that:

Underscoring and ~~strikeouts~~ are as shown in enrolled act

(a) The proposed capital expenditure is less than three percent of the annual operating budget of the facility applying for a waiver, ~~and the expenditure is required solely to meet mandatory federal or state requirements of law~~; or

(b) The construction or modification is not related to direct patient care services, such as parking lots, sprinkler systems, heating or air conditioning equipment, fire doors, food service equipment, building maintenance, or other constructions or modifications of a like nature;

(c) The construction or modification is exclusively for ambulatory care services; or

(d) The construction or modification is for an experimental or demonstration project.

The commissioner of health, after consultation with the state planning agency and the health systems agencies, may by rule provide for the granting of waivers under other situations the commissioner of health deems appropriate and not inconsistent with sections 145.832 to 145.845 and 42 U.S.C., Section 300k, et seq.

Proposed criteria for waivers in clauses (c) and (d) of this section shall be published in the state register by June 1, 1982 and the public shall be given an opportunity to review and comment on the proposed criteria prior to implementation. The criteria are not subject to the requirements of sections 15.0412 to 15.0417. The criteria shall be published in the state register and implemented by August 15, 1982.

The request for a waiver shall be submitted by the applicant to the health systems agency at the same time the applicant submits a notice of intent to the health systems agency pursuant to subdivision 1. Within 30 days of the request, the health systems agency shall submit its recommendation on the issue of the waiver to the commissioner of health, but the recommendation shall not be binding on the commissioner of health. The commissioner of health shall notify the applicant and the health systems agency of the decision to grant or deny the waiver within 30 days of receipt of the recommendation from the health systems agency.

Sec. 7. **Monitoring the effects; transitional period.**

Subdivision 1. **Development of performance indicators.** The commissioner of health shall consult with the commissioner of energy, planning and development and the commissioner of public welfare and other interested persons to define industry economic performance indicators to be used to monitor the effect of the amendments to the certificate of need act on the costs of health care.

Subd. 2. **Public review and comment.** By August 15, 1982, the commissioner of health shall publish in the state register proposed industry economic performance indicators to be used to monitor the effect of sections 3 to 5 on the health care system. These indicators shall not be subject to the requirements of sections 15.0412 to 15.0417 but the public shall be given the opportunity to review and comment on the indicators prior to their imple-

mentation. Final industry economic performance indicators shall be published in the state register and implemented by October 15, 1982.

Subd. 3. **Monitor; report.** The commissioner shall monitor the economic performance of the industry and shall provide the legislature with a report concerning the preliminary effects, especially the financial impact, on the health care system created by sections 3 to 5.

Subd. 4. **Facility reports.** All health care facilities which commence construction or modification projects not now reviewable pursuant to sections 3 to 5, but which would have been reviewed prior to implementation of this section, shall submit to the commissioner of health at the time of project commencement the following information:

(a) an estimate of capital expenditures associated with the construction or modification; and

(b) an estimate of expenses and revenues projected to be associated with the construction or modification for a period of five years after initial operation of the project involved.

Sec. 8. Minnesota Statutes 1981 Supplement, Section 250.05, Subdivision 4, is amended to read:

Subd. 4. The Gillette hospital board, acting through its board of directors, may contract with the governing body and the owners of the Ramsey county hospital and of any other hospital or institution, for the joint maintenance and operation of the Gillette children's hospital in conjunction with existing or contemplated facilities at the Ramsey county hospital. Contracts may include agreements for the joint employment and utilization of personnel, the joint purchase of supplies and equipment, and joint construction, acquisition, or leasing of space for offices, outpatient facilities, operating rooms, and other medical facilities for use in training in the care and treatment of crippled and handicapped children, the operation of a brace shop, and the conduct of patient education programs. No contract shall however, provide for the expenditure of funds for additional patient bed capacity. ~~The Gillette hospital board shall be subject to the certificate of need act provided in sections 145.832 to 145.845. In any case wherein a certificate of need is required, the Gillette hospital board shall, at the time of application, notify the house committee on appropriations and the senate finance committee, whose opinion shall be advisory only.~~

Sec. 9. Minnesota Statutes 1981 Supplement, Section 447.45, Subdivision 1, is amended to read:

Subdivision 1. Any county, city, or hospital district, except cities of the first class and counties in which are located any cities of the first class, is authorized, in addition to and not in substitution for any other power granted to it by law, to issue revenue bonds by resolution or resolutions of its governing body to finance the acquisition and betterment of hospital, nursing home and related medical facilities, or any of them, including but without limitation the payment of interest during construction and for a reasonable period thereafter and the establishment of reserves for bond payment and for working capital, and, in connection with the acquisition of any existing hospital or nursing home facilities, to retire outstanding

indebtedness incurred to finance the construction of the existing facilities. ~~The authority granted by this section shall not apply to any facility to which sections 145.822 to 145.845 apply, unless a certificate of need has been issued.~~

Sec. 10. Minnesota Statutes 1981 Supplement, Section 474.03, is amended to read:

474.03. Powers

Any municipality or redevelopment agency, in addition to the powers prescribed elsewhere by the laws of this state, shall have the power to:

(1) Acquire, construct, and hold any lands, buildings, easements, water and air rights, improvements to lands and buildings, and capital equipment to be located permanently or used exclusively on a designated site and solid waste disposal and pollution control equipment, and alternative energy equipment and inventory, regardless of where located, which are deemed necessary in connection with a project to be situated within the state, whether wholly or partially within or without the municipality or redevelopment agency, and construct, reconstruct, improve, better, and extend such project;

(2) Issue revenue bonds, in anticipation of the collection of revenues of such project, to finance, in whole or in part, the cost of the acquisition, construction, reconstruction, improvement, betterment, or extension thereof and, in the case of an alternative energy project, in addition to the other powers granted by this chapter, to finance the acquisition and leasing or sale of equipment and products to others;

(3) Issue revenue bonds to pay, purchase or discharge all or any part of the outstanding indebtedness of a contracting party engaged primarily in the operation of one or more nonprofit hospitals or nursing homes, theretofore incurred in the acquisition or betterment of its existing hospital or nursing home facilities, including, to the extent deemed necessary by the governing body of the municipality or redevelopment agency, any unpaid interest on such indebtedness accrued or to accrue to the date on which such indebtedness is finally paid; and any premium the governing body of the municipality or redevelopment agency determines to be necessary to be paid to pay, purchase or defease such outstanding indebtedness; if revenue bonds are issued for this purpose, the refinancing and the existing properties of the contracting party shall be deemed to constitute a project under section 474.02, subdivision 1c. Industrial revenue bonds shall only be available under this provision if the commissioner of securities and real estate has been shown that a reduction in debt service charges to patients and third party payors will occur. All reductions in debt service charges pursuant to this program shall be passed on to patients and third party payors. These industrial revenue bonds may not be used for any purpose not consistent with the provisions of ~~sections 145.822 to 145.845 or~~ chapter 256B;

Nothing in this subdivision is intended to prohibit the use of revenue bond proceeds to pay outstanding indebtedness of a contracting party to the extent now permitted by law;

(4) Enter into a revenue agreement with any person, firm, or public or private corporation or federal or state governmental subdivision or agency

in such manner that payments required thereby to be made by the contracting party shall be fixed, and revised from time to time as necessary, so as to produce income and revenue sufficient to provide for the prompt payment of principal of and interest on all bonds issued hereunder when due, and the revenue agreement shall also provide that the contracting party shall be required to pay all expenses of the operation and maintenance of the project including, but without limitation, adequate insurance thereon and insurance against all liability for injury to persons or property arising from the operation thereof, and all taxes and special assessments levied upon or with respect to the project and payable during the term of the revenue agreement, during which term a tax shall be imposed and collected pursuant to the provisions of section 272.01, subdivision 2, for the privilege of using and possessing the project, in the same amount and to the same extent as though the contracting party were the owner of all real and personal property comprising the project;

(5) Pledge and assign to the holders of such bonds or a trustee therefor all or any part of the revenues of one or more projects and define and segregate such revenues or provide for the payment thereof to a trustee, whether or not such trustee is in possession of the project under a mortgage or otherwise;

(6) Mortgage or otherwise encumber such projects in favor of the municipality or redevelopment agency, the holders of such bonds, or a trustee therefor, provided that in creating any such mortgages or encumbrances a municipality or redevelopment agency shall not have the power to obligate itself except with respect to the project;

(7) Make all contracts, execute all instruments, and do all things necessary or convenient in the exercise of the powers herein granted, or in the performance of its covenants or duties, or in order to secure the payment of its bonds; including, but without limitation, a contract entered into prior to the construction of the project authorizing the contracting party, subject to such terms and conditions as the municipality or redevelopment agency shall find necessary or desirable and proper, to provide for the construction, acquisition, and installation of the buildings, improvements, and equipment to be included in the project by any means available to the contracting party and in the manner determined by the contracting party and without advertisement for bids as may be required for the construction or acquisition of other municipal facilities;

(8) Enter into and perform such contracts and agreements with other municipalities, political subdivisions, and state agencies, authorities, and institutions as the respective governing bodies of the same may deem proper and feasible for or concerning the planning, construction, lease, purchase, mortgaging or other acquisition, and the financing of a project, and the maintenance thereof, including an agreement whereby one municipality issues its revenue bonds in behalf of one or more other municipalities pursuant to revenue agreements with the same or different contracting parties, which contracts and agreements may establish a board, commission, or such other body as may be deemed proper for the supervision and general management of the facilities of the project; provided, no municipality or

redevelopment agency shall [illegible]r perform any contract or agreement with any school district [illegible]nich the municipality or redevelopment agency issues its revenue bonds or otherwise provides for the construction of school facilities and the school leases or otherwise acquires these facilities;

(9) Accept from any authorized agency of the federal government loans or grants for the planning, construction, acquisition, leasing, purchase, or other provision of any project, and enter into agreements with such agency respecting such loans or grants;

(10) Sell and convey all properties acquired in connection with such projects, including without limitation the sale and conveyance thereof subject to such mortgage as herein provided, and the sale and conveyance thereof under an option granted to the lessee of the project, for such price, and at such time as the governing body of the municipality or redevelopment agency may determine, provided, however, that no sale or conveyance of such properties shall ever be made in such manner as to impair the rights or interests of the holder, or holders, of any bonds issued under the authority of this chapter;

(11) Issue revenue bonds to refund, in whole or in part, bonds previously issued by such municipality or redevelopment agency under authority of this chapter;

(12) If so provided in the revenue agreement, terminate the agreement and re-enter or repossess the project upon the default of the contracting party, and operate, lease, or sell the project in such manner as may be authorized or required by the provisions of the revenue agreement or of the resolution or indenture securing the bonds issued for the project; any revenue agreement which includes provision for a conveyance of real estate to the contracting party may be terminated in accordance with the revenue agreement, notwithstanding that such revenue agreement may constitute an equitable mortgage provided that no municipality or redevelopment agency shall have power otherwise to operate any project referred to in this chapter as a business or in any manner whatsoever, and nothing herein authorizes any municipality or redevelopment agency to expend any funds on any project herein described, other than the revenues of such projects, or the proceeds of revenue bonds and notes issued hereunder, or other funds granted to the municipality or redevelopment agency for the purposes herein contemplated, except as may be otherwise permitted by law and except to enforce any right or remedy under any revenue agreement or related agreement for the benefit of the bondholders or for the protection of any security given in connection with a revenue agreement, provided that the public cost of redevelopment of land paid by a city or its redevelopment agency shall not be deemed part of the cost of any project situated on such land;

(13) Invest or deposit, or authorize a trustee to invest or deposit, any money on hand in funds or accounts established in connection with a project or payment of bonds issued therefor, to the extent they are not presently needed for the purposes for which such funds or accounts were created, in accordance with section 471.56, as amended; and

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(14) Waive or require the furnishing of a contractors payment and performance bond of the kind described in section 574.26 and if such bond shall be required, then the provisions of chapter 514 relating to liens for labor and materials, shall not be applicable in respect of any work done or labor or materials supplied for the project, and if such bond be waived then the said provisions of chapter 514 shall apply in respect of work done or labor or materials supplied for the project.

Sec. 11. **Regional health planning report.**

The commissioner of energy, planning and development shall address the discontinuance of health systems agencies due to the elimination of federal funds and prepare recommendations to the legislature by January 2, 1983 concerning alternative organizational arrangements and funding sources which could maintain statewide or statewide and regional participation in a state health planning system.

Sec. 12. **Repealer.**

Minnesota Statutes 1980, Sections 145.832; 145.833; 145.835, as amended by Laws 1981, Chapter 356, Section 172; 145.836, as amended by Laws 1981, Chapter 356, Section 173; 145.837, as amended by Laws 1981, Chapter 356, Section 174; 145.838, as amended by Laws 1981, First Special Session, Chapter 4, Article I, Section 80; 145.839; 145.84; 145.841; 145.842; 145.843; 145.844; Minnesota Statutes 1981 Supplement, Sections 620.22, Subdivision 6; 145.834; and 145.845, are repealed.

Sec. 13. **Effective date.**

Sections 1, 3 to 7 and 11 are effective the day following enactment. Section 2 shall become effective for a specified provider group on March 1, 1983 if the commissioner of health certifies to the health and welfare committees of the house and senate that the voluntary efforts by the provider group to promote price competition and to implement the reporting requirements of section 2 have not made satisfactory progress. This certification shall take the form of a written report delivered to the chairmen of the house and senate committees by January 2, 1983. Notice of the date of the delivery shall be published in the state register. Sections 8 to 10 and 12 are effective March 15, 1984.

Approved March 23, 1982.

JUVENILE JUSTICE AGENCY

CHAPTER 615

H.F.No. 1803

An Act relating to juveniles; designating a juvenile justice agency; providing for termination of jurisdiction over juveniles; providing for the apprehension of juvenile absconders and

UTAH CODE ANNOTATED

SECOND REPLACEMENT
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1981 Pocket Supplement

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Edited by
The Publisher's Editorial Staff

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Indianapolis, Indiana 46202

Repeal effective 6/30/83

CHAPTER 22

PRO-COMPETITIVE CERTIFICATE OF NEED ACT

Section
26-22-1. Short title.
26-22-2. Legislative findings — Purpose of chapter.
26-22-3. Definitions.
26-22-4. Projects subject to review.
26-22-5. Projects exempt from requirement for certificate of need.
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26-22-17. Rules of department, statewide health coordinating council, and committee — Coordination of procedures.
26-22-18. District court jurisdiction — Injunctions and civil penalties.
26-22-19. Judicial review — Time for filing — Jurisdiction.
26-22-20. Judicial review — Record filed by department — Powers of court — Orders.
26-22-21. Immunity from civil actions — Committee and statewide health coordinating council members held harmless.
26-22-22. Repeal of chapter.

26-22-1. Short title. This chapter shall be known and may be cited as the "Utah Pro-competitive Certificate of Need Act."

History: C. 1953, 26-22-1, enacted by L. 1981, ch. 126, § 21.

Compiler's Notes.

Laws 1981, ch. 126, § 1 repealed old sections 26-22-1 to 26-22-42 (L. 1967, ch. 31, §§ 1 to 42; 1969, ch. 197, § 70), the County-wide Health Districts Act. New sections 26-22-1 to 26-22-22 were enacted by § 21 of the act. For present provisions, see 26-24-1 et seq.

Law Reviews.

Utah Legislative Survey — 1979, 1980 Utah L. Rev. 155.

26-22-2. Legislative findings — Purpose of chapter. (1) The legislature finds that duplication and excess investment in and supply of health facilities, equipment, and services contribute to the rising cost of health services and the financial ability of the public to obtain necessary care. The legislature also finds that the prevailing systems of public and other third party payment for health care sometimes provide inappropriate economic incentives for new investment and service development and inadequately deter duplication and overinvestment. The legislature concludes that development of a facility for the provision of health services is affected with a public interest and such development should be granted only on an affirmative demonstration of the desirability of such facility and the services rendered therein, its necessity, and its economic appropriateness.

(2) The legislature finds that regulation of the growth and development of health services will not obviate the need for maintaining competitive conditions

(5) Upon review of a department decision, order, or action, the court may enter its order:

(a) Affirming and enforcing or otherwise requiring compliance with the agency action;

(b) Compelling agency action unlawfully withheld or unreasonably delayed;

(c) Remanding for further agency proceeding consistent with the court's opinion or order where agency action is held unlawful and set aside; or

(d) Reversing or modifying the agency action and substituting the court's order, where the agency action is held unlawful and to that extent set aside on grounds of law which are applicable without regard for further or alternative findings of fact or exercise of discretion by the agency.

History: C. 1953, 26-22-20, enacted by L. 1981, ch. 126, § 21.

26-22-21. Immunity from civil actions — Committee and statewide health coordinating council members held harmless. (1) No member of the committee, the statewide health coordinating council, and any health systems agency governing body or advisory committees or councils shall be subject to a civil action in court or be liable for the payment of damages for any action, failure to act or statement made in the performance of any function or responsibility required or authorized by this chapter if such member has acted within the scope of such function or responsibility and has acted in good faith.

(2) The department shall hold harmless the committee and statewide health coordinating council members for reasonable costs incurred in defending any civil action for which such members have immunity pursuant to subsection (1). Every health systems agency shall hold harmless health planning councils and health systems agency advisory committees, councils, or board members for reasonable costs incurred in defending any civil action for which such members have immunity pursuant to subsection (1).

History: C. 1953, 26-22-21, enacted by L. 1981, ch. 126, § 21.

26-22-22. Repeal of chapter. Chapter 22 of Title 26, Utah Code Annotated 1953, shall be repealed and have no force or effect after June 30, 1983, or at such earlier date as federal health planning funding to the state to support certificate of need terminates.

History: C. 1953, 26-22-22, enacted by L. 1981, ch. 126, § 21.

CHAPTER 23

ENFORCEMENT PROVISIONS AND PENALTIES

Section

26-23-1. Legal advice and representation for department.
26-23-2. Administrative review of actions of department or director — Hearings — Judicial review.
26-23-3. Violation of public health laws or orders unlawful.
26-23-4. Unlawful acts by department officers and employees.
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26-23-6. Criminal and civil penalties and liability for violations.
26-23-7. Application of enforcement procedures and penalties.

ARIZONA REVISED STATUTES

ANNOTATED

1975-1982

Supplementary Pamphlet

Replacing Pocket Part for use in 1981-1982
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For Use With Main Volume
In 1982-1983

Volume 11A
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licensure, supervision, regulation, or control, department of health services should advise facility operator that continued presence of persons needing hospital, personal, or nursing care or of more than four persons not otherwise exempt needing supervisory care is a violation of this section and §§ 36-430 (prohibiting unlicensed operations) and 36-431.01 (setting civil penalties for violations); in such event, the operator, if qualified, could obtain a license to provide the level of care which the patients' needs require or could elect to avoid or mitigate prosecution by having the patient leave within whatever time the department may reasonably allow. Op.Atty.Gen. No. 180-180.

§ 36-431.01. Violations; civil penalty

A. Any person who violates any provision of this chapter or any rule or regulation promulgated under authority of this chapter may be assessed a civil penalty by the director in an amount not to exceed three hundred dollars for each violation after a hearing conducted pursuant to title 41, chapter 6, article 1.[1] Each day that a violation continues shall constitute a separate violation.

B. Actions to enforce the collection of penalties assessed pursuant to subsection A shall be brought by the attorney general or the county attorney in the name of the state in the justice court or the superior court of the county in which the violation occurred.

C. Penalties assessed under this section are in addition to and not in limitation of other penalties imposed pursuant to this chapter.

Added by Laws 1978, Ch. 205, § 2

[1] Section 41-1001 et seq.

Notes of Decisions

1. In general

In the case of an unlicensed facility not exempted by § 36-402 listing services not subject to licensure, supervision, regulation, or control, department of health services should advise facility operater that continued presence of persons needing hospital, personal, or nursing care or of more than four persons not otherwise exempt needing supervisory care is a violation of this section and §§ 36-430 (prohibiting unlicensed operations) and 36-431 (describing violations and setting the penalties therefor); in such event, the operator, if qualified, could obtain a license to provide the level of care which the patients' needs require or could elect to avoid or mitigate prosecution by having the patient leave within whatever time the department may reasonably allow. Op.Atty.Gen. No. 180-180.

§ 36-432. Repealed by Laws 1980, Ch. 231, § 64

See, now, § 36-113.

For purpose of Laws 1980, Ch. 231, see note following § 3-104.

§ 36-433. Certificate of need; exemptions

A. Any new or substantially modified medical services and health-related services and facilities of health care institutions used in rendering such new or substantially modified services shall, unless otherwise exempted, require a certificate of need under any of the following circumstances:

1. Capital expenditures which are over seven hundred fifty thousand dollars.

2. Acceptance of a donation if such acceptance will cause increased expenditures, apart from the donation, of seven hundred fifty thousand dollars or more within twelve months of the date of the donation for any item for which a certificate of need is required as provided in this subsection.

3. Increases in bed capacity of more than ten beds or ten per cent of the total bed capacity, whichever is less, over a two year period.

4. Changes in the use of one or more existing beds if such changes will result in increased expenditures of more than seven hundred fifty thousand dollars within twelve months of the change.

5. New medical services, consisting of obstetrical units, neonatal special care units, pediatric inpatient services, open heart surgery units, cardiac catheterization services, radiation therapy services, end stage renal disease services, computed tomographic scanning, neurosurgical units, spinal injury units and burn treatment units.

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6. New medical services, in addition to those services enumerated in paragraph 5 of this subsection, if it has been found by the director based on substantial evidence presented at a public hearing that such new services will require annual operating costs of seven hundred fifty thousand dollars or more within twelve months of the date of institution of such services.

7. Replacement of medical equipment which provides medical and other health services and which costs in excess of seven hundred fifty thousand dollars.

8. A substantial change in an existing medical service provided through a health care facility, which apart from any capital expenditure entails a new or increased annual operating cost of seven hundred fifty thousand dollars or more.

B. An application for a certificate of need shall be filed with the authorized local agency in the area where the institution is located and with the department of health services prior to undertaking any substantial expenditures in preparation for such offering or development. If predevelopment expenses, including those associated with an application for a certificate of need, will be more than one hundred fifty thousand dollars, the applicant shall advise the director and the authorized local agency in writing before applying for the certificate of need. The director and the authorized local agency may then comment on the proposed application for a certificate of need. In the case of construction projects, the department of health services may by regulations define requirements for filing a letter of intent prior to the application in such detail as may be necessary to provide information about the scope and nature of the project at the earliest possible opportunity in the course of planning the project.

C. The department of health services shall establish by regulation the procedures for review of applications by the authorized local agencies and shall issue regulations defining the form and content of such applications except as provided in subsection G. Requests for information in connection with a review shall be limited to only that information which is necessary to perform the review of the proposed services or facility. The regulations shall pertain only to the following information to be included in the application for the proposed services or facilities:

1. The description, the geographical areas to be served, the nature and purpose, and the cost, including method of proposed construction in the case of facilities.

2. The health problem or needs that the population served or to be served by the services has for the services.

3. The ability of the applicant to comply with all applicable professional and institutional standards.

4. The relationship of services reviewed to the long-range plan, if any, of the applicant.

5. The availability of less costly or more effective alternative methods of providing the services.

6. The relationship of services reviewed to the existing health care system of the area in which the services are provided or proposed to be provided.

7. The efficiency and appropriateness of the use of existing services or facilities that are similar to those proposed.

8. The qualifications and ability of the applicant to provide and obtain proper financing, staffing, equipment, management and operation of the proposed services or facilities.

9. In the case of health services proposed to be provided, the effect of the proposed service on the clinical needs of health professional training programs, the extent that access to such health professional training programs will be provided and the extent to which the proposed services will be accessible to all the residents of the area to be served.

10. The special needs and circumstances of entities which provide a substantial portion of their services to individuals not residing in the health service areas in which the entities are located, and of health care services organizations.

11. The effect of competition on the financing of the health services being reviewed.

12. The impact of the project on the applicant's cost of providing existing and proposed health services.

13. The impact, including financial impact and utilization impact, of other similar existing or approved projects, services or facilities on the proposed project, and the impact of the proposed project on other similar projects, services or facilities.

14. The relationship of the services or facilities reviewed to the health plans adopted by the authorized local agency and the state health plan.

15. A statement that the applicant has reviewed, or attempted to review, the proposed construction or modification with other health care institutions in the area to be served for the purpose of exploring the feasibility of coordinating with such institutions' programs, services or facilities. In cases where coordination among institutions is planned, a statement concerning the implementation of such coordination shall be included. The statement shall state, if applicable, that the area to be served contains no other health care institution.

16. The time the applicant requires to make such service or equipment available or to obligate such expenditure and a timetable for making such service or equipment available or obligating such expenditure.

D. No certificate of need shall be required for services, facilities or construction if such services, facilities or construction are deemed necessary by the director for a presently licensed health care institution to maintain its license, to eliminate imminent safety hazards as defined by fire, building or life safety codes or regulations or to comply with accreditation or certification standards required to be eligible for reimbursement or payment from any public health care financing source.

E. A certificate of need shall not be required for:

1. Any project, including construction, of an institution which provides only supervisory care services.

2. Any project, including construction, acquisition of major medical equipment, substantial change in services, the addition, reduction or termination of new services or any capital expenditure proposed by this state or any political subdivision, department, board, commission or agency of this state, in connection with state, county or municipal correctional facilities.

3. Any project, including construction, of a residential care institution or supervisory care home providing supervisory care or personal care services.

4. Any project or program providing nursing, personal care or medical services in the home.

5. Any project, including construction, of a nursing care institution which provides only nursing services.

6. Energy conservation projects funded in part or in whole by federal grants.

7. Behavioral health agencies which do not provide inpatient or residential treatment services.

F. Health care services organizations shall be exempt from the requirements of this section, except those requirements pertaining to the construction of new hospitals, nursing care institutions or other inpatient health facilities and the acquisition of major medical equipment and capital expenditures for such new inpatient facilities. Any medical service provided by a health care services organization which on the effective date of this act would require inpatient care shall conform to the provisions of this section. Services provided by a health care services organization which are otherwise exempt from the provisions of this section shall be subject to the notification requirements established in subsection H of this section.

G. Regulations defining the form and content of an abbreviated application shall be promulgated and shall apply to all projects except the following:

1. Establishment of new services with annual operating costs of seventy-five thousand dollars or more;

2. Construction of a new health care institution; or

3. Capital expenditures, other than capital expenditures for the replacement of equipment, which are greater than one hundred fifty thousand dollars.

H. At least thirty days before any person acquires or enters into a contract to acquire an existing health care institution, such person shall notify the department and the authorized local agency in writing of his intent to acquire the health care institution, the services to be offered in the facility and its total bed capacity. A certificate of need shall not be required for the acquisition of the existing facilities of a health care institution

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unless the acquisition involves establishment of new services or facilities or substantial modification of existing services or facilities which would otherwise require that the health care institution obtain a certificate of need.

Added by Laws 1975, Ch. 129, § 3, eff. June 11, 1975. Amended by Laws 1976, Ch. 112, § 8; Laws 1977, Ch. 172, § 12, eff. Jan. 1, 1978; Laws 1980, Ch. 214, § 7; Laws 1981, Ch. 260, § 2; Laws 1982, Ch. 315, § 1.

This section is repealed by Laws 1982, Ch. 315, § 7, effective August 2, 1984.

For legislative intent regarding termination of provisions added or amended by Laws 1980, Ch. 214, see note following § 36–401.

For legislative intent regarding termination of provisions added or amended by Laws 1981, Ch. 260, see note following § 36–421.01.

Another § 36–433, added by Laws 1971, Ch. 203, § 1, was renumbered as § 36–445.02. See Reviser's Note following § 36–445.

For effective date provision of Laws 1977, Ch. 172, see note following § 20–1707.

Repeal

1976 Reviser's Note:

In paragraph 9 [now paragraph 14] of subsection C "this subsection" was substituted for "subsection C of this section", pursuant to authority of section 41–1304.02.

Cross References

Application for certificate of need by recipient of a temporary certificate, see § 36–434.

Application for construction permit, see § 36–421.

Findings on application, see § 36–433.01.

Issuance of certificate, see § 36–421.

Library References

Hospitals ⇐1.

C.J.S. Hospitals § 1 et seq.

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Review 1

½. In general

An applicant for a certificate of need to establish a new health care institution may not be required by health systems agency to designate the planned location of the proposed service with any greater degree of specificity than that required by this section, the rules adopted pursuant thereto, and the interpretation made thereof by the department of health services facility. Op.Atty.Gen. No. 179–95.

1. Review

When review of a local health agency's findings is not requested by an applicant, the findings must be adopted by the director of the Arizona department of health services unless the local agency's findings are determined to be arbitrary, capricious, or not supported by substantial evidence. Op.Atty.Gen. No. 179–10.

When review of a local health agency's findings is requested by an applicant, the director of the Arizona department of health services may entertain written or oral arguments from the parties in interest. Id.

Insertion of "initial" in provision of subsec. A, par. 1 of § 36–433.01 providing that no review of the authorized local agency shall take longer than one hundred forty-five days (now one hundred and five days) from the "initial" date of filing the application with the authorized local agency unless the agency and the applicant agree in writing for an extension of time required that the former one hundred forty-five day (now one hundred five day) review begin with the filing of the application with the agency and the department of health services; the completeness review was included within the one hundred forty-five day review. Op.Atty.Gen. No. 78–170.

§ 36–433.01. Review of certificate of need application; public hearing; written findings and recommendations; conflict of interests

A. The authorized local agency shall notify the applicant and other affected persons in writing of the beginning of the review. The director shall issue regulations defining the procedures for the review of the application which shall include the following provisions:

1. That no review by the authorized local agency shall take longer than one hundred five days from the initial date of filing the application with the authorized local agency, unless the agency and the applicant agree in writing to an extension of time.

2. That a public hearing shall be initiated within thirty days after the initial filing of the application and shall be concluded within thirty days after the initial session.

3. That the governing body of the local agency, with a majority of its members present, shall conduct a public hearing on any certificate of need application.

4. That written notice of the hearing shall be delivered to the applicant at least fifteen days prior to the hearing date. Such notice shall contain the names of the panel members

Nancy - FYI Dennis

The Cost of Excess Beds in Orange County

Hospital Council of Southern California

alaska state hospital association

319 Seward Street
Juneau, Alaska 99801

alaska state hospital association

319 Seward Street
Juneau, Alaska 99801

alaska state hospital association

319 Seward Street
Juneau, Alaska 99801

conducted by: ERNST & WHINNEY

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ABSTRACT

A basic tenet of recent health care public policy has been that there are a large number of excess beds in the hospital industry, and that this excess capacity is costly to both consumers and third-party payers for health care. Economic estimates for the United States project that capacity could be reduced by as much as 20 percent without endangering the health status of Americans. Estimates of the potential cost savings from such a reduction range from 12-16 percent of annual hospital costs. Similar estimates for California project that a 22 percent reduction in the bed supply would result in a 12 percent reduction in annual expenditures. These economic estimates are characterized by assumptions that the costs that would be avoided if a hospital were to be closed exceed 50 percent of that hospital's total cost. These estimates further assume that excess beds give rise to unnecessary (and costly) utilization of hospital facilities.

Public policy has been implemented and is being conducted by local, state, and national health planning agencies. These agencies enforce hospital certificate of need laws which require hospitals to obtain planning approval before commencing major projects to replace or expand existing facilities. It is believed that a restrictive certificate of need program will ultimately yield the same 12-16 percent savings that would result from closure of hospitals. Orange County has been a particular target of this policy, because it has low occupancy and presumably a high number of excess beds.

This study was undertaken to answer two questions:

- Are there excess beds in Orange County hospitals?
- If so, are these excess beds costly to consumers and third-party payers?

18 of the 39 general acute hospitals in Orange County participated in the study. The study group hospitals account for more than half of Orange County patient days and costs. These hospitals provided data on the actual level of use of the hospital, and the actual payments from patients during 1977, 1978, and 1979.

As a result of a detailed analysis of the utilization data, it was found that there were a substantial number of excess beds in the study group hospitals--approximately 18 percent of licensed beds. It was also found that hospital utilization is growing, and the number of excess beds are diminishing. If population growth continues, there will be no excess beds in Orange County by 1985.

If there are a substantial number of excess beds, then it is commonly believed that this excess causes "excess" hospital use (unnecessary hospitalizations). It is clear that there are excess beds in the study group and in Orange County. However, data published by California Hospital Association on hospital usage per thousand population does not

reflect excess usage. On the contrary, hospital usage in Orange County is below the average for California, and California is significantly below the national average. Although this data is not conclusive, it does not appear that excess beds cause excess hospital usage in Orange County.

The cost analysis performed as part of this study focused on the money actually paid by consumers that was spent to maintain, replace, expand, and pay off the debt on hospital facilities. The vast majority of this money was spent on needed capacity. The portion spent on excess beds amounted to only 0.75 percent of total hospital costs, or approximately $3.00 per patient day. The portion that was spent on excess capacity of all types amounted to 2 percent of total hospital costs, or $8.60 per patient day.

These savings estimates of 1-2 percent are substantially below the 12-16 percent figures that are widely quoted. Given this low level of potential savings, it is not clear that a public policy directed at controlling the supply of hospital beds in Orange County can ever be successful in significantly impacting the costs or health care to the consumer.

EXECUTIVE SUMMARY

THE EXCESS BEDS ISSUE

It is widely believed by health planning agencies and other regulators of the health care industry that there are a substantial number of excess beds in the hospital industry, and that there are substantial costs to consumers, insurance companies, and government payers for health care because of this excess. There are two basic ideas that underlie the conclusion that there is a costly excess beds problem. These ideas are:

- Hospitals have very high fixed costs. Fixed costs are those which must be incurred at any level of activity, and in the hospital industry are generally those costs associated with maintaining a given level of capacity to serve patients. It is commonly believed that these fixed costs represent as much as 60 percent of total hospital costs. Part of the argument that excess beds are costly goes that if there are too many beds, there is too much capacity. If the fixed costs of maintaining this capacity are 60 percent, then the cost of excess beds is 60 percent of the average cost per bed multiplied by the number of excess beds. This is an estimate of cost that would be avoided if the excess beds were not there.

- Demand for hospital services expands to fill the beds available. This idea is called the Roemer effect, after the original researcher. Roemer found that the use rate of hospital services, measured in patient days per thousand population, was highly related to the availability of beds, measured in beds per thousand population. In other words, areas with a high ratio of beds per thousand population tended to have a higher level of patient days per thousand population. As it relates to the excess beds issue, the Roemer effect is interpreted to mean that excess beds cause overutilization of hospital services. If there are too many beds, then there will be "too much" utilization of those beds--in other words, unnecessary hospitalizations. The cost of these unnecessary hospitalizations contributes to the cost of excess beds.

Public policy has addressed this issue through the structure of federal, state, and local agencies created by the 1975 National Health Planning and Development Act (PL93-641). One of the major thrusts of these agencies has been to control the supply of hospital beds, in the belief that such control would reduce the number of excess beds, and avoid the costs associated with this excess. The avoidance of the costs of excess beds is thought to make a major contribution to the containment of hospital costs.

Orange County has been a particular target of this policy, because it is believed that there are a substantial number of excess beds in Orange County hospitals.

ESTIMATES OF POTENTIAL SAVINGS RESULTING FROM REDUCTIONS TO THE BED SUPPLY

A number of economic estimates of the potential savings that would result from a reduction in the bed supply have been developed during the late 1970's. A key study is Reducing Excess Hospital Capacity by Walter McClure, published by InterStudy in 1976. This study concluded that a 20 percent reduction in hospital beds, accomplished by closing entire facilities, would result in a 16 percent reduction in annual hospital costs. In California, a California Hospital Association study authored by Zaretsky entitled The Economics of Excess Capacity concluded that a 22 percent reduction in the California bed supply would result in a savings of 12 percent of annual hospital costs. Zaretsky's results are lower because the Roemer effect was not included in the computation.

The basic methodology for these studies proceeds in two steps. In the first step, excess beds are estimated using the following formula:

- Needed beds = $\frac{\text{average daily census}}{\text{85 percent occupancy standard}}$

- Excess beds = licensed beds - needed beds

- Excess beds percent = $\frac{\text{excess beds} \times 100}{\text{licensed beds}}$

In the second step, the cost of potential savings from reduction of excess beds is computed:

- Average cost per bed = $\frac{\text{total cost}}{\text{total beds}}$

- Savings per bed = average cost per bed x number of excess beds x 50-60 percent fixed costs

- Total savings = savings per bed x number of excess beds

- Savings percentage = $\frac{\text{total savings} \times 100}{\text{total cost}}$

In some studies, additional potential savings are projected by estimating the number of unnecessary patient days "caused" by the availability of excess beds and multiplying these days by the average cost per day. These estimates are the estimate of the cost associated with the Roemer effect.

Virtually all of the economic estimates of potential savings assume that entire hospitals are closed, rather than portions of hospitals. While acknowledging the legal and social difficulty of government enforced closure of hospitals, most of the economic authors believe that a tight certificate of need program (which is recent government policy) will ultimately achieve the same results.

Central to all of these studies are five key assumptions. Specifically, these assumptions are:

- That 85 percent occupancy is a realistic occupancy standard.
- That licensed beds represent the number of beds that are available for use and which have costs associated with them.
- That an excess supply of beds will result in costly overutilization of hospital facilities.
- That fixed costs which relate to maintaining a hospital bed for one day exceed one-half of the average cost of a day's care in the hospital.
- That a tight certificate of need program to restrict the supply of beds will ultimately achieve the same potential savings that would result from closing entire hospitals.

Hospital industry critics of these estimates of potential savings have repeatedly challenged these assumptions, claiming that they are not reasonable, and do not reflect the realities of hospital operations.

A STUDY OF ORANGE COUNTY HOSPITALS

The objective of this study was to investigate the excess bed issue in Orange County hospitals. Specifically, the objectives were to determine whether there were a substantial number of excess beds in Orange County during the 1977-1979 period and, if so, were these excess beds costly to consumers, insurance companies, and government payers.

The study included 18 of the 39 acute general care hospitals in Orange County, who voluntarily agreed to participate in the study. Since the hospitals self selected whether or not to participate, the sample of hospitals was not random and no statistical assertion of representativeness can be made. A review of occupancy statistics disclosed that the study group of hospitals was probably somewhat less likely to have excess beds than the nonparticipating hospitals. However, the differences between the two groups of hospitals are not so marked that the excess bed condition did not exist in the study group. Further, the study group contains hospitals which accounted for more than half of the patient days and costs of all Orange County hospitals. Hence the results for the study group cannot be dismissed as unrepresentative of the excess bed issue in Orange County.

It was the intent of the study to investigate the excess bed issue using actual data to the maximum extent possible, and to make as few assumptions as possible. This approach was taken in an attempt to arrive at rigorous results and to avoid the controversy that has surrounded the assumptions used in prior studies.

The approach used to investigate the excess beds issue contained the following key elements:

- Actual hospital census data was analyzed for the three year study period, in order to determine the pattern of actual bed utilization. The number of needed beds for each hospital was set at a level below the number of beds that were actually used during peak periods. This level was set so that 1 out of 20 patients who actually used a particular hospital would have been turned away and forced to enter another hospital, had the actual beds available been equal to the defin l level of needed beds. The 1 out of 20 turnaway level was judge. to result in an acceptable level of patient and physician inconvenience. This methodology was employed rather than an arbitrary 85 percent occupancy standard assumption.

- Interviews were conducted with hospital managers and California Health Facilities Commission (CHFC) disclosure data was reviewed in order to determine how many beds were actually available at a study hospital during the study time period. This data on available beds was used in place of an assumption that all licensed beds were available for use. Beds which exist only on the paper of the hospital's license are not excess beds in the sense that there are potential savings associated with them. These "phantom" beds could be removed merely by changing the hospital's license, but the hospital's operations, revenues, and costs would be unchanged.

- An analysis was performed of actual financial data for the study group hospitals. The amount of money actually paid by consumers, insurance companies, and government payers was segregated into two categories:

  - Money which was used to pay for the day-to-day care of patients in the hospital, and

  - Money that was used to maintain, replace, expand, or pay off the debt on existing hospital facilities.

  This second category of funds is the money which is in fact used to maintain or expand a hospital's capacity, and represents the costs that are the focus of the current certificate of need program. This analysis was performed in order to more accurately determine the potential savings that would result from the elimination of excess beds. No single fixed cost assumption was used in order to estimate potential savings.

FINDINGS AND CONCLUSIONS--EXCESS BEDS AND HOSPITAL UTILIZATION

There are 3838 licensed beds in the study group hospitals. The three year average of average daily census during 1977-1979 was 2305 patients per day. The conventional computation of excess beds would result in 1126 excess beds, or 29 percent of total licensed beds. (2305 ADC ÷ 85 percent = 2712 needed beds. 3838 licensed beds - 2712 needed beds = 1126 excess beds.)

As a result of interviews with hospital management and analysis of CHFC data, it was determined that there were an average of 339 beds (9 percent of licensed beds) that were "phantom" beds. We conclude that almost one-third of the "excess bed problem" in the study group relates only to the fact that there are more beds on hospital licenses than there are beds available for use. These phantom excess beds were removed from further analysis since there are not any cost savings associated with a reduction of beds only on the hospital's license.

The results of the analysis of hospital average daily census data provided an alternative to the 85 percent occupancy standard. A 1 out of 20 "turnaway" probability was used to determine the number of needed beds for each hospital. The application of this probability to a statistical model of the distribution of average daily census for the hospital resulted in the determination of the number of needed beds. These needed beds were added up for all study group hospitals. The resulting total was 2788 needed beds which is an 82.6 percent occupancy standard and 76 more beds than the 2712 needed beds that result from the 85 percent occupancy standard. These 76 beds represent approximately 2 percent of total licensed beds.

In summary, the results of the study's excess bed computation show that of the 29 percent of the study group hospital beds which are nominally excess beds, 9 percent are phantom beds which appear only on the hospital license and have no cost impact, and 2 percent would be required in order to maintain a turnaway probability of 1 in 20. The remaining 18 percent are true excess beds.

The study also showed that the average daily census was growing at a rate of slightly more than 4 percent per year (from 2211 in 1977 to 2401 in 1979). As a result, the number of excess beds declined over the same period (from 816 beds in 1977 to 635 beds in 1979). If the trend in patient days continues at 4 percent per year, then the number of needed beds will be equal to the number of available beds by 1985.

We conclude that there was a substantial number of excess beds in the Orange County study group, although the true number of excess beds is considerably below the amount that would normally be reported. Further, the number of excess beds is going down, because average daily census and the related number of needed beds are growing.

Given that there were a substantial number of excess beds in the study group during the 1977-1979 period, one would expect that there would be some overutilization of hospital services due to the Roemer effect.

It was not possible to calculate use rates for the study group, since the population served by the study group represents an unknown portion of the Orange County population. However, data published by the California Hospital Association does show the utilization for Orange County in total during 1978. The number of patient days per thousand population was:

Orange County	816
California	867
United States	1,208

The utilization of hospitals in California is well under the national average, and Orange County is under the California average. Although this data for Orange County is not conclusive, it does raise questions about the causal relationship between the availability and use of hospital beds. It is unclear that the Roemer effect is a valid concept, at least for Orange County.

FINDINGS AND CONCLUSIONS--THE COST OF EXCESS BEDS

All of the economic estimates of potential savings assume that entire hospitals are closed. As a practical matter, no agency of the government is empowered to take this action. Health planning agencies are empowered to control the capital expenditures of hospitals through the certificate of need legislation. It is asserted by the authors of several of the estimates of potential savings that a tight certificate of need control on the bed supply will, in the long run, achieve the same results as closing hospitals.

Our approach focused on identifying the capacity costs of hospitals, and apportioning these capacity costs between excess capacity and needed capacity, as measured by needed beds and excess beds. Capacity costs represent that portion of the money received from patients and third-party payers which was spent to maintain, replace, expand, or repay the debt on hospital physical plant assets. While capacity costs are not the fixed costs used in the economic estimates, there are two compelling reasons why capacity cost is a viable concept for analyzing potential savings from reducing the bed supply:

- Capacity costs are costs <u>actually paid</u> by the consumer or third-party payer. If hospital facilities were replaced using funds from sources other than patient revenues (e.g., debt or donations), then these assets did not cost the current consumer anything, and the cost of such projects is not part of current capacity cost. Conversely, if patient revenues were used to retire debt used to finance existing assets or to accumulate savings to finance future capital projects, they are being paid by the current consumer and are current capacity costs.

- Capacity costs, not fixed costs, are the object of certificate of need controls. If a capital project does not receive a certificate of need, then the funds will not be spent, and current and future consumers will not be charged. No certificate of need approval is required to hire a new assistant administrator or director of nursing. Once hired, the costs of these personnel are largely fixed (unrelated to changes in volume). While it is true that these fixed costs could be avoided if the facility was closed down, no agency of government can enforce a hospital closure. More to the point, if the hospital was not needed and volumes and patient revenues declined enough so that it was approaching bankruptcy, these "fixed" costs would become variable costs--the personnel would be laid off.

Capacity costs for the study group ranged from 12-13 percent of consumer expenditures during the three year study period. We conclude that the potential for savings through capacity control is much smaller than generally estimated, because the total costs which are the target of regulatory control are less than 13 percent. This level of potential savings is substantially below the 50-60 percent of total cost used in the economic estimates.

Excess beds were used as an estimate of excess capacity, in order to split capacity costs between needed capacity and excess capacity. The results of this apportionment are that approximately 2 percent of total cost is related to excess capacity. This is equivalent to $8.60 per patient day. This is the estimate of the total potential for cost reduction through certificate of need control.

The focus of regulatory control is on the supply of beds. The majority of capacity costs do not relate to patient beds, but to ancillary and support services (e.g., radiology equipment, data processing equipment). If the excess capacity costs are split between the cost of beds and the cost of expenditures for other capacity purposes, then the potential savings drop to .75 percent, or $3.00 per patient day.

Economic estimates of the potential savings from a 20 percent capacity reduction range from 10-16 percent of total hospital expenditures. The results of our study indicated that a 18 percent reduction in capacity would be possible in the Orange County study group hospitals. Our estimate of the potential savings that would result from this capacity reduction range from 1-2 percent. The principal reasons for this substantial difference go back to the assumptions used in the economic estimates:

- An 85 percent occupancy standard is generally assumed. Our study results support a slightly lower 83 percent occupancy standard.

- Licensed beds are assumed to represent beds actually available for use. The results of our study indicated that 9 percent of licensed beds, or one-third of the excess beds, are "phantom" beds which exist only on the hospitals' licenses. There appears to be no savings associated with retiring these "phantom" beds.

- Excess beds are assumed to cause excess utilization (Roemer effect). Our study did not address this assumption directly. However, California Hospital Association statistics for all Orange County hospitals do not support the idea that there is significant overutilization in Orange County.

- It is assumed that fixed costs exceed one-half of total costs, and that these fixed costs could be avoided through elimination of excess capacity via a tight Certificate of Need program. In fact, the target costs of Certificate of Need programs are not fixed costs, but capacity costs. These costs represent only 13 percent of total costs in our study group--a dramatically smaller fraction than the 50-60 percent that has been commonly used.

In short, the economic estimates overestimate excess beds largely because they count phantom beds as excess beds. These estimates overestimate potential savings because they assume that fixed costs, not capacity costs, are the target of Certificate of Need regulation. Potential savings may also be overestimated because utilization is assumed to decline with the bed supply. After these factors have been taken into account, the potential savings drop from 10-16 percent to 1-2 percent for our study group. Given this low level of potential savings, it is unclear that a public policy directed at controlling the supply of hospital beds can ever have a significant impact on the cost of health care to the Orange County consumer.

THE COST OF EXCESS BEDS IN ORANGE COUNTY
1977-1979

I. INTRODUCTION

It is widely believed by health planning agencies and other regulators of the health care industry that there is a substantial excess capacity in the hospital industry, and that this excess capacity is costly to consumers, insurance companies and government payers for health care. Public policy has been directed at this perceived problem through an extensive network of health planning agencies, regulations and laws. The hospitals in Orange County have been particular targets of this policy, because of allegations of extensive excess hospital beds in the County.

This study was undertaken to assess the "excess bed problem" in Orange County. The objectives of this study were to estimate the number of excess beds in Orange County, and to estimate the costs of these beds to consumers and third-party payers. An additional objective of the study was to describe how this issue has evolved, and to discuss policy alternatives in light of the findings for Orange County.

Section II of this report describes how "excess beds" became an issue, and what the public policy response has been. Section III describes the approach taken in the study. Section IV describes the group of hospitals that agreed to participate. Section V discusses the alternative ways to measure excess beds, and presents the findings regarding excess beds in the study group. Section VI discusses policy alternatives and ways to measure the costs associated with excess beds which are consistent with various policy options. Conclusions are presented regarding the potential effectiveness of the policies currently being employed.

II. THE EXCESS BEDS ISSUE

EVOLUTION OF THE ISSUE

During the last twenty years, there has been considerable debate and discussion regarding the "excess bed problem" in the United States. The pace of the debate accelerated in 1976 when two studies of the problem were published. In a study by InterStudy published in 1976 called Reducing Excess Hospital Capacity, the principal finding was "(there is) substantial evidence of excess hospital capacity which contributes significantly to medical cost escalation with little or no benefit to health." 1) This study recommended a phased 20 percent reduction in capacity, and estimated savings of up to 16 percent of total hospital expenditures. In the same year, a study published by the Institute of Medicine of the National Academy of Sciences found "that significant surpluses of short-term general hospital beds exist or are developing in many areas of the United States and that these (surpluses) are contributing significantly to rising hospital care costs." 2)

Economic analysis of California hospitals by Zaretsky in 1977 was consistent with the national conclusion that a significant excess bed problem exists. That study concluded that "economic incentives for an appropriate balance between use and capacity are absent in the health industry. This has led to a current situation, especially in California, where capacity is substantially in excess and this excess is costly." 3) Zaretsky estimated that a reduction in capacity of 22 percent would result in a 12 percent savings in annual cost.

In a report published by the California Health Facilities Commission (CHFC), using 1978 data for Orange County, excess beds are estimated at 25.5 percent of licensed beds. The report goes on to state, "CHFC research indicates that 10.5 percent to 21 percent of statewide hospital total operating costs are related to excess capacity." 4)

There are two basic ideas that underlie the conclusion that excess beds are costly. The first idea is that hospitals have very high fixed costs. Fixed costs are those costs which must be incurred at any level of activity. Economic estimates of fixed costs published during the early 1970's indicated that fixed costs exceed 50 percent of total hospital costs. 5) Thus if there are too many hospitals and too many beds, then retiring beds will cause some level of fixed costs to be avoided. In particular, "retiring entire hospitals produces substantially more savings than an equivalent reduction closing portions of several hospitals." 1) Zaretsky, in commenting upon his cost estimate for empty beds, states "it is best to interpret this $20,000 per empty bed estimate as based upon the most cost effective way of eliminating empty beds--retiring entire institutions--rather than across-the-board cuts in beds in a large number of hospitals." 3)

The second basic idea that underlies that costly excess bed problem is frequently called the Roemer effect, after the original researcher. In work published in 1959, Roemer and Shain found that the use rate of hospital services, expressed in patient days per thousand population, was highly correlated with the availability of beds, expressed in beds per thousand population. They concluded that "hospital beds that are built tend to be used." 6) In other words, demand for hospital services seems to expand to meet the supply of beds available. Roemer and Shain further inferred that "the ultimate control over money spent for hospitalization . . . is the volume of beds provided."

PUBLIC POLICY

The passage of the National Health Planning and Resources Development Act in 1975 created a structure of national, state, and local planning agencies for the purpose of developing and implementing health planning policy. The law required states to adopt certificate of need programs for approving capital expenditures by hospital. Excess beds/capacity has been a concern of these agencies from the outset of the program. The stated purposes of the local Health Systems Agencies include "restraining increases in the cost of providing health service and preventing unnecessary duplication of health resources." 7) This law was amended in 1979, and the emphasis on eliminating excess beds/capacity was heightened. "The identification and discontinuance of duplicate or unneeded services and facilities" 8) became a national health priority.

In California, certificate on need legislation was initially adopted in 1976. The California law basically conforms to the requirements of the federal law. The Orange County Health Planning Council, which is the local planning agency, established a goal in their 1979 Health Systems Plan of "reduction of excess capacity through elimination or redistribution of health and medical care services and/or resources." 9)

Within the legal and organizational structure created by PL 93-641, the Secretary of Health and Human Services (HHS) is charged with developing guidelines for use by state and local agencies in health planning. In 1978, the first set of national guidelines were published. 10) These guidelines are directed, in part, at bed supply. A general guideline of four beds per thousand population was established. This guideline is based upon the Institute of Medicine's Report and the Interstudy report cited earlier. 1)2) Achievement of this guideline would mean a 10 percent reduction to the supply of beds. 10)

The National Guidelines also set specific occupancy standards for hospitals. The occupancy standard for general acute hospitals is 80 percent. This level is well above current national average of 75 percent. 10)

This federally mandated structure of agencies and regulation is currently being challenged by the Reagan Administration, as part of the emphasis on cost control in government and de-regulation.

California Office of Statewide Health Planning and Development guidelines for occupancy and bed are more sophisticated than the national guidelines, in that they take the number of patients by type of medical service within a planning area into account. Occupancy standards are generally established between 60 and 85 percent on a service-by-service basis, depending on the average daily census for that service in the health facilities planning area.

In summary, public policy has responded to the perceived "costly excess bed" problem by establishing goals to reduce beds. These goals have been implemented through the various levels of health planning agencies and the certificate of need process. It has been widely believed that the impact of placing capacity limits on hospitals will be to substantially reduce or contain the costs of health care to consumers, insurance companies, and government programs.

III. STUDY METHOD

OBJECTIVES

The objectives of the study were:

- To estimate the number of excess beds in Orange County
- To estimate the costs that are associated with operation and maintenance of all beds
- To estimate the cost of excess beds
- To discuss alternative courses of action for regulators and providers, in response to the "excess bed problem."

SCOPE

18 of the 39 general acute hospitals in Orange County chose to participate in this study. Since the hospitals self-selected whether or not to participate, no assertion can be made that the study group is a random sample of Orange County hospitals. Accordingly, the quantitative findings of the study are limited to the 18 hospitals which did participate.

The study included the collection and analysis of actual daily census and annual financial data for the three years 1977-1979. Fiscal year data for hospital fiscal years ending during this 36-month period was used and not adjusted to a common year-end. This procedure was used because we believed that such an adjustment would introduce more error than it would eliminate.

The focus of the study was to use actual data in place of assumptions wherever possible. This emphasis on actual data was made in an effort to arrive at realistic results, and in an effort to avoid the controversy that has attended the assumptions of prior studies.

The use of actual data had several consequences:

- Excess beds were computed based upon the actual utilization of a particular hospital in a given study year. Excess beds are commonly used as an estimate of excess capacity, a convention which was followed in this study as well. Although not a perfect estimate by any means, excess beds can at least be measured unlike excess capacity.
- The actual data reflects the actual use of the study group hospital, not what "should have" happened. Hence, the Roemer effect is not explicitly considered in the data analysis, and it is assumed that the actual usage of the hospitals was appropriate. Although the Roemer effect was not considered in the data

analysis, Orange County use rate data does tend to support the assumption that the actual usage was not inappropriate, and the Roemer effect can be ignored in developing estimates of potential savings from bed reductions.

- No opportunity cost analysis was performed. To the extent that phantom beds are being used for productive functions and these functions would require space if the space originally designed for beds was not constructed, there is an opportunity cost associated with "phantom bed" space. The study assumes that phantom bed space is being productively utilized, and that the actual costs reflect the economic value of that space. No analysis was made of the costs that would have been incurred to provide space for those functions (e.g., leasing outside space) had the bed space not been constructed in the first place.

- No fixed cost/variable cost assumptions were made. Rather, the money actually paid by consumers and third-party payers was analyzed and segregated into operating costs and capacity costs--the costs of maintaining, replacing, expanding, and paying off the debt on existing facilities. Capacity costs become the basis for estimating potential savings from reducing beds or capacity, rather than an assumption that an assumed level of fixed costs would be avoided through capacity reduction.

APPROACH

The approach taken to estimate the number of excess beds consisted of a statistical analysis of daily census data for each study group hospital. The number of beds needed for patients who actually used the hospital was compared to the number of beds that were available for use. This analysis results in an estimate of the number of excess beds in the hospital. These estimates were aggregated to estimate the total number of excess beds in the study group.

The approach taken to estimating the cost of the excess beds was to analyze the financial statements of the study hospitals for each year in the study period. Payments from patients and third-parties were identified as either related to day-to-day operations of the hospital, or to capacity costs. Capacity costs were then divided between "needed" beds and "excess beds" in order to estimate the cost of an excess bed. These excess bed costs were then aggregated to estimate the total cost of excess beds in the study group.

As part of the development of the approach, a review of the literature was performed in order to determine the strengths and weaknesses of the various methods that have been used. In the sections which follow, the results of this review will be discussed as a preface to a discussion of the specific methods and findings of this study.

IV. THE STUDY GROUP

During the 1977-1979 study period, there were 44 hospitals in Orange County. Of these 44 hospitals, 39 are acute general hospitals and 5 are psychiatric or rehabilitation hospitals. The 5 specialty hospitals were excluded from the study because they have substantially different operating characteristics than the acute general hospitals.

Of the 39 general acute hospitals, 18 agreed to participate in the study for all three years. At least one hospital from each of the 7 geographic health facilities planning areas was included in the study group. The group included both proprietary and non-profit hospitals. The study group hospitals ranged in size from 56 beds to 493 beds, with the average being 213 beds. The non-participating hospitals ranged in size from 24 beds to 268 beds, with an average size of 160 beds.

Table 1 presents a statistical comparison of the participating and non-participating hospitals. Table 1 shows that the overall occupancy in Orange County during the study period was low, although it improved from 1977 to 1979. Low occupancy is a preliminary indication that an excess bed condition probably does exist.

The occupancy for the study group is higher than the occupancy for the non-participating hospitals. The lower occupancy for the non-participating hospitals probably reflects the self-selection process. That is, hospitals with low occupancy and excess beds would be less willing to participate in a study of this type. Because of this self-selection, the study group is not a random sample of the hospitals in the County, and the quantitative findings are limited to the group studied. However, the study group does contain more than half of the patient days, revenues, and costs for the County. Hence findings for this group account for the majority of hospital care and hospital costs in Orange County.

TABLE 1

Statistical Comparison of Study Group

to Non-Participating Hospitals (A)

	Study Group	Non-Participating Hospitals	Total
1977			
Number of Hospitals	18	21	39
Licensed Beds	3,838	3,341	7,179
Average Occupancy (B)	57.46%	50.44%	53.68%
1978			
Number of Hospitals	18	21	39
Licensed Beds	3,838	3,363	7,201
Average Occupancy (B)	58.79%	50.19%	54.10%
1979			
Number of Hospitals	18	20(C)	38(C)
Licensed Beds	3,838	3,266	7,104
Average Occupancy	60.32%	52.94%	56.44%

(A) Source: California Health Facilities Disclosure Reports

(B) Average of individual hospital occupancies, where occupancy = $\frac{\text{(patient days} \div 365)}{\text{Licensed beds}}$

(C) One hospital was closed in 1979

V. COMPUTATION OF EXCESS BEDS

DEFINITION OF EXCESS BEDS

Although excess beds are alleged to be a major problem with the United States health care system, "the precise meaning of 'excess' as applied to hospital beds, has always been characterized by considerable ambiguity." 11) Excess beds have been defined to be beds which are never used; beds which are seldom used (excess reserve capacity); and beds which are misused (overutilized).

The most common definition of excess beds is based upon an occupancy standard. The 1976 InterStudy recommendations were based on an 85 percent occupancy standard. 1) The 1978 Health Planning Guidelines set a standard of 80 percent for general acute hospitals. 10) Using this guideline, excess beds would be computed as:

- Needed beds = $\frac{\text{average daily census (ADC)}}{80\%}$

- Excess beds = Licensed beds - needed beds

This type of approach, using an 85 percent occupancy standard, was used by the Orange County Health Planning Council in its 1980 Inventory of Health Services and Facilities to compute estimated excess beds in 1985. Calculations derived from data in the Inventory show: 12)

	Average Daily Census	Required Beds	Licensed Beds	Excess Beds	Percent of Licensed Beds
1978	3,748	4,409	6,629	2,220	33.5%
1985	4,598	5,430	6,629	1,199	18.0%

It is statistics like these that give rise to the allegations of substantial excess beds.

VARIABILITY OF HOSPITAL CENSUS

Occupancy standards have played a critical role in the regulation of health providers. There has been considerable controversy regarding what is an appropriate standard. Walter McClure, the author of the 1976 InterStudy report, describes 85 percent as "an average rate which is both efficient and achievable in practice." 1) MacStravic, in a recent article for CHA Insight, comments that "the old Hill-Burton standard of 85 percent still echos in the halls of planning and regulatory agencies, making up in familiarity what it lacks in sense." 13)

Hospitals cannot sustain 100 percent occupancy. They need to maintain a reserve capacity to accomodate fluctuations in the daily census, and to accomodate the different needs of different patients. This reserve capacity, added to the average daily census, constitutes the number of beds that are truly needed. Some of the often-cited 14) reasons for maintaining a reserve capacity include:

- Random nature of admissions—certain types of admissions are not predictable. For example, obstetrics, perinatal, and intensive care admissions. Capacity must be maintained to accomodate the random nature of these admissions.

- Certain types of patients require distinct patient facilities. For example, a patient requiring intensive coronary care cannot be accomodated in a normal medical/surgical bed. A hospital may have empty beds, but be "full" in a particular medical service. The more different units there are, the more reserve capacity is required, since a reserve for each unit must be maintained.

- Within a particular unit, certain patients are incompatible. For example, smokers and non-smokers, males and females, and patients with contagious diseases cannot be placed in the same room. If a hospital has all private (one-bed) rooms, then these constraints add little or nothing to required reserve capacity. For a hospital with three-bed wards, these constraints can dramatically reduce the effective capacity of the hospital.

- For units where admissions can be scheduled, there is frequently a drop in census over the weekend, because neither physicians nor patients wish to be in the hospital on a weekend.

A number of authors have demonstrated that control over these factors can substantially reduce required reserve capacity. For example, Hancock, et al state that medical/surgical occupancies in excess of 90 percent are achievable through admissions scheduling. 15)16) Gianfrancesco documents that a reduction in reserve capacity is possible if specialization (distinct patient facilities) is eliminated. 17) "Thompson and Fetter examined the implication of (patient incompatibility) restrictions for the attainable occupancy of a medical/surgical service. They concluded that if there is the potential to transfer patients from one room to another, patient incompatibilities have a negligible effect on attainable occupancy." 18)

This idea that census fluctuations can be controlled and occupancy standards raised is attractive to regulators. For example, the California Statewide Method for Estimating Bed Requirements, in commenting upon occupancy patterns, states: "The census is generally lower on weekends than during weekdays. This pattern is one largely determined by preference. Both physicians and patients often prefer that admission be deferred until a weekday and that discharge be arranged before the weekend. This practice may be endorsed by hospital management when it is

difficult to arrange weekend staffing at the same levels used during the week. Statewide policy does not provide for planning for excess capacity to accomodate such available variations in census, and thus no provisions have been explicitly made for it" 19)

It should be pointed out that much of the work which concludes that higher occupancy standards are achievable through control over census variability consists of simulations of what would happen if such controls were possible, not analysis of actual data. 15)16)18)

In the real world of hospital administration, admission scheduling may not be possible because of medical staff resistance. Special care units and other distinct patient care facilities exist and are maintained in order to care for patients in the most appropriate way. Patient incompatibilities do prevent beds from being filled, because both patients and physicians resist room transfers for the convenience of the hospital. Notwithstanding Statewide policy, there is a drop in census over the weekends to accomodate patient and physician preferences. As MacStravic points out, "whether such controls (of census variability) can be implemented in every hospital is open to question." 20)

USE OF STATISTICAL DISTRIBUTIONS TO MODEL CENSUS VARIABILITY

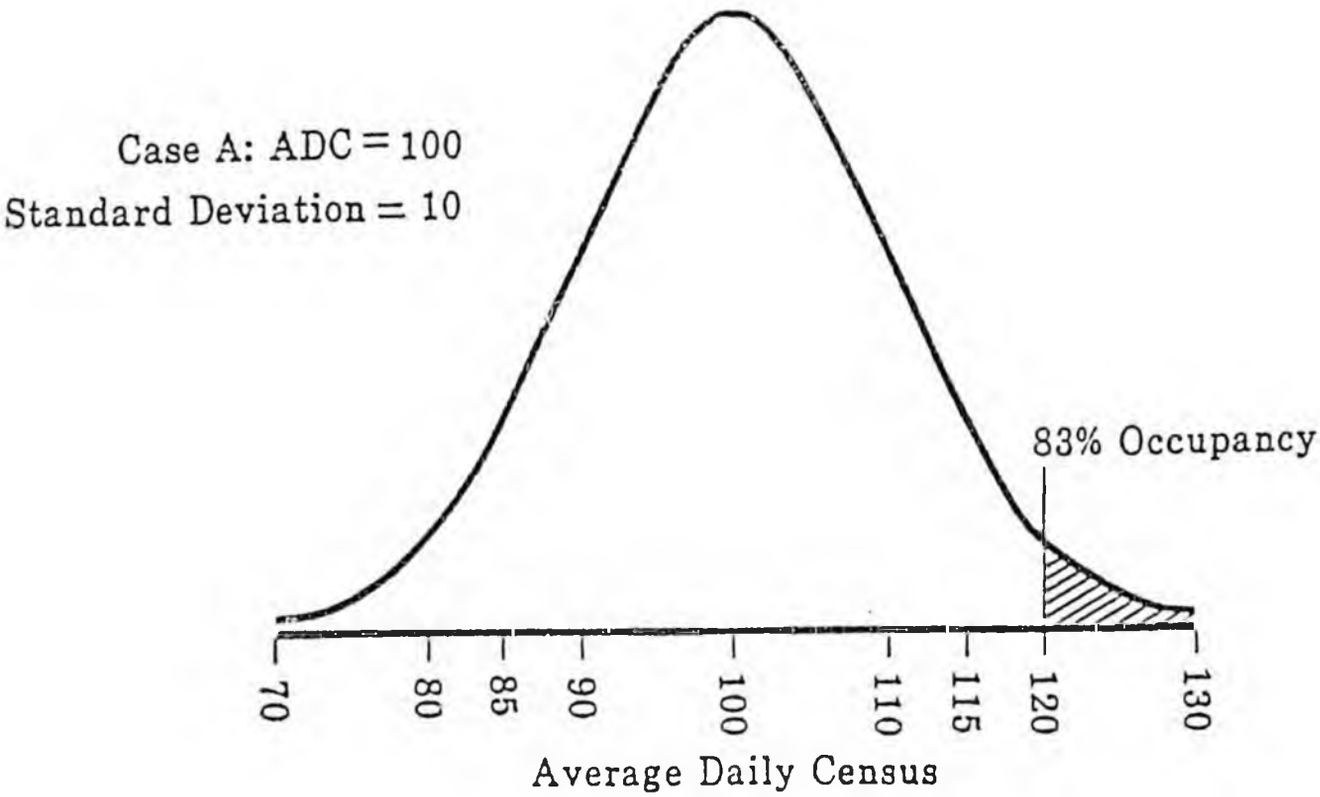
Although the impact of all of the above factors on an individual patient is not necessarily random, the combined impact of these factors on a population of patients is random. As a result, the distribution of average daily census data will generally look like a normal distribution--the well known "bell shaped curve." This fact has proved important to health planners, because it is possible to relate a given occupancy standard to a turnaway probability--the probability that a patient will arrive and be turned away because there is no bed available. The key factor which relates a given occupancy standard to a turnaway probability is the variability of the average daily census, as measured through the standard deviation. The greater the variability (standard deviation), the higher the turnaway probability at a given level of occupancy. As an illustration, Figure 1 shows two hypothetical distributions of average daily census. At the same level of occupancy, they have dramatically different turnaway probabilities.

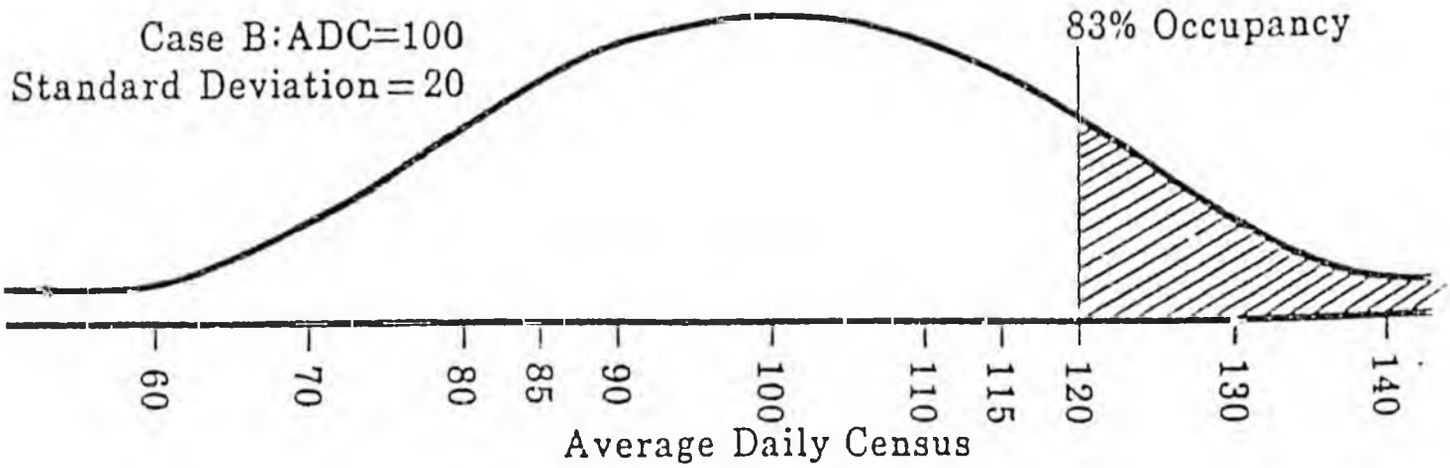
Case A has an average census of 100, and a standard deviation of 10. At an occupancy standard of 83 percent, 120 beds are "needed." At this level of beds, the turnaway probability is about 2 percent. In other words, patients will be turned away about seven days out of the year.

Case B has considerably more variability as indicated by a standard deviation of 20. The bell shaped curve is flatter. There is less clustering in the middle and more incidence of extreme values. At the same 83 percent occupancy standard, the turnaway probability rises to about 16 percent, or 58 days out of the year.

Figure 1:

Two Hypothetical Distributions of Average Daily Census





THE POISSON MODEL

A frequently used model for hospital census is a special case of the normal distribution, called the Poisson distribution. In the Poisson distribution, the standard deviation of the distribution is equal to the square root of the average daily census (mean). Case A is an example of a Poisson distribution, since the standard deviation is 10, which is equal to the square root of the average daily census ($\sqrt{100}$). This statistical model is particularly convenient, since all it requires is a single value (average daily census) to estimate both the mean and the variability of the distribution.

OFFICE OF STATEWIDE HEALTH PLANNING STANDARDS

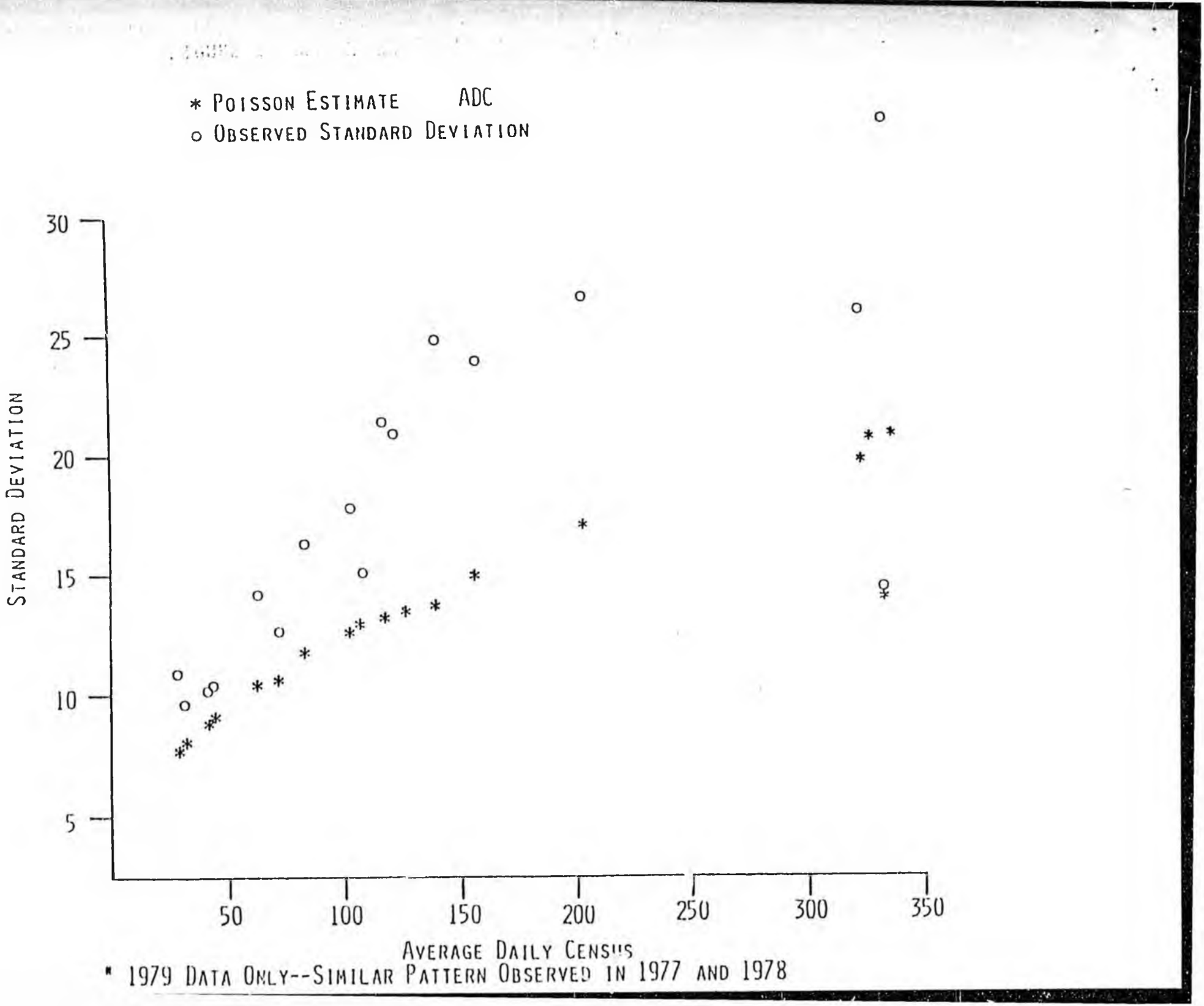
Although the Poisson model is widely used, a number of studies have shown that it is not an accurate reflection of the distribution of hospital use (see for example, MacStravic 20)). The California Office of Statewide Health Planning and Development (OSHPD) has developed standards for needed beds based upon a statistical model which results in needed beds estimates higher than the values which would result from the Poisson distribution. The OSHPD standards are intended for application to a health facilities planning area, and not an individual hospital.

EMPIRICAL ANALYSIS OF ACTUAL DISTRIBUTION OF ADC

Daily census values were collected for three years from the 18 study hospitals. In total, fifty-four years of data (3 x 18) were collected. For each year, the average daily census, the standard deviation, and frequency distribution were computed.

The actual frequency distributions were compared to a normal distribution specified with the empirical mean and standard deviation. The Kolmogorov-Smirnov one sample test was used to assess whether or not the actual distributions conformed to a normal distribution. 21) For all hospitals and years except one, the actual distribution was not significantly different from the normal distribution at the .01 significance level. We conclude that the distribution of average daily census values is a normal distribution.

Having established that the population is normal, we compared it to a Poisson normal distribution. We compared the actual variability (standard deviation) to the variability that would be associated with a Poisson normal distribution (i.e., standard deviation equal to $\sqrt{ADC}$). Figure 2 portrays the results for 1979. As shown in the figure, the observed variability (standard deviation) was always greater than the Poisson estimate. Similar results were obtained for 1977 and 1978. We conclude that a Poisson normal distribution does not fit the actual data, and would consistently underestimate the beds required to accomodate the peak periods actually observed in the data.


* Poisson Estimate
o Observed Standard Deviation
ADC
Standard Deviation
30
25
20
15
10
5
50
100
150
200
250
300
350
Average Daily Census
* 1979 Data Only--Similar Pattern Observed in 1977 and 1978

ESTIMATE OF NEEDED BEDS

We assumed that a turnaway probability of 5 percent (18 days a year) was appropriate for an individual hospital. Using this probability, needed beds were computed for each hospital for each year using the following formula:

Needed beds = ADC + 1.645 x standard deviation.

The 1.645 factor is an estimate of reserve capacity required so that patients are turned away one time out of twenty (5 percent). Table 2 summarizes the results for the study group.

Note that the occupancy standard implicit in the selection of a 5 percent turnaway probability ranges from 82 percent to 83.3 percent as ADC increases. This result is consistent with MacStravic's findings for clusters of hospitals 20) and slightly higher than the standard computed from OSHPD guidelines 19).

ESTIMATE OF EXCESS BEDS

The common computation for excess beds is: licensed beds - needed beds = excess beds. This computation ignores the fact that not all the beds on the license may in fact physically exist. It is not uncommon, particularly in older hospitals which have renovated their plant, to have space that was originally used for nursing units being currently used for some other purpose. Another situation is where a small multi-bed room is being used as a semi-private or private room. Hospitals make these adjustments in response to the demands and needs of patients, physicians, and employees. We will call beds on the license that do not physically exist "phantom" beds. Phantom beds are commonly included in the count of excess beds. If the hospital's license were changed, then these beds would not be counted. It is difficult to imagine what cost savings would accrue to the community solely as a result of a change in licensed beds. For this reason, we attempted to determine the number of phantom beds, so that they could be eliminated from the count of excess beds.

Management from each hospital in the study group was asked two questions:

- How many beds could you put into service within twenty-four hours without eliminating space currently being used for other productive purposes? (Assume sufficient staff would be available.)

- If the three hospitals closest to you closed over the weekend, how many patients could you take on Monday? (Assume sufficient staff would be available.)

TABLE 2

Estimate of Needed Beds for Study Group

Turnaway Probability = .05

Year	ADC	Needed Beds	Implicit Occupancy Standard
1977	2,211	2,694	82.0%
1978	2,302	2,787	82.6%
1979	2,401	2,883	83.2%

The point of these two questions was to determine the number of available beds at the hospital. The difference between this number and the number of licensed beds is considered to be phantom beds.

The available bed results obtained in this manner were basically consistent with available beds reported on the California Health Facilities disclosure report.

Table 3 presents a summary of findings for the three years 1977-1979. Table 4 presents a comparison to the conventional computation. Note that the average daily census is growing at approximately 4.3 percent per year. At that rate of compound growth, assuming an 83 percent occupancy standard, then needed beds would approximate available beds in 1985. Note also that the reserve beds component remains relatively constant over the three years.

True excess beds are going down as ADC increases. The average level over the three years was 18 percent. This amount is far lower than the 29 percent that would be developed with the conventional computation. 2 percent of the difference is accounted for in the use of an 82-83 percent occupancy standard, versus 85 percent. However, the majority of the difference is the 9 percent of the licensed beds which are phantom beds.

CONCLUSION

Analysis of actual average daily census data in the study group confirms that average daily census distributions are normal. Observed variability in the data exceeded the variability predicted from a Poisson-normal model. Use of Poisson models to estimate bed need will understate the true beds needed to accomodate the fluctuations in daily census.

Conventional computations of excess beds first compute needed beds as average daily census divided by an occupancy standard, and then subtract this amount from licensed beds. 85 percent is the current generally used standard.

Needed beds for the study group were determined using a 5 percent turnaway criteria for individual hospitals. The resulting occupancy standard was 82-83 percent. This result is consistent with the findings of MacStravic 20) and OSHPD guidelines 19).

In computing excess beds, beds not physically available were subtracted from licensed beds. The resulting available beds were compared to needed beds. The average level of excess beds was determined to be 18 percent of licensed beds. This amount is significantly smaller than the 29 percent figure arrived at through the conventional computation.

We conclude that there are a substantial number of excess beds in the study group, but the true level of excess beds is significantly below the result obtained through the conventional computation.

TABLE 3

Components of Bed Complement

1977-1979

	1977		1978		1979	
	Amount	Percent	Amount	Percent	Amount	Percent
Average daily census	2,211	58%	2,302	60%	2,401	63%
Reserve beds	483	12	485	13	482	13
Needed beds	2,694	70	2,787	73	2,883	75
Excess beds	816	21	683	18	635	17
Available beds	3,510	91	3,470	90	3,518	92
Phantom beds	328	9	368	10	320	8
Licensed beds	3,838	100%	3,838	100%	3,838	100%

TABLE 4

Comparison of Study Results to Conventional Computation

	Study Results 1977-1979 Average		Conventional Computation at 85% Occupancy	
	Amount	Percent	Amount	Percent
Average daily census	2,305	60%	2,305	60%
Reserve beds	483	13	407	11
Needed beds	2,788	73	2,712	71
Excess beds	711	18	1,126	29
Available beds	3,499	91	3,838	100
Phantom beds	339	9	0	0
Licensed beds	3,838	100%	3,838	100%

THE ROEMER EFFECT

The Roemer effect in essence states that patient days expand to fill the beds available. Hence in an area with a substantial number of excess beds, it would be expected that the relative use of hospital facilities would be higher than in areas without excess beds. One of the assumptions frequently used to project savings from reducing the bed supply is that reducing beds will curtail unneeded hospitalization that is assumed to take place in an overbedded area.

It is clear from our study that the study group and Orange County in general does have a substantial number of excess beds. If the Roemer effect is valid, then we would expect to see relatively higher utilization in Orange County relative to other areas in California and in the country.

It was not possible to develop use rates for the study group hospitals because the population served by these hospitals is the same population served by non-participating hospitals. However, a review of data published by the California Hospital Association disclosed the following use rates (patient days per thousand population) for 1976: 22)

Orange County	815.9
California	866.5
United States	1,204.3

Orange County is lower than the California average, and well below the national average. While not conclusive, these statistics do not support the idea that there was substantial overutilization of hospital facilities at a time where there were excess beds. It is not clear that the Roemer effect is valid, at least for Orange County.

VI. COST ESTIMATES

COMPUTATION OF COST OF EXCESS CAPACITY

Economic estimates of the cost of excess capacity generally proceed according to the following method:

- $\frac{\text{Excess beds}}{\text{Total beds}}$ = Percent excess capacity
- Percent excess capacity x fixed cost percent = percent savings from capacity reduction.

Computations of this type have resulted in savings estimates ranging from 12 percent to 16 percent of annual hospital expenditures.

ECONOMIC ESTIMATES

Central to the belief that excess beds are costly is the idea that hospitals have high fixed costs--costs which must be sustained at any level of activity. Estimates of the savings that would result from the reduction of capacity generally assume that entire hospitals are closed, and all of the fixed cost associated with operating the hospital is avoided.

The economic studies in the middle 1970's assumed that fixed costs represented over half of a hospital's total costs. The InterStudy report uses 50 percent as the estimate of fixed costs. 1) Zaretsky uses 60 percent in his 1977 study. 3)

These economic estimates of high fixed costs are based on econometric studies of the marginal cost/average cost (MC/AC) ratio. This ratio represents an estimate of the proportion of average cost that would be incurred to take care of an additional case or patient day. It is commonly interpreted as the proportion of costs which are variable. Hence 1 - (MC/AC) is taken to be the proportion of costs which are fixed.

Early values of the MC/AC ratio were developed by Lave and Lave in 1972. Their conclusion was that "marginal cost is between 40 and 65 percent of average cost." 5) Hence, if variable cost is 40 percent, fixed cost is 60 percent. This assumption was used by the Federal government in developing the Phase IV Economic Controls Program for hospitals and was also used in all the early estimates of excess capacity costs.

A number of other economic authors have studied this issue with widely varying results. Lipscomb, et al surveyed this work in 1978. 23) There was considerable variability in the estimates arrived at. The MC/AC ratio was estimated to range from 21 percent to 105 percent. This wide range makes the selection of an appropriate variable and fixed cost ratio for purposes of estimating savings from excess bed reductions a highly judgmental process. In a recent article by Schwartz and Joskow, 11) the

authors review the Lipscomb survey and conclude that 80 percent is a "best guess" of the marginal cost/average cost ratio. They point t that the amount could easily range from 60 percent to 90 percent. Using the related fixed cost proportion of 20 percent and a 7 percent capacity reduction, these authors conclude that the potential savings are slightly in excess of 1 percent of total hospital expenditures--a significantly lower result than previously estimated.

Although (1-MC/AC) is commonly used to estimate the proportion of costs which are fixed, and the savings that would result from a capacity reduction, there is a theoretical problem inherent in the use of this ratio. This problem has to do with the relevant range for making estimates. Lipscomb, et al point out that "the (MC/AC) ratios . . . are most reliable (in a predictive sense) for output levels in the neighborhood of the mean output levels, with which they were derived." 23) However, all authors acknowledge that the most significant savings would result from closing entire hospitals. 1)3) Although (1-MC/AC) may estimate the fixed cost proportion for a hospital at its average level of output. there is no assurance of the accuracy of this porportion if a hospital were to be closed down and have its output reduced to zero.

In summary, the economic estimates of the savings that would result from the reduction of capacity vary from a savings of 16 percent of expenditures associated with a 20 percent reduction in beds 1) to a savings of 1 percent of expenditures associated with a 7 percent reduction in beds. 11) This variability is a direct result of the assumptions employed for the MC/AC ratio and the complementary fixed cost ratio. In addition, there is some theoretical question as to the applicability of MC/AC ratios derived at mean levels of output to a situation where entire hospitals would go from mean output levels to zero output levels.

HOSPITAL INDUSTRY ESTIMATES

The contention that hospitals have very high fixed costs has been repeatedly denied by representatives of the hospital industry. In a report published in the Investor Owned Hospital Review in 1975, an estimate of 10 percent was put forward. 24) A financial executive for a major proprietary hospital chain was quoted in 1978 as saying, "The fixed costs of an empty bed in his corporation's hospitals are only 8.5 percent of the costs of a full bed." 25) The estimates provided by industry representatives are typically based upon the way a hospital classifies its costs.

Salaries, employee benefits, professional fees, supplies, and purchased services are typically classified as variable. Only interest and depreciation are viewed as "capacity" costs, in that they relate directly to the original acquisition of the assets. According to the California Health Facilities Commission, these costs accounted for approximately 5 percent of total hospital costs in Orange County during 1978. 4)

Critics of this approach point out that depreciation is based upon the historical cost, and understates the true cost of capacity in a replacement sense. They also point out that none of these are fixed costs in salaries, supplies, and purchased services (e.g., utilities) that are not included in the cost estimate.

POLICY ALTERNATIVES

In the 1976 InterStudy report, Walter McClure points out that "the savings produced by reducing excess hospital capacity could be substantial, but depend crucially on how it is done." 1) Four major alternatives have been identified: 1)3)11)

- Across-the-board bed reductions;
- Retiring services in individual hospitals;
- Closing entire institutions; and
- A moratorium on new construction (through a tight certificate of need program).

Virtually all authors agree that across-the-board bed reductions and retirement of individual services produce small savings. Hence, closing institutions or a moratorium on new construction seem to offer the potential for the greatest savings.

There are a number of problems associated with the policy of closing hospitals. In the first place, no agency of government is empowered to take this action. As the 1978 Health Guidelines point out, "Health Systems Agencies have no authority under Federal law to close existing hospitals or services, nor is the Federal government authorized to do so." 10)

Even if government regulators had the authority to close hospitals, it is unclear that it could be used. In a 1979 InterStudy report entitled Conversion and Other Policy Options to Reduce Excess Hospital Capacity, McClure and Kligman reported the results of 17 case studies. They conclude that "financial pressure, not planning pressure, appear to be the principal agent in retiring a hospital." They go on to state, "we suspect planners will have great difficulty acquiring authority to close hospitals on 'necessity' grounds, and even greater difficulty trying to exercise it if they do get it . . . Attempting to close an unnecessary hospital by delicensure in the absence of financial pressure violates the basic tenets of regulatory behavior." 26)

The remaining policy is a moratorium or set of controls over hospital construction/capital expenditures. It is asserted that this policy will ultimately result in the same savings that would be achievable through closure of hospitals. 1)3)11) This is in fact the policy that is being executed through the certificate of need laws in California and elsewhere. This policy is not directed at fixed costs, but at capital expenditures. It is felt that control over capital expenditures will limit the capacity costs of hospitals, where capacity costs are those

costs associated with the maintenance, replacement, or expansion of capital assets. Tight controls over capital expenditures and capacity costs are viewed as especially relevant in areas such as Orange County with substantial excess capacity, as measured by excess beds.

CONSUMER APPROACH

The cost analysis approach taken in this study was to determine what portion of the money actually paid by consumers was used to maintain, replace, expand, and pay off the debt on hospital plant assets. These costs are termed capacity costs, and are differentiated from the money paid by consumers for day-to-day operation of the hospital. Capacity costs are the costs which are the object of regulatory control. Essentially we were trying to test the assertion that a tight certificate of need program would result in substantial savings to the consumer, insurance companies, and government third-party payers. We have termed this approach the consumer approach, since it focuses on the money actually paid by consumers and insurors.

The starting point for this approach is annual hospital net revenue. This is the amount of money paid or payable to hospitals from consumers or insurors. Net revenue is then divided into two classifications: operating costs and capacity costs. Operating costs include the money spent to operate the hospital, except for the costs associated with the Housekeeping, Operation of Plant, and Maintenance of Plant cost centers. Increases to working capital constitutes an increase to operating costs. Working capital decreases reduce operating costs.

Capacity costs are monies expended or put aside to maintain, renovate, replace, or pay off debt on plant assets. Capacity funds include Housekeeping costs, Operation and Maintenance of Plant costs, interest and principal payments on long-term debt originally used to finance capital equipment, the equity portion of capital expenditures for renovation and replacement of capital assets, and the funding of reserves which will be used to finance future asset additions. To the extent that capacity costs were paid from sources other than net revenue from patients, (e.g., withdrawals from funded reserves or new long-term debt) these sources are subtracted from total capacity costs to arrive at the portion funded by net revenues from patients.

Capacity costs can be further subdivided into costs related to patient rooms (beds) and costs related to capacity for ancillary and support services. This division is accomplished either through specific identification of capacity costs to their purposes, or through an allocation based upon square feet.

Capacity costs can fluctuate from hospital to hospital and from year to year. For example, a major construction program will increase capacity costs for one year. The same hospital will have a much lower level of capacity costs the following year after the construction project is completed. In order to smooth out the fluctuations, totals for the study group and averages across three years are used.

In summary, the consumer approach is directed at identifying that portion of the money actually paid to hospitals by consumers that was used to maintain, renovate, replace, and pay off the debt on hospital plant assets. It is these same funds that are the object of certificate of need regulation.

ANALYSIS OF EMPIRICAL DATA

For each study group hospital for each year, CHFC financial statements were obtained and analyzed. Capacity costs were identified from the departmental income statement and the sources and applications of funds statement. Interviews were conducted with financial officers of each study group hospital to specifically identify capacity costs as bed-related or non-bed-related. Capacity cost and bed-capacity cost were divided by total available beds in order to determine per bed capacity costs. These per bed amounts were applied on a hospital by hospital basis to the estimated excess beds in order to arrive at the estimated cost of excess beds. These excess bed costs were aggregated for all hospitals.

Table 5 shows the total operating and capacity costs for the three years in the study. Table 6 shows the results of the apportionment of capacity costs between beds and other capacity.

The Estimated Cost of Excess Capacity appears in Table 7. These estimates were developed by apportioning capacity costs between the needed beds (at a 1 in 20 turnaway probability) and excess beds. Phantom beds were not included in the analysis. In this context, the proportion of excess beds to available beds is used as an estimate of excess capacity. Given the assumption that excess beds measure excess capacity, then Table 7 shows that an average 18 percent excess capacity condition cost the consumer 3.15 percent of his annual expenditures on hospital care. This amount approximates $8.60 per patient day, or $10,400 per excess bed per year.

Table 7 also shows the outcome when the study results are focused on beds *per se*. These estimates reflect an apportionment between bed related capacity funds and other capacity funds. Of the 3.15 percent excess capacity cost estimate, .75 percent related to beds and 2.4 percent related to other capacity. The excess bed cost averaged $3.03 per patient day and $3,640 per excess bed.

TABLE 5

Apportionment of Net Patient Revenue

(000's Omitted)

	1977	1978	1979
Net patient revenue	$291.508	$339,356	$392,222
Operating Costs			
Salaries, benefits, fees, supplies	$244,661	$290,058	$331,582
Income taxes	2,264	1,612	2,580
Increase in working capital	4,729	2,941	7,997
Increase in non-current assets related to operations	5,767	1,448	417
Less: Non-operating revenue related to operations	(1,333)	(1,967)	(1,717)
NET OPERATING COSTS	256,088	294,092	340,859
Capacity Costs			
Housekeeping and plant maintenance expenses (including utilities)	19,156	22,476	25,026
Purchase of property, plant, and equipment	30,245	12,419	22,008
Interest	7,998	8,305	9,991
Principal payments	6,920	3,357	3,196
Increase in assets designated for future acquisition of property	723	2,757	683
Increase (decrease) in non-current assets related to capacity	(996)	2,631	(771)
Less: Additional long-term debt	(26,989)	(3,640)	(3,653)
Non-operating revenue related to capacity	(1,637)	(3,041)	(5,117)
NET CAPACITY COSTS	35,420	45,264	51,363
TOTAL OPERATING AND CAPACITY COSTS	$291,508	$339.356	$392,222
Capacity Costs as Percent of Net Patient Revenue	12.2%	13.3%	13.1%

TABLE 6

Apportionment of Capacity Cost Between Beds and Other Capacity

(000's Omitted)

	1977	1978	1979
Bed capacity cost	$11,276	$11,807	$15,820
Other capacity cost	24,144	33,457	35,543
Total Capacity Cost	$35.420	$45,264	$51,363
Bed-capacity cost as percent of total	31.8%	26.1%	30.8%

TABLE 7

Estimated Cost of Excess Capacity

(000's Omitted)

	1977	1978	1979	Average
Net patient revenue	$291,508	$339,356	$397,222	
Excess beds	816	683	635	711
Patient days	807,015	840,230	876,365	841,203
Excess Capacity Cost				
Total excess capacity cost	$ 6,788	$ 7,290	$ 7,673	
Percent of net patient revenue	2.33%	2.15%	1.96%	2.15%
Per excess bed (in dollars)	8,319	10,674	12,085	$ 10,360
Per patient day	$8.41	$8.68	$8.76	$8.62
Excess Bed Capacity Cost				
Total excess bed capacity cost	$ 2,463	$ 2,393	$ 2,795	
Percent of net patient revenue	.84%	.71%	.71%	.75%
Per excess bed (in dollars)	3,018	3,504	4,402	$ 3,641
Per patient day	$3.05	$2.85	$3.19	$3.03

CONCLUSION

Economic estimates of the cost of excess beds/capacity range from a potential for a 16 percent savings associated with a 20 percent capacity reduction to a potential for a 12 percent savings associated with a 22 percent capacity reduction. These estimates rely heavily on an assumed proportion of fixed costs which exceeds half of total costs. Estimates of this fixed cost proportion are not consistent, and of questionable reliability for that reason. In addition, these estimates assume that entire hospitals are closed, presumably through government action. Hospital closure is a policy alternative that is neither legal nor likely to be particularly effective if it were legal.

The policy alternative that is in fact being executed is a tight certificate of need program. This program is alleged to have the same cost reduction potential as closure of hospitals. A certificate of need program focuses specifically on capital expenditures and more generally on the level of funds required to maintain, renovate, or replace capital assets.

Direct measurement of money actually paid to hospitals that went to maintain, renovate, replace, or provide for capital assets resulted in much lower estimates of potential savings. Over the three year study period, these capacity funds averaged 18.5 percent of hospital net revenue. During a time period when an excess beds/capacity condition of 18 percent prevailed, the costs associated with this excess amounted to only 3.2 percent of hospital expenditures. The costs associated with excess beds *per se* were only .76 percent of hospital expenditures.

We conclude that a tight certificate of need program will not yield savings that are even close to the 10-16 percent of expenditures estimates. They are directed at costs which *in total* account for less than 20 percent of hospital expenditures. Since a substantial majority of these capacity costs are for the purposes of maintaining and enhancing "non-excess" capacity, then potential savings must fall well below 5 percent.

We also conclude that the regulatory focus on beds *per se* is even less likely to yield significant results. Beds are not a good measure of capacity in the first place, and the funds to maintain beds *per se* are a trivial portion of the total.

Based upon the analysis presented in this paper, the basic assumption that excess beds are costly--an assumption which is at the foundation of current health planning law and regulation—is open to serious challenge. It is unclear that there are significant costs associated with excess capacity in Orange County hospitals. It is then equally unclear whether a policy directed at capacity control can ever succeed in impacting the costs of health care to the consumers of Orange County.

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Transition Briefing Memo 21

October 28, 1982

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. SPECIAL PLANS AND PROJECTS

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

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

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

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

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

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

April 11, 1983

Joe Josephson
Alaska State Senate
Pouch V
Juneau, Alaska 99811

Dear Senator Josephson:

As you consider Committee Substitute for Senate bill 85 "An act suspending the Certificate of Need program" we would hope that you would consider the following additional information.

Health care costs continue to rise at rates higher than other sectors of the economy. In the last federal fiscal year health care costs rose 11.4%, more than double the overall rate of inflation. Hospital costs rose 15.2%. The consumer price index for medical care for Anchorage rose 12.3% between January, 1981 and January, 1982.

The only cost containment provision that would remain on the books in Alaska if CSSB85 were to pass would be the prospective reimbursement section which addresses only Medicare reimbursement. The revenue sharing portion does reduce state funds for hospitals as well. However, there is nothing remaining to address hospital cost increases overall, no protection for the consumer.

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

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

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

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

Sincerely,

Margaret McClure Wilson

Margaret M. Wilson
Executive Director

MMW/ab

Enclosure

C. TOTAL PROPORTION OF OUTLIER PAYMENTS

Present law

No provision.

House bill

Under the House bill, the Secretary would be required to provide additional payments for outlier cases amounting to not less than 4 percent of total DRG related payments.

Senate amendment

Under the Senate amendment, the Secretary would be required to provide additional payments for outlier cases amounting to not less than 5 percent, and not more than 6 percent, of total projected or estimated DRG related payments.

Conference agreement

The conference agreement follows the Senate amendment.

5. CAPITAL EXPENSES

A. CAPITAL IN GENERAL

Present law

Under present law, medicare reimburses hospitals for the reasonable costs of capital (including depreciation, interest and rent).

House bill

Under the House bill, capital expenses, as defined by the Secretary, would be specifically excluded from the prospective payment proposal and would continue to be reimbursed on a reasonable cost basis.

Senate amendment

Under the Senate amendment, capital expenses, as defined by the Secretary, would be specifically excluded from the prospective payment system until October 1, 1986, during which time they would continue to be reimbursed on a reasonable cost basis. After October 1, 1986, such expenses would no longer be excluded.

Conference agreement

The conference agreement follows the Senate amendment. The managers intend that capital, as defined by the Secretary, includes return on equity. The managers also note that the Secretary is required to complete, within 18 months, a thorough review of the methods by which capital, including return on equity, can be incorporated into the prospective payment system. The managers expect that additional legislation will be enacted by Congress to deal with capital-related issues under the prospective payment system before October 1, 1986. However, if the Secretary has implemented a system of prospective payment for capital without legislative action and the mandatory section 1122 capital planning approval provision has gone into effect, the conferees intend that the Secretary

will adjust the prospective payment for capital to reflect a disapproval project under section 1122.

B. RETURN ON EQUITY

Present law

Under present law, medicare reimburses proprietary institutions a return on equity.

House bill

The House bill provides for the phase-out of return on equity for hospitals under the prospective payment system over the three-year transition period during which the cost-based payment is being phased out (75% in the first year, 50% in the second year and 25% in the third year). No payment for a return on equity would be made for cost reporting periods beginning on or after October 1, 1986.

Senate amendment

No provision.

Conference agreement

Under the conference agreement, effective with respect to cost reporting periods beginning on or after the date of enactment, the rate of return on equity will be reduced from one and one-half times to an amount equal to the rate of interest paid by the Federal Treasury on the assets of the Hospital Insurance Trust Fund.

C. NEW CAPITAL

Present law

No provision.

House bill

The House bill expresses the intent of Congress that, in implementing a system for including capital-related costs under a prospective payment system, costs related to capital projects initiated on or after March 1, 1983, may be distinguished and treated differently from projects initiated before such date.

Senate amendment

The Senate amendment expresses the intent of Congress that, in implementing a system for including capital-related costs under a prospective payment system, costs related to capital projects initiated on or after the effective date of the implementation of such system may or may not be distinguished and treated differently from projects initiated before such date.

Conference agreement

The conference agreement follows the Senate amendment. The managers believe no assurances can be given that, under a new system of paying for capital, projects obligated (as defined by regulations under section 1122) after the date of enactment of this legislation will continue to be paid on a reasonable cost basis.

D. SECTION 1122 CAPITAL APPROVAL

Present law

Under present law, the Secretary is authorized to exclude from reimbursement to providers certain costs related to capital expenditures that have been disapproved by a section 1122 planning agency.

House bill

Under the House bill, at the end of 3 years, medicare would not make payment for a new capital project unless the State had a section 1122 capital approval process and the capital expenditures had been recommended by the State under such mechanism.

Senate amendment

The Senate amendment changes for cost reporting periods prior to October 1, 1986: (1) the financing of reviews of capital projects from the Hospital Insurance Trust Fund to general revenues; (2) increases the amount of capital projects that is subject to the 1122 approval process from $100,000 to $600,000; (3) exempts from the review process expenditures made by or on behalf of a health care facility where 75 percent of the patients using the services of such facility are enrollees in HMO's or CMP's and such expenditures are for services and facilities needed by such organization to operate efficiently; and (4) requires hospitals to make their overall expenditure plans and capital budgets available to section 1122 agencies.

Conference agreement

The conference agreement follows the provision in the House bill with the following modification: the requirement that medicare payment for new capital projects be conditional on section 1122 approval would be effective October 1, 1986, only if no legislation were enacted by that date which includes capital-related costs in the prospective reimbursement system. In addition, effective upon enactment (1) the financing of reviews of capital projects would be made from general revenues; (2) the maximum threshold a State may use for determining which capital projects are subject to the section 1122 review process would be increased from $100,000 to $600,000; States would be permitted to set a lower threshold; (3) in order for a health care facility, where 75 percent of the patients are HMO or CMP enrollees, to be exempt from the section 1122 review process because needed services and facilities are not otherwise readily accessible, the organization must establish that one of the following five conditions is met:

(a) the facilities are geographically dispersed

(b) the facilities are not available under a contract of reasonable duration

(c) full and equal medical staff privileges are not available

(d) the arrangements are not administratively feasible, or

(e) the services are more costly than if provided by the HMO or CMP; and

PLEASE NOTE: THE FOLLOWING PAGES WERE TREATED AS A UNIT IN THE ORIGINAL DOCUMENT

alaska state hospital association

Dennis L. DeWitt
PRESIDENT

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

2/25/83

JOE -

This is the information on the Bed need increase we talked about

DENNIS

PROVIDENCE
HOSPITAL

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

SISTERS OF
PROVIDENCE

SERVING IN THE WEST SINCE 1856

February 24, 1983

TO: Dennis DeWitt

FROM: Kaaren Riehl

RE: Municipal Health Commission Meeting - February 23, 1983

Attached is the part of the minutes from the Joint Project Review Committee meeting of February 12, 1983, where both Providence Hospital and Humana Hospital Alaska applications were discussed concurrently and the recommendations were developed to approve both, since the bed need was higher than projected.

To update you further, the Anchorage Municipal Health Commission met on February 23, 1983, and acted on the four main motions from the Joint Project Review Committee meeting of the 12th in the following order:

Motion #4
Page 3

It was moved to approve the applications of Providence Hospital and Humana Hospital Alaska on the basis they have met all eleven (11) criteria and therefore are in fact approvable under Phase I.

Motion passed - unanimous

Motion #6
Page 4

To deny both applications on the basis that Lake Otis Hospital, as a viable operation, would satisfy all the identified bed needs for the Municipality of Anchorage.

Motion failed, 1 yes, 20 no

Motion #8
Page 5

Whereas the population growth in Anchorage has increased dramatically and appeared to be growing at a faster rate than assumption 2 in the Position Paper on acute care beds needs projects; and

Whereas it appears from other sources the population outside the Anchorage area is growing at a rate faster than the projected in assumption 7; and

Whereas the eligibility changes for service at public health hospitals in Alaska results in larger numbers seeking private health care; and

Whereas substantial planning time and facility disruption during construction should be minimized in hospitals; and

Whereas construction costs will probably be cheaper in 1983-85 than in 1990; and

Whereas constructed beds would only be staffed and open as community-wide utilization rates indicate a need;

Therefore the Committee provides for an increase in the identified bed need number, allowing an additional 14 beds to accommodate potential individuals recently declared ineligible for public health service, to total a base need of 620 in planning horizon 1995 and additionally allow a deviation factor of 16% to accommodate the uncertainties of planning for 1995 horizon.

16% = 99 beds
Total Now 719 beds

Motion passed, 13 yes, 8 no

Motion #5
Page 3

Whereas the bed population, and use projections do not consider Lake Otis Hospital, and

Whereas Lake Otis Hospital has not shown progress toward completion to the planning horizon 1995, and

Whereas population and use needs are in question, and

Whereas both current applicants have met all review criteria and have shown ability and resources to immediately proceed to meet the need identified,

Hereby move to recommend to the Municipal Health Commission and the South Central Health Planning and Development, Inc. *in order to avoid the risk of having insufficient beds in 1995*, that both applications of Providence Hospital and Humana Hospital Alaska be approved.

Motion passed, 17 yes, 4 no, with amendment in last paragraph in italics.

JOINT PROJECT REVIEW COMMITTEE
Summary Minutes
February 12, 1983
Step 11 of Phase I

The Chair reconvened the meeting at 1:30 p.m.

Chair, P. Gallagher asked the applicants and Committee if there were any objections to L. Korn participating in the discussion as outlined in Step 11, as he was not present during Providence Hospital's review on February 11th. No objections were made.

David Williams, staff member from the State Division of Health Planning and Development, was asked by the Chair to advise the Committee what his office will be looking for from the Phase I review. Mr. Williams indicated that all motions from this point on must be clearly stated, giving findings (reasons) which support each recommendation.

A. Review of Scope of Need Statements In Relationship to the Sum Total of the Applications

The Executive Director, Margaret Wilson, of the South Central Health Planning and Development, Inc. summarized (a) development of community bed need projections involved in the adopted local and regional Health Systems Plans, (b) the prescribed public review process, and (c) recent January, 1983, review and updating of the community bed need projections for acute care and development of bed need projections for inpatient rehabilitation. She noted that the position paper on acute care bed need projections for Anchorage, adopted 1/12/83 by the Health Commission did not vary significantly from the acute care bed need projections (as adopted by the Assembly) using a high-range population figure for Anchorage and factoring in for possible changes in Indian Health Service policy, and recent 1981 hospital utilization data. The planning horizon in the position paper is 1995.

attached

The Committee discussed, as reflected in the motions, the adopted community bed need projections and assumptions for acute care and rehabilitation, and rejected the following three motions aimed at increasing and modifying bed need projections:

(1) It was moved by R. Fain, seconded by D. Van Wieringen that the Jt. HSA/MHC Project Review Committees, given the lead time associated with actually opening a new bed in the community, the escalating cost of construction of new beds, and questions about the utilization of population groups such as natives, their non-native dependents, and the military, should adopt a more realistic planning horizon for the purposes of this review of the year 2000.

Roll call vote: S. Anderson, conflict; D. Bantz, no; L. Calhoon, no; K. Carpenter, no; R. Fain, yes; P. Gallagher no; L. Korn, yes; S. Lesko, no; S. Norrell, no; J. Sewell, no; J. Tanner, no; D. Van Wieringen, no; M. Wolfe, yes.

Motion failed: 3 yes, 9 no, 1 conflict

(2) It was moved by M. Wolfe, seconded by R. Fain to

Move the following action:

Whereas the population growth in Anchorage has increase dramatically and appeared to be growing at a faster rate than assumption 2 in the Position Paper on acute care bed needs projects; and

Whereas it appears from other sources the population outside the Anchorage area is growing at a rate faster than projected in assumption 7; and

Whereas the eligibility changes for service at public health hospitals in Alaska results in larger numbers seeking private health care; and

Whereas substantial planning time and facility disruption during construction should be minimized in hospitals; and

Whereas construction costs will probably be cheaper in 1983-85 than in 1990; and

Whereas constructed beds would only be staffed as utilization rate indicates a need;

Therefore the Committee provides for an increase in the identified bed need numbers, allowing an additional 13 beds to accomodate potential individuals recently declare ineligible for public health service, to total a base need of 619 in planning horizon 1995 and additionally allow a deviation factor of 15% to accomodate the uncertainties of planning for 1995 horizon.

Roll call vote: S. Anderson, conflict; D. Bantz, no; L. Calhoon, no; K. Carpenter, no; L. Charles, yes; R. Fain, yes; P. Gallagher, no; L. Korn, yes; S. Lesko, no; S. Norrell, no; J. Sewell, no; J. Tanner, no; D. Van Wieringen, yes; M. Wolfe, yes.

Motion failed: 5 yes, 8 no, 1 conflict

(3) It was moved by S. Norrell, seconded by D. Van Wieringe to increase the bed need estimates shown on the Table Section 5, under acute bed needs, by 20%, each figure.

Roll call vote: S. Anderson, conflict; D. Bantz, no; L. Calhoon, no; K. Carpenter, no; L. Charles, yes; R. Fain, yes; P. Gallagher, no; L. Korn, yes; S. Lesko, no; S. Norrell, yes; J. Sewell, no; J. Tanner, no; D. Van Wieringen, yes; M. Wolfe, no.

Motion failed: 5 yes, 8 no, 1 conflict

B. Consideration of Approvability of All Applications in Phase I

#1 (4) It was moved by M. Wolfe, seconded by R. Fain to approve the applications of Providence Hospital and Humana Hospital Alaska on the basis they have met all eleven (11) criteria and therefore are in fact approvable under Phase I.

Roll Call vote: S. Anderson, conflict; D. Bantz, yes; L. Calhoon, yes; K. Carpenter, yes; L. Charles, yes; R. Fain, yes; P. Gallagher, yes; L. Korn, yes; S. Lesko, yes; S. Norrell, yes; J. Sewell, yes; J. Tanner, yes; D. Van Wieringen, yes; M. Wolfe, yes.

Motion carried: 13 yes, 0 no, 1 conflict

C. If Appropriate, Consideration of Approving All Applications As Reviewed

#4 (5) It was moved by D. Van Wieringen, seconded by J. Sewell that

Whereas the bed population, and use projections do not consider Lake Otis Hospital, and

Whereas Lake Otis Hospital has not shown progress toward completion to the planning horizon 1995, and

Whereas population and use needs are in question, and

Whereas both current applicants have met all review criteria and have shown ability and resources to immediately proceed to meet the need identified,

Hereby move to recommend to the Municipal Health Commission and the South Central Health Planning and Development, Inc. that both applications of Providence Hospital and Humana Hospital Alaska be approved.

Discussion on the motion: Each applicant was asked whether their proposals could be modified to some lesser scope of service than proposed. Each applicant responded no, their proposals were based on the entire, integrated proposal.

The Chair noted that it would expect a second-scenario motion addressing Lake Otis Hospital's beds following roll call vote.

Roll call vote: S. Anderson, conflict; D. Bantz, no; L. Calhoon, yes; K. Carpenter, no; L. Charles, yes; R. Fain, no; P. Gallagher, no; L. Korn, yes; S. Lesko, yes; S. Norrell, no; J. Sewell, yes; J. Tanner, yes; D. Van Wieringen, yes; M. Wolfe, yes.

Motion carried: 8 yes, 5 no, 1 conflict

The second scenario motion was made by D. Van Wieringen, seconded by R. Fain

#2 (6) To deny both applications on the basis that Lake Otis Hospital, as a viable operation, would satisfy all of the identified bed needs for the Municipality of Anchorage.

Discussion:

- This motion was made t satisfy legal requirements; recommend defeating the motion.
- Staff reminded the Committee that it is incumbent on them to be absolutely clear on the rationale and findings that support the actions that have been taken.

Roll call vote: S. Anderson, conflict, D. Bantz, no; L. Calhoon, no; K. Carpenter, abstain; L. Charles, no; R. Fain, no; P. Gallagher, yes; L. Korn, no; S. Lesko, no; S. Norrell, no; J. Sewell, no; J. Tanner, no; D. Van Wieringen, no; M. Wolfe, no.

Motion failed: 1 yes, 11 no, 1 conflict, 1 abstention

D. Motion To Move All Applications To Phase II

(7) It was moved by K. Carpenter, seconded by R. Fain, that the proposals from Humana Hospital Alaska and Providence Hospital go to Phase II review because the services proposed collectively requested exceed community adopted bed need projections.

Roll call vote: S. Anderson, conflict; D. Bantz, yes; L. Calhoon, yes; K. Carpenter, yes; L. Charles, yes; R. Fain, yes; P. Gallagher, yes; L. Korn, no; S. Lesko, no; S. Norrell, yes; J. Sewell, no; J. Tanner, no; D. Van Wieringen, no; M. Wolfe, no.

Motion carried: 7 yes, 6 no, 1 conflict

The Chair declared that the Committee now had approved two conflicting motions, in that adopted community bed need was less than the number of beds requested, and called for clarification of the intent of Committee's actions.

(8) It was moved by M. Wolfe, seconded by L. Korn

To move the following action:

#3

Whereas the population growth in Anchorage has increased dramatically and appeared to be growing at a faster rate than assumption 2 in the Position Paper on acute care beds needs projects; and

Whereas it appears from other sources the population outside the Anchorage area is growing at a rate faster than the projected in assumption 7; and

Whereas the eligibility changes for service at public health hospitals in Alaska results in larger numbers seeking private health care; and

Whereas substantial planning time and facility disruption during construction should be minimized in hospitals; and

Whereas construction costs will probably be cheaper in 1983-85 than in 1990; and

Whereas constructed beds would only staffed and open as community-wide utilization rates indicates a need;

Therefore the Committee provides for an increase in the identified bed need numbers, allowing an additional 14 beds to accomodate potential individuals recently declared ineligible for public health service, to total a base need of 620 in planning horizon 1995 and additionally allow a deviation factor of 16% to accomodate the uncertainties of planning for 1995 horizon.

Discussion:

- Project Review Committee acts as advisory to the Municipal Health Commission and HSA Board, and has the right to consider and accept information which changes figures and projections.
- This review is dealing with feeling about the way Anchorage really is, which is more unpredictable than the rest of the country. There is no empirical way to prove this.
- Inappropriate for the Committee to use any bed projections other than those as adopted in the local and regional Health Systems Plans.
- The Committee was reminded that in order to alter, adjust, or modify adopted bed need projections that empirical justification is required.

- A deviation factor means plus or minus, and assigns some degree of error to give flexibility to planning.

Roll call vote: S. Anderson, conflict; D. Bantz, no; L. Calhoon, yes; K. Carpenter, no; L. Charles, yes; R. Fain, no; P. Gallagher, no; L. Korn, yes; S. Lesko, no; S. Norrell, yes; J. Sewell, no; J. Tanner, yes; D. Van Wieringen, yes; M. Wolfe, yes.

Motion carried: 7 yes, 6 no, 1 conflict

(9) It was moved by L. Calhoon, seconded by D. Van Wieringen to reconsider the motion (#7) to move into Phase II.

Voice vote: Motion carried

(10) It was moved by L. Calhoon, seconded by D. Van Wieringen that the proposal from Humana Hospital Alaska and Providence Hospital go to Phase II review because the services proposed collectively requested exceed community adopted bed need projections.

Roll call vote: S. Anderson, conflict; D. Bantz, no; L. Calhoon, no; K. Carpenter, yes; L. Charles, no; R. Fain, yes; P. Gallagher, no; L. Korn, no; S. Lesko, no; S. Norrell, no; J. Sewell, no; J. Tanner, no; D. Van Wieringen, no; M. Wolfe, no.

Motion failed: 2 yes, 11 no, 1 conflict

(11) Move to adjourn was made by L. Korn, seconded by R. Fain

Roll call vote: S. Anderson, conflict; D. Bantz, yes; L. Calhoon, yes; K. Carpenter, yes; L. Charles, no; R. Fain, yes; P. Gallagher, no; L. Korn, yes; S. Lesko, no; S. Norrell, no; J. Sewell, no; J. Tanner, yes; D. Van Wieringen, no; M. Wolfe, no.

Motion failed: 6 yes, 7 no, 1 conflict

The Committee suggested that the Chair/Vice Chair write a formal finding of fact to be sent to the Municipal Health Commission and the Health Systems Agency.

The Chair indicated this be taken under advisement.

It was moved by R. Fain, seconded by D. Bantz, that the meeting be adjourned.

Voice vote: motion carried

The meeting was adjourned at 4:30 p.m.

A POSITION PAPER

A REPORT ON ACUTE CARE

BED NEED PROJECTIONS

FOR ANCHORAGE

MHC Fwd 4/14/83

Acute care bed need projections for civilian, non-Native hospital services in Anchorage are included in the South Central Health Planning and Development (SCHPD) Health Systems Plan 1982-1986 and the Anchorage Health Systems Plan 1982-84 (herein referred to as the Plans). The methodology, assumptions, and analyses in both documents was developed jointly by SCHPD and Municipal Health Commission (MHC) staff.

Assumptions Underlying Community Bed Need Projections

The assumptions underlying the projections contained in the planning documents include:

1. Population distributions by age for the Municipality (excluding military) are assumed to be appropriate for the civilian non-Native (CNN) population in Anchorage.

2. The official Municipal 1985 projected total population is 231,000. The assumptions used to support this projected figure are viewed by experts to be optimistic. Therefore, this 1985 figure is likely to be high. Projections based upon a lower range of population growth are available in the SCHPD 1982 Health Systems Plan.

3. Age categories will remain approximately the same through 2000. Figures assume that the slowly increasing average age of the population will not significantly affect the use of Anchorage hospitals for the study period.

4. The availability of 80 to 100 skilled nursing beds in the Anchorage Pioneer Home will allow growing numbers with chronic conditions to have access to a skilled and/or intermediate level of care (Nakoyia's beds will likely come open as eligible patients transfer to the Pioneer Home).

5. There will be no major change in the array of services (beds) at Elmendorf Air Force Base Hospital and no substantial change in policy with respect to military use of private sector facilities.

6. Native use of private sector services may be effected by some changes in federal budgetary restraints, which effect other PHS facilities outside Anchorage (Bethel, Bristol Bay).

7. The population outside Anchorage will continue to increase at approximately the same annual rate which is lower (less than 3.0%) than the rate for the Anchorage area (greater than 3.0%). The same proportion of Alaskans will continue to use health services outside Alaska.

8. The non-Anchorage patient days may be effected by the new or expanded services of non-Anchorage facilities, such as in Palmer, Soldotna, Homer, Cordova.

9. It is possible that length-of-stay will increase in medical/surgical services or pediatrics. As more routine surgeries, typically requiring a shorter stay, are done on an outpatient basis, average acute length-of-stay might increase. Obstetric use rates will probably not increase, and may decline with increased use of alternative birthing opportunities. However, the addition of a neonatologist, more non-Anchorage high risk obstetric cases may by treated in Anchorage.

10. References to existing beds in projections refers to those acute care hospital beds in private facilities (Providence and Humana Hospital Alaska) that are officially licensed as such by the State of Alaska, as of the date of this paper (December 1982). (Providence 250 and Humana 199.) Note: Humana Hospital Alaska has 199 licensed acute beds and intends to request that the 21 beds currently used for the Chemical Dependency Unit (CDU) be used as general acute care when needed. Assuming that conversion, the community supply of licensed acute care beds would then be 250 plus 199 to equal 449 beds.

Table I: Comparison of Community Bed Need Projections 1985-1995

A summary of the analysis included in the plans is included in the first column of Table I. Figures are expressed as ranges due to the use of different population projections used in the SCHPD(HSA) and MHC planning process. Throughout this paper the lower figures in the left are from the SCHPD Plan and the higher figures on the right are from the MHC plan (see SCHPD plan for details).

The bed need projections in the plans were based on 1980 utilization data from Providence and Humana Hospitals. In order to determine how more recent information might affect the projections, staff obtained 1981 utilization and population data and re-calculated the bed projections. Utilization and patient origin data for 1981 were obtained from both hospitals. Results of the calculations are shown in the second column of Table I.

Table I also includes projections of community bed need contained in the most recent Certificate of Need applications submitted by Providence Hospital and Humana Hospital Alaska. Humana projected community bed need to 1985 and 1990. Providence estimated community bed need for 1995. Summaries of the projections contained in those applications are included in Table I.

There is discrepancy between projections for medial/surgical and ICU/PCU/CCU as shown in SCHPD/MHC plans and the Providence application. This reflects the difference in actual use of those beds as compared to optimum use, or that which would have occurred had space in the appropriate type of bed been available. For example, patients needing a general medical/surgical bed might have had to stay longer than necessary in a PCU or ICU bed because the medical/surgical beds were full. The net result of this situation would be an increase in the apparent demand for PCU beds. When calculating patient days by service the PCU days would be higher than under optimum conditions of available medical/surgical beds. Hospitals adjust for this phenomena through a House Convenience Report which shows where patients are actually placed and where they should have been placed under optimum circumstances.

SCHPD & MHC staff did not have access to the house convenience data for use in the plans. However, the medical-surgical subtotal projections are consistent, and are perhaps more useful than the specific service projections for ICU/CCU, PCU and medical-surgical beds.

TABLE I
COMPARISON OF COMMUNITY ACUTE CARE BED NEED PROJECTIONS 1985 - 1995

Service	HSA/MHC Plans[1]	HSA/MHC 1981 Data Update[2]	Providence C/N Application June 82	Humana C/N Application October 82
Medical/Surgical[3]				
Anchorage Use Rate - 1980/Proj.	491	459	561/586	491
Projected Anchorage Use	76.2%	74.5%	75.9%	76.2%
Population - Anchorage CNN				
1985	118,642/141,312	Same as in Plans	-	141,312
1990	135,045/151,132	Same as in Plans	-	151,132
1995	- /168,797	Same as in Plans	172,077	-
Community Bed Need				
1985	247/294	236/281	-	293
1990	281/314	268/300	-	314
1995	- /351	- /336	376[4]	-
ICU/CCU				
Anchorage Use Rate - 1980 Proj.	54	52	-	54
Projected Anchorage Use	76.2%	74.5%	-	76.2%
Community Bed Need				
1985	39/46	38/45	-	47
1990	44/49	43/48	-	48
1995	-/55	-/54	42[5]	-
PCU				
Anchorage Use Rate - 1980 Proj.	52	50	-	52
Projected Anchorage Use	76.2%	74.5%	-	72.2%
Community Bed Need				
1985	30/37	29/34	-	35
1990	34/39	33/37	-	39
1995	-/44	-/41	37[5]	-

COMPARISON OF COMMUNITY ACUTE CARE BED NEED PROJECTIONS 1985 - 1995

Service	HSA/MHC Plans[1]	HSA/MHC 1981 Data Update[2]	Providence C/N Application June 82	Humana C/N Application October 82
Medical/Surgical Subtotal				
1985	316/377	303/360	-	375
1990	359/402	344/385	-	401
1995	-/450	-/431	455[5]	-
Obstetrics				
Anchorage Use Rate - 1980/Proj.	226	259[13]	216/216	/226
Projected Anchorage Use	90.1%	87.0%	91.6%[6]	90%
Population				
1985	42,768/50,940	Same as in Plans	-	50,940
1990	48,681/54,480	Same as in Plans	-	
1995	- /60,848	Same as in Plans	59,753	-
Community Bed Need				
1985	40/47	46/55[13]	-	47
1990	45/50	53/59[13]	-	50
1995	-/56	-/66[13]	52-53[17]	-
Pediatrics				
Anchorage Use Rate - 1980/Proj.	134	132	140	172
Projected Anchorage Use	78.2%	78.3%[14]	79.2%[6]	78.2%
Population				
1985	39,758/47,355	Same as in Plans	-	47,355
1990	45,253/50,646	Same as in Plans	-	50,646
1995	- /56,566	Same as in Plans	58,095	-
Community Bed Need				
1985	29/35	29/34	-	34
1990	33/37	33/36	-	37
1995	- /41	-/41	43-44[11]	-

Table 1 Con't

COMPARISON OF COMMUNITY ACUTE CARE BED NEED PROJECTIONS 1985 - 1995

Service	HSA/MHC Plans[1]	HSA/MHC 1981 Data Update[2]	Providence C/N Application June 82	Humana C/N Application October 82
Thermal				
Anchorage Use Rate - 1980/Proj.	10	11	4[9]	-
Projected Anchorage Use	76.2%	73.7%[11]	-	-
Population	Same as Med/Surg			
Community Bed Need				
1985	9/10	11/12	-	-
1990	10/11	12/13	-	-
1995	-/12	-/14	13	-
Psychiatry				
Anchorage Use Rate - 1980/Proj.	24	27	29.1	-
Projected Anchorage Use	83.1%	83.1%	86.8%[10]	-
Population	Same as Med/Surg			
Community Bed Need				
1985	12/13	13/15	-	-
1990	13/14	14/16	-	-
1995	-/16	-/18	19	-
ACUTE CARE TOTAL[12]				
1985	406/482	403/476[13]	-	464
1990	460/514	456/509[13]	-	496
1995	-/575	-/570[13]	583	-
Neonatal Intensive Care				
Use Rate	470		474	
Live Births				
1985	11,435		-	
1990	13,779		-	
1995	-		16,604	
Community NICU Bed/Need				
1985	30		-	
1990	36		-	
1995	-		43	

Table I Con't

Footnotes to Table I

1. SCHPD Health Systems Plan 1982-86; Anchorage Health Systems Plan, 1982-84.

2. Application of acute care bed need projection methods, as used in the plans, adjusted for 1981 hospital utilization data and 1981 population figures. The following tables include utilization and population data used for calculations in the update column.

1981 Population Data	
Total	187,761
Native	9,876
Military	
Active	11,210
Dependent	16,061
Civilian Non-Native	150,614
Women 15-44 (27%)	40,666
Adults (14+)(74.9%)	112,810
Children (25.1%)	37,804

Source: MOA Community Planning Department

1981 Patient Days and Percent Occupancy

	Providence Patient Days[a]	%Occ	Humana Patient Days[b]	%Occ	Optimum Occupancy[c]
Medical/Surgical	59,773	90.0	23,646	39.7	85%
M/S	47,276	93.8	21,962	39.6	85%
ICU/CCU	5,096	69.8	2,684	40.8	60%
PCU	7,401	92.1	---	--	75%
Obstetrics	4,827	50.8	4,463	81.5	75%
Pediatrics	3,480	52.9	2,591	50.7	65%
Psychiatry	3,586	65.4	---	--	85%
Thermal	1,592	39.6	---	--	50%
Total	72,658	79.6	31,700	43.6	80%

Note: 1. Occupancies calculated using Providence 250 licensed beds, Humana 199 C/N'd beds (See Assumption #10).
2. Humana M/S Occupancy does not include CDU patient days.
3. If assume proportion of L&D days to patient days in HHA are same as in Providence (21.8%), could deduct 973 from OB days to yield 3,490 patient days at 63.7% occupancy of HHA's 15 OB beds.

Sources: [a] Providence Hospital C/N application, p. 114
[b] Humana Hospital Alaska C/N application, p. 58
[c] SCHPD and MIC Plans

Anchorage Patient Days Compared to Total Patient Days for Providence, Humana and the Community in 1981

Service	Providence		Humana		Community		
	Anch.	Total	Anch.	Total	Anch.	Total	%
Med-Surg.	43,122	60,323	19,556	23,808	62,678	84,131	74.5
OB	5,982[1]	7,065[1]	4,509	5,026	10,521	12,091	87.0
Ped	3,912	5,500[2]	2,437	2,880	6,349	8,380	75.8

[1] Labor and delivery day total of 1054 days added to total: 84% (Prov. OB% from Anch. added to Anchorage day total).
[2] Previous total received from Providence for pediatrics was 3,480; the higher figures (3912/5500) include NSCN which cannot be broken out from Peds.

3. Includes orthopedics.

4. See p. 120 of Providence C/N aplication dated June 1982, (Anch. CNN patient days for 1995 divided by total patient days).

5. See p. 194 of Providence C/N aplication (HHA existing beds plus Providence 1995 forecast).

6. See p. 127, p. 130 of Providence C/N (Anchorage CNN patient days forecast for 1995 divided by total patient days).

7. See p. 130 of Providence C/N total patient days (then divide by 365 to get average daily census, and by minimum occupancy of 65%). Alternative method: see p. 194 (HHA beds + Providence 1995 forecast).

8. See p. 127 of Providence C/N, total patient days (then divide by 365 to get average daily census, and by minimum occupancy of 75%).

9. Use rate based on state population.

10. See p. 134 of Providence C/N (Anch. CNN patient days divided by total).

11. Providence medical/surgical Anchorage use rate was used rather than a community-wide proportion.

12. Excluding chemical dependency service at Humana.

13. Use includes labor and delivery days for both hospitals as Humana was unable to separate their labor and delivery days out from OB patient days. Total projections

then include labor and delivery beds which are not included in a total bed count nor as licensed beds.

14. Unable to redo with 1981 patient origin data since Providence Hospital has some NSCN days in pediatric days. (Total in patient origin information provided were not consistent with pediatric service totals.)

Table II: Comparison of Bed Need Projections with Existing Supply of Acute Care Beds

Table II capsulizes the information obtained in Table I and compares the projections completed by the planning agencies (SCHPD and MHC) with current built bed capacity.

The data from the table show that there are currently 449 acute care beds built and/or licensed (250 at Providence and 199 at Humana).

Projections of communitywide need for beds in 1985 ranges from 403 to 432 beds depending on population figures, use rates and methodologies used. Neither Providence's nor Humana's proposed additional beds would be available for use by 1985.

Projections of community need for beds in 1990 range from 456 to 514 beds. By 1990 the combined total of additional beds proposed through Providence's and Humana's C/N's would be 243 (Providence, 150; Humana, 93). The addition of those 243 beds to the existing 449 beds would yield a supply of 692 beds. This level of supply would exceed the projected communitywide demand by 178 to 236 beds.

Projections of community need for beds in 1995 range from 570 to 583 beds. Assuming the addition of 243 proposed new beds (Providence, 150; Humana, 93), to the community, there would still be an excess of 109 to 122 beds beyond demand.

Please note that the derivation of projections of communitywide acute bed need, from the plans or in the 1981 update, does not include consideration of need for inpatient acute rehabilitation beds. However, both C/N proposals of 150 and 93 beds respectively, each include a 20 bed inpatient rehabilitation unit. Therefore, a more accurate comparison of need to proposed supply could be achieved by deducting 20 beds from each hospital's total proposed number, i.e. from 150 to 130 for Providence, and from 93 to 73 for Humana.

TABLE II

COMPARISON OF BED NEED PROJECTIONS WITH EXISTING SUPPLY OF ACUTE CARE BEDS

Service	Existing Acute Beds			Community Bed Need Projections						Beds Proposed Beyond Existing	
				Plans		'81 Update					
	Providence	Humana	Total	HSA	MIC	HSA	MIC	Providence C/N	Humana C/N	Providence C/N	Humana C/N
Medical/Surgical	138	152	290								
1985				247	294	238	281	—	293		
1990				281	314	268	300	—	314	88	31
1995				-	351	-	336	376	—		
ICU/CCU	20	18	38								
1985				39	46	38	45	—	47		
1990				44	49	41	48	—	48	8	10
1995				-	55	-	54	42	—		
ICU	22	—	22								
1985				30	37	29	34	—	35		
1990				34	39	31	37	—	39	6	10
1995				-	44	-	41	37	—		
Obstetrics	26	15	41					—	34		
1985				40	47	46	55	—	34		
1990				49	50	51	59	—	58	12	17
1995				-	56	-	66	52-53	--		
Pediatrics	18	14	32					—	34		
1985				29	35	29	34	—	34		
1990				33	37	33	36	—	37	10	5
1995				-	41	-	41	43-44	—		
Thermal	11	—	11								
1985				9	10	11	12	—	—		
1990				10	11	12	13	—	—	1	
1995				-	12	-	14	13	—		
Psychiatry	15	—	15								
1985				12	13	13	15	--	—		
1990				13	14	14	16	—	—	5	
1995				-	16	-	18	19	—		
TOTAL	250	199	449								
1985				400	482	407	476	—	464		
1990				466	514	456	509	—	496		73
1995				-	575	-	570	583	-	130	
Plus Proposed Inpatient Rehabilitation Beds										20	20
TOTAL PROPOSED ADDITIONS										150	93

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The net result of that adjustment would yield the following comparisons:

	Communitywide Need (Range)	Additional Beds Proposed			Community Bed Supply w/Additions of all Proposed Beds
1985	403 to 482	Proposed beds not available yet			449
		Prov	HHA	Total	
1990	456 to 514	130	73	203	652
1995	570 to 583	130	73	203	652

Therefore, if all beds proposed by Providence (130) and Humana (73) (excluding temporarily the proposed rehabilitation beds) were added to the current community bed supply the comparison of need to supply would be as shown below:

	Communitywide Need (Range)	Supply	Supply Status (Range)
1985	403 to 482	449	excess of 46 to deficit of 33 beds
1990	456 to 514	652	excess of 138 to 196 beds
1995	570 to 583	652	excess of 69 to 82 beds

OTHER CONSIDERATIONS

An important factor is the use of a specific planning horizon. Though projections of bed need are estimated for specified years, it is recognized that services cannot practically be added in small increments. Therefore, beds are planned for and built before all will be used to full capacity. While facilities typically project need for a period three years beyond anticipated opening of a service, a longer horizon might be considered. The impact of improved technology and fluctuations in population numbers and characteristics can significantly alter the trends on which projection assumptions are drawn. Given construction timetables and a usual 3-year post start-up planning horizon, a 1990 projection would be appropriate at a minimum. Taking into account the unknowns with regard to the population of the Municipality of Anchorage and Alaska, as well as the additional factors cited above, a 1995 projection may be the more prudent. The adoption of a specific planning horizon by the Plan Development Committees of the HSA and MHC, would constitute an addition to the assumptions which underly the projections (See page 1).

An additional consideration in the determination of future need for acute care beds, is the presence of 125 general acute care beds, considered by the State to be existing by virtue of a grandfathered C/N held by Lake Otis Hospital, Inc.

In order to show the impact of those 125 beds on the local need and supply status one must recognize that those 125 beds are not yet built. It typically takes about three years to build and open hospital beds. If one assumed construction to begin in early 1983, it would be at least 1986 before the beds would be open and available for use. (As of this time LOH has not indicated when those beds would be open and available.) Therefore, the comparison of needs and supply, not considering the beds proposed by Providence and Humana, would be as shown below:

Community Need (Range)		Bed Supply	Supply Status
1985	403 to 482	449	excess of 46 to deficit of 33 beds
1990	456 to 514	574	excess of 60 to 118 beds
1995	570 to 583	574	excess of 23 to deficit of 4 beds

NOTE: MHC need figures from the 1982-84 HSP are:

	Beds Needed
1985	482
1990	514
1995	575

If MHC:PDC were to use their HSP need figures only, the Bed Supply Status would be:

1985	deficit of 33 beds
1990	excess of 60 beds
1995	deficit of 4 bed

SUMMARY

In summary, by 1985 the Anchorage community may experience either a small excess (46 beds) or an even smaller deficit (33 beds), of hospital beds depending on the assumptions and figures used for projecting need. By 1990, assuming the approved 125 LOH beds are built and opened, the community may experience an excess of beds ranging from 60 to 118, again depending on projection methodologies used. By 1995, with 125 LOH beds in place, there may be either an excess of 23 beds or a small deficit of 4 beds.

If one considers the supply not to include LOH, then the resultant need for beds will vary depending on the number of beds contributed to the supply through either or both the Providence and/or Humana proposals.

Therefore, it appears that the ability of the health care system to meet projected demand for acute care beds between 1985 and 1995 is largely dependent upon (1) the date by which and the specific type of beds Lake Otis Hospital will open within the 125 bed facility, or (2) the ability of other providers to somehow meet the community's needs.

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PLEASE NOTE: THE PRECEDING PAGES WERE TREATED AS A UNIT IN THE ORIGINAL DOCUMENT.

BRIEFING PAPER
PROSPECTIVE PAYMENT VS. RETROSPECTIVE REIMBURSEMENT

I. General Overview

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

Prospective payment, on the other hand, provides for establishment of the payment rate prior to the fiscal year, and the facility must operate and provide care at this predetermined rate.

The retrospective approach is advantageous to providers in that reimbursement for their allowable costs of operation is assured. This is a fundamental weakness of retrospective systems as it is completely devoid of incentives for efficiency and cost control. This method provides no incentives for control over staffing levels, equipment purchases, wage increases, service expansion, etc.

II. Problems with Retrospective Cost-Based Reimbursement Systems

- Tendency toward ineffective cost containment -- The key problem with a retrospective system is the lack of incentives to control expenditures so that unnecessary costs are not incurred.

- Dependence upon auditing and monitoring procedures -- A retrospective cost-based reimbursement system must have a tight, effective auditing system to monitor numerous categories of reported costs and statistical information, and auditing procedures must be constantly analyzed and up-dated. This is crucial to curb the inherent abuses of the system, but is very costly, complex and time-consuming.

- Tendency of the system to become static and inflexible -- Decisions are often made by accountants based on "generally acceptable accounting principles" rather than on the merits of each individual situation.

- Providers incur costs that are non-allowable but do not realize this until the fiscal year is complete and final cost reports are reviewed by the Department.

- Uncertainty of the program costs until the fiscal year is well over -- Final cost figures may not be known to the State until 6 months after a fiscal year ends.

- Cost Shifting occurs to the extent that unallowable costs under Medicaid are borne by other payors (insurance and private payors).

III. Advantages of a Prospective Payment System

- Based on the principle that predetermined rates will result in lower costs.
- Predictability of costs to the State.
- Predictability of revenues to the facilities.
- The technique encourages development of more sophisticated budgeting and cost monitoring capabilities, which are desirable management tools. The State is able to see how a facilities' budget is built and discuss the assumptions in each of the major cost categories.

IV. Disadvantages of a Prospective Payment System

- A potential disadvantage of the prospective determination of rates is that the staff time and other resources required for administration of the system are generally greater than those of a retrospective system. However, administrative costs vary greatly according to the design of the system, and as such, this factor is not necessarily of significant concern.
- ~~Artificial~~ Arbitrary (Caps, freezes, Lids etc) cost limiters may be introduced into the prospective system to balance costs versus revenues. This eventually places hospitals and nursing homes in a no win situation since the rates do not fairly reflect efficiently run facilities' costs.
- If rates are not applied industry wide, cost shifting can still occur if Medicaid rates are set unrealistically low by the State.

V. Operation of a Prospective Payment System

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

A common element of a prospective rate payment setting mechanism is an allowable rate of increase in per diem cost for the following year. This percentage is normally calculated through application of economic indicates such as U.S. Department of Labor wholesale and consumer price

indexes. The percentage is then routinely applied to actual cost from the previous period to arrive at the prospective rate. Determination of allowable rates of increase can be undertaken for individual facilities or groups of facilities.

Another aspect of a prospective payment system is the degree of specificity in the use of cost categories and associated economic indicators combined with uniform reporting costs to the State. A breakdown of total cost into components presumably increases the accuracy of inflation forecasts. An obvious breakdown would be labor/non-labor and further categorization is possible within these areas. The advanced example which follows uses "natural" expense categories in contrast to cost centers normally found in facility accounting.

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

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

Some level of categorization is necessary to assure accuracy of prediction. While an approach such as that outlined above may be elected, it should be stressed that a requirement for facilities to prepare both historical and budget costs in this fashion requires a significant level of accounting time and expertise. The compromise approach shown below may often suffice:

- Salaries and fringe benefits

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

There is precedent either to include or exclude "cost settlement" in a prospective payment system. The justification for cost settlement is that factors beyond the control of hospitals and nursing homes may adversely influence costs in relation to the prospective rate. These factors include changes in the general level of inflation, natural disasters and loss of patient volume. The major argument against allowing adjustment is that it may return the burden of cost increases possibly caused by poor management or budget procedures to the third-party payor, which is counter to the original objective of the

prospective payment concept. This matter has to be addressed by each state; however, an automatic adjustment is not recommended. Any adjustment mechanism should require written appeals, and defined criteria should be published as to the conditions under which an appeal will be considered.

VI. State Reimbursement Trends

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

VII. Why Alaska Needs Prospective Payment Now

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

In any period, total spending is always a function of, 1) the number of recipients, 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.

These three factors (recipients, volume, and unit price) need to be considered collectively in any fiscal year.

Breakdown of FY84 Total Spending Increase

- Unit Price
- Increased Eligibles
- Services Utilization

_____ %

This clearly presents a serious problem in a retrospective environment as critical decisions concerning eligible populations, service coverages and unit price are handled independent of each other and do not produce a final cost figure until the fiscal year is past. If total spending is to be contained at a level below 20%, these choices must be made before each fiscal year starts.

- Federal funding for Medicaid is being reduced for FY84 and later years. The State is facing an estimated 4 to 5 million dollar cutback in federal funding for FY84. Absent additional funding to replace these lost federal revenues, critical decisions need to be made prospectively to bring program spending in line with available resources.

- Prospective Payment System cause decisions relating to unit price to be made before a fiscal year starts. A consensus is now developing that prospective rate setting is effective in lowering the rate of increase in hospital spending by several percentage points a year--at least in mature rate-setting programs, after an initial start-up periodof ___ years, after which the State can expect to see some minor savings. However, prospective payment will not eliminate the shortfall in medical spending for FY84 as the size of the projected shortfall is far larger than a 1 or 2% savings can offset. Rather, prospective reimbursement will force critical decisions governing eligible populations, service coverages and unit price to be resolved in the Legislative process in advance of each fiscal year. It 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 as competitive or cost-efficient as that possible in urban areas such as Anchorage and Fairbanks.

- The Legislature must specifically approve adoption of prospective payments in Alaska. The Alaska Attorney General has ruled that present Alaska Statutes preclude adoption of a prospective payment system. This leaves the Department in the position of needing either, 1) specific legislative approval to replace diminishing federal resources, or 2) specific approval to adopt a prospective payment system and specific guidance as to the resources available for medical care in FY84, or 3) Governor's guidance in how to impose a $4-5 million reduction in medical coverage and rates of payment in FY84. The Department may not adopt prospective payments until the Legislature specifically endorses this change in hospital and nursing home payment system.

Alaska State Legislature

Senate

Committee on Finance

September 12,1983

Senator Joe Josephson
921 West Sixth Ave, Rm 230
Anchorage, Alaska 99501

Health Care Facility
CERTIFICATE OF NEED PROGRAM

Dear Joe,

The health care facilities Certificate of Need Program study, as authorized by Senate Resolve 2, is now in the process of announcing public hearings on the subject.

Your name has been obtained from an assortment of materials which have been collected from the various legislators who have taken an active role in the State's Certificate of Need Program. Because of your past involvement with the CON process you may wish to continue your efforts and may be interested in participating in any of the following hearings:

September 22, 1983 - 2pm in Juneau - State Capitol Building - Butrovich Room

October 18, 1983 - 2pm in Fairbanks - Fairbanks Memorial Hospital - Eva McGown Room

November 3, 1983 - 2pm in Anchorage - Legislative Information Office - 1016 Sixth Avenue

If you are unable to attend any of the hearings but would still like to contribute input to the CON study, please do not hesitate to contact my office by phone (452-7624) or by writing (315 Barnette Street, Suite 103, Fairbanks, Alaska 99701).

Best Regards,

Senator Don Bennett

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DRAFT

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

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 regardng 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 4/13/82)

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 1/19/82)

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)

ALPHA CENTERPIECE NOVEMBER-DECEMBER 1982
A report on health policy issues

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SETTING AFFORDABLE LIMITS ON CAPITAL EXPENDITURES

A fundamental issue in any discussion of health care costs is the increasing demand for capital investment in the hospital industry. Projections of the need for hospital capital in the decade of the 1980s range from $80 billion to close to $200 billion. For the hospitals a major concern is how to gain access to the capital needed to finance future construction projects. But for the states the critical question is: how much of this capital investment can they afford?

Some states are exploring ways to limit capital spending in the health care industry through regulation. Others believe that under a competitive approach, market forces would inevitably control expenditures. Regardless of which strategy a state chooses, many observers predict that the supply of capital will be insufficient to meet all the competing demands. Thus, only a certain number of facilities will be able to get financing for their proposed projects. The concern about relying on the capital market as the "new regulator" is that the investor-owned and the well-established nonprofit hospitals will be favored in the marketplace. Inner-city and rural hospitals, especially public facilities, will be particularly disadvantaged, yet they may actually have a greater need for financing for capital projects.

In this issue of ALPHA CENTERPIECE, we look at how states can limit total capital spending by incorporating the concept of affordability into their regulatory programs. If states step in to regulate the level of capital investment, they may also be able to help direct the limited supply of dollars to those projects that are needed most.

Growth in Capital Demands

The capital demands of the hospital industry have increased significantly over the last 30 to 40 years, beginning with enactment of the Hill-Burton program in 1946. That federal program provided grants and loans to health care facilities for construction projects. Before World War II, hospitals depended mainly on philanthropy as the source for investment capital.

In the 1960s, passage of Medicare and Medicaid, as well as the expansion of private insurance, spurred further capital growth. Hospitals sought to invest in capital projects to meet the increased demand for services generated by the third-party payment programs. In providing reimbursement for depreciation and interest, the public and private insurance programs improved the financial stability of many hospitals, enabling them to finance construction and renovation through borrowing.

The incentives for debt financing increased, resulting in more demand for capital investment. Hospitals' access to borrowed funds was enhanced with the availability of tax-exempt revenue bonds in the 1960s. While direct funding and philanthropy declined as sources of capital financing in the hospital industry, debt financing rose from 38.7 percent in 1968 to 61.2 percent in 1979, according to a November 1981 article by R. Mullner in *Hospital Financial Management*.

Projected Increase in Capital Investment

Investment in hospital capital construction totalled $5.8 billion in 1980 and almost $50 billion in the years 1971-1980, according to the U.S. Bureau of the Census. For a variety of reasons the trend toward capital growth—financed mainly through debt—is expected to continue in the decade of the 1980s. Projections on the total capital investment vary widely. Michael Hernandez of Kidder, Peabody & Co., Inc., has estimated that total capital demands of community hospitals in this decade will reach $158 billion, assuming a bed capacity reduction of 15 percent; without a reduction, the total may exceed $190 billion, he predicted. Estimates of other analysts are lower. Donald Cohodes and Brian Kinkead, authors of a Johns Hopkins study on hospital capital formation, concluded that capital requirements in the 1980s will be no more than $100 billion, still about twice the level in the preceding decade.

One major factor for the expected increase in capital investment is the so-called "Hill-Burton bulge." Many facilities built in the 1950s and 1960s with Hill-Burton money will seek replacement or renovations in the coming years. Second, the current cost-based reimbursement system encourages additional capital investment and debt financing.

Another reason for continued growth in capital demand in this decade is the increase in population, particularly those 65 and over. Population increases mean greater hospital utilization, and the rate of utilization is much higher among the elderly. The expected continuing shift in the population to growth states will also create demand for additional capital investment. In

addition, some predict that the growing supply of physicians in the 1980s may generate increased demand for new facilities and services.

Finally, more capital will be demanded to finance the latest medical and technological innovations in equipment and services. A hospital's survival may depend on its ability to acquire the most up-to-date technological advances, as pointed out in the Johns Hopkins study.

Regardless of the estimate used, these pressures mean that the capital demand in the hospital industry will be substantial in the years ahead. But the amount of capital sought by the health facilities may outstrip the amount of capital available to them, and may far exceed what we can afford. Not only will the facilities have to compete among themselves for capital, they will have to compete with the demands for capital replacements and improvements from other public systems, such as transportation and sewers.

Impact on Health Care Costs

The cost of capital investment goes far beyond the money needed to finance specific projects. Because the current reimbursement system covers interest and depreciation expenses, capital financing has a profound impact on overall health care costs. The more demand there is for capital investment financed through debt, the higher the interest rates and therefore the level of costs reimbursable under the current payment system.

A hospital's capital expenditures can also add to its operating expenses. While capital investment in other industries is undertaken to reduce production costs, in the hospital industry "it is typically undertaken because the new technology promises to improve the quality of care, not reduce the cost," according to a paper entitled "State Limitation on Capital Expenditures by Hospitals Can Help to Contain Rising Hospital Costs," prepared by the Michigan Office of Health and Medical Affairs. "In fact, this improvement in quality usually adds to the costs of care; the new technology normally requires more intensive use of labor and other associated resources than the technologies it replaced," the Michigan document said.

A similar conclusion was reached in a study by Arthur D. Little, Inc. (ADL), conducted for the U.S. Department of Health and Human Services. "Hospital capital investment is contributing to the seemingly inexorable rise in the cost of health care as a percentage of GNP [Gross National Product]," concluded the ADL report titled "Development of an Evaluation Methodology for Use in Assessing Data Available to the Certificate of Need (CON) and Health Planning Programs."

Up to now the only tool states have had to control capital expenditures has been certificate of need. State CON laws are designed to curb health care costs by allowing approval of only those projects for which there is a demonstrated need. Some studies have found that CON can be effective in controlling health care costs, particularly institutional costs and especially when combined with other regulatory methods. But CON programs generally have little effect on the total statewide level of hospital capital spending. Even where CON laws have been shown to be effective in limiting specific capital expenditures, the total amount of investment approved is believed by many to be beyond what we can afford.

One reason for the failure of many CON programs to control health care costs is their focus on capital expenditures rather than on operating expenses, explained a paper entitled "New Approaches to Using the Determination of Need Processes to Contain Hospital Costs," prepared for the Massachusetts Department of Public Health. While operating costs and capital costs are linked directly through the reimbursement system's payment of depreciation and interest expenses, the Massachuesetts paper said, "no look at capital expenditures alone can measure the cost of a proposed project to the payment system."

Relative Need

Even with strong CON programs, most states are unable to keep total capital spending within affordable bounds because CON procedures apply "a test of absolute need," the Michigan paper said. Federal criteria for CON review require consideration of the direct and indirect costs of proposed projects, as well as their need, financial feasibility and other factors. For the most part, however, CON programs have concentrated on the criterion of need, resulting in approval of almost any project for which need can be demonstrated. Such an approach, said the Michigan document in describing the state's CON statute, "ignores the fact that all needs are relative. Resources are scarce, which means that no society can afford to devote resources to every use that promises some positive benefit."

To some extent many states have applied the idea of relative need to their CON process by reviewing applications for similar proposed projects in batches, evaluating them in relation to one another, as now required by federal regulation. Although such batching results in comparison of the relative needs of competing proposals, it does not compare those needs with the needs for other types of projects and other ways of delivering health care; it does not look at a proposal in the context of its effect on systemwide health care costs.

Because resources are limited, because there are limitations to what society can afford, "there must be priorities—even among 'needs'," according to the Massachusetts paper. If states are going to attempt to limit capital spending to an affordable level, they must evaluate the need for one proposed capital project in relation to the need for others, setting priorities and making tradeoffs.

Defining Affordability

Applying the concept of affordability means developing a capital expenditures budget, setting a limit on capital spending, and determining just how much the state is willing to allow for capital investment in the health care industry in rela-

tion to other public demands for capital. The decision to define that level "is basically a value judgment rather than a technical question," according to the Michigan publication. "The correct amount is the amount the people of the state believe balances the need for high quality medical care with the need to meet other socially desirable objectives." Once established, the level should be reviewed periodically to make sure the amount is not too high or too low, the document added.

There are a number of different approaches states can take in placing a cap on health facility capital expenditures. For instance, after establishing the amount of the cap, the state could rank all applications submitted, evaluating every proposed project in relation to all others. Such a process would involve comparing dissimilar projects and establishing priorities among them.

Another method is to determine a statewide budget and then to allocate that cap to specific regions. Under this system, proposals could be considered relative to similar applications in the region, or they could be ranked with all proposed projects in the region. This approach might include a provision to apportion over several years the cost of a very expensive project.

A problem with a regional cap is the design of an allocation formula that is equitable to all in the state. A number of characteristics of each region would have to be weighed against those in other areas. Among the factors that could be considered are: population size; population characteristics, especially relative age; patient admission patterns; age of physical plants; and relative construction costs.

Analysis of Effect on Operating Costs

Besides setting caps on capital expenditures, states can apply the affordability concept by analyzing proposed projects in terms of their effect on operating costs. For example, instead of limiting the total level of capital spending on a statewide or regional basis, states could establish limits on the operating costs generated by proposed projects. Such an approach is being considered in Massachusetts. Or states could establish maximum operating cost increases for specific types of projects, so that projects with operating costs above the established level would be disapproved or would be reimbursed only to the allowable limit.

Another option is to set facility-specific capital limits, a method now being tried in New Jersey. This approach could limit the total capital expenditures of a specific facility to a certain maximum percentage of its operating budget.

At the very least states can increase affordability analysis in the CON review process by focusing more on a project's impact on overall costs and by requiring applications to include, for example, an assessment of less costly alternatives and the effect on operating costs.

In the following examples we look at the approaches underway or being considered in three states to control health care costs by setting affordable limits on capital expenditures.

Moratorium, 5-Year Plan for Capital Allocation Proposed in New York

New York State's Blue Ribbon Panel on Capital Affordability has called for a one-year moratorium on all CON applications involving capital expenditures so as to allow the state to institute major revisions in the CON program. The proposed changes in the CON process, part of a package of recommendations submitted to Governor Hugh Carey in December, are aimed at applying the principles of relative need and affordability to help control rapidly accelerating capital expenditures in the state. Unless the state takes action, requests by hospitals for capital spending for replacement projects are expected to exceed $5 billion through 1984, the panel reported.

The committee, appointed by the Governor, included representatives of the business community, insurers, investment bankers and state policy councils. After reviewing the group's report, Governor Carey will offer his own recommendations to the new governor.

During the first six months of the moratorium proposed by the panel, acute and long-term care facilities would prepare five-year capital plans and budgets to be submitted to the HSAs and the Department of Health (DOH). At the same time, the state would develop a plan for resource allocation and a five-year projection on the availability of resources. DOH would analyze the institutions' and state's budgets and then, with the aid of the HSAs, complete a comprehensive, statewide five-year plan for capital resources allocation. The plan would set priorities among the capital projects expected to be needed over the period.

The panel also recommended that the existing CON review criteria —need, character, competence, and financial feasibility—be amended to include explicitly the concepts of relative need and affordability. Further, the committee suggested additions to the content of CON applications to increase affordability analysis.

To control the frequent rise in costs between preliminary approval and final permission to proceed with construction, the panel recommended that once a project clears both stages, the Rate-Setting Commission would establish the reimbursement rate for a three-year period. Any costs above the established rate would have to be absorbed by the applicant. The panel also recommended that if the cost of a proposed project exceeded the preliminary estimate by a specified percentage, the application would be returned to the first stage for further review.

The panel made a number of other recommendations, including a proposal for a guaranteed loan program to help financially distressed hospitals gain access to capital for critically needed projects.

New Jersey Applying Facility-Specific Capital Cap

Concerned over high interest rates and the impact of capital financing costs on overall health care costs,

New Jersey adopted a cap on interest rates in 1979 in the hope of stemming capital expenditures in the 1980s. Because of the "Hill-Burton bulge," almost 85 percent of hospitals in the state are expected to seek replacement between 1984 and 1987. But this approach—which "shut down everything, whether of value or not," said Gar Reed in the Department of Health's Health Economics Services—was abandoned after a year and replaced in 1981 with a cap on the ratio of capital reimbursement to total reimbursement. The limit on capital expenditures is applied on a hospital-by-hospital basis, rather than statewide. The advantage of this type of cap, Reed explained, is that it takes into account "the historical use of capital and it allows a hospital to adjust project size in relation to the price of capital, or interest rate."

The cap, adjusted annually, was set at 12.9 percent for 1982. To get that figure, department health economists took the ratio of capital reimbursement to total reimbursement for all hospitals in the state, distributed the ratios along a scale of low to high, and then used a point at the 97.5 percentile of distribution as the cap. Excluded from the calculations were hospitals with special arrangements to exceed the previous year's cap because of demonstrated efficiencies.

The cap is implemented through the CON review process. The state estimates a hospital's total reimbursement (including both operation and capital costs) for the first year in which a proposed project is expected to be in operation. If the ratio of capital reimbursement to total reimbursement exceeds the cap, the hospital has three options. First, it can demonstrate that the proposed project will result in cost efficiencies, thus reducing future operating costs. Or, the hospital can reduce the scope of the project, thus decreasing its cost. The third option is for the applicant to give reasons unrelated to cost why the project should be approved, such as it provides a much needed, albeit expensive, regional service.

The problem with the facility-specific approach, Reed said, is that it makes no direct effort to control overall capital spending in the state, to limit capital growth. What is needed, he said, is a way to set a growth target for the industry so as to smooth out over a ten-year period the rebuilding sought as a result of the "Hill-Burton bulge."

Capital Limit Based on Operating Costs Proposed in Massachusetts

A proposal under consideration in Massachusetts would incorporate the measure of affordability into the CON review process by setting a statewide limit on the total incremental costs associated with proposed new projects or services. Such a constraint on capital approvals would be the most effective way to limit "aggregate cost impacts on the hospital system," concluded the Work Group on Capital and Operating Cost Limits in its November 1982 report to the Governor's Health Care Cost Containment Coalition. In 1981, the state approved $217 million in hospital capital expenditures, 26 percent above the previous year. Pending requests currently total $750 million, most of which is for hospital plant replacement.

Although the work group did not suggest a specific budget figure, the coalition is expected to recommend to Governor King in its final report, due December 20, a limit of up to 2 percent of total operating costs associated with capital expenditures, according to William Decker, the coalition's staff director. A 2 percent cap would mean that about $240 million would be available. This figure was derived from the estimate by Blue Cross of Massachusetts that each $1.00 of capital cost approved annually means $.30 in new operating costs—$.19 of additional depreciation and interest and $.11 of additional operating expenses.

The advantage of linking capital costs to total incremental costs, the work group said in its report, is that "allowable capital cost increases will be a function of the rate of growth of operating costs in the hospital system." Such an approach will also encourage hospitals to contain their costs, thus promoting construction of the least expensive health care delivery modes and contributing to reduced interest expenses.

Under the plan proposed by the panel, the state cap would be allocated on a regional basis "to insure that quality and accessibility of care is maximized within that economic constraint." The proposal emphasized the role of proposed regional health care cost coalitions (RHCCCs) in helping the state to define local capital needs and to allocate the budget to hospitals in the region.

Another work group looked at interest expense and concluded that these costs could be reduced by requiring a certain percentage of equity contribution, based on the dollar size or type of proposed project.

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northern alaska health resources association, inc.

February 03, 198.

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Josephson,

The Honorable Joe Josephson
Alaska State Legislature
Pouch V (MS 3100)
Juneau, Alaska 99811

Dear Senator Josephson:

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

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

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

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

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

1. Increase the threshold level which triggers a CON review from $150,000 to 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.

SENATE HESS COMMITTEE OBSERVER/WITNESS SIGN-UP SHEET

DATE: 3/14/83 SPONSOR:

SUBJECT(S): SB 85 (HESS CS)

NAME	REPRESENTING	ADDRESS	PHONE	Observer	Witness		
Rodman Wilson MD	Municipality ANCH	Box 6-650 Anch 99502	264-4621		✓		
Ronald A. Pavellas	Alaska State Hospital Assoc.	JUNEAU	586-1790		✓		
Jim Burns	Bartlett Hospital	3260 Hospital Drive Juneau, AK 99801	586-2611		✓		
M. Treadwell	Blue Cross	605 Dimond Hill	344-2112				
Mason Anderson	DHSS	Room 309 AOB Juneau	364-3247	✓			
John Pugh	DHSS	Pouch H-01	465-3030		✓		
Rod Betit	DHSS/DPA	Pouch H-07	465-3355	✓			
~~Dennis~~ Elliott	Hospital Association	315 Seward St	586-1750		✓		
Sandy Stone	Sen. Sam Cole	Pouch V	465-4523	✓			

Give to Nancy ✓

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

September 13, 1983

Senator Joe Josephson, Chairman
Senate HESS Committee
1526 "F" Street
Anchorage, Alaska 99501

Dear Senator Josephson:

The attached paper is a review and summary of the current literature on swing bed/long term care services.

Since we are answering requests for copies of this paper from projects throughout the state, we thought you might be interested in receiving a copy. I hope you will find it helpful in your decision making.

Please don't hesitate to call this office if we can be of further assistance.

Sincerely,

Barbara Berger

Barbara Berger
Program Manager

BB/ab

Attachment

Need to check out

RECEIVED
1983
Josephson

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

September 16, 1983

To: Senate and House HESS Members

From: Arlene Brovald for Barbara Berger

Enclosed is the paper on swingbed/long term care services which was inadvertently left out of Barbara Berger's letter of September 13, 1983. I apologize and hope this oversight has not inconvenienced you.

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

OVERVIEW OF
SWING BED CONCEPT

RECEIVED
SEP 1983
Josephson,

Introduction

The term "swing bed" refers to the use of hospital beds to provide both acute care and long term care depending on the need at any given time. The federal government has recently published regulations which allow for appropriate Medicare and Medicaid reimbursement to small rural hospitals who implement the swing bed concept.

This paper looks at the swing bed concept and nationwide program, how it has developed, what it offers, and advantages and/or disadvantages for hospitals in Alaska.

History

Prior to the advent of Medicare in the mid-1960s, most general hospitals offered comprehensive care that did not divide acute from extended care. Title XVIII of the Medicare legislation encouraged the development of freestanding extended care facilities that were designed primarily to shorten the hospital stays of patients over 65 who no longer required the intensity of hospital services. But the high cost of construction along with small populations precluded the practical development of long term care facilities in most rural areas. An irony, therefore, existed especially for small rural hospitals - while they typically had occupancy rates of less than 50%, there was a shortage of long term care beds.

In Utah in 1973 and later in South Dakota, Iowa and Texas, an experimental program was initiated whereby 25 rural hospitals with 10 to 95 beds and an occupancy of under 60% were permitted to use beds that were consistently empty for long term patients on a continuing or an intermittent basis, depending on need. Extensive evaluation of these experiments by HCFA showed that hospitals with swing bed programs could offer long term care services to patients in a cost-effective manner without sacrificing quality of care.

In the Omnibus Reconciliation Act of 1980, Congress amended Titles XVIII and XIX of the Social Security Act to provide that hospitals may enter into an agreement with the Secretary "under which its inpatient hospital facilities may be used for the furnishing of services of the type which, if furnished by a skilled nursing facility, would constitute extended care services". Regulations implementing this swing bed program were published in the July 20, 1982 Federal Register. The program is now receiving a great deal of national attention and support. While the guidelines for participation are set, there is no question that with increasing feedback on its effectiveness, the program will expand and be modified through future regulations.

Eligibility and Requirements

In order for a hospital to be eligible to receive Medicare and Medicaid reimbursement for the provision of long term care services, several conditions must exist:

- .The hospital must be located in a rural area.
- .The institution must have fewer than 50 acute care beds (excluding bassinets and intensive-care unit beds).
- .A swing bed hospital may not have in effect a 24-hour nursing waiver; a registered nurse must be present in the hospital at all times.
- .If the hospital does not already offer long term care, it is considered a "new service" and would require a Certificate of Need.

The federal regulations state that eligible hospitals are required to meet six standards (in addition to those required for acute care) to qualify for Medicare reimbursement under the swing bed program. These standards are:

- .Patients' rights. For example, "a patient must be fully informed of available services, and a patient may be transferred or discharged when medically necessary or when such action is in the best interest of that or other patients".
- .Specialized rehabililative services. Services such as occupational therapy and physical therapy must be available (within the hospital or by consulting contract) as needed by the patients.
- .Social Services. The social and emotional needs of the long term care patient are especially important and must be provided for either in-house or on referral arrangements by a qualified social worker.
- .Patient activities. A qualified patient activities coordinator (e.g. a Physical therapist or Occupational therapist) must be designated to promote the physical, social, and mental well-being of patients.
- .Dental Services. A hospital must establish an agreement with a dentist to consult in staff education for nursing and other appropriate personnel and to recommend oral hygiene policies and practices in the care of patients.
- .Discharge Planning. An organized discharge planning program must exist and be evaluated by the hospital's utilization review committee.

Reimbursement

Swing bed programs offer opportunities for hospitals to improve their cash-flow problems by offering a reliable source of operating revenues for previously empty beds or during times of census fluctuations. Once a hospital meets the eligibility and service requirements, it will be able to bill federal (Medicare) and state (Medicaid) insurers for swing bed services. In general swing bed services are subject to the same coverage requirements and coinsurance provisions that apply to skilled nursing facilities.

The method of reimbursement outlined in the regulations is called a

"carve-out" method. The rate is established based on the previous year's Medicaid rate for SNF and ICF, and Medicare will be computed based on the hospital's routine service costs (revenues from ancillary services are handled and reimbursed separately as they are for acute care). Swing bed costs not covered by Medicaid SNF and ICF rates will be included in the hospital routine cost base and potentially be recovered through inpatient acute care rates. At present only minimal alterations of a hospital's financial system are required to implement a swing bed program.

Advantages and Disadvantages

The swing bed program provides a unique opportunity for small hospitals in rural areas to offer expanded services in their communities. The elderly (over 65) population is projected to grow at twice the rate of the total population during the 1980's. Since this is the population group most likely to utilize a swing bed program, the availability of this kind of program could be a valuable community resource as well as an additional source of revenue to a hospital. In addition to the fact that patients would not have to be transferred away from familiar surroundings it would also be a cost savings to family and friends who support the long term care patient.

The cost savings of not building a separate facility are significant to the community. For the rural hospitals that lack the economy of scale and shared services available to their urban counterparts, the advantages of the swing bed concept include increased efficiency of staff and greater economy from such departments as pharmacy.

Implementation of a swing bed program can be an incentive to small hospitals to diversify even more into such services as home health care, adult day care, and hospice to name a few.

With all the apparent advantages, there are also some potential problems with a swing bed program. Most of these were realized during the development years in the experimental projects. Summarized, these areas of possible concern are:

- .Additional professional staff required for the program may not be readily available.
- .Orientation of care for long term care patients is very different from short term care and may be a difficult transition for regular staff to do well.
- .Visiting patterns differ for acute care patients (frequent) and long term care patients (less frequent) and some long term patients can become a drain on staff.
- .Long term patients often have multiple problems that are frequently accompanied by antisocial behavior.
- .Remaining in the same bed (wing, or institution) while transiting from acute to long term care can confuse the patient's (and family's) expectations for care.
- .Even with the carve-out method for calculating expenses, long term care in a swing bed program is more expensive per bed than care in an existing SNF, based on the calculation of total costs as they are spread over the whole operation.

.Though quality of care is difficult to formally "regulate", reports from the experiments indicate that the facility, patient, and problem measures of the quality of care were significantly higher for comparison nursing homes than the experimental swing bed programs.

There may be, of course, many more potential problems, but despite all of those encountered in the experimental programs, the program is still recommended by national program observers.

Conclusion

Taking into account all of the above information, the decision to implement a swing bed program should obviously be done only after a careful examination of a hospital's situation (a feasibility study) and comprehensive in depth planning throughout the process. The following are ten major areas for consideration in the feasibility study and planning process (not necessarily in sequence or order of importance).

1. Hospital occupancy If the annual utilization rate is relatively high (60-70%), it is not likely that participation in a swing bed program would be substantial. Also there may be more need for flexibility for acute care use if use fluctuations are high or in case of an emergency.
2. Nursing home occupancy If nursing homes in a hospital's community are underutilized and provide adequate care, then a swing bed program may not be needed.
3. Physician acceptance If, after becoming familiar with the swing bed concept, physicians are neither neutral nor positive about attempting a swing bed program, it will probably prove impossible to implement successfully.
4. Reimbursement An understanding and acceptance of the carve-out method of reimbursement is necessary to implement a comprehensive approach to swing bed care. Those who are against this approach to reimbursement should perhaps not become involved in swing bed care.
5. Nursing staff acceptance The evaluation studies on the experimental programs have shown that, with experience, nurses have become increasingly impressed with the value of providing long term care in acute care beds. However, just as with physicians, if the nurses believe that the program should not be undertaken, it probably shouldn't.
6. Community acceptance and understanding Discussions regarding the potential for swing bed care should start with the hospital board, then other community health providers, and other interested community organizations and individuals. Aim for full understanding.
7. Utilization projections A reasonable number of beds to be designated and patient days utilization can be made by talking to nursing homes, physicians, interested public and home health nurses. Designating more beds than can reasonably be expected to be used may create unnecessary anxiety on the hospital staff and allow for possible over use before all details of the transition are tested and evaluated. Once a shospital has a swing bed program more beds can easily be added as needed.

8. Appropriateness of long term care Especially, the question of whether the hospital wants to offer long term care services along with acute care. This is true for hospitals that have no experience in long term care or keep staff's separate awareness of how the services differ is important. The hospital must foster a new , different environment of learning, adaptiveness, program development, a concept because any swing bed program will take at least two to three years to mature.
9. Regulatory requirements A hospital must be willing and able to follow all of the requirements of the program (see references).
10. Use of resources for planning When all of the above have been thoroughly considered there will undoubtedly be many questions that this short overview cannot answer. Below is a listing of sources of additional information.

.John Supplitt, Project Director
American Hospital Association Center for Small and Rural Hospitals
Telephone (312) 280-6400

.Dan Meddleton, Director
State Health Planning and Development Agency
DHSS
Telephone (907) 465-3082

.Portia Kaufman, Manager
Division of Health Facilities Certification and Licensing
Telephone (207) 561-4350

.Your respective Health Systems Agency:

South Central Health Planning and Development, Inc.
Telephone (907) 278-3631

Northern Alaska Health Resources Association
Telephone (907) 456-2553

South East Alaska Health Systems Agency
Telephone (907) 225-9631

References

1. Omnibus Reconciliation Act of 1980 (Public Law 96-499)-Amendments to Titles XVIII and XIX of the Social Security Act.

2. Federal Register, Vol. 47 # 139, Tuesday, July 20, 1983, PP. 31518-31528.

3. "Program Information Letter", Bureau of Health Planning, U.S. Department of Health and Human Services, # 82-24, September 20, 1982.

4. Technical Assistance Memo #71, "Rural Hospital Diversification Strategies: by E. Anthony Golda MPH, Western Center for Health Planning. January 15, 1981

5. Volunteer Memo # 1, "Planning for Health Facilities: A Conceptual Overview" by Joseph P. Peters. Western Center for Health Planning. February 25, 1981.

6. An Evaluation of Swing Bed Experiments to Provide Long Term Care in Rural Hospitals. Volumes 1 and 11, Center for Health Services Research, University of Colorado Health Sciences Center, March 1980.

7. A Position Paper on Swing-Bed Care in Hospitals by Ann Trickler, Center for Health Services Research, Univeristy of Colorado Medical Center, June 15, 1979.

8. Small or Rural Hospital Report, Vol 6 #4, American Hospital Association. 1982.

9. Small or Rural Hospital Report, American Hospital Association, January February, 1983.

10. Small or Rural Hospital Report, American Hospital Association, March-April, 1983.

11. "Small Hospitals find Swing Beds Profitable", by Dr. Bruce A. Walter, J.Donald West, and Mark D. Elggren, HCFA Forum, June 1980.

12. "Swing Beds Can Work - With Good Planning", by Dulcey B. Miller, Hospitals, May 16, 1980.

13. "Swing Beds meet Patient's Needs and Improve Hospitals Cash-Flow. Hospitals, July 1, 1982

14. Swing Bed Series:
    .Swing Beds: New Diversification Opportunity for Small and Rural Hospitals, by John T. Supplitt
    .Quality Assurance: Evaluating Services of Small Swing Bed Hospitals, by William F. Jessee, MD.
    .Reimbursement: Carve-out Method Benefits Swing Bed Hospitals, by Fran Pennell.
    .Planning: Implementing New Swing Bed Programs, by Peter W. Shaughnessy and Robert E. Schlenker.
    Hospitals, pp. 67-90, November 16, 1982

Give to Nancy

Alaska State Legislature

Senate

Committee on Finance

Official Business

September 12,1983

Pouch V
State Capitol
Juneau, Alaska 99811

Senator Joe Josephson
921 West Sixth Ave, Rm 230
Anchorage, Alaska 99501

Health Care Facility
CERTIFICATE OF NEED PROGRAM

Dear Joe,

The health care facilities Certificate of Need Program study, as authorized by Senate Resolve 2, is now in the process of announcing public hearings on the subject.

Your name has been obtained from an assortment of materials which have been collected from the various legislators who have taken an active role in the State's Certificate of Need Program. Because of your past involvement with the CON process you may wish to continue your efforts and may be interested in participating in any of the following hearings:

September 22, 1983 - 2pm in Juneau - State Capitol Building - Butrovich Room

October 18, 1983 - 2pm in Fairbanks - Fairbanks Memorial Hospital - Eva McGown Room

November 3, 1983 - 2pm in Anchorage - Legislative Information Office - 1016 Sixth Avenue

If you are unable to attend any of the hearings but would still like to contribute input to the CON study, please do not hesitate to contact my office by phone (452-7624) or by writing (315 Barnette Street, Suite 103, Fairbanks, Alaska 99701).

Best Regards,

Senator Don Bennett

DB/kf

RECEIVED
SEP 1 - 1983

Josephson.

Give to Nancy ✓

ANCHORAGE INFANT LEARNING PROGRAM

Alaska Treatment Center
3710 East 20th Avenue
Anchorage, AK 99504
(907) 272-0586 Ext. 42 & 43

SEptember 16, 1983

Senator Joe Josephson
1526 F St.
Anchorage, AK 99501

Dear SEnator Josephson:

Anchorage area legislators have been valuable allies to Infant Learning Programs throughout the state. Your assistance in funding our programs has had a tremendous impact on our ability to serve families with disabled children.

The Anchorage Infant Learning Program was started in 1976 to provide expert training for parents in early intervention techniques. The home-based nature of the program allows parents and siblings the opportunity to improve the skills and potentials of a disabled child in a healthy and normal setting.

Each year since 1976 the number of clients needing appropriate training has increased, yet the budget has not kept pace. This past year the Anchorage program has tripled its projected case load. More than 350 families are expected to be served in FY 84.

One of the reasons for this increase is due to significant developments in prenatal and postnatal care. The number of premature infants surviving in Anchorage has grown at an enormous rate. The services provided by the Anchorage Infant Learning Program are exciting and we would like to share that excitement with you and your staff. During the week of October 3 - 7 we hope to schedule a time for you or a key staff member to share in a home visit with a member of our staff. We will be in touch next week to schedule a time if you are interested. Again, thank you for your continued support.

Sincerely,

Mary Carr

Mary Carr
Director of Infant Learning

/bp

cc: Josef Reum, Handicapped Services Coordinator

PLEASE NOTE: THE FOLLOWING PAGES WERE TREATED AS A UNIT IN THE ORIGINAL DOCUMENT

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

To: Persons interested in the new Swing Bed concept

From: Susan Callan, Project Review Staff Susan Callan

Subject: Introduction to Swing Bed Concept Paper

Date: August 15, 1983

You may be involved (now in the near future) in making decisions about swing bed/long term care services.

The attached paper is a review and summary of the current literature. I hope you will find it helpful in your decision making.

Please don't hesitate to call this office if we can be of further assistance.

SMC/ab

Attachment

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

OVERVIEW OF SWING BED CONCEPT

Introduction

The term "swing bed" refers to the use of hospital beds to provide both acute care and long term care depending on the need at any given time. The federal government has recently published regulations which allow for appropriate Medicare and Medicaid reimbursement to small rural hospitals who implement the swing bed concept.

This paper looks at the swing bed concept and nationwide program, how it has developed, what it offers, and advantages and/or disadvantages for hospitals in Alaska.

History

Prior to the advent of Medicare in the mid-1960s, most general hospitals offered comprehensive care that did not divide acute from extended care. Title XVIII of the Medicare legislation encouraged the development of freestanding extended care facilities that were designed primarily to shorten the hospital stays of patients over 65 who no longer required the intensity of hospital services. But the high cost of construction along with small populations precluded the practical development of long term care facilities in most rural areas. An irony, therefore, existed especially for small rural hospitals - while they typically had occupancy rates of less than 50%, there was a shortage of long term care beds.

In Utah in 1973 and later in South Dakota, Iowa and Texas, an experimental program was initiated whereby 25 rural hospitals with 10 to 95 beds and an occupancy of under 60% were permitted to use beds that were consistently empty for long term patients on a continuing or an intermittent basis, depending on need. Extensive evaluation of these experiments by HCFA showed that hospitals with swing bed programs could offer long term care services to patients in a cost-effective manner without sacrificing quality of care.

In the Omnibus Reconciliation Act of 1980, Congress amended Titles XVIII and XIX of the Social Security Act to provide that hospitals may enter into an agreement with the Secretary "under which its inpatient hospital facilities may be used for the furnishing of services of the type which, if furnished by a skilled nursing facility, would constitute extended care services". Regulations implementing this swing bed program were published in the July 20, 1982 Federal Register. The program is now receiving a great deal of national attention and support. While the guidelines for participation are set, there is no question that with increasing feedback on its effectiveness, the program will expand and be modified through future regulations.

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The method of reimbursement outlined in the regulations is called a

Alaska State Legislature

Senate

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

September 15, 1983

Senator Don Bennett
315 Barnette Street, Suite 103
Fairbanks, Alaska 99707

Dear Senator Bennett:

Thank you for your letter concerning Certificate of Need hearings, as I've maintained a considerable interest in the topic having closely followed this issue in my three years with the HESS Committee. I hope the materials lent to your research were valuable, and I am sorry that I turned the many national reports collected since 1981 over to the state library. Both NCSL and the Health Care Financing Administration are excellent resources on CON studies.

Because of other commitments, I will not be able to attend the hearings in Juneau and Anchorage but I would be very interested in the directions of the testimony if you put together any final data.

I have recently received a research paper, attached, on the "swing bed" concept of Medicare and Medicaid payments and their requirements through regulation, which include a Certificate of Need process. Swing beds would allow rural hospitals to use beds as acute or long term care, depending on the current need, increasing both occupancy rate and revenues. Since this option has been discussed for Alaska in the past, I thought it may be of interest to the committee.

Sincerely yours,

Nancy Deirrick
Senate HESS Committee Aide

Official Business

Alaska State Legislature

Senate

Committee on Finance

Pouch V
State Capitol
Juneau, Alaska 99811

September 12, 1983

Nancy Dietrick
c/o SENATOR JOE JOSEPHSON
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Health Care Facilities
CERTIFICATE OF NEED PROGRAM

Dear Nancy:

The health care facilities Certificate of Need Program study, as authorized by Senate Resolve 2, is now in the process of announcing public hearings on the subject.

Your name has been obtained from an assortment of materials which have been collected from the various legislators who have taken an active role in the State's Certificate of Need Program. Because of your past involvement with the CON process you may wish to continue your efforts and may be interested in participating in any of the following public hearings:

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November 3, 1983 - 2pm in Anchorage - Legislative Info Office - 1016 W. Sixth Avenue

If you are unable to attend any of the hearings but would still like to contribute input to the CON study, please do not hesitate to contact my office by phone (452-7624) or by writing (315 Barnette St., Suite 103, Fbks, AK. 99701).

Best regards,

Senator Don Bennett

DB/jan

PLEASE NOTE: THE PRECEDING PAGES WERE TREATED AS A UNIT IN THE ORIGINAL DOCUMENT.

NOTICE OF ADOPTION OF EMERGENCY REGULATIONS
BY THE DEPARTMENT OF HEALTH & SOCIAL SERVICES

As required by AS 44.62.250, notice is given that, under authority vested by AS 47.05.010, 47.07.050, and section 8, ch. 95, SLA 1983, the Department of Health and Social Services adopted on this date, as emergency regulations, new regulations, amendments of regulations, and repeals of various sections of 7 AAC 43 relating to the establishment of an interim prospective payment system for the Medicaid and General Relief Medical programs.

This action is not expected to require an increased appropriation.

Copies of these regulations may be obtained by writing or calling Kimberly Busch, Medical Assistance Program Officer, Division of Public Assistance, Pouch H-07, Juneau, Alaska 99811, (907) 465-3347.

The Department expects that permanent regulations will be adopted in the future to establish a prospective payment system under the Medicaid Rate Commission. However, if it does not appear that the Commission is ready to adopt those regulations before the end of the 120-day limit of effectiveness of these emergency regulations, the Department will provide public notice of a hearing and comment period necessary to make these emergency regulations permanent, until such time that the Commission adopts regulations.

DATE: 10/18/83

Juneau, Alaska

Robert London Smith

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

7 AAC 43.040(b) is amended to read:

(b) Repealed / / .

7 AAC 43.090 is amended by adding new paragraphs to read:

(23) "facility" means a hospital, SNF, ICF, ICF/MR, rehabilitation facility, inpatient psychiatric facility, home health agency, rural health clinic, and outpatient surgical clinic;

(24) "commission" means the medicaid rate commission authorized by AS 47.07.110 -- 47.07.190. (Eff. 8/18/79, Reg. 71; am / / , Reg.)

Authority: AS 47.05.010
AS 47.07.050
AS 47.07.080
AS 47.07.195

7 AAC 43.170 is amended to read:

7 AAC 43.170. CONDITIONS FOR PAYMENT. (a) Requirements for payment under medicaid as a SNF or ICF are that

(1) the facility has been certified by the division as in compliance with federal certification requirements

(A) SNF certified for medicaid -- certification is by the division for the federal Department of Health and Human Services,

(B) ICF -- certification is by the division;

(2) a level-of-care decision has been made by the division or fiscal agent indicating that the beneficiary requires the level of care that the facility is certified to provide;

(3) there be a current provider agreement on file with the division

(b) Payment will be made by the division in accordance with 7 AAC 43.675 -- 7 AAC 43.707. (Eff. 8/18/79, Reg. 71; am / / , Reg.)

Authority: AS 47.05.010
AS 47.07.050
AS 47.07.070

7 AAC 43.215(a) is amended to read:

(a) Payment will be made by the division in accordance with 7 AAC 43.675 -- 7 AAC 43.707. (Eff. 8/18/79, Reg. 71: am / / , Reg.)

Authority: AS 47.05.010
AS 47.07.050
AS 47.07.070

7 AAC 43.235(a) is amended to read:

(a) Payment by the division is payment in full for those services authorized under medicaid. If the facility obtains from another source any additional payment for the care provided to a beneficiary for services that have been paid for by medicaid, it is the obligation of the facility to refund or credit the additional payments to the division. (Eff. 8/18/79, Reg. 71; am / / , Reg.)

Authority: AS 47.05.010
AS 47.07.070

7 AAC 43.240 is amended to read:

(a) Payment will be made by the division in accordance with 7 AAC 43.675 -- 7 AAC 43.705.

(b) Rates will not be issued to out-of-state facilities. Payment for care in out-of-state facilities will be made under the general provisions of the rules established by the medicaid state agency in the state where the facility is located. (Eff. 8/18/79, Reg. 71; am / / , Reg.)

Authority: AS 47.05.010
AS 47.07.070

7 AAC 43.310(3) is amended to read:

(3) comply with the requirements of 7 AAC 43.675 -- 7 AAC 43.705. (Eff. 8/18/79, Reg. 71; am / / , Reg.)

Authority: AS 47.05.010
AS 47.07.070

7 AAC 43.360 is amended to read:

7 AAC 43.360. PAYMENT. (a) Payment will be made by the division in accordance with 7 AAC 43.675 -- 7 AAC 43.705.

(b) Payment will be made for the day of admission but not for the day of discharge, transfer, or death.

Authority: AS 47.05.010
AS 47.07.050
AS 47.07.070

7 AAC 43.365 is amended to read:

7 AAC 43.365. CONDITIONS FOR PAYMENT. To receive payment under medicaid, a hospital must

(1) must be licensed under state law;

(2) comply with the requirements of 7 AAC Chapter 43;

(3) have a division-approved plan of utilization review. (Eff. 8/18/79, Reg. 71; am / / , Reg.)

(4) have a current provider agreement on file with the Division

Authority: AS 47.05.010
AS 47.07.050

7 AAC 43.400(a) is amended to read:

(a) Repealed / / .

7 AAC 43.400(b) is amended to read:

(b) Repealed / / .

7 AAC 43.560(2) is amended to read:

(2) comply with the requirements of 7 AAC 43.675 -- 7 AAC 43.705. (Eff. 8/18/79, Reg. 71; am / / , Reg.)

Authority: AS 47.05.010
AS 47.07.050

7 AAC 43.675 is amended to read:

7 AAC 43.675. ALLOWABLE REIMBURSEMENT COSTS. (a) Until June 30, 1983, payment to a facility will be governed by the medicare cost reporting principles contained in 42 CFR 405.401 -- 405.488 (which are further clarified through the Medicare Provider Reimbursement Manual, HIM-15 published by the Health Care Financing Administration), medicaid cost reporting principles contained in 42 CFR 447.250 -- 447.371, and 7 AAC 43.675 -- 7 AAC 43.705.

(b) Payment to a facility whose fiscal year begins on or after July 1, 1983, will be governed by AS 47.07.070 and Section 2 of Chapter 95, SLA 1983.

Authority: AS 47.05.010
AS 47.07.050
AS 47.07.070

7 AAC 43.680 is amended to read:

7 AAC 43.680. COST REPORTING. (a) A facility must file an annual cost report, as follows:

(1) A reporting period of less than one year may be allowed for a facility entering the program after the beginning of its established fiscal year, or for a facility terminating its participation in the medicaid program before the end of its fiscal year;

(2) If a facility is enrolled for participation in both medicare medicaid, the annual reporting period under this section must conform to that required by the medicare program;

(3) A facility must submit its cost report, including a copy of its annual financial statement and a copy of its medicare cost report, to the division within 90 days after the close of the facility's fiscal year. An extension of 30 days may be granted by the division upon timely application;

(4) Upon change of ownership at a time other than the end of a facility's fiscal year, a facility must file a cost report within 120 days.

(b) The cost report is to be completed on forms prescribed by the division. (Eff. 8/18/79, Reg. 71; am / / , Reg.)

Authority: AS 47.05.010
AS 47.07.050
AS 47.07.070
AS 47.07.071

7 AAC 43.685 is amended to read:

7 AAC 43.685. MEDICAID AUDIT SECTION. All reports are to be submitted to the medicaid audit section of the division. The medicaid audit section is responsible for

(1) reviewing cost reports;

(2) making recommendations concerning the division's annual cost settlement with each facility; and

(3) providing information upon which the division establishes the rate to be paid a health facility under 7 AAC 43.675 -- 7 AAC 43.705. (Eff. 8/18/79, Reg. 71; am / / , Reg.)

Authority: AS 47.05.010
AS 47.07.050
AS 47.07.070
AS 47.07.071

7 AAC 43.690(a) is amended to read:

7 AAC 43.690. ANNUAL COST SETTLEMENT. (a) Cost settlement for a facility for services before July 1, 1983, will be made when desk review of its cost report is completed by the medicaid audit section. At the discretion of the division, the full amount necessary to accomplish the settlement will be paid by the division or the facility within 30 days of submittal of a completed cost report. (Eff. 8/18/79, Reg. 71; am / / , Reg.)

Authority: AS 47.05.010
AS 47.07.050
AS 47.07.070

7 AAC 43.700 is amended to read:

7 AAC 43.700. AUDIT AND INSTITUTIONAL REVIEW. (a) As a condition of participation in the medicaid program, a facility under 7 AAC 43.675 -- 7 AAC 43.705 must provide reasonable access to fiscal and patient care records for all medicaid beneficiaries.

(b) A facility must allow inspection of its records by authorized representatives of state and federal agencies which administer the medicaid program.

(c) Repealed / / .
(Eff. 8/18/79, Reg. 71; am / / , Reg.

Authority: AS 47.05.010
AS 47.07.050
AS 47.07.070

7 AAC 43 is amended by adding new sections to article 12 to read:

7 AAC 43.701. INTERIM PROSPECTIVE PAYMENT SYSTEM. (a) The provisions of 7 AAC 43.685 -- 7 AAC 43.705 implement the interim prospective payment system for facilities for state fiscal year 1984 as required by section 8, ch. 95, SLA 1983.

(b) The interim prospective payment system will apply to a facility beginning July 1, 1983. (Eff. / / , Reg.)

Authority: AS 47.05.010
AS 47.07.050
Sec. 8, ch. 95, SLA 1983

7 AAC 43.702. INTERIM PROSPECTIVE PAYMENT RATE. (a) The division will set an interim prospective payment rate for a facility participating in the interim prospective payment system.

(b) For a facility with a fiscal year ending June 30th that receives payment on a per-diem basis, the facility's rate in use on June 30, 1983 will become the rate which, when increased by an annual inflation factor of 8 percent, will be the interim rate until the Commission establishes a rate or the rate is adjusted pursuant to 7 AAC 43.703.

(c) For a facility with a fiscal year ending June 30th that receives payment on a percentage-of-charges basis, the division will continue to use the percent in use as of June 30, 1983 until revised by the Commission or by the Division pursuant to 7 AAC 43.703.

(d) For a facility with a fiscal year that ends after July 1, 1983, payment will be made to the facility at the present per diem or percent-of-charges rate until revised by the Commission or by the Division pursuant to 7 AAC 43.703.

7 AAC 43.703. ADJUSTMENT OF INTERIM PROSPECTIVE PAYMENT RATE.
(a) The division may adjust an interim prospective payment rate upon the request of a facility if

(1) the facility is sold;

(2) an extraordinary circumstance occurs such as damage from fire, natural disaster, or breakdown of major equipment necessitating repair or replacement;

(3) the facility will experience a substantial change in costs that reasonably will not be met by the previously established rate.

(4) a significant mathematical, mechanical, or clerical error exists in financial data submitted by the facility.

(b) The division will review the documented requests and consult with the representative of the facility and approve, deny, or propose modifications to the adjustment within 30 days after receipt of all information required. Adjustments shall be effective July 1, 1983 and retroactive payment will be made as soon as possible. (Eff. / / , Reg.).

(c) Interim prospective rates established pursuant to 7 AAC 42.702 or this section shall be subject to review and further revision by the Medicaid Rate Commission, when it is formed, if a facility applies for a revision.

Authority: AS 47.05.010
AS 47.07.050
Sec. 8, ch. 95, SLA 1983

7 AAC 43.704. DEFINITIONS. In 7 AAC 43.675 -- 7 AAC 43.707

(1) "interim prospective payment rate" means the payment rate established by the division to implement the interim prospective payment system;

(2) "percentage of charges" means a payment that is a percent of the usual and customary charges of a facility for services provided to the general public;

(3) "per-diem rate" means the rate approveded by the Division for each day of services provided by the facility.
(Eff. / / , Reg.)

Authority: AS 47.05.010
AS 47.07.050
Sec. 8, ch. 95, SLA 1983

7 AAC 43.705. APPEAL. A facility that disagrees with the interim prospective payment rate established under 7 AAC 43.675 -- 7 AAC 43.705 may appeal the rate determination under 7 AAC 43.085. (Eff. / / , Reg.)

Authority: AS 47.05.010
AS 47.07.050
Sec. 8, ch. 95, SLA 1983

7 AAC 43.805 is amended by adding a new subsection to read:

(d) Payment will be made by the division in accordance with 7 AAC 43.675 -- 7 AAC 43.705. (Eff. 8/18/79, Reg. 71; am / / , Reg.)

Authority: AS 47.05.010
AS 47.07.050

7 AAC 43.810. BILLING RATE. Repealed / / .

7 AAC 43.850(3) is amended to read:

(3) comply with the requirements of 7 AAC 43.675 -- 7 AAC 43.705. (Eff. 8/18/79, Reg. 71; am / / , Reg.)

Authority: AS 47.05.010
AS 47.07.050

7 AAC 43.880 is amended to read:

7 AAC 43.880. CONDITIONS FOR PAYMENT. For payment under medicaid, an outpatient surgical clinic must:

(1) have a system to transfer patients requiring emergency admittance or overnight care to a fully-licensed, medicaid enrolled facility following any surgical procedure performed at the outpatient surgical clinic;

(2) comply with the requirements of 7 AAC 43.675 -- 7 AAC 43.705;

(3) have a division-approved plan of utilization review. (Eff. 8/18/79, Reg. 71; am / / , Reg.)

(4) have a current provider agreement on file with the Division.

Authority: AS 47.05.010
AS 47.07.050

7 AAC 43.885 is amended to read:

7 AAC 43.885. PAYMENT. Payment for services rendered by an outpatient surgical clinic to beneficiaries will be paid in accordance with 7 AAC 43.675 -- 7 AAC 43.705. This payment fee covers all operative functions attendant to medically-necessary surgery performed at the center by a private physician or dentist, including admitting and laboratory tests, patient history and examination, operating room staffing and attendants, recovery room care, and discharge. It includes all supplies related to the surgical care of the beneficiary while in the center. The payment excludes the physician, radiologist, or anesthesiologist fee. (Eff. 8/18/79, Reg. 71; am / / , Reg.)

Authority: AS 47.05.010
AS 47.07.050

7 AAC 43.890 is amended to read:

7 AAC 43.890. BILLING RATE. Repealed / / .

PLEASE NOTE: THE FOLLOWING PAGES WERE TREATED AS A UNIT IN THE ORIGINAL DOCUMENT

Alaska Health Coalition

520 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,

Chas M. Kaltenbach

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

CMK:sem

Enclosure

Coalition Members

J. B. Carnahan, Fairbanks; Joseph Chadombos, Juneau;
Charles Kaltenbach, Dr. P.H., Fairbanks; Steve Lesko, 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.[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

1 U.S. Congress, Congressional Budget Office. Health Planning Issues for Reauthorization. Washington, D.C. March 1982.

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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."

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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.

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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.

PLEASE NOTE: THE PRECEDING PAGES WERE TREATED AS A UNIT IN THE ORIGINAL DOCUMENT.

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

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 paper concludes that there is merit in the Certificate of Need program though modifications should be made.

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

RECEIVED
FEB 18 1983
Josephson,

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 Chekaios, Juneau;
Charles Kaltenbach, Dr. P.H., Fairbanks; Steve Lesko, Anchorage;
John Manning, Ketchikan; Lillie McCarvey, Anchorage; Art Willcox, 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 1985) 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 these 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.[6]

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

MODIFY THE CON PROCESS

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

RECOMMENDATIONS

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

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

1. Increase the threshold level which triggers a CON review from $150,000 to at least:
   a. $600,000 for capital expenditures
   b. $400,000 for major medical equipment
   c. $250,000 for operating expenses associated with new services.

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

3. Expedite review of capital equipment replacement.

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

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

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

REFERENCES CITED

1 U.S. Congress, Congressional Budget Office. Health Planning Issues for Reauthorization. Washington, D.C. March 1982.

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Give to Nancy

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

October 6, 1983

Senator Joe Josephson
1016 West 6th Avenue
Anchorage, Alaska 99501

Nov. 2
1-4pm

Dear Senator Josephson:

We appreciated the opportunity to discuss public health issues and our agency's activities with you. We agree with your suggestion that our agency can be a resource in upcoming needs assessments and program evaluation activities.

Please do contact us as soon as the date for your teleconference on public health issues is established. We will offer to notify our Board and other public health agencies in our region.

I have enclosed a copy of the paper on certificate of need which you requested. Please contact our agency again if you would like further information on this subject.

Sincerely,

Barbara Berger

Barbara Berger
Program Manager

Enclosure

Conference in Anch.
Info from other States.

And notice on
Community living
hearing.

RECEIVED

Josephson,

CERTIFICATE OF NEED:

REVISION OR REPEAL

Prepared in
the
Public Interest
by
the

ALASKA HEALTH COALITION
February, 1983

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EXECUTIVE SUMMARY

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

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

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

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

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

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

CERTIFICATE OF NEED PROGRAM

PURPOSE

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

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

WHO MUST APPLY

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

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

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

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

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

THE PROCESS

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

EFFECTIVENESS

Nationwide

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

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

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

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

Alaska

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

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

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

Deterrent Effects

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

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

Improved Institutional Planning

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

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

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

Better Conformance with Identified Community Needs

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

Summary

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

PROBLEMS WITH THE CON PROCESS AND RECOMMENDATIONS FOR IMPROVEMENT

INTRODUCTION

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

COSTS

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

DELAYS

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

COMMUNITY CONTROL

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

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

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

MARKETPLACE ECONOMICS: COMPETITION vs. "REGULATION"

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

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

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

> An effective market is one in which there is competition on the basis of both price and quality, and in which those who sell services are limited in their ability to influence the volume of services they sell and are constrained in the prices they set by competitive pressures. By this definition, 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.[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

1 U.S. Congress, Congressional Budget Office. Health Planning Issues for Reauthorization. Washington, D.C. March 1982.

2 Howell, Julianne. Regulating Hospital Investment: The Experience in Massachusetts. Hyattsville, Maryland. DHHS/Health Resources Administration, (DHS) 81-8298. March 1981.

3 Headen, A. "The Impact of Certificate of Need Regulation on Hospital Investment: New Evidence." Presented at American Economic Association Health Economics Research Organization. Washington, D.C. December 1981.

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.

5 Arthur D. Little, Inc. A Study of Intermediate Outcomes of the CON Review Process. DHHS/Health Resources Administration. Contract #233-81-0018, Task Order #2. March 1982.

6 Enthoven, A.C. Consumer Choice Health Plan (in two parts). New England Journal of Medicine. 298:650-658, 709-720. March 1978.

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

8 Needleman, 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.

2-16-83

SB 85 - Certificate of Need

Dr. David Beale, Anch - Ak State Med. Assoc.
supports repeal. CON increases costs
Vic question - raising threshold; maintain review.
No level
Mass question -

Jan Faiks -

Ron Pavellas - Humana
Michael Herring St. Perin Humer
Al Cumasso - Providence

OMNIBUS MEASURE SUGGESTED BY JCE TO DEAL WITH CRA ISSUES ETC. (P.R.P.) ONE ISSUE MAY SUPPORT OTHERS, MUST HAVE SOME

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PROVIDENCE
HOSPITAL

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December 27, 1982

DEC 29 1982
Rec
HEP DIR. OFC

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

Alaska
state
hospital
association

319 Seward St., Juneau, Alaska 99801 • (907) 586-179(

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Central Peninsula Hospital
Soldotna

Delegate to the American
Health Care Association
and Board
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Iliamna

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Association
[illegible]
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Physician Member of
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Anchorage

President
Dennis L. DeVivi
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.

to the editor

Hospital bed shortage

Dear Editor:

As a physician in practice in Anchorage, I wish to call attention to a serious problem relating to health care in the community.

Both private hospitals in town at this time are experiencing an acute bed shortage, which has been an intermittent problem episodically over the past year. At this time, both hospitals are filled to capacity, and I have had several patients who have either not been admitted to the hospital when they should have been or have had admissioins delayed as a result of this problem.

I wish to emphasize to the public that both hospitals have and have had for some time plans to expand and meet this need. These plans have been obstructed and delayed as a result of federal and/or state regulations which require all plans for hospital expansion to be approved by central health planners at various bureaucratic levels. This has come about in a mistaken belief that it would result in a lowering of health care cost by reducing hospital expenses.

Quite the opposite has occurred, with increased demand and increased medical costs related to delays in obtaining necessary medical care. Of greater concern is the serious threat to the public's health resulting from the current bed shortage.

The naive assumption that government bureaucrats can better determine the need for new or expanded health facilities than health care providers or consumers should now be laid to rest. No hospital bed shortage in this community would exist at present if free market forces had been allowed to prevail in the absence of artificial restriction. The need for more hospital beds in this community is painfully obvious to any sick person in one of our emergency rooms. Why has it been less obvious to our legislators and congressman? Perhaps they obtain their health care in Seattle or Washington, D.C,

Richard Farleigh, M.D.
Anchorage

CERTIFICATE OF NEED LAW REPEAL

The biggest impediment to orderly, timely, and intelligent expansion of health facilities in Alaska is the Certificate of Need Statute (AS 18.07) and regulations 7 AAC 07.010 - .120.

In an expanding economy the certificate of need process serves only to distort and stultify planning, delay construction, and raise costs.

The law should be repealed as early in the 1983 legislative session as possible.

Copy of a letter and attachments from a hospital administrator to the Mayor of Anchorage about this is attached.

Attachments
RW21/p/D4

INVOLUNTARY CONFINEMENT OF PERSONS WITH ACTIVE TUBERCULOSIS

Alaska is one of two States not having an involuntary confinement law for quarantine of persons with dangerous infectious diseases like tuberculosis. Yet Alaska continues to have the highest rate of tuberculosis in the nation, and the rate has been rising in the past few years.

Attached is material supporting the need for an involuntary confinement act or regulation for persons with open tuberculosis.

Attachment
RW22/p/D4

FAIRBANKS HEALTH CENTER
800 AIRPORT WAY
FAIRBANKS, ALASKA 99701

2/18/80

November 5, 1979

Robert I. Fraser, M.D.
Chief, Communicable Disease Control
Division of Public Health
Department of Health and Social Services
MacKay Building, Room 222
338 Denali Street
Anchorage, Alaska 99501

Dear Dr. Fraser,

I am writing to support the concept of involuntary confinement of patients with active tuberculosis who refuse to cooperate, or, because of their life styles, are incapable of cooperating, in the required treatment program. The need to invoke involuntary confinement would not occur often but without treatment these patients will infect other people.

For example, a Fairbanks resident, who is an alcoholic and has active tuberculosis, has not returned to her doctor for treatment and has successfully evaded all attempts to locate her. Meanwhile she has infected a five year old niece and a nine year old nephew who are now under treatment for primary active tuberculosis. If it had been legally possible to commit this adult for three to six months of intensive treatment, these children would not have been infected.

Sincerely,

Patricia L. Rogers
Public Health Nursing Supervisor

PLR/nlr

City of Galena
Antoski Hall • P.O. Box 149 • Galena, Alaska 99741 • Telephone (907) 656-1281

Resolution 82-22

A RESOLUTION ENCOURAGING LEGISLATION SUPPORTING ENFORCEMENT OF TREATMENT OF COMMUNICABLE DISEASES, PARTICULARLY TUBERCULOSIS, IN ALASKA.

WHEREAS, the City Council of Galena is the duly authorized governing body of the City of Galena, and;

WHEREAS, the City of Galena has experienced an ongoing problem with tuberculosis and a recent outbreak of the disease, and;

WHEREAS, the City is experiencing an incident where one individual who has active tuberculosis is refusing treatment, and;

WHEREAS, the nature of the tuberculosis disease is that it can be highly contagious and endanger a whole community, and;

WHEREAS, the disease can be prevented with adequate treatment, and;

WHEREAS, there is no legislation to enforce treatment, and;

WHEREAS, the City of Galena has a strong committment to protect the citizens, and;

NOW, THEREFORE, Be It Resolved That the City Council of Galena requests the legislators to enact legislation to require individuals to obtain treatment for tuberculosis and other communicable disease.

PASSED AND APPROVE this 16th day of December ,1982

ATTEST:

Vernon White
Mayor

Pat Myers
City Manager

18.35.135 INVESTIGATION AND EXAMINATION OF SUSPECTED TUBERCULOSIS CASES - ISOLATION - QUARANTINE.

(1) Whenever the Public Health Medical Officer shall determine on reasonable grounds that an examination of any person is necessary for the preservation and protection of the public health, he shall issue a written order directing said medical examination, setting forth the name of the person to be examined, the time and place of the examination, and such other terms and conditions as he may deem necessary. A copy of such an order shall be served upon the patient. Such an examination shall be made by a licensed physician of the examinee's own choice under such terms and conditions as the health officer may specify.

(2) Any person who depends exclusively on prayer for healing in accordance with the teachings of any well recognized religious sect or denomination, and claims exemption on such grounds shall nevertheless be subject to examination and provisions of this article concerning isolation and quarantine which apply when there is probable cause to suspect such a person is infected with tuberculosis in a communicable stage. Such person shall not be required to submit to any medical treatment or be confined in a hospital or other medical institution if he can safely be quarantined or isolated in his own home or other suitable place of his choice.

18.35.136 QUARANTINE OR ISOLATION ORDER

(1) Whenever a Medical Officer of the Division of Public Health shall determine that quarantine or isolation in a particular case is necessary for the preservation and protection of the public health, he shall make an isolation or quarantine order in writing, setting forth the name of the patient to be isolated and the initial period of time, not to exceed six months, during which the order shall remain effective; the place of isolation or quarantine; and such other terms and conditions as may be immediately necessary to protect the public health. A copy of such order shall be served upon the patient. The patient shall be re-examined at the time the initial order expires, or at any other time the patient so requests, to ascertain whether his tuberculosis continues to be infectious. Whenever it shall be medically determined that the patient is no longer infectious and communicable and that the patient has received sufficient treatment of his disease, the patient shall be relieved from all further liability or duty imposed by this article.

(2) Upon the receipt of information that any examination, quarantine, or isolation order, made and served as herein provided, has been violated, the Public Health Medical Officer shall advise the District Attorney of the pertinent facts relating to the violation.

18.35.137 VIOLATION AND PENALTY

(1) Any person who, after service upon him of an order of the Division of Public Health Medical Officer directing his isolation or examination as provided in 18.35.135 and 18.35.136, violates or fails to

comply with same or any provisions thereof is guilty of a misdemeanor and in addition to any penalties which may be imposed by law upon such convictions, the court may now make an appropriate order providing for isolation, quarantine or treatment.

November 1, 1979

REPEAL OF REQUIREMENT FOR BLOOD TEST FOR SYPHILIS BEFORE MARRIAGE

There are fewer than 20 reported new cases of syphilis in Alaska annually, and most of these are among homosexual men.

It is unnecessary and very costly to test persons applying for marriage for syphilis because almost no one will have a positive test indicative of undiscovered untreated syphilis.

The proper time to test is provided otherwise in statute (AS 18.15.150) that is, at the time of pregnancy to be certain that syphilis does not occur in the baby.

The law (AS 25.05.101 and 105) allowing the Commissioner of Health and Social Services to test persons premaritally for infectious or heritable disease should not be repealed but language in Sec 25.05.105 should be clarified to make it discretionary on the part of the Commissioner as to whether any test is required. The present statute has been interpreted as requiring at least one test of some sort.

RW23/p/D4

WORKMEN'S COMPENSATION STATISTICAL INFORMATION

Present statute (AS 23.05.060(3)) empowers the Department of Labor to "make investigations, collect, and compile statistical information" relative to workmen's compensation matters.

Sec 23.20.110(a) speaks of sharing certain information with other state agencies or other States or the federal government but is silent about sharing information with a local government or with insurance carriers or other groups interested in on-the-job accidents and their costs.

Safety in the workplace is legitimate interest of local health departments. We request that the Department of Labor share statistical data including regional data with local governments and private organizations having valid interest in the matter.

RW24/p/D4

VITAL STATISTICS

Collection, collation, and analysis of vital statistics like births, deaths, marriages, divorces, and adoptions is ordinarily a state and federal function. In Alaska the Bureau of Vital Records within the Department of Health and Social Services does this. It prepares an annual report of Alaska Vital Statistics which is typically published over one year after the vital events.

Vital data is carefully protected by law and regulation (AS 18.50.300-320, 7 AAC 05.925, 7 AAC 05.200) in the interest of confidentiality and preventing misuse of statistics.

As principal health officer of the Municipality of Anchorage, I have need for more timely data particularly about deaths than the State can supply. I request help in obtaining copies of death certificates for statistical use.

Certain materials further explaining this are attached.

Attachments
RW25/p/D4

Municipality of Anchorage

MEMORANDUM

DATE: December 30, 1982

TO: Tom Klinkner, Assistant Municipal Attorney

FROM: Rodman Wilson, M.D., Director, Department of Health and Environmental Protection

SUBJECT: Request for Death Certificates From State Coroner

Attached is a copy of a letter I wrote to the State Coroner in July about death certificates.

At that time Mr. Kelly Fisher, formerly of your department, advised me that if I did not get a response that the legal department might assist me in this matter. Despite a telephone call about a month ago to Mr. Wilks, I have still heard nothing.

Collection of vital statistics is a State function, but I see no reason why I should not have timely data too. The State publishes an annual report of vital statistics, but this is not available until long after the close of the statistical year. For example, the department received the annual report of Alaska Statistics for 1980 in the fall of 1982.

Other city health departments appear to have little trouble in gathering vital statistics. Attached is a copy of a page which regularly appears in a publication of the Center For Disease Control showing up-to-date death statistics from a number of cities.

I would appreciate whatever assistance you may give me in the matter.

Rodman Wilson

Rodman Wilson, M.D.
Director

Attachment.

Municipality of Anchorage

POUCH 6-650
ANCHORAGE, ALASKA 99502-0650
(907) 264-4111

TONY KNOWLES, MAYOR

DEPARTMENT OF HEALTH AND ENVIRONMENTAL PROTECTION

August 12, 1982

Ms. Delores Wilks
Coroner
State of Alaska
941 W. 4th Avenue, Room 137
Anchorage, Alaska 99501

Dear Ms. Wilks:

As Health Officer for the Municipality of Anchorage I am responsible under statutes and ordinances for protection of the health of the public.

In fulfilling this charge, I want to inspect, preferably on a daily basis, copies of all death certificates prepared in Anchorage.

I am aware that the State keeps vital statistics but their annual reports are not suitable for my purposes.

Sincerely yours,

Rodman Wilson

Rodman Wilson, M.D.
Director, Department of Health
and Environmental Protection

D26/c

TABLE IV. Deaths in 121 U.S. cities,* week ending December 11, 1982 (49th week)

Reporting Area	All Causes, By Age (Years)						P&I** Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	661	441	156	31	20	13	56
Boston, Mass	188	112	51	13	6	6	24
Bridgeport, Conn	38	25	10	2	-	1	6
Cambridge, Mass	30	23	6	-	1	-	5
Fall River, Mass	26	19	5	1	1	-	-
Hartford, Conn	40	26	11	1	2	-	5
Lowell, Mass	35	19	11	1	3	1	1
Lynn, Mass	19	12	5	2	-	-	-
New Bedford, Mass	18	15	3	-	-	-	1
New Haven, Conn	68	42	17	5	1	3	2
Providence, RI §	56	52	-	2	-	2	5
Somerville, Mass	11	8	3	-	-	-	-
Springfield, Mass	36	28	5	-	3	-	4
Waterbury, Conn	43	28	12	2	1	-	1
Worcester, Mass	53	32	17	2	2	-	2
MID ATLANTIC	2,530	1,691	554	150	88	89	95
Albany, N Y	53	38	10	1	1	3	2
Allentown, Pa	17	13	4	-	-	-	1
Buffalo, N Y	100	74	21	1	1	3	5
Camden, N J	34	15	11	2	5	1	-
Elizabeth, N J	31	25	5	1	-	-	2
Erie, Pa †	43	22	17	4	-	-	2
Jersey City, N J	45	29	10	1	-	5	-
N Y City, N Y	1,415	947	296	108	36	28	48
Newark, N J	69	32	21	7	4	5	5
Paterson, N J	24	13	2	3	2	4	2
Philadelphia, Pa †	263	163	69	13	9	9	13
Pittsburgh, Pa †	60	40	13	3	-	4	-
Reading, Pa	32	22	9	-	-	1	1
Rochester, N Y	94	65	17	3	3	6	6
Schenectady, N Y	29	22	6	-	1	-	1
Scranton, Pa †	22	19	3	-	-	-	-
Syracuse, N Y	108	83	20	1	4	-	-
Trenton, N J	39	26	11	2	-	-	4
Utica, N Y	26	24	2	-	-	-	-
Yonkers, N Y	26	19	7	-	-	-	3
E N CENTRAL	2,285	1,408	572	154	67	86	68
Akron, Ohio	65	37	20	3	2	3	-
Canton, Ohio	42	29	9	2	1	1	1
Chicago, Ill	500	283	130	44	17	26	8
Cincinnati, Ohio	171	119	40	8	2	2	10
Cleveland, Ohio	153	77	50	10	5	11	3
Columbus, Ohio	140	80	43	8	3	6	-
Dayton, Ohio	109	74	24	3	5	3	1
Detroit, Mich	266	146	82	36	10	12	7
Evansville, Ind	40	24	12	2	-	2	2
Fort Wayne, Ind	42	25	15	1	-	1	4
Gary, Ind	21	11	8	2	2	-	1
Grand Rapids, Mich	55	37	14	2	1	1	1
Indianapolis, Ind	187	112	44	13	7	11	1
Madison, Wis	43	27	12	2	2	-	6
Milwaukee, Wis	132	100	24	6	1	1	3
Peoria, Ill	49	29	14	1	2	3	4
Rockford, Ill	33	26	4	3	-	-	2
South Bend, Ind	42	31	8	2	1	-	3
Toledo, Ohio	142	104	28	4	3	3	3
Youngstown, Ohio	53	35	13	2	3	-	-
W N CENTRAL	739	499	151	43	21	25	33
Des Moines, Iowa	57	34	17	3	3	-	2
Duluth, Minn	40	30	4	5	1	-	-
Kansas City, Kans	29	22	5	-	-	2	-
Kansas City, Mo	101	63	25	6	3	4	3
Lincoln, Nebr	34	28	2	3	-	1	1
Minneapolis, Minn	88	68	9	4	3	4	4
Omaha, Nebr	94	53	28	5	4	4	5
St. Louis, Mo	165	108	31	15	4	7	10
St. Paul, Minn	72	51	18	1	1	1	3
Wichita, Kans	59	42	12	1	2	2	5
S ATLANTIC	1,179	693	328	78	35	45	43
Atlanta, Ga	130	74	40	8	4	4	4
Baltimore, Md	196	110	53	19	7	7	4
Charlotte, N C	80	41	29	4	3	4	3
Jacksonville, Fla	92	51	30	6	4	1	7
Miami, Fla	90	41	34	8	4	3	-
Norfolk, Va	57	37	13	2	-	5	-
Richmond, Va	81	47	28	4	-	2	4
Savannah, Ga	51	27	10	5	5	4	3
St. Petersburg, Fla	93	69	20	2	1	1	6
Tampa, Fla	75	52	13	4	2	4	2
Washington, D C	189	115	47	15	4	8	6
Wilmington, Del	45	29	12	1	1	2	2
E S CENTRAL	903	568	232	44	33	25	53
Birmingham, Ala	135	92	28	10	4	1	5
Chattanooga, Tenn	75	54	14	3	1	3	5
Knoxville, Tenn	83	48	11	1	2	1	2
Louisville, Ky	111	56	34	10	5	6	11
Memphis, Tenn	228	138	65	8	5	11	12
Mobile, Ala	141	96	32	2	9	2	9
Montgomery, Ala	41	27	11	2	1	-	3
Nashville, Tenn	109	57	37	8	6	1	6
W S CENTRAL	1,298	751	310	111	57	69	61
Austin, Tex	47	32	8	3	3	1	3
Baton Rouge, La	43	28	13	-	1	1	1
Corpus Christi, Tex	58	42	8	5	-	1	2
Dallas, Tex	179	100	44	16	14	5	4
El Paso, Tex	82	46	16	7	5	8	14
Fort Worth, Tex	104	56	24	16	1	7	8
Houston, Tex	243	109	77	33	12	12	5
Little Rock, Ark	84	52	24	3	1	4	4
New Orleans, La	122	63	32	7	9	11	-
San Antonio, Tex	182	124	33	11	7	7	13
Shreveport, La	55	36	7	7	3	2	-
Tulsa, Okla	101	63	24	3	1	10	7
MOUNTAIN	678	434	143	40	27	34	27
Albuquerque, N Mex	78	50	10	6	5	5	1
Colo. Springs, Colo	36	29	3	4	-	-	1
Denver, Colo	124	85	29	3	5	2	5
Las Vegas, Nev	82	51	18	4	5	4	5
Ogden, Utah	19	11	2	1	-	4	1
Phoenix, Ariz	169	101	43	10	7	8	1
Pueblo, Colo	14	11	2	-	1	-	1
Salt Lake City, Utah	62	28	20	4	3	7	1
Tucson, Ariz	96	68	15	8	1	4	11
PACIFIC	1,795	1,210	406	77	43	57	102
Berkeley, Calif	20	14	4	-	1	-	-
Fresno, Calif	88	65	14	2	4	3	7
Glendale, Calif	38	28	7	1	-	-	1
Honolulu, Hawaii	56	35	12	2	1	1	6
Long Beach, Calif	105	60	37	1	1	6	5
Los Angeles, Calif	455	298	110	25	12	9	15
Oakland, Calif	59	43	9	4	2	1	3
Pasadena, Calif	30	19	7	1	-	3	2
Portland, Oreg	156	122	25	4	2	3	12
Sacramento, Calif	77	49	15	4	3	6	3
San Diego, Calif	135	84	36	7	4	4	11
San Francisco, Calif	107	111	36	11	6	3	10
San Jose, Calif	154	103	32	7	2	10	16
Seattle, Wash	153	105	35	4	3	6	2
Spokane, Wash	59	40	12	3	2	2	5
Tacoma, Wash	45	34	10	1	-	-	4
TOTAL	12,086††	7,893	2,852	728	389	423	538

* Mortality data in this table are voluntarily reported from 121 cities in the United States, most of which have populations of 100,000 or more. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.

** Pneumonia and influenza.

† Because of changes in reporting methods in these 4 Pennsylvania cities, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

†† Total includes unknown ages.

§ Data not available. Figures are estimates based on average of past 4 weeks.

ABOLITION OF TELEVISION ADVERTISING OF BEER AND WINE

Many young people drink beer all day long. Many drink enormous quantities of wine. Many people are confirmed alcoholics in their teens or twenties.

Much of the inducement to drink beer and wine comes from television advertising. The message is that social acceptance, relation, and enhanced sexuality come from drinking beer or wine.

Since this is patently false and clearly detrimental to many young people, it should be stopped, - just as television advertisement of smoking and drinking hard liquor was banned.

RW26/p/D4

PLEASE NOTE: THE FOLLOWING PAGES WERE TREATED AS A UNIT IN THE ORIGINAL DOCUMENT

Municipality of Anchorage

POUCH 6-650
ANCHORAGE, ALASKA 99502-0650
(907) 264-4111

TONY KNOWLES
MAYOR

DEPARTMENT OF PLANNING

January 14, 1983

The Plan Development Committee of the Anchorage Municipal Health Commission and South Central Health Planning and Development, Inc., are reviewing a variety of data to arrive at a position on projected community need for general acute care beds and inpatient rehabilitation beds. The results of the Committee's decisions will be used to guide the respective Project Review Committees as they review the Providence and Humana Hospital Alaska applications for certificates of need for major construction projects.

As part of the Plan Development Committee process of determining future need, members developed and reviewed position papers on both items (general acute and rehabilitation beds). These papers were sent to interested parties throughout the community, requesting pertinent comments and recommendations. To date we have received comments only from Providence and Humana Hospitals and the Alaska Treatment Center (ATC).

At the request of ATC, and with concurrence by the Plan Development Committee of the Commission, we strongly encourage members of the public to react to the contents of the inpatient rehabilitation position paper. While there appears to be some consensus on the question of the magnitude of the need for inpatient rehabilitation beds, the Committees are especially looking for guidance related to the issue of whether there should exist one or two (in one hospital or two) inpatient rehabilitation units. Evaluations of the impact of one or two units on (1) medical and support staffing, (2) optimum use of other existing community resources, (3) ability of units to complement an appropriate continuum of care, (4) other quality of care standards, etc., would be appreciated.

Please respond in writing as soon as possible to either:

Jan L. Gehler
c/o Human Resources Planning
Po ıch 6-650
Anchorage, Alaska 99502
264-4261

or

Margaret M. Wilson
c/o SCHPD, Inc.
1135 W. 8th Avenue
Anchorage, Alaska 99501
278-3631

An additional opportunity for input will exist during the State sponsored public hearing on the certificate of need applications, to be held on February 2, from 10:00 a.m. to 5:00 p.m. in Room C21 of the Federal Building. The time period from 1:00 to 3:00 p.m. has been set aside expressly for comments related to inpatient rehabilitation care.

Yours truly,

Jan L. Gehler

Margaret M. Wilson

jg4/e13

A POSITION PAPER

A REPORT ON ACUTE CARE

BED NEED PROJECTIONS

FOR ANCHORAGE

MHC Final 1/12/83

Acute care bed need projections for civilian, non-Native hospital services in Anchorage are included in the South Central Health Planning and Development (SCHPD) Health Systems Plan 1982-1986 and the Anchorage Health Systems Plan 1982-84 (herein referred to as the Plans). The methodology, assumptions, and analyses in both documents was developed jointly by SCHPD and Municipal Health Commission (MHC) staff.

Assumptions Underlying Community Bed Need Projections

The assumptions underlying the projections contained in the planning documents include:

1. Population distributions by age for the Municipality (excluding military) are assumed to be appropriate for the civilian non-Native (CNN) population in Anchorage.

2. The official Municipal 1985 projected total population is 231,000. The assumptions used to support this projected figure are viewed by experts to be optimistic. Therefore, this 1985 figure is likely to be high. Projections based upon a lower range of population growth are available in the SCHPD 1982 Health Systems Plan.

3. Age categories will remain approximately the same through 2000. Figures assume that the slowly increasing average age of the population will not significantly affect the use of Anchorage hospitals for the study period.

4. The availability of 80 to 100 skilled nursing beds in the Anchorage Pioneer Home will allow growing numbers with chronic conditions to have access to a skilled and/or intermediate level of care (Nakoyia's beds will likely come open as eligible patients transfer to the Pioneer Home).

5. There will be no major change in the array of services (beds) at Elmendorf Air Force Base Hospital and no substantial change in policy with respect to military use of private sector facilities.

6. Native use of private sector services may be effected by some changes in federal budgetary restraints, which effect other PHS facilities outside Anchorage (Bethel, Bristol Bay).

7. The population outside Anchorage will continue to increase at approximately the same annual rate which is lower (less than 3.0%) than the rate for the Anchorage area (greater than 3.0%). The same proportion of Alaskans will continue to use health services outside Alaska.

8. The non-Anchorage patient days may be effected by the new or expanded services of non-Anchorage facilities, such as in Palmer, Soldotna, Homer, Cordova.

9. It is possible that length-of-stay will increase in medical/surgical services or pediatrics. As more routine surgeries, typically requiring a shorter stay, are done on an outpatient basis, average acute length-of-stay might increase. Obstetric use rates will probably not increase, and may decline with increased use of alternative birthing opportunities. However, the addition of a neonatologist, more non-Anchorage high risk obstetric cases may by treated in Anchorage.

10. References to existing beds in projections refers to those acute care hospital beds in private facilities (Providence and Humana Hospital Alaska) that are officially licensed as such by the State of Alaska, as of the date of this paper (December 1982). (Providence 250 and Humana 199.) Note: Humana Hospital Alaska has 199 licensed acute beds and intends to request that the 21 beds currently used for the Chemical Dependency Unit (CDU) be used as general acute care when needed. Assuming that conversion, the community supply of licensed acute care beds would then be 250 plus 199 to equal 449 beds.

Table I: Comparison of Community Bed Need Projections 1985-1995

A summary of the analysis included in the plans is included in the first column of Table 1. Figures are expressed as ranges due to the use of different population projections used in the SCHPD(HSA) and MHC planning process. Throughout this paper the lower figures in the left are from the SCHPD Plan and the higher figures on the right are from the MHC plan (see SCHPD plan for details).

The bed need projections in the plans were based on 1980 utilization data from Providence and Humana Hospitals. In order to determine how more recent information might affect the projections, staff obtained 1981 utilization and population data and re-calculated the bed projections. Utilization and patient origin data for 1981 were obtained from both hospitals. Results of the calculations are shown in the second column of Table I.

Table I also includes projections of community bed need contained in the most recent Certificate of Need applications submitted by Providence Hospital and Humana Hospital Alaska. Humana projected community bed need to 1985 and 1990. Providence estimated community bed need for 1995. Summaries of the projections contained in those applications are included in Table I.

There is discrepancy between projections for medial/surgical and ICU/PCU/CCU as shown in SCHPD/MHC plans and the Providence application. This reflects the difference in actual use of those beds as compared to optimum use, or that which would have occurred had space in the appropriate type of bed been available. For example, patients needing a general medical/surgical bed might have had to stay longer than necessary in a PCU or ICU bed because the medical/surgical beds were full. The net result of this situation would be an increase in the apparent demand for PCU beds. When calculating patient days by service the PCU days would be higher than under optimum conditions of available medical/surgical beds. Hospitals adjust for this phenomena through a House Convenience Report which shows where patients are actually placed and where they should have been placed under optimum circumstances.

SCHPD & MHC staff did not have access to the house convenience data for use in the plans. However, the medical-surgical subtotal projections are consistent, and are perhaps more useful than the specific service projections for ICU/CCU, PCU and medical-surgical beds.

TABLE I
COMPARISON OF COMMUNITY ACUTE CARE BED NEED PROJECTIONS 1985 - 1995

Service	HSA/MHC Plans[1]	HSA/MHC 1981 Data Update[2]	Providence C/N Application June 82	Humana C/N Application October 82
Medical/Surgical[3]				
Anchorage Use Rate - 1980/Proj.	491	459	561/586	491
Projected Anchorage Use	76.2%	74.5%	75.9%	76.2%
Population - Anchorage CNN				
1985	118,642/141,312	Same as in Plans	-	141,312
1990	135,045/151,132	Same as in Plans	-	151,132
1995	- /168,797	Same as in Plans	172,077	-
Community Bed Need				
1985	247/294	236/281	-	293
1990	281/314	268/300	-	314
1995	- /351	- /336	376[4]	-
ICU/CCU				
Anchorage Use Rate - 1980 Proj.	54	52	-	54
Projected Anchorage Use	76.2%	74.5%	-	76.2%
Community Bed Need				
1985	39/46	38/45	-	47
1990	44/49	43/48	-	48
1995	-/55	-/54	42[5]	-
PCU				
Anchorage Use Rate - 1980 Proj.	52	50	-	52
Projected Anchorage Use	76.2%	74.5%	-	72.2%
Community Bed Need				
1985	30/37	29/34	-	35
1990	34/39	33/37	-	39
1995	-/44	-/41	37[5]	-

COMPARISON OF COMMUNITY ACUTE CARE BED NEED PROJECTIONS 1985 - 1995

Service	HSA/MHC Plans[1]	HSA/MHC 1981 Data Update[2]	Providence C/N Application June 82	Humana C/N Application October 82
Medical/Surgical Subtotal				
1985	316/377	303/360	-	375
1990	359/402	344/385	-	401
1995	-/450	-/431	455[5]	-
Obstetrics				
Anchorage Use Rate - 1980/Proj.	226	259[13]	216/216	/226
Projected Anchorage Use	90.1%	87.0%	91.6%[6]	90%
Population				
1985	42,768/50,940	Same as in Plans	-	50,940
1990	48,681/54,480	Same as in Plans	-	
1995	- /60,848	Same as in Plans	59,753	-
Community Bed Need				
1985	40/47	46/55[13]	-	47
1990	45/50	51/59[13]	-	50
1995	-/56	-/66[13]	52-53[17]	-
Pediatrics				
Anchorage Use Rate - 1980/Proj.	134	132	140	172
Projected Anchorage Use	78.2%	78.32[14]	79.2%[6]	78.2%
Population				
1985	39,758/47,455	Same as in Plans	-	47,155
1990	45,251/50,646	Same as in Plans	-	50,646
1995	- /56,566	Same as in Plans	58,095	-
Community Bed Need				
1985	29/35	29/34	-	34
1990	33/37	33/16	-	37
1995	- /41	-/41	41-44[8]	-

Table 1 Con't

COMPARISON OF COMMUNITY ACUTE CARE BED NEED PROJECTIONS 1985 - 1995

Service	HSA/MHC Plans[1]	HSA/MHC 1981 Data Update[2]	Providence C/N Application June 82	Humana C/N Application October 82
Thermal				
Anchorage Use Rate - 1980/Proj.	10	11	4[9]	-
Projected Anchorage Use	76.2%	73.7%[11]	-	-
Population	Same as Med/Surg			
Community Bed Need				
1985	9/10	11/12	-	-
1990	10/11	12/13	-	-
1995	-/12	-/14	13	-
Psychiatry				
Anchorage Use Rate - 1980/Proj.	24	27	29.1	-
Projected Anchorage Use	83.1%	83.1%	86.8%[10]	-
Population	Same as Med/Surg			
Community Bed Need				
1985	12/13	13/15	-	-
1990	13/14	14/16	-	-
1995	-/16	-/18	19	-
ACUTE CARE TOTAL[12]				
1985	406/482	404/476[13]	-	464
1990	460/514	456/509[13]	-	496
1995	-/575	-/570[13]	583	-
Neonatal Intensive Care				
Use Rate	470		474	
Live Births				
1985	11,435		-	
1990	13,779		-	
1995	-		16,604	
Community NICU Bed/Need				
1985	30		-	
1990	36		-	
1995	-		43	

Table 1 Con't

jq4/rt1

Footnotes to Table I

1. SCHPD Health Systems Plan 1982-86; Anchorage Health Systems Plan, 1982-84.

2. Application of acute care bed need projection methods, as used in the plans, adjusted for 1981 hospital utilization data and 1981 population figures. The following tables include utilization and population data used for calculations in the update column.

1981 Population Data	
Total	187,761
Native	9,876
Military	
Active	11,210
Dependent	16,061
Civilian Non-Native	150,614
Women 15-44 (27%)	40,666
Adults (14+)(74.9%)	112,810
Children (25.1%)	37,804
Source: MOA Community Planning Department	

1981 Patient Days and Percent Occupancy

	Providence Patient Days[a]	%Occ	Humana Patient Days[b]	%Occ	Optimum Occupancy[c]
Medical/Surgical	59,773	90.0	23,646	39.7	85%
M/S	47,276	93.8	21,962	39.6	85%
ICU/CCU	5,096	69.8	2,684	40.8	60%
PCU	7,401	92.1	---	--	75%
Obstetrics	4,827	50.8	4,463	81.5	75%
Pediatrics	3,480	52.9	2,5 91	50.7	65%
Psychiatry	3,586	65.4	---	--	85%
Thermal	1,592	39.6	---	--	50%
Total	72,658	79.6	31,700	43.6	80%

Note: 1. Occupancies calculated using Providence 250 licensed beds, Humana 199 C/N'd beds (See Assumption #10).
2. Humana M/S Occupancy does not include CDU patient days.
3. If assume proportion of L&D days to patient days in HHA are same as in Providence (21.8%), could deduct 973 from OB days to yield 3,490 patient days at 63.7% occupancy of HHA's 15 OB beds.

Sources: [a] Providence Hospital C/N application, p. 114
[b] Humana Hospital Alaska C/N application, p. 58
[c] SCHPD and MHC Plans

Anchorage Patient Days Compared to Total Patient Days for Providence, Humana and the Community in 1981

Service	Providence		Humana		Community		
	Anch.	Total	Anch.	Total	Anch.	Total	%
Med-Surg.	43,122	60,323	19,556	23,808	62,678	84,131	74.5
OB	5,982[1]	7,065[1]	4,509	5,026	10,521	12,091	87.0
Ped	3,912	5,500[2]	2,437	2,880	6,349	8,380	75.8

[1] Labor and delivery day total of 1054 days added to total: 84% (Prov. OB% from Anch. added to Anchorage day total).
[2] Previous total received from Providence for pediatrics was 3,480; the higher figures (3912/5500) include NSCN which cannot be broken out from Peds.

3. Includes orthopedics.

4. See p. 120 of Providence C/N aplication dated June 1982, (Anch. CNN patient days for 1995 divided by total patient days).

5. See p. 194 of Providence C/N aplication (HHA existing beds plus Providence 1995 forecast).

6. See p. 127, p. 130 of Providence C/N (Anchorage CNN patient days forecast for 1995 divided by total patient days).

7. See p. 130 of Providence C/N total patient days (then divide by 365 to get average daily census, and by minimum occupancy of 65%). Alternative method: see p. 194 (HHA beds + Providence 1995 forecast).

8. See p. 127 of Providence C/N, total patient days (then divide by 365 to get average daily census, and by minimum occupancy of 75%).

9. Use rate based on state population.

10. See p. 134 of Providence C/N (Anch. CNN patient days divided by total).

11. Providence medical/surgical Anchorage use rate was used rather than a community-wide proportion.

12. Excluding chemical dependency service at Humana.

13. Use includes labor and delivery days for both hospitals as Humana was unable to separate their labor and delivery days out from OB patient days. Total projections

then include labor and delivery beds which are not included in a total bed count nor as licensed beds.

14. Unable to redo with 1981 patient origin data since Providence Hospital has some NSCN days in pediatric days. (Total in patient origin information provided were not consistent with pediatric service totals.)

Table II: Comparison of Bed Need Projections with Existing Supply of Acute Care Beds

Table II capsulizes the information obtained in Table I and compares the projections completed by the planning agencies (SCHPD and MHC) with current built bed capacity.

The data from the table show that there are currently 449 acute care beds built and/or licensed (250 at Providence and 199 at Humana).

Projections of communitywide need for beds in 1985 ranges from 403 to 482 beds depending on population figures, use rates and methodologies used. Neither Providence's nor Humana's proposed additional beds would be available for use by 1985.

Projections of community need for beds in 1990 range from 456 to 514 beds. By 1990 the combined total of additional beds proposed through Providence's and Humana's C/N's would be 243 (Providence, 150; Humana, 93). The addition of those 243 beds to the existing 449 beds would yield a supply of 692 beds. This level of supply would exceed the projected communitywide demand by 178 to 236 beds.

Projections of community need for beds in 1995 range from 570 to 583 beds. Assuming the addition of 243 proposed new beds (Providence, 150; Humana, 93), to the community, there would still be an excess of 109 to 122 beds beyond demand.

Please note that the derivation of projections of communitywide acute bed need, from the plans or in the 1981 update, does not include consideration of need for inpatient acute rehabilitation beds. However, both C/N proposals of 150 and 93 beds respectively, each include a 20 bed inpatient rehabilitation unit. Therefore, a more accurate comparison of need to proposed supply could be achieved by deducting 20 beds from each hospital's total proposed number, i.e. from 150 to 130 for Providence, and from 93 to 73 for Humana.

TABLE II

COMPARISON OF BED NEED PROJECTIONS WITH EXISTING SUPPLY OF ACUTE CARE BEDS

Service	Existing Acute Beds			Community Bed Need Projections						Beds Proposed Beyond Existing	
				Plans		'81 Update					
	Providence	Humana	Total	HSA	MIC	HSA	MIC	Providence C/N	Humana C/N	Providence C/N	Humana C/N
Medical/Surgical	138	152	290								
1985				247	294	236	281	—	293		
1990				281	314	268	300	—	314	88	31
1995				-	351	-	336	376	—		
ICU/CCU	20	18	38								
1985				39	46	39	45	—	47		
1990				44	49	43	48	—	48	8	10
1995				-	55	-	54	42	—		
PCU	22	--	22								
1985				30	37	29	34	—	35		
1990				34	39	33	37	—	39	6	10
1995				-	44	-	41	37	—		
Obstetrics	26	15	41					—	34		
1985				40	47	46	55	—	34		
1990				45	50	51	59	—	50	12	17
1995				-	56	-	66	52-53	—		
Pediatrics	18	14	32					—	34		
1985				29	35	29	34	—	34		
1990				31	37	31	36	—	37	10	5
1995				-	41	-	41	41-44	—		
Thermal	11	—	11								
1985				9	10	11	12	—	—		
1990				10	11	12	13	—	—	1	
1995				-	12	-	14	13	—		
Psychiatry	15	--	15								
1985				12	13	14	15	--	--		
1990				14	14	14	16	—	—	5	
1995				-	16	-	18	19	—		
TOTAL	250	199	449								
1985				400	482	404	476	—	464		
1990				464	514	450	509	--	490		73
1995				-	575	-	570	503	-	130	
Plus Proposed Inpatient Rehabilitation Beds										20	20
TOTAL PROPOSED ADDITIONS										150	93

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The net result of that adjustment would yield the following comparisons:

	Communitywide Need (Range)	Additional Beds Proposed			Community Bed Supply w/Additions of all Proposed Beds
		Prov	HHA	Total	
1985	403 to 482	Proposed beds not available yet			449
1990	456 to 514	130	73	203	652
1995	570 to 583	130	73	203	652

Therefore, if all beds proposed by Providence (130) and Humana (73) (excluding temporarily the proposed rehabilitation beds) were added to the current community bed supply the comparison of need to supply would be as shown below:

	Communitywide Need (Range)	Supply	Supply Status (Range)
1985	403 to 482	449	excess of 46 to deficit of 33 beds
1990	456 to 514	652	excess of 138 to 196 beds
1995	570 to 583	652	excess of 69 to 82 beds

OTHER CONSIDERATIONS

An important factor is the use of a specific planning horizon. Though projections of bed need are estimated for specified years, it is recognized that services cannot practically be added in small increments. Therefore, beds are planned for and built before all will be used to full capacity. While facilities typically project need for a period three years beyond anticipated opening of a service, a longer horizon might be considered. The impact of improved technology and fluctuations in population numbers and characteristics can significantly alter the trends on which projection assumptions are drawn. Given construction timetables and a usual 3-year post start-up planning horizon, a 1990 projection would be appropriate at a minimum. Taking into account the unknowns with regard to the population of the Municipality of Anchorage and Alaska, as well as the additional factors cited above, a 1995 projection may be the more prudent. The adoption of a specific planning horizon by the Plan Development Committees of the HSA and MHC, would constitute an addition to the assumptions which underly the projections (See page 1).

An additional consideration in the determination of future need for acute care beds, is the presence of 125 general acute care beds, considered by the State to be existing by virtue of a grandfathered C/N held by Lake Otis Hospital, Inc.

In order to show the impact of those 125 beds on the local need and supply status one must recognize that those 125 beds are not yet built. It typically takes about three years to build and open hospital beds. If one assumed construction to begin in early 1983, it would be at least 1986 before the beds would be open and available for use. (As of this time LOH has not indicated when those beds would be open and available.) Therefore, the comparison of needs and supply, not considering the beds proposed by Providence and Humana, would be as shown below:

Community Need (Range)		Bed Supply	Supply Status
1985	403 to 482	449	excess of 46 to deficit of 33 beds
1990	456 to 514	574	excess of 60 to 118 beds
1995	570 to 583	574	excess of 23 to deficit of 4 beds

NOTE: MHC need figures from the 1982-84 HSP are:

	Beds Needed
1985	482
1990	514
1995	575

If MHC:PDC were to use their HSP need figures only, the Bed Supply Status would be:

1985	deficit of 33 beds
1990	excess of 60 beds
1995	deficit of 1 bed

SUMMARY

In summary, by 1985 the Anchorage community may experience either a small excess (46 beds) or an even smaller deficit (33 beds), of hospital beds depending on the assumptions and figures used for projecting need. By 1990, assuming the approved 125 LOH beds are built and opened, the community may experience an excess of beds ranging from 60 to 118, again depending on projection methodologies used. By 1995, with 125 LOH beds in place, there may be either an excess of 23 beds or a small deficit of 4 beds.

If one considers the supply not to include LOH, then the resultant need for beds will vary depending on the number of beds contributed to the supply through either or both the Providence and/or Humana proposals.

Therefore, it appears that the ability of the health care system to meet projected demand for acute care beds between 1985 and 1995 is largely dependent upon (1) the date by which and the specific type of beds Lake Otis Hospital will open within the 125 bed facility, or (2) the ability of other providers to somehow meet the community's needs.

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PLEASE NOTE: THE PRECEDING PAGES WERE TREATED AS A UNIT IN THE ORIGINAL DOCUMENT.

Health, Education and Social Services Committee

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811
465-4907
465-4908

Alaska State Legislature

Senate

February 9, 1983

Al M. Camosso
Administrator
Providence Hospital
3200 Providence Drive
Pouch 6604
Anchorage, Alaska 99502

Dear Al:

Thank you for your letter concerning the certificate of need legislation.

I expect that the Senate Committee on Health, Education and Social Services will conduct hearings on the bill in the near future. I will be sure that your views are available to all member of the Senate committee.

I am also aware that the hospitals of Alaska are looking forward to an early decision by the legislature because some projects are in the mill now, which would be subject to certificate of need unless there is repeal or modification of the current program.

With best wishes, I am

Sincerely,

Joe P. Josephson

JPJ/rmc

PROVIDENCE
HOSPITAL

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

SISTERS OF PROVIDENCE

SERVING IN THE WEST SINCE 1856

January 26, 1983

RECEIVED
JAN 31 1983
Josephson

The Honorable Joe Josephson
Alaska State Senate
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 Senator Josephson:

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

PLEASE NOTE: THE FOLLOWING PAGES WERE TREATED AS A UNIT IN THE ORIGINAL DOCUMENT

STATE OF ALASKA
DEPT. OF HEALTH AND SOCIAL SERVICES
STATEWIDE HEALTH COORDINATING COUNCIL

BILL SHEFFIELD, GOVERNOR

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

March 30, 1983

RECEIVED
APR 05 1983
Josephson,

The Honorable Joe Josephson
Chairman, Senate HESS Committee
Alaska State Senate
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Senator Josephson:

The Alaska Statewide Health Coordinating Council, a 20-member citizen advisory board to the Department of Health and Social Services and sponsor of the State Health Plan for Alaska, has been on record for several years in support of cost-containment of rising health care costs through the certificate of need program.

During the March 23, 1983 meeting of the Alaska Statewide Health Coordinating Council, there was unanimous agreement to support the February 1983 position paper by the Alaska Health Coalition, entitled "Certificate of Need: Revision or Repeal" (enclosed), which concludes that the certificate of need program has been effective and can be modified to be more efficient. More specifically, the position paper recommends that negotiations take place among members of the Alaska State Hospital Association, the Legislature, and the Administration to work out revised certificate of need regulations.

Thank you for considering our recommendation.

Sincerely,

Joe Cladouhos (ckp)

Joe Cladouhos, Chairman
Statewide Health Coordinating Council

Enclosure

cc: Robert London Smith
Vic Fischer
Rick Halford
Paul Fischer
Pappy Moss

CERTIFICATE OF NEED:

REVISION OR REPEAL

Prepared in
the
Public Interest
by
the

ALASKA HEALTH COALITION
February, 1983

RECEIVED

FEB 16 1983

Josephson,

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

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1983
Josephson,

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FEB 16 1983
Josephson,

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 Certi icate 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
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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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1 U.S. Congress, Congressional Budget Office. Health Planning Issues for Reauthorization. Washington, D.C. March 1982.

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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."

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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.

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Anchorage

President
Dennis L. DeWitt
Juneau

March 16, 1983

The Honorable Joe Josephson
Senator
Pouch V
Juneau, Alaska 99811

Dear Senator Josephson:

I have reviewed the attached Committee Substitute for SB85. I have reviewed the contents with the Executive Committee of the Alaska State Hospital Association and inform you of our support for this Committee Substitute. This omnibus legislation addresses Certificate of Need, prospective payment for Medicaid and GRM, and revenue sharing in a manner acceptable to us on the whole.

While this bill does not repeal Certificate of Need, we are confident that the experience gained over the next 7 years will prove the point we have been making as to its uselessness. The prospective payment portion embodies an independent commission approach, basic principles of reimbursement, and a fair appeals mechanism. The suspension of Capital Revenue Sharing for 7 years is consistent with our committment that CON and Capital Revenue Sharing should be dealt with on the same basis. Capping operational revenue sharing at $250,000 per facility is in our judgement appropriate in the context of this bill.

I would like to extend to you my personal as well as the Association's appreciation for your willingness to work through the difficult issues with us. It has been both an intense and successful process leading to better understandings between the legislature and the industry I represent. While the negotiations were exhilirating I must confess my pleasure that they are concluded. We can now get about explaining this package to the Senate and House.

Sincerely,

Dennis L. DeWitt
President

DLD:hb
cc: Association Membership

DeWitt's comments on CS SB 85

Section 1 – VERY Appropriate

Section 6 - OK – However This is DELT with IN CS SB 37 CEQA

section 7.a) We need BASIC PRINCIPLES – I believe OUR ~~PO~~ SUGGESTION of yesterday is about as NEUTRAL AS I CAN MOVE OUR BOARD

b) My people will SCREAM – I will DELIVER – I Hope

Sec 8 UNIFORM ACCT.
THANKS for (b)(3)

(d) I believe this is PRUDENT AND my people will buy it

~~Section 17.07~~

Appeal
I Think we can get agreement on this in context of bill with INCLUSION of BASIC PRINCIPLES IN Section 7(a)

Section 9 change (7) - ~~for~~ Drop "facility for the domiciliary care of the mentally retarded" to "Intermediate care facility for the mentally retarded"

The former is not a Medicaid service the latter is

section 10 - Thanks - sorry for my penmanship

Section 12 - We are OK on interim rate

Section 13 - OK on Suspension

Section 15 - I believe the shortness of the 4 years will cause a land rush - The 10 or 12 that Rod Wilson suggested would be a truer test

Section 17 should be Section 3 and 5

TELECOPY COVER SHEET
ANCHORAGE INFORMATION OFFICE

TO: Senator Joe Josephsons office FOR: _____ PHONE: _____

FROM: So. Cent. Health Planning & Dev. Inc PHONE: 228-3631

ADDITIONAL INSTRUCTIONS: _____

DATE/TIME SENT: 2/14 PLEASE ACK. RECEIPT: ✓

DISPOSAL OF ORIGINAL: _____ THROW AWAY

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NUMBER OF PAGES: 26 (NOT COUNTING COVER SHEET)

BY: Lou

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FEB 14 1983
Josephson

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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.

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

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.

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]

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

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.

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.

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

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

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.

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.

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CERTIFICATE OF NEED:

REVISION OR REPEAL

Prepared in
the
Public Interest
by
the

ALASKA HEALTH COALITION
February, 1983

Comment No. 1

- A formal mechanism should exist for citizen involvement in the expenditure of public funds for health program expenditures.

- Health outlays in recent years have been increasing at a greater rate than in other areas.

- The Federal and State outlays for health are increasing rapidly.

- Since substantial and increasing public monies provided by tax revenues are involved, citizen involvement in public program decision making is of increasing importance.

- The present formal mechanism for accomplishing citizen involvement could be open to changes and improvement based on careful analysis of past and present arrangements and potential new arrangements.

Comment No. 2

- Based on statutory and regulatory changes which are finally made, if any, in Federal and State laws related to State health planning efforts, including the health systems agencies, adequate financial support from the State and Federal level should be made available.

- An integral relation exists between a State Certificate of Need Program and outlays for health planning.

- Should the Certificate of Need Program on the Federal or State level, or both, be repealed, the financial outlays for the health systems agencies would be affected substantially as well, if not eliminated.

- A $100,000 authorized support level for each health systems agency will not be sufficient to have an effective planning staff capacity. Should only $100,000 be available for each agency, one of two developments would be indicated:

  1. Close the activity for three health systems agencies; or

  2. Combine the funds available into a single health systems agency with amended, limited functions and powers.

Summary of Private and Public Health Care Coverage in Alaska

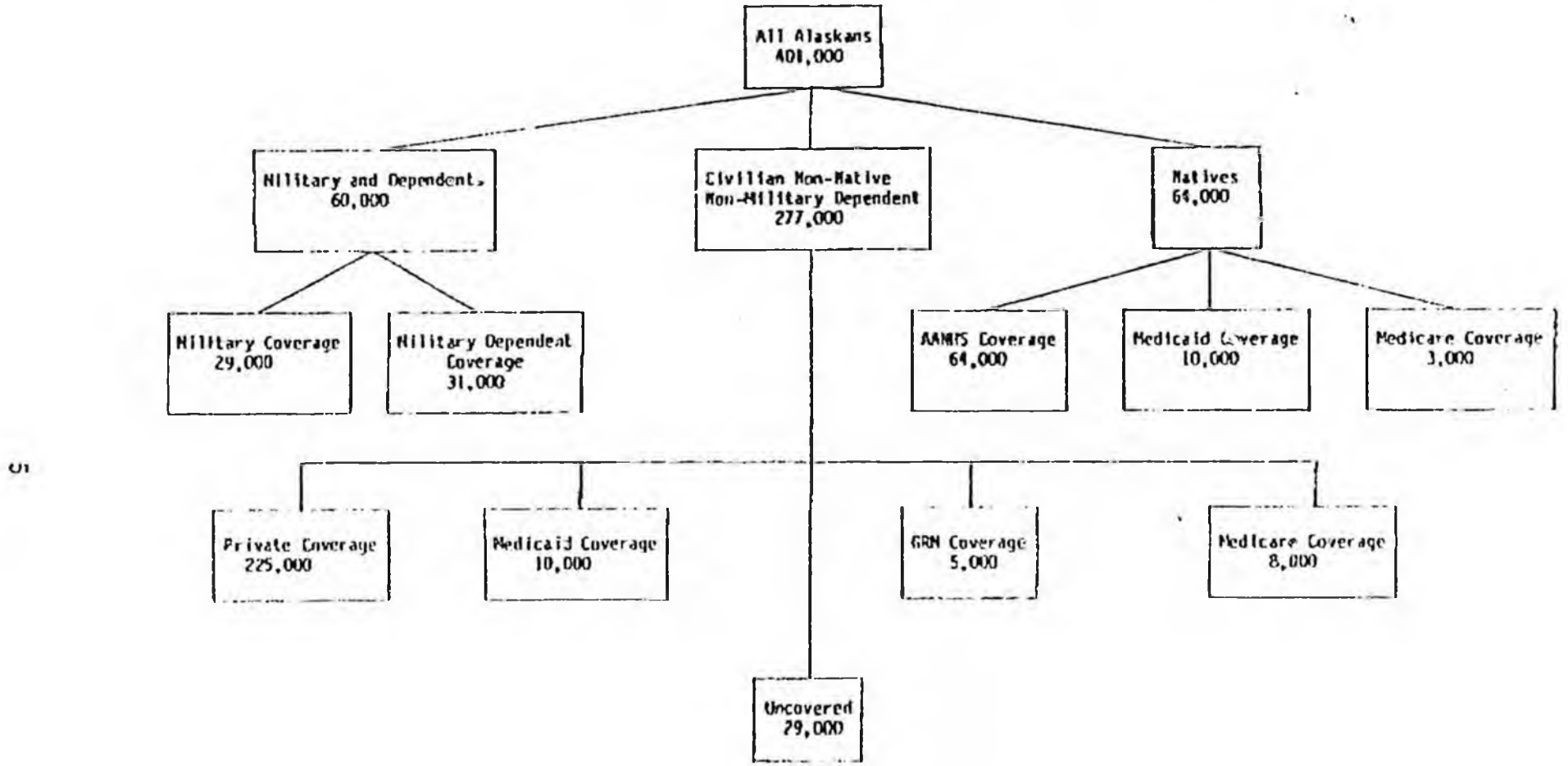

Figure 1.

Battelle Report —
F.A.T. - March, 1982

- dental, vision, and hearing care;
- prescription drugs; and
- alcoholism treatment.

The elderly population covered only by Medicare faces the risk of high out-of-pocket medical expenses. Similarly, many persons covered by private plans must make significant out-of-pocket payments to receive their benefits. The supposedly comprehensive Native health care benefits are quite limited in certain instances due to the AANHS budget constraints.

B.5. Expenditures and Expenditure Trends

The total health care bill in Alaska was $480 million in 1979; approximately 14% of that amount was paid by state and local governments, 31% by the federal government, and 55% by the private sector. About 64% of the state and federal share was used to provide direct services, and the other 36% was used to pay for various public health programs. About 63% of the private sector share was paid directly by consumers for out-of-pocket expenses and health insurance premiums, and 37% was paid by employers for health insurance premiums (See Figure I-1 in Volume I).

The total cost of health care has been rising dramatically in Alaska. Population increases and decreases in the relative price of medical care account for some of this, but the largest part is due simply to general inflation. Health care expenditures could reach $1 billion by 1990 if inflation continues at current rates.

C. OPTIONS FOR STATE ACTION

Weaknesses in the health care system determined during the survey of Alaska health care resources and financing were used to identify the types of options the state of Alaska could consider to improve the comprehensiveness and accessibility of health care. The principal barriers which reduce the accessibility of health care among the Alaska population, and specific actions that the state could consider for eliminating these barriers and improving

Comment No. 7 (cont'd)

in order to be equitable, must include all Alaskans. The implication of a State-sponsored comprehensive health insurance program must be considered only in relation to the Indian Health Service Program.

3. I strongly support the concept of cost sharing, co-payment, and deductible plans since such have been demonstrated to reduce over-utilization and abuse of both public and private and other health care insurance programs. If such arrangements are adopted, they should be fair, reasonable, and equitable and related to broad categories of ability to pay.

- With a population of approximately 450,000 in Alaska, a recent research study indicated that only 29,000 Alaskans (estimated) do not now have either private or public coverage. Any reasonable State program should probably focus on the uncovered populations. To do otherwise would be to displace program and financial responsibilities and result in shifting to the State financial responsibility not now assumed.

- The best plan for improving health coverage and financing should focus on improvement to Medicaid, General Relief Medical, and Catastrophic Illness Programs, including the possibility of creation of a high risk pool for persons who are not low income but cannot afford coverage of any kind, because they are unemployed, part-time employed. or too ill.

- While, for the above reasons, I oppose a comprehensive health insurance plan per se, any plan which would meet some of the more important objectives outlined above without creating counter-productive elements as indicated above would meet with my great interest and open mind.

* * *

WJS/jes

Comment No. 6

- It is understood that the private health sector may not under present arrangements be able to provide direct health services in all areas. This is especially the case in unusually remote locations and very small communities.

- The State should encourage wherever possible the providing of direct health services by the private sector, understanding that the Federal government has provided, and doubtless will continue to provide, a substantial level of direct health services in the rural regions.

- The State should not consider the automatic assumption of those direct health services which have been or may be terminated by the Federal government.

- The State should take all reasonable measures to work with the Federal government and insist that the Federal government continue an adequate level of direct health services which has been its historic responsibility and current responsibility under the applicable Federal statutes, programs, and policies.

Comment No. 7

- While I favor strongly the adequate and reasonable access to health services on behalf of every Alaskan, I am not convinced that a "comprehensive health insurance plan" with certain other provisions would be the best plan for the following reasons:

  1. Health insurance for tens of thousands of Alaskans is a program based upon negotiated labor agreements between hundreds of employers, employees, and their respective unions.

     The State should not take action to disrupt that part of the insurance arrangements which have worked exceedingly well, except for the growing costs.

  2. The Federal government has certain levels of responsibility for approximately 60,000 Alaskan Natives with an annual outlay of more than $100,000,000 for program services alone, excluding capital expenditures. Any program of comprehensive health insurance,

Comment No. 3

- It is my understanding that the Certificate of Need Programs on both Federal and State levels are faced with a measure of uncertainty.

- If the Certificate of Need Program is repealed by the State of Alaska, an appropriate program relating to planning of health services and facilities will be required based on the substantial public interest issues involved.

- While I oppose the continuation of the Certificate of Need Program "as presently designed", I could support an amended Certificate of Need Program within the State under two conditions:

  1. That no substantial multi-million dollar Federal penalty become applicable to Alaska due to the absence of a Certificate of Need Program; or

  2. The revised or amended Certificate of Need Program could remove some of the burdensome provisions related to the health facilities under a simplified and more efficient application and review process.

Comment No. 4

My views are expressed generally in line with the markings in the questionnaire under health education.

Comment No. 5

- Consideration should be given to a uniform "development of maturity" age for Alaskans which would take into account responsibilities related to voting age, military service age, and drinking age.

- To assume that a young person can exercise adequately some of the privileges and responsibilities of military service, voting for officials and using alcoholic beverages at different ages, I find problematical. However, substantial discussion and public input should be required before making changes in such important activities related to youth.

Strongly Support | Support | Oppose | Strongly Oppose

Alcohol abuse is widely recognized as a problem in Alaska. In addition to prevention and treatment programs, legislative changes have been proposed.

Indicate your feelings about the following legislative changes:

SS S O (SO) Increase the sales tax on alcohol.

SS S O (SO) Reduce the bar hours statewide (e.g., require closure for a minimum of 6 hours/day).

SS S (O) SO Raise the drinking age to 21 years.

SS S (O) SO Restrict alcohol advertising.

SS (S) O SO Implement more stringent penalties for driving while intoxicated/operating a motor vehicle while intoxicated.

SS (S) O SO Continue and/or increase State funding of treatment programs.

SS (S) O SO Continue and/or increase State support for prevention programs.

Comment see Comment No. 5, attached

Traditionally the State has provided prevention and public health services in all parts of Alaska leaving the provision of direct health care services to the private sector and the Federal government. The Federal government is cutting back on direct services offered. Due to the isolation of many areas of the State, it has not been economically feasible for the private sector to provide direct health care services in all areas. Indicate your opinion about the idea

SS S * O SO that the State should financially support direct health care services in those areas that are medically underserved

Comment see Comment No. 6, attached

In the past legislative session, a bill was introduced proposing a comprehensive health insurance plan which would allow a choice of coverage for residents on a cost-sharing basis based on ability to pay. Indicate your feelings about some

SS S * O SO form of state-supported comprehensive health insurance.

Comment see Comment No. 7, attached

Name Bill Sheffield

Sheffield Response to

HEALTH ISSUES QUESTIONNAIRE

Please circle the symbol that most closely corresponds to your opinion. If you wish, add any comments in the blank provided.

Strongly Support | Support | Oppose | Strongly Support

(SS) S O SO A formal mechanism should exist for citizen involvement in State health program decision-making.

Comment see Comment No. 1, attached

Governed by volunteer boards made up of health care providers as well as a "consumer" majority, the three Health Systems Agencies (HSAs) in Alaska have provided a process for citizen involvement in health care decisions. The HSAs operate with both Federal and State financial support. Federal support, previously at up to $300,000. and currently approximately $125,000., constituted 75% of each HSA's funding in the past. State support was $125,000. in FY 1976-77 and $100,000. in FY 1978-81. The most recent allocation reduced the subsequent annual authorized amount by 50% to $50,000. The Federal government has proposed eliminating support for Health Systems Agencies after the current fiscal year. Indicate your feelings about the following statements.

SS (S) O SO The State should increase the current level of State support to each agency to at least $300,000. to maintain citizen involvement in health decisions at the local level.

SS S (O) SO The State should continue support at the authorized level of $100,000. to maintain citizen involvement in health decisions at the local level.

SS S (O) SO The State should provide no support.

Comment see Comment No. 2, attached .

A program administered by the State requires that health care providers apply for a Certificate of Need prior to any capital expenditures in excess of $150,000. and/or any change in licensed bed capacity of 10 beds or 10 percent. Indicate your feelings about the alternative suggestions below.

SS S (O) SO The Certificate of Need program should continue as presently designed with review, public comment, and analysis at the regional level and the final decision at the Commissioner level.

SS (S) O SO The Certificate of Need program should continue with an increase in levels to at least $600,000.

SS S O (SO) The role of regional Health Systems Agencies should be eliminated, leaving the review, analysis, and final decision with the Commissioner of Health and Social Services.

Comment see Comment No. 3, attached

A number of groups have indicated support for health education in the schools as a way to prevent some of the major health problems in Alaska. Indicate your feelings about the following proposals.

(SS) S O SO Schools should have health education programs.

SS (S) O SO Comprehensive health education should address the range of health problems in Alaska including sessions on alcohol and drug abuse, mental health, sex education, and values clarification.

SS S (O) SO The Legislature should require comprehensive health education in all Alaskan schools.

SS (S) O SO The Legislature, while not requiring health education, should provide financial assistance and other incentives to school districts to encourage development of school health education programs.

Comment see Comment No. 4, attached

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,

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 Manaing, Ketchikan; Lillie McCarvey, Anchorage; Art Willman, Sitka; Margaret Wilson, Anchorage

FISCAL SAVINGS FROM CS SB 85 (HESS)

SUSPENSION OF HOSPITAL CONSTRUCTION FUNDING AS 29.90

Providence Hospital expansion project of $185.6 million projected costs will save the state $46.4 million alone plus untold savings from any other hospital expansion plans during the period of suspension.

CAP ON HOSPITAL REVENUE SHARING

Providence Hospital expansion of 150 beds will save the state $150,000 yearly by setting the cap in place.

PROSPECTIVE PAYMENT PROGRAM

Projected to save 1 - 3% of growth in the Medicaid and General Relief Medical Budgets. Projected FY 84 expenditures for these programs for hospital and long term care are $43,726.2, so a 1 -3% savings would be between $437,000 and $1,311,700.

Anch Daily News Feb 3, 1983

Two hospitals seek approval for expansion

By DON HUNTER
Daily News reporter

Two Anchorage hospitals are friendly antagonists in a struggle for a state certificate for expansion, but the success of either may hinge on the disposition of an existing certificate of need possessed by Dr. Michael Beirne.

Officials of Providence and Humana hospitals touted their multi-million dollar construction plans before a staff committee from the state Department of Health and Social Services on Wednesday. The committee will review the proposals and discuss them with hospital officials again Feb. 11 and 12, then send a recommendation to the municipal Health Commission and the Health Systems Agency, a Southcentral Alaska planning organization.

The decision on which hospital — or perhaps both to a more limited degree — gets to expand will be made by the health department commissioner, Robert Smith.

The $97 million Providence plan would add an additional 160 beds, bringing the hospital to a total of 400. It also would provide an in-patient rehabilitation center, and allow reallocations of space to make hospital care more efficient and effective, officials say.

The 93-bed Humana project would cost about $21.5 million and bring that hospital to a total of 292 beds.

In an interview Wednesday, Providence planning director Kaaren Riehle said ex-

See Back Page, PROVIDENCE

Providence, Humana hospitals seek OK for expansion

Continued from Page A-1

pansion there "is necessary if we're going to provide the quality of care we have given up to this point.

"We're operating at 100 percent capacity" at times now, she said. "Bed turnover is constant . . . The beds don't get cold."

Finding beds for new patients is a frequent problem, and one that sometimes leads to pediatric patients being assigned to adult wards or vice-versa, she said.

Doctors, nurses and former patients who spoke at the committee hearing echoed those concerns and asked the committee to allow the hospital to expand.

Ron Pavellas, the executive director of Humana, says the once-financially troubled hospital has recovered and currently reports annual occupancy rates of between 65 percent and 70 percent. "By 1985, both hospitals will be full," he predicted.

"We feel the community needs two strong acute care hospitals."

Neither Riehle nor Pavellas attempted Wednesday to critically undercut the construction bids of the opposing hospital, though both admit the institutions are in an adversarial position now.

Still clouding the expansion issue is the certificate of need held by Beirne, a former state representative who for more than a decade has been attempting to pull together financing for a new, 125-bed hospital on Lake Otis Parkway.

Beirne's proposed Lake Otis Clinic initially got a certificate of need because it was determined that construction was under way when the state law setting up the certification process was approved in the mid-1970s. However, only a few pilings have been driven at the Lake Otis site.

Beirne says extended lawsuits challenging the legitimacy of his certificate have prevented him from securing financing for his project.

Another decision on whether Beirne's certificate should be continued is now before state commissioner Smith.

Riehle acknowledged Wednesday that Beirne's certificate complicates the expansion applications of both Providence and Humana.

"It is a problem, because there are 125 beds that have a certificate of need," and the decision whether the two existing hospitals can expand is rooted in the number of hospital beds planners decide are needed in Anchorage, Riehle said.

Hein
3/14/83

Original sponsors: Faiks, P. Fischer and Pettyjohn

IN THE SENATE

BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

CS FOR SENATE BILL NO. 85 (HESS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

THIRTEENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act suspending the certificate of need program; amending provisions related to Medicaid and general relief assistance; and providing for an effective date."

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

* Section 1. FINDINGS AND DECLARATION OF POLICY. (a) The legislature finds and declares that health facilities are vital to the welfare of the people of the state. The legislature finds that the certificate of need program, as historically constituted and implemented in Alaska, has created delays in the construction of health care facilities, thus adding to the cost of such facilities both through the expenses of the administrative process itself and through the effects of delay-induced inflation. (b) Because the effects of the changes to be wrought by this Act will require monitoring, and because there is a degree of uncertainty concerning the federal statutory and regulatory environment, the legislature finds and declares that a suspension of the certificate of need process, with automatic review in future, is preferable to an outright repeal of the process at this time.

(c) The legislature acknowledges the need to pay health facilities for services provided to beneficiaries of state programs at a level that will meet the proportionate share of the total financial requirements of the facilities that are attributable to those programs given prudent and cost-effective management and operation of such facilities.

~~t. Sec. 6. FINDINGS.~~ The legislature finds that, because Medicaid is a joint state and federal program and because federal Medicaid funds have been and are likely to continue to be reduced dramatically, a retrospective payment system no longer serves as an adequate management tool, nor does it respond with adequate flexibility to continued federal cutbacks. A prospective payment system is necessary to prudently address payments to health facilities under the Medicaid and general relief assistance programs.

* Sec~~tion~~ 7. AS 18.07.021 is amended to read:

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

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* Sec. 4. AS 18.26.220 is repealed and reenacted to read:

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

* Sec. 5. AS 18.26.220 is repealed and reenacted to read:

Sec. 18.26.220. FACILITY COMPLIANCE WITH HEALTH AND SAFETY LAWS AND LICENSING REQUIREMENTS. A medical facility constructed, acquired, improved, or financed under the this chapter and all actions of the authority are subject to AS 18.07, AS 18.20, and any other state licensing requirement for the facilities or services provided under this chapter. A medical facility issued a certificate of need under Sec. 4, ch. 275, SLA 1976 by virtue of being in existence or under construction before July 1, 1976, must fully meet the requirements of AS 18.07 in order to be eligible for funding under this chapter.

* Sec. 6. AS 29.89.030(a)(1) is amended to read:

(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 in a hospital with not more than 50 acute care beds, limited to the number of beds provided for in the construction design of the hospital, or $250,000 per [A] hospital for those hospitals with 10 to 50 acute care [OR MORE] beds, or $50,000 per [A] hospital for those hospitals with less than 10 acute care 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;

* Section 7. AS 47.07.070 is repealed and reenacted to read:

Sec. 47.07.070. PAYMENT TO HEALTH FACILITIES. (a) The payment rate to a health facility shall be determined by the ~~Medical Rate~~ Commission on the basis of a fair rate for reasonable costs ~~that are~~ incurred by the facility. The Commission shall ~~promulgate regulations setting forth the factors of which the Commission shall take cognizance~~ by regulation list the factors it considers in reaching its determinations under this section

(b) Prospective payments to hospitals shall be made at a rate in proportion to the rate of occupancy in acute care hospital beds. Maximum payment under this chapter may be made ~~only~~ to

a hospital with ~~more~~ more than 50 acute care beds only if the hospital has an acute care bed occupancy rate of 90 percent or more.

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

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

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

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

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

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

(2) variations among health facilities in the ~~following areas:~~

~~(3)~~ types of health care services provided by health facilities;

(4) other factors the department considers relevant.

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

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

(2) consistent with the policies of this chapter.

Sec. 47.07.075. AUDITS AND INSPECTIONS. As a condition of obtaining payment under AS 47.07.070, a health facility shall allow

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

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

Sec. 47.07.076. APPLICATION OF ADMINISTRATIVE PROCEDURE ACT. Actions of the ~~department~~ commission under AS 47.07 are subject to the provisions of the Administrative Procedure Act (AS 44.62).

* Sec. 9. AS 47.07.080 is amended by adding a new paragraph to read:

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

(~~6~~7) "health facility" includes a hospital, skilled nursing facility, intermediate care facility, rehabilitation facility, inpatient psychiatric facility, home health agency, rural health clinic, and outpatient surgical clinic.

Inter Care facility for MR.

* Section 10. AS 47.07 is amended by adding new sections to read:

ARTICLE 2. MEDICAL ~~ASSISTANCE PROSPECTIVE PAYMENT~~ RATE COMMISSION.

Sec. 47.07.110. MEDICAL RATE COMMISSION ESTABLISHED. The Medical Rate Commission is established in the Department ~~of Health and Social Services~~.

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

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

(2) the commissioner of administration, ~~or~~ the commissioner of health and social services, or the appointed ~~commissioner's~~ designee; [of either commissioner]

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

(4) a certified public accountant with relevant experience;

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

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

Sec. 47.07.140. TERM OF MEMBERSHIP. A member of the commission is appointed for a term of three years, and may not be appointed to a successive term. The terms of the members shall be staggered. A member appointed to fill a vacancy serves for the unexpired term of the member he succeeds. A term shall be measured from January 1 of the year in which the term of the vacant

position begins, regardless of when the vacancy is filled.

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

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

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

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

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

* Sec. ~~10.~~ AS 47.25 is amended by adding a new section to read:

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

(b) A health facility receiving a payment under this chapter is subject to the requirements of AS 47.07.070 - 47.07.076.

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

* Sec. 12 ~~11~~. INTERIM PROSPECTIVE PAYMENT SYSTEM. The department shall establish an interim system of prospective payments for health facilities under this Act for the period July 1, 1983 to June 30, 1984.

* Sec. 13 ~~12~~. This Act does not affect funds to which the sponsor of a hospital or health facility construction project is entitled under AS 29.90 on the effective date of this Sec. 17 Act.

* Sec. ~~13.~~ The operation of AS 18.07.031 - 18.07.101, 18.07.111(1)-(4), 18.07.111(7)-(9), 18.07.111(11); and AS 47.80.140(b) is suspended for a period of ~~two~~ four years after the effective date of sec. 17 ~~15~~ of this Act.

* Sec. ~~14.~~ AS 29.90 and AS 47.07.080(1) ~~is~~ are repealed.

* Sec. 16 ~~14~~. Sections 2 and 4 of this Act take effect ~~two~~ four years after the effective date of sec. 17 ~~15~~ of this Act.

* Sec. 17 ~~15~~. Sections 1, 3 and 5 - 15 ~~13~~ of this Act take effect immediately in accordance with AS 01.10.070(c).

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because federal Medicaid funds have been and are likely to continue to be reduced dramatically, a retrospective payment system no longer serves as an adequate ~~management tool~~ method of compensation, nor does it respond with adequate flexibility to continued federal cutbacks. A prospective payment system is necessary to prudently address payments to health facilities under the Medicaid and general relief assistance programs.

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

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

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* Sec. 4. AS 18.26.220 is repealed and reenacted to read:

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

the licensing requirements of this chapter.

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* Sec. 6. AS 29.89.030(a)(1) is amended to read:

(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 in a hospital with more than 250 acute care beds, limited to the number of beds provided for in the construction design of the hospital, or $250,000 per [A] hospital for those hospitals with 10 ~~to 50~~ + 250 acute care [OR MORE] beds, or $50,000 per [A] hospital for those hospitals with less than 10 acute care 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;

* Sec. 7. AS 47.07.070 is repealed and reenacted to read:

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(b) Prospective payments to hospitals shall be made at a rate in

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

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

(2) variations among health facilities in the types of

health care services provided by health facilities;

(3) other factors the commission considers relevant, including size, organizational structure, and methods of obtaining payments.

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

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the licensing requirements of this chapter.

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(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 in a hospital with more than 250 acute care beds, limited to the number of beds provided for in the construction design of the hospital; or $250,000 per [A] hospital for those hospitals with 10 to 250 acute care [OR MORE] beds; or $50,000 per [A] hospital for those hospitals with less than 10 acute care 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;

Sec. 7. AS 47.07.070 is repealed and reenacted to read:

Sec. 47.07.070. PAYMENT TO HEALTH FACILITIES. (a) The payment rate to a health facility shall be determined by the commission on the basis of a fair rate for reasonable costs incurred by the facility. The commission shall be regulation list the factors it considers in reaching its determinations under this section.

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(b) The commission, in determining the payment rate to a health facility, may consider whether the rate of occupancy in acute care beds within the facility is lowered because of improvident or careless facility development by the facility during the period when the provisions of section 14 of this chapter are in effect.

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

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

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

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

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

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

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

(3) other factors the commission considers relevant, including but not limited to size, organizational structure, and methods of obtaining payments.

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

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

(2) consistent with the policies of this chapter.

(d) Any other provisions of this section notwithstanding, the commission may modify, by regulation generally applicable to facilities having fewer than 25 acute care beds, the system of accounting, budgeting, and financial reporting, for the purpose of reducing to such facilities the costs of their operations.

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

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

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

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

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* Sec. 9. AS 47.07.080 is amended by adding new paragraphs to read:

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

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

* Sec. 10. AS 47.07 is amended by adding new sections to read:

ARTICLE 2. MEDICAID RATE COMMISSION.

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

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

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

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

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

(4) a certified public accountant with relevant experience;

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

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

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

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

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

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

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

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

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* Sec. 11. AS 47.25 is amended by adding a new section to read:

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

(b) A health facility receiving a payment under this chapter is subject to the requirements of AS 47.07.070 - AS 47.07.076.

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

* Sec. 12. INTERIM PROSPECTIVE PAYMENT SYSTEM. The department shall establish an interim system of prospective payments for health facilities under this Act for the period July 1, 1983 to June 30, 1984.

* Sec. 13. This Act does not affect funds to which the sponsor of a hospital or health facility construction project is entitled under AS 29.90 on the effective date of sec. 18 of this Act.

* Sec. 14. The operation of AS 18.07.031 - 18.07.101, 18.07.111(1)-(4), 18.07.111(7) - (9), 18.07.111(11); and AS 47.80.140(b) is suspended for a period of four years after the effective date of sec. 18 of this Act.

* Sec. 15. The operation of AS 29.90 is suspended for a period of four years after the effective date of sec. 18 of this Act.

* Sec. 16. AS 47.07.080(1) is repealed.

* Sec. 17. Sections 2 and 4 of this Act take effect four years after the effective date of section 18 of this Act.

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A M E N D M E N T

Offered in the SENATE

By Josephson

TO: CSSB 85(Fin)

Page 1, line 6, after "to" insert "certificate of need,"

Page 1, after line 9, insert the following new section to read:

"* Section 1. AS 18.07.031 is amended to read:

Sec. 18.07.031. CERTIFICATE OF NEED REQUIRED. No person may make an expenditure of $1,000,000 or more for any of [UNDERTAKE] the following unless authorized under the terms of a certificate of need issued by the office:

(1) construction of a health care facility;

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

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

Renumber remaining sections.

A M E N D M E N T

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

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

Renumber remaining sections.

SENATE AMENDMENT

By Josephson

To: Committee Substitute for SENATE BILL No. 85 (Finance)

To: _____ HOUSE BILL No. _____

PAGE: 6 LINE: 20

Add a new section to the bill to read:

Sec.____. The sponsor of a hospital or healthfacility construction project who is receiving or entitled to receive state aid under AS 29,90 on the day preceding the effective date of this act shall continue to receive state aid until the sponsor has received an amount which, combined with state matching money for hospituction 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.

SENATE AMENDMENT

BY Josephson

To: Committee Substitute for SENATE BILL No. 85(Finance)

To: _____ HOUSE BILL No. _____

PAGE: 6 LINE: 19

Add to Section 8:

Sec.8. AS 47.07.080(1) and AS 29.90 are[is] repealed.

TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982 (TEFRA)

H.R. 4961 was passed by Congress, with the regulations promulgated by the Department of Health and Human Services becoming effective on October 1, 1982.

TEFRA is an attempt to control the rising costs of health care by implementing cost limitations for hospital and nursing home charges to the Medicaid program. Alaska's use of the Medicare principles of reimbursement have allowed a 14.5% (hospital) and a 19.5% (nursing home) annual percentage growth over the last four years.

The program increased from 19.5 million in FY 78 to 32.8 million in FY 82. The FY 84 budget of 43.8 million is a 125% increase in this six year period - a 20% average annual increase.

The Federal system has tightened up the budget for Medicare and Medicaid. The regulations implementing TEFRA are aimed primarily at nursing homes and result in a 25% decrease in reimbursement for FY 84, and an 8% decrease for hospital services.

The Routine Service Cost Limits have not been applied by the state of Alaska since 1981, mainly because Alaska's Medicaid reimbursement supports 95% of nursing home costs in the state, and the limitations are based on costs in the lower 48 with no higher living allowance for Alaska.

The effects of not applying the TEFRA law is that we owe the Federal government $5 million since 1981, and an additional $1.8 million for FY 83. This year, the state will be forced to implement TEFRA - and that will cause several of the nursing homes in Alaska to shut down operations for lack of funding.

The effects on hospitals are not so severe since there is a sole community provider exemption, and the limitations will therefore affect only Humana and Providence.

The only way to avoid TEFRA is to institute a Prospective Payment System for Medicaid payments, which would guarantee the Federal government that we are attempting to control costs. It will also allow Alaska to set their own rates according to reasonable costs in the state.

The Prospective Payment Program outlined in SB 85 and HB 19 was worked out carefully through a committee of providers and DH&SS personnel over a number of months, and refined through several meetings in Senate HESS. The costs of establishing the Commission to review and set rates is quite minimal when compared to the savings proposed by retention of facilities. The Federal Government will still alter its matching rate for nursing home and hospital reimbursement, but the state will be able to develop cost controls.

THE LEGISLATURE OF THE STATE OF ALASKA
THIRTEENTH LEGISLATURE

FISCAL NOTE

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

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

EXPENDITURES (Thousands of Dollars)

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

FUNDING (Thousands of Dollars)

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

POSITIONS

FULL TIME	2	2	2	2	2	
PART TIME						
TEMPORARY						

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

See Attachment A

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

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

33-001 (Rev. 12/82)

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

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

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

SECTION ANALYSIS FOR CS FOR SB 85)FINANCE)

SECTION 1 FINDINGS AND DECLARATION OF POLICY

THAT THE RETROSPECTIVE METHOD OF PAYMENT TO HEALTH FACILITIES IS INADEQUATE, AND THAT THE LEGISLATURE INTENDS TO CHANGE TO A PROSPECTIVE PAYMENT METHOD.

SECTION 2 GIVES THE COMMISSION THE MANDATE TO PROSPECTIVELY SET HEALTH FACILITY RATES BASED ON REASONABLE COSTS. AND LIST FACTORS BY REGULATION.

(b) IN SETTING RATES, THE COMMISSION SHALL DETERMINE THE PROPORTIONATE SHARE OF THE FACILITY'S FINANCIAL REQUIREMENTS, AND SETS ACCOUNTING PRINCIPLES TO BE FACTORED IN.

(c) PROVIDES AUTHORITY TO THE COMMISSION IN RATE SETTING FOR OVERBUILT OR OVERBEDDED FACILITIES.

SECTION 3 EACH HEALTH FACILITY IS REQUIRED TO SUBMIT A FINANCIAL REPORT TO THE COMMISSION BY 120 DAYS AFTER THE END OF THE FISCAL YEAR.

THE COMMISSION SHALL SUBMIT A REPORT TO THE GOVERNOR BY SEPTEMBER 30TH OF EACH YEAR ON PROSPECTIVE PAYMENTS MADE AND AN ESTIMATE OF CURRENT AND SUBSEQUENT YEAR.

A UNIFORM BUDGETING, ACCOUNTING AND FINANCIAL REPORTING SYSTEM WILL BE ESTABLISHED BY THE COMMISSION BY REGULATION WHICH TAKES INTO CONSIDERATION CURRENT SYSTEMS, DIFFERENCES IN FACILITIES AND THEIR SERVICES, AND OTHER FACTORS DETERMINED RELEVANT.

THE COMMISSION HAS THE POWER TO WAIVE OR MODIFY AN ACCOUNTING REQUIREMENT ON A CASE BY CASE BASIS.

THE COMMISSION MAY MODIFY REQUIREMENTS BY REGULATION FOR FACILITIES HAVING LESS THAN 25 ACUTE CARE BEDS.

AUDITS ARE REQUIRED, AND HEALTH FACILITIES SHALL ALLOW REASONABLE ACCESS TO FINANCIAL RECORDS BY THE COMMISSION, THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES AND ANY FEDERAL AGENCIES REQUIRED BY LAW.

ACTIONS OF THE COMMISSION ARE SUBJECT TO THE ADMINISTRATIVE PROCEDURES ACT.

SECTION 4 DEFINITIONS

SECTION 5 ESTABLISHES THE MEDICAL RATE COMMISSION WITHIN THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES.

LISTS THE FIVE MEMBERS TO BE APPOINTED BY THE GOVERNOR FOR THREE YEAR STAGGERED TERMS.

MEMBERS OF THE COMMISSION SERVE WITHOUT COMPENSATION BUT RECEIVE PER DIEM AND TRAVEL EXPENSES.

BOARD MEMBERS WILL SELECT A CHAIR AT THE FIRST MEETING OF EACH YEAR.

THE COMMISSION WILL MEET AS OFTEN AS NECESSARY WITH THREE MEMBERS CONSTITUTING A QUORUM.

THE DUTY OF THE COMMISSION IS TO ESTABLISH RATES PAID TO HEALTH FACILITIES FOR MEDICAID AND GENERAL RELIEF MEDICAL PROGRAMS.

THE COMMISSION MAY EMPLOY AN EXECUTIVE DIRECTOR WHO MAY HIRE ADDITIONAL STAFF AT THE APPROVAL OF THE COMMISSION. PERSONNEL OF THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES WILL PROVIDE ASSISTANCE TO THE COMMISSION.

SECTION 6 GIVES THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES THE AUTHORITY TO ESTABLISH A PROSPECTIVE PAYMENT PROGRAM FOR GENERAL RELIEF PAYMENTS TO HEALTH FACILITIES.

SECTION 7 THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES SHALL DEVELOP AN INTERIM PROSPECTIVE RATE SYSTEM FOR THE PERIOD JULY 1, 1983 TO JUNE 30, 1984.

SECTION 8 REPEALS THE RETROSPECTIVE METHOD OF PAYMENT CURRENTLY IN USE.

SECTION 9 IMMEDIATE EFFECTIVE DATE.

alaska state hospital association

NORTHERN CARE

Published by the Alaska State Hospital Association

Vol. 6 May 1983 No. 5

June 5 - 8, 1983
AHCA Congressional Conference
Washington, D.C.

June 20, 1983
ASHA Executive Committee
Anchorage, Alaska

June 21, 1983
DRG Seminar
Sheraton Hotel
Anchorage, Alaska

August 1 - 3, 1983
AHA Convention
Houston, Texas

August 4 - 12, 1983
Western Network Institute
Berkeley, California

August 29 -30, 1983
ACHA Seminar: Staff Evaluation
Anchorage, Alaska

September 18 - 21, 1983
ASHA Annual Meeting
Valdez, Alaska

CON REPEAL MOVES

On Thursday M[illegible] 5th, the House of Representatives voted to repeal the Alaska certificate of need [illegible]gram. Then on Tuesday May 10th, on a motion to reconsider its May 5th action [illegible]e body amended House Bill 19 to include a prospective payment program for Medicaid, place a $250,00 cap on operation revenue sharing, and to repeal capital revenue sharing concurrent with the repeal of certificate of need. This action supported by the Alaska State Hospital Association rejected the Finance Committee recommendation to simply increase the thresholds for certificate of need.

Leading the fight for repeal of the certificate of need were Rep. Milo Fritz, (R) Anchor Point, who rebuted claims that doctors admit patients to fill empty beds; Rep. Walt Furnace, (R) Anchorage, who questioned the necessity of an archaic system; Rep. Jack McBride, (D) Ketchikan, who assured the body that his experience as a labor negotiator demonstrated that there was no consumer indifference about health costs at the bargaining table; and Rep. Fred Zharoff, (D) Kodiak, who pointed out the excessive costs of the program and the inequities caused because many state and federal facilities are exempt.

Rep. Don Clocksin, (D) Achorage, lead the opposition to repeal continuing his allegation that supply creates demand for hospital beds and claiming that certificate of need is the only way we have of controlling the cost of health care. He was joined by Rep. Peter Goll, (D) Haines, who claimed that the public supports the program, and Rep. Terry Martin, (R) Anchorage, who suggested the legislature needed some other agency to make sure that grants the legislature makes to hospitals are appropriate.

The debate over the two days ran well over two hours. In the end, on a 25-13 vote the House adopted the sponsor substitute for House Bill 19 which would repeal certificate of need and rejected the Finance Committee substitute which would have raised some thresholds to $1 million. Then on a 32-6 vote the House added the amendments on prospective payment and revenue sharing and sent the measure on the Senate. In the Senate it has been referred to the Health, Education and Social Services Committee and the Finance Committee.

According to Ron Pavellas, executive director of Humana Hospital Alaska and chairman of the Alaska State Hospital Association, "While it is only one of many battles we have had to win on this issue, the significance of winning such a battle on the floor of the House cannot be overstated. I was pleased that we were able to get our message to our elected representatives so effectively. It was a real team — grass roots — effort with people from Ketchikan to Nome involved. This is one more visible step toward becoming the effective advocacy force as outlined in our mission statement."

NOMINATING COMMITTEE APPOINTED

The 1983 Nominating Committee has been appointed by Association Chairman Ron Pavellas. The committee is chaired by Immediate Past Chairman Tom Mingen and includes Chairman Pavellas and Chairman-Elect Mark Hawkins. Offices to be filled are: chairman-elect; secretary/treasurer; delegate and alternate delegate to the American Health Care Association; trustee delegate and alternate delegate to the American Hospital Association; and physician member of the board. Nominations should be sent to the association office in Juneau before June 15.

DRG SEMINAR JUNE 21

Now is the time to make plans to attend the June 21st seminar on Diagnostic-Related Groups (DRG's) to be held at the Sheraton Hotel in Anchorage. The DRG seminar is sponsored by the Alaska State Hospital Association in cooperation with Providence Hospital.

Robert Barclay Fetter, D.B.A., director of the Health Systems Management Group, School of Organization and Management at Yale University will lead the seminar. He will discuss the effects on administrators and physicians as health care in the United States enters this new phase of reimbursement. The use of DRG's for measurement and control of both cost and quality of care will be the seminar's central focus.

A registration fee of $85.00 per person is required. Pre-registration is encouraged, however participants may also register at the hotel at 8:30 A.M. the morning of the sessions. The seminar will begin at 9:00 A.M. and close at 5:00 P.M. Lunch is provided. Brochures and registration forms will be in the mail to health facilities by May 20. For further information, contact Bob Palanuk or Tedd Kessel at Providence Hospital, 562-2211.

BENNETT INTRODUCES CON STUDY

Senator Don Bennett, (R) Fairbanks, Co-Chairman of the Senate Finance Committee has introduced Senate Resolution 5 which would direct the Senate Finance Committee to conduct a comprehensive study of the state certificate of need program to determine the feasibility of maintaining the program in some form that is in compliance with federal law and if it is found ineffective, to recommend alternatives.

The resolution will be heard in the Senate Finance Committee on May 19. (The day after Northern Care goes to press.) The Association will testify that it feels the study is unnecessary but that we have no fears about such a study as it will demonstrate that certificate of need is an unnecessary appendage to health facility construction in Alaska. Further, if the Senate Finance Committee is unwilling to deal with repeal this year it is imperative that the certifcate of need thresholds be increased and that the prospective payment portions of the bill (SB 85) be moved this year.

CORDOVA HOSTS NURSING WORKSHOP

More than 25 nurses and nurses sides met in Cordova in late April for a two-day workshop on rehabilitative nursing care. Fourteen of the participants came to Cordova from health facilities in Homer, Kodiak and Anchorage. The classes offered inservice education for the local nurses as well as allowing them to earn continuing education credits.

The workshop was organized and sponsored by Cordova Community Hospital and the Alaska State Hospital Association. Sharon Randall, L.P.T. who works at the Cordova hospital did most of the organizing legwork of the sessions. Kathleen Van Dyke, R.N., from the Good Samaritan Hospital and Rehabilitation Center Puyallup, Washington instructed the workshop.

SITKA COMMUNITY HOSPITAL NEW FACILITY

As a result of 3 years planning, design, and fundraising, the new physical plant for the Sitka Community Hospital opened its doors to accept patients on May 8. In terms of floorspace, the new facility is four times the size of the old structure with expanded ancillary sections and modern heating and ventilation systems. Accorking to Mark Hawkins, hospital administrator, "the new facility allows us to serve as a 1983 hospital versus a 1950 hospital."

Although the number of patient beds has not changed, they are now organized in single patient rooms including a new birthing room and minimal security areas.

On permanent display in the foyer of the new hospital is a large placque listing the names of individuals and groups who donated to the $11.2 million project.

AT HUMANA — FAMILIES SHARE SURGERY

Relatives of patients at Humana Hospital Alaska in Anchorage now have an opportunity to view a family member's surgery — as it happens — on closed curcuit T.V. The surgeon may explain procedures involving the ears, eyes, nose and throat as they progress and answer questions through a two-way phone system that links the surgery room with Humana's newly-opened video viewing room. One family videotaped a son's operation so he could show it to his science class afterwards.

Dr. David Williams, Humana physician who was instrumental in bringing video into the operating room, said "I wanted to bring surgeries live to the parents or spouse of those having surgery. I want them to see what's involved and understand it."

"It's not creepy or gory," a young wife reported after watching delicate ear surgery on her husband. "It was wonderful to be a part of the operation as opposed to sitting it out in a waiting room, twiddling my thumbs and wondering how things are progressing."

AMENDMENT TO SB 85

After line 27, insert:

"Section 3 AS 29.90.010-29.90.030 is repealed.

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

1982 amendment
limited CONSTRUCTION
funding prior to July 1, 1980

file copy
return to:

alaska state hospital association
Dennis L. DeWitt
PRESIDENT
(907) 586-1790
319 Seward St.
Juneau, Alaska 99801

RECEIVED
JUN 28 1982
DEPUTY COMMISSIONER
DEPT. OF HEALTH & SOCIAL SVS
ANCHORAGE

BEFORE THE
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
STATE OF ALASKA

In the Matter of the Revocation of the Certificate of Need for LAKE OTIS HOSPITAL

PROPOSED DECISION

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INTRODUCTION

Respondent, Lake Otis Clinic (hereinafter "LOC") was formally issued a grandfathered certificate of need (hereinafter "C/N") for construction of a 125-bed acute medical care hospital in Anchorage on July 27, 1977. The hospital has not yet been constructed. Petitioner, South Central Health Planning and Development, Inc. (hereinafter "South Central"), filed an accusation for revocation of respondent's C/N on August 8, 1980, alleging, in pertinent part, that LOC has neither "shown continuing progress toward commencement of the activities" contemplated by its C/N nor demonstrated "good cause" for its failure to complete construction of the hospital. AS 18.07.081(d)(1) and (2). Following substantial discovery, the case came on for hearing pursuant to the Administrative Procedure Act on January 25, 1982 and continued through February 2, 1982. Testimony from many witnesses, and numerous exhibits, were submitted by the parties. Post-hearing briefs were filed thereafter.

Having considered all the evidence and arguments presented, and after conducting independent research, it is the hearing officer's recommendation that respondent's certificate of need be revoked pursuant to AS 18.07.081(d)(2). Because the fact situations relevant to this determination cover many years and a variety of complex activities on the part of numerous individuals as well as private and governmental entities, and because an understanding of the sequence of events in this case is essential to the rendition of a reasoned opinion in this matter, and finally, because no transcript of these proceedings has been ordered, unusually extensive findings of fact have been prepared and are set forth below. A draft of these findings was submitted to counsel and their objections received and considered in finalizing this proposed decision. See, Pleadings, Tabs 40 - 42.

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FINDINGS OF FACT

I. Background Information

1. In the mid-seventies, federal and state legislation was passed to provide for coordinated state-wide health planning. The lawmakers' intent was to facilitate access to health care at a reasonable cost. Hammett testimony.

2. Pursuant to these statutes, a hierarchy of quasi-public and public bodies within the State of Alaska was authorized to carry out the legislative mandate. As pertains to this case, the agencies include the Anchorage Municipal Health Commission at the municipal level (preceded by the Comprehensive Health Planning Council); South Central Health Planning and Development, Inc., the Health Services Agency ("HSA"), at the regional level; the Office of State Health Planning and Development ("SHPDA"); and, finally, the Commissioner of Health and Social Services.

3. South Central is organized as a nonprofit corporation. Policies are established by a board of directors from nine sub-areas. The majority of the board membership is comprised of consumers. Health care providers, presently including administrators from existing area hospitals, are also represented.

4. Under state law, no health care facility may be constructed, altered, or added to without issuance of a certificate of need from the state. AS 18.07.031. Applications for C/Ns in the Anchorage area must undergo a review process in which the municipal commission advises South Central which in turn makes a recommendation to SHPDA which presents its view to the Commissioner who ultimately issues or denies the C/N.

5. Central to the entire legislative plan and certificate of need process is the premise that traditional supply and

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demand economics do not apply to the area of hospital costs. According to Margaret Wilson, health planner with South Central, the cost of maintaining an empty hospital bed is 40 - 60 percent that of maintaining an occupied bed. Vacant beds can result in longer hospital stays. Hammett testimony. And patients generally do not "hospital shop," but rather use the facility in which their physician has staff privileges. Thus, the appropriateness of issuing a certificate of need for construction of a new hospital may hinge on a determination of whether development of the new facility would result in the community being "over-bedded," thus raising health care costs to the consumer. See, AS 18.07.041.

6. Certificates of need for hospital construction establish the number of beds a facility is entitled to have and can put into operation with reasonably little effort. A hospital's licensed capacity, on the other hand, is the number of beds actually approved after inspection for adequate lighting, heating, etc. Open beds are those licensed beds currently staffed. Hammett testimony.

7. Dr. Michael Beirne is a medical doctor, legislator, and businessman. He is the president of Lake Otis Clinic, Inc., the non-profit corporation formed to develop the Lake Otis Community Hospital ("LOCH"). The corporation is closely held, consisting of Beirne and family members on both the three-person board and in the officers' positions.

II. Chronology

1960's

8. 1962 - Three doctors, including Beirne, purchased a 10-acre tract of land for development of a professional building and hospital. In the mid-sixties, a plat was recorded for this tract, identified as "Medical Park Subdivision." The southern

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five acres was depicted as a hospital site.

1970

9. January, 1970 - Beirne hired Don Emmal to assist him in the management of three operating clinics and to initiate development of the hospital project.

10. March, 1970 - LOC was organized and incorporated.

11. Spring, 1970 - Application for recommended approval of the hospital was made to the Comprehensive Health Planning Council.

1971 - 1972

a. LOCH activities

12. The Comprehensive Health Planning Council initially recommended approval of LOC's application, then denial, with affirmation of that denial recommendation some time later. According to Beirne, Providence and Alaska (then "Community") hospitals opposed LOC's request for approval. While there was no certificate of need law requiring agency approval at the time, Beirne testified that the action of the municipal commission effectively precluded FHA financing for the project. FHA financing was desired because FHA interest rates were then one to two percent lower than conventional financing.

13. January, 1972 - A feasiblity study was performed by Hospital Associates at a cost of $10,000. Exh. R-2.

14. January 17, 1972 - LOC applied for tax exempt status. No mention was made of the hospital project in this application. On Exhibit K to the application, Beirne indicated that he and Emmal spent approximately five and 15 percent of their time, respectively, working on corporation-related activities. Exh. P-39.

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15. Negotiations commenced with General Health Services, Inc. ("GHS") regarding private development and operation of the hospital. Exh. P-110 at 2.

b. Activities at other Anchorage hospitals

16. Providence Hospital was licensed for 150 beds. Community Hospital was licensed for 85 beds. Community Hospital requested 80 additional beds. LOC objected. The state authorized 40 additional beds on the condition that Community Hospital relocate. Beirne testimony.

1973-74

a. LOCH activities

17. An agreement was reached with GHS for financing and management of the project. Exh. R-3A. Beirne testified that GHS had obtained long-term financing under an agreement providing that it would not be obliged to close the transaction if the interest rate exceeded 10 percent.

18. Contracts were signed with Channen Construction Company (general contractors), Luckman & Associates (architects), K?FF (structural engineers) and others for construction of the hospital. Exh. P-110 at 3. Coopers & Lybrand performed a feasibility study.

19. Interim construction loans were obtained by GHS and LOC from Peoples Bank in the amount of $900,000. Interest payments, if made timely would have amounted to $61,617.19. Exh. P-95. Deeds of trust on various pieces of real estate owned by Beirne were taken as collateral.

20. Site work was commenced in mid-1973 with clearance of brush, excavation and removal of peat, refilling with gravel, and installation of pilings. Work was stopped in May or June, 1974 when the $900,000 had been expended. Beirne waited for

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a drop in interest rates. Beirne testimony.

21. Due to the escalation of the prime interest rate above the maximum acceptable to GHS, GHS terminated the financing and management agreements with LOC. LOC and Beirne proceeded to liquidate properties over a period of approximately three years to indemnify GHS which in turn was obliged to repay the loans from Peoples Bank. Beirne testimony.

b. Beirne's salary arrangements/representations

22. April 1, 1973 - Beirne entered into an employment contract with LOC which entitled him to a salary of $70,000 per annum (adjustable upwards thereafter) plus benefits, for a term of 10 years. The contract provided, inter alia, that Beirne "shall devote substantial time to the performance of his duties as may from time to time be required." The agreement also recited that

> It is understood that Employee is presently serving as an executive officer of other corporations including a corporation providing pathology and laboratory services and owning and operating real properties and that some of Employee's time may be devoted to such corporations.

Exh. P-37.

23. April 30, 1973 - Beirne signed a grant application which was filed with the Department of Health, Education and Welfare seeking funding for Fairview Health Care Center, to be operated by LOC with Beirne as project manager and Emmal as assistant project manager. The grant application budget provided that both those positions would be full time with salaries of $41,650 and $29,750, respectively. Exh. P-38A.

c. Status of LOCH site

24. Beirne testified that in 1973, he deeded the hospital site to LOC.

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d. Activities re. other Anchorage hospitals

25. During this same period, the Teamsters acquired Community Hospital and began construction of that facility's new building, thereafter known as "Alaska Hospital."

26. Providence Hospital was operating 150 beds in its south tower, 58 of those beds not conforming to legal requirements. Hill-Burton funds in the amount of $3.5 million were approved for construction of a north tower, with total bed capacity set at 219. Exh. R-74. (Exh. R-74 contains hearsay statements. The exhibit, however, is a 1979 letter from a disinterested party, Dr. McGinnis, to Al Camosso, Administrator at Providence. Dr. McGinnis was in a position to have access to records of past activities regarding Providence's bed status, and there is no reason to doubt the reliability of the historical information he presents. Most of the numbers and dates referenced in Exh. R-74 also appear in Exhs. R-51, R-51A, R-52, R-53, R-70, and/or R-71. R-74 is relied on in these Findings, thus, to delineate the approximate sequence of events leading to Providence's non-conforming bed waiver and increased licensure.)

27. May 14, 1974 - Providence applied to the Department for revenue sharing funds to modernize its south tower and eliminate the 58 non-conforming beds in that structure. Exh. R-74.

1975

a. LOCH activities

28. Beirne became more actively involved in the hospital project, meeting with GHS, and with Chalista, NANA and Aleut Native corporations. Emmal was transferred to the Aleut Corporation on July 1, 1975 to work on the project, but Beirne declined to extend the agreement with this party, because he believed the arrangement to be "too one-sided." Beirne testimony.

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29. Local achitect Richard Sears was hired to change the plans to meet new code provisions, and to make the project more cost-effective. Kingston Peters was hired to help liquidate the debt to GHS.

30. October, 1975 - GHS filed a foreclosure suit on LOC's debt to GHS.

31. LOC received $312,000 in state revenue sharing funds. Exh. P-38.

b. Status of LOCH site

32. Beirne transferred the hospital site to GHS by warranty deed. Beirne testimony. Beirne testified that [notwithstanding the legal significance of a warranty deed] this transaction was intended only to give GHS a security interest in the property.

c. Activities re. other Anchorage hospitals

33. Providence's May 14, 1974 application for revenue sharing funds to modernize its south tower was approved by the Department. Exh. R-74.

1976

a. LOCH activities

34. March 13, 1976 - A letter of agreement was entered into with Modern Construction, Inc.-Tri/Alaska Construction, Inc. for design and estimating work on the hospital project. The Modern-Tri/Alaska joint venture was to operate as architect and contractor for the project if construction became feasible. Exh. R-9.

35. A contract was entered into with Gilgan & Company to obtain economic feasibility studies, planning studies and mortgage financing. Exh. P-110 at 3. Beirne testified that Gilgan initiated the process of obtaining a FHA loan, which effort was not successful.

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35. June, 1976 - Cost estimates were completed by Modern-Tri/Alaska. Exh. R-10; Prichard testimony.

37. June 12, 1976 - Coopers and Lybrand updated its feasibility study in draft form. Exh. R-8

38. July, 1976 - Modern stopped work on the project. Beirne testimony. Circumstantial evidence suggests the possibility of pressure from individuals associated with Providence Hospital. Starke, Forsythe depositions; Prichard testimony. Modern's Les Gundersen denied that there was any visit from Providence representatives. Gundersen deposition at 20-21.

39. September 17, 1976 - Modern's interest in the project was transferred to Tri/Alaska. Exh. P-26.

b. Status of LOCH site

40. May 30, 1976 - Beirne wrote Commissioner McAnerney stating that "Title to property has been transferred to facility sponsor" and "swear[ing] that all the above stated facts and figures are true to the best of my knowledge." Exh. P-38 at 5-6.

c. Beirne's salary arrangements/representations

41. May 30, 1976 - Beirne's communication to McAnerney identified the following salaries as part of total project costs:

Director - 50/50 time = 30g/yr x 6 yrs. . .180,000

Ass't Director - 50/50 time = 20g/yr x 6 yrs. . .- 120,000.

Exh. P-38 at 5.

d. Activities re. other Anchorage hospitals

42. June 7, 1976 - Providence applied to the state for an increase in licensed beds from 150 to 235. Exh. R-70.

43. July 1, 1976 - Providence was licensed for 228 beds through June 30, 1977. Exh. R-70.

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44. October, 1976 - Alaska Hospital completed construction and opened its doors with 200 beds. Beirne testimony; Exh. R-74.

45. November, 1976 - Providence completed its north tower. Exh. R-74.

46. November 26, 1976 - Providence was issued a new license for 268 beds. Exhs. R-70 and R-74.

e. Bed need projections

47. March 1, 1976 - The Alaska State Plan for hospital construction placed bed need at 350. Exh. P-33.

48. May 6, 1976 - After receiving requests for an update by Gilgan and Beirne, the state re-estimated bed need at 579. Exh. R-6; Beirne testimony.

49. July 20, 1976 - The state notified Beirne that Anchorage bed need projections had been revised again, this time to 413. Exh. R-7.

1977

a. LOCH activities

50. April 12, 1977 - Beirne wrote Frank Cox, District Director, Small Business Administration, stating that "in 1973 I borrowed $1.5 million on a one-year note to begin construction on this hospital that year." Exh. P-41.

51. April 14, 1977 - Nix wrote Beirne advising him as follows:

> If we borrow $17,250,000 the equity will be approximately 2%. This will be a major problem to overcome for a sophisticated investor unless we can convince him the state pays 25% of the construction cost, and he considers this equity.
>
> I am not including this information in my report but just want to pass on to you my thoughts.

Exh. P-45.

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52. June 21, 1977 - Beirne and associates on the project presented their proposal to the Anchorage Assembly for sponorship by the Assembly of tax-exempt bonds.

53. June 28, 1977 - The Assembly considered sponsorship again. Bonnie McGee from the Municipal Health Commission testified, requesting that the Assembly delay taking action until the Commission had an opportunity to review the project. Beirne opposed a three week postponement on the grounds that LOC would like the hospital to be under construction by September 1, 1977. George Shecter, LOC's consultant, testified at the hearing on this accusation that approximately 150 days would be required from the date of passage of such a resolution before construction could realistically be expected to commence. He indicated that a minimum of 90 days would be consumed in getting issuance of the bonds from such time as the underwriting documents were prepared, and another 60 days would be required to obtain the steel necessary to start construction. Contrary to Beirne's statement in Exh. P-44, no one from South Central testified in opposition to the resolution. The Assembly voted to approve the resolution sponsoring the tax exempt bonds. Exh. P-48.

54. July 1, 1977 - The state certificate of need law became effective.

55. July 5, 1977 - Mayor George Sullivan vetoed the Lake Otis Hospital resolution based on the overbedding in the community and the failure to have the project reviewed by the Municipal Health Commission. Sullivan indicated that his "primary concern" was the opposition voiced by the Commission. Exh. R-16B. Newspaper articles appeared in The Anchorage Times and The Anchorage Daily News reporting Municipal Health Commission support for the mayor's veto. Exh. R-15.

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56. July 15, 1977 - LOC obtained a foundation building permit for $7,500 from the City of Anchorage. Exh. P-44.

57. July 15, 1977 - South Central's Board president Paul Foutz wrote Assembly Chairman Ernest Brannon identifying "certain facts regarding the economics of health care," but not openly articulating a position on the LOC proposal. Exh. R-54.

58. July 19, 1977 - An attempt to override the mayor's veto failed. Exh. P-44; Beirne testimony.

59. July 27, 1977 - Acting Commissioner Lund granted LOC a certificate of need "to construct a 125 bed hospital in Anchorage, Alaska." Exh. R-11, Tab 1. The certificate was issued pursuant to SLA 1976, Ch. 275, Sec. 4 which provided:

> All health care facilities in existence or under construction before July 1, 1976 shall be issued a certificate of need.

Regulations defining "under construction" did not come into effect until January, 1978. Exh. R-11, Tab 10. The certificate provided:

> This certificate shall expire 18 months from the date of issue, unless an extension has been granted and shall be subject to revocation by the Department of Health and Social Services for failure to comply with the laws of Alaska or rules and regulations as provided under the Alaska Administrative Code.

Exh. R-11, Tab 1.

60. August 22, 1977 - A formal presentation was made to the Wasilla City Council. The Council approved a bond sponsorship resolution. Exh. R-17.

61. Mid - Fall, 1977 - Investment broker Don Cincotta and William Nix Associates worked on tax exempt financing for the project. Exh. P-44 at 4 and 5; Beirne testimony.

62. October 7, 1977 - An offer to construct the hospital was transmitted by Howard S. Lease Construction Co.

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& Associates. The contract was contingent upon LOC obtaining financing satisfactory to Lease Co.'s bank and surety. Exh. R-16A.

63. December 12, 1977 - The GHS foreclosure suit was dismissed after satisfaction of the debt to GHS. Exh. P-44 at 10; Beirne testimony. Beirne testified that the GHS loan ultimately cost him $1.5 million: $900,000 principal; $250,000 interest; $100,000 to Kingston Peters for assistance in the liquidation process; and $250,000 for attorney's and accountants' fees, real estate fees, and Beirne's own expenses.

b. Status of LOCH site

64. October 25, 1977 - General Hospital Services deeded the Lake Otis Hospital site property to Beirne. Exh. R-4.

c. Activities of health planning agencies re. LOCH and bed need projections

65. June 1977 - As noted Finding 53, supra, the Municipal Health Commission's chairman testified before the Anchorage Assembly in opposition to its proposed sponsorship of tax exempt bonds for LOCH.

66. July 15, 1977 - As noted in Finding 57, supra, South Central president Foutz wrote Assemblymembers drawing attention to various factors relevant to the Assembly's consideration of the LOC proposal.

67. September 14, 1977 - The Municipal Health Commission determined that Anchorage was over-bedded and adopted the following resolution:

> 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.

Exh. R-55.

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68. Beirne testified that South Central endorsed the moratorium concept within a month. See also, Exh. P-44 at 5. Hammett's testimony and documentary evidence indicate that strict endorsement of the moratorium was not approved by South Central. However, at its September 23, 1977 meeting, petitioner's board of directors did adopt the folowing motion:

> 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 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 two efforts to Blue Cross, the State and others who have funding authority.

Exh. R-56 at 3.

69. September 29, 1977 - Letters containing the language of the South Central motion were sent by petitioner's president to Governor Hammond, Mayor Sullivan, and Armand Hoppel, president of Blue Cross of Washington and Alaska. Exh. R-57. A response from Hoppel indicating that Blue Cross would "support the intent of the motion" was sent to petitioner on October 5, 1977, and forwarded by South Central to Governor Hammond and Mayor Sullivan. Exh. R-58. An article appeared in The Anchorage Times based on information obtained from South Central and erroneously captioned: "Blue Cross Chief Says Insurance Won't Pay at Beirne's Hospital." Exh. R-58A. Petitioner did not seek to obtain a correction of this caption in a future issue of the paper. On December 15, 1977, Bonnie McGee, Chairman of the Municipal Health Commission wrote the Commissioner of Health and Social Services requesting that the Commission's moratorium resolution and South Central's motion be incorporated into the State Facilities Plan. Exh. R-68.

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d. Activities re. other Anchorage hospitals

70. March 30, 1977 - A meeting between Providence and Department representatives resulted in a tentative agreement to reduce Providence's bed capacity to 250. Exh. R-51A. (While this is hearsay, there was other testimony that such a meeting took place with this result. The 250 figure is corroborated by the existence of Exh. R-51A, and the July 1, 1977 license contained in R-70.)

71. April 27, 1977 - Hammett wrote the State Office of Planning and Research supporting Providence's request to license 250 beds with a waiver of square footage requirements for 44 beds. Bed need was not discussed though it was considered by South Central. Exhs. R-51 and R-52.

72. May 6, 1977 - The Department approved a waiver for Providence's utilization of 31 non-conforming beds. Exh. R-74.

73. May 20, 1977 - The Department corrected its waiver approval to reflect the existence of 44 non-conforming beds. Exh. R-74. The waiver was premised on the belief that remodeling costs to bring the rooms into conformity with legal standards would increase costs to patients while patient care would not suffer as a result of the non-conformity. Regional bed need was not addressed in consideration of the waiver. Exh. R-71.

74. July 1, 1977 - Providence was officially licensed for 250 beds, 44 non-complying. Exhs. R-70 & 74.

75. July 27, 1977 - Providence submitted a second application for the modernization funds awarded by the state in 1975. This revised application indicated that the 44 beds would remain out of compliance. R-71.

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76. August 15, 1977 - The Department approved Providence's July 27 revised application. Exh. R-71.

e. Revenue sharing litigation

77. November 1, 1977 - Beirne and the State each sued the other over revenue sharing funds.

1978

a. LOCH Activities

78. January, 1978 - George Shecter, health economist with the USC Medical School Center for Health Research, was hired as a consultant to LOC. The Nix Associates contract was extended to July, 1978. Exh. P-44, corroborated in substance by Beirne testimony.

79. April 14, 1978 - Beirne, Shecter and Cincotta met with various union representatives to elicit union support for the project. Exh. R-19.

80. April 27, 1978- A favorable ruling was received from the I.R.S. re. the Wasilla bonds. Exh. R-20.

81. May, 1978 - Shecter wrote letters to union representatives seeking patient days commitments and indicating that "Lake Otis Community Hospital is a reality and construction will start this summer. . . ." Exhs. P-11 and 12. No working drawings had been prepared at this time and no financing had been secured. Shecter testimony. See also, Finding 53. Realistically, construction could not have been expected to start in the summer of 1978, but in the Fall at the very earliest.

82. June 30, 1978 - LOC's last construction license expired. Regulations now required approval of working drawings prior to issuance of a construction license. Beirne was unwilling to incur the expense of obtaining completed working drawings until construction financing was secured. Beirne testimony.

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83. July 18, 1978 - U.S.C. feasibility study was completed. Exh. R-31.

84. August 9, 1978 - Beirne states that as of this date he anticipated final approval of financing details by the Wasilla City Council on August 28 with construction able to "begin again the next day." Exh. P-44 at 25.

85. August 12, 1978 - Beirne informed the state that as of this date, bond counsel Borge indicated his intent to withdraw because of a change in I.R.S. rules rendering funding mechanism on bonds subject to closer I.R.S. scrutiny. Exh. P-44 at 26.

86. August 28, 1978 - A Wasilla bond resolution affirming support for the project was passed by the City Council. Beirne testimony. Exh. R-28.

87. October 20, 1978 - Beirne requested an extension for the LOC C/N. See, Exh. R-11, Tab 2.

88. November 28, 1978 - A special election was held in Wasilla; continued sponsorship of the hospital was defeated. Exh. R-29; Beirne testimony.

89. November, 1978 - Beirne wrote to the Alaska Medical Facility Authority for information on funding. Beirne testimony.

90. December 27, 1978 - Beirne sent McGinnis a letter with documentation in support of LOC's request for an extension of its C/N. Beirne stated: "[y]ou must understand that the contractors are ready to begin this project tomorrow provided that financing is available." Exh. R-11, Tab 3, letter of 12/27/78 at 3.

91. December 29, 1978 - LOC's certificate of need was extended for a six month period to June 30, 1979. McGinnis found, first, "reasonable justification for not having accomplished 'substantial implementation'" because of Wasilla's with-

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drawal of bonding support and the delay in implementation of the Alaska Medical Facilities Authority legislation occasioned by the necessity of amending the statute to conform to I.R.S. requirements. McGinnis also ruled that LOC had "a reasonable likelihood of accomplishing that 'substantial implementation' within the terms of the requested extension." This determination was based on the likelihood of being able to process an application through AMFA within the extension period, and the possibility of financing being accomplished through a Native corporation during the same time frame. The Commission relied in part on documentary evidence submitted by LOC indicating a state of readiness to proceed immediately with construction once financing was obtained. Exh. R-11, Tab 4.

b. Activities of health planning agencies re. LOCH

92. May 16, 1978 - South Central Administrator Ron Hammett wrote Mayor Hjellen of Wasilla opposing Wasilla support of LOCH based on considerations of overbedding and other factors. Exh. R-21.

93. May 18, 1978 - Hammett wrote to Beirne seeking to schedule a public meeting at a time convenient to Beirne for the purpose of discussing bed need. Exh. P-56.

94. June 22, 1978 - Newspaper articles reflecting opposition to LOCH by South Central and the Municipal Health Commission appeared in local papers beginning this date and extending through the special election. Exh. R-29.

95. October 13, 1978 - Hammett wrote Anchorage mayor Sullivan indicating a desire to support the Municipality in taking "whatever appropriate legal action is necessary to prevent the development of the proposed Lake Otis Hospital." Exh. R-70.

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96. November 11, 1978 - Hammett and citizen Harold Pomeroy participated in a debate against Beirne and Bob Ogden sponsored by the Wasilla Chamber of Commerce. Exh. P-58.

c. Activities re. other Anchorage hospitals

97. February 2, 1978 - Beirne met with Department officials and OPR staff re. Providence's 219-bed limit. As a result of this conference, the Department requested an Attorney General's opinion. Exh P-44.

98. May 16, 1978 - An Attorney General's opinion was issued stating that unless need for the increase in beds from 219 to 250 could be demonstrated as of 1977, Providence would have to reduce bed capacity to 219 or forego previously approved revenue sharing funds. Exh. R-71.

99. July 31, 1978 - The Municipal Health Commission affirmed its support of 250 beds for Providence in a letter to the Commissioner. LOCH's projected beds were not referenced in any manner. Economies of scale were considered. Exh. R-65.

100. August 8, 1978 - Hammett wrote the Commissioner reaffirming South Central's support of Providence's request for 250 beds with a waiver of requirements for 44 of those beds. South Central did not include LOCH in its bed need calculations. Exh. R-52.

101. August 15, 1978 - The Office of Planning and Research included 43 beds approved but not licensed for Alaska Hospital and Lake Otis Hospital's 125 beds in assessing bed need. OPR recommended that the Department either (1) relicense Providence at 219 beds and investigate rescission of LOC's grandfathered C/N; or (2) investigate rescission of LOC's C/N without revising Providence's license. Exh. R-53.

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102. November 28, 1978 - The Office of Planning and Research revised its August 15, 1978 determination of bed need based on altered directives from federal authorities allowing the exclusion of grandfathered facilities for which progress had not been made. As a result of the revised calculations, OPR found that there was a demonstrated need for additional beds at the time of Providence's license application. OPR therefore supported Providence's request for 250 beds. Exh. R-73.

103. December 1, 1978 - The Department determined to continue its waiver approval for Providence's 44 non-conforming beds and its revenue sharing funding. Exh. R-74.

1979

a. LOCH Activities

104. January 4-5, 1979 - Beirne and Shecter exchanged correspondence suggesting solicitation of Native help in financing LOCH. Beirne reported that after conferring with McGinnis he believed there was "a reasonable opportunity" of obtaining funds through AMFA. Exhs. P-13 and 13A.

105. January 31, 1979 - Beirne filed LOC's application for tax exempt bond financing with the Alaska Medical Facility Authority. Documentation referenced in the application remained to be submitted. The application stated that engineering and architects' plans and specifications were completed and that "all outside funding sources [had] been approved." Beirne claimed as well that the project was eligible under AS 18.26.220, the provision which requires compliance with the certificate of need application and approval sections of AS 18.07.011-111. The application recited that "over a million and a half dollars was borrowed and invested in the project[.]" The narrative portion of the application concluded with the statement that

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"As of this date, Lake Otis Clinic, Inc. is a fully licensed and certificated institution with plans, specs, and contracts completed, ready to resume construction immediately on securing adequate financing." Exh. R-33. Cf. Findings 108, 112, 123, 154. Beirne testified that the $1,000 application fee was not remitted to AMFA because Beirne knew that the application was unlikely to succeed in light of the certificate of need requirements of the legislation. Beirne testimony.

106. June 4, 1979 - Beirne wrote McGinnis requesting a second extension of LOC's certificate of need. Reporting on the present status of the project, Beirne referenced the AMFA application without indicating that it had never been completed nor accompanied by the requisite fee. Beirne noted that AMFA was still in the process of being restructured, following legislative amendments in April. Beirne went on to state:

> We have no reason to believe that our application to the Authority will not be approved. Numerous conferences with our consultants conclude that the merits of the project are such that the Board will have no reason to reject the application.
>
> However, in all candidness, it is obvious that with four health planners on the Board, our application may encounter difficulties that would be based not on merit but on political interests. We are prepared to file an anti-trust action to include the individual Board members if necessary.

Exh. R-11, Tab 5.

107. June 6, 1979 - McGinnis granted Beirne's request for a second extension, the certificate of need to be valid from July 1, 1979 to December 31, 1979. In a letter accompanying issuance of the C/N, McGinnis wrote that his decision was based

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on Beirne's representations set forth in his letter of June 4, 1979 regarding the status of the project.

108. June 6, 1979 - Architect Alexander Bertulis wrote Beirne, stating:

> I expect to expend about 400 man-hours during June in bringing the plans up to date. They will be far from complete but I think they will be comprehensive enough to submit to the State architect for review. It would be too much to expect of the State architect to approve these plans on the first go-around, even if the plans were 100% complete!

109. June 18, 1979 - A financial feasibility study summary was prepared by Shecter to support the AMFA application. The document states that "Lake Otis Community Hospital complies with the requirements of the Act and is clearly entitled to the issuance of these bonds by the Authority[.]" Exh. R-37 at 1.

110. June 19, 1979 - Assistant Attorney General Wyanne Bunyan issued an Attorney General's opinion holding that grandfathered institutions applying for AMFA funding had to comply with current substantive and procedural requirements of AS 18.07. Exh. R-11, Tab 26.

111. June 21, 1979 - An AMFA meeting was held at which time the LOC project was discussed and questions regarding the necessity of complying with the certificate of need requirements were raised. Exh. P-74. The application was merely "received," not acted upon. Beirne prepared a file memorandum on the meeting in which he stated that there is an "outside chance" that the project can comply with the 'substantive and procedural requirements' referenced by Assistant Attorney General Bunyan [without submitting to a certificate of need review]. Beirne relates:

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> I really never expected that we could overcome this legal hurdle, but we had to go through the process and be denied in order that I can appeal to the Legislature to remove this clause from the law.

Exh. P-72 at 2.

112. June 29, 1979 - Consulting engineer W.C. Koskinen wrote Beirne and Forsythe stressing that at least three pile load tests were "urgently need[ed]" in order to finalize the design. Exh. P-11. Beirne testified that these tests were never authorized as he was unwilling to expend more funds while financing was uncertain.

113. July 20, 1979 - Beirne submitted schematic plans and specifications to Walter Moyle, Department architect.

114. July 26, 1979 - Anchorage Municipal Health Commission filed suit against LOC challenging the issuance of LOC's initial "grandfathered" C/N as well as the two extensions of the C/N. Exh. R-38. Beirne testified that the lawsuit "stopped the project totally" because financing was unobtainable under the cloud of litigation. He did not indicate what, if any, financing efforts were under way other than the AMFA application.

115. July 30, 1979 - Moyle wrote Beirne identifying questions and revisions required in plans submitted on July 20, 1979. Moyle stated that his office's review was "continuing." Exh. P-19.

116. August 8, 1979 - Beirne wrote AMFA Chairman Tom Williams requesting that he temporarily set aside the LOC application pending resolution of the municipal lawsuit and determination of the certificate of need question. Exh. R-35.

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117. August 27, 1979 - Shecter responded to Moyle's letter stating "we are most anxious to cooperate with your office. . . . " Exh. P-20.

118. October 12, 1979 - Legal Assistant Theresa Hillhouse wrote an Attorney General's opinion stating that C/Ns are not transferable from one owner of a facility to another. Exh. R-47A.

119. November 12, 1979 - Funding of a private loan through the auspices of attorney John Frolich and intermidiary Charles Devlin was obtained, closing to be contingent, inter alia, on "[a]ny additional . . . items felt necessary by the Lender or its counsel which are not determinable." Exh. P-36A, Letter of October 26, 1979 from Frolich to Devlin and telegram of 11/12/79.

120. November 13, 1979 - The municipal lawsuit against LOC was dismissed for want of capacity of the Municipal Health Commission to bring the litigation. Exh. R-38.

121. November 15, 1979 - Lease/Crucher/Kissee, general contractors, submitted their offer to construct the hospital at a maximum cost of $14,016,233 contingent upon procurement of financing satisfactory to the contractors' bank and surety prior to December 31, 1979. Exh. R-39.

122. December 7, 1979 - Beirne wrote McGinnis requesting confirmation that LOCH is "substantially implemented" and thus possessed of a continous certificate of need. Beirne contended that as a matter of law, LOCH was "substantially implemented" because such was the requirement for issuance of the grandfathered certificate in July, 1977. Beirne also claimed that the hospital project satisfied the substantial implementation provisions of 7 AAC 08.090(e)(4) and (6). Exh. R-11, Tab 9.

123. December 12, 1979 - Shecter wrote Bertulis stressing the "critical" need of hiring a kitchen consultant. Exh. P-22.

124. December 14, 1979 - A contract was entered into with Arctic Steel to install the additional 79 pilings. Exh. R-40.

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125. December 17, 1979 - Frolich wrote Devlin saying the lenders were "raising 'hell'" because their funds had been tied up without receipt of the plans and specifications and the one percent loan application fee. Frohlich said; "You better see that Dr. Beirne gets his act together. . . . " Exh. P-36A.

126. December 31, 1979 - McGinnis wrote Beirne expressing a "conditional determination" that LOC's C/N would continue in effect after December 31, 1979 based on "the apparent fulfillment of the minimal requirements of 'substantial implementation. . . .'" Applying the criteria set forth in 7 AAC 07.090(e)(1)-(6) and (f) for evaluating questions of "substantial implementation," McGinnis found that contracts may have been signed meeting the requirement of subparagraph (4) and acquisition of the site satisfied subparagraph (f). Copies of the conditional determination were sent to affected parties. McGinnis disclosed that his final determination would be based in part on consultation with South Central. He noted that LOC's failure to show "continuing progress toward commencement of activities" or to "complete the activities authorized by the certificate" could lead to revocation of the C/N. Exh. R-11, Tab 10.

1980

a. LOCH activities

127. January 23, 1980 - Devlin wrote Beirne inquiring of LOC's intentions "in fulfilling your obligations under our contract[.]" Exh. P-36A.

128. February 11, 1980 - Beirne wrote McGinnis explaining the status of certain contracts which appeared to have expired. He advised of ongoing negotiations with Cincotta; stated that the "expired Lease Co. contract is still good" as Lease would continue to extend data as it had done in the past; and reported

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that although the contract with Devlin and Frolich actually expired on December 15, 1979, he was continuing to work with them. Exh. P-36. Beirne ultimately refused to consummate the Frolich/Devlin transaction. He testified that he was concerned about the absense of a concrete loan package and his lack of information regarding the identify of the lenders; the possibility of new terms being added to the contract; and the insufficient financial benefit he would derive from the arrangement.

129. March 10, 1980 - McGinnis issued a final determination of "substantial implementation" validating LOC's C/N. That determination was based on the same considerations outlined in the conditional determination letter. Exh. R-11, Tab 19.

130. March 24, 1980 - South Central and Providence each wrote McGinnis appealing the substantial implementation decision and requesting a hearing. Exh. R-11, Tabs 21 and 22. Robert J. Dickson, on behalf of Provicence, expressed that institution's desire to undertake further expansion, which plan could be thwarted as long as LOC's C/N was outstanding.

131. April 8, 1980 - Providence brought a civil action against the Department to void McGinnis' final determination of "substantial implementation." Exh. R-12.

132. April 30, 1980 - The revenue sharing litigation was concluded with a decision and order directing Beirne and LOC to repay to the state the funds granted to LOC plus interest. Exh. P-28. An appeal of that decision is presently pending in the Alaska Supreme Court.

133. June, 1980 - LOC entered into discussions with Alaska Pacific Bank for commercial financing of the hospital. See, Exh. P-24.

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134. July 1, 1980 - Liberalized revenue sharing provisions of AS 29.90.010 and 030(3) became effective, allowing

interest expenses to be included in computing "total project costs" for the first time. Both Shechter and Tom Behan of Alaska Pacific Bank testified that the availability of this source of financing made the project "attractive."

135. July 31, 1980 - McGinnis informed South Central and Providence that their requests for hearing would be denied based on an Attorney General's opinion holding that the appropriate procedure would be a petition for revocation of LOC's C/N rather than an appeal of McGinnis' decision. Exh. R-11, Tab 24.

136. August, 1980 - Alaska Pacific Bank financing was pursued by Cabot Jones on behalf of LOC; Beirne considered backup financing through tax-exempt bonding from Valdez or Houston. See, Exh. P-66.

137. August 8, 1980 - South Central filed its accusation in this case for revocation of LOC's C/N.

138. August 28, 1980 - Beirne wrote Chuck Considine, explaining the delay in proceeding with the project as follows:

> While we can cite many specific interferences by the health planning groups and the other hospital interests which have in one or another way prevented the completion of financing, the basic reason is that we have not had sufficient capital to fight the Sisters of Providence. . . . who have virtually unlimited resources, and are commited [sic] to preventing any completition [sic] from the Lake Otis Hospital....I have discovered what many thinly capitalized entrepreneurs have discovered: the absolute necessity of having sufficient capital in launching a project.

Exh. P-68.

139. September 3, 1980 - Stolte-Easley, Joint Venture, proposed to perform construction for a guaranteed maximum cost of $17,162,000, assuming financing satisfactory to the contractors' bank and surety was obtained prior to November 2, 1980. Exh. R-44.

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140. September 30, 1980 - Beirne conveyed an endeavor fee in the amount of $15,000 to Alaska Pacific Bank. Exh. R-41.

141. October, 1980 - Alaska Pacific Bank declined to proceed with the loan due in part to the litigation challenging LOC's C/N and the lack of commitment from a municipality to sponsor tax exempt bonds. Behan testimony.

142. November, 1980 - An update of financial data on LOCH was performed. Exh. R-42.

b. Status of LOCH site

143. February 11, 1980 - Beirne wrote McGinnis stating that "the ownership and control of the Hospital site is now and always has been in Lake Otis Clinic, Inc. and Mike F. Beirne." He further asserts:

> In 1973, the Hospital site was deeded to the Lake Otis Clinic, Inc. and it remained in that ownership until late 1977 at which time the title was transferred back to my personal name where it remains. During this latter time frame lawsuits required the recording of a deed of trust and even a warranty deed with a caveat.

Exh. P-61.

c. Activities re. other Anchorage hospitals

144. August, 1980 - Providence was issued a grandfathered C/N for 250 beds. AK Hosp ?

d. Activities of health planning agencies re LOCH

145. January 24, 1980 - The Municipal Health Commission sent McGinnis a letter in opposition to his conditional determination of substantial implementation. The Municipal Health Commission contended, inter alia, that 7 AAC 07.090(e)(4) must be interpreted to require signing of a contract for a substantial portion of the project construction in order to be consistent with the overall intent of the regulation. Exh. R-11, Tab 11.

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146. February 18, 1980 - South Central sent McGinnis a letter in response to his conditional determination of substantial implementation. South Central acknowledged that it had no evidence that the literal requirements of 7 AAC 07.090(e)(4) and (6) and (f) had not been met. Petitioner also forwarded its' attorney's preliminary conclusion that granting a continuous C/N to LOC would be improper. Petitioner recommended, finally, that any continuation of LOC's C/N be conditioned on a 180-day time period for presentation of secured financial commitments of at least 50 per cent of the total estimated construction costs. Exh. R-11, Tab 15.

147. March 24, 1980 - As set forth in Finding 130, supra, South Central notified McGinnis of its decision to "pursue an appeal and hearing under the procedures set forth in 7 AAC 07.080. Exh. R-11, Tab 21.

148. August 8, 1980 - As set forth in Finding 132, supra, South Central filed the accusation in this case for revocation of respondent's C/N.

149. September, 1980 - Representatives of Brookwood Medical Services, potential contractors to provide management services for LOCH, contacted petitioner's staff regarding the status of LOC's C/N. South Central staff informed Brookwood personnel that Anchorage was over-bedded and that revocation proceedings had been initiated. [illegible]

1981

a. LOCH activities

150. January, 1981 - Hospital Corporation of America ("HCA") contacted Beirne to discuss possible financing of the hospital project. Beirne testimony.

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151. Spring, 1981 - Contract negotiations were undertaken with Brookwood Health Services. Brookwood was ultimately taken over by "AMI" which company was not interested in operating in Alaska. Shecter testimony.

152. May 6, 1981 - LOC obtained summary judgment in the Providence litigation; an appeal is presently pending in the Alaska Supreme Court. Beirne testimony; Exh. P-69.

153. May 13, 1981 - Stolte-Easley, Joint Venture informed Beirne that construction, if started by August 14, 1981, would cost approximately $18,660,000. Exh. P-101. Beirne responded on May 15, 1981, stating, inter alia, that no contractual relationship currently existed between LOC and Stolte-Easley. Exh. P-102.

154. May 13, 1981 - Consulting engineer W.C. Koskinen informed Beirne that the structural engineering design and drawings were "20 percent from completion." Exh. P-70.

155. June 11, 1981 - Assistant Attorney General Elizabeth Shaw wrote an Attorney General's opinion which declared that "Although a certificate of need is 'non-transferable' by itself, it may be 'transferred' along with the health facility." Exh. 47B.

156. June 30, 1981 - LOC entered into an option agreement with HCA whereby HCA would purchase LOC's C/N and the hospital property and LOC's interest in the development of the hospital. Exh. R-46.

157. September 19, 1981 - Elizabeth Shaw wrote another Attorney General's opinion indicating that a C/N was not required for the purchase of a health care facility. Exh. P-77.

158. October, 1981 - HCA declined to proceed with the option agreement, according to Beirne, because of the uncertainty surrounding the transferability of the C/N and the pending litigation. Beirne testimony.

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159. November 5, 1981 - Beirne authorized Reynolds Construction to proceed with specified on-site electrical and fill work to maintain the City building permit. Exh. P-71; Beirne testimony.

Present Status

a. LOCH activities

160. Beirne anticipates no further expenditures on behalf of the hospital project until legal obstacles are cleared.

b. Activities re. other Anchorage hospitals/bed need

161. Providence is operating at near capacity at present, hoping to add 132 beds to be ready for occupancy in 1985. Alaska Hospital has a high occupancy rate for those beds it has placed in operation, but not for those licensed. Exh. R-77, Camosso testimony.

162. According to calculations performed by South Central and Providence, at least 30 new beds will be needed in the Anchorage area by 1985. Exhs. R-51A and R-76, respectively.

ULTIMATE FINDINGS OF FACT

1. Dr. Beirne was not a credible witness. Beirne demonstrated a willingness to mislead governmental authorities on matters including, but not necessarily limited to, the following: (a) the ownership of the hospital site (Findings of Fact 32, 40, 64, 143); (b) his salary entitlements (Findings of Fact 22, 23, 41); (c) the timetable for commencing construction on the project (Findings of Fact 53, 85, 90, 105, 100, 112, 123, 154); (d) the bona fide nature (or lack thereof) of LOC's filing with AMFA (Findings of Fact 105, 106, 111); and (e) the size and source of his and LOC's financial obligations (Findings of Fact 19, 50, 105.)

2. LOC's hospital project has been undercapitalized. Exhs. P-28 at 44 and P-68, Beirne testimony.

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3. Beirne has twice avoided review by planning agencies and thus effectively negated LOC's prospects for Anchorage bond sponsorship and AMFA funding, respectively. 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.

4. South Central and the Municipal Health Commission have opposed construction of the Lake Otis hospital since respondent attempted to obtain tax exempt bond sponsorship from the Municipality of Anchorage. The agencies' motivation was the promotion of quality patient care at a reasonable cost. No personal animus towards Dr. Beirne, nor any conspiracy with Providence or Alaska Hospitals was demonstrated. Findings of Fact 53, 57, 65-69, 92, 93, 95, 96, 114, 130, 137, 145-148. Hammett testimony. Hammett testified that when it appeared that Alaska Hospital would be sold to the federal government, he went to Beirne's office to inquire if LOC could replace the Alaska Hospital beds.

5. The Municipal Health Commission's opposition to the hospital played a substantial part in the mayor's subsequent veto of the Anchorage Assembly resolution supporting bond sponsorship. South Central's activities in regard to the Wasilla bond sponsorship also played some part in the defeat of the Wasilla resolution.

6. The state's revenue sharing litigation against Beirne affected Beirne's credibility and thus adversely affected his prospects for obtaining financing for LOCH.

7. LOC effectively "wasted" the period of time between September, 1978, when the Wasilla bond sponsorship ceased to be a viable option, and July, 1979, when the Municipal Health Commission action was filed, by making no bona fide effort during

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those months to obtain financing. The AMFA application was a sham. There were almost four more months after the Municipal lawsuit was dismissed and the time for appeal had expired, and before the Providence and South Central appeals were filed with the Department, when again no legitimate efforts to obtain financing were made. Even while the Municipal litigation was pending, Beirne apparently had the option of accepting the Devlin/Frolich financing. This latter possibility was either (a) never a realistic, feasible source, or (b) never seriously considered by Beirne because of lack of financial advantage to him.

8. The Municipal Health Commission litigation, and more clearly the Providence and South Central actions, interfered substantially with LOC's ability to obtain financing for the hospital.

9. LOC's efforts to obtain financing for, and construct, the hospital entailed the expenditure of substantial sums of money and substantial effort on the part of Dr. Beirne and various associates.

10. In March, 1977, prior to the effective date of the certificate of need legislation, Providence was licensed for 250 beds. At that time, before LOC's C/N was issued, and again, in 1978, after LOC received its grandfathered C/N, South Central recommended approval of the 250 figure based on bed need calculations as of early 1977. The 250 beds represented an increase of 22 beds over the 228 previously licensed in 1976, and 31 more beds than the 219 approved in 1974. LOC's proposed 125 beds were not included in petitioner's calculations of bed need.

11. The Alaska Hospital opened in 1976 with a bed capacity of 200; it was licensed for 154 beds. In December, 1978,

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Alaska Hospital was licensed for 45 more beds. There is no indication of any health planning agency involvement in that licensing decision.

CONCLUSIONS OF LAW

I. PETITIONER HAS NOT DEMONSTRATED GROUNDS FOR REVOCATION OF LOC'S CERTIFICATE OF NEED BASED ON AS 18.07.081(d)(1).

South Central has contended, first, that respondent's certificate of need should be revoked because of failure to comply with the requirements set forth in AS 18.07.081(d)(1). That section provides:

> (d) A certificate of need may be revoked if
>
> (1) the sponsor has not shown continuing progress toward commencement of the activities authorized under AS 18.07.041 after six months of issue.

"Commencement of activities," in turn, is defined as

> the visible commencement of actual operations on the ground for the construction of a building . . . which operations are readily recognizable as such and which operations are done with intent to continue the work until such activities are complete. . .

There is no question that there was "visible commencement of actual operations on the ground for the construction of a building" in 1973 and 1974 when the original site preparation and piling work was acomplished. The only issues, thus, are whether Sec. 81(d)(1) is even applicable to work accomplished prior to issuance of a grandfathered C/N and, if so, whether the work in this case was performed with "intent to continue . . . until such activities are complete."

Respondent's argument on the first point arises from the fact that LOC received a grandfathered certificate because, in the language of SLA 1976, Ch. 275, Sec. 4, the hospital was

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found to be "under construction before July 1, 1976." Respondent contends that since it has been determined that the project was "under construction" prior to issuance of its C/N, there could not logically be a finding now that Lake Otis has not made "continuing progress towards commencement. . . ." To the same end, respondent argues that AS 18.07.081(d)(1) is inapplicable, because it premises revocation on failure to commence activities authorized under AS 18.07.041, while Lake Otis was issued a grandfathered certificate pursuant to SLA 1976, Ch. 275, Sec. 4.

These arguments are well taken. It is conceivable that sponsors could place a facility "under construction" for purposes of the grandfathering legislation, and yet not possess the requisite intent to pursue construction through to completion under the revocation statute. This dichotomy, however, defies common sense. While the language in the two statutes is not identical, the basic import seems to be that a good faith start on hospital construction must be underway to authorize grandfathering, on the one hand, or to withstand revocation, on the other.

This conclusion is buttressed by the specific language of the revocation statute. As cited previously, AS 18.07.081(d) provides:

> A certificate of need may be revoked if
>
> . . . .

Subsections (2), (4) and (6) provide, respectively:

> (2) the applicant fails, without good cause, to complete activities authorized by the certificate;
>
> . . . .
>
> (4) the sponsor knowingly misrepresents a material fact in obtaining the certificate;
>
> . . . .

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

(Emph. added.) Only subsection (1) refers to activities "authorized under AS 18.07.041," instead of activities authorized under "the certificate." It appears that the Legislature did intend to make a distinction between the first grounds for revocation and the others that follow. Revocation for failure to make "continuing progress toward the commencement of activities" was not designed to apply to certificates awarded under the grandfathering legislation.

Even if this conclusion is erroneous, however, LOC has demonstrated compliance with the terms of AS 18.07.081(d)(1). "Intent" is not defined in the statute. Black's Law Dictionary (Fifth Ed. 1979) states:

> Intent. Design, resolve, or determination with which person acts. [Citation.] Being a state of mind, is rarely susceptible of direct proof, but must ordinarily be inferred from the facts. . . .[Citation.] A mental attitude which can seldom be proved by direct evidence, but must ordinarily be proved by circumstances from which it may be inferred. [Citation.]

In this case, petitioner contends that the fact that respondent possessed only short-term financing for $900,000 through GHS and Peoples Bank at the time construction started indicates the absense of any intent on Beirne's part to pursue construction to completion. However, there is no evidence that Beirne harbored any ulterior motive in commencing the work in 1973. The state's certificate of need legislation was not in effect, so there is no basis for inferring a design to accomplish just enough construction to establish grandfather rights. Beirne testified, moreover, that the rise in interest rates in 1974 was an "anomaly." He reasonably expected the GHS financing plans to be consumated.

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While Beirne's judgment in proceeding with only a short-term commitment may be questioned, there is no basis for disputing his resolve to build the entire hospital. His attempts, after indemnifying GHS, to secure other financing further support LOC's position that construction was commenced with the intent to pursue the effort to completion.

II. PETITIONER HAS DEMONSTRATED GROUNDS FOR REVOCATION OF LOC'S CERTIFICATE OF NEED UNDER AS 18.07.081(d)(2).

South Central's second contention, to which most of the evidence at the hearing was directed, is predicated on respondent's failure to complete the hospital construction. AS 18.07.081-(d)(2) provides:

> (d) A certificate of need may be revoked if
>
> . . .
>
> (2) The applicant fails, without good cause, to complete activities authorized by the certificate.

Construction of the hospital certainly has not been completed. The question is whether "good cause" exists.

A. Definition of "Good Cause"

Analysis of respondent's claim of "good cause" requires definition of that term. Petitioner refers the Commissioner to cases resolving contract disputes by invoking the doctrines of "impossibility" or "frustration of purpose." Those authorities generally hold that a promissor must be held to his duty to perform unless he can demonstrate the intervention of events which were not foreseeable nor part of his calculated risk in making the initial agreement. Further, to excuse a contracting party from its obligations, the effect of such events must be to render performance impossible, vitally different from that anticipated, or unreasonably expensive to the point of extreme hardship. E.g., Glendale Fed. S.&L. Ass'n v. Marina View, Etc., 135 Cal. Rptr.

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802, 66 Cal. App. 3d 154 (1977); Natus Corporation v. United States, 371 F.2d 450 (Ct. Claims 1967); Foster v. Atlantic Refining Company, 329 F.2d 485 (5th Cir. 1964); Oosten v. Hay Haulers Dairy Employers and Helpers U., 291 P.2d 17 (Cal. 1956); Lloyd v. Murphy, 153 P.2d 47 (Cal. 1944).

Respondent, on the other hand, cites authority which suggests that permits once issued cannot be revoked absent a showing of "compelling public necessity" (O'Hagen v. Board of Zoning Adjustment. City of Santa Rosa, 96 Cal. Rptr. 484, 19 Cal. App. 3d 51 [1971]) and cases indicating that temporary impossibilities caused by litigation or other factors work to toll the time for performance, but do not excuse it. E.g., Colorado Coal Furnace Distributors v. Prill Mfg., 605 F.2d 499 (10th Cir. 1979).

Respondent's citations regarding the impact of litigation are relevant to those periods in LOC's history when it was subject to legal action. The "compelling public necessity" standard, however, is inapposite. In O'Hagen v. Board of Zoning Adjustment, City of Santa Rosa, supra, the court determined that a drive-in restaurant owner had a "vested interest" in his use permit. In light of this property right, the court held that only a "compelling public necessity" could justify revocation of the permit.

The concept of "vested interest," however, is not applicable in such a simplistic form to the certificate of need legislation. By its very terms, AS 18.07 contemplates the possibility of modification, suspension and revocation proceedings attendant upon specified occurrences or non-occurrences. The public interest in appropriate health planning and facilities construction colors the entire C/N process. The standard for revocation of certificates of need must, of necessity, give governing authorities more flex-

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ibility than is required in connection with use permits for drive-in restuarants.

Petitioner's authorities provide more appropriate guidance. The impossibility and frustration of purpose doctrines arise specifically from contractual relations. Courts in these cases are asked to determine which of two or more parties should bear the ill consequences of a particular turn of events. In the certificate of need context, a similar balance must be struck between the C/N holder's interest in protecting his financial and other investments and the public's interest in maintaining a legislatively mandated process for planning and implementation of adequate and cost-efficient health care.

Utilizing much of the reasoning found in the impossibility and frustration of purpose cases, thus, a finding of "good cause" should be made under AS 18.07.081(d)(2), when

> (1) Factors not present at the time the C/N was granted intervened thereafter; (2) through no fault of the certificate holder; (3) which factors were not foreseeable nor part of the calculated risk at the time of issuance of the C/N; and (4) which factors rendered performance under the C/N impossible or so unreasonably expensive as to impose extreme hardship on the certificate holder over an extended period of time.

This definition is admittedly a stringent one. It requires, essentially, that project sponsors not impact the planning process beyond a reasonable period of time unless they have the wherewithal and sound planning sufficient to fulfill the expectations they raise.

Application of this standard to grandfathered certificates is appropriate. The holders of such permits are already advantaged by acquiring initial authorization to construct without exposure to the review process. They should not, thereafter,

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receive extra privileges not accorded to those facilities undergoing routine scrutiny.

B. Analysis of Allegations of Good Cause *

Respondent advances two grounds to support a finding of good cause. First, LOC claims that it

> has demonstrated good cause on the basis of its efforts to advance the hospital project toward completion, particularly its efforts to obtain financing since 1977, and on the basis of the present feasibility of the project.

Respondent['s] Post-Hearing Memorandum at 15, Pleading Tab 33. Second, LOC contends that "improper interference" with the hospital project by South Central and others also constitutes good cause. Id. at 16. In light of the evidence introduced at the hearing, it seems appropriate to consider as distinct, although overlapping categories of potential "good cause," the failure of various financing options and the impact of litigation against respondent.

1. Respondent's efforts to arrange financing and current (alleged) feasibility of the project.

The fact that respondent has made substantial efforts to obtain financing is relevant to the determination of an appropriate remedy in this case. However, respondent's activities undertaken to pursue the project, while arguably evidence of "good faith" in attempting to construct the hospital, do not constitute

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*The parties acknowledge that petitioner has the burden of proving the claims contained in its accusation. Alaska Alcoholic Beverage Control Board v. Malcolm, Inc., 391 P.2d 441 (Alaska 1964). And there is further agreement that respondent has the burden of going forward with evidence supporting its allegations of "good cause" for failure to complete the authorized activities. Petitioner contends, however, and respondent disputes, that Lake Otis also has the burden of proof on the question of good cause. After considerable research and analysis, the hearing officer has determined that the burden should fall on LOC. However, no finding of fact or conclusion of law has been based on this allocation. As dictum, the analysis of the burden of proof issue has been excluded from this decision.

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evidence of "good cause" in failing to do so. Present feasibility is also outside the scope of an analysis of what has happened to date.

2. Failure to obtain financing

a. Collapse of the GHS arrangement.

Circumstances surrounding the contractual arrangements between LOC and GHS do not support a finding of good cause. First, this episode largely pre-dates enactment of the certificate of need legislation and issuance of respondent's C/N. While the Commissioner need not discount totally events which occurred prior to issuance of LOC's certificate, it would be inappropriate to predicate either failure to complete construction, or good cause for such failure, on such early developments. The holder of a grandfathered certificate is entitled to have its progress evaluated on the same basis as one who has been through the review process. Equity requires this, since prior to adoption of the C/N law in 1976, respondent had no reason to fear that failure to make progress with its construction could result in denial of the opportunity to proceed at all. Respondent's Exhibit R-82 appropriately depicts only events which transpired during the period 1977-1981.

However, even if GHS' withdrawal from the project is considered on its merits, good cause cannot be established. Dr. Beirne testified that the contract for long-term financing itself contemplated withdrawal by GHS if interest rates rose too high. Lake Otis certainly made no effort to contest GHS' right to cease its involvement with the project; LOC ultimately reimbursed GHS in full on its obligation to Peoples Bank. Thus, respondent assumed a risk which although not expected to materialize, was envisioned clearly enough to be contained within contract negotiations. See,

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Glendale Federal Savings and Loan Assn. v. Marina View, Etc., 135 Cal. Rptr. 802, 833, 66 Cal. App. 3d 85 (1977).

b. Failure to obtain Anchorage sponsorship of tax-exempt bonds.

The Anchorage Assembly considered sponsorship of the Lake Otis bonds on June 21, 1977 and again on June 28, 1977. At the latter meeting, the chairperson of the Municipal Health Commission opposed Assembly approval of the Lake Otis resolution and sought a delay for purposes of conducting a Commission review of the proposal. Beirne opposed any postponement, disingenuously asserting that any delay would interfere with his construction schedule. In reality, he knew that it was virtually certain that the Commission would find no need for the project. While the Assembly abided by Beirne's wishes and representations and approved the resolution, the mayor subsequently vetoed it in response to Municipal Health Commission data and LOC's circumvention of the Commission process. The Assembly could not override the veto. Findings of Fact 52, 53, 55, and 58. South Central also communicated with the Anchorage Assembly, although its message took the form of providing factors for Assembly consideration, rather than expressing specific opposition to the project. Finding of Fact 57. The mayor's veto did not indicate any reliance on petitioner's correspondence.

It is evident that the Municipal Health Commission's opposition played a pivotal role in the mayoral veto of the Anchorage resolution. Upon initial consideration, it appeared that equity required a finding of good cause in this instance. The resolution's defeat, after all, was premised on bed need projections. And bed need projections were eliminated by the Legislature when it determined to authorize grandfather certificates for facilities such as the Lake Otis Community Hospital.

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To hold respondent effectively accountable for a loss arising out of bed need calculations seemed, thus, to negate legislative intent.

The risk that particular financing options may not prove workable, however, is inherent in a venture of this sort. Most critically, respondent recognized from the outset of this enterprise that the project's feasibility -- and thus its ability to garner financial support -- was dependent upon a finding of need for the additional beds the hospital would provide. In its 1972 feasibility study, American Health Facilities, Inc. states:

> In the fall of 1971, it was not possible for the Anchorage comprehensive 'B' agency to make recommendations relative to certificate of need applications because it lacked adequate information and analysis on health care delivery in its area. Two reports, one completed and one being completed, should satisfy the requirement for area studies.

Exh. R-2, "Background." The bulk of the study consists of an analysis of service area needs and utilization estimates. Thus, years prior to enactment of the state certificate of need legislation, project sponsors were aware that bed need was an issue to be reckoned with and constituted, therefore, a risk then assumed. In light of this early awareness, loss of the Anchorage bond resolution cannot provide "good cause" for LOC's failure to complete construction.

c. Failure to obtain Wasilla bond sponsorship.

Wasilla constituted a more protracted replay of the Anchorage situation, with South Central rather than the Municipal Health Commission actively opposing the bond resolution. For the reasons stated previously, the Wasilla defeat cannot support a finding of "good cause." Beirne's own statements, moreover, indicate that financing through the Wasilla mechanism ceased to

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be a realistic option some months before the resolution was actually defeated at the polls.

On August 12, 1978, bond counsel Borge notified Beirne of his intent to withdraw from representation of LOC based on changes in I.R.S. rules which rendered the bond package less secure. According to Beirne, Borge's actual withdrawal took place no later than August 24, 1978. Exh. P-44, p. 28. Beirne's reflections on this event include the following statements:

> Unless Cincotta can find other legal counsel, the deal is off, and the project is postponed indefinitely. There appears to be no way at this time Cincotta says to finance the bonds by a simple straight forward bond sale of the 21.5 million. He needs this refunding mechanism in order to strengthen the bond issue. . . .

Id. And on October 9, 1978, Beirne wrote to Ed Gilgan:

> No, we don't have the Hospital package put together yet. We almost had it in August but it slipped through our fingers again. The little city of Wasilla, about 50 miles north of Anchorage sponsored our bonds so we were able to get tax exempt bonding, but we can't sell the bonds yet.. . . We have to find some way to strengthen the bonds.

Exh. P-59. The petition requesting a referendum on the Wasilla bond resolution was not certified by the clerk's office until September 22, 1978. Exh. R-28. And the election was almost two months later. Yet, as seen above, as of late August, Beirne knew that this source of financing was of little present benefit to Lake Otis.

Like the defeat at the polls, the change in I.R.S. rules and subsequent withdrawal of bond counsel cannot establish good cause. There is no vested right to rely on the continued existence of a particular piece of legislation or regulation. See, Arctic Structures, Inc. v. Wedmore, 605 P.2d 426, 436 (Alaska 1979);

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Lloyd v. Murphy, supra at 51. Legislative changes relating to desirable funding mechanisms constituted a foreseeable risk from the time the project was conceived. And loss of the refunding mechanism did not make the bond sale impossible, only less attractive. Beirne simply never generated the Native or union support which he judged necessary to strengthen the bonds. See Exhs. P-13 and P-13A.

d. Failure to obtain AMFA financing.

The AMFA application was never pursued in good faith. The relevant statute provided:

> AS 18.26.220. Facility compliance with health and safety laws and licensing requirements. . . . A medical facility issued a certificate of need under Sec. 4, ch. 275, SLA 1976 by virtue of being in existence or under construction before July 1, 1976, must nevertheless fully meet the requirements of AS 18.07.011 - 18.07.111 in order to be eligible for funding under [the AMFA legislation].

Exh. R-32. The referenced sections, AS 18.07.011-111, include those establishing the requirement for obtaining a certificate of need based, in part, on the availability and quality of existing health care resources. The AMFA legislation, thus, required LOC to undergo a standard C/N review process if it hoped to obtain funds through this agency. Beirne (a legislator), was aware of this fact. Finding of Fact 111. He was also aware that in all likelihood, LOC would not receive the blessings of the health planning agencies in light of their bed need projections at the time. So he filed the application, but not the supporting documentation and not the $1,000 filing fee. Ultimately, he informed AMFA to withhold consideration of LOC's application indefinitely in light of pending litigation. Finding of Fact 116. Good cause for failure to complete construction cannot be predicated in any part on LOC's non-processing of its incomplete and deceptive AMFA application.

e. Failure to obtain financing through either the Alaska Pacific Bank or Hospital Corporation of America.

On March 24, 1980, Providence and South Central both filed administrative appeals from Deputy Commissioner McGinnis' determination of substantial implementation. On April 8, 1980, Providence brought its civil action against the Department in superior court. And on August 8, 1980, South Central initiated these revocation proceedings. Findings of Fact 130, 131 and 137.

Petitioner has acknowledged that it is appropriate to consider respondent's failure to complete construction only up to the time this proceeding was commenced. As indicated previously, moreover, respondent's authorities indicate that time frames for completing activities under various governmental permits or licenses should be tolled when performance is rendered impossible or impracticable by virtue of adverse administrative or judicial proceedings. E.g., Smith v. Board of Appeals of Brooklyn, 316 N.E.2d 501 (Mass. 1974); Belfer v. Building Comm'n of Boston, 294 N.E.2d 847 (Mass. 1973). Common sense and principles of equity require no less.

In light of the fact that the bank and HCA financing sources were pursued, and failed, under the cloud of the Providence and South Central actions, good cause exists for failing to complete construction during this period.

3. Withdrawal of Modern Construction.

Modern Construction, in joint ventureship with Tri/Alaska Construction, agreed to perform design and estimating work on the hospital project in mid-March, 1976. In July, 1976, Modern declined to proceed with further work on the project. Finding of Fact 38. Regardless of the reasons for Modern's withdrawal, this incident cannot support respondent's effort to show "good cause." Modern's involvement predated issuance of the certificate

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of need. Modern's services moreover, were engaged at a time when new financing was not being actively pursued (with the possible, short-lived investigation into FHA financing) in light of the GHS debt liquidation process. Modern's work product, additionally, and interest in the joint venture, were transferred to Tri/Alaska which continued to contribute to the project. Other contractors were subsequently brought on board without any showing of material prejudice to respondent.

4. Interference by South Central, the Municipal Health Commission, and Providence.

Respondent focuses tremendous energy on, and attention to, the allegedly conspiratorial efforts by South Central, the Municipal Health Commission, and local hospitals, particularly Providence, to thwart LOC's construction plans. See, e.g., Findings of Fact 106, 138. These entitites certainly have voiced opposition to the Lake Otis Hospital. As indicated above, in the case of litigation filed against respondent, good cause does exist for LOC's failure to complete its authorized activities during the time periods involved. Other actions of these agencies and competitors, however, do not justify additional findings of "good cause."

The health planning agencies expressed their views openly, primarily through correspondence with and testimony before elected officials. The message was virtually the same throughout: existing bed need did not justify construction of the Lake Otis hospital. Other concerns raised, such as economies of scale, were of a similarly legitimate nature. No underhanded or devious tactics, no ad hominen attacks on Dr. Beirne or otherwise questionable grounds for opposing the project, were established at hearing. Even if respondent's version of the events

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surrounding Modern's withdrawal from the project were to be accepted, it is evident that this action by one contractor had no bearing on LOC's overriding problem: its inability to obtain financing.

Agency opposition materially impacted the project in 1977 and 1978, when first the Municipal Health Commission, and then South Central, were instrumental in achieving the defeat of the Anchorage and Wasilla bond resolutions, respectively. The agencies' actions however, should have come as no surprise to Beirne. Beirne had previously subjected the project to review by the forerunner of the Municipal Health Commission, the Comprehensive Health Planning Council. Findings of Fact 2, 11. By ordinance, the Commission was charged with advising the mayor and Assembly on issues affecting comprehensive health planning. See, GAAB OR-73-141; AMC 16.05.050. As discussed, infra at pp. 53-54, South Central was similarly directed to seek implementation of its health plan for the region. And as discussed, supra, at p. 43, respondent had long been aware that bed need was a critical factor in project feasibility. Beirne had reason, thus, to anticipate the concerns raised by these two agencies; respondent cannot predicate "good cause" on the fact that South Central and the Commission performed their legally mandated duties.

C. Opportunity to Complete Construction Prior to the Instigation of Litigation.

"Good cause" has been found for LOC's failure to secure financing from July 26, 1979 when the municipal litigation was filed, to the present time. An ultimate conclusion of "good cause" would be inappropriate, however, if respondent had the opportunity to make substantial progress on its project prior

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to this time. Respondent's own arguments suggest that it had such opportunity.

Respondent has represented that two years is an appropriate period of time in which it may be expected that a C/N holder can "acquire financing, . . . acquire the necessary construction licensure and . . . complete architectural and engineering drawings prior to commencement of construction of a hospital." Respondent's Post-Hearing Memorandum at 31, Pleading Tab 33. Respondent's source is Exh. R-76, the Brown Affidavit. Mr. Brown's only mention of a two-year period is in paragraph 12 of his affidavit, in which he estimates that two years could be required to "complete construction of a 125-bed acute-care hospital facility in Anchorage." Exh. R-76 at 4. Brown indicates that Providence anticipates the need for only seven months from the date of receipt of a certificate of need to the commencement of on-site construction activities. And LOC's 1977 C/N was granted for a period of 18 months, in keeping with the provisions of 7 AAC 07.090(d).

The two years after receipt of its C/N and prior to the filing of the first legal action against LOC would seem, thus, to have constituted a reasonable period of time to expect respondent at least to obtain financing and re-commence on-site work with the expectation of finishing construction this year at the latest. Because this time was available to LOC (quite apart from the earlier years of project initiation), it cannot be said to have demonstrated "good cause" for its failure to complete construction.

III. RESPONDENT'S CERTIFICATE OF NEED SHOULD BE REVOKED.

A. Commissioner's Discretion.

As 18.07.081(d)(2) provides that "a certificate of need may be revoked" (emphasis added) if the sponsor fails,

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without good cause, to complete construction. Respondent correctly observes that this language is not mandatory, allowing for consideration of matters of equity or public policy. See, Fields v. Kodiak City Council, 628 P.2d 927 (Alaska 1981); State v. Smith, 593 P.2d 625, 629 (Alaska 1979); Railroad Commission v. Brown Express, Inc., 399 S.W.3d 863 (Tex. 1966), rev'd on other grds, 415 S.W.2d 397 (Tex. 1967); Copper Co. v. Industrial Commission, 188 P.2d 1102 (Ariz. 1941). The Commissioner, however, cannot act in an arbitrary fashion; she is restrained by the doctrines of due process, equal protection, and excessive delegation of legislative authority from straying far afield from the criteria enumerated in the statute. See, e.g., Marks v. City of Anchorage, 500 P.2d 644 (Alaska 1972); Panama Refining Co. v. Ryan, 293 U.S. 388 (1939); Yick Wo. v. Hopkins, 118 U.S. 356 (1886).

B. Respondent's Defense of Unclean Hands.

1. Amendment of pleadings.

On January 20, 1982, five days prior to the commencement of the hearing in this case, respondent notified petitioner and the hearing officer by letter that it intended to raise the doctrines of laches and unclean hands at the hearing. The laches defense was subsequently withdrawn, but respondent sought to amend the pleadings to include its defense of unclean hands. It is LOC's position that South Central's previous opposition to, and alleged interference with, the development of the hospital project should preclude petitioner from now complaining of respondent's failure to complete this project.

Petitioner vigorously opposed this motion at the hearing. It was taken under advisement at that time, and the parties thereafter submitted memoranda addressing both the appropriateness

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of granting the motion to amend and the merits of the defense itself.

In opposing amendment of the pleadings, petitioner relies primarily upon the provisions of AS 44.62.390 which allow a respondent to request a hearing and present new matters by way of defense within 15 days after service upon him of an accusation. However, petitioner fails to direct the Commissioner's attention to that portion of AS 44.62.390(b) which states:

> Within the time specified [15 days] the respondent may file one or more notices of defense upon any or all of the grounds set out in (a) of this section but all of the notices shall be filed within that period unless the agency in its discretion authorizes the filing of a later notice.

(Emphasis added.) AS 44.62.400 allows the agency to file, or permit the filing of, an amended accusation "at any time before the matter is submitted for decision." Sections 44.62.390(b) and 44.62.400, taken together, suggest a policy akin to that found in Civil Rule 15(a) which authorizes amendments more than 20 days after service of an answer upon "leave by court." The rule further states: "[L]eave shall be freely given when justice so requires."

In Wright v. Vickaryous, 598 P.2d 490 (Alaska 1979), the court set forth guidelines for the exercise of discretion under Rule 15(a):

> The Supreme Court described in Foman v. Davis, 371 U.S. 178, 182, 83 S.Ct. 277, 230, 9 L.Ed.2d 222, 226 (1962), the conditions under which denial of an amendment might be proper:
>
> > Rule 15(a) declares that leave to amend "shall be freely given when justice so requires"; this mandate is to be heeded. See generally, 3 Moore, Federal Practice (2d ed. 1948), [Sections] 15.08, 15.10. If the underlying facts or circumstances relied upon by a plaintiff may be a proper subject of relief, he ought to be afforded an opportunity to test his claim on the merits. In the absence of any apparent

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> or declared reason--such as undue delay, bad faith or dilatory motive on the part of the movant, repeated failure to cure deficiencies by amendments previously allowed, undue prejudice to the opposing party by virtue of allowance of the amendment, futility of amendment, etc.--the leave sought should as the rules require, be "freely given.

This court has stated:

> Probably the most frequent reason for denying leave to amend is that it would be prejudicial to the opposing party. The prejudice can result from the opposing party being put to an added expense, a more burdensome and lengthy trial, or if the issues being raised in the amendment are remote from the scope of the original case.

Estate of Thompson v. Mercedes-Benz, Inc., 514 P.2d 1269, 1271 (Alaska 1973) (footnotes omitted).

The court noted that the plaintiffs' amended complaint only introduced a new theory, observing that "the Vickaryouses were still suing on the same conduct of Wright which was the subject of the initial complaint." Id.

The same situation prevails here. Petitioner did not claim that respondent's amendment would raise new factual issues. No showing of prejudice, no request for continuance or opportunity to supplement the record to respond to this defense was made. Petitioner's counsel was accompanied throughout the hearing by Ron Hammett, the individual responsible for allegedly improper actions on petitioner's behalf throughout much of LOC's history. Two other South Central staff members also testified at the hearing. Recognizing that the interests of justice are best served when all claims are reached on the merits, and finding no prejudice to petitioner, respondent's motion for leave to amend its pleadings to include the defense of unclean hands is granted.

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2. The doctrine of unclean hands applied to this case.

The clean hands doctrine has been stated as follows:

> 'The maxim and principle for which it stands signifies that a litigant may be denied relief by a court of equity on the ground that his conduct has been inequitable, unfair and dishonest, or fraudulent and deceitful as to the controversy in issue.'

Cedar Mem. Park Cem. Ass'n v. Personnel Assoc., Inc., 178 N.W.2d 343 (Iowa 1970), citing, 22 Am. Jur. 2d, Equity, Sec. 136. The cases hold that the acts complained of must not only have been wrongful, but committed with wrongful intent. Regional Transp. Auth. v. Burlington Northern, 426 N.E.2d 1143, 1148 (Ill. App. 1981); Edmunds and Edmunds, 633 P.2d 4, 6 (Or. App. 1981). The party raising the defense of "unclean hands" must have been injured by the conduct in question. Arevalo v. Velvet Door, Inc., 508 S.W.2d 184, 186 (Tex. Civ. App. 1974); Jacobsen v. Pederson, 190 N.W.2d 1,4 (N.D. 1971). Finally, numerous cases acknowledge that notwithstanding the doctrine's seeming applicability to a given situation, it will not be enforced if to do so will do injury to the public interest. United States v. City of Milwaukee, 395 F. Supp. 725, 727 (E.D. Wis. 1975); United States v. Philadelphia Electric Co., 351 F. Supp. 1394, 1398 (E.D. Pa. 1972); Edar Memorial Park Cem. Ass'n v. Personnel Assoc., Inc., supra at 353; Travel House of Buffalo, Inc. v. Grzechowiak, 296 N.Y. 2d 689, 698 (App. Div. 1968). Applying these principles to the facts of South Central's prior involvement with LOC, it is evident that South Central has not violated the clean hands doctrine.

There is, first of all, no indication that petitioner performed a wrongful act. 42 U.S.C. 3001-2(a) provides that

> each health systems agency shall have as its primary responsibility the provision of effective health planning for its health service area and the promotion of the develop-

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ment within the area of health services, manpower, and facilities which meet identified needs, reduce documented inefficiencies, and implement the health plans of the agency.

(Emph. added.) 42 U.S.C. 3001-3(c)(1) requires that "The agency . . . seek, to the extent practicable, to implement its HSP and AIP with the assistance of individuals and public and private entities in its health services area." In subsection (d), HSAs are enjoined to "coordinate [their] activities with . . . (5) any other appropriate entity." Petitioner's actions in opposing hospital construction which would contravene its health plans were within the scope of its federal mandate. See, Bendix Corporation v. Adams, 610 P.2d 24 (Alaska 1980).

There is, furthermore, no indication of any wrongful intent on the part of petitioner's employees and board members. Nor, as previously discussed, were petitioner's actions the determining cause of respondent's inability to complete construction. Finally, it must be concluded that invocation of the doctrine of clean hands in this instance would serve to benefit only respondent, and would contravene the public interest in reaching a resolution of this case on merits.

There is an additional reason for rejecting the clean hands defense under the circumstances presented here. As discussed throughout this decision, respondent and its representatives have themselves engaged in unethical conduct. The maxim "he who seeks equity, must do equity" -- the doctrine of unclean hands -- would appear to apply more directly to respondent and Dr. Beirne than to petitioner.

C. Appropriateness of Revocation in Light of Other Equitable and Policy Considerations.

There are essentially two "equitable" grounds supporting maintenance of LOC's C/N notwithstanding the existence of grounds

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for revocation. There is, first, the fact of substantial sums expended on the project by Dr. Beirne. Second, there are the allowances made for Providence and Alaska Hospitals during the time of respondent's ongoing struggles.

It must be acknowledged that Beirne and his associates have invested great sums of money, time and energy in the hospital project. Ordinarily, this consideration would be entitled to significant weight. In this case, however, it represents something of a bootstrap argument. For respondent's approach to financing, perhaps because of LOC's admittedly thin capitalization, appears to have carried with it the seeds of the project's current downfall.

Evidence presented at the hearing suggests that from 1973 on, LOC actively pursued only one financing option during any given time frame. While "back up possibilities" were mentioned at the hearing, documentation of such efforts, exemplified by the purported interest of Native corporations, was never provided. Respondent's Exh. R-82, while perhaps intended as a simplification, corroborates the single-minded approach taken by Lake Otis, at least from 1977 forward.

In 1973, LOC undertook construction with only short-term financing at hand. It took three years thereafter to extricate the hospital and Beirne from the resultant indebtedness to GHS. In 1977, the Anchorage bond effort was pursued. When that failed, the next 15 months were devoted to virtually the same campaign in connection with another municipality 50 miles down the road subject to the same kinds of agency and political pressures. And of course, in 1979, no genuine effort was made to obtain financing. The Peoples Bank and HCA strategies in 1980 and 1981, respectively, appeared more straightforward. But again, they constituted single-

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focus attempts, this time undertaken under the shadow of litigation known to have an adverse impact on negotiations.

With the exception of the early GHS endeavor, moreover, respondent's efforts all seemed to hinge on the receipt of some advantageous, legislatively decreed financing mechanism, such as the federal refunding arrangement, municipal bonding, or state AMFA grants. LOC's success or failure, thus, has generally been dependent on the continued viability of governmental sponsorship of one kind or another and the desire of government to dispense its largesse in LOC's direction.

The public would seem to have no equitable obligation to extend special consideration to Dr. Beirne because of losses sustained, in substantial part, through his own lack of capitalization and limited financial tactics. Beirne's deceptiveness in connection with various funding attempts further detracts from any weight which might otherwise be given this factor.

There are, however, more significant questions of equity and policy surrounding increases in bed allocations afforded Providence and Alaska Hospitals during the time that LOC's construction was being assailed by health planning agencies and others as violative of current bed need projections. The record reveals the following sequence of events in regard to the existing hospitals:

	Providence	Alaska
1971-72	Licensed for 150 beds	Licensed for 85 beds
1973-74	150 beds in operation in the south tower, 58 non-conforming	Requested 80 additional beds, received 40 more beds on condition move hospital
	3.5 million in revenue sharing approved for north tower construction for a total bed capacity of 219	

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	Applied for revenue sharing funds to modernize south tower and eliminate non-conforming beds	
1975	Application to modernize south tower approved	
6/76	Application to increase licensed beds from 150 - 235.	
7/76	Licensed for 228 beds	
11/76	North tower completed; licensed for 268 beds	Alaska Hospital opens with 200 bed capacity, 154 licensed
3/77	License reduced to 250 beds	
8/77	Waiver for 44 non-conforming beds approved	
7-8/78	Review of waiver decision underway; South Central and Municipal Health Commission recommend approval of waiver based on bed need as of 1977 licensure. Neither agency includes LOCH beds in calculating bed need:	
12/78		45 more beds licensed
7/79	Department continues waiver and 250 bed licensure.	

The information contained in the above outline demonstrates that South Central and the Municipal Health Commission recommended approval of the 250 beds at Providence, and the waiver for 44 of those non-conforming beds, based in part on bed-need. These recommendations were made in 1977 and reiterated in 1978, the second time after Lake Otis' C/N had been issued, without taking into account respondent's 125 beds. Moreover, the agencies' opposition to respondent in its attempt to secure municipal bond sponsorship was predicated on the alleged absense of bed need

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at the same time the agencies were supporting the increase in Providence's bed capacity. Finally, while the record does not reveal how Alaska came to add on its ever-increasing number of beds, its licensed capacity certainly mushroomed during this period.

Petitioner's response to these realities appears to be that all the Alaska and Providence beds were either in existence or under construction at the time the certificate of need law became effective and the agencies' input was solicited. A dispassionate observer cannot help but conclude, however, that true bed need evaluations in regard to Providence in 1977 and 1978 would have required consideration of LOC's plans. That, after all, is the thrust of this entire proceeding: that with respondent's hospital on the drawing boards (at least partially), the health planners are obliged to consider LOC's 125 beds in projecting future needs.

The relative leniency afforded respondent's competitor and the role played in that process by the planning agencies are the primary factors mitigating in respondent's favor at this stage of the revocation analysis. Fundamental notions of fairness and equal protection are offended by the juxtaposition between past relaxation of governmental rules for Providence (and possibly Alaska) and prospective adherence to revocation standards as applied to Lake Otis.

The case, however, is not so simple. Certainly, respondent benefited as much as Providence from the grandfathering authorization of the certificate of need legislation. The Commissioner, furthermore, granted two extensions of LOC's C/N, somewhat analogous to the increases in bed licensure afforded respondent's

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competitors. And, finally, this revocation decision is in no way predicated on any lack of bed need, and is not, thus, building upon any inconsistencies that might be found in prior positions taken by petitioner or Department representatives.

There are, moreover, countervailing considerations of public policy which support revocation at this time. First, contrary to respondent's assertions, there is no assurance based on the record in this case that Lake Otis could secure financing for the hospital in the relatively near future. The record contains Beirne's prior representations to governmental officials that construction could begin virtually instantaneously if only this, that, or the other obstacle were removed. The current revenue sharing provisions in Title 29 are now propounded as the salvation for LOC's financial woes. Notwithstanding the apparently mandatory language of AS 29.90.010, however, it cannot be assumed that LOC will receive further state monies in light of the pending revenue sharing litigation. Nor would such appropriation be sufficient in and of itself to fund hospital construction. As of the November, 1980 "Update of Financial Data," respondent was once again predicating its financing plans on the procurement of a tax-exempt bond issue. Exh. R-42, p. 46. Yet no source for these bonds has been identified. Nor is it clear that, in the alternative, any private arrangement could be made that would satisfy Beirne's financial desires.

This lack of assurance that Beirne could be relied upon to "get his act together" (to invoke John Frolich's terminology) becomes critical when it is recognized that, ironically, all parties to this controversy now agree that more beds will be needed in Anchorage by 1985. Respondent has requested a two-year grace period following the conclusion of all litigation. Yet there is

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no reason to believe the litigation will be resolved even within one year. Regardless of what transpires in the Providence lawsuit, the hearing officer's decision in this case must be acted upon by the Commissioner; the Commissioner's decision could be subjected to motions for reconsideration; superior and supreme court appeals are clearly possible; and there is the potential for remands for further administrative action all along the way. If only one year is allotted for termination of litigation, another two years for securing financing and completing plans and licensing activities, and two additional years for construction, beds would not be available for occupancy before 1987, two years after it is anticipated that they will be needed. Finding of Fact 162. Construction costs will have further escalated during this period, potentially raising the cost of patient care as well.

On balance, thus, there do not appear to be sound reasons based on considerations of public policy and equity to refrain from taking the revocation action authorized by statute. Respondent's own responsibility for much of its predicament, as well as its past deceitful practices, reinforce this conclusion.

CONCLUSION

This case posed extremely close and difficult questions of fact and law in an area devoid of relevant precedent. Counsel for both sides competently researched and presented their parties' respective positions in written memoranda and at hearing.

Under the interpretation of "good cause" set forth in this decision, respondent was required to demonstrate that it had not assumed the risks which ultimately accounted for its failure to complete construction and that it was not itself responsible, in material part, for that failure. The equitable considerations applied in many of the conclusions of law were inherent

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in this "good cause" definition. The evidence introduced at hearing disclosed that LOC's approach to hospital financing was inadequate to the task and consisted largely of calculated risks which ultimately did not inure to respondent's benefit. "Good cause," therefore, was not established.

The hardship attendant upon so drastic an action as revocation of a certificate of need under the circumstances of this case cannot be overlooked. The options of retaining, modifying and revoking respondent's C/N were each considered. Painstaking evaluation of the facts, law, and applicable public policy, however, resulted in the conclusion that grounds for revocation exist, and that revocation, furthermore, constitutes the most appropriate remedy in this situation.

Recommended this 25th day of June, 1982.

Joan M. Katz
Hearing Officer

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Hospital expansion plans would inflate health costs

By Rep. DON CLOCKSIN

Do you want the cost of a day in the hospital to increase from $833 to $1,600 between 1982 and 1988? Do you want the State of Alaska to pay $46 million to help build a new hospital wing we don't need? Do you want your health insurance premiums to go up to pay for empty hospital beds and expensive, unused medical equipment?

I think not. I think the citizens of Anchorage want health care costs to be controlled while we continue to improve the quality of that care. However, if both Humana Hospital and Providence Hospital are allowed to build new buildings, we'll see this kind of skyrocketing costs and waste of money — yours and mine.

Both Humana and Providence have requested approval from the state to build new hospital wings — both will be five-story towers and both will expand the number of available hospital beds.

The two projects together are unnecessary. Providence proposes to add 150 beds; Humana proposes 93. If both projects are approved, Anchorage will have 692 hospital beds in 1990. That's 170 more than required, according to local health care projections. (The hospitals cannot criticize those projections; they helped prepare them.) And this excess bed capacity does not take into account the Lake Otis Hospital, which has approval to build another 125 beds. If Lake Otis Hospital is eventually built, Anchorage will have 295 beds more than it needs. More than one of every three hospital beds will be unnecessary!

Why does it make any difference?

First, both projects will be paid for largely by two sources — government health care funds and your own health insurance premiums. Humana admits that 30 percent of the revenues from their new structure will come from government programs — Medicaid, Medicare and the like. Providence, on the other hand, is eligible for $46 million in state revenue-sharing to help build its facility.

In the past three years, the state has paid out more than $153 million in both construction and operating assistance to hospitals and nursing homes. We must demand accountability in the spending of that amount of taxpayer money.

Second, an excess of hospital beds will cause unnecessary and wasteful health care expenditures. It is well documented in studies that the "demand" for health care expands to meet the supply available. In other words, patients that normally could be treated with outpatient facilities and simple procedures are instead given expensive, unnecessary hospital care. Doctors and hospitals will find ways to fill those empty beds, at an increased cost to you and me.

Some serious questions need to be asked of those who support approval of both hospital projects. Why did Providence raise its hospital rates 18 percent last year while its costs only went up 10 percent? (Although Providence is supposed to be a non-profit hospital, that type of rate increase has produced $55 million in accumulated "profits" in the last few years.) Why is the per-bed cost of building Providence's new addition *more than twice* that of Humana's project ($527,227 versus $232,039)? Why is Humana expanding when 30 percent of its existing licensed beds are empty? Why should we add this excess bed space when increased use of free-standing surgical centers, birthing centers and rehabilitation centers are reducing the demand for more expensive acute care hospital beds? Why are two hospitals less than three miles apart duplicating so many services — at our expense?

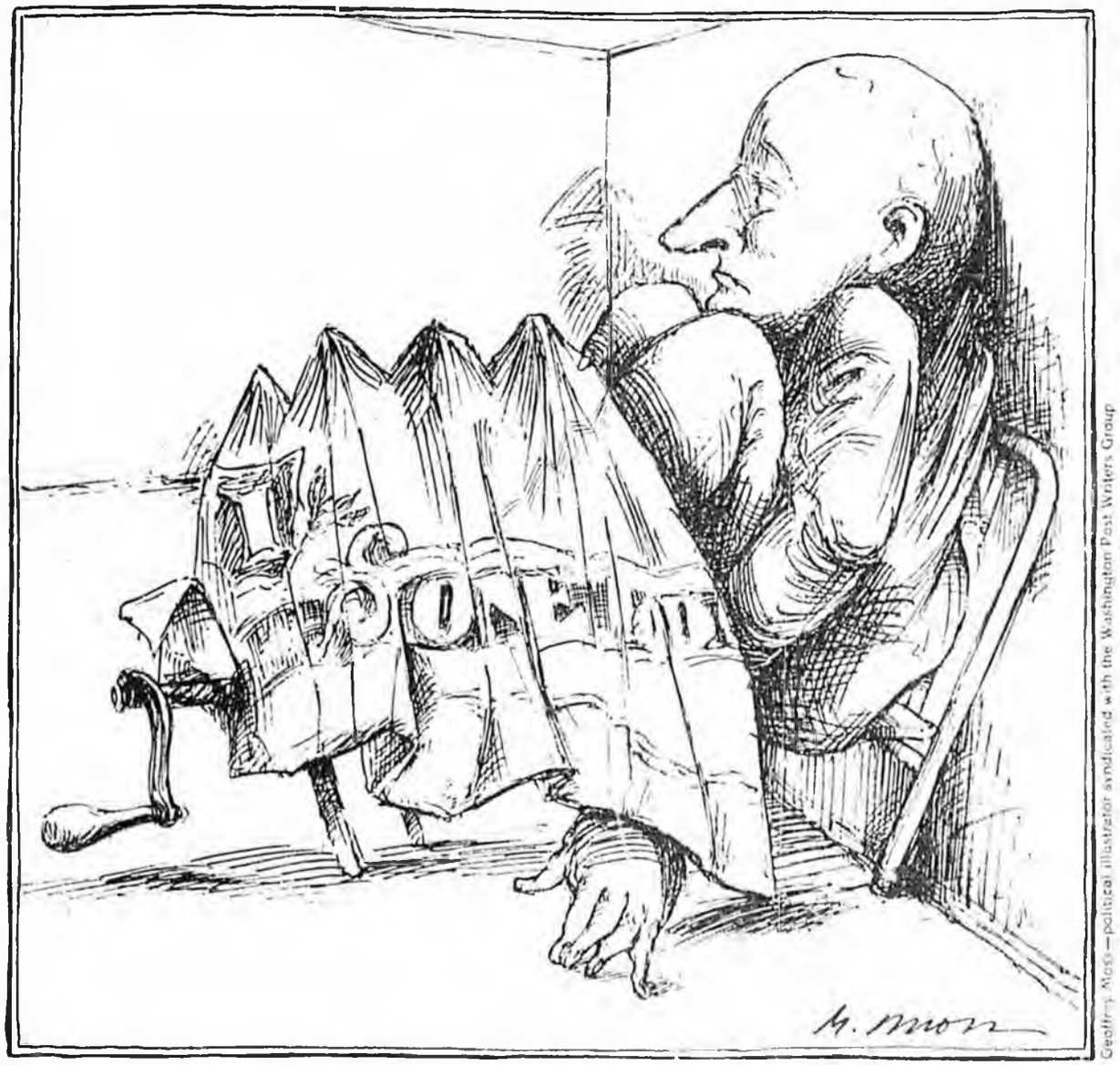
The only way we can get the answers to those questions and make sure our health care costs are not unnecessarily increased is the Certificate of Need Program. That program, established in Alaska in 1976, provides for review of proposals like the ones by Humana and Providence and requires approval by the Commissioner of the State Department of Health and Social Services before construction can begin.

The Certificate of Need Program was established to prevent hospital costs from rising unnecessarily because of frivolous spending or competition, and to aid health facilities in project planning and review. There is unassailable proof that the Certificate of Need Program holds down health costs. A recent study by Arthur P. Little, Inc. of Certificate of Need in six states found a definite reduction in costs.

In Alaska, the Certificate of Need Program has helped smaller health facilities in rural communities plan more economical improvements. In larger cities, like Anchorage, the Certificate of Need Program answers questions like those raised on the Humana and Providence proposals. In the past five yeras, $149 million in projects have been approved while $12.4 million have been rejected. In addition, numerous projects have been dropped or redesigned after Certificate of Need review, at a substantial savings.

Two bills — HB 19 and SB 85 — would repeal the Certificate of Need Program. I oppose those bills. The argument in favor of repeal is basically that the free, open competitive market will provide the best and cheapest medical care. That simply isn't true.

First, decisions on the use of medical services are almost always made by doctors and paid for by insurance companies or the government, so the patient often doesn't know or care what the cost of his or her treatment was. This "consumer indifference" means there is essentially no free market shopping for health care.



Geoffrey Moss—political illustrator syndicated with the Washington Post Writers Group

Second, since there is no competition on price, the only competition is based on services, amenities and conveniences — and that results in duplication and higher costs, not lower costs.

Third, the concept of "supply creating demand" — discussed earlier — means that excess supply will expand the demand for medical services — even though those services aren't necessary.

Fourth, a "free market" does not exist where one of the major sources of funds is the government.

I am not prepared to allow a hospital to expand willy-nilly, expecting me as a taxpayer to pay the costs of that expansion. Studies show that for every dollar spent to build or expand a health care facility, $1.84 is spent in the next five years in increased operating costs — paid largely by the taxpayer.

The repeal of Certificate of Need will permanently cripple any efforts to control health care costs. The approval of both the Humana and Providence hospital projects will increase the per day hospital rate by as much as 98 percent, increase your health insurance premiums to cover that increase, and continue to escalate the costs to taxpayers of public health care programs.

Don Clocksin represents downtown Anchorage in the Alaska House of Representatives. Natalie Hill assisted in the preparation of this article.

Hospital decision goes to state

by Cary Virtue
Times Writer

A health commission Saturday refused to take a stand on whether Anchorage needs two major multi-million dollar hospital expansions — and voted to dump the hot issue into the lap of the state health commissioner.

But at least one member of the state Health System Commission said she felt the committee was "copping out." She said they should have compared Providence's $97 million proposal to build 160 new hospital beds against Humana's $21.5 million package to add an additional 93 beds.

"To not have given the people a definitive decision was a cop out," said Health Systems Commission member Beth Taeschner. "And to (now) expect the health commissioner to make a decision is unfair to him and to the two hospital applicants."

It is now up to state Health and Social Service Commissioner Ron Smith to decide by April 4 — without any final local citizen recommendations — who gets to expand and by how much. Hospitals must obtain a certificate of need from the state to erect any building that costs more than $450,000.

If both hospitals receive certification to expand, Anchorage could wind up with 772 beds, more than the 606 beds that city and state health planners say is needed.

Hospital officials, however, have said Anchorage is growing fast enough to accommodate both projects. And they say both hospitals will fill their combined total bed capacity of 449 beds by 1985.

The 16-member state Health Systems Agency met for five hours Saturday at the Municipal Assembly building — and after voting some 21 times — decided to forward both projects to the state without comparing the projects.

"It was the only fair thing to do," said Rebecca Fain, chairman of committee. "We never did a comparative review of the two projects."

In fact, the committees which reviewed the hospital projects in February also did not compare the two proposals. And members of the Health Systems Agency, the last citizen committee to review the two projects, felt it was too late to change the process.

"It's too late to do a comparative review," he said Bill Orfitelli. "The joint project review committee opted out of its process and I think that was unfortunate."

In February, a joint subcommittee of the state Health Systems Agency and the Anchorage Muncipal Health Commission said that a comparative review wasn't necessary because Anchorage was growing so fast that both expansions were needed. The full Muncipial health commission agreed.

Both decisions were based on an "instinctive" and "gut" feeling that adopted city and state tables showing a total need of 606 beds for 1995 was too low.

But the Health System Agency disagreed Saturday, and voted as follows:

- That both Humana and Providence — if considered separately and without regard to the competing project — met the minumum requirements to qualify for a certificate of need. But the group declined to compare the projects, or draw any conclusions.
- The city's Muncipal Helath Plan showing a need for 606 beds by 1995 should not be inflated because of "gut" feelings that the city would grow by leaps and bounds.
- Urged the state health commissioner to decide whether or not to repeal Dr. Mike Beirne's certificate of need to build a 125-bed Lake Otis hospital. Beirne's project has been tied up in lawsuits involving Lake Otis, Providence and the state.

Humana wants to spend $21.5 million to create 93 new beds (for a total of 93 new beds) by building a 71,345-square foot, five-story hospital tower by 1985. Hospital staff estimated construction and remodeling to costs about $19.5 million, and financing and interest at about $2 million.

Providence proposes spending $97 milion to increase its bed capacity from 250 licensed beds to 410 beds. The project involves remodelling about 84,000 square feet, and building a five-story, 186,000-square-foot hospital tower by 1986.

Providence last June released estimates that pegged construction costs at $80 million, remodelling at $19 million , and financing and interest at about $1.7 million.

Each hospital expects to remodel most of its departments. For example, Providence plans to expand its new-born intensive care unit, and relocate the emergency rooms closer to radiology. Humana wants to build a morgue, a new electro-diagnostic unit and double the size of its radiology department.

Both hospitals also want to set aside 20 beds each for rehabilitation patients. Neither hospital has in-house beds for long-term therapy patients.