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399

health association of alaska

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REPRESENTING ACUTE, LONG TERM AND OUTPATIENT FACILITIES

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Seward General Hospital

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Government Institutions Respresentative
Frank Sutton
Mt. Edgecumbe Hospital
Sitka

Outpatient Facilities Representative
John J. Conway
Veterans Administration
Anchorage

President/CEO
Harlan R. Knudson

April 27, 1990

Senator Paul Fischer, Chairman
Committee on Health, Education &
Social Services
Alaska State Senate
Capitol Building
Juneau, AK 99801

Dear Senator Fischer:

The administrators of hospitals and nursing homes across the state are opposed to CSHB 399, amending the current state certificate of need law.

The intent of the Department of Health and Social Services is to remove many statutory safeguards and replace them with regulatory options.

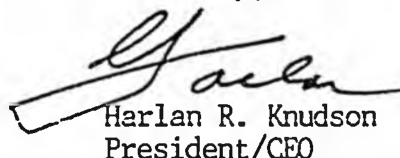
As you know, the certificate of need process regulates only private community hospitals and nursing homes. It does not take into account federal, state and community facilities and programs that duplicate services of the hospital or nursing home. The Pioneer Home system is a good example of a state program that does not comply with CON requirements.

The bill also authorizes fees up to $20,000 for a facility to go through the CON process, but gives no accounting how or where these funds will be used.

We would recommend that the Legislature take a hard look at the CON process to see if truly is having an impact on controlling health costs.

Many thanks.

Sincerely,



Harlan R. Knudson
President/CEO

Encl: Proposed Amendments CSHB 399.

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April 16, 1990

HEALTH ASSOCIATION OF ALASKA

COMMENTS ON CSHB 399(HESS)

INTRODUCTION

The Health Association of Alaska opposes any amendments to AS 18.07 at this time. It is the Association's position that any amendments to the certificate of need program should be made only as a coordinated part of a comprehensive review of the State's health care programs, not as an isolated piece of legislation.

Nevertheless, if the Legislature continues to consider proposed HB 399, then the Association sees the need for numerous amendments to eliminate some of the problems that make the present version of the bill unworkable.

In the changes proposed below, brackets and underlining indicate deletions from and additions to CSHB 399(HESS). Following each proposed change is a brief Comment on the purpose of the change.

FOR MORE INFORMATION CONTACT:

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PRESIDENT/CEO
HEALTH ASSOCIATION OF ALASKA

JERRY REINWAND - 586-8966

SECTION 3--AMENDMENTS TO AS 18.07.031

The Association proposes the following revisions to this section:

> Sec. 18.07.031. CERTIFICATE OF NEED REQUIRED. Unless authorized under the terms of a certificate of need issued by the department, a person may not
>
> (1) make a capital expenditure[, INCLUDING A REDEDICATION OF ASSETS] of $1,000,000 or more for construction of a health care facility;
>
> (2) alter or redistribute the bed capacity of a health care facility by more than 10 beds or 10 percent of the number of beds in the facility, whichever is fewer, within two years of the most recent alteration or redistribution of bed capacity;
>
> (3) make a capital expenditure of $1,000,000 or more to add or eliminate a category of health services to or from those provided by the health care facility; [OR]
>
> (4) add or eliminate a category of health services to or from those provided by a health care facility, if the addition or elimination of the category of health services is reasonably projected to result in a net increase of $1,000,000 or more in the facility's annual operating costs for the first year after the change compared to the previous year;
>
> (5) make a capital expenditure of $1,000,000 or more to acquire a health care facility [AT A COST OF $1,000,000 OR MORE]; or
>
> (6) make a capital expenditure of $1,000,000 or more to convert an existing building or part of a building to a health care facility.

COMMENT: Subsections (3), (4), and (6) deal specifically with proposed new uses of existing space without using the vague term "rededication of assets." That term is not a recognized accounting term that could be readily applied by the facilities or the Department. Because it has no generally accepted meaning and is

vague and undefined, use of the term in the statute grants excessive power to the Department, through regulations, to define the scope of the certificate of need law.

Subsection (2) regarding changes in bed capacity needs to specify a time period within which the authorized small changes may occur. Without a time period, it would not be clear, for example, whether a facility could add ten beds each year or only ten beds over the life of the facility. The two year period that is proposed is derived from the Department's current regulation--7 AAC 07.010(a)(2).

SECTION 6--NEW SUBSECTIONS IN AS 18.07.061

The Association proposes that new subsections (b) and (c) in AS 18.07.061 be revised, as follows:

> (b) An application for transfer of a certificate shall be made on forms provided by the department and must contain
>
> (1) evidence, of the type the department may require by regulation that the transferee is able to assume ownership or operation of the health care facility and to provide the appropriate health services;
>
> (2) evidence that the transferee is acquiring the health care facility at no more than its current fair market value; and
>
> (3) other information relevant to the purposes of this chapter that the department may require.
>
> (c) [TRANSFER OF A CERTIFICATE IS SUBJECT TO CONDITIONS THE DEPARTMENT CONSIDERS NECESSARY.] The department's approval of a transfer may impose reasonable conditions that the department finds are necessary for the accomplishment of the purposes of this chapter.

COMMENT: Both a facility's obligation to provide information and the Department's right to impose conditions should be limited by the Legislature's intended purposes for the certificate of need law. The department should not be given unrestricted authority to demand information or to impose conditions that are unrelated to achieving the purposes of the statute.

SECTION 8--NEW SECTION AS 18.07.079

The Association proposes that subsection (a)(1) be revised as follows:

> (a) Within 150 days after it determines that it has received a complete application, the department shall take one or more of the following actions:
>
> (1) approve part or all of the application and issue a certificate of need; [THAT] the certificate of need may include[S] reasonable conditions that the department finds are necessary for the accomplishment of the purposes of this chapter [CONSIDERS APPROPRIATE]; the conditions must be directly related to the activities for which the application was made; . . . .

COMMENT: As with the changes proposed above to Section 6 of the bill, the department's authority to impose conditions should be limited by the Legislature's intended purposes of the certificate of need program.

SECTION 15--DEFINITION OF "CATEGORY OF HEALTH SERVICES"

The Association proposes that the definition of "category of health services" in AS 18.07.111(1) not be changed from the way it appears in the current statute. To accomplish this, the bill would have to be revised as follows:

> (1) "category of health services" means [A SERVICE THAT IS RECOGNIZED AS A DISTINCT SERVICE FOR THE PURPOSES OF HEALTH CARE FACILITY LICENSURE AND CERTIFICATION UNDER REGULATIONS ADOPTED UNDER AS 18.20.010 - 18.20.130] a major, type, program, unit, division, or department of care provided through a health care facility whether inpatient or outpatient, including an outpatient department, psychiatric wing, kidney dialysis program, radiotherapy, burn unit, or newborn intensive care unit, except that "service" does not include the lawful practice of a profession or vocation conducted independently of a health care facility and in accordance with applicable licensing laws of the state; . . . .

COMMENT: The department's licensing regulations--7 AAC 12.010 to 7 AAC 12.990--currently license types of facilities; they do not license "distinct services" that are provided by those facilities. If this definition were dependent on the licensing regulations, the scope and application of the certificate of need program could be changed significantly--and unpredictably-- by a change in those regulations.

SECTION 15--DEFINITION OF "CONSTRUCTION"

The Association proposes that the definition of "construction" in AS 18.07.111(6) be revised as follows:

> (6) "construction" means excavation, erection, alteration, modification, reconstruction, modernization, improvement, extension, or other development by or on behalf of a health care facility, and includes the lease or purchase of equipment, but does not include the lease or purchase of replacement equipment.

COMMENT: The lease or purchase of equipment for the purpose of replacing existing equipment does not need to be regulated through the certificate of need program. Requiring certificate of need review for replacement equipment would be unnecessarily burdensome for the facilities and for the Department and would do little, if anything, to further the purposes of the statute.

SECTION 15--DEFINITION OF "HEALTH CARE FACILITY"

The Association proposes that the definition of "health care facility" in AS 18.07.111(8) be revised as follows:

> (8) "health care facility" means an institutional health service provider, whether public or private, whether a partnership or corporation, whether organized for profit or not, [AND WHETHER OR NOT] that is licensed or required to be licensed [IN WHOLE OR IN PART] by the state, and includes a hospital, psychiatric hospital, substance abuse hospital, tuberculosis hospital, skilled nursing facility, kidney disease treatment center (including freestanding hemodialysis units), intermediate care facility, ambulatory surgical facility, freestanding emergency care facility, osteopathic facility, and independent diagnostic laboratory[, AND CENTRAL SERVICE FACILITY]; "health care facility" does not include:
>
> (A) an Alaska Pioneers' Home administered by the Department of Administration under AS 44.21.020(10) and AS 47.25.010 - 47.25.100;
>
> (B) the offices of private physicians or dentists, whether in individual or group practice, occupied on a regular basis to perform the range of diagnostic and treatment services usually performed by physicians and dentists on an outpatient basis;
>
> (C) office buildings built by or on behalf of a health care facility for the exclusive use of physicians, dentists, and other practitioners of the healing arts[, OR OTHER INVESTMENTS MADE BY OR ON BEHALF OF A HEALTH CARE FACILITY, UNLESS CAPITAL EXPENDITURES OR OPERATING EXPENSES WILL BE CHARGED OR REIMBURSED IN THE FUTURE AS COSTS FOR PROVIDING PATIENT SERVICES OFFERED BY A HEALTH CARE FACILITY.]

COMMENT: The current version of the bill would expand the Department's authority considerably by adding to the definition of "health care facility" facilities that are not within the Department's licensing authority. This means that, under AS 18.07.091(a), "Reporting Requirements," the Department would be able to impose unspecified reporting requirements on facilities that

are not otherwise subject to Department regulation, and the certificate of need requirements would also apply to those otherwise unregulated facilities. This is an unwarranted expansion of the Department's authority, and it is not necessary for the purposes of the certificate of need statute.

The Association proposes that "central service facility" be eliminated from the definition because the term is too vague. It does not appear that it refers to a facility offering clinical health services, and therefore it should not be subject to the certificate of need requirement.

The Association proposes that the last clause of subsection (C) be deleted. It is impossible to determine what "will be charged or reimbursed in the future," and the necessity of obtaining a certificate of need should not be made to depend on a future event. State and federal reimbursement programs change frequently, and something that does not appear to be reimbursable today may well be reimbursable tomorrow, or vice versa. The statute should define the scope of the certificate of need program with clarity, by describing the types of facilities and services that are subject to the requirement. Reimbursement issues, on the other hand, should be dealt with separately, in statutes dealing with the reimbursement programs.

SECTION 19--REPEALER

The Association recommends that AS 18.07.041 not be repealed and that it therefore not be listed in the repealer section of the bill. AS 18.07.041 currently provides:

> **Standard of review for applications for certificates of need.** The office shall grant a sponsor a certificate of need or modify a certificate of need if the availability and quality of existing health care resources or the accessibility to those resources is less than the current or projected requirement for health services required to maintain the good health of Alaska citizens.

COMMENT: Section 19 of the bill now under consideration calls for the repeal of this section of the statute. No other section of the bill, however, provides comparable standards for the Department to apply in making certificate of need decisions. In order to provide appropriate statutory guidance to the Department, this section should remain in the statute.

PSA 841/5951.0

1989 State Regulatory Survey Executive Summary

The State Issues Forum (SIF) 1989 State Regulatory Survey was undertaken to collect and summarize information about the health planning political environment in states with Certificate-of-Need (CON) programs. Surveys were mailed to every state hospital association and the **District of Columbia** Hospital Association.

The survey information is intended to complement data gathered by the AHA's Office of Public Policy Analysis (OPPA) on states' capital expenditure review programs. The OPPA has conducted these surveys periodically over the past several years.

Eleven states have eliminated the CON program for all services and facilities. They are: **Arizona, California, Colorado, Idaho, Kansas, Minnesota, New Mexico, South Dakota, Texas, Utah** and **Wyoming. Arkansas** removed hospitals from the state's CON process except for nursing home services; the program also covers all nursing home and home health services. **Indiana** maintains CON for skilled nursing facilities and intermediate care facilities, including those for the mentally retarded. **Louisiana** has a stripped-down CON program that applies only to Medicaid reimbursement for skilled nursing facility beds, intermediate care facility beds/mentally retarded, and psychiatric facility beds. **Montana** exempts hospitals except for the addition of long-term care, psychiatric or inpatient rehabilitation beds. **Oklahoma** limits CON review to long-term care and psychiatric and substance abuse services, and **Wisconsin's** CON process applies to nursing homes.

Several state statutes include sunset dates for the CON program. Slated to expire in 1991 are CON programs in **Montana, Tennessee, Virginia** (for hospitals, but not nursing homes) and **West Virginia. Indiana's** program has a 1991 sunset date. Although **Ohio's** CON law is supposed to sunset in July, lawmakers are expected to extend the sunset date to allow them time to pass a revised CON law.

The survey information that follows summarizes by state current CON policy; hospital associations' policy positions regarding CON and arguments to support those positions; and association advocacy efforts to effectuate CON changes. Associations' policy positions also are delineated on grids, as are the policy positions of several key political groups in the states, including the legislature, governor, health department and special interest groups.

Of 39 states and the **District of Columbia** that have some sort of CON program in place, nine hospital associations want to continue the program in its current form: **Alaska, Arkansas, Delaware, Mississippi, New Hampshire, North Carolina, Tennessee, Virginia** and **West Virginia**. The **Indiana, Montana** and **Oklahoma** hospital associations support the elimination of CON.

Twenty-five states advocate or have advocated changing the program either by liberalizing thresholds, expanding CON in certain areas, or eliminating specific categories from CON review. Memberships of the **South Carolina** Hospital Association and the Healthcare Association of **Hawaii** are divided over hospitals' policy stance on CON, and the **Louisiana** Hospital Association has taken a neutral position on CON.

In some states, CON is not a hot political issue this year because the CON law recently was addressed or revised by the legislature, because other health care issues take priority or both. Both **Vermont** and **Virginia** have made other more pressing health care issues priorities this year, including Medicaid reimbursement and uncompensated care. **Arkansas** already has enacted CON amendments this year, as have **Montana, Nebraska, Oklahoma, Oregon** and **Washington.**

Within the past three years: **Delaware** revised its CON program in 1987; **Maryland** passed CON changes that took effect July 1988; Massachusetts' 1988 Universal Health Care Act liberalized the state's CON process; **Michigan** revised CON statutes effective October 1987; Rhode Island increased CON thresholds over the past three years; and **South Carolina** passed CON amendments last year. In Illinois and Iowa, hospitals are preparing CON strategies for the legislatures' next sessions.

Raising thresholds, expanding CON to other health care providers, such as physicians' offices, and removing such non-clinically related services as parking garages and telephone systems from CON review were among policy changes most frequently proposed by state hospital associations. The argument most often cited for expanding CON to other health care providers was "to create a level playing field" and ensure equal competition in the health care marketplace.

In trying to change CON policy either through the legislative or regulatory process, hospital association advocacy efforts include educating legislators and other policymakers about the effect of CON laws on states' hospitals and participating in coalitions or task forces formulating recommendations for CON reform.

Although the political climate surrounding CON varies among states, state health departments, for the most part, favor CON retention in varying degrees, while legislators tend to be more open to the possibility of CON reform. Physicians in most states support eliminating CON and, in those states where they are exempt from review, favor maintaining the status quo. Labor, business and consumer advocates, although tending to favor the program, generally are not involved in active lobbying on behalf of CON. In **Michigan**, however, both the labor and business communities are strong advocates of CON retention.