SB

256

ALASKA STATE LEGISLATURE

Interim:
600 East Railroad Avenue
Wasilla, Alaska 99654
(907) 376-3370
(907) 376-3157 Fax

Session:
State Capitol
Juneau, Alaska 99801-1182
(907) 465-6600
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SENATOR LYDA GREEN
SENATE DISTRICT N

Sectional Analysis CS SB 256 "P"

Section 1: Amends AS 18.07.031 (a) to provide that an expenditure of $1,000,000 for new construction of, or addition of beds to a nursing home or psychiatric care facility anywhere in Alaska requires a certificate of need, and
An expenditure of $2,000,000 for construction or $1,000,000 for equipment at any other type of health care facility not in an organized borough with a population more than 55,000 requires a certificate of need.

Section 2: Allows for the replacement/relocation of any type of healthcare facility within a community without a certificate of need provided that there are no new health services and no increase in beds or categories of services.

Section 3: New subsection (d) provides for replacement of a healthcare facility on the same site without a certificate of need

New subsection (e) includes the cost of studies, plans, etc when determining the cost of a project for certificate of need threshold determination

New subsection (f) includes the value of donated property in determining the cost of a project for certificate of need threshold determination

Section 4: Requires the Department of Health and Social Services to set a time limit in regulation for determination of the completeness of a certificate of need application.

Section 5: Requires that the Department of Health and Social Services set time limits and procedures in regulation for when a public hearing must be held;

Requires that a certificate of need must be approved or denied within 120 days of when the application is determined to be complete.

Section 6: Places all certificate of need applications under the same standards that currently exist for nursing home beds

Section 7: Technical change required by section 6

Section 8: Technical change required by section 6

Section 9: Technical change required by section 6

Section 10: Technical change required by section 6

Section 11: Technical change required by section 6

Section 12: Requires the State Mental Health Plan to include a master plan for children's mental health services developed in conjunction with the Alaska Mental Health Trust Authority, Alaska Mental Health Board, and Advisory Board on Alcoholism and Drug Abuse

Section 13: Repeals certificate of need thresholds and standards that are replaced in section 1 and section 6

Section 14: Provides for a 1 year moratorium on the construction of child and adolescent psychiatric beds

Section 15: Sets up a five member working group to analyze issues regarding and make recommendations, prior to the start of the next legislative session, concerning the state's certificate of need program.

Section 16: Provides that the initial master plan added in section 12 shall be completed and delivered prior to the first day of the next legislative session.

Section 17: Provides that sections 1-11 and 13 this act apply to applications for certificates of need initially filed after the effective date of the act.

Section 18: Immediate effective date

Talking Points for CON Bill, CS SB 256 version P

- The State of Alaska has a direct interest in the numbers and types of nursing home beds as 86% of the cost of nursing home beds are paid for by Medicaid. SB 256 requires a CON for nursing home beds.

- The State of Alaska has a direct interest in the numbers and types of psychiatric care beds as 85% of the cost of child and adolescent psychiatric care is paid for by Medicaid. SB 256 requires a CON for psychiatric care beds.

- Small community hospitals may need protection from competition to insure that appropriate types of medical care are provided in each community. SB 256 requires a CON for healthcare facility construction at $2 million and medical equipment at $1 million in all but the three largest communities in Alaska.

- Larger markets can benefit from competition in the provision of healthcare services. CON requirements are removed for healthcare facilities in the three largest communities in Alaska. Anchorage, Fairbanks and Mat-Su.

- Testimony and research has not shown that the CON process is effective in reducing the growth in healthcare costs. Some testimony shows that it keeps costs up and prevents the introduction of more cost effective treatments

- The CON process in Alaska lacks definite timelines, standards and procedures to insure objectivity and rational decision-making. SB 256 adds timelines, and sets up a working group to analyze and recommend statutory, regulatory and procedural changes necessary to make the program work.

- The child and adolescent psychiatric treatment system in Alaska does not currently have all the necessary levels of treatment in place. SB 256 places a moratorium on new acute care psychiatric beds and directs the Mental Health Board, the Mental Health Trust Authority and the Advisory Board on Alcoholism and Drug Abuse to create a master plan for children's mental health services.

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22-LS1261\P.1
Lauterbach
3/14/02

AMENDMENT

OFFERED IN THE SENATE BY SENATOR GREEN

TO: CSSB 256(HES), Draft Version "P"

Page 1, line 1, following "**program;**":

Insert "**establishing a temporary moratorium on the issuance of certificates of need related to certain types of psychiatric beds for children and youths;**"

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SENATOR LYDA GREEN
SENATE DISTRICT N

Sponsor Statement
CS Senate Bill 345

Under the federal Individuals Disabilities Education Act (IDEA), school districts are required to provide rehabilitative services to qualifying students. Currently the federal government pays approximately 16% of the costs of services required by IDEA and the balance is paid out of the foundation formula with a mix of state and local funding. To the extent that these students qualify for Medicaid, federal law allows for schools to bill the state Medicaid program for many of these services. However, Alaska state law does not authorize school districts to be Medicaid providers. Senate Bill 345 authorizes the Alaska Department of Health and Social Services to promulgate the necessary regulations and to contract with school districts to reimburse the districts for rehabilitative services for students who qualify under the Medicaid program. Currently 42 other states fund school-based services through the Medicaid program.

Under the provisions of SB 345, the school district pays the state match for the Medicaid services it receives. The only state cost under this bill is the cost of promulgating the regulations and some small administrative costs. School districts benefit by receiving the federal matching dollars under the Medicaid program for services that they must provide, regardless of how they are funded. For each school district dollar expended for these covered services, the school district would receive approximately $1.50 in additional federal dollars, which can help defray the costs of providing special education services.

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SENATOR LYDA GREEN
SENATE DISTRICT N

Sectional Analysis CS SB 256 "P"

Section 1: Amends AS 18.07.031 (a) to provide that an expenditure of $1,000,000 for new construction of, or addition of beds to a nursing home or psychiatric care facility anywhere in Alaska requires a certificate of need, and
An expenditure of $2,000,000 for construction or $1,000,000 for equipment at any other type of health care facility not in an organized borough with a population more than 55,000 requires a certificate of need.

Section 2: Allows for the replacement/relocation of any type of healthcare facility within a community without a certificate of need provided that there are no new health services and no increase in beds or categories of services.

Section 3: New subsection (d) provides for replacement of a healthcare facility on the same site without a certificate of need

New subsection (e) includes the cost of studies, plans, etc when determining the cost of a project for certificate of need threshold determination

New subsection (f) includes the value of donated property in determining the cost of a project for certificate of need threshold determination

Section 4: Requires the Department of Health and Social Services to set a time limit in regulation for determination of the completeness of a certificate of need application.

Section 5: Requires that the Department of Health and Social Services set time limits and procedures in regulation for when a public hearing must be held;

Requires that a certificate of need must be approved or denied within 120 days of when the application is determined to be complete.

Section 6: Places all certificate of need applications under the same standards that currently exist for nursing home beds

Section 7: Technical change required by section 6

Section 8: Technical change required by section 6

Section 9: Technical change required by section 6

Section 10: Technical change required by section 6

Section 11: Technical change required by section 6

Section 12: Requires the State Mental Health Plan to include a master plan for children's mental health services developed in conjunction with the Alaska Mental Health Trust Authority, Alaska Mental Health Board, and Advisory Board on Alcoholism and Drug Abuse

Section 13: Repeals certificate of need thresholds and standards that are replaced in section 1 and section 6

Section 14: Provides for a 1 year moratorium on the construction of child and adolescent psychiatric beds

Section 15: Sets up a five member working group to analyze issues regarding and make recommendations, prior to the start of the next legislative session, concerning the state's certificate of need program.

Section 16: Provides that the initial master plan added in section 12 shall be completed and delivered prior to the first day of the next legislative session.

Section 17: Provides that sections 1-11 and 13 this act apply to applications for certificates of need initially filed after the effective date of the act.

Section 18: Immediate effective date

Talking Points for CON Bill, CS SB 256 version P

- The State of Alaska has a direct interest in the numbers and types of nursing home beds as 86% of the cost of nursing home beds are paid for by Medicaid. SB 256 requires a CON for nursing home beds.

- The State of Alaska has a direct interest in the numbers and types of psychiatric care beds as 85% of the cost of child and adolescent psychiatric care is paid for by Medicaid. SB 256 requires a CON for psychiatric care beds.

- Small community hospitals may need protection from competition to insure that appropriate types of medical care are provided in each community. SB 256 requires a CON for healthcare facility construction at $2 million and medical equipment at $1 million in all but the three largest communities in Alaska.

- Larger markets can benefit from competition in the provision of healthcare services. CON requirements are removed for healthcare facilities in the three largest communities in Alaska. Anchorage, Fairbanks and Mat-Su.

- Testimony and research has <u>not</u> shown that the CON process is effective in reducing the growth in healthcare costs. Some testimony shows that it keeps costs up and prevents the introduction of more cost effective treatments

- The CON process in Alaska lacks definite timelines, standards and procedures to insure objectivity and rational decision-making. SB 256 adds timelines, and sets up a working group to analyze and recommend statutory, regulatory and procedural changes necessary to make the program work.

- The child and adolescent psychiatric treatment system in Alaska does not currently have all the necessary levels of treatment in place. SB 256 places a moratorium on new acute care psychiatric beds and directs the Mental Health Board, the Mental Health Trust Authority and the Advisory Board on Alcoholism and Drug Abuse to create a master plan for children's mental health services.

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22-LS1261\O
Lauterbach
3/4/02

CS FOR SENATE BILL NO. 256(HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SECOND LEGISLATURE - SECOND SESSION

BY THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): SENATOR GREEN

A BILL

FOR AN ACT ENTITLED

"An Act relating to the certificate of need program; establishing a working group on psychiatric care services and the certificate of need program; and providing for an effective date."

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

* Section 1. AS 18.07.031(a) is amended to read:

(a) Except as provided in (c) and (d) of this section, a person may not, [MAKE AN EXPENDITURE OF $1,000,000 OR MORE FOR ANY OF THE FOLLOWING] unless authorized under the terms of a certificate of need issued by the department, make an expenditure of [:]

(1) any amount for

(A) construction of a health care facility that is a nursing home or has nursing home beds;

(B) the addition of nursing home beds to an existing health care facility;

New Text Underlined [DELETED TEXT BRACKETED]

(C) construction of a health care facility that includes psychiatric beds and requires licensure under AS 18.20 as a general acute care hospital, rural primary care hospital, critical access hospital, or specialized hospital primarily engaged in the treatment of one specific type of illness or disability; or

(D) the addition of psychiatric beds to an existing health care facility;

(2) $2,000,000 or more for construction of a health care facility not covered under (1) of this subsection, [; (2)] alteration of the bed capacity of a health care facility not covered under (1) of this subsection, [;] or [(3)] addition of a category of health services provided by a health care facility, other than a category of health services covered under (1) of this subsection, if the facility is or will be located in the unorganized borough or in an organized borough with a population of less than 55,000 at the time of commencement of activities, according to the latest reliable population data approved by the Department of Community and Economic Development; or

(3) $1,000,000 or more for major medical equipment if the equipment will be located in the unorganized borough or in an organized borough with a population of less than 55,000, according to the latest reliable population data approved by the Department of Community and Economic Development.

* **Sec. 2.** AS 18.07.031(c) is amended to read:

(c) Notwithstanding (a) of this section, a person who is lawfully operating a health care facility [THAT IS AN AMBULATORY SURGICAL FACILITY] at a site may make an expenditure of any amount in order to relocate the services of that facility to a new site in the same community without obtaining a certificate of need as long as neither the bed capacity nor the number of categories of health services provided at the new site is greater and no new category of health services is provided at the new site. However, notwithstanding the expenditure thresholds, population thresholds, and other provisions of [THRESHOLD IN] (a) of this section, a person may not use the site from which the health care facility relocated for

another health care facility unless authorized under a certificate of need issued by the department.

* **Sec. 3.** AS 18.07.031 is amended by adding new subsections to read:

(d) Notwithstanding (a) of this section, a person who is lawfully operating a health care facility at a site may make an expenditure of any amount in order to demolish and reconstruct a health care facility at the same site without obtaining a certificate of need as long as neither the bed capacity nor the number of categories of health services provided in the reconstructed facility is greater and no new category of health services is provided in the renovated or reconstructed facility.

(e) When determining whether an expenditure meets or exceeds the threshold requirements in (a)(2) or (3) of this section, the value of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the construction, alteration of bed capacity, addition of service, or acquisition of the major medical equipment, as applicable, shall be included.

(f) A donation or transfer of equipment or facilities to a health care facility that, if acquired directly by the facility for fair market value, would require a certificate of need under this section is subject to the certificate of need requirement; the donation or transfer may not take place without prior approval of a certificate of need that authorizes the donation or transfer.

* **Sec. 4.** AS 18.07.035 is amended to read:

Sec. 18.07.035. Application and fees. Application for a certificate of need shall be made to the department upon a form provided by the department and must contain the information the department requires to reach a decision **about whether to issue the certificate of need** [UNDER THIS CHAPTER]. Each application for a certificate of need must be accompanied by an application fee established by the department by regulation. **The department shall, by regulation, set a time limit by which the department shall determine whether an application submitted under this section is complete and contains all of the information the department requires to reach a decision about whether to issue the certificate of need.**

* **Sec. 5.** AS 18.07 is amended by adding new sections to read:

Sec. 18.07.037. Public hearing required. Except as provided in

AS 18.07.071, the department shall hold a public hearing within a reasonable time after determining that an application under AS 18.07.035 is complete. By regulation, the department shall establish

(1) a time limit by which a public hearing required under this section shall be held; and

(2) procedures for conducting a public hearing held under this section.

Sec. 18.07.039. Time limit for decision on application. Based on the standards for review under this chapter, the department shall, within 120 days after determining that an application under AS 18.07.035 is complete, approve or deny the application.

* **Sec. 6.** AS 18.07.043 is amended to read:

Sec. 18.07.043. Standard of review for applications for certificates of need and applications to modify certificates of need [RELATING TO NURSING HOMES AND NURSING HOME BEDS]. (a) The department shall develop review standards for an application for a certificate of need, or for a modification of a certificate of need, issued under this chapter [FOR A HEALTH CARE FACILITY THAT IS A NURSING HOME OR HAS NURSING HOME BEDS].

(b) **When determining whether to approve an application for a new certificate of need or to modify an existing certificate of need** [IN DEVELOPING THE REVIEW STANDARDS UNDER (a) OF THIS SECTION], the department shall consider whether

(1) a public process and existing appropriate statewide, regional, and local plans were included in planning and designing the **project** [ADDITIONAL NURSING HOME BEDS OR THE HEALTH CARE FACILITY];

(2) the **project will meet** [ADDITIONAL NURSING HOME BEDS OR THE HEALTH CARE FACILITY MEETS] minimum required use rates for **the proposed services without causing the** [NEW NURSING BEDS, AND THE EFFECT ON] use rates for existing **providers of the services to fall below minimum required use rates** [NURSING HOME BEDS];

(3) the **project** [ADDITIONAL NURSING HOME BEDS OR THE HEALTH CARE FACILITY] demonstrates consideration of the community, regional,

and statewide needs [FOR NEW NURSING HOME BEDS];

(4) the **project** [ADDITIONAL NURSING HOME BEDS OR THE HEALTH CARE FACILITY] meets the minimum **standards of the department that are designed** [NUMBER OF NEW NURSING BEDS THAT SHOULD BE REQUIRED IN A FACILITY] to ensure efficiency and economies of scale;

(5) the **project** [ADDITIONAL NURSING HOME BEDS OR THE HEALTH CARE FACILITY] demonstrates the proposed service will provide a quality of care equivalent to existing community, regional, or statewide services;

(6) the **project** [ADDITIONAL NURSING HOME BEDS OR THE HEALTH CARE FACILITY] demonstrates financial feasibility, including long-term viability, and what the financial effect will be on consumers and the state; and

(7) the sponsor has demonstrated cost effectiveness through considering the availability of appropriate, less costly alternatives of providing the services planned.

(c) The department shall grant a sponsor a certificate of need or modify a certificate of need [THAT AUTHORIZES NURSING HOME BEDS OR THAT IS FOR A HEALTH CARE FACILITY THAT IS A NURSING HOME] if the department finds that the sponsor meets the standards established in or under this chapter.

* **Sec. 7.** AS 18.07.071(b) is amended to read:

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

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

(2) adverse effect to the public interest by reason of delay occasioned by compliance with the requirements of **AS 18.07.043** [AS 18.07.041, 18.07.043,] and application procedures prescribed by regulations under this chapter.

* **Sec. 8.** AS 18.07.071(c) is amended to read:

(c) A temporary certificate granted under (b) of this section does not confer vested rights on behalf of the applicant. The department shall impose those special limitations and restrictions concerning duration and right of extension that the

department considers appropriate. A temporary certificate may not be granted for a period longer than necessary for the sponsor to obtain review of the action certified by the temporary certificate under AS 18.07.051. Application for a certificate of need **that will be reviewed** under **AS 18.07.043** [AS 18.07.041 OR 18.07.043] must commence within 60 days **after** [OF] the date of issuance of the temporary certificate.

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

(c) A certificate of need shall be suspended if an accusation is filed before the commencement of activities authorized under **AS 18.07.043** [AS 18.07.041 OR 18.07.043] that charges that factors upon which the certificate of need was issued have changed or new factors have been discovered that significantly alter the need for the activity authorized. A suspension of a certificate may not exceed 60 days. At the end of this period or sooner, the department shall revoke or reinstate the certificate.

* **Sec. 10.** AS 18.07.081(d) is amended to read:

(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 18.07.043 within** [AS 18.07.041 OR 18.07.043 AFTER] six months **after the date** of issuance **of the certificate:**

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

(3) the sponsor fails to comply with [THE PROVISIONS OF] this chapter or regulations adopted under this chapter;

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

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

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

* **Sec. 11.** AS 18.07.111(2) is amended to read:

(2) "certificate" means a certificate of need issued by the department under **AS 18.07.043 or 18.07.071** [AS 18.07.041, 18.07.043, OR 18.07.071];

* **Sec. 12.** AS 18.07.031(b) and 18.07.041 are repealed.

* **Sec. 13.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TEMPORARY MORATORIUM ON CERTAIN PSYCHIATRIC BEDS. (a) Notwithstanding the provisions of AS 18.07, the Department of Health and Social Services may not, until July 1, 2003, issue a certificate of need for construction of a health care facility that both

(1) includes psychiatric beds designated for children who are at least five years of age but younger than 13 years of age or for adolescents who are at least 13 years of age but younger than 20 years of age; and

(2) requires licensure under AS 18.20.020 as a general acute care hospital, rural primary care hospital, critical access hospital, or specialized hospital primarily engaged in the treatment of one specific type of illness or disability.

(b) The restriction in (a) of this section applies to applications for a certificate of need for which a certificate was not issued before the effective date of this section.

* **Sec. 14.** The uncodified law of the State of Alaska is amended by adding a new section to read:

WORKING GROUP ON PSYCHIATRIC CARE SERVICES AND CERTIFICATE OF NEED PROGRAM. (a) There is established a seven-member working group to analyze issues regarding psychiatric care services in the state and to make recommendations concerning the state's certificate of need program for all types of health care facilities. The members of the group are

(1) two individuals appointed by the governor who are providers of mental health services in Alaska;

(2) two individuals appointed by the governor who are consumers or parents or guardians of consumers of mental health services in Alaska;

(3) one individual appointed by the governor who is a physician whose primary practice is not the provision of mental health services;

(4) one individual appointed by the governor who is the administrator of a hospital that is not primarily a provider of mental health services; and

(5) the commissioner of health and social services, or the commissioner's

designee.

(b) The working group established under this section may select a presiding officer from among its members. For budgetary purposes, the working group is in the Office of the Governor, and the Office of the Governor shall provide any staff, supplies, working space, and other services or materials appropriate for the working group's purposes.

(c) The members of the working group appointed under (a)(1) - (4) of this section are not entitled to compensation or to per diem or travel expenses for their time spent on activities of the working group.

(d) After gathering information through the methods considered appropriate by the group, the working group established under this section shall prepare a report that includes the following:

(1) a description of the current status and costs of the state's system for providing psychiatric care services;

(2) the projected number of state residents who will be needing psychiatric care services through the years 2005, 2010, and 2020;

(3) the projected costs to the state, based on the projection of needs under (2) of this subsection, if no changes are made to the state's present system of psychiatric care services;

(4) an estimated number of state residents who are currently receiving care in out-of-state psychiatric facilities who could be more appropriately served in the state psychiatric facilities or in home and community-based care;

(5) an estimated number of state residents who are currently receiving care in in-state psychiatric facilities who could be more appropriately served in home and community-based care;

(6) a description of the alternative methods available to provide psychiatric care services to state residents and the relative cost to the state for these methods;

(7) recommendations for principles that should be used to guide the development of the state's psychiatric care system, especially regarding appropriate means for promoting the proper mix of acute care and home- and community-based care and including principles that should guide the certificate-of-need process under AS 18.07;

(8) specific recommendations for changes in statutes and regulations

governing the certificate of need program that would clarify the standards that will be applied during review of an application for a certificate of need.

(e) The working group shall deliver its report to the governor by the first day of the First Regular Session of the Twenty-Third Alaska State Legislature, and the working group is terminated on that day.

* **Sec. 15.** The uncodified law of the State of Alaska is amended by adding a new section to read:

APPLICABILITY. AS 18.07, as amended by this Act, applies to applications for certificates of need that are initially filed on or after the effective date of this Act.

* **Sec. 16.** This Act takes effect immediately under AS 01.10.070(c).

22-LS1261\F
Lauterbach
1/29/02

DRAFT

CS FOR SENATE BILL NO. 256(HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SECOND LEGISLATURE - SECOND SESSION

BY THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): SENATOR GREEN

A BILL

FOR AN ACT ENTITLED

"An Act relating to the certificate of need program; establishing a working group on psychiatric care services; and providing for an effective date."

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

*** Section 1.** AS 18.07.031(a) is amended to read:

(a) Except as provided in (c) of this section, a person may not make an expenditure of **$10,000,000** [$1,000,000] or more for any of the following unless authorized under the terms of a certificate of need issued by the department:

(1) construction of a health care facility;

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

(3) addition of a category of health services provided by a health care facility.

*** Sec. 2.** AS 18.07.031(c) is amended to read:

(c) Notwithstanding (a) of this section, a person who is lawfully operating a health care facility [THAT IS AN AMBULATORY SURGICAL FACILITY] at a site

may make an expenditure of any amount in order to relocate the services of that facility to a new site in the same community without obtaining a certificate of need as long as neither the bed capacity nor the number of categories of health services provided at the new site is greater. However, notwithstanding the expenditure threshold in (a) of this section, a person may not use the site from which the health care facility relocated for another health care facility unless authorized under a certificate of need issued by the department.

* **Sec. 3. AS 18.07.041** is amended to read:

Sec. 18.07.041. Standard of review for applications for certificates of need relating to non-nursing home beds and services. The department shall grant a sponsor a certificate of need or modify a certificate of need that authorizes beds other than nursing home beds or that is for a health care facility other than a nursing home if

(1) 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 citizens of this state;

(2) the facility demonstrates the financial feasibility of the project for which the certificate is sought, including the project's long-term viability; and

(3) the facility provides an explanation and forecast of the probable financial effect of the project on consumers of health care and on the state's fiscal condition.

* **Sec. 4.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TEMPORARY MORATORIUM ON PSYCHIATRIC BEDS. Notwithstanding the provisions of AS 18.07, the Department of Health and Social Services may not, until July 1, 2003, issue a certificate of need for construction of a health care facility that includes psychiatric beds and requires licensure under AS 18.20.020 as a general acute care hospital, rural primary care hospital, critical access hospital, or specialized hospital primarily engaged in the treatment of one specific type of illness or disability. The restriction in this section applies to applications for a certificate of need for which a certificate was not issued before the effective date of this section.

* **Sec. 5.** The uncodified law of the State of Alaska is amended by adding a new section to

read:

WORKING GROUP ON PSYCHIATRIC CARE SERVICES. (a) There is established a six-member working group to analyze issues regarding psychiatric care services in the state. The members of the group are

(1) two individuals appointed by the governor who are providers of mental health services in Alaska;

(2) two individuals appointed by the governor who are consumers or parents or guardians of consumers of mental health services in Alaska;

(3) the commissioner of administration, or the commissioner's designee; and

(4) the commissioner of health and social services, or the commissioner's designee.

(b) The working group established under this section may select a presiding officer from among its members. For budgetary purposes, the working group is in the Office of the Governor, and the Office of the Governor shall provide any staff, supplies, working space, and other services or materials appropriate for the working group's purposes.

(c) The members of the working group appointed under (a)(1) and (2) of this section are not entitled to compensation or to per diem or travel expenses for their time spent on activities of the working group.

(d) After gathering information through the methods considered appropriate by the group, the working group established under this section shall prepare a report that includes the following:

(1) a description of the current status and costs of the state's system for providing psychiatric care services;

(2) the projected number of state residents who will be needing psychiatric care services through the years 2005, 2010, and 2020;

(3) the projected costs to the state, based on the projection of needs under (2) of this subsection, if no changes are made to the state's present system of psychiatric care services;

(4) an estimated number of state residents who are currently receiving care in out-of-state psychiatric facilities who could be more appropriately served in the state psychiatric facilities or in home and community-based care;

(5) an estimated number of state residents who are currently receiving care in in-state psychiatric facilities who could be more appropriately served in home and community-based care;

(6) a description of the alternative methods available to provide psychiatric care services to state residents and the relative cost to the state for these methods;

(7) recommendations for principles that should be used to guide the development of the state's psychiatric care system, including principles that should guide the certificate-of-need process under AS 18.07.

(e) The working group shall deliver its report to the governor by the first day of the First Regular Session of the Twenty-Third Alaska State Legislature, and the working group is terminated on that day.

* **Sec. 6.** The uncodified law of the State of Alaska is amended by adding a new section to read:

APPLICABILITY. AS 18.07.041, as amended by sec. 3 of this Act, applies to applications for certificates of need that are initially filed on or after the effective date of this Act.

* **Sec. 7.** This Act takes effect immediately under AS 01.10.070(c).

22-LS1261\L
Lauterbach
2/22/02

CS FOR SENATE BILL NO. 256(HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SECOND LEGISLATURE - SECOND SESSION

BY THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): SENATOR GREEN

A BILL

FOR AN ACT ENTITLED

"An Act relating to the certificate of need program; establishing a working group on psychiatric care services; and providing for an effective date."

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

*** Section 1.** AS 18.07.031(a) is amended to read:

(a) Except as provided in (c) **and (d)** of this section, a person may not, [MAKE AN EXPENDITURE OF $1,000,000 OR MORE FOR ANY OF THE FOLLOWING] unless authorized under the terms of a certificate of need issued by the department, **make an expenditure of** [:]

(1) any amount for

(A) construction of a health care facility that is a nursing home or has nursing home beds;

(B) the addition of nursing home beds to an existing health care facility;

(C) construction of a health care facility that includes

psychiatric beds and requires licensure under AS 18.20 as a general acute care hospital, rural primary care hospital, critical access hospital, or specialized hospital primarily engaged in the treatment of one specific type of illness or disability; or

(D) the addition of psychiatric beds to an existing health care facility;

(2) $2,000,000 or more for construction of a health care facility **not covered under (1) of this subsection,** [; (2)] alteration of the bed capacity of a health care facility **not covered under (1) of this subsection,** [;] or [(3)] addition of a category of health services provided by a health care facility**, other than a category of health services covered under (1) of this subsection, if the facility is or will be located in the unorganized borough or in an organized borough with a population of less than 55,000 at the time of commencement of activities, according to the latest reliable population data approved by the Department of Community and Economic Development; or**

(3) $1,000,000 or more for major medical equipment if the equipment will be located in the unorganized borough or in an organized borough with a population of less than 55,000, according to the latest reliable population data approved by the Department of Community and Economic Development.

* **Sec. 2.** AS 18.07.031(c) is amended to read:

(c) Notwithstanding (a) of this section, a person who is lawfully operating a health care facility [THAT IS AN AMBULATORY SURGICAL FACILITY] at a site may make an expenditure of any amount in order to relocate the services of that facility to a new site in the same community without obtaining a certificate of need as long as neither the bed capacity nor the number of categories of health services provided at the new site is greater **and no new category of health services is provided at the new site**. However, notwithstanding the expenditure **thresholds, population thresholds, and other provisions of** [THRESHOLD IN] (a) of this section, a person may not use the site from which the health care facility relocated for another health care facility unless authorized under a certificate of need issued by the

department.

* **Sec. 3.** AS 18.07.031 is amended by adding new subsections to read:

(d) Notwithstanding (a) of this section, a person who is lawfully operating a health care facility at a site may make an expenditure of any amount in order to demolish and reconstruct a health care facility at the same site without obtaining a certificate of need as long as neither the bed capacity nor the number of categories of health services provided in the reconstructed facility is greater and no new category of health services is provided in the renovated or reconstructed facility.

(e) When determining whether an expenditure meets or exceeds the threshold requirements in (a)(2) or (3) of this section, the value of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the construction, alteration of bed capacity, addition of service, or acquisition of the major medical equipment, as applicable, shall be included.

(f) A donation or transfer of equipment or facilities to a health care facility that, if acquired directly by the facility for fair market value, would require a certificate of need under this section is subject to the certificate of need requirement; the donation or transfer may not take pla without prior approval of a certificate of need that authorizes the donation or transfer.

* **Sec. 4.** AS 18.07.035 is amended to read:

Sec. 18.07.035. Application and fees. Application for a certificate of need shall be made to the department upon a form provided by the department and must contain the information the department requires to reach a decision **about whether to issue the certificate of need** [UNDER THIS CHAPTER]. Each application for a certificate of need must be accompanied by an application fee established by the department by regulation. **The department shall, by regulation, set a time limit by which the department shall determine whether an application submitted under this section is complete and contains all of the information the department requires to reach a decision about whether to issue the certificate of need.**

* **Sec. 5.** AS 18.07 is amended by adding new sections to read:

Sec. 18.07.037. Public hearing required. Except as provided in AS 18.07.071, the department shall hold a public hearing within a reasonable time

after determining that an application under AS 18.07.035 is complete. By regulation, the department shall establish

(1) a time limit by which a public hearing required under this section shall be held; and

(2) procedures for conducting a public hearing held under this section.

Sec. 18.07.039. Time limit for decision on application. Based on the standards for review under this chapter, the department shall, within 120 days after determining that an application under AS 18.07.035 is complete, approve or deny the application except that, if the application is for a nonsubstantive project, as determined under AS 18.07.045, the department shall approve or deny the application within 60 days after determining that the application is complete.

* **Sec. 6.** AS 18.07.043 is amended to read:

Sec. 18.07.043. Standard of review for applications for certificates of need and applications to modify certificates of need [RELATING TO NURSING HOMES AND NURSING HOME BEDS]. (a) The department shall develop review standards for an application for a certificate of need, or for a modification of a certificate of need, issued under this chapter**. Except as provided in AS 18.07.045, the standards must require the department to consider the**

(1) size, composition, and growth trends of the population of the area to be served;

(2) number of existing and planned facilities in the area that offer services similar to those being requested under the application; and

(3) extent to which existing facilities and services are being used in the area to be served [FOR A HEALTH CARE FACILITY THAT IS A NURSING HOME OR HAS NURSING HOME BEDS].

(b) **Except as provided under AS 18.07.045, when determining whether to approve an application for a new certificate of need or to modify an existing certificate of need** [IN DEVELOPING THE REVIEW STANDARDS UNDER (a) OF THIS SECTION], the department shall **evaluate** [CONSIDER] whether

(1) **safeguards are provided that ensure that the project for which the application is submitted is consistent with the public interest;**

(2) the economic feasibility of the project is demonstrated in terms of

(A) the effect of the project on the existing and projected operating budget of the applicant and of the health care facility;

(B) the applicant's ability to establish and operate the project in compliance with applicable licensure regulations; and

(C) the projected effect of the project on the total health care expenditures in the facility and in the community;

(3) the proposed project is consistent with the orderly and economic development of health care facilities in the state;

(4) a public process and existing appropriate statewide, regional, and local plans were included in planning and designing the project [ADDITIONAL NURSING HOME BEDS OR THE HEALTH CARE FACILITY];

(5) the type of services that would be offered under the project are insufficient in the area;

(6) the personnel necessary to operate the project are available;

(7) [(2)] the project will meet [ADDITIONAL NURSING HOME BEDS OR THE HEALTH CARE FACILITY MEETS] minimum required use rates for the proposed services without causing the [NEW NURSING BEDS, AND THE EFFECT ON] use rates for existing providers of the services to fall below minimum required use rates [NURSING HOME BEDS];

(8) [(3)] the project [ADDITIONAL NURSING HOME BEDS OR THE HEALTH CARE FACILITY] demonstrates consideration of the community, regional, and statewide needs in the case of a project by a religious body or denomination, the needs of the members of the religious body or denomination may be considered to be a public need [FOR NEW NURSING HOME BEDS];

(9) [(4)] the project [ADDITIONAL NURSING HOME BEDS OR THE HEALTH CARE FACILITY] meets the minimum standards of the department that are designed [NUMBER OF NEW NURSING BEDS THAT SHOULD BE REQUIRED IN A FACILITY] to ensure efficiency and economies of scale;

(10) [(5)] the **project** [ADDITIONAL NURSING HOME BEDS OR THE HEALTH CARE FACILITY] demonstrates the proposed service will provide a quality of care equivalent to existing community, regional, or statewide services;

(11) [(6)] the **project** [ADDITIONAL NURSING HOME BEDS OR THE HEALTH CARE FACILITY] demonstrates financial **and economic** feasibility, including long-term viability, **considering the criteria described in (2) of this subsection** and [WHAT] the financial effect [WILL BE] on consumers and the state; and

(12) [(7)] the sponsor has demonstrated cost effectiveness through considering the availability of appropriate, less costly alternatives of providing the services planned.

(c) The department shall grant a sponsor a certificate of need or modify a certificate of need [THAT AUTHORIZES NURSING HOME BEDS OR THAT IS FOR A HEALTH CARE FACILITY THAT IS A NURSING HOME] if the department finds that the sponsor meets the standards established in or under this chapter.

* **Sec. 7.** AS 18.07 is amended by adding a new section to read:

Sec. 18.07.045. Certificates for nonsubstantive projects. (a) Notwithstanding the other provisions of this chapter, the department may issue a certificate of need on an expedited basis and according to standards different from those specified in AS 18.07.043 if

(1) the application submitted under AS 18.07.035 is for the construction of a health care facility; and

(2) the department determines that the sponsor has demonstrated that the project for which the certificate is sought is nonsubstantive in nature.

(b) The department shall adopt regulations to implement this section.

* **Sec. 8.** AS 18.07.051 is amended to read:

Sec. 18.07.051. Terms of issuance of the certificate. Each certificate issued must specify terms of issuance describing the nature and extent of the activities authorized by the certificate. **A certificate is valid only for the activities described, for the site specified, for the amount specified, and for the person named on the**

certificate. A certificate is not transferable or assignable. Unless revoked under AS 18.07.081, a certificate is valid until the project authorized in the certificate has been completed.

* **Sec. 9.** AS 18.07.071 is amended to read:

Sec. 18.07.071. Temporary and emergency certificates. (a) The department shall grant a sponsor an emergency certificate for the construction of a health care facility for which a certificate is required under AS 18.07.031 if the sponsor shows, by affidavit or formal hearing, that the act of construction consists of effecting [EMERGENCY] repairs **that are emergent in nature and must be undertaken immediately in order to prevent or correct structural deficiencies or hazardous conditions that may harm or injure persons in the facility. The department is not required to hold a public hearing before issuing an emergency certificate under this subsection**.

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

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

(2) adverse effect to the public interest by reason of delay occasioned by compliance with the requirements of **AS 18.07.043 or 18.07.045** [AS 18.07.041, 18.07.043,] and application procedures prescribed by regulations under this chapter.

(c) A temporary certificate granted under (b) of this section does not confer vested rights on behalf of the applicant. The department shall impose those special limitations and restrictions concerning duration and right of extension that the department considers appropriate. A temporary certificate may not be granted for a period longer than necessary for the sponsor to obtain review of the action certified by the temporary certificate under AS 18.07.051. Application for a certificate of need **that will be reviewed** under **AS 18.07.043 or 18.07.045** [AS 18.07.041 OR 18.07.043] must commence within 60 days **after** [OF] the date of issuance of the temporary certificate.

* **Sec. 10.** AS 18.07.081(c) is amended to read:

(c) A certificate of need shall be suspended if an accusation is filed before the

commencement of activities authorized under **AS 18.07.043 or 18.07.045** [AS 18.07.041 OR 18.07.043] that charges that factors upon which the certificate of need was issued have changed or new factors have been discovered that significantly alter the need for the activity authorized. A suspension of a certificate may not exceed 60 days. At the end of this period or sooner, the department shall revoke or reinstate the certificate.

*** Sec. 11.** AS 18.07.081(d) is amended to read

(d) A certificate of need may be revoked if

(1) the sponsor has not shown

(A) continuing progress toward commencement of the activities authorized under **AS 18.07.043 or 18.07.045 within** [AS 18.07.041 OR 18.07.043 AFTER] six months **after the date** of issuance **of the certificate;**

(B) full obligation for the authorized activities, as determined by the department, within 12 months after the date of issuance of the certificate if the certificate was issued for a project other than major construction, as defined in regulations adopted by the department; the commissioner may extend the time limit set under this subparagraph upon a showing of good cause by the sponsor;

(C) full obligation for the authorized activities, as determined by the department, within 18 months after the date of issuance of the certificate if the certificate was issued for major construction, as defined in regulations adopted by the department; the commissioner may extend the time limit set under this subparagraph upon a showing of good cause by the sponsor; or

(D) due diligence toward commencement and completion of the activities authorized under the certificate;

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

(3) the sponsor fails to comply with [THE PROVISIONS OF] this chapter or regulations adopted under this chapter;

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

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

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

* **Sec. 12.** AS 18.07.091 is amended by adding a new subsection to read:

(c) A person who violates AS 18.07.031 or who violates the terms of a certificate issued under this chapter

(1) may be fined up to $25,000 in a civil action brought by the state; and

(2) is not eligible, until the person is in compliance with AS 18.07.031 and the terms of the certificate,

(A) to apply for a license for the facility, equipment, or service constructed, modified, acquired, or added in violation of AS 18.07.031 or in violation of the terms of the certificate; and

(B) for payment by the state for a service rendered in the facility where the violation occurred.

* **Sec. 13.** AS 18.07.101 is amended to read:

Sec. 18.07.101. Regulations; records. The commissioner shall adopt, in accordance with AS 44.62 (Administrative Procedure Act), regulations that

(1) establish procedures under which sponsors may make application for certificates of need required by this chapter and that govern the review of those applications by the department;

(2) [,] establish requirements for a uniform statewide system of reporting financial and other operating data;

(3) establish a procedure under which an applicant whose application is determined to be incomplete may submit additional information and that govern the review of the resubmitted application by the department; [,] and

(4) otherwise carry out the purposes of this chapter.

* **Sec. 14.** AS 18.07.101 is amended by adding a new subsection to read:

(b) The department shall keep a complete record of the following:

(1) notices of hearing issued under this chapter;

(2) complaints, pleadings, and motions filed by the department under this chapter; and

(3) reports and orders issued by the department or by an administrative hearing officer in a proceeding under this chapter.

* **Sec. 15.** AS 18.07 is amended by adding a new section to read:

Sec. 18.07.105. Coordination with other agencies. When performing duties under this chapter, the department shall coordinate with other state agencies that have responsibilities that affect health care facilities, including responsibilities relating to licensure and cost reporting.

* **Sec. 16.** AS 18.07.111(2) is amended to read:

(2) "certificate" means a certificate of need issued by the department under **AS 18.07.043, 18.07.045, or 18.07.071** [AS 18.07.041, 18.07.043, OR 18.07.071];

* **Sec. 17.** AS 18.07.111(6) is amended to read:

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

* **Sec. 18.** AS 18.07.111(8) is amended to read:

(8) "health care facility" means a private, municipal, **or** state [OR FEDERAL] hospital, psychiatric hospital, **critical access** [TUBERCULOSIS] hospital, [SKILLED] nursing facility **as defined in 42 U.S.C. 1396r**, kidney disease treatment center (including freestanding hemodialysis units), **clinical laboratory, diagnostic** [INTERMEDIATE CARE] facility, and ambulatory surgical facility, **if the hospital or facility requires licensure under AS 18.20**; the term excludes

(A) an Alaska Pioneers' Home administered by the Department of Administration under AS 44.21.020(09) and AS 47.55; [AND]

(B) the offices of private physicians or dentists whether in

individual or group practice;

(C) federally owned facilities; and

(D) facilities used solely for healing by prayer or spiritual means;

*** Sec. 19.** AS 18.07.031(b) and 18.07.041 are repealed.

*** Sec. 20.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TEMPORARY MORATORIUM ON CERTAIN PSYCHIATRIC BEDS. (a) Notwithstanding the provisions of AS 18.07, the Department of Health and Social Services may not, until July 1, 2003, issue a certificate of need for construction of a health care facility that both

(1) includes psychiatric beds designated for children who are at least five years of age but younger than 13 years of age or for adolescents who are at least 13 years of age but younger than 20 years of age; and

(2) requires licensure under AS 18.20.020 as a general acute care hospital, rural primary care hospital, critical access hospital, or specialized hospital primarily engaged in the treatment of one specific type of illness or disability.

(b) The restriction in (a) of this section applies to applications for a certificate of need for which a certificate was not issued before the effective date of this section.

*** Sec. 21.** The uncodified law of the State of Alaska is amended by adding a new section to read:

WORKING GROUP ON PSYCHIATRIC CARE SERVICES. (a) There is established a six-member working group to analyze issues regarding psychiatric care services in the state. The members of the group are

(1) two individuals appointed by the governor who are providers of mental health services in Alaska;

(2) two individuals appointed by the governor who are consumers or parents or guardians of consumers of mental health services in Alaska;

(3) the commissioner of administration, or the commissioner's designee; and

(4) the commissioner of health and social services, or the commissioner's designee.

(b) The working group established under this section may select a presiding officer from among its members. For budgetary purposes, the working group is in the Office of the Governor, and the Office of the Governor shall provide any staff, supplies, working space, and other services or materials appropriate for the working group's purposes.

(c) The members of the working group appointed under (a)(1) and (2) of this section are not entitled to compensation or to per diem or travel expenses for their time spent on activities of the working group.

(d) After gathering information through the methods considered appropriate by the group, the working group established under this section shall prepare a report that includes the following:

(1) a description of the current status and costs of the state's system for providing psychiatric care services;

(2) the projected number of state residents who will be needing psychiatric care services through the years 2005, 2010, and 2020;

(3) the projected costs to the state, based on the projection of needs under (2) of this subsection, if no changes are made to the state's present system of psychiatric care services;

(4) an estimated number of state residents who are currently receiving care in out-of-state psychiatric facilities who could be more appropriately served in the state psychiatric facilities or in home and community-based care;

(5) an estimated number of state residents who are currently receiving care in in-state psychiatric facilities who could be more appropriately served in home and community-based care;

(6) a description of the alternative methods available to provide psychiatric care services to state residents and the relative cost to the state for these methods;

(7) recommendations for principles that should be used to guide the development of the state's psychiatric care system, including principles that should guide the certificate-of-need process under AS 13.07.

(e) The working group shall deliver its report to the governor by the first day of the First Regular Session of the Twenty-Third Alaska State Legislature, and the working group is terminated on that day.

*** Sec. 22.** The uncodified law of the State of Alaska is amended by adding a new section to read:

APPLICABILITY. AS 18.07, as amended by this Act, applies to applications for certificates of need that are initially filed on or after the effective date of this Act.

*** Sec. 23.** This Act takes effect immediately under AS 01.10.070(c).

FISCAL NOTE

FEB 0 4 2002

STATE OF ALASKA
2002 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB 256
( ) Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Health & Social Services
Title: RELATING TO THE CERTIFICATE OF NEED PROGRAM
BRU: Medical Assistance
Component: Medicaid Services

Sponsor: GREEN
Requestor: SENATE (HES)
Component Number: 2077

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims	732.0	23,255.8	28,251.7	35,137.3	36,628.1	38,053.3
Miscellaneous						
TOTAL OPERATING	732.0	23,255.8	28,251.7	35,137.3	36,628.1	38,053.3
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE	(Thousands of Dollars)					
1002 Federal Receipts	426.5	18,401.9	21,503.9	27,194.5	28,288.7	29,381.0
1003 GF Match	305.5	4,853.9	6,747.8	7,942.8	8,339.4	8,672.3
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type–do not abbreviate)						
TOTAL	732.0	23,255.8	28,251.7	35,137.3	36,628.1	38,053.3

Estimate of any current year (FY2002) cost:

Check this box (X) if funding for this bill is included in the Governor's FY 2003 budget proposal: [ ]

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

This bill would increase the expenditure limit for a Certificate of Need (CON) review from $1 million to $10 million. The purpose of the CON is to act as a deterrent to overbuilding health care facility capacity. Increasing the financial ceiling for a CON review has the potential of increasing the Medicaid budget for hospital, ambulatory surgical center, and nursing home services. The last change in the CON threshhold was in 1983 when it was increased from $150,000 to $1 million. There have been 30 CON applications since 1996, 10 (1/3) have been for projects costing $10 million or more. The total cost of the projects reviewed that were under $10 million was $78.6 million. Many more projects would likely have been built if the threshhold had been $10 million, because many more inquiries were received. This increase would give Alaska the highest CON threshhold in the nation.

Prepared by: Nancy Weller
Phone 465-3355
Division Medical Assistance
Date/Time 01/31/2002
Approved by: Elmer A. Lindstrom, Deputy Commissioner
Date 02/01/2002
Agency Department of Health & Social Services

For distribution information, call the Governor's Legislative Office

(Rev 2/7/2001 OMB)

FISCAL NOTE

STATE OF ALASKA
2002 LEGISLATIVE SESSION

BILL NO. SB 256

ANALYSIS CONTINUATION

The Medicaid Rate Advisory Commission estimates that a hospital capital expenditure of $10 million amortized over 15 years at a 20% Medicaid utilization rate will result in a $150.0 annual cost increase to rates. Nursing facilities in the state average 80% Medicaid occupancy; for $10 million, a 20 bed nursing home can be constructed resulting in a $2.5 million annual increase in the Medicaid budget.

Certificate of Need staff in the Division of Administrative Services, DHSS, estimate that a number of facilities with pending CON will be constructed in the near future if the limits are increased. The construction of these facilties is anticipated to increase the Medicaid Services costs as shown in the above fiscal note - no facility costs are included other than the pending projects. Assumptions in creating these projections include: use of the 58.27% FMAP rate for FFY03 for each year, use of the 4% FY03 DRI inflation factor for facility costs for each year, and assumption that nursing facilities constructed by tribal health corporations will be filled with Alaska Native patients whose costs can be claimed at 100% federal funds.

Future Medicaid cost impacts from the increase in the certificate of need limit is largely unknown; the cost estimates in this fiscal note are based only on those projects currently with a certificate of need on file. Actual costs could be much greater than shown.

Estimated Nursing Home & Acute Care Growth in Alaska including Construction/Conversion/Replacement - 1/2002

CN/LOI or Plans	Potential New Projects	Est. Cost of Construction	Medicaid Deprec/Fac Cost	Medicaid Oper. Costs	Total Est. Medicaid	Completion Date	Info. Received
Anchorage ASC (AUA)	2 OR suites	$ 1,500,000	$ 50,000		$ 50,000	2002	2001
Anch - Providence	Potential Acute						2001
Barrow	15 New NH	$ 4,000,000	$ 137,600	$ 3,147,400	$ 3,285,000	2004	1999
Bethel	35 New NH	$ 9,500,000	$ 326,800	$ 7,338,200	$ 7,665,000	2003	1996
Chugiak	20 New NH	$ 7,500,000	$ 258,000	$ 3,735,625	$ 3,993,625	2003	1999
Fairbanks Memorial	2 OR suites	$ 1,300,000	$ 17,333		$ 17,333	2002	1999
Fairbanks - TVC	2 OR suites	$ 4,200,000	$ 50,000		$ 50,000	2002	1999
Fairbanks ASC	2 OR suites	$ 5,500,000	$ 50,000		$ 50,000	2002	1999
Fairbanks Kidney Ctr.	12 Stations	$ 1,900,000	$ 65,360	$ 399,344	$ 464,704	2002	
Homer - So. Pen. Hosp.	Potential NH	unknown	unknown	unknown	unknown		1999
Juneau ASC	2 OR Suites	$ 1,500,000	$ 50,000		$ 50,000	2002	1999
Kotzebue (Manillaq)	15 New NH	$ 6,500,000	$ 223,600	$ 3,735,625	$ 3,959,225	2003	1999
Kenai ASC	2 OR Suites	$ 1,500,000	$ 50,000		$ 50,000	2002	1999
Seward - Wesley	35 New NH	$ 9,500,000	$ 326,800	$ 3,735,625	$ 4,062,425	2004	
Sitka Community Hsp	14 New	$ 1,164,988	$ 40,868	$ 2,549,956	$ 2,590,824	2005	1997
Wasilla	47 New	$ 8,500,000	$ 292,400	$ 5,852,480	$ 6,144,880	2003	1999
Wasilla	Potential Acute	unknown	unknown	unknown	unknown		2000
Totals		$ 64,064,988	$ 1,938,761	$ 30,494,256	$ 32,433,017		

Total Growth in Medicaid Costs (Acute + Nursing Home Beds) = $ 32.4 Million Annually by 2005

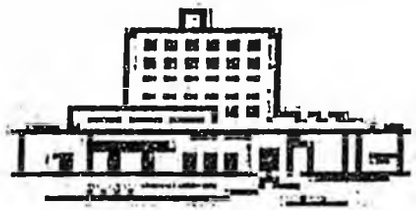
Source: State of Alaska, DHSS, Administrative Services, Facilities & Planning Section

Juneau - Wildflower PL	New NH Beds	unknown	unknown	unknown	unknown		

The Alaska Certificate of Need Program

Department of Health & Social Services
Division of Administrative Services
Facilities & Planning Section
Juneau, Alaska

Introduction



- A review process since 1976
- For Capital projects
- Applicants must show need
- Most projects approved, but extensive costs avoided
- 74% of States have CON
- States without CON regulate health care development by other processes
- State to state variation based on local factors

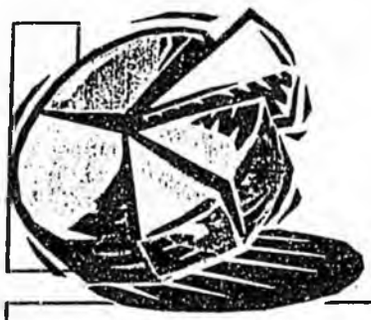
The Need for the Program

Development Perspectives -

- There is a need for regionalization of services to ensure quality care and cost effectiveness
- There is a need for public involvement

Payment Perspective -

- Medicaid pays 86% of Long-Term Care & about 20% of Acute Care costs
- Total Medicaid expenditures in 2000 = $467.4 million
- Hospitals & Nursing Homes = $148.5 million;
  25% Acute Hospital; 11% LTC; 10% Inpatient Psych
- Hospital & Nursing Home costs increased 38% since 92



Certificate of Need Goals

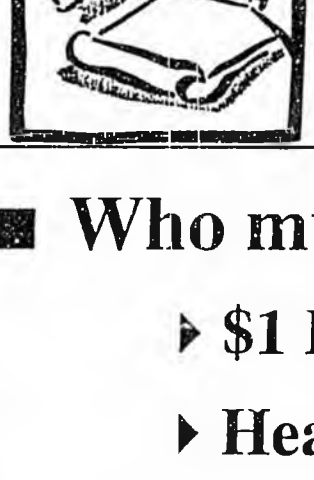
- Improved Decision Making/Regionalization
- Increases Choice/Considers Alternatives
- Stretches Limited Resources
- Decreases Duplication
- Ensures Public Process
- Promotes Quality
- Cost Containment
- Promotes Program Stability
- Promotes Balance/Continuum of Care

CON Program History

- Hill/Burton, 1122 Rev.
- 1976 (PL 93-641 - Health Planning & Resource Development Act, 1974)
- 1983 - $1M Threshold; Last Health Plan
- 1988 - HSAs Close; Planning Reduced
- 1990 - Routine Replacement Clause
- 1995 - Conversion of Assisted Living Beds
- 1996 - Moratorium on New Nursing Beds
- 1996 - Internet Page
- 1998 - Electronic Notification
- 1998 - CN Education
- 1999-2000 - Law & Regulations Changes

Changes in CON Law - 1999

- **All LTC bed conversions must submit a CON application, regardless of the cost**
- **New LTC review standards include:**
  - **Consideration of alternatives such as Assisted Living**
  - **Minimum use rates**
  - **Minimum number of beds**
  - **Financial feasibility, and**
  - **The financial effect on consumers and the State**
- **2000 – Ambulatory Surgery allowed to move without a CON**



The Application Process

- **Who must Apply?**
  - $1 Million Cost
  - Health Care Facility
  - All LTC Conversions

- **How to Apply:**
  - Letter of Intent
  - 60-Day Wait
  - Pre-Application Conference
  - Application Packet

The Review Process

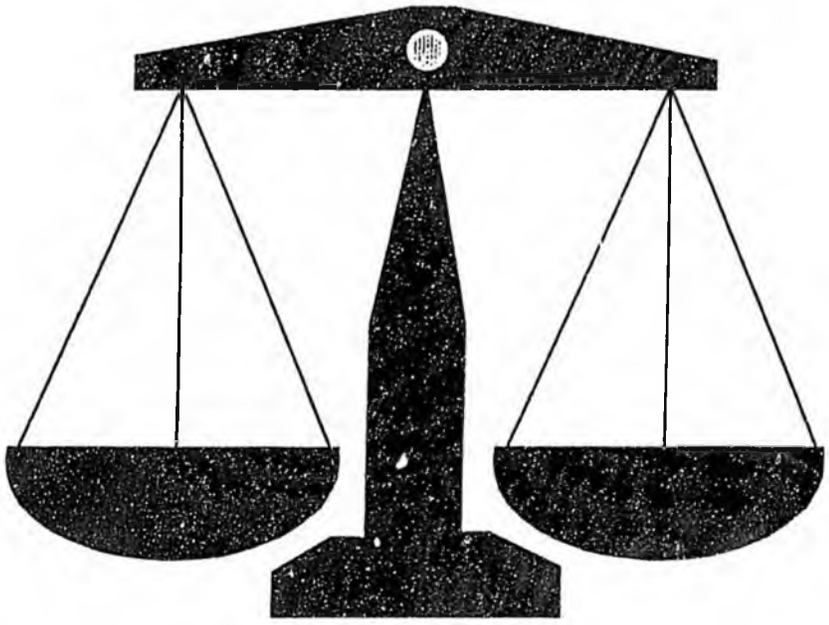
- **Review & Analysis**
  - Site Visit
  - Criteria & Standards
  - Findings & Recommendations
  - Criteria & Standards

- **Public Process**
- **Commissioner's Decision**

THE PUBLIC PROCESS

- 30-day written comment Period
- Public Meeting
- Notification of interested individuals
- Notice published in two consecutive issues of one statewide & one local newspaper

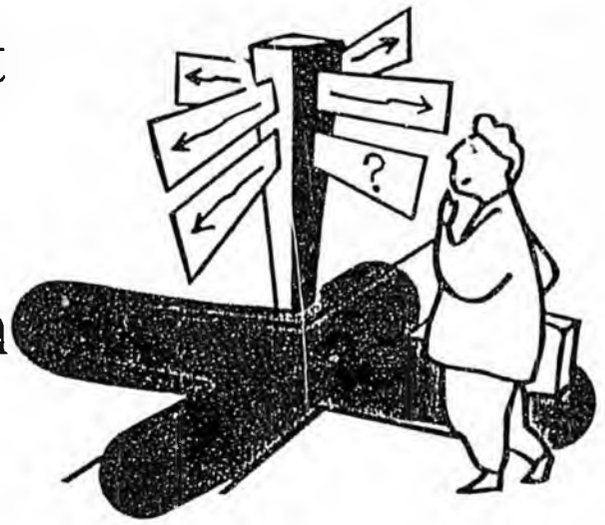
APPEAL



- Must be written & submitted within 30 days after notice
- Must be sent to the Commissioner
- Levels of Appeal: hearing, legal case
- Solution attempted at lowest level

Effectiveness of the Program

- **CN is one of many tools for effective system development**
- **Since Program Inception, Over 500 additional beds prevented over $75 million in construction costs avoided, plus millions in operating costs.**
- **Some facilities developed better systems.**
- **Increased choice/balance in system.**



Applications Under Review/Expected

■ Sitka 5 Nursing Home Beds	■ $25,000
■ Ketchikan MRI Scanner	■ $1 Million
■ Providence 60-bed child/adolescent psych facility	■ $21 Million
■ Valdez Hospital Replacement	■ $24 Million
■ Providence N. Tower CON Modification	■ $ 6 Million
■ Expected 2001-2002:	
- API Replacement	■ $42 Million
- Fairbanks Kidney Dialysis	■ $ 1 Million
- Maniilaq 15-bed LTC Unit	■ $ 4 Million
- Wesley Rehab & Care Unit	■ Unkown

THE HENRY J. KAISER FAMILY FOUNDATION

STATE HEALTH FACTS *Online*

http://statehealthfa

Your source for state he

Health Care Employment as Percent of Total Employment, 1999

- ☐ Less than 6.0%
- ☐ 6.0% to 6.8%
- ☐ 6.9% to 7.8%
- ■ More than 7.8%
- ☐ No data available/NSD

Health Care Employment as Percent of Total Employment, 1999

Sort by: Rank

Health Care Employment as Percent of Total Employment, 1999		
Rank	**State**	**%**
	United States	6.9
1	District of Columbia	14.1
2	Rhode Island	9.2
3	Massachusetts	8.8

3	North Dakota	8.8
5	New York	8.5
5	West Virginia	8.5
7	Pennsylvania	8.0
8	Connecticut	7.9
8	South Dakota	7.9
10	Louisiana	7.8
10	Maine	7.8
10	Minnesota	7.8
10	Nebraska	7.8
10	Ohio	7.8
15	Missouri	7.6
16	Arkansas	7.4
17	Kentucky	7.3
17	Maryland	7.3
19	Iowa	7.1
19	New Jersey	7.1
21	Tennessee	7.0
21	Wisconsin	7.0
23	Delaware	6.9
23	Florida	6.9
23	Indiana	6.9
23	North Carolina	6.9
23	Oklahoma	6.9
28	Kansas	6.8
28	Michigan	6.8
28	Mississippi	6.8
31	Alabama	6.7
31	Illinois	6.7
31	Texas	6.7
34	Hawaii	6.5
34	Montana	6.5
36	Utah	6.4
37	Arizona	6.2
37	New Hampshire	6.2
39	Idaho	6.0
40	Vermont	5.9
41	New Mexico	5.8
41	South Carolina	5.8
41	Wyoming	5.8
44	California	5.7
44	Oregon	5.7
44	Washington	5.7
47	Georgia	5.6
47	Virginia	5.6
49	Colorado	5.5
50	Nevada	5.0
51	Alaska	4.9
NR	Guam	NA
NR	Puerto Rico	NA
NR	Virgin Islands	NA
NR	Residence Unknown	NA

Notes: Health care employment includes the following occupations from the Bureau of Labor Statistics' Standard Occupational Classification System: Medical and Health Services Managers (11-9111), Healthcare Practitioners and Technical Occupations (29-0000), and Healthcare Support Occupations (31-0000).

Sources: Health care employment from Bureau of Labor Statistics, State Occupational Employment and Wage Estimates at http://stats.bls.gov/oeshome.htm .
Total employment from Bureau of Labor Statistics, State and Regional Unemployment, 2000 Annual Averages, at ftp://ftp.bls.gov/pub/news.release/srgune.txt .

THE HENRY J. KAISER FAMILY FOUNDATION

STATE HEALTH FACTS *Online*

http://statehealthfa

Your source for state he

Rate of Nonfederal Physicians per 100,000 Civilian Population, 1999

- ☐ Less than 225
- ☐ 225 to 255
- ☐ 256 to 282
- ■ More than 282
- ☐ No data available/NSD

Rate of Nonfederal Physicians per 100,000 Civilian Population, 1999

Sort by: Rank ▼

Rate of Nonfederal Physicians per 100,000 Civilian Population, 1999		
Rank	**State**	**#**
	United States	285
1	District of Columbia	811
2	Massachusetts	454
3	New York	423

4	Maryland	413
5	Connecticut	397
6	Rhode Island	372
7	Vermont	362
8	New Jersey	327
9	Pennsylvania	321
10	Hawaii	306
11	Florida	290
12	Illinois	287
13	Minnesota	282
14	California	280
15	Colorado	274
16	New Hampshire	273
17	Washington	272
18	Louisiana	270
19	Tennessee	269
19	Virginia	269
21	Maine	268
22	Oregon	266
23	Delaware	264
24	North Carolina	262
25	Ohio	261
26	Wisconsin	256
27	Missouri	250
28	Michigan	249
29	Nebraska	247
30	North Dakota	246
31	New Mexico	243
32	Arizona	240
33	West Virginia	239
34	South Carolina	234
35	Kansas	232
35	Kentucky	232
37	Georgia	230
38	Montana	228
39	Utah	225
40	Texas	222
41	Indiana	219
42	Alabama	217
43	Arkansas	214
44	South Dakota	211
45	Iowa	200
46	Nevada	199
47	Wyoming	198
48	Oklahoma	187
49	Alaska	186
50	Mississippi	180
51	Idaho	179
NR	Guam	NA
NR	Puerto Rico	NA
NR	Virgin Islands	NA
NR	Residence Unknown	NA

Notes: Nonfederal physicians are employed in the private sector of the US physician population. They represent 98% of total physicians.
The US total excludes physicians and population in the possessions.

Sources: Physician Characteristics and Distribution in the US, 2001-2002 Edition, American Medical Association, copyright 2001, Table 5.20, p. 348.

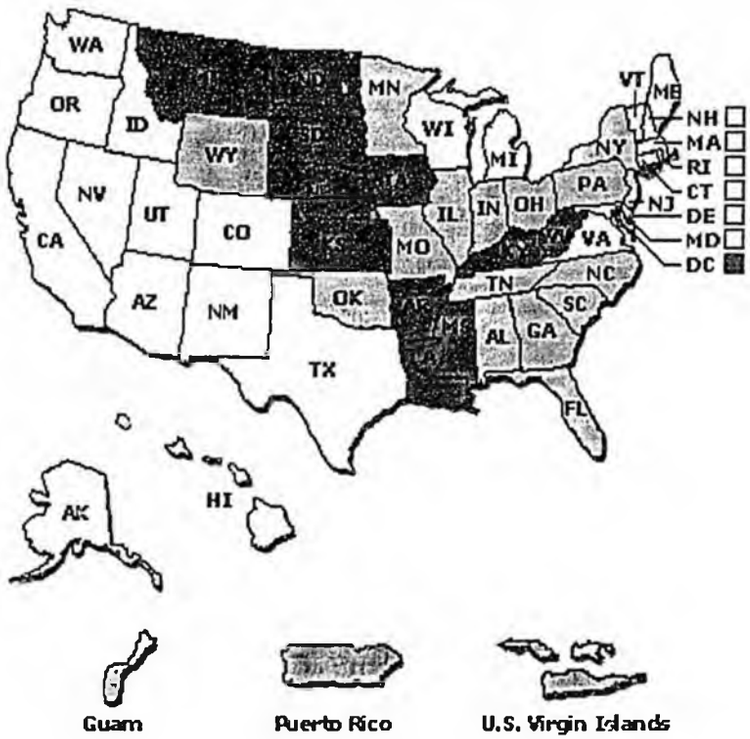
THE HENRY J. KAISER FAMILY FOUNDATION

STATE HEALTH FACTS *Online*

http://statehealthfa

Your source for state he

Hospital Beds per 1,000 Population, 1999



Guam

Puerto Rico

U.S. Virgin Islands

- ☐ Less than 2.4
- ☐ 2.4 to 2.9
- ☐ 3.0 to 3.8
- ■ More than 3.8
- ☑ No data available/NSD

Hospital Beds per 1,000 Population, 1999

Sort by: Rank ▼

Hospital Beds per 1,000 Population, 1999		
Rank	**State**	**#**
	United States	3.0
1	District of Columbia	6.9
2	North Dakota	6.4
3	South Dakota	6.2
4	Montana	5.2
5	Nebraska	5.0
6	Mississippi	4.8
7	West Virginia	4.6
8	Kansas	4.5
9	Iowa	4.2
10	Arkansas	4.0
11	Kentucky	3.9
11	Louisiana	3.9
13	Wyoming	3.8
14	Alabama	3.7
14	Missouri	3.7
14	New York	3.7
14	Pennsylvania	3.7
14	Tennessee	3.7
19	Minnesota	3.4
19	Oklahoma	3.4
21	Florida	3.3
21	Indiana	3.3
23	Georgia	3.2
24	Illinois	3.1
24	North Carolina	3.1
26	New Jersey	3.0
26	Ohio	3.0
26	South Carolina	3.0
29	Maine	2.9
29	Wisconsin	2.9
31	Idaho	2.8
31	Texas	2.8
31	Vermont	2.8
34	Delaware	2.6
34	Massachusetts	2.6
34	Michigan	2.6
37	Virginia	2.5
38	Connecticut	2.4
38	Hawaii	2.4
38	New Hampshire	2.4
38	Rhode Island	2.4
42	Maryland	2.3
43	Arizona	2.2
43	California	2.2
43	Colorado	2.2
46	Alaska	2.0
46	Washington	2.0
48	Nevada	1.9
48	New Mexico	1.9
48	Oregon	1.9
48	Utah	1.9
NR	Guam	NA
NR	Puerto Rico	NA
NR	Virgin Islands	NA
NR	Residence Unknown	NA

Sources: 1999 AHA Annual Survey, Copyright 2001 by Health Forum LLC, an affiliate of the American Hospital Association. Link to Health Forum: http://www.aha.org .

State of Alaska
Certificate of Need
Application Packet

Tony Knowles
Governor

Jay Livey
Commissioner

TABLE OF CONTENTS

CERTIFICATE OF NEED APPLICATION PACKAGE

Table of Contents, continued

Reprinted July, 1993

STATE OF ALASKA

Application Form
for
CERTIFICATE OF NEED

INSTRUCTIONS

This packet includes forms for your use in preparing a Certificate of Need (CON) application. Excerpts from Alaska's statutes and regulations that relate to Certificate of Need are also included for your information. The statutes and regulations cover which projects are subject to Certificate of Need and detail the CON application process. Also included is a regulation limiting certain Medicaid rates to the amounts stated in the CON application. Please review these instructions, the forms, and the statutes and regulations carefully before preparing your application.

- Please type all of your responses. Number responses to correspond to the questions.
- Answer all of the questions that apply to your proposed project. Indicate when and why an item of requested information does not apply.
- Please attach and identify any schedules or continuation sheets necessary to complete sections of the form.
- The criteria that are on the page following these instructions will be used in the review of your application. You will note that the requested application information closely follows these criteria. Well written, complete answers will facilitate review of your application.
- Please list the sources of any factual data or information included in your application (e.g. population projections). If the sources are not commonly available, providing a copy of the source information in an appendix will help the reviewers. The reviewers may request copies of sources (articles, statistics, population tables, etc.) if they are not provided.
- Please assure that information, numbers, etc. that are presented more than once in the application match each other. A final overall review of the application before submittal should reveal inconsistencies, if any.
- If this is an application for modification of an existing Certificate of Need project (7 AAC 07.095), contact the State Health Planning and Development Agency to determine the extent of information necessary in the application. This will depend on the nature and amount of variance from the approved project. An application for modification uses the cover sheet found later in this package with the regular application forms attached as necessary.

Please submit eight copies of your application to the State Health Planning and Development Agency at the address listed below. One copy must have an original signature on the Certification of Accuracy. In addition, retain one copy of the application for public inspection at the applicant's place of business; the availability of this copy will be announced in public notices after the application is declared complete.

Within 20 days after receipt of your application, we will advise you if the application is complete, or request additional information. Technical assistance and additional information may be obtained from the state agency.

State Health Planning And Development Agency
Planning Section
Division of Administrative Services
Department of Health and Social Services
P. O. Box 110650
Juneau, Alaska 99811-0650
(907) 465-3015

Certificate of Need Review Criteria

(1) The relationship of the health services being reviewed to the applicable health systems plan and annual implementation plan adopted pursuant to section 1513(b) (2) and (3), respectively, of the Act.

(2) The relationship of services reviewed to the long-range development plan (if any) of the person providing or proposing such services.

(3) (i) The need that the population served or to be served has for the services proposed to be offered or expanded, and the extent to which low income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups are likely to have access to those services.

(ii) In the case of a reduction or elimination of a service, including the relocation of a facility or a service, the need that the population that is presently served has for the service, the extent to which that need will be met adequately by the proposed relocation or by alternative arrangement, and the effect of the reduction, elimination or relocation of the service on the ability of low income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups to obtain needed health care.

(4) The availability of less costly or more effective alternative methods of providing the services to be offered, expanded, reduced, relocated or eliminated.

(5) The immediate and long-term financial feasibility of the proposal, as well as the probable impact of the proposal on the costs of and charges for providing health services by the person proposing the new institutional health services.

(6) The relationship of the services proposed to be provided to the existing health care system of the area in which such services are proposed to be provided.

(7) The availability of resources (including health manpower, management personnel, and funds for capital and operating needs) for the provision of the services proposed to be provided and the availability of alternative uses of such resources for the provision of other health services.

(8) The relationship, including the organizational relationship, of the health services proposed to be provided to ancillary or support services.

(9) Special needs and circumstances of those entities which provide a substantial portion of their services or resources or both, to individuals not residing in the health service areas in which the entities are located or in adjacent health services areas. Such entities may include medical and other health professional schools, multidisciplinary clinics and specialty centers.

(10) The special needs and circumstances of Health Maintenance Organizations for which assistance may be provided under Title XIII of the Social Security Act. Such needs and circumstances shall be limited to:

(i) The needs of enrolled members and reasonably anticipated new members of the HMO or proposed HMO for the new institutional health services proposed to be provided by the organization.

(ii) The availability of the new health services from non-HMO providers or other HMO's in a reasonable and cost-effective manner which is consistent with the basic method of operation of the HMO or proposed HMO. In assessing the availability of these health services from these providers, the agency shall consider only whether the services from these providers:

(A) Would be available under a contract of at least five years duration;
(B) Would be available and conveniently accessible through physicians and other health professionals associated with the HMO (For example - whether physicians associated with the HMO have or will have full staff privileges at a non-HMO hospital);
(C) Would cost no more than if the services were provided by the HMO or proposed HMO; and
(D) Would be available in a manner which is administratively feasible to the HMO or proposed HMO.

(iii) Any other factors that the State Agency may propose and the Secretary may, in accordance with paragraph (c) of this section, find to be consistent with the purpose of Title XIII of the Act.

(11) The special needs and circumstances of biometrical and behavioral research projects which are designed to meet a national need and for which local conditions offer special advantages.

(12) In the case of a construction project -

(i) The costs and methods of the proposed construction, including the costs and methods of energy provision, and

(ii) The probable impact of the construction project reviewed on the costs of providing health services by the person proposing such construction project.

(13) The contribution of the proposed new institutional health service in meeting the health related needs of members of medically underserved groups which have traditionally experienced difficulties in obtaining equal access to health services (for example, low income persons, racial and ethnic minorities, women, and handicapped persons), particularly those needs identified in the applicable health systems plan and annual implementation plan as deserving of priority.

(14) The special circumstances of health care facilities and HMO's with respect to the need for conserving energy.

STATE OF ALASKA

CERTIFICATE OF NEED APPLICATION FORM

SECTION I: GENERAL APPLICANT INFORMATION

Facility Name_____

Street Address_____

City, State_____ Zip_____

Applicant Name_____

Applicant Address (if different)_____

_____

Facility Administrator_____ Phone_____

Medicaid Provider #_____ Medicare Provider #_____

PERSON AUTHORIZED TO ANSWER QUESTIONS, ACT
AND RECEIVE SERVICE ON BEHALF OF THE APPLICANT
(if other than the facility administrator)

Name_____ Phone_____

Title_____ Firm_____

Address_____

City, State_____ Zip_____

CERTIFICATION OF ACCURACY

I certify that the information contained in this application, including all documents which form a part of it, is true, to the best of my knowledge and belief.

Name_____

Title_____

Signature_____ Date_____

Name & Address of Facility Owner_____

_____

_____

_____

Facility Owner Type

___For profit: individual
___For profit: partnership
___For profit: corporation
___Not for Profit: government
___Not for profit: corporation
___Other:_____

Name & Address of Organization Which Operates the Facility (if different from above):

_____

_____

_____

_____

In an attachment to this page, please provide the following information:

For individual owners and partnerships, list the names, titles, and addresses of the owner or partners.

For corporations, list the names, titles, and addresses of the corporate officers and Board of Directors.

For governmental owners, list the names and addresses of hospital board members.

DESCRIPTION OF PROJECT

Please provide a brief summary description of the project proposed by this application (i.e., new construction, addition, or renovation: number of beds involved or major equipment to be purchased*; estimated total cost):

*Note: If building modifications are needed to accommodate new equipment, describe the necessary modifications.

SECTION II-DESCRIPTIVE DATA ON FACILITIES AND SERVICES

A. Proposed changes in bed capacity, by service.

SERVICES	NUMBER OF BEDS Currently Licensed	To Be Added Or Deleted	Proposed Total
Acute Care			
Med/Surg			
ICU/CCU			
Obstetrics			
Psychiatric			
Pediatric			
Other (list):			
Long Term Care			
ICF			
SNF			
ICF-MR			
OTHER (list):			
TOTAL-ALL BEDS			

B. Distribution of beds, by unit size.

	NUMBER OF ROOMS OR UNITS		
Room or Unit Size	Existing	To Be Added Or Deleted	Total Proposed
1 bed/unit 2 beds/unit 3 beds/unit 4 beds/unit Other:			

C. Provide a short history of the facility and describe any changes that have occurred during the past five years in the number of beds or services offered.

D. Provide a narrative description of the services or equipment to be provided by this proposal. Include, as appropriate, all general services shown in "A" above; all ancillary services such as emergency, laboratory, pharmacy, physical therapy, radiology, dietary, etc.; all specialized services such as renal dialysis, nuclear medicine, open heart surgery, etc.

For those services which are to be added, expanded, or deleted, please include information relative to the scope and level of service as part of the narrative. Historical and projected future utilization, revenue, and expense data for EACH SERVICE that is identified for change must be provided in Sections IV (utilization) and VII (financial data).

FOR PROJECT OR WHOLE FACILITY

SECTION III: STAFFING REQUIREMENTS

A. MEDICAL STAFF - Specify number of medical staff by specialty.

	PROPOSED STAFF		EXISTING STAFF	
Specialty	Employed	Active or Contract	Employed	Active or Contract
Anesthesiology Family Practice Gerontology Internal Medicine Neurology Nuclear Medicine Neurosurgery OB/Gyn Opthalmology Oral Surgery Orthopedics Otolaryngology Pathology Pediatrics Psychiatry Radiology -Diagnosis -Therapy Surgery Urology Other (list)				
TOTAL				

B. HEALTH CARE FACILITY PERSONNEL - Specify number of personnel by category (express as full-time equivalents).

CATEGORY	EXISTING NUMBER OF FTE's	NO. TO BE ADDED OR (DELETED)	TOTAL PROPOSED
Registered Nurses LPNs/LVNs Aides & Orderlies Occ./Rec. Therapists Physical Therapists Inhalation Therapists Laboratory Tech. X-ray Technicians Pharmacists Dieticians Social Workers Discharge Planners Medical Records Clerical Support Accounting Executives/Admin. Maintenance/Housekpg. Engineers Other Personnel --including food service, laundry, etc.			
TOTAL			

C. Discuss any manpower training programs provided or proposed by the applicant that relate to the proposed project by retraining existing staff for the new project or by training new staff.

SECTION IV - NARRATIVE REVIEW QUESTIONS

A. RELATIONSHIP TO APPLICABLE PLANS

Indicate how the application fits in with relevant plans, including the applicant's long range plan, the State Health Plan, appropriate local or regional plans, and current planning guidelines of recognized medical and health care groups. If the proposal is at variance with any of these plans and guidelines, please explain why.

B. DEMONSTRATION OF NEED

1. Identify the problems being addressed by the project. For example, identify whether this project is for: (1) a new service; (2) an expanded or reduced service; or (3) an upgraded service. Also, describe whether (and how) this project (1) addresses an unmet community need; (2) satisfies an increasing demand for services; or (3) corrects an internal deficiency of the facility. Document all deficiencies noted by the regulatory authorities listed as follows, even if they are not to be corrected by the proposed project. Pertinent authorities include the state health facility licensing authority, the Medicaid/Medicare certification authority, the state and/or local fire marshal, the local building inspection official, and the state health facility construction licensing authority; any other regulatory authority whose citation of deficiency affects the project or the implementation of the proposed services also must be reported. Note what efforts have been taken to correct the deficiencies, and (if appropriate) how this project will affect the deficiencies. Attach as an appendix the inspection reports or other documentation of these deficiencies.

2. Identify the defined population to be served by this project. The "defined population" is the population that is or may reasonably be expected to be served by a health care facility. The population can be defined in one or more ways:

   (a) A geographical service area can be documented for an existing health care facility or service by means of a patient origin analysis. Even if a formal patient origin analysis is not available, the applicant should specify and justify the customary geographical area served by the facility. This is the "service area" referenced in questions that follow.

   (b) U.S. census data and supplemental information from the State Demographer, Alaska Dept. of Labor, can be used to describe population trends, age/sex breakdowns and other characteristics pertinent to the rationale for need.

   (c) The population to be served can be defined according to the unique needs of patients requiring specialized or tertiary care (e.g. heart, cancer, kidney, alcoholism, etc.) or the needs of underserved groups.

Indicate the source information and methodology used to determine the population

(existing and projected into the future). Explain projected growth trends or demographic changes.

3. Describe the anticipated utilization of the services on which the project is based and the method by which this projection was derived. This should include evidence of the number of persons from the defined population now using and who will continue to use the service, or evidence of the number of persons who will begin to use services which are not now available, accessible, or acceptable to the defined population. Utilization and demand trends for at least the past three years should be reported for an existing facility. If an increase in utilization is projected, list the factors which will affect the increase. If the project is an acquisition of a new piece of major equipment, provide utilization information for similar existing equipment or older technology. Indicate whether similar existing equipment will continue to be used, and the project's effect on its utilization.

   Provide yearly statistics for the three prior years (for existing services) and three years projected after the completion of the project for the facility as a whole and, if the proposal is affecting specific services, for each service to be affected by the proposal:

   a) admissions or discharges
   b) patient days
   c) average length of stay
   d) percent occupancy
   e) average daily census
   f) number of licensed beds
   g) number of beds set up

4. In the case where certain services will be reduced, indicate how the proposed reduction meets the need of the service area and how the reduction will affect access to the service.

5. Provide any other information that may be pertinent to establishing the need for this project.

6. Attach letters of support from local and regional agencies, other health care facilities, individuals, governmental bodies, etc.

C. AVAILABILITY OF LESS COSTLY OR MORE EFFECTIVE ALTERNATIVES

1. Please review alternative methods of providing the services to be offered, expanded, reduced, relocated, or eliminated. Explain why the proposal contained in this application was selected in preference to these alternatives.

   Explain the relevancy of the proposal in relation to changing trends in service delivery and community health service needs of the foreseeable future.

D. RELATIONSHIP TO EXISTING HEALTH CARE SYSTEM AND TO ANCILLARY OR SUPPORT SERVICES

1. Identify any existing comparable services within the service area or, if located outside the service area, those services usually utilized by the defined population. Describe any special factors affecting utilization, including accessibility and acceptability. Describe any significant differences from existing services in the service area.

2. State how the proposal will affect the pattern and scope of health services available in the region. Explain whether or not each proposed service will: (1) complement existing services; (2) provide a service unique to the area; (3) provide a service for a defined population; and (4) provide services for which there is an unmet need (if so, identify those factors of need which are unmet). Describe the probable effect on other community resources, including the anticipated impact on other facilities offering the same or similar services in the area.

3. Identify existing working relationships with hospitals, nursing homes, and other resources serving the defined population and the service area. The discussion can include cooperative planning activities, sharing of services (i.e. agreements assigning services such as emergency or obstetrics) and transfer agreements. If other organizations provide ancillary or support services to your facility, describe the relationship. Attach copies of relevant agreements in the appendix to the application.

E. AVAILABILITY OF RESOURCES

1. Comment on any proposed changes in medical staff or other facility personnel, especially with respect to the recruiting and retaining of adequate staff (cross reference with Section III A & B). How will recruitment of staff for your project affect other health facilities in the service area? If the project involves acquisition of new diagnostic/therapeutic technology, describe how existing personnel will be trained to use it and/or how trained staff will be recruited; describe the volume of procedures necessary to assure proficiency with the equipment and how this volume will be reached/maintained.

2. Are necessary ancillary and support services available in the service area? (Cross-reference to information in Section IV D(3) above.)

F. ACCESS TO SERVICE BY THE GENERAL POPULATION AND UNDERSERVED GROUPS

1. Provide information on needs of and access to service by medically underserved groups of people, for example, low income persons, racial and ethnic minorities, women, handicapped persons. Discuss any plans to overcome language and cultural barriers of groups to be served.

2. Indicate the amount of charity care provided in the last three years (by year) and projections of charity care when the project is completed.

3. Address the following:

   a) transportation and travel time to the facility
   b) special architectural provisions for the handicapped and aged
   c) service hours of operation
   d) the institution's policies for non-discrimination in patient services

G. ARE THERE ANY SPECIAL NEEDS AND CIRCUMSTANCES?

These may be related to special training or research programs or facilities, Health Maintenance Organizations (HMOs), or other special needs. Describe any special needs and circumstances.

SECTION V - CONSIDERATION OF QUALITY, EFFECTIVENESS, EFFICIENCY AND BENEFITS OF THE APPLICANT'S SERVICES.

Discuss in narrative form, the following:

1. The Applicant's accreditation and licensure status, indicating source; date; length; etc. and information relative to certification for Medicare.

2. How the Applicant plans to conduct quality control programs to insure high quality service;

3. Plans for optimum utilization and appropriate ratios of professional, subprofessional and ancillary personnel;

4. Development of ambulatory care, home health services, and preventive health care programs to eliminate or reduce inappropriate use of in-patient services;

5. Planned use of modern diagnostic and treatment devices to enhance the accuracy and reliability of diagnostic and treatment procedures;

6. Employment of labor-saving equipment and programs to provide operating economies;

7. What are your plans for future evaluation of the proposed activity to ensure that it fulfills present expectations and benefits?

8. Describe your facility organizational structure including major position qualification requirements.

9. Describe your board representation including representation from community economic and ethnic groups.

SECTION VI - CONSTRUCTION DATA

A. Project description

1. Construction type ☐ New ☐ Expansion ☐ Renovation
2. Basement ☐ Full ☐ Part ☐ None
3. Heating System ☐ Water ☐ Steam ☐ Air ☐ Use Existing
4. Air Conditioning ☐ Full ☐ Part ☐ None ☐ Use Existing

Description of heating/air conditioning system

_____

_____

5. Structural framing

_____

_____

6. Floor system

_____

_____

7. Facility size

_____

_____

8. No. of floors (including basement)

_____

9. No. of proposed beds (if applicable) _____
10. Area per bed (if applicable) _____ sq. ft.
11. Gross floor area _____ sq ft.
12. Percent of total floor area used for direct service (non-bed projects) _____
13. Area per volume of service* (non-bed projects) _____ sq. ft. per _____

*This is a productivity measure--how productive will the space be? Specify the service measure used. E.g., a 1000 sq. ft. lab addition with 200 additional lab tests expected per year would yield 5 sq. ft. per lab test.

B. Project development schedule

	Date
1. Estimated completion of final drawings and specifications	_____
2. Estimated project construction begin by	_____
3. Estimated project construction complete by	_____
4. Estimated implementation of proposed services	_____

C. Facility site data

Provide the following, as attachments (referenced by the subsection and item number):

1. Architectural master plan to include long-range concept and development of total facility.

2. Schematic floor plan drawings (or conceptual drawings) of proposed facility, delineating various facility functions.

3. Diagrammatic plan showing:

   a. Dimensions and location of structure(s), easements, rights-of-way or encroachments;

   b. Location of all utility services available to the site;

   c. Service roads, parking facilities and walkways within site boundaries.

4. Legal description and area of the proposed site. Is the site now owned by the facility? If not, how secure are the arrangements to acquire the site?

5. Documented clearances regarding zone restrictions, fire protection, sewage and other waste disposal arrangements (under special circumstances, in lieu of the documented clearances, it may be acceptable to present evidence of conditional approvals from city councils, borough governments, and regulatory agencies).

D. Describe the plan for accomplishing construction and the effect construction activities will have on existing services.

SECTION VII - FINANCIAL DATA - RELATIVE ACQUISITIONS

Acquisition type:

1. ☐ Lease ☐ Rent ☐ Donation ☐ Purchase
   ☐ Purchase of business only (not the facility)

Cost data: Omit Cents

1. Total acquisition cost* $_____
2. Amount to be financed $_____
3. Difference between items B-1 and B-2 (list, and document as Schedule I, available resources to be used, e.g. available cash, investments, grants, community funds, real estate exchanges, etc.) $_____

4. Anticipated interest rate _____ %, term _____ years.

5. Anticipated interest amount $_____
6. Total B-1 and B-5 $_____
7. Estimated annual debt service requirements $_____

* Acquisition costs must include (as appropriate):
   a. Total purchase price of land and improvements (if donated, estimated value)
   b. "Goodwill" or "purchase of business" costs
   c. Lease amount (annual lease amount x term of lease)
   d. Consultant or brokers fees paid by person acquiring the facility
   e. Other pre-development costs to date.

Site acquisition should be stated as "book" value, i.e. actual purchase price plus costs of development. If desired, applicant may elect to state as "fair market value," in which case, give reason and basis.

SECTION VII - FINANCIAL DATA - CONSTRUCTION ONLY

A. Construction Method

1. ☐ Conventional bid ☐ Contract management ☐ Design and build
2. ☐ Phased
3. ☐ Single project
4. ☐ Fast Track

B. Construction Cost	Omit Cents
1. Site acquisition*	$_____
2. Estimated general construction	$_____
3. Fixed equipment, not included in B-2	$_____
4. Total construction costs (sum of items 1, 2, and 3)	$_____
5. Major movable equipment	$_____
6. Other cost:	
a. Administration expense	$_____
b. Site Survey, Soils Investigation and Materials testing	$_____
c. Architects and Engineering fees	$_____
d. Other consultation fees (preparation of CON application included)	$_____
e. Legal Fees	$_____
f. Land development and landscaping	$_____
g. Building permits and utility assessments (including water, sewer, electrical, phones, etc.)	$_____

*Site acquisition should be stated as "book" value, i.e., actual purchase price (or estimate of value if donated) plus costs of development. If desired, applicant may elect to state as "fair market value," in which case, so indicate.

h. Additional project inspection fees (clerk of the works)	$_____
i. Project contingency fund	$_____

j. Insurance (required during construction period) $_____

7. **Total project cost (sum of items 4, 5, 6)** $_____

8. Amount to be financed $_____

9. Difference between B-7 and B-8 (list, as Schedule I, available resources to be used, e.g., available cash, investments, grants funds, community contributions, etc.) $_____

10. Anticipated long-term interest rate_____%

11. Anticipated interim (construction) interest rate _____%

12. Anticipated long-term interest amount $_____

13. Anticipated interim interest amount $_____

14. **Total items 7, 12, and 13** $_____

15. Estimated annual debt service requirement $_____

16. Construction cost per sq. ft. $_____

17. Construction cost per bed $_____

18. Project cost per sq. ft. $_____

19. Project cost per bed $_____

Note: Items B-1 through B-6 are to be certified estimates (where appropriate)

SECTION VIII - FINANCIAL DATA - ALL PROPOSED ACTIVITIES

Note: For each of the schedules below, provide a narrative explanation if there are any significant trends or large changes in any item or group of items from year to year. Indicate whether you are using a calendar year or other fiscal year period.

A. Attach Schedule II - Facility Income Statements (see form following this section)
   1. For most recent 3 prior full fiscal or calendar years
   2. Projections during construction or implementation period (if applicable)
   3. Projection for 3 years following completion of construction, or implementation of proposed activity.

B. Attach Schedule III - Facility Balance Sheet (see form following this section)
   1. For most recent 3 prior fiscal or calendar years.
   2. Current fiscal or calendar year to date

C. Attach Schedule IV - Average per diem patient cost and revenue amounts and (for facilities with a per diem rate) the per diem rate
   1. For most recent 3 prior full fiscal or calendar years
   2. Current fiscal or calendar year to date
   3. Projection for 3 years following completion of construction or implementation.

D. Attach Schedule V - Current and projected (2 years beyond completion) line item capital and operating budgets for the proposed activity. What alternative plans have been made should deficits occur?

E. Attach Schedule VI - A debt service cash flow schedule over the life of the debt, if applicable, for all long term debt of the facility. Identify each debt, including any for the proposed activity, and break out interest, principal and other.

F. Attach as Schedule VII the form following showing reimbursement sources for the facility for the previous three full years and projected for 3 years after implementation.

G. Attach as Schedule VIII the form following showing a depreciation schedule for all items acquired through the proposed project. Note that the straight-line method must be used. Indicate on the depreciation schedule or separately which major movable equipment is being purchased for the project (reference page 17, item B5.)

* Note: Information for item C-1 may be obtained on total patient load, directly from your respective years' Medicare Cost Reports.

SCHEDULE II

FACILITY INCOME STATEMENT
For Latest 3 Years and Projections
Through 3 Years Beyond Project Completion

Revenue & Expense Categories	19	19	19
REVENUE:			
Revenue From Patients			
Inpatient			
Outpatient			
Resident (LTC)			
Total Patient Revenue			
Less Deductions			
Charity Care			
Contractual Allowances			
Bad Debts			
Total Deductions			
Net Operating Revenues			
All Other Revenues			
EXPENSES:			
Salaries			
Benefits			
Supplies			
Utilities			
Property Tax			
Rent			
Lease			
Other Expenses			
Depreciation			
Interest			
Total Expenses			
Excess (Shortage) of Revenue Over Expenditures			

NOTE: Use one copy of this form for the previous three years, another for construction or development period, and another for projected three years beyond implementation.

SCHEDULE III

FACILITY BALANCE SHEET

	FY___	FY___	FY___	Current FY___ To Date
ASSETS				
Current Assets				
Net Patient Accts. Rec.				
Accts. Rec.-Other				
Inventories				
Prepaid Expenses				
Other				
Total Current Assets				
Property & Equipment				
Land & Improvements				
Building/Fixed Equip.				
Major Movable Equip.				
Accumulated Deprec.				
Net Property & Equipment				
Other Assets				
TOTAL ASSETS				
LIABILITIES/FUND BALANCE				
Current Liabilities				
Accts. Payable				
Accrued Expenses				
Accrued Compensation				
Other Accruals				
Total Current Liabilities				
Long Term Liabilities				
Long Term Debt				
Other				
Total Long Term Liabilities				
Fund Balance				
TOTAL LIABILITIES & FUND BALANCE				

SCHEDULE VII

REIMBURSEMENT SOURCES
3 Previous Years and 3 Years Projected

FY____

Reimbursement Service	Number of Patients	Gross Patient Charges		Deductions		Net Patient Revenues
Medicare			-		=	
Medicaid			-		=	
Private Insurance			-		=	
Charity			-		=	
Self Pay			-		=	
Other			-		=	
TOTAL			-		=	

NOTE: Duplicate this form for use in showing revenue sources for each of the last three years and for three projected years. Indicate in the top left corner of each form the applicable fiscal year.

SCHEDULE VIII

Depreciation Schedule
For All Items Acquired Through Proposed Project

(USE STRAIGHT LINE METHOD ONLY)

General Identifier	Year It Will Enter Svc.	Useful Life	Cost	Years Depreciation

COVER PAGE

APPLICATION

FOR MODIFICATION OF

A CERTIFICATE OF NEED

COVER PAGE
APPLICATION
FOR MODIFICATION OF
A CERTIFICATE OF NEED

STATE OF ALASKA

APPLICANT

Name of facility	City

If the owner, applicant organization, or contact person has changed since the Certificate of Need was issued, please provide the new name, title, and address as appropriate:

BASIS OF MODIFICATION APPLICATION

- ☐ Change in scope of authorized activity
- ☐ Change in cost of authorized activity
- ☐ Change in time schedule of authorized activity

****Attach completed CON application forms to this cover page.*****

CERTIFICATION:

I certify that the information contained in this application, including all documents which form a part of it, is true to the best of my knowledge and belief.

Applicant's signature: _____

Applicant's title: _____

Date: _____

PERIODIC PROGRESS REPORT

CERTIFICATE OF NEED ACTIVITY

PERIODIC PROGRESS REPORT

Name & Address of Applicant: _____

_____

_____

_____

Project Description: _____

Date CON Issued: _____

Approved Cost: _____

All applicants who have been granted a Certificate of Need (CON) are required to submit periodic reports until the project has been completed (7 AAC 07.105(a)). These reports should be submitted every six months following the issuance of a CON and upon completion of the project.

Please respond to the following questions. If the question is not applicable, please state why.

1. **Is the project fully obligated?*** If not, explain. If yes, indicate the nature and date of all obligations incurred to date. If the project is not fully obligated, indicate the cost and date those obligations will be incurred.

* An obligation is defined as an enforceable contract for acquisition, construction, or lease of a capital asset; or, in the case of donated property, the date on which the gift is completed in accordance with applicable state law.

2. **What are all of expenditures** by category (e.g., land fees, construction, etc.) made to date on the project?

3. **What is the anticipated completion date** (operational date)? How does this differ from the project schedule submitted in the CON application? Please explain any significant **differences** in the schedules. How will future milestones in the schedule be affected?

4. In the case of construction projects, has the construction started and what has been completed to date (e.g., footings, foundations, etc.)?
What percentage of total construction is complete?

5. Are construction/project activities progressing in conformance with the scope of the project approved by the Commissioner? Explain any variations (e.g.,in size or type of construction).

6. Is the projected final project cost currently **within the limits** approved by the Commissioner? If the project is complete, please submit a **final capital budget.**

7. Are there any **changes in the services or programs** from those which were originally proposed and approved? If so, please indicate those changes.

I hereby certify that the statements made in this report are correct to the best of my knowledge and belief.

Signature of Responsible Officer: _____

Title: _____

Telephone: _____

Date: _____

Send to:

State Health Planning and Development Agency
Planning Section
Division of Administrative Services, DHSS
P. O. Box 110650
Juneau, Alaska 99811-0650

ALASKA STATUTES

AS 18.07.011 - .111

Certificate of Need Law - AS 18.07.010 - .111

Sec. 18.07.010. [Repealed, Sec. 1 ch 275 SLA 1976]. Repealed or Renumbered

Sec. 18.07.011. Statewide Health Coordinating Council. [Repealed, Sec. 21 ch 6 SLA 1993]. Repealed or Renumbered

Sec. 18.07.020. [Repealed, Sec. 1 ch 275 SLA 1976]. Repealed or Renumbered

Sec. 18.07.021. Administration.

The department shall administer the certificate of need program under this chapter and perform other functions prescribed in this chapter.

Sec. 18.07.030. [Repealed, Sec. 1 ch 275 SLA 1976]. Repealed or Renumbered

Sec. 18.07.031. Certificate of need required; relocations.

(a) Except as provided in (c) of this section, a person may not make an expenditure of $1,000,000 or more for any of the following unless authorized under the terms of a certificate of need issued by the department:

(1) construction of a health care facility;

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

(3) addition of a category of health services provided by a health care facility.

(b) Notwithstanding the expenditure threshold in (a) of this section, a person may not convert a building or part of a building to a nursing home that requires licensure under AS 18.20.020 unless authorized under the terms of a certificate of need issued by the department.

(c) Notwithstanding (a) of this section, a person who is lawfully operating a health care facility that is an ambulatory surgical facility at a site may make an expenditure of any amount in order to relocate the services of that facility to a new site in the same community without obtaining a certificate of need as long as neither the bed capacity

nor the number of categories of health services provided at the new site is greater. However, notwithstanding the expenditure threshold in (a) of this section, a person may not use the site from which the health care facility relocated for another health care facility unless authorized under a certificate of need issued by the department.

Sec. 18.07.035. Application and fees.

Application for a certificate of need shall be made to the department upon a form provided by the department and must contain the information the department requires to reach a decision under this chapter. Each application for a certificate of need must be accompanied by an application fee established by the department by regulation.

Sec. 18.07.040. [Repealed, Sec. 1 ch 275 SLA 1976]. Repealed or Renumbered

Sec. 18.07.041. Standard of review for applications for certificates of need relating to non-nursing home beds and services.

The department shall grant a sponsor a certificate of need or modify a certificate of need that authorizes beds other than nursing home beds or that is for a health care facility other than a nursing home 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 citizens of this state.

Sec. 18.07.043. Standard of review for applications for certificates of need relating to nursing homes and nursing home beds.

(a) The department shall develop review standards for an application for a certificate of need, or for a modification of a certificate of need, issued under this chapter for a health care facility that is a nursing home or has nursing home beds.

(b) In developing the review standards under (a) of this section, the department shall consider whether

(1) a public process and existing appropriate statewide, regional, and local plans were included in planning and designing the additional nursing home beds or the health care facility;

(2) the additional nursing home beds or the health care facility meets minimum required use rates for new nursing beds, and the effect on use rates for existing nursing home beds;

(3) the additional nursing home beds or the health care facility demonstrates consideration of the community, regional, and statewide needs for new nursing home beds;

(4) the additional nursing home beds or the health care facility meets the minimum number of new nursing beds that should be required in a facility to ensure efficiency and economies of scale;

(5) the additional nursing home beds or the health care facility demonstrates the proposed service will provide a quality of care equivalent to existing community, regional, or statewide services;

(6) the additional nursing home beds or the health care facility demonstrates financial feasibility. including long-term viability, and what the financial effect will be on consumers and the state; and

(7) the sponsor has demonstrated cost effectiveness through considering the availability of appropriate, less costly alternatives of providing the services planned.

(c) The department shall grant a sponsor a certificate of need or modify a certificate of need that authorizes nursing home beds or that is for a health care facility that is a nursing home if the department finds that the sponsor meets the standards established in or under this chapter.

Sec. 18.07.050. [Repealed, Sec. 1 ch 275 SLA 1976]. Repealed or Renumbered

Sec. 18.07.051. Terms of issuance of the certificate.

Each certificate issued must specify terms of issuance describing the nature and extent of the activities authorized by the certificate.

Sec. 18.07.060. [Repealed, Sec. 1 ch 275 SLA 1976]. Repealed or Renumbered

Sec. 18.07.061. Modification and termination of activities.

The certificate holder shall apply to the department for a modification of the certificate before terminating part of the activities authorized by the terms of issuance, but the certificate holder is not required to obtain the acquiescence of the department before terminating all the activities authorized by the certificate. If a certificate holder terminates all of the activities authorized by a certificate, the certificate holder is required to notify the department 60 days before termination and to surrender the certificate to the department within 30 days of termination.

Sec. 18.07.070. [Repealed, Sec. 1 ch 275 SLA 1976] Repealed or Renumbered

Sec. 18.07.071. Temporary and emergency certificates.

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

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

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

(2) adverse effect to the public interest by reason of delay occasioned by compliance with the requirements of AS 18.07.041 , 18.07.043, and application procedures prescribed by regulations under this chapter.

(c) A temporary certificate granted under (b) of this section does not confer vested rights on behalf of the applicant. The department shall impose those special limitations

and restrictions concerning duration and right of extension that the department considers appropriate. A temporary certificate may not be granted for a period longer than necessary for the sponsor to obtain review of the action certified by the temporary certificate under AS 18.07.051 . Application for a certificate of need under AS 18.07.041 or 18.07.043 must commence within 60 days of the date of issuance of the temporary certificate.

Sec. 18.07.080. [Repealed, Sec. 1 ch 275 SLA 1976]. Repealed or Renumbered

Sec. 18.07.081. Proceedings for modification, suspension, and revocation.

(a) The department, a member of the public who is substantially affected by activities authorized by the certificate, or another applicant for a certificate of need may initiate a hearing to obtain modification, suspension, or revocation of an existing certificate of need by filing an accusation with the commissioner as prescribed under AS 44.62.360 . A revocation, modification, or suspension of an outstanding certificate may not be undertaken unless it is in accordance with AS 44.62.330 - 44.62.630.

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

(c) A certificate of need shall be suspended if an accusation is filed before the commencement of activities authorized under AS 18.07.041 or 18.07.043 that charges that factors upon which the certificate of need was issued have changed or new factors have been discovered that significantly alter the need for the activity authorized. A suspension of a certificate may not exceed 60 days. At the end of this period or sooner, the department shall revoke or reinstate the certificate.

(d) A certificate of need may be revoked if

(1) the sponsor has not shown continuing progress toward commencement of the activities authorized under AS 18.07.041 or 18.07.043 after six months of issuance;

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

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

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

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

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

(e) A person may not file an accusation seeking suspension or revocation of a certificate of need under this section, knowing that the charges stated in the accusation are untrue or that the charges do not constitute grounds for revocation or suspension under this chapter.

Sec. 18.07.090. [Repealed, Sec. 1 ch 275 SLA 1976]. Repealed or Renumbered

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

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

(b) A person who files an accusation seeking suspension or revocation of a certificate of need, knowing that the charges are untrue or that the charges do not constitute grounds for revocation or suspension under this chapter, is guilty of a misdemeanor and upon conviction is punishable by a fine of not more than $1,000. The

sponsor or holder of a certificate of need injured by the violation of AS 18.07.081 (e) may recover damages for loss incurred by reason of delay caused by a suspension.

Sec. 18.07.100. [Repealed, Sec. 1 ch 275 SLA 1976]. Repealed or Renumbered

Sec. 18.07.101. Regulations.

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

Sec. 18.07.111. Definitions. In this chapter,

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

(2) "certificate" means a certificate of need issued by the department under AS 18.07.041 , 18.07.043, or 18.07.071;

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

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

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

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

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

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

(A) an Alaska Pioneers' Home administered by the Department of Administration under AS 44.21.020 (09) and AS 47.55; and

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

(9) "nursing home bed" means a bed not used for acute care in which nursing care and related medical services are provided over a period of 24 hours a day to individuals admitted to the health care facility because of illness, disease, or physical infirmity.

ALASKA ADMINISTRATIVE CODE SUPPLEMENT

7 AAC 07.010 - .130

Chapter 07 Certificate of Need Regulations

Section

7 AAC 07.010. ACTIVITIES REQUIRING A CERTIFICATE OF NEED

(a) Under AS 18.07.031 , a certificate of need is required before any person undertakes any of the following activities:

(1) any capital expenditure for the excavation, erection, building, alteration, extension, reconstruction, improvement, repair, purchase, or other development of a health care facility, including lease or purchase of equipment, and including

(A) any donation or lease by any person to a health care facility for any of these purposes, in cash or fair market value; and

(B) the cost of any studies, surveys, designs, plans, working drawings, site acquisitions and preparation, and other activities essential to an activity stated in this paragraph;

(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 of a health care facility or redistributes beds among different categories of service; and

(3) any addition of a major type, program, unit, division, or department of care in or through a health care facility which has not been offered in or through the health care facility, or any elimination of a major type, program, unit, division, or department of care in or through a health care facility which has been offered in or through the health care facility.

(b) Upon request, and after the appropriate health systems agency has been provided an opportunity to comment on the request, a health care facility in existence or under construction before July 1, 1977 will be granted a certificate of need approving the continuous undertaking of those activities.

History: Eff. 10/26/77, Register 64; am 8/13/80, Register 75; am 8/8/90, Register 115; am 12/5/90, Register 116; am 5/19/91, Register 118

Authority: AS 18.07.031 AS 18.07.101

7 AAC 07.020. EMERGENCY AND TEMPORARY CERTIFICATES OF NEED

(a) The commissioner will grant or deny an emergency or temporary certificate of need as provided by AS 18.07.071 after a review of a sponsor's affidavit or, when in his discretion, he determines that it is necessary, after a formal hearing.

(b) Before the commissioner will take action under (a) of this section, each affidavit requesting an emergency or temporary certificate of need must be reviewed by the state agency under the criteria set forth by AS 18.07.071 , 42 C.F.R. 123.409 - 123.410 (adopted 4/2/79) and 42 C.F.R. 123.411 (adopted 1/21/77). The state agency shall promptly submit its findings and recommendation to the commissioner.

History: Eff. 10/26/77, Register 64; am 8/13/80, Register 75

Authority: AS 18.07.041 AS 18.07.071 AS 18.07.101 AS 44.17.010

7 AAC 07.030. LETTER OF INTENT

(a) Any person who intends to apply for a certificate of need shall mail a letter of intent not less than 60 days nor more than one year before the application for a certificate of need to the state agency and the appropriate health systems agency, except in the case of an application for an emergency or temporary certificate of need. The requirement of a letter of intent will, in the commissioner's discretion, be waived by the commissioner upon a showing of good cause by the applicant and after consideration of any written recommendation submitted by the appropriate health systems agency, except for applications which propose new construction.

(b) Each letter of intent must contain

(1) a clear, complete, and current description of the activity proposed to be undertaken;

(2) an estimate of the cost of the proposed activity; and

(3) an estimated starting date and completion date for the proposed activity.

(c) The state agency shall furnish written notification within 20 days after receipt of a letter of intent to the person submitting the letter of intent, stating whether the proposed activity is subject to AS 18.07 and the reasons for the determination. The state agency shall also forward the appropriate forms, information, and instructions necessary to make application.

(d) A preapplication conference before submission of an application between a prospective applicant and the state agency will be held upon request of the state agency or a prospective applicant who has been advised that a proposed activity is subject to AS 18.07. The purpose of the preapplication conference is to obtain guidance and technical assistance from the state agency. The state agency may not assist in the actual preparation or completion of the application, but shall make available all pertinent records, forecasts, plans, and other data to assist the applicant in preparing a full and accurate application. The appropriate health systems agency will be invited by the state agency to participate in the preapplication conference.

History: Eff. 10/26/77, Register 64; am 8/13/80, Register 75

Authority: AS 18.07.101

7 AAC 07.040. APPLICATION SUBMISSION

(a) Each application for a certificate of need must be made in writing to the state agency on forms provided by the state agency. The content of an application must be limited to:

(1) a timetable for completing the proposed activity;

(2) a listing of the total proposed amount of capital expenditures necessary to complete the proposal; and

(3) the information necessary for the state agency to determine whether the criteria applicable to the proposed activity as set out in AS 18.07, 42 C.F.R. 123.409 - 42 C.F.R. 123.410 (adopted 4/2/79) and 42 C.F.R. 123.411 (adopted 1/21/77) have been met.

(b) An applicant shall submit four copies of the application to the state agency and two copies to the appropriate health systems agency. The state agency shall provide one copy to the Alaska State Library in Juneau.

(c) An applicant may withdraw the application at any time during the review process by written notification to the state agency.

History: Eff. 10/26/77, Register 64; am 8/13/80, Register 75

Authority: AS 18.07.101

7 AAC 07.050. REVIEW FOR COMPLETENESS

(a) The state agency shall review each application received to determine if it is complete. Within 20 days after receipt of the application, the state agency shall

(1) notify the applicant by mail that the application has been accepted as complete; or

(2) request additional information as necessary to complete the application; the applicant will have 60 days to submit the requested information or the application will be denied; any application denied on the grounds of untimely submission of requested information may be resubmitted with the requested information and an explanation of why it was not timely filed; once the additional information is received by the state agency, and it determines that there was good cause for the late submission, if any, the state agency shall notify the applicant within 20 days that the application is complete; an applicant whose application is denied may submit a new application;

(b) Upon acceptance of an application as complete, the state agency shall provide reasonable written notification to the public, each health care facility located in the health service area, any person directly affected, and to each person on the state agency mailing list of:

(1) acceptance of the application;

(2) the proposed schedule for the review;

(3) the name of any health systems agency participating in the review;

(4) the period within which a person may request a public meeting according to sec. 60(e) of this chapter; and

(5) the manner of notification of the time and place of any public meeting or hearing to be held concerning the application, as provided in sec. 60(e).

(c) The state agency shall notify the public and persons directly affected of the information listed in (b) of this section by publication of a notice in two consecutive issues of at least one newspaper of general circulation in the state and one newspaper of general circulation in

the appropriate health service area. Other notifications required under this section must be sent by mail to the person's last known address.

History: Eff. 10/26/77, Register 64; am 8/13/80, Register 75

Authority: AS 18.07.101

7 AAC 07.060. REVIEW PROCESS

(a) In the commissioner's discretion, the agency shall defer commencement of the review process for a period not to exceed 60 days after the determination that the application is complete to enable the state agency and the appropriate health systems agency to receive and consider concurrently applications from each person who has submitted a letter of intent in accordance with sec. 30 of this chapter proposing an activity within the appropriate health service area which is similar to the activity proposed by the applicant.

(b) The state agency shall review the application and submit an analysis and recommendation to the commissioner within 90 days after the date the notice is sent to the applicant stating that the application is complete. The state agency shall make specific written findings regarding criteria set out in AS 18.07, 42 C.F.R. 123.409 - 123.410 (adopted 4/2/79) and 42 C.F.R. 123.411 (adopted 1/21/77) in formulating its recommendation.

(c) The appropriate health systems agency shall submit any findings and a recommendation to the commissioner, with copies to the state agency, to the applicant, and to others upon request, within 60 days after the date the notice is sent to the applicant stating that the application is complete. These findings and recommendations are subject to the same requirements as to content as the findings and recommendations submitted by the state agency to the commissioner under (b) of this section.

(d) In the commissioner's discretion, the review periods set in (b) and (c) of this section will be extended for not more than 30 days, for any of the following reasons:

(1) with the approval of the applicant, and upon demonstrating good cause for the request, the appropriate health systems agency requests an extension of time within which to make findings and recommendations; each health systems agency shall adopt criteria for determining when to request an extension;

(2) the applicant amends the application;

(3) the state agency requests an extension of time within which to prepare its findings and recommendations.

(e) Any person directly affected may request a public meeting by written request submitted to the state agency no later than 30 days after the last publication date of the last newspaper notice announcing review of the application. The state agency shall schedule such a meeting to be held during the review period, and shall give public notice of the meeting no less than 15 nor more than 30 days before the meeting. The notice must contain the name of the applicant, a brief statement of the subject matter to be considered, and the date, time, and place of the meeting. The applicant, person requesting the meeting,

appropriate health systems agency, and persons on the state agency mailing list must be notified by mail at their last known address. The public must be notified in accordance with sec. 50(c) of this chapter. The state agency may not and the commissioner will not impose fees for such a meeting. Public meetings conducted under this section must conform to 42 U.S.C. 300n-1(b)(12)(A).

(f) The state agency shall, upon written request, notify by mail any interested person of the status of the application, of any formal findings made during the course of the review, and of other reasonable information requested regarding the review.

(g) The state agency may delegate to the appropriate health systems agency the authority to conduct the public meeting under this section.

History: Eff. 10/26/77, Register 64; am 8/13/80, Register 75

Authority: AS 18.07.101

7 AAC 07.065. EXPEDITED REVIEW

(a) Any person planning to submit an application for a certificate of need may obtain a determination as to whether the proposed activity qualifies for an expedited review before the submission of the application, by making a written request to the state agency and submitting a copy of the request to the appropriate health systems agency. The state agency shall consult with the appropriate health systems agency and must receive its written agreement to an expedited review before an application may be given an expedited review. The state agency shall respond in writing to an applicant's written request for an expedited review within 20 days after the request is received.

(b) The request for an expedited review must be set out in a letter of intent as submitted under sec. 30 of this chapter and state the reason for requesting an expedited review.

(c) The following criteria will be followed to determine whether expedited review is appropriate:

(1) a request is for reissuance of a certificate of need;

(2) the proposed activity would replace existing equipment having the same basic purpose and scope and would not substantially increase the service volume capability or to advance substantially the technological capability of the health care facility;

(3) the request is for approval of a variance in scope, time schedule of completion, or cost of a previously certificated activity;

(4) the proposed activity is to comply with the requirements of a governmental agency;

(5) the variation in service is caused by the availability of professional health personnel.

(d) The expedited review process will not exceed 50 calendar days from the date on which the state agency determines, in accordance with sec. 50 of this chapter, that the application is complete. The appropriate health systems agency shall submit written findings and

recommendations to the state agency within 30 days after the beginning of the review process. The state agency shall complete its review and the commissioner will make a decision whether to issue a certificate of need within 20 days after receipt of the appropriate health systems agency review.

History: Eff. 8/13/80, Register 75

Authority: AS 18.07.071 AS 18.07.101

7 AAC 07.070. DECISION BY COMMISSIONER

(a) The decision of the commissioner to issue or deny a certificate of need will be in writing, stating the maximum capital expenditure which may be obligated for the proposed activity, the bed capacity, the type of service as set out in sec. 10 of this chapter, and the completion date. The following will be considered:

(1) the findings and recommendations of the state agency and the appropriate health systems agency;

(2) the record of any public meeting held in accordance with sec. 60(e) of this chapter;

(3) state and federal laws and regulations; and

(4) the current state health plan.

(b) The commissioner will mail a copy of the decision and findings to the applicant and will advise the applicant of the availability of a hearing under sec. 80 of this chapter.

(c) The commissioner will mail copies of the decision and findings to the appropriate health systems agency, to the Regional Health Administrator of the U.S. Public Health Service, and to others upon request. The public will be notified of the commissioner's decision in the same manner as provided in sec. 50(c) of this chapter.

(d) The commissioner's decision and findings will include a written statement of the reasons for a decision that is inconsistent with a recommendation of the appropriate health systems agency, the goals of the applicable health systems plan, and the priorities of the applicable health systems agency's implementation plan adopted under P.L. 96 - 79, sec. 1513(b).

History: Eff. 10/26/77, Register 64; am 8/13/80, Register 75

Authority: AS 18.07.041 AS 18.07.101

7 AAC 07.080. HEARING AND APPEAL

(a) An applicant dissatisfied with a decision of the commissioner to grant, deny, or modify a certificate of need is entitled to a hearing if the request for a hearing is made in writing and received by the commissioner, no later than 30 days after receiving the commissioner's decision. The hearing will be conducted in accordance with AS 44.62.330 - 44.62.630.

(b) Any person other than the applicant who is dissatisfied with a decision of the commissioner to grant, deny, or modify a certificate of need may request a hearing by making a written request which is received by the commissioner no later than 30 days after the last newspaper notice published under sec. 70(c) of this chapter. Hearings conducted under this subsection will be governed by the provisions of (a) of this section. The commissioner will grant the request for a hearing if good cause is demonstrated. Good cause is considered to have been demonstrated if the request

(1) presents significant relevant information not previously considered by the state agency;

(2) demonstrates that there have been significant changes in factors or circumstances relied upon by the commissioner in reaching his decision;

(3) demonstrates that the state agency or the commissioner has failed to follow procedures stated in this chapter; or

(4) provides such other bases for a hearing as the commissioner determines is good cause.

(c) Hearings under (a) of this section and hearings under (b) of this section will, in the commissioner's discretion, be consolidated.

(d) Notice of the time and place of a hearing under this section must be mailed to the person requesting the hearing, to the applicant, and to the appropriate health systems agency no later than 15 days before the hearing. Notice to others who request notice must be mailed no later than 15 days before the hearing if they have requested it by that time, and must be mailed to them promptly upon request if the request is made later than that.

(e) No fee for conducting the hearing may be charged the applicant or other person at whose request the hearing was held.

(f) Repealed 6/3/88.

History: Eff. 10/26/77, Register 64; am 8/13/80, Register 75; am 6/3/88, Register 106

Authority: AS 18.07.101

7 AAC 07.090. TERM OF CERTIFICATE OF NEED Repealed 8/13/80.

7 AAC 07.095. MODIFICATION, SUSPENSION, OR REVOCATION OF A CERTIFICATE OF NEED

a) If the scope of an activity authorized by a certificate of need varies or is expected to vary, or the cost of the proposed activity increases or is expected to increase by more than 15 percent in excess of inflation costs above the approved maximum capital expenditure, the holder of that certificate shall make written request to the commissioner for a modification of the issued certificate of need. If the commissioner determines the variation from the original application to be minimal, an expedited review as provided for in sec. 65 of this chapter will be conducted. If the commissioner determines that the variation from the original application warrants a new application, a full application and review under this chapter is required.

(b) Modification, suspension, or revocation of a certificate of need will be handled in accordance with AS 18.07.081 .

(c) A decision of the commissioner to modify, suspend, or revoke a certificate of need will be publicized in accordance with sec. 50(c) of this chapter.

History: Eff. 8/13/80, Register 75

Authority: AS 18.07.081 AS 18.07.091 AS 18.07.101

7 AAC 07.100. TRANSFER OF CERTIFICATE OF NEED PROHIBITED

(a) A certificate of need is not transferable.

(b) Repealed 8/13/80.

History: Eff. 10/26/77, Register 64; am 8/13/80, Register 75

Authority: AS 18.07.101

7 AAC 07.105. PERIODIC REPORTS

(a) Any person who submits a letter of intent regarding an activity which is subject to sec. 10 of this chapter or who is granted a certificate of need shall provide the state agency with a written report on the development of the activity at least once every six months until the activity has been completed or abandoned.

(b) The state agency shall prepare and publish an annual report on the status of letters of intent, applications, and reviews. It must include a general statement of the findings and decisions for each completed review.

(c) Health care facilities shall provide the state agency with information regarding available health care services and the rates schedule when requested on forms which are provided by the state agency.

History: Eff. 8/13/80, Register 75

Authority: AS 18.07.101

7 AAC 07.110. NOTICE Repealed 8/13/80.

7 AAC 07.120. ABBREVIATED REVIEW Repealed 8/13/80.

7 AAC 07.130. DEFINITIONS

In this chapter, unless the context indicates otherwise,

(1) "applicant" means any person applying for a certificate of need;

(2) "appropriate health systems agency" means the health systems agency in whose health systems area an activity described in sec. 10 of this chapter has been or will be undertaken;

(3) "capital expenditure" means an expenditure made by or on behalf of a health care facility which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance; "capital expenditure" does not include routine maintenance nor routine replacement;

(4) "certificate of need" means the official order of the commissioner signifying approval of a proposed activity as set out in sec. 10 of this chapter;

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

(6) "days" means calendar days;

(7) "health care facility" means any of those entities listed in AS 18.07.111 , as defined, where appropriate, in 42 C.F.R. 123.401 (adopted 1/21/77);

(8) "health maintenance organization" means a private or public organization (exclusive of insurance companies or similar associations whose primary function is the payment of costs or charges incurred by or on behalf of its policy holders for health services received by them) authorized by Alaska statutes to provide services through a health care facility by providing or otherwise making available to enrolled participants, at least the following basic health care services: usual physician services, hospitalization, laboratory, x-ray, emergency and preventive services, and out-of-area coverage, and which

(A) compensates patients or providers (except for copayments) for these basic health care services and any other health care services provided to enrolled participants on a predetermined periodic rate basis; or

(B) provides physicians' services primarily directly through physicians who are either employees or partners of the organization, or through arrangements with individual physicians or one or more groups of physicians organized on a group practice or individual basis;

(9) "hospital" means an institution primarily engaged in providing to inpatients, by or under the supervision of physicians, diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation of injured, disabled, or sick persons;

(10) "person" includes, in addition to the entities specified in AS 01.10.060 (7), a health maintenance organization, estate, political subdivision or instrumentality (including a municipal corporation) of the State of Alaska, the State of Alaska, and any other legal entity recognized by the State of Alaska;

(11) "person directly affected" means

(A) the state agency;

(B) the commissioner;

(C) members of the public to be served by the activity for which a certificate of need is required;

(D) health care facilities located in the health service area in which the activity is proposed to occur which provide services similar to the proposed activity or which have indicated to the commissioner, by filing a letter of intent under sec. 30 of this chapter, an intention to engage in the activity for which the certificate of need is requested;

(E) any agency which sets or regulates the rates charged by health care facilities;

(F) any health systems agency which is engaged in health planning for the health service area within which the activity for which a certificate of need is requested would occur or for a health services area contiguous to that area;

(12) "public meeting" means a meeting open to the public which is held by the state agency for the purpose of gathering or disseminating information relative to a request for a certificate of need;

(13) "state agency" means the division of state health planning and development, referred to as the office of planning and research in AS 18.07.021 ;

(14) repealed 5/19/91;

(15) repealed 5/19/91;

(16) repealed 5/19/91;

(17) repealed 5/19/91;

(18) repealed 5/19/91.

History: Eff. 10/26/77, Register 64; am 8/13/80, Register 75; am 8/8/90, Register 115; am 12/5/90, Register 116; am 5/19/91, Register 118

Authority: AS 18.07.101 AS 18.07.111

ALASKA ADMINISTRATIVE CODE SUPPLEMENT

7 AAC 43.686 and 7 AAC 43.709

7 AAC 43.686. ALLOWABLE REASONABLE OPERATING COSTS. (a) The commission will set prospective payment rates at a level sufficient to pay a fair rate for reasonable costs of a facility attributable to state programs. The commission will consider only financial requirements that are consistent with efficient cost-effective management. The prospective payment rates will include operating costs that are directly related to the delivery of health care services. These costs include those incurred for patient services, education for accredited health-care-related programs and in-house training, and research if research efforts are approved in advance by the commission. These costs will, in the commission's discretion, include

(1) wages, salaries, and employee benefits;
(2) purchased services;
(3) supplies;
(4) utilities;
(5) depreciation, rental, lease;
(6) taxes, excluding local, state, and federal income taxes;
(7) interest expense;
(8) maintenance; and

(9) minor remodeling.

(b) Operating costs are the costs of providing health care services that are necessary and reasonable and that are not excluded in this section or by the manual.

(c) In its budget, a facility must reduce operating costs by the costs of activities other than health care services that generate revenue or financial benefits to the facility. If a facility sells goods or services to persons other than to patients, the amount of the reduction in allowable costs will be the actual costs of the item, service, or activity. In the absence of adequate documentation of costs, the amount of the reduction in allowable costs will be the amount of revenue received for an item, service, or activity. If financial benefits such as purchase discounts, courtesy allowances, or rebates are received, the amount of the reduction will be the amount of the discount or rebate.

(d) Types of operating costs include the following:

(1) Standards attainment. Costs that a facility incurs in providing health care and in meeting state and federal standards for providing health care are allowable costs. Costs are allowable only if they are documented, ordinary, and related to the provision of health care services to authorized Medicaid and General Relief Medical patients. Necessary and reasonable costs will, in the commission's discretion, include

(A) meeting licensing and certification standards;

(B) meeting standards for providing patient care;

(C) fulfilling accounting and reporting requirements imposed by 7 AAC 43.679; and

(D) performing any patient assessment activity required by the Department of Health and Social Services.

(2) Abandoned planning projects. The costs of planning projects that are abandoned are allowable costs if they are amortized over not less than 60 consecutive months beginning with the month in which the project is considered abandoned in accordance with generally accepted accounting principles.

(3) Startup and organization costs. Startup costs and organization costs are allowable costs if they are amortized over not less than 60 consecutive months beginning with the month in which the first patient is admitted for care. Allowable organization costs include legal fees incurred in establishing the corporation or other organization, and fees paid to states for incorporation. They do not include costs relating to goodwill or to the issuance and sale of shares of capital stock or securities.

(4) Education and training costs. The following are allowable education and training costs:

(A) reasonable costs of on-the-job and in-service training directly related to health care services;

(B) reasonable costs of nursing assistant training;

(C) reasonable costs of training for volunteers, conducted by the health facility;

(D) reasonable costs of health-related community service training programs for other non-employees.

(5) Research costs. Reasonable costs of research directly related to health care services are allowable costs if they are amortized over not less than 60 consecutive months beginning with the month in which the research is completed.

(6) Management fees. The costs of a facility's home office that are reasonably attributable to the management of a facility are allowable costs for the facility. A facility must file with its annual budget any management agreement or change to a management agreement with a firm or individual, other than an employee, that will manage the facility during the period of the budget. Reasonable management fees paid to a firm or individual who is not an employee of the facility or of the facility's home office are allowable costs if

(A) the fees are paid according to the terms of a written management agreement that creates a principal/agent relationship between the facility and the manager, and sets out the items, services, and activities to be provided by the manager;

(B) the facility documents the actual delivery of management services;

(C) the services do not duplicate management services otherwise provided to the facility.

(7) Interest cost.

(A) Interest cost is allowable if the principal sum of the indebtedness is to be applied to a financial need of the facility and is to be applied for a purpose related to patient care. If the principal sum of an indebtedness is to be used for a business opportunity or for the purchase of goodwill, interest on the indebtedness is not an allowable cost.

(B) Interest cost is allowable if the rate of interest is not in excess of the rate that a prudent borrower would pay in an arm's-length transaction at the time the indebtedness is incurred. If the debt is secured by a parent entity of the facility, the average interest rate percent on the parent's total debt will be allowed unless the debt is specific to the facility and documented on the home office cost report submitted to Medicare.

(C) Interest cost includes the amortization of bond discounts and the costs related to the issuance of bonds. If a bond issue is refinanced, the unamortized bond discount and those costs related to the old bond issue are allowable costs in the year in which the refinancing takes place in accordance with generally accepted accounting principles. Discounts and costs of issuance must be amortized over the period from the date of sale to the date of maturity, or, if earlier, the date of retirement of the bonds.

(D) In computing allowable interest costs, interest income from the investment or lending of unrestricted funds must be deducted from allowable interest cost. Interest income from the investment or lending of restricted funds or funded depreciation need not be deducted from allowable costs as long as the interest generated from these funds accrues and is restricted to these funds. Funds that are commingled will be considered unrestricted funds.

(E) If incurred during the period of construction, loan origination fees and interest costs related to construction of a facility must be capitalized and amortized in accordance with generally accepted accounting principles.

(8) Rental and lease cost. Reasonable rent and lease costs under arm's-length operating leases are allowable costs.

(9) Depreciation.

(A) The following costs must be capitalized and not expensed:

(i) expenses for equipment with a historical cost in excess of $1,000 per unit and a useful life of more than one year after the date of purchase;

(ii) expenses for equipment with a historical cost of $1,000 or less per unit if the item was part of the initial stock of the facility.

(B) Depreciation expense for depreciable assets required in the regular course of providing patient care is an allowable cost, if it is

(i) identifiable and recorded in the facility's accounting records;

(ii) computed using the depreciation base, lives, and methods specified in this paragraph; and

(iii) recognized under Medicare principles as a depreciation allowance on facilities leased for a nominal amount as identified in the U.S. Department of Health and Human Services, Health Care Financing Administration, HCFA-Pub. 15-1, Provider Reimbursement Manual, Part 1, Section 112, dated December 1974.

(C) Depreciable assets include the following tangible assets if owned by a facility:

(i) structures;

(ii) building fixed equipment;

(iii) land improvements;

(iv) assets held by the facility through a capital lease;

(v) major movable equipment; and

(vi) minor equipment.

(D) The historical cost to the health facility of acquiring the asset in an arm's-length transaction and of preparing it for use, less amounts attributable to goodwill, is presumed to be the depreciation base. However, the commission will, in its discretion,

require a facility to establish the fair market value of the asset at the time of the purchase by means of an appraisal. After the appraisal is conducted, the depreciation base of the asset may not exceed its fair market value less accumulated depreciation. For long-term care facility acquisitions on or after October 1, 1985, the increase in the depreciable base is limited to one-half of the percentage increase since the date of the seller's acquisition, in the Dodge Construction Systems Cost for Nursing Homes, or, one-half of the percentage increase in the Consumer Price Index for All Urban Consumers (United States City Average), whichever is less. In addition:

(i) If depreciable assets are acquired from a related organization, the facility's depreciation base may not exceed the base the related organization had or would have had if the asset had been used for providing services to eligible state program recipients from the date of purchase.

(ii) The depreciation base of a donated asset is calculated as of the date of donation. The depreciation base of an asset received through testate or intestate distribution other than a donation is the fair market value at the date of death of the testate or intestate. However, if a donation or distribution is between related organizations, the depreciation base is the lesser of the fair market value, or the depreciation base the related organization had or would have had for the asset under a contract with the division of medical assistance.

(E) In preparing its annual budget, a facility shall account for depreciation by using useful lives for depreciable assets that are no shorter than useful lives for similar assets in the 1983 edition of "Estimated Useful Lives of Depreciable Hospital Assets," published by American Hospital Publishing, Inc.

(F) A facility shall measure the life of a depreciable asset from the date of the most recent arm's-length acquisition of the asset.

(G) A facility shall depreciate a building improvement over the remaining useful life of the building or building improvement, whichever is less, and must depreciate equipment over the remaining useful life of the equipment or over the remaining useful life of the building in which the equipment is located, whichever is less. If the remaining book value of the building is less than the equipment expenditure, the remaining life of the building must be evaluated for possible extension.

(H) A facility shall depreciate improvements to leased property for which it is responsible under the terms of the lease over the useful life of the improvement or the remaining term of the lease and available options to renew the lease, whichever is less.

(I) A facility may change the estimate of an asset's useful life to a longer life for the purpose of depreciation.

(J) In preparing its annual budget as required by 7 AAC 43.679, and in accordance with the provisions of the manual, a facility shall depreciate buildings, land improvements, and equipment, using the straight-line method.

(K) If depreciable assets are permanently abandoned or disposed of through sale, trade-in, scrapping, exchange, theft, wrecking, or fire or other casualty, a facility may no longer depreciate the assets, and the assets are considered retired assets.

(L) A gain or loss on the retirement of an asset is the difference between the remaining undepreciated base of the asset and any proceeds due from the retirement of the asset.

(M) If a retired asset is replaced, a facility shall deduct the gain from the depreciation base of the replacement asset in its annual budget or budget amendment. The loss to the depreciation base of the retired asset, if any, may be added to the depreciation base of the replacement asset if the facility has made reasonable effort to recover at least the undepreciated base of the retired asset.

(10) Costs authorized by a certificate of need.

(A) Interest, depreciation, and other capital costs will not be recognized on assets purchased after January 18, 1990 if a certificate of need was required and the facility did not secure one. Recognition of interest, depreciation, and other capital costs for which a certificate of need was required will be no greater than the amounts described within the certificate of need application and other information the applicant provided as a basis for approval of the certificate of need.

(B) Prospective payment rates for facilities which are calculated and paid on a per diem rate basis will be no greater than the per diem rates proposed within the certificate of need application and other information the applicant provided as a basis for approval of the certificate of need for a period of 24 months following:

(1) opening of the new or modified health care facility;

(2) alteration of the bed capacity; or

(3) the implementation date of a change in offered categories of health service or bed capacity.

(C) In determining whether interest, depreciation, and other capital costs exceed those amounts approved under a certificate of need, and for determining the maximum prospective per diem rate approved under a certificate of need, the department will consider

(1) the terms of issuance describing the nature and extent of the activities authorized by the certificate; and

(2) the facts and assertions presented by the facility within the application and certificate of need review record, including purchase or contract prices, the rate of interest identified or

assumed for any borrowed capital, lease costs, donations, development costs, staffing and administration costs, and other information the facility provided as a basis for approval of the certificate of need.

(D) If a certificate is issued, authorizing only part of the activities proposed within a certificate of need application, the limitation of rates will be based upon the factors noted under (C) of this paragraph.

(11) Limits on operating costs provided by related organizations. Costs of services, facilities, and supplies furnished to a facility by organizations related to the facility are allowable costs only to the extent that these costs do not exceed the lower of

(A) the documented costs of the services, facilities, or supplies to the related organization; or

(B) the reasonable price of comparable services, facilities, or supplies offered by a vendor not related to the facility.

(12) Related organization cost documentation. A facility shall document the cost to a related organization for services, facilities, or supplies furnished to the facility by the related organization. The commission will permit the cost to be included in the operating base of a prospective payment rate only if the cost to be included is fully documented as prescribed in the manual.

(13) Pharmaceutical supplies and materials. Pharmaceutical supplies and materials as defined in the manual for recipients who are residents of a long-term care facility, or an intermediate care facility for the mentally retarded, are reimbursed in accordance with 7 AAC 43.255(b) and 7 AAC 43.312(a). These costs, with the exception of the costs of nonprescription drugs dispensed as ordered by a physician, are excluded from facility prospective payment rates.

(e) OBRA '87-related nurse aide training and competency evaluation incremental costs as described in 7 AAC 43.695 are excluded from allowable operating costs. (Eff. 8/9/86, Register 99; am 7/20/88, Register 107; am 1/18/90, Register 113; am 4/12/90, Register 114; am 9/21/90, Register 116)

Authority: AS 47.07.070
AS 47.07.073
AS 47.07.180

7 AAC 43.709. DEFINITIONS. In 7 AAC 43.670 — 7 AAC 43.709

(1) "adjusted admission" means an adjustment to inpatient admissions that increases the number of admissions by outpatient revenue, at the rate of one additional admission for outpatient revenue equal to the inpatient rate;

(2) "ancillary costs" means, in the long-term care rate, patient-billed charges for additional services in long-term care facilities, such as pharmacy prescriptions, specific supplies, and physician-ordered laboratory tests; specifically excluded items a general physical therapy costs, general supplies, and other items not specifically ordered by a physician;

(3) "appraisal" means the process of establishing the fair market value of an asset by a professional designated by the American Institute of Real Estate Appraisers as a member appraisal institute

(MAI), or designated by the Society of Real Estate Appraisers as a senior real estate analyst (SREA) or a senior real property appraiser (SRPA); "appraisal" includes a systematic, analytic determination of the nature of property rights and investment in property and a determination of values based on a personal inspection and inventory of the property;

(4) "arm's-length transaction" means a transaction resulting from good-faith bargaining between a willing buyer and a willing seller who are not related organizations;

(5) "assets" means all economic resources of a health facility, recognized and measured in conformity with generally accepted accounting principles, including certain deferred charges that are not resources but that are recognized and measured in accordance with generally accepted accounting principles;

(6) "board-designated assets" means assets that have been designated or appropriated by the governing board of a facility for special uses and not for facility operations;

(7) "budget" and "budgeting" mean the financial data for, and the process of, developing a budget for annual submission to the department, by a facility receiving payment from the division of medical assistance, to support the projected prospective payment rates for the facility's fiscal year;

(8) "charges" means amounts that patients are billed for health care services provided by a facility;

(9) "commingled" funds means cash or cash equivalents, including restricted funds and board-designated assets which are accumulated in the same physical account as general operating cash or cash equivalents;

(10) "division of medical assistance" means the division within the Department of Health and Social Services responsible for administering the Medicaid and General Relief Medical assistance programs;

(11) "depreciation" means the systematic distribution of the cost or other base of a tangible asset over the estimated useful life of the asset;

(12) "donated asset" means an asset that the facility acquired nominally or with no payment in the form of cash, property, or services;

(13) "effective date" means the date on which a new or modified prospective payment rate is determined by the department to be effective;

(14) "employee benefits" means operating costs that include FICA; ESC; group health insurance; group life insurance; pension and retirement; worker's compensation insurance; and non-payroll-related employee benefits such as employee discounts, employee health centers, and child centers;

(15) "facility" means an acute care hospital, specialty hospital, skilled nursing facility, intermediate care facility, intermediate care facility for the mentally retarded, rehabilitation facility, inpatient psychiatric facility, home health agency, rural health clinic, or outpatient surgical clinic;

(16) "fair market value" means the lesser of the appraised value or the sales price of an asset in an arm's-length transaction;

(17) "findings and recommendations" means the analysis of a facility budget or budget amendment, the resulting findings, and commission staff recommendations relating to the acceptance or modification of a facility's proposed prospective payment rates or effective dates;

(18) "fiscal year" means the operating or business year of a facility, which includes 12 consecutive calendar months;

(19) "funded depreciation" means the investment of funds generated from an allowance for depreciation plus the accumulated interest earnings;

(20) "generally accepted accounting principles" means accounting principles approved by the Financial Accounting Standard Board (FASB);

(21) "general mailing list" means a mailing list maintained by the commission consisting of all persons who have requested in writing to be included on the list;

(22) "goodwill" means the advantage or benefit acquired by a facility beyond the mere value of the capital, stocks, funds, or property it holds, as a result of the general public patronage and encouragement it receives from constant or habitual customers because of its local position, common celebrity, reputation for skill or affluence or punctuality, or from other accidental circumstances or necessities;

(23) "historical cost" means the actual cost incurred in acquiring and preparing an asset for use;

(24) "intermediate care facility" means a licensed facility certified to deliver intermediate care services as defined in 7 AAC 43.185;

(25) "intermediate care facility for the mentally retarded" means a licensed facility as defined in 7 AAC 12.300;

(26) "long-term care facility" includes intermediate care facilities and skilled nursing care facilities;

(27) "manual" means the Medicaid Rate Commission Accounting and Reporting Manual, dated June 1987 and published by the commission, including all reporting forms and instructions;

(28) "notify" means to place written notice of an action in the United States mail, addressed to the last known address of a person, or to deliver written notice by hand to a person;

(29) "operating lease" means a lease under which rents or lease payments are included in current operating expenses;

(30) "patient day" means a calendar day of patient care;

(31) "person" means an individual, partnership, association, corporation, facility, municipal corporation, or the state;

(32) "prospective payment rate" means the rate authorized by the department to be paid by the division of medical assistance to a facility for services provided to Medicaid and General Relief Medical assistance recipients, as described in 7 AAC 43.676;

(33) "rate" means the average revenue per defined unit of service for each revenue center identified in the manual;

(34) "related organizations" means organizations having a relationship of the sort described in sec. 267(b) and 267(c) of the U.S. Internal Revenue Code as amended by P.L. 95-628, November 10, 1978;

(35) "restricted funds" means money that by agreement with or direction of the donor is restricted in the use of its principal or interest to a specific purpose;

(36) "skilled nursing facility" means a licensed facility certified to deliver skilled nursing care services to medical care recipients, as defined in 7 AAC 12.250 — 7 AAC 12.290;

(37) "state programs" means the Medicaid and General Relief Medical assistance programs of the state;

(38) "unrestricted funds" means money that is not restricted to a specific use by the donor;

(39) "occasion of service" means adjusted admission, as applied to acute care and specialty hospitals; patient day, as applied to long-term care facilities; surgery, as applied to outpatient surgery centers; and visit, as applied to rural health clinics;

(40) "rural health clinic visit" means a face-to-face encounter between a rural health clinic patient and any health care professional whose services are reimbursed by the division of medical assistance; encounters with more than one health care professional, and multiple encounters with the same health care professional, regarding the same illness or injury, which take place on the same day and at a single location, constitute a single visit;

(41) "rural health clinic" means a facility that has filed an agreement with the Department of Health and Social Services to provide rural health clinic services under Medicaid;

(42) "outpatient surgical clinic" means an ambulatory surgical center which operates as a distinct entity exclusively for the purpose of providing surgical services to patients not requiring hospitalization;

(43) "medicaid utilization rates" means the percentage of medicaid patient days within an acute care hospital's total patient days for a fiscal year;

(44) "the state" means the State of Alaska;

(45) "commission" means the Medicaid Rate Advisory Commission;

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

(47) "commissioner" means the commissioner of the Department of Health and Social Services or his or her designee;

(48) "deputy commissioner" means the deputy commissioner of the Department of Health and Social Services or his or her designee;

(49) "executive director" means the executive director of the Medicaid Rate Advisory Commission or his or her designee;

(50) "base year" means the facility's fiscal year ending 12 months before the prospective fiscal year;

(51) "certificate" means a certificate of need authorized by AS 18.07.031 — 18.07.111;

(52) "terms of issuance" means the terms specified by a certificate of need describing the nature and extent of the activities authorized by the certificate;

(53) "appropriate region" means the region described in the 1990 publication of *Alaska Wage Rates for Selected Occupations*, published by the Alaska Department of Labor, that is most applicable to a facility. (Eff. 8/9/86, Register 99; am 7/4/87, Register 102; am 5/8/88, Register 106; am 6/19/88, Register 106; am 7/20/88, Register 107: am 3/16/89, Register 109; am 3/13/89, Register 110; am 8/25/89, Register 111; am 10/11/89, Register 112; am 1/18/90, Register 113; am 9/21/90, Register 116)

Authority: AS 47.07.070
AS 47.07.073
AS 47.07.180

Editor's notes. — Copies of the publication *Alaska Wage Rates for Selected Occupations*, adopted by reference in 7 AAC 43.709(53), may be obtained from the Department of Labor, Division of Administrative Services, Research and Analysis, P.O. Box 21149, Juneau, AK 99802, telephone number 465-4500.

List of Certificate of Need Applications - 1996-2001: Amounts Requested and Approved and Actions

#	Facility	Project	Amount Requested	Amount Approved	Action
		2001			
1	Fairbanks - Renal Care	12-Station Dialysis	$ 1,900,000	$ -	Under Review
2	Providence (PAMC)	60 bed MH facility	$ 25,000,000	$ -	Under Review
3	Providence (PAMC)	North Tower Mod.	$ 8,550,000	$ -	Under Review
4	Valdez Community Hsp	Replacement Hosp.	$ 24,100,000	$ -	Under Review
5	Ketchikan Gen. Hosp	MRI/Remodel	$ 1,182,720	$ 1,182,720	Approved
6	Bartlett Regional (Jun)	8 New Beds/Expand	$ 40,000,000	$ 39,200,000	Garden Denied
7	Sitka Community	5 New NH Beds	$ 13,500	$ -	Under Review
8	Providence (PAMC)	PET Scanner	$ 3,200,000	$ 3,200,000	Approved
		2000			
9	Alaska Regional Hosp.	Expand/Remodel	$ 12,300,000	$ 12,300,000	Approved
		1999			
10	Tanana Vally Clinic	2 OP surg. suites	$ 4,200,000	0	Denied
11	Fairbanks ASC	2 OP surg. suites	$ 5,500,000	0	Denied
12	Fairbanks Mem Hosp.	2 OP surg. suites	$ 1,300,000	0	Denied
13	So. Peninsula Hosp.	10 New NH Beds	$ 2,967,000	$ 2,967,000	5 Beds Denied
14	Providence (PAMC)	N. Tower Mod.	$ 25,000,000	$ 25,000,000	Approved
15	Alaska Psych Inst.	CON Mod.	$ 50,868,000	0	Withdrawn
16	Fairbanks Mem Hosp.	20-Bed MH Unit	$ 3,388,000	$ 3,388,000	Approved
17	Valley Hospital	Expand/Remodel	$ 10,000,000	$ 10,000,000	Approved
20	Central Peninsula Hosp.	MRI	$ 1,410,000	$ 1,410,000	Approved
		1998			
21	So. Peninsula Hosp.	Remodel Acute	$ 6,333,756	$ 6,333,756	Approved
22	Alaska Regional Hosp.	Open Heart/Trauma	$ 1,313,000	$ 1,313,000	OH suite delayed
23	Alaska Regional Hosp.	Open Arc. MRI	$ 1,263,000	$ 1,263,000	Approved
24	Fairbanks ASC. Inc	2 OP Surg Suites	$ 2,894,606	0	Denied
25	St. Ann's Care Center	44-Bed Nurs Home	$ 14,948,573	$ 14,948,573	Asst Liv Req'd
		1997			
26	Providence (PAMC)	Heart Center	$ 1,600,000	$ 1,600,000	OH suite delayed
27	Bartlett Regional (Jun)	Expand/Remodel	$ 6,777,300	$ 6,777,300	Approved
28	Valley Hospital	60-Bed Nurs Home	$ 6,700,000	$ 6,700,000	Withdrawn
29	Providence (PAMC)	Pediatric Center	$ 7,000,000	$ 7,000,000	Approved
		1996			
30	Providence (PAMC)	Heart Center	$ 3,500,000	$ 3,500,000	Approved
31	Providence-Seward MC	Replacement Hosp.	$ 7,500,000	$ 7,500,000	Approved
	Total		$ 280,709,455	$ 155,583,349	

Source: State of Alaska/DHSS/DAS/Facilities & Planning

ALASKA STATE LEGISLATURE

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600 East Railroad Avenue
Wasilla, Alaska 99654
(907) 376-3370
(907) 376-3157 Fax

Session:
State Capitol
Juneau, Alaska 99801-1182
(907) 465-6600
(907) 465-3805 Fax

SENATOR LYDA GREEN
SENATE DISTRICT N

Sectional Analysis
CS Senate Bill 256

"An Act relating to the certificate of need program; establishing a working group on psychiatric care services; and providing an effective date."

Section 1:	Increases the threshold for certificate of need from $1,000,000 to $10,000,000 for facility construction, alteration or addition of a new category of health services at a health care facility.
Section 2:	Allows for the relocation of any health care facility within the same community without a certificate of need provided the facility does not increase number of beds or categories of services. Current statute allows only for ambulatory surgical facilities to relocate without a certificate of need.
Section 3:	Adds two new requirements to the standard of review for non-nursing home beds; the financial feasibility and long term viability of the project; and the forecast of the probable financial effect of the project on consumers and the state's fiscal condition
Section 4:	Provides for a temporary moratorium on certificates of need for psychiatric beds from the passage of the bill until July 1, 2003.
Section 5:	Establishes a six-member working group appointed by the Governor to analyze issues regarding psychiatric care services in Alaska. This group will report to the Legislature by the first day of the First Regular Session of the Twenty-Third Alaska Legislature.
Section 6:	Provides that the provisions of section 3 apply to applications of certificates of need that are initially filed on or before the effective date of this Act.
Section 7:	Provides for an immediate effective date

Prepared by Jerry Burnett
Legislative Staff to Senator Lyda Green
February 4, 2002

PIERCE TESTIMONY
FROM SHES 11/9/01

MR. DAVID PIERCE, Health Planner, said he is also known as the Certificate of Need Coordinator and that the office had been active since 1976. Most of the states established these offices in the 1970s; 74 percent of them still have Certificate of Need programs.

CHAIRWOMAN GREEN interrupted him to say the reason they are talking about it at all today is its tie-in to Medicaid.

MR. PIERCE explained that some of the big issues it deals with are rational development of health care, quality of care, access and to decrease unnecessary duplication and cost containment. It also has a public involvement component where people who are involved in the projects have input into the process. Most projects are approved, but over the past 20 years about 500 nursing home beds were proposed and not built. If all those beds had been built, it would save about $60 million per year.

Other states like Texas and California contract for certain numbers of beds rather than reviewing projects as they come in. Other states have also put moratoriums on construction to limit growth. Certificate of Need programs vary by state depending on the need. One of the key issues to think about in Alaska is that the small populations are served.

CHAIRWOMAN GREEN asked him to explain that further.

MR. PIERCE replied that some types of care will only be in the larger communities. Alaska doesn't have a CAT scanner, a type of radiology that detects cancer.

TAPE 02-52, SIDE B

There has to be a certain level of use to be able to support a piece of equipment financially. Also, certain types of services like open heart surgery, that if you don't have a high enough level of use of that service, the skill level of the physicians will not be maintained and there will be more complications with those surgeries.

MR. PIERCE said that approximately 86 percent of the nursing home bed care is Medicaid related. The average cost of a day in

a nursing home statewide is $306. So, basically, for every 10 nursing home beds is going to cost $1 million to Medicaid.

CHAIRWOMAN GREEN asked for an example of [indisc] versus long-term care.

MR. PIERCE replied the Mary Conrad Center with 90 beds and they are all full.

CHAIRWOMAN GREEN asked if anyone who walks through the door and qualifies for Medicaid can stay in that bed.

MR. PIERCE replied no. There are two kinds of payments. The other 14 percent of people are private pay or Veterans Administration.

CHAIRWOMAN GREEN asked if they are not in the Certificate of Need process and suppose Mary Conrad needed 10 more beds, does Medicaid have the ability to say they hadn't approved the beds and therefore, they wouldn't pay for the people.

MR. PIERCE said no, because once a place is licensed as a Medicaid provider, it is able to take patients.

CHAIRWOMAN GREEN asked why they would then need a Certificate of Need.

MS. JANET CLARKE, Department of Health and Social Services, said this was a good question. Mr. Pierce was talking about licensing, which comes after the Certificate of Need process, which comes prior to construction. Long-term care has been the concern of the Alaskan legislature for some time and declared a moratorium for a number of years. "When David says that once you're licensed, if someone comes in they are eligible for that is correct, but the Certificate of Need process is where the review happens."

Typically, someone will need skilled long-term nursing care, but is not eligible right away because they have to spend down some of their assets.

SENATOR TAYLOR commented that we have to bankrupt them first.

MS. CLARKE said that was right.

CHAIRWOMAN GREEN said she didn't want to be protected by the government all the time and she finds it strange that someone in

an office in Juneau can determine how many CAT scanners can be in the state of Alaska. If she wants one of the scanners at a hospital, she should be able to go out and buy one and go broke if that's what happens.

MS. CLARKE replied that a few years ago the legislature passed amendments to the Certificate of Need law and there care more stringent requirements for long-term care - because the legislature was concerned about the implications for Medicaid.

CHAIRWOMAN GREEN said there had been three major attempts to revise the process.

MS. CLARKE said she understands what the Senator is getting at, but:

> What I was trying to get at that - the Certificate of Need program as far as considering cost implications to Medicaid - based on the law - can only do that for long-term care. For the other parts, acute care or CAT scans, they can't consider the implications for Medicaid or cost. It's based on need and access, etc. The way the legislature has structured the law, there are two different review standards, and I think, because of the implications for Medicaid.

MR. PIERCE said one important thing to remember is that in most of the hospitals there's only one market in the state, Anchorage, where there's competition between hospitals. In most of the other communities there is one facility. In these cases, if someone goes bankrupt, you end up with people not having anything.

SENATOR TAYLOR said he wanted to get away from the Medicaid aspects of this.

> Why should anyone have to go through the process if economically they believe it's a good investment for them to put in an MRI or should they tell all patients in Ketchikan you can't have an MRI here. You need to buy a $350 - $400 airplane ticket and fly up to Juneau and use Juneau's machine, which, by the way, hasn't been approved yet, either.

CHAIRWOMAN GREEN asked if she knew of any case where people had been denied access to Providence.

MR. PIERCE replied that he didn't know of any circumstance like that.

MS. CLARKE reminded everyone that CON applies for capital construction of over $1 million; it's not for operating costs.

MR. PIERCE said a lot of health care is moving from the in-patient to the out-patient areas. He said, "Hospitals do a variety of things that some of them get more money than what they pay out in costs for the service."

CHAIRWOMAN GREEN asked for an example.

MR. PIERCE replied a critical care unit or an ICU or maybe in-patient services.

CHAIRWOMAN GREEN commented that this was more discouraging to her than encouraging.

MR. RICK JOHNSON, Valley Hospital Operating Board of Directors, said he thought Mr. Pierce was trying to say is that there is a concern about "cherry picking." He said:

> If you open up an out-patient surgery center and are in direct competition with Valley Hospital where we have to accept a reduced rate for Medicaid and Medicare, then all those services are going to go elsewhere where we make some money to be able to support our community hospital - that's going to be gone.

CHAIRWOMAN GREEN said everyone understands that. She was concerned that hospitals operate under a different set of rules when it comes time to make their reports to the federal government and when they pay taxes.

MR. JOHNSON said that was correct.

CHAIRWOMAN GREEN said she was perfectly willing to have his Board make decisions and not have an office telling them what they can and can't do.

MR. JOHNSON asked what happens when they don't have a Certificate of Need process and someone opens up a shop "out here" and takes everything away from Valley Hospital that makes money.

I'm not saying that we shouldn't be efficient and being able to compete, but we need to be able to do that - but they take everything else away from Valley Hospital and we don't have an opportunity, because we have to take everybody that walks through the door. We have to take Medicare and Medicaid patients at a lower reimbursement level and the only way that we can support ourselves is through profit centers. These other folks that open up a facility out here, they don't have to take Medicaid or Medicare.

CHAIRWOMAN GREEN asked:

Who's to say that they don't want to take low pay, co-pay private - just like the whole raft of assortment that you...Are you saying that because the law doesn't require them to do that?

MR. JOHNSON said that was correct.

CHAIRWOMAN GREEN said maybe that was the point they needed to address. She found it strange that he would turn over his decision-making ability to an agency in state government.

MR. JOHNSON agreed and said it was a strange paradox.

12:25

SENATOR TAYLOR said he was concerned about all the different rates that are charged for the same service and because they:

...Have a ticket to play, they are the only game in town and that Certificate of Need becomes how do we protect our monopoly to make certain that nobody else does come in a cherry pick. There's never been a level playing field; there's not going to be one..."

MR. JOHNSON responded:

But, we have requirements, but how do we correct those federal requirements, the state requirements that we have...We only get x amount of reimbursement on those particular things and we have to accept everybody who walks through the door and somebody can go down the street and open up a shop and they don't have to take them.

SENATOR TAYLOR said, "You have my complete sympathy; I understand. I was just trying the clarify the reality of where we're at today."

CHAIRWOMAN GREEN said she thought they could set aside the federal requirements. She doesn't have any delusion about making any substantive change in the Certificate of Need process. "I've got to tell you there is something massively wrong with the system right now and we either have to change the dollar amount, we have to change the requirement of people who come in and want to play; we have to do something where we don't say it's okay for Providence or Regional…

MR. JOHNSON said he is just looking for a level playing field.

CHAIRWOMAN GREEN said the problem is how do they get there.

MR. JOHNSON said their strategic plan is to build a new facility and they want to double their capacity and he doesn't want to have to go through the CON process. But he is also concerned that other people can build facility and not have the same requirements that his hospital does.

MR. PIERCE said that they are trying to educate the administrators so they can get up to speed and get the CONs in and not have the delays.

SENATOR DAVIS asked if it was correct that 74 percent of the states use the CON. Mr. Johnson said that was correct.

SENATOR DAVIS asked if he knew what the other states did who did not use that process and what kind of problems did they have.

MR. JOHNSON said he didn't, but he could get her some information.

SENATOR DAVIS said they had to have information on things that are working in other states because it might help the situation in Alaska.

MS. CLARKE said some of the other states might contract for a certain number of beds and that's all they'll pay for for Medicaid, for example.

Alaska State Hospital & Nursing Home Association

We're helping people care for people!

February 1, 2002

Senator Jerry Ward
Member, Health, Education and Social Services
State Capitol
Juneau, AK 99801-1182

Dear Senator Ward:

RE: Opposition to SB 256

I am writing as the representative of the Alaska State Hospital and Nursing Home Association (ASHNHA). ASHNHA is an association of hospitals and nursing homes in the State of Alaska. With the exception of Nome and Barrow, all hospitals and nursing homes belong to the Association. At ASHNHA's fall Board meeting on November 8, 2001, the Board voted to oppose any certificate of need legislation in favor of having the law remain as it is currently written.

There are several reasons I am asking you to oppose the bill. Member hospitals, trustees and other concerned providers will be communicating their opposition to this legislation. Since they are directly involved in the delivery of health care to your constituents, I will let them iterate the details. The legislation will probably not affect the smaller, rural hospitals as there is not enough business in these communities for additional facilities. It will affect hospitals in medium to large population centers.

However, my concern is with all facilities in the State. Hospitals must deliver care to all who come to their doors, twenty-four hours a day, whether they can pay or not. Other types of providers, i.e., ambulatory surgery or imaging centers do not. As so frequently happens, we get unintended consequences with legislation. If SB256 passes from your committee, minimally, I would like to see it referred to the Finance Committee so that there might be a comprehensive analysis to determine what the financial effect on Medicaid would be.

If you would like to discuss ASHNHA's opposition to this legislation, please do not hesitate to contact me.

Sincerely,

Laraine

Laraine L. Derr
President/CEO

426 Main Street, Juneau, Alaska 99801
Phone: 907-586-1790 • Fax: 907-463-3573 • Web: ashnha.com

From: "Bill Patten" <billpattenjr@hotmail.com> Sun 11:34 AM
Subject: CON legislation
To: Senator_Lyda_Green@legis.state.ak.us
CC: Senator_Jerry_Ward@legis.state.ak.us, Senator_Bettye_Davis@legis.state.ak.us, Senator_Gary_Wilken@legis.state.ak.us, Senator_Loren_Leman@legis.state.ak.us

Dear Senator Green:
I understand that you have introduced SB 256 which will raise the limit on CON projects to $10,000,000.
I support such a change. However, I would suggest that other changes are also necessary.
As you may know, Sitka Community Hospital has been pursing the conversion of 5 acute care beds to 5 long-term care beds for sometime. In fact, we submitted our initial letter in November, 2000 and the completed application went to the Commissioner in July, 2001. Since that time, our CON has received no formal action.
Our project is estimated to cost us less then $35,000 to implement and yet it was subjected to the entire CON process. We have clearly identified the need for these additional long-term care beds. The issue now, as I understand it, is whether the State can afford these additional beds based upon our current rate of reimbursement.
While we do recieve a very attractive rate, two key points need to be mentioned. First, this rate is determined by state formulas, it is not something that results from our aggressive negoiations. Second, our current rate will expire in June of this year. We project a reduction of almost $200 per resident per day (a range of $400k - $600k in lost revenue).
We have clearly established the need for our additonal beds - from the presecpitive of the number of people in our area who have to leave their home town in order to receive long-term care. But there is also a financial side to this picture. The additional beds will help us replace revenue that we fully expect to lose at the end of June, 2002.
The CON process needs more then a higher limit. If small projects like ours are going to be subjected to this process, it should be renamed because need seems to have little to do with the current process.
I fully understand the financial pressure the State faces. Our organization has similiar challenges. It is discouraging when we are limited in our ability to perform our Mission to meet the needs of our local residents because of the State beuacracy.
At your convenience and as you may require, I am happy to discuss this matter with you further.
Thank you!
Bill Patten
CEO/Administrator
Sitka Community Hospital
Sitka, AK
907-747-1738

Alaska State Legislature
Public Opinion Messages

J Harold Michal,
Po Box 3549
Valdez, AK 99686
Phone: -
E-mail:

Constituency: N
Distribution: 27
Affiliation:
Reg Voter: Y

Subject/Bill SB 256 Opposes

Sec. 1a provided in (c) A person any amount of one million dollars or more of public state or taxpayers money should never be permitted as an expenditure without corroberation of a board of directors or legislative body.
Date Sent: 01/25/2002

Comparison of Draft and Final versions of MSRG Ambulatory Surgery Need Analysis

Executive Summary: The September 5, 1999 draft of the MSRG report was circulated to the CON applicants. To determine the need for ambulatory surgery services, the authors recommended "...looking at actual utilization and challenging hospital assumptions..." to understand the demand for ambulatory surgery services in Fairbanks. They performed a review of "...national benchmarking data and comparison studies of the three CON proposals." This approach is consistent with accepted research principals, and could accurately define the need for ambulatory surgical service in Fairbanks. After performing this rigorous analysis the report concluded that "TVC presented the most viable plan for a freestanding ASC". The report also noted that "...a cost advantage can be gained from an ambulatory surgery center..." However, after the preliminary release of the report, it was substantially edited, changed to such an extent that it often contradicts the first draft, even when drawing conclusions from the same data. The cost savings data was deleted. The "...looking at actual utilization...", and use of "...national benchmarking data and comparative analysis of the CON applications" were completely eliminated, presumably because both led to conclusions favorable to TVC's application. The Washington formula, required by law, was altered to favor the hospital and fully 25,000 minutes of FMH surgery scheduling capacity was created out of thin air. Comments critical of FMH data were eliminated, and a recommendation to limit additional FMH surgical suites was replaced with suggestions that FMH add a surgery suite. The change in the report, when taken together, present a disturbing picture. Either there was a very serious problem at the MSRG group that caused them to alter their report, or the Department bowed to pressure from FMH and gutted the MSRG report, exchanging well reason analysis for inconsistent, illogical conclusions. The Department then hired 3 professional peer reviewers to analyze the MSRG report, and 2 of the 3 were very critical of the lack of a population-based review of utilization (which had been at the heart of the original report) and concluded that the altered report was of limited or no value in determining need for ambulatory surgical services in Fairbanks. Nonetheless, the Department released the altered report and used its flawed analysis as the basis for denying a CON to TVC, thus protecting the status quo and guaranteeing a monopoly for FMH. The Department apparently sees no problem with this result.

A copy of the draft and altered final report are presented, along with a guide to the changes, to facilitate a side-by-side comparison of the 2 reports. In addition the 2 critical peer reviews are attached. Please contact Brian Slocum at 459 – 3509 with any questions. Thank you.

Comparison of Draft and Final versions of MSRG Ambulatory Surgery Need Analysis

Draft Dated September 5, 1999	**Final** Dated September 12, 1999
Executive Summary Conclusions page #4 states: "Access is only an issue sporadically. High season for trauma might create an access issue since elective (non-life threatening) surgery cases may be **bumped off the schedule** in favor of emergency cases."	No mention of access problems due to patients "**...bumped off the schedule...**";
Page #5 "Background Information" paragraph #2, last sentence states "To conduct a fair and impartial assessment of community needs, the interview process was supplemented with **national benchmarking data and comparison studies of the three CON proposals.**"	Deleted "**...national benchmarking data and comparison studies of three CON proposals...**";
Page # 6, "Situation Analysis" first paragraph: "**94,248 (-) 68,850 (x) 2 = +50,796 minutes, TOTAL ADDITIONAL CAPACITY 145,044 minutes**"	Page # 6, "Situation Analysis" first paragraph: "**94,248 (-) 68,850 (x) 3 = +76,194 minutes, TOTAL ADDITIONAL CAPACITY 170,442 minutes**" Invented extra 25,398 minutes of surgery capacity for FMH;
Page #7, "Methodology" states "**Three main methods were employed** to determine 1) the level of unmet need that exists for ambulatory surgical capacity in the Fairbanks health service area; 2) the impact of each proposal on cost,	Page #7, "Methodology" states "**Two main methods were employed** to determine 1) the level of unmet need that exists for ambulatory surgical capacity in the Fairbanks health service area; 2) the impact of each proposal on

Comparison of Draft and Final versions of MSRG Ambulatory Surgery Need Analysis

Draft	**Final**
quality and access to services, especially to under- or uninsured residents; and 3) the overall effect of a realignment of providers within the community."	cost, quality and access to services, especially to under- or uninsured residents; ….."
"The methods included…….a comparative analysis of the CON applications based on thoroughness of analysis, feasibility of facility staffing, design, and realistic financial expectations and assumptions; and lastly, a quantitative analysis of capacity, **utilization** and projected demand using the Washington methodology, factoring in demographics changes and unique community factors."	Deleted reference to **"…a comparative analysis of the CON applications based on thoroughness of analysis, feasibility of facility staffing, design, and realistic financial expectations and assumptions;** Deleted any reference to "…**utilization…**" as a measure of unmet need;
Page #8, CON Competitive Analysis: Nearly a full page of information is listed covering how MSRG used "…intense scrutiny…" to perform a "…**comparative analysis**…." of all 3 CON applications. Page 22, Exhibit C**, the comparative analysis scoring page, listed TVC as the clear winner** with a score of 35 points, vs. FMH's 22.5 points and Dr. McGuire's 18 points ;	This **entire section was deleted** from the final version. **Exhibit C,** the comparative analysis scoring page, which listed TVC as the winner, **was also completely eliminated;**
Page #10 "Scheduled capacity (-) projected demand = excess operations capacity…" consistent with the required Washington State methodology formula;	Page #9 "Scheduled capacity (-) projected demand = excess operations capacity **using FMH surgery suite schedule**…" modifies the statutorily required Washington State methodology formula to artificially inflate

Comparison of Draft and Final versions of MSRG Ambulatory Surgery Need Analysis

Draft	Final
Page #12, "Population Trends", "Considering this shift in population, **projected demand** (as stated in each CON application) **was compared with national averages to determine if over- or under-utilization exists. The hospital projections are unreliable** when compared to an ambulatory surgery center since FMH does not maintain any dedicated, outpatient surgery suites. **The utilization projected by TVC seems to be on target**....."	FMH surgery capacity; Page 11, "Population Trends", **deleted** entire paragraph discussing "...**projected demand .... Was compared to antional averages**....." and "**The hospital projections are unreliable**....." and "**The utilization projected by TVC seems to be on target**.....";
Page #12 - 14, "Utilization Benchmarks", discusses how "...**utilization varies by geographic region**...", provides 3 tables of utilization rates and references the authoritative U.S. Dept of Health and Human Services study "**Ambulatory Surgery in the United States, 1996**" which lists national utilization rates for ambulatory surgery.	Pages #12 – 14, **deleted** "Utilization Benchmarks" in its entirety, including 3 charts and all references to U.S. Dept of Health and Human Services study "Ambulatory Surgery in the United States, 1996";
Page 15 - 16 "Cost, Quality and Access", "The table below presents a **comparison of costs for ambulatory surgical procedures performed in hospital outpatient centers and freestanding ambulatory surgery centers** provided by HCIA. ....**The table clearly demonstrates cost savings possible within all medical specialty areas**....." Table lists 19 surgery procedures, with savings of 50% - 85% available in an ASC.	Page #12, "Cost, Quality and Access" **Paragraph describing savings and Table F demonstrating 50% - 85% cost savings eliminated** in final version;

Comparison of Draft and Final versions of MSRG Ambulatory Surgery Need Analysis

Draft	Final
Page #17, regarding ASC savings, states "In the typical case, however, **it is reasonable to assume cost savings of at least 20%…**"	Page #12, cost savings statement deleted;
Page 18, "Discussion of Issues" #4, speaks of using the Washington methodology to estimate need, and states "….**MSRG recommends looking at actual utilization and challenging hospital assumptions** to fully understand the capacity versus demand issue.";	Page 14, "Discussion of Issues" #4, states "….**MSRG recommends looking at actual scheduled capacity** to fully understand the capacity versus demand issue."; the recommendation to review actual utilization and challenge hospital assumptions deleted;
Page #20, " Final Comments, "**A cost advantage can be gained from an ambulatory surgery center, as well as providing the community with options of care settings and care providers, competitive pricing and enhanced access and quality**."	Page #16, Final Comments, "A cost advantage can be gained from an ambulatory surgery center**, in a highly competitive, well-managed environment.**" Change in working completely changes the meaning and eliminates all references to providing options in care settings and providers, competitive pricing and enhanced access;
Page #20, "Final Comments" "When addressing FMH expansion plans the study says "**Given the current excess capacity at FMH, the addition of another surgery suite appears to be unnecessary at this time.**"	Page #16, "Final Comments, "**If FMH opened one additional surgery suite, it would satisfy demand for another five years**" precisely contradicting their draft recommendation that another FMH surgery suite was unnecessary;
Page #21, "Final Comments", "**TVC presented the most viable plan for a freestanding ASC**"	Page #17, "Final Comments" statement eliminated.
Page #22, "CON Comparative Analysis" **scores TVC highest** at 35 out of 40 points (88%), vs FMH at 22.5 out of 40 points (56%).	

Prices for Surgery in Fairbanks: Who's offers lower cost?

The discussion of who offers the lowest cost for surgery services in Fairbanks is confused, because the hospital does not bill for its services in the same way a freestanding Ambulatory Surgery Center (ASC) bills.

How a hospital bills: Fairbanks Memorial bills on a "menu" basis. If it was a restaurant, the hospital would advertise a steak for $15, but have to add a salad for $5, a baked potato for $4 and coffee for $2.00. Your steak dinner would then cost you $26.00, not the $15 that was advertised. Same with surgery. The hospital tells you their surgery costs, say $1,000 but they don't tell you that they add on charges that eventually might cost you, say $2,250 for the total package.

How a freestanding ambulatory surgery (ASC) center bills: Freestanding ambulatory surgery centers bill on a one-price-covers-all basis. If it was a restaurant, you would buy a steak for $18, which initially looks more expensive than the hospital's $15 steak. But, unlike the hospital, the $18 steak includes the salad, balked potato and coffee. Thus you get the steak diner for $18, not the $26.00 the hospital charges for the whole dinner. The same with surgery. A freestanding ASC charges perhaps $1,200 which looks higher than the hospitals advertised $1,000, but there are no add-ons that run up the bill. So your surgery at the ASC costs $1,200 vs the hospitals $2,250. You save $1,050 with the ASC.

Summary: When the discussion of ambulatory surgery arise, the hospital claims that their prices are lower than an ASC. But remember the steak diner story. **The hospitals quoted price is only part of the story – the total surgery charge when it's done in a hospital, is higher than the same surgery done in a freestanding ASC** - end of story.

[Code of Federal Regulations]
[Title 42, Volume 2, Parts 400 to 429]
[Revised as of October 1, 1998]
From the U.S. Government Printing Office via GPO Access
[CITE: 42CFR413.118]

[Page 436-437]

TITLE 42 --PUBLIC HEALTH

CHAPTER IV --HEALTH CARE FINANCING ADMINIS TRATION, DEPARTMENT OF HEA LTH AND HUMAN SERVIC ES

PART 413-- PRINCIPLES OF REASONABLE COST REIMBURSEME NT; PAYMENT FOR END- STAGE RENAL D

Subpart F --Specific Categories of Costs

Sec. 413.118 Payment for facility services related to covered ASC surgical procedur

(a) Basis and scope. This section imp lements section 1833(a)(4) and (i)(3) of the Act and establishes the met hod for determining Medicare payments for services related to covered ambulatory surgical center (ASC) procedures performed in a hospital on an outpatient basis. It does not apply to services furnished by an ASC operated by a hospital that has an agreement with HCFA to be paid in accordance with Sec. 416.30 of this chapter. (For regulations governing ASCs see part 416 of this chapter.)

(b) Definitions. For purposes of this section--

Facility services are those items and services, as specified in Sec. 416.61 of this chapter, that are fur nished by a hospital on an outpatient basis in connection with cover ed ASC surgical procedures, as described in Sec. 416.65 of this chapter.

[[Page 437]]

Standard overhead amount means an amo unt equal to the prospectively determined payment rate that would be pai d for the procedure if it had been furnished by an ASC in the same geog raphic area.

(c) Payment principle. The aggregate amount of payments for facility services, furnished in a hospital on an o utpatient basis, that are related to covered ASC surgical procedure s (covered under Sec. 416.65 of this chapter) is equal to the lesser of --

(1) The hospital's reasonable cost or customary charges, as determined in accordance with Sec. 413.13 , reduced by deductibles and coinsurance; or

(2) The blended payment amount as des cribed in paragraph (d) of this section, which is based on hospital -specific cost and charge data and rates paid to free-standing ASCs.

(d) Blended payment amount. (1) For c ost reporting periods beginning on or after October 1, 1987 but before Oc tober 1, 1988, the blended payment amount is equal to the sum of --

(i) 75 percent of the hospital -specific amount (the lesser of the hospital's reasonable cost or customary c harges, reduced by deductibles and coinsurance); and

(ii) 25 percent of the ASC payment am ount (that is, 80 percent of the result obtained by subtracting the de ductibles from the sum of the standard overhead amounts.)

(2) For the period of time beginning with the first day of a

hospital's cost reporting period that beg ins on or after October 1, 1988 and ends on December 31, 1990, the blende d payment amount is equal to 50 percent of the hospital -specific amount and 50 percent of the ASC payment amount.

(3) For portions of cost reporting pe riods beginning on or after January 1, 1991, the blended payment amou nt is equal to 42 percent of the hospital -specific amount and 58 percent of the ASC payment amount.

(4) For cost reporting periods beginn ing on or after October 1, 1988 and before January 1, 1995, the blended p ayment amount is equal to the sum of 75 percent of the hospital -specific amount and 25 percent of the ASC payment amount for a hospital that ma kes an application to its fiscal intermediary and meets the followi ng requireme s.

(i) More than 60 percent of the hospi tal's inpatient hospital discharges, as described in Sec. 412.60 o f this chapter, occurring during its cost reporting period beginnin g on or after October 1, 1986 and before October 1, 1987, are classifie d in diagnosis related groups 36 through 74.

(ii) During its cost reporting period beginning on or after October 1, 1986 and before October 1, 1987, more than 50 percent of the hospital's total revenues is derived from outpatient services.

(e) Aggregation of cost, charges, and the blended amount. For purposes of determining the correct payme nt amount under paragraphs (c) and (d) of this section, all reasonable c osts and customary charges attributable to facility services furnish ed during a cost reporting period are aggregated and treated separat ely from the reasonable costs and customary charges attributable to all other services furnished in the hospital.

[52 FR 36773, Oct. 1, 1987; 52 FR 37715, Oct. 8, 1987, as amended at 55 FR 33699, Aug. 17, 1990; 55 FR 34797, Aug . 24, 1990; 57 FR 36017, Aug. 12, 1992; 57 FR 45113, Sept. 30, 1992]

Compilation of Comments on the Failure of CON Laws

Excerpted from "*BEYOND HEALTH CARE REFORM: RECONSIDERING CERTIFICATE OF NEED LAWS IN A MANAGED COMPETITION SYSTEM*"

By PATRICK JOHN MCGINLEY

CON laws evolved from the health care reforms of the 1940s and were heavily promoted well into the 1970s by health care providers, who found CON effective in sheltering their businesses from the costly effects of a competitive marketplace. Congress mandated CON in 1974, but quickly repealed the mandate when CON failed to lower the nation's health care costs.

"In one comparison of health care prices and expenses, it was shown that such prices and expenses are actually higher in areas with CON regulations than they are in areas without CON."[1] In fact, national hospital care expenditures increased from $52.4 billion when Congress enacted the 1974 National Health Act to an estimated $230.1 billion in 1989.[2] Today, Americans are spending nearly a trillion dollars annually on health care.[3] In searching the scholarly journals, one cannot find a single article that asserts that CON laws succeed in lowering health care costs.[4] CON "has elicited a remarkable evaluative consensus—that it does not work."[5]

CON, in addition to failing to decrease national health care expenses, was having detrimental effects on the provision of health care in local communities. The effect of CON on local communities was perhaps best related to Congress by the words of Representative Rowland of the Eighth District of Georgia. Representative Rowland recognized that CON appeared to be a good idea in theory, yet in reality failed to control health care costs and was often insensitive to community needs. ("At first glance, the idea [of certificate of need] may have looked pretty good. In practice, however, the effect of certificate-of-need on health care costs has been dubious, at best. And the program has certainly been insensitive in many instances to the true needs of our communities.") [6]

One may question the wisdom of continuing any form of state regulation that failed to produce its desired goal when implemented nationwide.[7] As the review of Congress's intent indicates, CON had one goal—to save money. However, in those states which retained their CON laws, the retention was often supported by new and creative justifications, many of which were unrelated to saving money. Commentators, in their traditional role of explaining the reason behind events, have set forth many justifications explaining why states have kept the same old CON laws.[8] All these justifications, however, are the crafty work of commentators, and not the motivation of state legislatures. No state legislature has codified any of these new justifications as legislative intent.[9] These justifications should therefore carry little weight in a proper analysis.[10]

Where certificate-of-need laws limit resources effectively, the owners of existing facilities are in a seller's market. They can charge inflated prices for their facilities,..... [C]ertificate-of-need laws will continue to raise health care costs by restricting the entry of cost-effective providers into the market.[11].

1. Mark E. Kaplan, Comment, *An Economic Analysis of Florida's Hospital Certificate of Need Program and Recommendations for Change*, 19 FLA. ST. U. L. REV. at 487 (1991).
2. *Id.* at 487 n.102.
3. Clark C. Havighurst, *Contract Failure in the Market for Health Services*, 29 WAKE FOREST L. REV. at 47. (1994).
4. One author contends that the proper evaluative analysis is not whether certificate of need succeeded in lowering the nation's health care costs, but whether it thwarted the rate of increase in the nation's health care costs. *See* Kaplan, *supra* note 1, at 487. That author concedes, however, that certificate of need is a failure even under his alternative analysis. *Id.*
5. *Id.* (quoting Lawrence D. Brown, *Common Sense Meets Implementation: Certificate-of-Need Regulation in the States*, 8 J. HEALTH POL., POL'Y & L. 480, 481 (1983)).
6. 134 CONG. REC. H9455-01 (1988)
7. For legislators, wisdom can sometimes fall prey to lobbyists. For example, the Texas Medical Association was instrumental in reinstating certificate of need laws after the Texas legislature repealed the regulations. *See Statelines—Texas: Certificate-of-Need Program Reinstituted*, 1 AMERICAN HEALTH LINE, June 16, 1992. In New Jersey, a coalition of twenty urban and teaching hospitals demanded that certificate of need laws not be repealed, warning that deregulation could force hospitals out of business, and stating that they were "concerned there is a push to a deregulated environment." *Statelines—New Jersey: Many Hospitals Fear Deregulation*, 1 AMERICAN HEALTH LINE, Nov. 19, 1992. Likewise in Georgia, the Atlanta Health Care Alliance says it has "supported the certificate-of-need law and health-planning regulations . . . . Duplicative, unnecessary health-care services have been very costly to our members." *Access, Quality, Cost—Cost Containment: Regulation "Back into Vogue,"* 1 AMERICAN HEALTH LINE, May 11, 1992. *See also* Clark C. Havighurst, *Regulation of Health Facilities and Services by "Certificate of Need"*, 59 VA. L. REV. 1143, 1148-51 (1973) [hereinafter Havighurst, *Regulation by CON*], at 1216 (noting that "avoidance of 'duplication' is of course consistent with a cartel's preference for minimizing competition"). Hospital lobbyists demand the protection of certificate of need, because "business coalitions . . . see planning as a way to control costs for their members." *Access, Quality, Cost — Cost Containment: Regulation "Back into Vogue"*, 1 AMERICAN HEALTH LINE, May 11, 1992 (quoting James Kimmey, Dean of the School of Public Health at St. Louis University).

Hospitals are aware that, instead of controlling costs (or "revenue" as seen from the hospital's perspective), certificate of need had the opposite effect. *See supra* part I.B.2. "Viewed in the light of possibilities for more fundamental changes in the market for insurance and health services, certificate-of-need laws may appear as conservative measures, designed to preserve the very institutions [that] create the problems to which they are addressed." *See* Havighurst, *Regulation by CON*], supra note 6, at 1156. Hospitals therefore fight to keep certificate of need alive.

8. *See generally* Kaplan, *supra* note 1; Maja Campbell-Eaton, Note, *Antitrust and Certificate of Need: A Doubtful Prognosis*, 69 IOWA L. REV. 1451, 1453 (1984).; Scott D. Makar, *Antitrust Immunity Under Florida's Certificate of Need Program*, 19 FLA. ST. U. L. REV. 149, 150 (1991); Bruce Babbitt & Jonathan Rose, *Building a Better Mousetrap: Health Care Reform and the Arizona Program*, 3 YALE J. ON REG. 243 (1986); Norman Daniels, *Technology and Resource Allocation: Old Problems in New Clothes*, 65 S. CAL. L. REV. 225 (1991); Mark A. Hall, *Managed Competition and Integrated Health Care Delivery Systems*, 29 WAKE FOREST L. REV. 1, 2 (1994); Carl J. Schramm & Steven C. Renn, *Hospital Mergers, Market Concentration and the Herfindahl-Hirschman Index*, 33 EMORY L.J. 869, 881 n.30 (1984) ("[H]istorically, demonstrating 'need' has often been an easy task, and less than one-quarter of all proposed projects fail to win planning agency approval."). The Supreme Court has held that "need" is not an unconstitutionally vague standard in regulatory statutes; John A. Robertson, *Asking the "Woman Question" About Health Care Reform*, 3 TEX. J. WOMEN & L. 1 (1994); David M. Frankford, *Privatizing Health Care: Economic Magic To Cure Legal Medicine*, 66 S. CAL. L. REV. 1 (1992). Examples of new justifications for old certificate of need laws include curbing "excessive competition," solving a "moral hazard," rectifying "inadequate information," and eliminating "inefficient incentives." *See, e.g.*, Kaplan, *supra* note 1, at 479-84. The true reasons for retaining CON are far more pragmatic. *See supra* note 6.

9. *E.g.*, CODE OF ALABAMA §§ 22-21-260 to 278 (1994); ALASKA STAT. §§ 18.07.021-.111 (1995); CAL. HEALTH & SAFETY CODE §§ 437.10, 439.7 (1995); CAL. GOV'T CODE § 15438.1 (1994); CONN. GEN. STAT. §§ 19a-154 to 155 (1994) (licensing and budget review law); 16 DEL. CODE ANN. §§ 9301-11 (1994); D.C. CODE ANN. §§ 32-326 (1981); FLA. STAT. ch. 408 (1993 and Supp. 1994); GA. CODE ANN. §§ 31-6-1 to 70 (1994); HAW. REV. STAT. §§ 323D-1 to 54 (1989); IND. CODE ANN. §§ 16-29-1 1 to 16 (Burns 1994) (expiring July 1, 1996 pursuant to IND. CODE ANN. § 16-29-1-16); IOWA CODE §§ 135.621-.73 (1994); KAN. STAT. ANN. §§ 65-4802 to 4822 (1992); KY. REV. STAT. ANN. §§ 216B.010-.310 (Baldwin 1994); ME. REV. STAT. ANN. tit. 22, 301-24 (1994); MD. CODE ANN., HEALTH-GEN., 19-101 to 222 (1994); MICH. COMP. LAWS §§ 333.22201-60 (1995); MISS. CODE §§ 41-7-171 to 209 (1995); MO. REV. STAT. §§ 197.30-.65 (1995); MONT. CODE ANN. §§ 50-5-301 to 316 (1994); NEB. REV. STAT. §§ 71-5801 to 70 (1994); N.H. REV. STAT.

ANN. §§ 151-C:1 to 15 (1994); N.J. REV. STAT. §§ 26:2H-1 to 2I-39 (1994); N.C. GEN. STAT. §§ 131E-175 to 190 (1994); N.D. CENT. CODE §§ 23-17.2-01 to 15 (1993); OHIO REV. CODE ANN. §§ 3702.51-.60 (Anderson 1995); OKLA. STAT. tit. 63, 1-850 to 858 (1995); OR. REV. STAT. §§ 442.58-.86 (1992); 35 PA. CONS. STAT. §§ 448.701-.712 (1995) (expiring 1996); S.C. CODE ANN. §§ 44-7-320 to 460 (Law. Co-op. 1976); TENN. CODE ANN. §§ 68-11-101 to 125 (1994); VT. STAT. ANN. tit. 18, 9431-44 (1994); VA. CODE ANN. §§ 32.1-102.1 to 102.11 (Michie 1994); V.I. CODE ANN. tit. 19, 223 (1994); WASH. REV. CODE §§ 70.38.015-.920 (1995); W. VA. CODE §§ 16-2D-1 to 15 (1995)..

10. A proper analysis of certificate of need should focus on the benefits of a regulated bed supply. After all, the purpose of certificate of need regulations is to control the size and growth of the bed supply. *See* discussion *supra* parts II.A., II.B. Therefore, to properly evaluate certificate of need laws, the effect of CON bed supply controls should be measured against the resulting increase or decrease in health care prices.

    Regulatory restraint on the growth of bed supply will result in somewhat higher prices than an unregulated marketplace would produce no matter how well the health care industry is regulated. Havighurst, *Regulation by CON, supra* note 4, at 1218. Certificate of need laws monitor only certain kinds of hospital costs, and therefore "may merely divert inflationary pressures and achieve no control." *Id.* In many instances, this diversion leads to a higher price for health care. For example, imagine two hospitals, one regulated by certificate of need, the other unregulated. Further imagine an unexpected increase in hospital wage costs. *Id.* (revealing that this type of event is rather common in the health care industry by stating that increases in hospital wages and "other types of cost increases . . . are equally likely to occur"). The unregulated hospital has the opportunity to add beds and thereby allocate the increase in wage costs over a greater number of patients, resulting in a smaller increase in health care cost per patient. *See id.* The regulated hospital, however, cannot add beds because of certificate of need regulations. *See id.* (implying that, when a hospital's bed supply is fixed, then its maximum revenue is fixed, even though maximum costs are not). The regulated hospital must allocate the increased cost to a smaller number of patients, resulting in a larger increase in health care costs per patient. In that case, a hospital would face increased costs because certificate of need laws do not regulate wages, yet the hospital would experience no increase in revenue because certificate of need has capped the hospital's maximum revenue. Certificate of need, therefore, can prove rather costly to individual patients.

11. Peter P. Budetti, *Public Policy Issues Surrounding Certificate of Need*, 1978 UTAH L. REV. at 44-45.

Additional Comments on the Failure of CON Legislation

"A recent study by Georgia State University of 37 papers on CON concluded with this statement "Our review of the research literature indicates that Certificate of Need programs have not only failed to achieve lower hospital costs, but they may have contributed to higher costs, greater inefficiency and lower quality of care. Although there have been no major studies of CON laws in the last five years, the evolution of the healthcare delivery system has removed much of the rational for these programs existence"".[1]

"Certificate of Need is based on the dubious economic theory that increased supply and competition will increase prices" [2]

"Today, thee is no evidence that CON reduces medical cots. In fact, thee is considerable evidence that CON increases the cost of health care. It dose so in three ways:

1) Administrative Costs – The CON program itself imposes substantial costs on both health care providers and the government. Since its inception, federal and state governments have spent more than $1 billion administering the program. For providers, preparing and defending a CON application can be time-consuming and expensive process. Needless to say, the added cost is late passed along to consumers.
2) Lack of competition – CON requirements erect barriers to market entry, thereby reducing competition among health care providers. In effect, existing providers are granted a monopoly. Providers frequently attempt to use the CON process to obstruct would be competitors. The impact of entry barriers is made even worse because the new provider seeking to enter the market is often more innovative and cost-effective than the established providers. Some health care economists estimate that CON barriers to market entry increase hospital costs by as much as 5 percent.
3) Shortages – Where CON requirements have produced a shortage of a particular health care service, prices for those services that are available are certain to rise. At the same time, consumers may be forced to shift to alternative services that are often more expensive.

   The Federal Trade Commission estimates that CON regulations increase the cost of hospital care nationwide by more than $1.3 billion annually. Certificate of Need programs also reduce access to health care for those who need it the most.

   It is time to realize that Soviet-style central planning is as big a failure in health care as in all other aspects of the economy. States should repeal their CON requirements".[3]

1. John Steen, Director of the State of Georgia Certificate of Need Program, "*Certificate of Need: A Review*", from the "AHPA Net" web site of the American He lth Planning Association, 2001.
2. Michael D. Turner, CATO Institute, Washington, D.C. "*Ending the CON Game*", pg 1, The Heartland Institute: Intellectual Ammunition, Jan – Feb 1996, from the web site, www.heartland.org, 2001.
3. Turner, supra note 2, page 1-2.

'The cost of applying for a CON can be considerable, exceeding $100,000 for major projects. If litigation is required, the cost may reach $300,000...".[4]

"If the (CON) process does not make a significant contribution toward cost containment and equitable distribution of health care resources, and it provides, as some critics suggest, an obstacle to improved health care, it may be that the CON requirements should be abandoned." [5]

"The enormous expenditure of time and money by both administrative agencies and health care provides in complying with the CON process substantially reduces any savings that might be attributable to it. For all its promise, CON review has resulted in the elimination of few projects. Of over 20,000 CON applications reviewed throughout the country between 1979 and 1981, only ten percent were ultimately disapproved." [6]

4. Roberta M. Ross, "*Certificate of Need for Health Care Facilities: A Time for Reexamination*", 7 Pace Law Review 491 (1987), from web site http://php.iupui.edu/~healthw/chapqo~1.htm
5. Ross, supra note 4, page 3.
6. Ross, supra note 4, page 3.

Additional comments on the Failure of CON and the value of Competition

"Health facilities exist to serve the public. How is the public served by a virtual monopoly over this most critical of all public needs"? *Former Mississippi Governor Kirk Fordice, in an address to the Mississippi Legislature, 1999, from the Mississippi state web page (wwwgovoff.state.ms.us/main/gc/gc020299.html);*

"CON laws, born out of an effort to control cost, may actually increase health care costs by suppressing competition, as noted by Department of Health Executive Director Dr. Ed Thompson in his 1995 response to PEER questions. A Daniel N. Mendelson and Judith Arnold study, based on extensive empirical analysis of hospital costs, concluded that CON programs have not held down hospital costs. These researchers also found no evidence of increased costs in the initial twelve states that repealed CON requirements." *Ibid.*

"According to the FTC complaint detailing the charges in this case, the [*ambulatory surgery center*] acquisition would violate antitrust laws by substantially reducing competition for outpatient surgery services in Anchorage. The market for these services is highly concentrated, having few competitors, and entry by new entities is difficult because of state certificate-of-need requirements, the complaint states. Thus, the FTC alleged, it is unlikely that, absent the divestiture required by the settlement, a new competitor could be established quickly enough to deter any anticompetitive behavior by Columbia/HCA. Moreover, the acquisition could increase the probability of collusion among remaining sources of outpatient surgery in the market and could, therefore, deny patients and others the benefits of competition based on price, quality and service for outpatient surgery services in Anchorage." *Press release from the Federal Trade Commission, September 15 1995, as listed on the FTC web site (www.ftc.gov/opa/predawn/F95/columbia-mca.htm);*

FEDERAL TRADE COMMISSION ECONOMICS STUDY FINDS CERTIFICATE-OF-NEED REQUIREMETNS INCREASE HOSPITAL PRICES AN COSTS

Consumers Benefit from Hospital Competition

"Certificate-of-need (CON) requirements, which were intended to control health-care costs, have actually increased hospital prices by four percent, according to a study issued today by the Federal Trade Commission's Bureau of Economics." *Press release from the Federal Trade Commission, May 5 1987, from the web site (www.ftc.gov/opa/predawn/F87/hospitals.txt);*

"In addition, the study found, hospital expenses are higher in states that have CON laws. According to the study, "There is no evidence that CON laws have resulted in the resource savings they were purportedly designed to promote." "*Ibid.*

"The study also found that in areas where there are more independent hospitals, consumers get higher quality at the same price because of the increased competition. However, CON laws may be used to reduce the number of hospitals, thereby injuring consumers, according to the Bureau of Economics. "Therefore recent plans and decisions to repeal CON laws in some states should increase consumer welfare," the study states." *Ibid.*

"According to Federal Trade Commission Chairman Daniel Oliver, "Their findings concerning CON laws provide further support for my belief that government restrictions on competition are a major source of consumer injury." " *Ibid.*

"Our regulatory treatment of ASCs recognizes the Department's historical policy of promoting greater utilization of ASCs because of the substantial cost savings to Federal health care programs when procedures are performed in ASCs rather than in more costly hospital inpatient or outpatient facilities." *U.S. Department of Health and Human Services, Federal Register, 11/19/99, (volume 64, number 223), page 38*;

"Many commenters noted that ASCs have saved Medicare hundreds of millions of dollars, forcing hospitals to become more competitive, because ASC payment rates are typically lower than hospital payment rates for the same procedures. Several commenters stated that ASCs foster patient access to care, particularly in medically underserved regions. Moreover, many commenters observed that patients generally prefer outpatient surgical care at an ASC to hospital care. .... We agree that ASCs can significantly reduce costs for Federal health care programs, while simultaneously benefiting patients." *Ibid. page 40;*

".....subsidies to promote the overall financial health of safety net hospitals are determined through often complex allocation mechanisms not directly related to the provision of services, and..... the demarcation of support for public health and specialty services versus care for the poor and uninsured is unclear. He suggests that in order to assure community access to vital public health and specialized services grants should be used to target, financial support for those services essential for community care." *Christine Grant, Chairperson, Commissioner of Health and Senior Services, quoting Darrell J. Gaskin, in Report of the Certificate of Need Study Commission, New Jersey, February 2000*;

"Mr. Havighurst was very critical of CON and supports a totally free market approach to the development of health care facilities and services. He believes CON is poorly conceived and has been responsible for serious policy mistakes that actually increased costs in the health care system;" *Ibid, citing Clark Havighurst, Wm. Neal Reynolds Professor of Law, Duke University School of Law*;

"Mr. Sweeney basically supported deregulation of CON because of the difficulty in balancing market forces and a strong CON program which might limit entry into the market." *Ibid, citing Raymond D. Sweeney, Executive Vice President, Healthcare Association of New York State (HANYS);*

"Ms. Dickson provided an historic overview and analytical analysis of CON. Her analysis indicated that CON does not reduce acute care costs..." *Ibid, citing Pamela Dickson, Senior Program Officer, Robert Wood Johnson Foundation.*

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SENATOR LYDA GREEN
SENATE DISTRICT N

Sponsor Statement
Senate Bill 256

Certificate of Need (CON)

Senate Bill 256 increases the threshold for the certificate of need from $1 million to $10 million

"Certificate of need" laws were designed to keep health care costs low by requiring advance approval by a state agency for most hospital expansions and major equipment purchases. In 1974, the U.S. Congress required all states to enact CON laws but had repealed that requirement by 1986, as Congress found that the CON process was not effective in controlling healthcare costs. Over the past several years the trend nationwide has been to repeal or amend CON to make them less restrictive and to increase the threshold.

The current $1 million threshold for certificate of need in Alaska has been in effect since 1983. Over the past 19 years construction costs have increased. With the $1 million threshold the Department of Social and Health reviews applications for facility expansion and equipment that should be left to the providers and the marketplace.

Alaska is not facing an over supply of hospital beds, healthcare providers, doctors or healthcare workers in general. The more typical Alaskan experience is to find a shortage of healthcare options and to travel out of state for treatment. In fact, among in the United States, Alaska ranks 46th in the number of hospital beds per 1000 population, 51st in the number of healthcare workers as a percentage of our workforce, and 49th in the number of physicians per capita, according to the Kaiser Family Foundation, State Health Facts Online. Restricting the supply of health care resources in Alaska is not the answer to keeping health care costs down. Instead, easing restrictions on the expansion of current services is likely to bring consumers back to Alaska and provide lower healthcare costs through competition.

Bill History/Action Display

H

BILL: SB 256 SHORT TITLE:CERTIFICATE OF NEED PROGRAM
BILL VERSION:
SPONSOR(S): SENATOR(S) GREEN
CURRENT STATUS: (S) HES STATUS DATE: 01/23/02
THEN FIN
HEARING: (S) HES Feb 04 1:30 PM BUTROVICH 205 TELECONFERENCE

Committee Hearing History

TITLE: "An Act relating to the certificate of need program; and providing for an effective date."

Full Text No Fiscal Notes Available

Bill History

Jrn-Date	Jrn-Page		Action
01/23/02	2018	(S)	READ THE FIRST TIME - REFERRALS
01/23/02	2018	(S)	HES, FIN
01/23/02	2018	(S)	REFERRED TO HEALTH, ED & SOCIAL SVCS
02/04/02	Text	(S)	HES AT 1:30 PM BUTROVICH 205

Similar Subject Match or Exact Subject Match
CONSTRUCTION
HEALTH & SOCIAL SERVICES
HOSPITALS
MEDICAL CARE
NURSING HOMES
PIONEERS' HOMES

Bill Root: Display Bill Root

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PREVIOUS ACTION