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II. Context & History

Improving Health Care is but the most recent, and perhaps the most visible, example of the decades-long FTC effort to shape the climate of opinion on health care.[4] In a February 9, 1987, letter to the Health Systems Agency of New York City, advising the agency to not try to reduce excess hospital bed capacity in the city, Jeffrey Zuckerman, Director of the FTC's Bureau of Competition, noted that the FTC had "been engaged in extensive efforts to preserve and promote competition in health care markets" for more than a decade.[5] A year earlier, Terry Calvani, FTC Acting Chairman, had made it clear that CON was a part of that effort:

> "A major initiative for the coming year . . . will be a program to halt actions by health-care providers which are designed to raise the costs and deter the entry of competitors. For example, state law frequently requires a hospital to obtain a "certificate of need" (CON) before it can build a new facility. The Commission has discovered that existing hospitals have sometimes opposed these CON applications, not in good faith, but merely to delay the entry of a new competitor and to burden it with heavy costs. The Commission will watch for such activities and will challenge them as trade restraints where appropriate."[6]

In other words, certificate of need (CON) regulation has long been anathema to the FTC. The Commission has actively opposed CON programs for at least the last two decades.

It is unclear how the FTC ascertained the motivation and intent of hospitals participating in CON review processes, but its attack on CON has not been limited to, or even meaningfully related to, preventing existing service providers from engaging in restraint of trade. Beginning in the mid-1980s, Commission staff regularly urged State policymakers and health care officials to eliminate or, alternatively, limit CON regulation. The period between 1986 and 1989 was particularly intense. Beyond its sustained generic opposition, during this period alone the FTC formally

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[4] Apparently, the Commission had no great concern about the structure and nature of the health care system before the advent the Medicare program and the economic and system changes dating from that period. There is little, if any, evidence of FTC concern about the structure and operational aspects of the health care system as long as its was dominated by market forces, i.e., before Medicare and other government-sponsored health and health-related programs.

[5] Jeffrey Zuckerman, Director, Bureau of Competition, U.S. Federal Trade Commission, to Giri Vuppala, Assistant Director, Planning and Implementation, Health Systems Agency of New York City, February 9, 1987, p. 2.

[6] See FTC press release, February 21, 1986 at www.ftc.gov. See also FTC annual reports for 1986 and 1987, U.S. Federal Trade Commission, Washington, D.C.

opposed CON regulation in Georgia[7], Hawaii[8], Maryland[9], Michigan[10], Nebraska[11], New York[12], North Carolina[13], Ohio[14], Pennsylvania[15], and Virginia.[16]

FTC attacks have been multifaceted, with arguments ranging from the purported failure of CON regulation to meet legislative cost control objectives to assertions that it results in higher operating costs and charges, threatens quality, reduces innovation and system efficiency, and

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[7] In March 1988, FTC staff said "We believe the continued existence of CON regulation is contrary to the interests of health care consumers in Georgia. . . . More importantly, CON regulation tends to foster higher prices, lower quality and reduced innovation in health care markets". See FTC press release, March 7, 1988, at www.ftc.gov.

[8] In early1987, FTC staff told Hawaii legislators "we strongly encourage repeal of CON legislation. There is no evidence that the CON regulatory process has served its intended purpose of controlling health care costs. Indeed, CON regulation may well increase prices to consumers by restricting supply of hospital services below the level that would exist in a non regulated competitive environment." See FTC press release, March 17, 1987, at www.ftc.gov.

[9] In 1987, FTC staff advised Maryland policymakers to not control ambulatory surgery center development under the State's CON program. See FTC Annual Report, 1987, U. S. Federal Trade Commission, Washington, D.C. at www.ftc.gov.

[10] In March 1988, FTC staff advised Michigan health officials that the State's CON regulations were (are) "contrary to the interests of health care consumers in Michigan" because they "tend to decrease efficiency and impede competition." The staff also asserted "any potential benefits of CON regulation are likely to be outweighed by its adverse effects on competition in health care markets." See FTC press release, May 9, 1988, at www.ftc.gov.

[11] In February 1989, FTC staff informed the Nebraska Legislature "continuing CON regulation is likely to harm consumers by increasing the price and decreasing the quality of health services." See FTC press release, February 24, 1989, at www.ftc.gov

[12] In February 1987, FTC staff advised New York City Health Systems Agency officials that a contemplated reduction in excess hospital capacity "would substantially reduce the incentives for hospitals in New York City to improve the price and quality of their services." Consequently, officials should "rely on the hospitals themselves, rather than government regulation, to determine appropriate capacity levels." See FTC press release, February 10, 1987, at www.ftc.gov.

[13] In March 1989, FTC staff told the North Carolina policy-makers "CON regulation does not appear to be an efficient way to ensure the quality of health care services, to assure that health care is available to the indigent, or to control Medicaid expenditures for nursing home beds." Staff also argued "consumers would most likely be better served if CON regulations were removed." See FTC press release, March 14, 1989, at www.ftc.gov.

[14] In June 1989, FTC staff told the Ohio State Senate "'there is near universal agreement' among health care economists that Certificate of Need regulation 'has been unsuccessful in containing health care costs.'" See FTC press release June 22, 1989, at www.ftc.gov.

[15] In April 1988, FTC staff urged Pennsylvania to eliminate CON regulation, arguing "the benefits of CON regulation, if any, are likely to be outweighed by the adverse effects of such regulation on competition in health care markets. Consequently, continuing CON regulation is likely to harm consumers by increasing the price and decreasing the quality of health services in the state." See FTC press release, April 1, 1988, at www.ftc.gov

[16] In August 1987, FTC staff advised Virginia officials to eliminate its CON regulation of health care facilities because such regulation is "contrary to the interests of health care consumers" and "market forces generally allocate society's resources far better than decisions of government planners." FTC staff also asserted "any potential benefits of CON regulation are likely to be outweighed by the adverse effects of such regulation on competition in health care markets. Consequently, CON regulation is likely to harm consumers on balance by increasing the price, and decreasing the quality, of health services in Virginia." See FTC press release, August 10, 1987, at www.ftc.gov.

limits access to care. Whatever the focus of the argument presented in individual states, the underlying FTC argument in all cases was, and remains, that in health care—as in other sectors of the economy—an unregulated market is superior to planning and regulation in assuring quality, access and cost-effectiveness. In addition to consistently opposing CON regulation for at least the last 20 years, the FTC has also opposed related state planning and regulatory initiatives.[17]

Fourteen states have dropped their CON programs since the mid-1980s. It is not clear how many of these states, if any, responded to FTC arguments or recommendations. Commission staff was active in a number of them, responding to the inquiries of CON opponents, advising state lawmakers to oppose or otherwise limit CON regulation, and preaching the redeeming value of market forces in health care. FTC officials have devoted substantial effort to opposing CON regulation and appear to believe their campaign was necessary, if not uniformly successful. After a brief hiatus, they now appear ready to resume the crusade.

Ostensibly, *Improving Health Care* was issued as an "educational resource" to States and other interested parties. It is unclear how State policymakers will respond to the current FTC advice. Those engaged in the day-to-day struggle to make health care available and affordable, or at least nominally accessible, to all in need necessarily have proven resistant to the siren song of free markets and unfettered competition as *the* solution to cost, quality and access problems. Nevertheless, the 2004 report will certainly encourage opponents of CON, whatever their motivation.[18] There is likely to be much discussion in State legislatures during upcoming legislative sessions. CON regulation is likely to remain in the FTC crosshairs as long as a significant number of States have such programs.

III. Nature of the FTC Critique

Stated simply, the FTC argument against CON regulation holds that health care is as much subject to orthodox economic principles and doctrine as any other sector of the economy. Consequently, the best (i.e., the surest, most effective, most efficient) way to assure quality, efficiency, access, innovation, and lower prices is to rely on market forces and competition. The Commission recognizes that many do not view health care as a commodity that is, or should be, responsive to market forces. The authors lament that much of the public, nationally and internationally, view health care as "a special good" that is "not subject to normal market forces, with significant obligational norms to provide necessary care without regard to ability to pay."

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[17] The FTC opposed the enactment of "certificate of public advantage" legislation in a number of states in the 1990s. These legislative initiatives attempted to provide guidance and "safe harbors" for certain cooperative arrangements that appeared warranted, especially following the sharp nationwide reduction in inpatient hospital use during the previous decade, to promote efficiency and the financial viability of some services. On March 10, 1993, FTC staff advised North Dakota officials that such legislation "could raise costs and reduce quality". See FTC press release, March 10, 1993 at www.ftc.gov. Similar advice was presented to Vermont officials on October 20, 1994. See FTC press release, October 20, 1994 at www.ftc.gov

[18] See, for example, the Virginia Department of Planning and Budget's *Economic Impact Analysis* of proposed revisions to Virginia's Certificate of Public Need State Medical Facilities Plan. The "analysis" is a gratuitous attack on certificate of need regulation, clearly modeled after the FTC argument and assumptions. Copies of the Virginia report are available from the Health Systems Agency of Northern Virginia, Falls Church, VA.

An underlying objective of the report is to change views on this question, especially among policymakers. The authors' recognize that mediating forces (insurance, public health and payer programs, lack of accurate and reliable cost and quality information, and the absence of a truly independent and sovereign consumer) make the current health care market an imperfect one. They insist that, given this circumstance, all efforts should be directed at perfecting the market, and paying directly any additional cost that a free unfettered market may entail.

FTC arguments presented in opposition to CON regulation, and in support of unrestrained market forces, are necessarily largely doctrinaire. There is little analytical or factual basis for the criticism of CON or for the recommendation to eliminate it. Similarly, other than recitation of orthodox economic doctrine, little is presented to demonstrate that market forces have had, or are likely to have, the positive effects in the health care system that the authors claim or assume.

The FTC opposes most barriers to market entry, whatever their nature, purpose or function, as an article of faith. The report makes clear that the FTC opposition is grounded in orthodox economic doctrine and the principles of the "American" market system. The Executive Summary of the report concludes with the report anthem:

> "The fundamental premise of the American free-market system is that consumer welfare is maximized by open competition and consumer sovereignty – even when complex products and services such as health care are involved. . . . The Agencies do not have a pre-existing preference for any particular model for the financing and delivery of health care. Such matters are best left to the impersonal workings of the marketplace." ***Improving Health Care: A Dose of Competition, Executive Summary***, p. 11.

In other words, the FTC is not in favor of a particular model as long as the *de facto* model is the "American free market" model. Doctrine, or perhaps faith and hope, trump experience and reason. This is not surprising, given the FTC's mission of promoting competition. This inherent bias, though understandable, does not absolve the Commission of its responsibility to avoid substituting belief for fact, or to refrain from accepting uncorroborated allegations of interested parties as fact. The report, and the record compiled in producing it, shows the Commission relied on belief and uncorroborated allegations rather than demonstrated fact in its rebuke of CON.

Although packaged and presented as a major new report, the evidence and argument against CON regulation is either a rehash of FTC arguments from the 1980s,[19] or the uncorroborated self-serving allegations of interested parties.[20] There is a notable absence of documented fact or cogent analysis. No new evidence is offered to support the claim that, by raising market entry barriers for some services, CON raises costs, impedes access, or threatens quality. References to

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[19] See Keith B. Anderson and David I. Kass, ***Certificate of Need Regulation of Entry into Home Health Care***, FTC staff report, January 1986; Monica Noether, ***Competition Among Hospitals***, FTC staff report, May 1987; and Daniel Sherman, ***The Effect of State Certificate-of-Need Laws on Hospital Costs: An Economic Policy Analysis***, FTC staff report, January 1988.

[20] See unsupported and anecdotal testimony of John Hennessy, Executive Director, Kansas City Cancer Centers (a subsidiary of U. S. Oncology) and Megan Price, Director, Contracts and Communications, Professional Nurses Association. Both were (are) disappointed CON applicants who made bold, uncorroborated assertions that are problematic on their face.

recent empirical evidence of the value of regional planning and CON regulation in helping control costs and maintaining quality are dismissed by citing the anecdotal comments of CON opponents.[21]

To the extent the FTC argument against CON is grounded in analysis, it is based largely on three FTC staff reports produced in the mid-1980s. These are unusually weak studies. All three are macro econometric studies that involve multivariate regression analysis of aggregated data obtained from standard sources, e.g., state licensure programs, American Hospital Association surveys, and Medicare data. All are burdened by the inherent weaknesses of such examinations of the health care system. Concerns include whether the factors being examined are actually being measured, whether the data used are accurate, reliable, or relevant, and whether the methods used are actually applicable to the question raised. For example, though undertaken in the mid-1980s, the health service and cost data examined in the three FTC staff reports comes from 1977-78 (Noether, Hospital Competition), 1981 (Anderson, Home Health Care Costs), and 1983-84 (Sherman, Hospital Costs).

Underlying assumptions that planning and CON regulation of certain capital costs had (or could have) readily discernible effects in such a short period (PL 93-641 was enacted in 1974 and implemented in 1976) are problematic, attempts to account analytically for these deficiencies notwithstanding. The accuracy and reliability of the data used in these studies are equally questionable. If ever of any value, all three have been eclipsed by changes over the last two decades and have lost any relevance they may have had. Repeated citation by the FTC does not improve or add to the credibility of these studies, or of similar reports that have been cited repeatedly but conflict with experience.

Virtually all of the arguments against CON made by the FTC to State policymakers have been conjecture, based on theory and doctrine rather than acknowledged fact or demonstrated cause and effect. There are few reliable studies of the effects, if any, on the costs and charges for services subject to CON regulation. The results of studies that have been performed have been mixed. In the 1980s, when the FTC staff made representations about the negative effects of CON regulation on access, quality, innovation, and system efficiency, there were few, if any, studies or data that supported these arguments. They were assertions derived from an abiding faith in the effectiveness and unalloyed good of market forces.

Even today there are few studies that try to assess objectively the effects of CON regulation on regulated services. Whatever the purported results, all are regression and correlation studies that do not demonstrate or explain cause and effect. Recent studies that try to discern quality effects of CON regulation generally favor CON regulation.[22] Notwithstanding the repeated claims of FTC staff, there are still no reliable studies that show negative access, innovation, or system efficiency

[21] Recent favorable reports of lower automaker health care costs in states with CON programs, and reports of lower open-heart surgery mortality rates in states with CON programs, are dismissed in this fashion.

[22] See, for example, General Motors Corporation. Statement of General Motors Corporation on the Certificate of Need (CON) Program in Michigan, February 12, 2002; Ford Motor Company. Relative Cost Data vs Certificate of Need (CON) for States in Which Ford has a Major Presence, February, 2002; DaimlerChrysler Corporation. Certificate of Need: Endorsement by DaimlerChrysler Corporation, February 2002. Vaughan-Sarrazin, MS, Hannan, EL, Gormley, CJ, Rosenthal, GE. "Mortality in Medicare Beneficiaries Following Coronary Artery Bypass Graft Surgery in States With and Without Certificate of Need Regulation," JAMA, Vol. 288 No. 15, October 16, 2002, 1859-1866.

effects of CON regulation. Statements to the contrary notwithstanding, these are doctrinaire assertions, not demonstrated fact.

IV. Allusive Arguments

The FTC assertion that, rather than helping control costs, "there is considerable evidence" that CON "can actually drive up prices by fostering anticompetitive barrier to entry" is not supported by credible evidence. This uncorroborated assertion is typical of the argument presented. No source for this conclusion is cited. The language, like the argument itself, is in the subjunctive, opaque and indirect. Considerable evidence is not otherwise defined or identified. So-called "anticompetitive barriers," such as CON, are not clearly distinguished from barriers such as licensure and insurance payment rules and regulations that, though they limit or otherwise affect market entry as forcefully as CON regulation, presumably do not rise to the level of being an "anticompetitive barrier".

The opaque assertion that CON "can actually drive up prices" permits the writers to project their views without having to meet the burden of proving them. Orthodox economic theory holds that market entry barriers "can," and often do result in higher prices in many markets, but there is no credible evidence that CON has, or necessarily does, lead to higher costs in health care. Recourse to theory is necessary if the argument is to appear plausible. In other words, if there is not evidence to document the practice or effect, simply assert repeatedly the belief or theory.

V. Related Opinions and Findings

The attack on CON, though sharp, is a small part of *Improving Health Care*. Perhaps more problematic are the related assumptions, beliefs and recommendations that, if implemented, would undermine community and regional planning, and subject those in need of health services to the vagaries of unfettered market forces. These views and assumptions include:

- *Opposition to Internal Subsidies (Cross-subsidies).* The report recommends that governments (federal and state) re-examine their support of policies and practices that underlie cross-subsidies in health care markets. The rationale offered for this recommendation is that internal (service-to-service) subsidies are inefficient and have the "potential to distort competition."

  The report is indifferent to the implications of the loss of service to those who now benefit from these subsidies, noting that "competition cannot provide resources to those who lack them; it does not work well when certain facilities are expected to use higher profits in certain areas to cross-subsidize uncompensated care." If there is a genuine commitment to assist those benefiting from cross-subsidization, the necessity of such assistance should be weighed and, if found meritorious, be provided directly to recipients (presumably through direct payment or vouchers) because that approach would be "more efficient" and "transparent". There is no discussion of the practicality of this approach or of the likely affects on current beneficiaries of subsidies. The net social and health system gain (benefit) of eliminating cross-subsidization is assumed to be positive.

- *Health Insurance Distorts Markets and Competition.* The report does not recommend specific changes in the Medicare program or in other health insurer coverage or payment practices, but asserts repeatedly that insurance coverage and payment

practices, particularly those of the Medicare program ("government administered pricing"), interfere with market forces and competition.[23]

The report cites approvingly the commentary of Newt Gingrich that "the third party payment model is inherently conflict ridden"[24] and that these insurance schemes "distort incentives and have unintended consequences". According to the report, these distortions explain the rise of ambulatory surgery centers and single-specialty hospitals, particularly cardiovascular services specialty hospitals. The import of the argument is that both Medicare and other third party payers are problematic because they shield individuals from the economic effects and implications of their health care choices and use. From the FTC perspective, if third party payment is to be permitted, high deductible and high co-payment coverage structures are desirable.

- *Government Purchasing of Services*. The report is highly skeptical of government purchasing of health care services on behalf of citizens, because it shields the recipient of such care from the disciplining effects of market forces. Hence, although neutrality is claimed on possible financing schemes, the authors warn against single-payer financing arrangements on the grounds that "government purchasing that reflects monopsony power would likely reduce output and innovation."[25] The report makes clear that this and related concerns apply to both the existing Medicare and Medicaid programs and to any expansion of them such as any effort (e.g., government purchasing or regulation) to control the costs of, or improve access to, prescription drugs.

- *Physician Self-Referral*. Although the FTC and DOJ are charged with preventing monopoly and rooting out restraint of trade practices, and oppose collective bargaining among independent physicians on these grounds, they show little concern about self-referral among physicians. They note approvingly that single-specialty hospitals (SSHs) established recently in states without CON programs "differ from their predecessors in that many of the physicians who refer patients have an ownership interest in the facility." Rather than question this arrangement, or examine carefully the significance of physician-driven decisions in health care and the underlying incentives and practices, the authors "encourage further research into the competitive significance of SSHs." The FTC is especially interested in determining "whether payors can discipline general acute care hospitals by shifting a larger percentage of patients to SSHs."[26]

- *Excess Capacity*. Stated simply, the "Roemer effect" is not recognized by the FTC. As indicated in its recommendation to the New York City Health Systems Agency, a market driven system does not have, or will not long have, excess capacity. According to market

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[23] "Any administered pricing system inevitably has difficulty in replicating the price that would prevail in a competitive market. Not surprisingly, one unintended consequence of the CMS administered pricing systems has been to make some hospital services extraordinarily lucrative and others unprofitable. As a result, some services are more available (and others less available) than they would be in a competitive market." ***Improving Health Care: A Dose of Competition, Executive Summary, p. 9.***

[24] "A large majority of consumers purchase health care through multiple agents. This multiplicity of agents is a major source of problems in the market for health care services. Agents often do not have adequate information about the preferences of those they represent or sufficient incentive to serve those interests." ***Improving Health Care: A Dose of Competition, Executive Summary***, p. 11.

[25] ***Improving Health Care: A Dose of Competition, Executive Summary***, p. 20.

[26] ***Improving Health Care: A Dose of Competition***, Chapter 3, p. 18.

theory, some level of surplus capacity—the level to be determined by market forces—is necessary for a competitive system. FTC staff assumes that the market will punish, and ultimately root out, surplus capacity, inappropriately low occupancy levels, and inefficiency (e.g., low throughput). In other words, there cannot be too many hospitals, hospital beds, or too much service capacity of any kind in a free market.[27]

VI. Supportable Report Findings and Recommendations

- *Information Asymmetry*. The report recognizes that a major imperfection in the current system is the lack of accurate and reliable cost and quality information consumers can use in seeking health services. The recommendation for a concerted, system-wide effort to make more of such information available is commendable. Unfortunately, the report does not recognize or acknowledge that knowledge and information asymmetry is inherent (unavoidable), nor does it suggest ways to deal with this question.

- *Enhance Incentives to Lower Costs and Improve Quality*. The recommendations offered in the report are generic in nature and unobjectionable. The need to improve incentives to reduce or control costs, and to improve quality is recognized and accepted by nearly everyone. Unfortunately, little guidance is offered about the specific questions to be addressed, the means to address them, or the problems likely to be encountered in dealing with them.

- *Implement Institute of Medicine Licensure Reforms.* The suggestion that the membership, and consumer representation on state health facility and service licensing boards be broadened is laudable. Both the scope and substance of licensing decisions, and the processes used in making them, need reform.

VII. Problematic Report Findings and Recommendations

- *Eliminate CON Regulation*. The recommendation that CON programs be eliminated is based largely on doctrine. The argument is a repackaged version of decades-old FTC arguments and positions. No new studies or analyses are offered. Empirical evidence and recent studies and experience showing the benefits of CON regulation are largely dismissed, not disproved.

- *Re-examine Subsidies in Health Care Services*. The value of all health care polices and practices should be examined periodically as a matter of course. In fact, most are. The underlying FTC argument against cross-subsidization is based on orthodox economic doctrine, not on an assessment of their intrinsic merit or the rationale for them. Most subsidies are in place for notably laudable purposes. Some, perhaps all, may need to be reconsidered, but not for theoretical or doctrinal reasons. The evolved connection between cross-subsidization, provision of charity care, and CON review contingencies and conditions is of considerable social value. Current practices should not be changed unless meaningful alternatives are in place.

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[27] Jeffrey Zuckerman, Director, Bureau of Competition, U. S. Federal Trade Commission, to Giri Vuppala, Assistant Director, Planning and Implementation, Health Systems Agency of New York City, February 9, 1987.

- *Prohibition of Physician Collective Bargaining*. Though a relatively small issue, the argument against collective bargaining among independent physicians is doctrinal in nature. The presumed negative effects of collective bargaining on quality and costs are theoretical. The FTC position appears to be more a statement of the Commission's social views, not one based on analysis or evidence.

- *Regulation of Pharmacy Benefits Manager Transparency*. The problems with prescription drug prices, and with obtaining reliable information about their efficacy and cost, are manifest. The FTC recommendation that there be no government regulation of pharmacy managers appears to be an attempt at preemption. The argument and recommendation are illustrative of the doctrinal nature of the FTC positions. The report acknowledges that accurate and reliable information is necessary, but rejects government action to ensure that such information is available to payers and consumers. It falls back on the doctrinal argument that a free market should be relied on to produce the information that is needed to discipline the system.

- *Service mandates*. As with cross-subsidization, the FTC argument against service mandates is based largely on orthodox economic theory, and hence doctrinal in nature. There is no meaningful analysis of the rationale for, the value of, or the costs of mandates compared with alternatives. The merits and costs of service coverage mandates should be reviewed periodically, but eliminating them in the name of economic orthodoxy is not warranted.

VIII. Arguments Against FTC Assertions and Assumptions

- *The health care market is inherently imperfect*. The FTC recognizes that the usual benefits of competition are not achievable in the health care system under current conditions. The report acknowledges a number of glaring market imperfections that need to be cured if market forces and competition are to have their presumed beneficial effects. The problems cited include the mediating influence of service selection and purchasing intermediaries such as insurance, Medicare, physicians and other health care professionals, the lack of price and quality information, legislatively imposed service mandates, cross-subsidization within the system, and service to all in urgent and emergent circumstances regardless of ability to pay.

  The report argues that these imperfections should be cured as quickly as possible. Whatever the merit of this view and argument, cures are not likely soon. Even if acted upon aggressively, the changes required would take years to accomplish in most cases. Community-based planning and CON regulation are linked to, and help compensate for, a number of these imperfections. It is important to maintain and strengthen planning and targeted CON regulation until the related market imperfections are corrected.

- *Health care is not, and should not be treated as, a commodity*. Although the FTC does not state directly that health care should be treated as an economic commodity, its arguments and assumptions make practical sense only if that were the case. Even in theory, much less in practice, market forces can have the system-shaping effects the FTC calls for, and argues will result from unfettered competition, only if health care is treated as any other economic good. The report laments that many, if not most, people see health care as "a special good" that is not, and should not be, subject to orthodox market forces. The

positive aspects of planning, CON regulation, facility licensure, and a number of other mediating social constraints are in place, in part, because market forces do not, and probably cannot, be used to discipline this market.

- *The studies critical of CON cited by the FTC are not reliable.* The argument that planning and CON regulation result in higher costs and prices, inferior quality, reduced access, less innovation, and lower operating efficiency, though asserted repeatedly, is not supported by demonstrated fact. This refrain is based largely on an unwavering adherence to orthodox economic doctrine.

  Most of the sources cited that purportedly show negative economic and quality effects of CON regulation, are FTC staff reports and FTC staff statements, which, in turn, are often based on these studies. Thus, many of the citations are self-referential. The base studies themselves are suspect. The data used, the timeframes covered, and analytical processes relied upon are problematic. The conclusions drawn are debatable. Based on multivariate regression analysis and statistical correlation, none of these "studies" demonstrates cause and effect and, beyond theoretical conjecture, none explains the method or mechanism by which the changes observed were achieved.

  Analyses that try to examine the economic and quality effects of CON regulation yield mixed findings, not the uniformly negative results asserted in the FTC report. Contrary to the impression conveyed in the FTC report, there are no reliable studies showing the effects of CON regulation on access to care, system efficiency, innovation, or other specific system characteristics.

- *Empirical evidence and experience are ignored or treated dismissively.* The recently reported experience of U.S. automakers showing lower costs in States with CON programs, and published analyses showing significantly lower mortality rates among open-heart surgery patients in States with CON programs, are dismissed. This information, when acknowledged, is usually cited in the testimony of a commentator or hearing panel member and dismissed by pairing it with opposing anecdotal testimony of CON critics.

- *Health care as a privilege.* The FTC prides itself on working in the interest of the consumer, the average citizen. It argues that "consumer driven" health care system is desirable and possible if market forces are permitted free reign. The paean to consumer control, though superficially attractive, borders on the disingenuous when examined in the light of economic and health system realities. The report prescribes theoretical cures to real problems. The discussion is at the macroeconomic level. The assumption appears to be that, if you address, at least theoretically, overarching system questions and imperfections, maximum benefit will flow (trickle down) to the individual.

  Unfortunately, the individual is treated as a theoretical economic entity or construct. Market realities are such that, under FTC prescriptions access, to quality health care would become a privilege, not a right or reasonable social expectation, dependent upon the economic standing, the knowledge base, and the social status of the individual. The report appears to anticipate and endorse this outcome. It speaks approvingly of consumers needing incentives to "balance costs and benefits and search for lower cost health care with the

level of quality that they prefer."[28] Presumably, the poor might "prefer" a "level of quality" consonant with what they could afford. As with any other commodity, an unfettered health care system will offer many different quality levels or categories, in both clinical and economic terms.

IX. Arguments in Favor of Planning and CON Regulation

- *CON is a useful market balancing tool*. In a necessarily imperfect, and an increasingly inequitable, health care system, community-based planning and CON regulation are flexible tools that, when used intelligently and objectively, help protect the critical health care infrastructure that is required to meet both expected and unanticipated public need. Market forces are invaluable in balancing the cost, supply, access, and quality of most goods and services. Market fluctuations and vagaries are acceptable for most commodities, but are problematic for essential social goods and services, especially health care.

- *Under current and expected health system market conditions, community-based planning and CON regulation are useful in promoting competition*. CON regulation, and related planning, can be and has been used to provide consumers and other purchasers with price and quality information. They also are used to stimulate direct competition and market entry where evidence indicates this would improve system operations and efficiency.

- *Recent empirical evidence shows substantial economic and service quality benefit from CON regulation and related planning*. Empirical studies by all three major U.S. automakers show substantially lower health care costs in states with CON programs.[29] Similarly, the most recent and largest study of CON regulation on treatment outcomes found that open heart surgery mortality rates are more than 20% lower in states with CON regulation than in states without regional planning and regulation.[30]

- *CON regulation is one of the few practical planning tools available to policymakers.* Whatever its limitations, CON regulation, with related community-based planning, is one of the few tools that policymakers, health system officials, and ordinary citizens have available for use in trying to compensate for known weaknesses and deficiencies in the existing health care system. CON decision-making processes provide a unique forum where all interested parties, and ordinary citizens, can express their views and state their needs. This oversight is distinct in that it often is the only light available to illuminate important quality, cost, and access concerns that are important to consumers.

- *CON regulation is the only practical tool available to implement basic planning policies and practices*. The relationship between average annual service volume and treatment

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[28] ***Improving Health Care: A Dose of Competition,*** *Executive Summary*, p. 5.

[29] General Motors Corporation. *Statement of General Motors Corporation on the Certificate of Need (CON) Program in Michigan,* February 12, 2002; Ford Motor Company. *Relative Cost Data vs Certificate of Need (CON) for States in Which Ford has a Major Presence*, February, 2002; DaimlerChrysler Corporation. *Certificate of Need Endorsement by DaimlerChrysler Corporation*, February 2002.

[30] Vaughan-Sarrazin, MS, Hannan, EL, Gormley, CJ, Rosenthal, GE. "Mortality in Medicare Beneficiaries Following Coronary Artery Bypass Graft Surgery in States With and Without Certificate of Need Regulation," *JAMA*, Vol. 288 No. 15, October 16, 2002, *1859-1866*

outcome is well known. It has been documented repeatedly for many of the services regulated under CON programs. CON regulation is the most reliable and practicable tool for implementing service, institutional and regional planning policies and practices that facilitate and ensure appropriately high program volumes.

X. Conclusions

Improving Health Care: A Dose of Competition appears to be largely a political treatise. It is not an analytical study. The underlying purpose appears to be an attempt to frame (shape) the debate over the nature and evolutionary direction of the U.S. health care system. It touts a "consumer driven" system as the ultimate goal. The report argues that this is possible if the nation has the courage to forgo internal subsidies, service mandates, over-reliance on insurance and government financing and purchasing, government regulation, and associated practices. Reliance on unrestrained market forces is prescribed as the best approach to determining health care capacity, cost, quality, and access. The negative effects of unfettered competition are not examined.

In terms of health planning and CON regulation, the report repackages and restates decades-old arguments against regulation. No new data, information or analysis is offered, and empirical evidence indicative of the efficacy of CON regulation and associated planning is dismissed. By almost any measure, the presentation is largely doctrinaire, based on an unwavering belief in the applicability of orthodox economic doctrine in health care rather than an objective analysis of market realities and experience.

The stated FTC goals of market efficiency, consumer control and informed stakeholders have been integral to community-based health planning for more than 40 years. The community has always been, and remains, an integral part of the planning, development and regulatory processes. The principal difference between FTC beliefs and assumptions, and those favoring planning and targeted regulation is how best to manage the tension between public and private interests, and between short-term and long-term perspectives and incentives. AHPA has always believed in the importance of community-oriented health care services and systems, and encourages ongoing reassessment of health planning and CON regulation to ensure they remain responsive to technological change, evolving health care practices, and community values and needs. The Association will continue to support these principles and practices.

ASHNHA
Alaska State Hospital and Nursing Home Association

REASONS FOR CONTINUING CERTIFICATE OF NEED IN ALASKA

- **Health care is not a conventional market; its economic forces are different.**
  - Health care has a finite need in each community. Introduction of additional medical providers redistributes finite revenue among more providers with 'winners and losers' in the community. Community hospitals will be the 'losers' as profitable services are aggressively sought by new imaging, surgery and specialty hospital providers. This will have profound adverse impact on their ability to fully meet community expectations.
  - Hospitals and nursing homes must offer a full range of outpatient inpatient and emergency services 24 hours a day, 7 days a week, 365 days a year. A number of these essential services do not produce adequate revenue to offset their cost of operation yet they must be offered to fully meet the needs of the community.
  - Health care is heavily regulated by federal & state laws. These regulations do not afford the health care provider the same flexibility and efficiency found in other markets. For example, a reduction in profitable service lines cannot be recovered by increased pricing as nearly one-half of hospital revenue comes from sources that set their own pricing (Medicare and Medicaid).
  - There is no assurance that introducing additional health care providers in a community will reduce cost to the consumer. In fact there is recent research that continues to suggest otherwise.
- **Hospitals must serve all persons in the community that need care regardless of ability to pay and are the key responder in community disaster response.**
  - Without CON, specialty providers can enter the market and create unfair competition by offering only the most profitable medical services and limiting the number of non-paying and underinsured patients that they will see.
  - 18 of Alaska's 25 hospitals are 'sole community providers' which risk financial instability and irreparable harm to community residents if the State does not insure that there is need for more health care infrastructure before it is introduced into the community.
  - Hospitals invest preparedness funds and extensive training to serve the community in event of natural disasters, pandemic flu, biological, and chemical threats. These expenses are not recovered from health care purchasers and only partially offset by federal/state grants. CON helps assure these important services will not be threatened by loss of critical revenue to keep these protections in place.

- **CON is an important health policy tool that balances community need with growth.**

  - There are many examples of health care projects initiated in communities around the country where "profit" motives take priority above overall "community good". The CON review process focuses on these issues and assures the project is in the best interest of patients as well as the community.

  - Without a strong CON process, over-building of health care services will occur in some areas, while critically needed medical services will not be developed in other areas. Developers will go into geographic areas where they see an opportunity, not into areas where they see marginal return on investment.

  - 36 states plus the District of Columbia continue to require CON approval for one or more categories of health services. Further, some states have gone beyond CON and put moratoriums in place to prohibit growth in certain medical services.

- **Current CON laws are not preventing needed growth in Alaska's health care infrastructure.**

  - Since reopening of the CON process in 2005, the Department of Health & Social Services has approved a number of new health care projects and has allowed others to proceed without CON review.

  - Alask 's hospitals and nursing homes are required to apply for CON approval before embarking on any new expansion project. Other parties interested in providing health care services should be exposed to the same rigorous review with the exception of 'physician offices' which are exempted from CON under current law.

- **Over building of medical infrastructure will worsen Alaska's workforce shortage.**

  - Alaska is already facing a critical shortage of physicians and nurses. This situation is not expected to improve in the short term. Many of the projects subject to CON review would require the most specialized professionals in radiology and surgery.

  - If we do not control the growth in Alaska's medical infrastructure we will see staffing shortages in our hospitals and nursing homes beyond anything we have experienced to date.

Health Program

Certificate of Need: State Health Laws and Programs

December 1, 2006 - preliminary edition

Certificate of Need (C.O.N.) programs are aimed at restraining health care facility costs and to allow coordinated planning of new services and construction. Laws authorizing such programs are one mechanism by which state governments seek to reduce overall health and medical costs. Many "CON" laws were put into effect across the nation as part of the federal "Health Planning Resources Development Act" of 1974. Despite numerous changes in the past 30 years, about 36 states retain some type of CON program, law or agency as of mid-2006.

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HISTORY

In 1964, New York became the first state to enacted a statute granting the state government power to determine whether there was a need for any new hospital or nursing home before it was approved for construction. Four years later the American Hospital Association expressed an interest in Certificate of Need laws. The AHA started a national campaign for states to generate their own CON laws. By 1975, 20 states had enacted CON laws; by 1978, 36 states had enacted them.

The 1974 federal Act required all 50 states to submit proposals and obtain approval from a state health planning agency before beginning any major capital projects such as building expansions or ordering new high-tech devices. Many states implemented CON programs in part because of the incentive of federal funds.

The federal mandate was repealed in 1987, along with its federal funding. In the decade that followed, 14 states discontinued their CON programs.However, 36 states currently maintain some form of CON program, and even the 14 that repealed their state CON laws still retain some mechanisms intended to regulate costs and duplication of services. Puerto Rico and the District of Columbia also have CON programs.

States that have retained CON programs currently tend to concentrate activities on outpatient facilities and long-term care. This is largely due to the trend toward free-standing, physician owned facilities that constitute an increasing segment of the health-care market.

INTENT

The basic assumption underlying CON regulation is that excess capacity (in the form of facility overbuilding) directly results in health care price inflation. When a hospital cannot fill its beds, fixed costs must be met through higher charges for the beds that are used. Bigger institutions have bigger costs, so CON supporters say it makes sense to limit facilities to building only enough capacity to meet actual needs.

CON programs originated to regulate the number of beds in hospitals and nursing homes, and to prevent overbuying of expensive equipment. Mandatory regulation through health planning agencies determined the most urgent health care needs, contributed to solutions for these needs, and attempted to manage the fluctuations in prices often caused by a competitive market. The idea was that new or improved facilities or equipment would be approved based only on a genuine need in a community. Statutory criteria often were created to help planning agencies decide what was necessary for a given location. By reviewing the activities and resources of hospitals, the agencies made judgments about what needed to be improved. Once need was established, the applicant organization (corporation, not-for-profit, partnership or public entity) was granted permission to begin a project. These approvals were known as "Certificates of Need."

C.O.N. SUPPORTERS' VIEWS	C.O.N. OPPONENTS' VIEWS
Advocates of CON programs say that health care cannot be considered as a "typical" economic product. They argue that many "market forces" do not obey the same rules for	CON programs also have been subject to wide criticism. To start, it is not clear that these state-sponsored programs actually controlled health care costs. For example, by restricting new construction, CON

health care services as they do for other products. In support of this argument, it is often pointed out that, since most health services (like an x-ray) are "ordered" for patients by physicians, patients do not "shop" for these services the way they do for other commodities. This makes hospital, lab and other services insensitive to market effects on price, and suggests a regulatory approach based on public interest.

The American Health Planning Association (AHPA) is the professional group of state agencies responsible for regulation and planning. They identify three factors that suggest the need for CON programs. The primary argument is that CON programs limit health-care spending. CONs can promote appropriate competition while maintaining lower costs for treatment services. The AHPA argues that by controlling construction and purchasing, state governments can oversee what expenditures are necessary and where funds will be used most effectively. This helps eliminate projects that detract attention from more urgent and useful investments and reduces excessive costs. AHPA also asserts that CONs have a valuable impact on the quality of care. When facilities and equipment are monitored, hospitals and other treatment centers can acknowledge what sort of services are in demand and how effectively patients are being taken care of. Additionally, according to supporters, the programs distribute care to areas that could be ignored by new medical centers. CON programs are a resource for policymakers. CON regulations are described as a reliable way to implement basic planning policies and practices, and aid in distributing health care to all demographic areas. The CON process can call attention to areas in need because planners can track and evaluate the requests of hospitals, doctors and citizens and see which areas are underserved or need to be improved and developed.

programs may reduce price competition between facilities, and may actually keep prices high. Barriers to new building were seen as unfair restrictions, sometimes by both existing facilities and their potential new competitors. There is little direct broad proof that overcapacity or duplication leads to higher charges. In 2004 the Federal Trade Commission (FTC) and the Department of Justice both claimed that CON programs actually *contribute* to rising prices because they inhibit competitive markets that should be able to control the costs of care and guarantee quality and access to treatment and services. *(1)*

Some opponents felt that changes in the Medicare payment system (such as paying hospitals according to Diagnostic Related Groups – "DRGs") would make external regulatory controls unnecessary, because health care organizations would be more subject to market pressures. Some pointed out that the CON programs are not consistently administered. A 'flexible' program could allow development, to the dismay of competitors. A 'restrictive' program could limit competition, with the same effect. Many argued that health facility development should be left to the economics of each institution, in light of its own market analysis, rather than being subject to political influence.

Some evidence suggests that lack of competition paradoxically *encouraged* construction and additional spending. Some opponents of CON programs believe an open health care market, based on quality rather than price, might be the best principle for containing rising costs. Proponents of CON programs disagree. This debate rests on the same arguments as many other "Regulated market" vs. "Open market" discussions.

In theory, Certificates of Need are granted based on objective analysis of community need, rather than the economic self-interest of any single facility. However, opponents of CON programs claim that the programs have not worked this way. They cite examples in which CONs were apparently granted on the basis of political influence, institutional prestige or other factors apart from the interests of the community. Furthermore, it is sometimes a matter of debate what sort of development is actually in the community's interest, with people of good will sharply divided on how to determine this.

Other Approaches

Many approaches have been tried to controlling health care costs, including government and industry regulation, provider incentives, "free market" incentives and educational efforts. Some of these include:

1. Limitations on physician referrals to facilities in which they or a family member have a financial interest (so-called "Stark regulations").
2. Supervision by insurers to make sure a treatment request is necessary (precertification, concurrent or retrospective medical necessity review).
3. Prepayment for insured or covered services ("managed care")
4. Fixed payments for defined services ("Information Individual Programs DRGs"- uniform Diagnostic-Related Groups)
5. Providing information to patients about the costs and necessity of certain tests and treatment (includes "transparency" and disclosure programs)
6. Providing information to patients about the quality of and outcomes at certain medical facilities.

Footnotes:

1. The Federal Trade Commission, Department of Justice, *Improving Health Care: A Dose of Competition* (Washington D.C.: FTC, DOJ, 2004) 361 pages PDF.

STATES WITH CON PROGRAMS

State Certificate of Need Laws, 2006

CON law: state approval may be required

CON law repealed or not in effect

Compiled by NCSL, based on data from AHPA, June 2006

State/District with CON Programs	Dates of Programs	Certificate of Need Contact Information	Individual CON Websites
Alabama	1977-present	**James E. Sanders,** Deputy Director Phone: 334-242-4103; Fax: 334-242-4113 james.sanders@shpda.alabama.gov	http://www.shpda.state.al.us
Alaska	1976-present	**David Pierce,** CON Coordinator Phone: 907-465-3001; Fax: 907-465-4101 david_pierce@health.state.ak.us	Alaska's Certificate of Need Program
Arizona	1971-1985		No CON Program; see planning agency below
Arkansas	1975-present	**Deborah Frazier,** Director Phone: 501-661-2509; Fax:501-661-2399 dfrazier@healthyarkansas.com	http://www.arhspa.org
California	1969-1987		No CON Program; see planning agency below
Colorado	1973-1987		No CON Program; see planning agency below
Connecticut	1973-present	**Susan Cole,** Director Phone: 860-418-7038; Fax: 860-418-7053 susan.colecngland@po.state.ct.us	Connecticut's Certificate of Need Program
Delaware	1978-present	**Francis Osei-Afriyie,** Management Analyst Phone: 302-741-2960; Fax: 302-741-2970 francis.osei-afriyie@state.de.us	Delaware's Certificate of Public Review Program
District of Columbia	1968-present	**Amaha Selassie,** Chief, Project Review Phone: 202-442-5875; Fax: 202-442-4824	DC Certificate of Need Website
Florida	1972-present	**Jeff Gregg,** Bureau Chief Phone: 850-922-8672; Fax: 850-488-6964 gregg@fdhc.state.fl.us	Florida Licensing and Certification
Georgia	1979-present	**Robert Rozier,** Esq., Executive Director Phone: 404-657-7198; Fax: 404-656-0554 rrozier@dch.ga.gov	Georgia's Certificate of Need Program
Hawaii	1974-present	**David Sakamoto,** MD, Administrator Phone: 808-587-0788; Fax: 808-587-0783 david@shpda.org	Hawai'i's Website for Certificate of Need
Idaho	1980-1983		No CON Program; see planning agency below
Illinois	1974-present	**Jeffrey Mark,** Health Planning Board Phone: 217-783-3516; Fax: 217-785-4308	http://www.idph.state.il.us/about/hfpb.htm

		jmark@idph.state.il.us	
Indiana	1980-1996, 1997-1999		No CON Program; see planning agency below
Iowa	1977-present	**Barb Nervig**, Program Manager Phone: 515-281-4344; Fax: 515-281-4958 bnervig@idph.state.ia.us	http://www.idph.state.ia.us/do/cert_of_need.asp
Kansas	1972-1985		No CON Program; see planning agency below
Kentucky	1972-present	**Chris Corbin**, Executive Director Phone: 502-564-9589; Fax: 502-564-0302	http://chfs.ky.gov/ohp/con
Louisiana	1991-present	**James Taylor**, Program Manager Phone: 225-342-3881; Fax: 225-342-3893 jmtaylor@bhh.la.gov	http://www.dhh.state.la.us/
Maine	1978-present	**Catherine Cobb**, Director Phone: 207-287-2979; Fax: 207-287-5282 catherine.cobb@maine.gov	Maine Certificate of Need Procedures Manual Maine Government Website
Maryland	1968-present	**Paul Parker**, Acting Chief Phone: 410-764-3261; Fax: 410-358-1311 pparker@mhcc.state.md.us	Maryland Certificate of Need Program
Massachusetts	1972-present	**Joan Gorga**, Acting Director Phone: 617-753-7340; Fax: 617-753-7349 Joan.Gorga@state.ma.us	http://www.state.ma.us/dph/dhcq/don.htm
Michigan	1972-present	**Larry Horvath**, Manager Phone: 517-241-3343; Fax: 517-241-2962 horvathl@michigan.gov	http://www.michigan.gov/con
Minnesota	1971-1985		No CON Program; see planning agency below
Mississippi	1979-present	**Rachel Pittman**, Chief, P&RD Phone: 601-576-7874; Fax: 601-576-7530 rachel.pittman@msdh.state.ms.us	Mississippi Certificate of Need Program
Missouri	1979-present	**Thomas Piper**, Director Phone: 5573-751-6043; Fax: 573-751-7894 tpiper@mail.state.mo.us	www.dhss.mo.gov/con
Montana	1975-present	**Pamela Sourbeer**, Administrative Officer Phone: 406-444-9519; Fax: 406-444-1742 psourbeer@mt.gov	Administrative Rules of Montana CON
Nebraska	1979-present	**Claire Titus**, Section Program Manager Phone: 402-471-4963; Fax: 402-471-3577 claire.titus@hhss.ne.gov	http://www.hhs.state.ne.us/crl/need.htm
Nevada	1971-present	**Lynn Solano**, Rn, Health Resource Analyst Phone: 775-684-4177; Fax: 775-684-4156 lsolano@nvdh.state.nv.us	http://www.health2k.state.nv.us/ss/letter.htm
New Hampshire	1979-present	**Margaret Heatley**, Administrator Phone: 603-271-4606; Fax: 603-271-4141 m.heatley@dhhs.state.nh.us	http://www.nhha.org/nhha/state_law/con.php
New Jersey	1971-present	**John Calabria**, Director Phone: 609-292-8773; Fax: 609-292-3780 john.calabria@doh.state.nj.us	(none) http://www.state.nj.us/health/hcsa/con-2_7a.pdf (application only)
New Mexico	1978-1993		No CON Program; see planning agency below
New York	1966-present	**Christopher Delker**, Program Research Sp Phone: 518-402-0966; Fax: 518-402-0971 cpd02@health.state.ny.us	http://www.health.state.ny.us/nysdoh/consumer.htm
North Carolina	1978-present	**Lee Hoffman**, Chief Phone: 919-855-3873; Fax: 919-733-8139 Lee.Hoffman@ncmail.net	http://facility-services.state.nc.us/
North Dakota	1971-1995		No CON Program
Ohio	1975-present	**Christine Kenney**, CON Director Phone:	Ohio CON webpage

		614-644-3325; Fax: 614-752-4157 christine.kenney@odh.ohio.gov	
Oklahoma	1971-present	**Darlene Simmons**, Director Phone: 405-271-9444; Fax: 405-271-7360 darlen@health.state.ok.gov	Oklahoma CON Abstract
Oregon	1971-present	**Jana Fussell**, CON Coordinator Phone: 503-731-4320; Fax: 503-731-4078 jana.fussell@state.or.us	Oregon CON Webpage
Pennsylvania	1979-1996		No CON Program; see planning agency below
Puerto Rico	1975-present		Consultant CON webpage
Rhode Island	1968-present	**Michael K. Dexter**, Chief, Office of Health Systems Development Phone: 410-222-2788; Fax: 410-273-4350 michael.dexter@health.ri.gov	http://www.health.ri.gov/hsr/healthsystems/index.php
South Carolina	1971-present	**Joel C. Grice**, Director Phone: 803-545-4200; Fax: 803-545-4570 grocjc@dhec.sc.gov	http://www.scdhec.gov/hr/cofn/
South Dakota	1972-1988		No CON Program; see planning agency below
Tennessee	1973-present	**Melane M. Hill**, Executive Director Phone: 615-741-2364; Fax: 615-741-9884 melanie.hill@state.tn.us	http://tennessee.gov/hsda/cert_need_sum.html
Texas	1975-1985		No CON Program; see planning agency below
Utah	1979-1984		No CON Program; see planning agency below
Vermont	1979-present	**Jennifer Garson**, CON Analyst Phone: 802-828-2900; Fax: 802-828-2949 jgarson@bishca.state.vt.us	Vermont CON program
Virginia	1973-present	**Erik Bodin**, Director Phone: 804-367-2126; Fax: 804-367-2206 Erik.Bodin@vdh.virginia.gov	http://www.cvhpa.org/CON.htm
Washington	1971-present	**Janis Sigman**, Manager Phone: 360-236-2955; Fax: 360-236-2901 janis.sigman@doh.wa.gov	Washington CON program
West Virginia	1977-present	**Dayle CON PlanningStepp**, CON Director Phone: 304-558-7000, Fax: 304-559-7001 dstepp@hcawv.org	http://www.hcawv.org/CertOfNeed/contname.htm
Wisconsin	1977-1978, 1993-present	**C. David Lund**, Chief, N.H. Section Phone: 608-266-2021; Fax: 608-264-7720 lundcd@dhfs.state.wi.us	Wisconsin Resource Allocation Program
Wyoming	1977-1989		No CON Program; see planning agency below

HEALTH PLANNING AGENCIES IN STATES WITHOUT CURRENT C.O.N. PROGRAMS

State	Dates of CON law	Planning Agency & Contacts	
Arizona	1971-1985	**Patricia Taranga**, Chief Phone: 602-542-1219; Fax: 602-542-2011 ptaranga@hs.state.az.us	No CON Program
California	1969-1967	**Jonathan M. Teague**, Manager Phone: 916-322-2814; Fax: 916-324-9242 jteague@oshpd.state.ca.us	No CON Program
Colorado	1973-1987	**Susan Rehak**, Contact Phone: 303-692-2470; Fax: 303-782-5576 susan.rehak@state.co.us	No CON Program
Idaho	1980-1983	**Jane Smith**, Chief Phone: 208-334-5976; Fax: 208-332-7303 smithj2@idhw.state.id.us	No CON Program
Indiana	1980-1996, 1997-	**Tom Reed**, Public Health Administrator Phone:	No CON Program

	1999	317-233-7541; Fax: 317-233-7157 treed@isdh.state.in.us	
Kansas	1972-1985	**Richard J. Morrissey**, Interim Director Phone: 785-296-1343; Fax: 785-296-1562 rmorriss@kdhe.state.ks.us	No CON Program
Minnesota	1971-1985	**Sheila Brunelle**, Principal Planner Phone: 651-282-3853; Fax: 651-297-5808 sheila.brunelle@health.state.mn.us	No CON Program
New Mexico	1978-1983	**Karen Meader**, Deputy Director Phone: 505-424-3200; Fax: 505-424-3222 kmeader@hpc.state.nm.us	No CON Program
North Dakota	1971-1995	**Gary Garland**, Contact Phone: 701-328-2894; Fax: 701-328-1890 ggarland@state.nk.us	No CON Program
Pensylvania	1979-1996	**Michelle S. Davis**, Deputy Secretary Phone: 717-783-8804; Fax: 717-772-6959 msdavis@state.pa.us	No CON Program
South Dakota	1972-1988	**Doneen Hollingsworth**, Secretary Phone: 605-773-3361; Fax: 605-773-5683 doneen.hollingsworth@state.sd.us	No CON Program
Texas	1975-1985	**Connie Turney**, Project Director Phone: 512-458-7261; Fax: 512-458-7344 connie.turney@dshs.state.tx.us	No CON Program
Utah	1979-1984	**Scott Williams**, MD, MPH, Executive Director Phone: 801-538-6111 sdwilliams@utah.gov	No CON Program
Wyoming	1977-1989	**Morris Gardner**, Senior Advisor Phone: 307-777-7656; Fax: 307-777-7439 mgardn@state.wy.us	No CON Program

Contact information obtained from American Health Planning Association National Directory, 2006 edition.

FACILITIES AND SERVICES REGULATED BY C.O.N.

Regulated Services	States, with Districts & Commonwealth
Acute Hospital Beds	AL, AK, CT, DE, FL, GA, HI, IL, KY, ME, MD, MI, MS, MO, NV, NH, NJ, NY, NC, RI, SC, TN, VT, VA, WA, WV, DC, PR
Air Ambulance	AK, CT, HI, ME, MA, MI, NC, TN, VT
Ambulatory Surgical Centers	AL, AK, CT, DE, GA, HI, IL, IA, KY, ME, MD, MA, MI, MS, MT, NV, NH, NY, NC, RI, SC, TN, VT, VA, WA, WV, DC, PR
Assisted Living *(also see Residential Care, below)*	AK
Behavioral Health	WV
Birthing Centers	DE
Burn Care	AK, CT, FL, HI, IL, ME, MD, NJ, NY, NC, VT, WA, WV
Business Computers	CT, VT, WV
Cardiac Catheterization	AL, AK, CT, DE, GA, HI, IL, IA, KY, ME, MD, MI, MS, MO, NH, NJ, NY, NC, RI, SC, TN, VT, VA, WA, WV, DC
Computed Tomography (CT) Scanners	AK, CT, GA, HI, ME, MI, MO, NH, NY, NC, RI, TN, VT, VA, DC, PR
Gamma Knives	AL, AK, CT, GA, HI, IL, ME, MA, MI, MS, MO, NY, NC, RI, SC, VT, VA, WV, DC
Home Health	AL, AK, AR, GA, HI, KY, MD, MS, MT, NJ, NY, NC, SC, TN, VT, WA, WV, DC
Hospice	AL, AK, AR, CT, FL, IL, KY, MD, MS, NV, NY, NC, OH, TN, VT, WA, WV, PR
Hospital *(also see Acute Hospital, above)*	MI, MO
Intensive Care	NC

Intermediate Care Facilities/Mental Retardation (ICF/MR)	AR, FL, GA, HI, IL, IA, KY, LA, ME, MD, MS, MO, MT, NV, NJ, NY, NC, OK, SC, TN, VT, VA, WV, WI, PR
Long Term Acute Care (LTAC)	AL, AK, CT, DE, FL, GA, HI, IL, KT, ME, MD, MA, MI, MS, MO, NV, NH, NJ, NY, NC, RI, SC, TN, VT, VA, WA, WV, DC, PR
Lithotripsy	AL, AK, CT, DE, GA, HI, KY, ME, MA, MI, MS, MO, NH, NY, NC, SC, TN, VT, VA, WV, DC.
Long Term Care	AL, AK, AR, CT, DE, FL, GA, HI, IL, IA, KY, LA, ME, MD, MA, MI, MS, MO, MT, NE, NH, NV, NJ, NY, NC, OH, OK, OR, RI, SC, TN, VT, VA, WA, WV, WI, DC, PR
Medical Office Buildings	CT, GA, DC
Medical Services for Indigents (MSI)	VA
Mobile Hi Technology (CT / MRI / PET, etc)	AK, CT, GA, HI, KY, ME, MI, MO, NH, NY, NC, RI, SC, VT, VA, WV, DC
Mobile Medical Services	KY
Magnetic Resonance Imaging (MRI) Scanners	AL, AK, CT, GA, HI, KY, ME, MA, MI, MS, MO, NH, NY, NC, RI, SC, TN, VT VA, WV, DC
Neo-Natal Intensive Care	AL, AK, CT, FL, GA, HI, IL, KY, ME, MD, MA, MI, NJ, NY, NC, RI, SC, TN, VT, VA, WA, WV, DC
Obstetrics Services	AL, AK, CT, GA, HI, IL, ME, MD, NY, RI, SC, VT, VA, WA, WV, DC
Open Heart Services	AL, AK, CT, FL, GA, HI, IL, IA, KY, ME, MD, MA, MI, MS, MO, NH, NJ, NY, NC, RI, SC, TN, VT, VA, WA, WV, DC
Organ Transplants	AL, AK, CT, FL, GA, HI, IL, IA, KY, ME, MD, MA, MI, MO, NJ, NY, NC, RI, VT, VA, WA, WV, DC
Positron Emission Tomography (PET) Scanners	AL, AK, CT, DE, GA, HI, IL, IA, ME, MA, MI, MS, MO, NH, NY, NC, RI, SC, TN, VT, VA, WV, DC, PR
Psychiatric Services	AL, AK, CT, FL, GA, HI, IL, KY, ME, MD, MA, MI, MS, NH, NJ, NY, NC, OK, RI, SC, TN, VT, VA, WV, DC, PR
Radiation Therapy	AL, AK, CT, DE, GA, HI, IL, IA, KY, ME, MD, MA, MI, MS, MO, NH, NY, NC, RI, SC, TN, VT, VA, WV, DC
Rehabilitation	AL, AK, CT, GA, HI, IL, KY, ME, MD, MA, MS, MT, NE, NV, NH, NJ, NY, NC, RI, SC, TN, VT, VA, WA, WV, DC
Renal Failure/Dialysis	AL, AK, HI, IL, ME, MS, MO, NY, NC, VT, WA, WV, DC
Assisted Living & Residential Care Facilities	AK, AR, CT, GA, KY, MA, MS, MO, NJ, NY, NC, WV
Single Photon Emission Computed Tomography (SPECT)	VA
Subacute Services	AK, AR, FL, GA, HI, IL, KY, MD, NV, OK, RI, SC, TN, WA, WI, DC
Substance/Drug Abuse	AL, AK, CT, FL, GA, HI, ME, MD, MA, MS, MT, NV, NH, NY, NC, OK, RI, SC, TN, VT, VA, WV, DC
Surgery *(also see Amulatory Surgical Centers)*	MI
Swing Beds	AL, AK, AR, CT, GA, HI, IL, ME, MI, MS, MT, NY, NC, OR, RI, TN, VT, WA, WV, DC
Ultra-Sound	AK, CT, ME, MO, NY
Other (Not otherwise covered)	AL, AR, CT, GA, IL, KY, MD, MA, MI, NC, OK, TN, WA, WI, PR

NOTE: The categories listed above are for general information. See state-specific limitations, exceptions and requirements.

CON Online Sources & Resources:

1. http://www.ahpanet.org/articlesessn.html Articles and essays collected from American Health Planning Association

2. [illegible] Opponent view of CON Program using Washington State as example.

3. www.ftc.gov The Federal Trade Commission website

4. http://www.ahpanet.org/websites.cfm.html American Health and Planning Association with other planning related websites and a list of websites for the CON programs of each state.

http://www.ahpanet.org/index.html

5. http://content.healthaffairs.org/cgi/reprint/hlthaff.25.w337v1

6. http://rss.net/tn.jsp?t=hxgabxbab.0.r8qvn8n6.ucoukvu6.124901&p=http%3A%2F%2Fwww.healthaffairs.org

7. Monopoly is not the Answer' an abstract of how regulations hav cted the markets. *Health Affairs*, August 9, 2005.

8. 'Effects of Physician-Owned Limited Service Hospitals: Evidence from Arizona' an abstract. *Health Affairs*, October 25, 2005.

9. 'Political Evolution of Federal Health Care Regulation' *Health Affairs*, Copyright 1992.

10. 'Specialty Versus Community Hospitals: What Role for the Law?' *Health Affairs*, August 9, 2005.

11. 'Rules of the Game: How Public Policy affects local Health Care Markets' *Health Affairs*, Copyright 1998.

12. http://www.law.fsu.edu/journals/lawreview/issues/231/loading.html

2005-06 Examples of CON State Legislation

State/Bill/Web link/Sponsor *yellow background=enacted*	Descriptions of Bills/Excerpts of bill text
AK HB 287 Rep. Lynn	An act amending the certificate of need requirements to apply only to health care facilities and nursing homes located in borough with a population of not more than 25,000, in the unorganized borough, or in a community with a critical access hospital. *(Filed 4/27/05; did not pass by end of regular session, 2006)*
CA* SB 6[illegible] Sen. Aan[illegible]rad	An act to amend Section 1250 of the Health and Safety Code, relating to health facilities. *(Filed 2/22/05; passed House 60y-4n, 9/8/05; passed Senate 44y-1n, 9/8/05; signed into law by Governor as Chapter 443, 9/30/05)*
CT HB 5242 Rep. Dillon	An examination of the State's current and future hospital bed capacity and hospital-based graduate medical education. *(Filed 2/16/06; did not pass by end of regular session, 2006)*
CT HB 5468 Public Hlth. Comm.	To increase the certificate of need threshold for all capital expenditures, including major medical equipment, to three million dollars. *(Filed 2/22/06; passed House 142y-0n 4/11/2006; passed Senate 35y-0n 4/21/06; signed into law by Governor 5/8/06)*
CT HB 5719 Public Hlth. Comm.	To make the certificate of need process for new or expanded emergency medical services clearer and more consistent. *(Filed 3/3/06; did not pass by end of regular session, 2006)*
CT SB [illegible] Public Hlth. Comm.	To allow certified or licensed emergency medical service providers to add one emergency vehicle to their service every three years without undergoing a needs assessment by the Office of Emergency Medical Services, to clarify the Commissioner of Public Health's responsibilities with respect to establishing methods for setting emergency service rates for certified ambulance services and to protect patients from the dangers of secondhand smoke while being transported to or from nonemergency medical services. *(Filed 2/22/06; did not pass by end of regular session, 2006)*
CT	To revise statutes pertaining to the Office of Health Care Access.

SB 386 Public Needelman WouldHlth. Comm.	*(Filed 2/23/06; passed Senate 33y-0n 4/20/06; passed House 146y-0n 4/28/06; signed into law by Governor 5/19/06)*
CT SB 621 Public Hlth. Comm.	To require the Department of Health to establish a standard set of exemptions for single specialty outpatient surgical facilities from licensure and certificate of need requirements. *(Filed 3/8/06; did not bass by end of regular session, 2006)*
FL HB 1565 Rep. Needelman	Would require county commissioners board to issue certificate of public convenience & necessity to any municipality that applies for such certificate to provide advanced life support transport or nontransport emergency medical services within its geographic limits or outside its geographic limits by mutual agreement with governing body of jurisdiction served, etc. *(Filed 3/8/05; died in committee 5/6/05)*
FL HB 1829	For Holmes County Hospital Corporation, amends special act and revises provisions regarding corporation's issuance of bonds to construct and erect new hospital facility in Holmes County; repeals various provisions of said special act. *(Passed House and Senate; signed into law by governor as Chapter No. 2005-352, 6/13/06)* |
FL HB 7051 Rep. Gibson	Extends moratorium on certificates of need for additional community nursing home beds until July 1, 2011; specifies nonapplication of moratorium for addition of nursing home beds in certain specified facilities; provides for repeal upon expiration of moratorium; exempts nursing home that is created by combining certain licensed beds from requirements for obtaining certificate of need from AHCA, etc. *(Filed 2/22/06; passed House 120y-0n 4/19/06; passed Senate 34y-0n 4/20/06; signed into law by Governor 6/9/2006)*
FL HB 7141 Rep. Garcia	Requires healthcare providers to display licenses; exempts nursing home created by combining certain licensed beds from requirements for obtaining certificate of need from AHCA; establishes trauma center startup grant program, etc. *(Filed 3/17/2006; passed House 114y-0n, 4/28/06; passed Senate 40y-0n, 5/4/06; signed into law by Governor 6/12/06)*
FL SB 1516 Sen. Wilson	Would create intergenerational respite care assisted living facility pilot program; provides duties of AHCA re program; provides requirements & standards for program; provides for rules; requires report to Legislature. *(Filed 2/15/05; did not pass by end of regular session, 2006)*
FL SB 2158 Sen.	Would amend provision re health-care-related projects subject to review for certificate of need; exempts class II specialty hospitals specializing in delivery of health services to pediatric patients from requirement to obtain certificate of need from AHCA; provides criteria for such exemption. *(Filed 2/16/06; died in committee 3/22/06; did not pass by end of regular session)*
GA HB 390 Rep. Scott	State Commission on the Efficacy of the Certificate of Need Program *(Filed 2/9/05; passed House 151y-0n 3/3/05; passed Senate 42y-0n, 3/22/05; signed into law by Governor 4/7/05)*
GA SB 24 Sen. Hudgens	Relates to the certificate of need program, so as to provide for an exemption from the certificate of need requirements for the voluntarily relocation of a health care facility under certain conditions; to provide for an exemption from the certificate of need requirements for the relocation, repair, or replacement of a health care facility that is damaged, destroyed, or rendered inoperable under certain conditions; to provide for related matters; to provide for an effective date; to repeal conflicting laws; and for other purposes. (Filed 2/23/05; did not pass by end of regular session, 2005)
HI HB 337 Rep. Evans	Exempts all long-term care facilities at all levels of care from the certificate of need process under the state health planning and development agency. *(Filed 1/20/2005; carried over to 2006 session 12/2/05)*
IL SB 505 Sen. Garrett	Amends the Illinois Health Facilities Planning Act. Provides that "capital expenditure minimum" means $10,000,000 (now, 6,000,000) and "non-clinical service area" includes research facilities, auditoriums, and medical office buildings. Provides that permits are not required for the establishment of swing-beds authorized under Title XVIII of the federal Social Security Act, or for the modification of a hospital's bed capacity. Provides that the Illinois Health Facilities Planning Act is repealed on July 1, 2011 (now July 1, 2006). Effective immediately. *(Filed 2/17/05; passed Senate 56y-0n 4/14/05; did not pass by end of regular session, 2005)*
IL SB 2436 Sen. Crotty	Amends the Illinois Health Facilities Planning Act. Requires inventories of certain skilled or intermediate care facilities to be conducted annually by July 1, to list services provided, and to differentiate between active and inactive beds. Effective immediately.

	(Filed 1/18/06; passed Senate 57y-0n 3/2/06; passed House 105y-4n 5/4/06; signed into law by Governor 6/30/06)
IN SB 161 Sen. Miller	Moratorium on comprehensive care beds. Imposes a moratorium on the construction or addition of comprehensive care beds through June 30, 2007, with certain exceptions. *(Filed 1/9/06; passed Senate 45y-2n 1/26/06; passed House 88y-0n 3/1/06; signed into law by Governor 3/20/06)*
IA HSB 614 SSB 3072 Chair Upmeyer	An Act relating to placing nursing facility beds in reserve. *(Filed 1/31/06; did not pass by end of regular session, 2006)*
KS HB 2799	Concerns adult care homes, relating to home plus beds. *(Filed 2/1/06; did not pass by end of regular session, 2006)*
KS HR 6036	Would Memorialize the Congress of the United States regarding the benefits of speciality hospitals. *(Filed and sent to committee, 4/29/06; did not pass by end of session, 6/06)*
KS S.R. 1856, SR 1862	Memorializes the U.S. Congress to continue the current federal moratorium on specialty hospitals. *(Filed 4/1/06; SR 1862 passed Senate 4/30/06)* |
KY SB 61 Sen. Kelly	To replace the Office of Certificate of Need with the Office of Health Policy for Health and Family Services. *(Filed 1/6/06; passed Senate 92y-3n, 3/24/06; passed House 4/11/06; signed into law by Governor in Acts Chapter 181, 4/18/06)*
LA HB 1337 Rep. Thompson	To provide for the certificate of rural necessity program. *(Filed 4/18/06; did not pass by end of regular session, 2006)*
LA SB 311 Sen. Hines	Provides for the needs assessment review for the approval of federally qualified healthcare centers. *(Filed 3/17/06; did not pass by end of regular session, 2006)*
LA SB 754 Sen. Cravins	Related to adult day healthcare providers and to provide for related matters. *(Filed 6/1/06; passed House 90y-0n, 6/16/06; passed Senate 32y-0n, 6/16/06; signed into law by Governor as Act 637, 6/23/06)*

ME HB 1254 LD 1614 Rep. Miller	Proposes to amend the certificate of need law to improve review procedures in the certificate of need program within the Department of Health and Human Services. *(Filed 12/28/2005; died in committee 4/26/06)*
ME HB 1315 LD 1875 Rep. Millett	Provides improved services to persons in rehabilitation programs; Directs the Department of Health and Human Services, Office of Substance Abuse to evaluate need when issuing licenses, etc. *(Filed 1/3/06; passed House 3/23/06; passed Senate 3/27/06; signed into law by Governor 3/30/06)*
ME SB 225 LD 678 Sen. Dow	An act to ensure access to swing beds in hospital *(Filed 2/10/05; died in committee 5/23/05)*
ME SB 490 LD 1401 Sen. Brennan	To further coordinate the laws regarding certificate of need, the state health plan and the Capital Investment Fund. *(Filed 3/22/05; passed House 6/8/05; passed Senate 6/8/05; signed into law by Governor 6/10/05)*
ME SB 701/LR 2677 LD 1793 Sen. Rosen	Requires the Department of Health and Human Services to allow construction contingency budgeting for capital projects that is consistent with industry standards in a certificate of need application. *(Filed 12/30/05; passed House 4/10/06; passed Senate 4/10/06; signed into law by Governor 4/13/06)*
ME SB 852 LD 2110 Comm. of HHS	Repeals the Hospital Cooperation Act of 1992; Enacts the Hospital and Health Care Provider Cooperation Act. *(Filed 4/13/06; passed House5/23/06; passed Senate5/23/06; signed into law by Governor 5/30/06)*
MD HB 1015/SB 832 Rep. Pendergrass	Altering the level of capital expenditures made by or on behalf of a hospital or a health care facility other than a hospital that requires a certificate of need, etc. *(Filed 2/9/06; passed House 4/1/06; passed Senate 4/1/06; Governor vetoed 5/26/06)*

MD HB 1105 Rep. Morhaim	Requiring the Maryland Health Care Commission to adopt rules and regulations for certification of need that provide consideration for hospital projects that incorporate the requirements for a high performance building; and requiring the Health Services Cost Review Commission, in the determination of reasonable rates for each facility, to take into account the costs of hospital projects that incorporate the requirements for a high performance building *(Filed 2/9/06; passed House 3/17/06; did not pass by end of regular session, 2006)*
MD HB 1420/SB 529 Rep. Smigiel	Repealing a specified requirement for a specified State health plan relating to the certificate of need program, etc. *(Filed 2/10/06; did not pass by end of regular session, 2006)*
MA S 1293 Sen. Moore	Determination of need for hospital beds. *(Filed 1/26/05; did not pass by end of regular session, 2005)*
MA S. 1299	Would study the delivery of specialty hospitals. *(Filed 1/5/05; did not pass by end of regular session, 3/20/06)*
MA S 2141 Public Hlth Comm.	Amends law regulating need for hospital beds. *(Filed 6/30/05; did not pass by end of regular session, 2006)*
MA HD 4853 Rep. Koutoujian	The Department of Public Health be required to hold public hearings before the removal of publicly-funded beds under the jurisdiction of the Commonwealth. *(Filed 12/19/05; did not pass by end of regular session, 2006)*
MN HF 1380/ SF 1297 Solberg	Human services; extends deadline for a nursing facility moratorium exception project in Aitkin County. *(Filed 2/28/05; did not pass by end of regular session, 2005)*
MN HF 1422 Rep. Bradley	To modifying license fees, state-operated services, nursing facility reimbursement, children and families programs, and other provisions; providing positive abortion alternatives; and appropriating money. *(Filed 2/28/05; did not pass by end of regular session, 2005)*
MN HF 1862 Rep. Abeler	Creates evidence-based practice standards, achieves cost-containment measures, allows discounted payments, modifies other health insurance provisions and appropriates money. *(Filed 3/16/05; did not pass by end of regular session, 2006)*
MN HF 3633 Rep. Westrom	Hospital construction and modification moratorium and public interest review requirements for hospitals eliminated. *(Filed 3/27/06; did not pa end of regular session, 2006)*
MN SF 2232/ HF 2360 Sen. Belanger	Nursing home bed moratorium exception project deadline extension. *(Filed 4/18/06; did not pass by end of regular session, 2006)*
MN SF 2576/ HF 3048 Sen. Sparks	Ambulance purchase and lease regulations; hospital construction proposals; alternative approval process, etc. *(Filed 5/26/06; passed House 5/20/06; passed Senate 5/20/06; signed into law by Governor 5/26/06)*
MS HB 0[illegible] Rep. Woods	Removes all except specialty hospitals from application of certificate of need law; Authorizes construction of new acute care hospital. *(Filed 1/3/06; died in committee 1/31/06)*
MS HB 296 Rep. Flaggs	Certificate of need; authorizes nursing home for disabled adults. *(Filed 1/5/06; died in committee 1/31/06)*
MS HB 452 Rep. Fillingane	Nursing homes may add up to 60 new beds if have 95% occupancy rate. *(Filed 1/6/06; died in committee 1/31/06)*
MS HB 457 Rep. Fillingane	Repeal sections 41-7-171 through 41-7-209 from Mississippi Code of 1972, which are the Mississippi Health Care Certificate of Need Law of 1979 etc. *(Filed 1/6/06; died in committee 1/31/06)*
MS HB 386 Rep. Holland	To amend sections 41-7-173 and 31-7-191 from Mississippi Code of 1972 regarding hospices requiring a health care certificate of need by the State Department of Health. *(Filed 1/10/06; died in committee 1/31/06)*
MS HB 599 Rep. Holland	To require the Division of Medicaid to allow certain faith-based assisted living facilities to participate in the Medicaid Assisted Living Waiver Program and related purposes. *(Filed 1/10/06; died in committee 2/28/06)*

MS HB 600 Rep. Robinson	Amends section 41-7-191 of Mississippi Code of 1972 to issue a certificate of need for the addition of hospital beds. *(Filed 1/10/06; died in committee 1/31/06)*
MS HB 601 Rep. Martinson	Amends section 41-7-191 of Mississippi Code of 1972 to authorize a health care certificate of need for ICF-MR beds in community living programs for developmentally disabled adults. *(Filed 1/10/06; died in committee 1/31/06)*
MS HB 1095 Rep. Young	For the State Department of Health to provide a health care certificate of need for Psychiatric Residential Treatment Facility beds to be transferred; etc. *(Filed 1/16/06; died in committee 1/31/06)*
MS HB 1221 Rep. Compretta	Relates to moving nursing home beds from one facility to another; etc. *(Filed 1/16/06; passed House 3/22/06; passed Senate 3/22/06; signed into law by Governor 3/29/06)*
MS HB 1231/HB 1232/HB 1234 Rep. Flaggs	Relates to an ambulatory surgical facility; certain offices of private physicians shall require certificates of need; Revises the list of activities that require certificates of need. *(Filed 1/16/06; died in committee 1/31/06)*
MS HB 1283 Rep. Baker	Specifies requirements for issuance of CON for relocation of a health care facility. *(Filed 1/16/06; died in committee 1/31/06)*
MS SB 2011/SB 2018 Sen. Thomas	Certificate of Need Program for ICF/MR beds in a community living program for developmentally disabled adults; Nursing facility beds at "Green House Model" campus located in Yazoo city. *(Filed 1/4/06; died in committee 1/31/06)*
MS SB 2455 Sen. Nunnelee	Certificate of Need Program for community living program for developmentally disabled adults in Madison County. *(Filed 1/10/06; died in committee 1/31/06)*
MS SB 2482 Sen. Thomas	Clarifies Certificate of Need Program for the relocation of a health care facility. *(Filed 1/12/06; died in committee 1/31/06)*
MS SB 2522 Sen. Jackson	Creates an establishment for the Home Health Agency in Kemper County. *(Filed 1/12/06; died in committee 1/31/06)*
MS SB 2593 Sen. Burton	Relates to certificates of need that will transfer ICF/MR and child psychiatric beds from one facility to another. *(Filed 1/13/06; died in committee 1/31/06)*
MS SB 2645 Sen. Brown	Medicaid reimbursement for nursing facility beds under Certificate of Need Programs in Columbus. *(Filed 1/13/06; died in committee 1/31/06)*
MS SB 2653 Sen. Lee	Relates to psychiatric treatment facility beds in Simpson County. *(Filed 1/16/06; died in committee 1/31/06)*
MS SB 2661 Sen. Burton	Clarifies definition of ambulatory surgical facilities under Certificate of Need Program. *(Filed 1/16/06; died in committee 1/31/06)*
MS SB 2675 Sen. Nunnelee	Revises definition of ambulatory surgical facilities and licensure under Certificate of Need Program. *(Filed 1/16/06; died in committee 1/31/06)*
MS SB 2691 Sen. Nunnelee	Relates to health care facility activities under Certificate of Need Program. *(Filed 1/16/06; died in committee 1/31/06)*
MS SB 2710 Sen. Dawkins	Would impose a certificate of need moratorium on specialized programs offered by hospitals. *(Filed 1/16/06; died in committee 1/31/06)*
MS SB 2764 Sen. Horhn	Would authorize a certificate of need program for a nursing facility in any underserved minority zip code area in the state. *(Filed 1/16/06; died in committee 1/31/06)*
MS SB 2859	Would move nursing home beds from one facility to another and to construct another facility. *(Filed 1/16/06; died in committee 1/31/06)*

Sen. Kirby	
MS SB 2959 Sen. Lee	Would transfer certificates of need from Hancock to Stone and other counties. *(Filed 1/16/06; died in committee 1/31/06)*
MO HB 1537 Rep. Shaaf	Refers to 'long-term care facilities' for the purpose of the Certificate of Need Program and limits application of certificate of need requirements to long-term care facilities. *(Filed 1/25/06; did not pass by end of regular session, 2006)*
NJ AB 1469 Asmb. O'Toole	Requires certain background checks for assisted living administrators and applicants for certificate of need. *(Filed 1/10/06; Referred to committee 2/2/06)*
NJ AB 2691 Asmb. Stanley	Prohibits granting certificates of need for hospital closures in service areas with high incidence of morbidity unless DHSS has plan to manage public health emergency. *(Filed 2/23/06; Referred to committee 2/27/06)*
NJ ACR 120/SCR 53 Asmb. Van Drew	Urges DHSS to allocate 25% of new slots that are available in FY 2006 under Enhanced Community Options waiver to assisted living program providers. *(Filed 1/17/06; Referred to committee 2/26/06)*
NY AB 3263 Rep. Gottfried	To amend the public health law, in relation to nursing home staffing levels. *(Filed 2/1/06; Referred to committee 2/1/06)*
NY AB 3266 Rep. Gottfried	To amend the public health law, in relation to a nurse staffing centers; Additional powers and duties for the Commissioner of Health; Authorizes such commissioner to establish an advisory committee to advise in related issues; etc. *(Filed 2/1/06; Referred to committee 2/1/06)*
NY AB 3928 Rep. Brennan	An act to amend the mental hygiene law, in relation to establishing minimum staffing ratios in facilities operated under the jurisdiction of the office of mental health. *(Filed 2/7/06; Referred to committee 2/7/06)*
NY AB 5346 Rep. Gottfried	An act to amend the public health law, in relation to hospital establishment. *(Filed 2/18/06; Referred to committee 2/18/06)*
NY AB 11920/ S 7494 Rep. Gottfried	Relates to the limitation on the number of continuing care retirement community beds in the state. *(Filed 6/16/06; passed House 6/23/06; passed Senate 6/23/06)*
NY SB 3949 Sen. Oppenheimer	Requires health commissioner to make certain findings concerning access to health care services as a prerequisite to approving applications for establishment, incorporation or construction of certain health care facilities. *(Filed 4/5/05; Referred to committee 4/4/05)*
NY SB 4572 Comm. for Public Hlth.	Establishes minimum staffing levels of types of various personnel in nursing homes throughout any particular day; creates the advisory council on nursing home staffing to make recommendations to the governor, legislature and commissioner of health on nursing home staffing; requires public disclosure by each nursing home of its staffing levels and reporting thereof to the department of health. *(Filed 4/15/05; Referred to committee 4/15/05)*
NY SB 6716/AB 8877	Relates to increasing availability of services in certain assisted living programs. *(Filed 6/15/05; passed Assembly 6/23/05; passed Senate 6/23/05; signed into law by Governor Chapter 593, 8/23/05)*
NY	The Commission on Health Care Facilities in the 21st Century report proposes major adjustments in existing facilities including closings and downsizing. **A Prescription for New York City's Health Care Crisis:** Recommendations of the New York City Council Hospital Closing Task Force. *(Report issued 11/06; implementation pending 1/07)*
NC HB 465 Rep. Culpepper	To amend the Certificate of Need Laws. *(Filed 3/24/05; referred to committee 4/6/05)*
NC HB 1160 Rep. Wright	To change the definition of "Critical Access Hospital" to conform to federal law. *(Filed 3/30/05; passed House 4/13/05; passed Senate 8/23/05; signed into law by Governor 9/02/05)*
NC HB 2115	To appropriate funds to the Department of Health and Human Services, Division of facility services, to enhance fair and consistent application of the certificate of need law and health planning process.

Rep. Nye	*(Filed 5/22/06; Referred to committee 5/23/06)*
NC SB 740 Sen. Rand	To amend the Certificate of Need Laws. *(Filed 3/21/05; passed House 7/13/05; passed Senate 8/16/05; signed into law by Governor 8/26/05)*
NC SB 1161/HB 1112 Sen. Apodaca	Requires the Department of Health and Human Services to develop a central registry of available beds in mental health facilities to assist in the placement of individuals involuntarily committed to the facilities. *(Filed 3/23/05; did not pass by end of regular session, 2006)*
PA HB 2443 Rep. Killian	Relates to health care; delegating responsibilities to the State Health Coordinating Council, etc., providing certificates of need for health care providers and prescribing penalties, etc. *(Filed 2/8/06; Referred to committee 6/13/06)*
PA SB 1253 Sen. Greenleaf	Exempts continuing care retirement communities from the medical assistance bed approval process and allowing nursing facilities operated by continuing care retirement communities to obtain medical assistance certified beds under limited terms and conditions. *(Filed 6/22/06; Referred to committee 6/22/06)*
RI HB 5868 Rep. Landroche	Relating to Businesses and Professions, Board of Medical Licensure and Discipline, and self-referral. *(Filed 3/1/05; Did not pass by end of regular session, 2005)*
RI HB 5870 Rep. Lewiss	Relates to health and safety and the licensing of health care facilities. *(Filed 3/1/05; Did not pass by end of regular session, 2005)*
RI HB 5915 Rep. Savage	Relates to determination of need for new health care equipment and new institutional health care institutions. *(Filed 3/1/05; Did not pass by end of regular session, 2005)*
RI HB 7622 Rep. Long	Relates to determination of need for new health care equipment and new institutional health care institutions. *(Filed 2/16/06; Did not pass by end of regular session, 2006)*
RI HB 8058 Rep. Long	Determination of Need for New Health Care Equipment and New Institutional Health Services *(Filed 5/2/06, passed House6/22/06; passed Senate 6/23/06); signed into law by Governor, 7/5/06)*
RI HB 8246 Rep. Slater	Amends the definitions section, review and approval section, procedures for review section, and application fees section in the "Determination of Need for New Health Care Equipment and New Institutional Health Services" *(Filed 6/15/06; Did not pass by end of regular session, 2006)*
RI SB 426 Sen. Gibbs	To analyze applications for certificate of need. *(Filed 2/10/05; Did not pass by end of regular session, 2005)*
RI SB 784 Sen. Roberts	Amends sections in the Determination of Need for New Health Care Equipment and New Institutional Health Services. *(Filed 2/17/05; Did not pass by end of regular session, 2005)*
RI SB 796 Sen. Badeau	Relates to self-referral by medical practitioners; remove the capital cost test for application/installation of radiologic equipment. *(Filed 2/17/05; Did not pass by end of regular session, 2005)*
RI SB 2741 Sen. Roberts	To reduce the size and make-up of the health services council. *(Filed 2/14/06; passed House 6/23/06; passed Senate 6/22/06; signed into law by Governor 7/5/06)*
SC HB 3601/SB 592 Rep. Pitts	Relates to the State Health Planning Committee including the development and contents of the state health plan for use in the Administration of the Certificate of Need Program, so as to require the state health plan to include a provision that the Department of Health and Environmental Control shall approve a certificate of need application for open heart surgery if the applicant meets certain criteria. *(Filed 2/22/05; Referred to committee 2/22/05)*
SC SB 1053 Sen. Peeler	Relates to the State Health Planning Committee including the development and contents of the state health plan for use in the approval of certificates of need, including a certificate of need for methadone treatment facilities; provides that a certificate of need is required for the acquisition of certain medical equipment. *(Filed 1/18/06; Referred to committee 1/19/06)*
SC SB 1296	Relates to certificate of need requirements for home health agencies, so as to exempt from these requirements private duty home care agencies that participate in state-funded waiver programs, that

Sen. Hutto	continuously have provided these services since January 1, 2001, and that are accredited by the Joint Commission for the accreditation of health care organizations. *(Filed 3/16/06; Referred to committee 3/16/06)*
TN HB 228/SB 1751 Rep. Overbey	To increase state expenditures to the extent the replacement facility increases the nursing home bed pool, there could be an increase in the number of beds. Such an increase could result in an increase in expenditures exceeding $1,000,000 ($360,000 in state fund and $640,000 in federal funds). *(Filed 2/1/05; passed House 94y-0n, 5/22/05; passed Senate 32y-0n, 5/4/05; signed into law by Governor as Chapter 385, 5/23/05)*
TN HB 1088/SB 1007 Sen. Ford	Concerns hospitals and health care facilities; revises certificate of need requirements for relocation and partial replacement of nursing home beds and facilities. *(Filed 2/4/05; passed House 93y-0n 5/27/05; passed Senate 30y-0n 5/19/05; signed into law by Governor as Public Chapter 445, 6/24/05)*
TN HB 1112/SB 687 Rep. McMillan	Prohibits issuance of certificates of need for new nursing home beds between July 1, 2005 and June 30, 2007, except for certain Medicare skilled nursing facility beds. *(Filed 2/4/05; passed House 97y-0n, 5/12/05; passed Senate 31y-on, 4/28/05; signed into law by Governor as Chapter 237, 5/27/05)*
TN HB 1986/ SB 2113 Rep. Harmon	Exempts PACE program from certificate of need required to provide nursing home *(Filed 2/17/05; Referred to committee 3/30/05)*
TN HB 2010/SB 2103 Sen. Strader	Imposes a one-year moratorium on certificates of need for non-residential methadone treatment facilities. *(Filed 2/17/05; Referred to committee 4/17/05)*
TN HB 2211/SB 1551 Rep. Buck	Changes the maximum time allowed for reviewing agencies to report concerning a certificate of need application to the health services and development agency from 60 to 50 days. *(Filed 2/3/05; Did not pass by end of regular session, 2005)*
TN HB 3324/SB 3349 Rep. Finney	Clarifies that applications for a certificate of need shall be filed within five business days from the date of publication of the letter of intent *(Filed 2/16/06; Referred to committee 3/5/06)*
TN SB 2958/HB 3026 Sen. Cooper	Increases the total number of beds in ICF/MR facilities that have been providing state-contracted services to persons with developmental disabilities for at least five years by 50 beds per year for the next four years after July 1, 2006. This change would result in a maximum of 868 beds by June 30, 2009. *(Filed 2/17/06; passed House 98y-0n 5/11/06; passed Senate 32y-0n 4/20/06; signed into law by Governor as Chapter 761, 5/25/06)*
VT HB 35 Rep. Obuchowski	Health; health care administration; health facilities; discontinuance of services; licensing of hospitals; open meetings; public records; certificate of need; hospital budgets. *(Filed 1/13/05; Referred to committee 1/13/05)*
VT HB 459 Rep. Hube	To reform Vermont's Certificate of Need Laws. *(Filed 3/8/05; Referred to committee 3/8/05)*
VT HB 567 Rep. Keenan	Relates to exemption from certificates of need and HMO requirements for PACE. *(Filed 1/20/06; passed House 2/3/06; passed Senate 2/3/06; signed into law by Governor 2/15/06*
VA HB 267 Rep. Cole	Authorizes the submission of an application for an increase in nursing home beds, either on-site or through relocation within the same city or county, for a facility that was licensed for less than 40 beds under certain specific conditions. *(Filed 1/4/06; passed House 98y-1n, 2/14/06; passed Senate 40y-0n, 3/7/06; signed into law by Governor as Chapter 816, 4/6/06)*
VA HB 381 Rep. Suit	The bill authorizes the facility to request an amendment to its previous certificate of public need to admit persons, other than residents of the cooperative units, to its nursing home facility beds. The facility must be: (i) operated by an association described in § 55-458; (ii) created in connection with a real estate cooperative; and (iii) providing its residents a level of nursing services consistent with the definition of continuing care in Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2. *(Filed 1/6/06; passed House 94y-0n, 1/24/06; passed Senate 40y-0n; 3/6/06; signed into law by Governor as Chapter 776, 4/6/06)*
VA HB 1139 Rep. Cline	Requires the Board of Health to develop staffing regulations specific to entities that are concurrently licensed as a hospice and an assisted living facility that would not require the presence on each shift of a registered nurse for any concurrently licensed facility that has no more than four beds and operates

	within an integrated healthcare system. *(Filed 1/11/06; Died in committee 1/24/06)*
VA HB 2243 Rep. O'Bannon	Revises the designation of the parties to the case if an informal fact-finding conference is determined to be necessary by the Department of Health or is requested by a person seeking good cause standing. In such cases, the designation of the parties to the case will include the relevant health planning agency. *(Filed 1/11/05; passed House 96y-0n, 2/7/05; passed Senate 40y-0n 2/22/05; signed into law by Governor as Chapter 404, 3/21/05)*
VA HB 2316 Rep. Griffith	Certificate of Public Need; relocation of certain nursing home beds under limited circumstances. *(Filed 1/11/05; passed House 79y-17n, 1/26/05; passed Senate 38y-1n, 2/21/05; signed into law by Governor as Chapter 99, 3/24/05)*
VA HB 2639 Rep. Hurt	Requires the Commissioner of Health to reissue a Request for Applications for 60 new nursing home or nursing facility beds in Planning District 12 when the scheduled construction date has passed, the company issued a certificate pursuant to a 1997 Request for Applications has not begun construction, and the certificate has expired. *(Filed 1/12/05; passed House 97y-0n, 2/1/05; passed Senate 40y-0n, 2/14/05; signed into law by Governor as Chapter 838, 3/26/05)*
VA HB 2626/ SB 1237 Rep. Orrock	Authorizes DMHMRSAS to license providers of services under the Medicaid Brain Injury Waiver and providers of residential services for persons with brain injury. The bill requires the State Board of Mental Health, Mental Retardation and Substance Abuse Services to promulgate necessary regulations within 280 days of enactment. *(Filed 1/19/05; passed House 94y-2n, 2/8/05; passed Senate 40y-0n, 2/22/05; signed into law by Governor as Chapter 725, 3/25/05)*
VA SB 426 Sen. Lambert III	Defines "reduced rate," for the purpose of the Commissioner's conditions on approval of a certificate of need. *(Filed 1/11/06; Died in committee 1/19/06)*
VA SB 839 Sen. Cuccinelli	Requires the regulation of abortion clinics as a category of outpatient surgical hospital and sets forth the requirements for the licensure of abortion clinics in a new article. Abortion clinics will not be required to comply with certificate of public need requirements or health care data reporting. The provision becomes effective on January 1, 2006. *(Filed 1/3/05; Referred to committee 2/3/05)*
WA HB 1688 Rep.	Creating a task force to review the certificate of need program and the health care facilities bonding program. *(Filed 2/2/05; passed House 71y-25n, 3/14/05; passed Senate 34y-11n, 4/7/05; signed into law by Governor as Chapter 283, 5/4/05)*
WA SB 5178	Establishes a moratorium on licensing physician owned specialty hospitals, from Jan 1, 2005 to July 1, 2006. *(Filed 1/17/05; passed Senate and House; signed into law by governor as Chapter 39, 4/13/06)*
WA SB 6278	Relates to licensing specialty hospitals. *(Filed 1/10/06; favorable report 2/1/06; did not pass by end of session 3/06)*
WV HB 4082 Rep. Amores	Establishing standards for and guidance to the West Virginia Health Care Authority in amending and modifying certificate of need standards. *(Filed 2/21/06; Referred to committee 2/21/06)*
WV SB 569 Sen. Caruth	Exempting ventilator beds from certificate of need requirement. *(Filed 2/15/06; Referred to committee 2/15/06)*
WV SB 765 Sen. Bowman	Authorizing certain nursing homes to obtain certificates of need for additional beds. *(Filed 2/20/06; Referred to committee 2/20/06)*
WV SB 773 Sen. Kessler	Establishes certificate of need standards. *(Filed 2/22/06; passed House 3/10/06; passed Senate 3/1/06; signed into law by Governor as Chapter 101, 3/23/06)*
WY SB 57	Provides for a study of medical specialty centers and new general hospitals by the Wyoming health care commission. Provides a temporary moratorium on licensing of new hospitals or medical specialty centers, requires a report by November 2006; provides an appropriation. *(Filed 1/24/06; passed Senate and House; signed into law by governor as Chapter 112, 3/24/06)*

Researched and written by Ariel Victoroff for the NCSL Health Program. Initial edition, August 2006
Research and updates under the direction of Richard Cauchi, Health Program Director, Denver, Colorado

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LEGISLATIVE RESEARCH REPORT

JANUARY 30, 2008

REPORT NUMBER 08.127

ALASKA'S STATE HEALTH PLANS

PREPARED FOR REPRESENTATIVE SHARON CISSNA

BY CHUCK BURNHAM, LEGISLATIVE ANALYST

You asked that we identify Alaska's current statewide health plans. You also asked that we provide information on the integration of the state plans with those of the Alaska Native Tribal Health Consortium (ANTHC).[1] In addition, you wanted us to identify states that have undertaken processes that have resulted in successful strategic health plans.

[1] We have requested a copy of the ANTHC strategic plan and will include that document as an addendum to this report when it becomes available. It appears that the ANTHC coordinates its efforts, to some extent, with the state as evidenced by the Department of Health and Social Service's website at *http://hss.state.ak.us/dph/targets/ha2010/volume3/summaries/ANTHCplan.htm*. The Department maintains a reference list of Native Health organizations online at *http://www.hss.state.ak.us/dph/targets/ha2010/volume3/native_ref.htm*.

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SUMMARY

Alaska's current state health planning regime began in the early 1990s through the framework of the federal "Healthy People 2000" program. Under that model, broad-based assessments of the health status indicators of Alaskans were conducted. These assessments served as the baseline health measures against which goals and objectives were established through a grant from the Robert Wood Johnson Foundation's "Turning Point" collaborative, which, in turn, spurred the creation of the Alaska Public Health Improvement Process. These earlier activities served as the foundation for the development of the state's current health plans under the "Healthy People 2010" model.

Two overarching documents currently supply the primary framework for Alaska's public health planning.[2] First, "Healthy Alaskans 2010," consisting of three volumes, contains goals and objectives for twenty-six health "problem areas." Cumulatively, the chapters associated with those areas have been the basis for numerous—at least 38—individual implementation plans and specific program plans. Second, "Moving Forward" is the state's comprehensive integrated mental health plan, which is required as a separate document under Alaska statute.

In the timeframe allowed for this report, we were unable to conduct extensive assessments of other states' planning processes. We do identify, however, publications that discuss "best practices" for cross-disciplinary collaborative planning processes, and we attach documents that examine the experiences of selected states in public health planning and improvement. In addition, we include links to online resources through which you may review assessments of numerous states' activities in specific areas of public health planning and practice.

TURNING POINT

According to Alice Rarig, Health Planner IV, Alaska Department of Health and Social Services (DHSS), Alaska's current health planning regime began in 1999 with the state's involvement with the "Turning Point" collaborative.[3] Formed in 1997, Turning Point is described on the organization's website as follows:

> Turning Point is an initiative of The Robert Wood Johnson Foundation and the W.K. Kellogg Foundation. Its mission was to transform and strengthen the public health system in the United States by making it more community-based and collaborative. The initial idea for Turning Point came from the foundations' concerns about the capacity of the public health system to respond to emerging

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[2] A third document—the Medicaid State Plan—also serves as a vital component of overall statewide health planning. This plan, however, largely concerns the means of financing aspects of the state's plans, and addresses the technical aspects and requirements of federal Medicaid law. The document is, in our view, a detailing of the means of executing health policy rather than a planning document, per se. The plan can be found online at *http://www.hss.state.ak.us/commissioner/medicaidstateplan/Default.htm#top*.

[3] Ms. Rarig can be reached at (907) 465-1285. Extensive information on Turning Point is available on the organization's website at *http://www.turningpointprogram.org/index.html*. Alaska's involvement inTurning Point is conducted by the Department of Health and Social Services. Additional information on the state's current Turning Point activities are available online at *http://hss.state.ak.us/dph/improving/turningpoint/default.htm*, and from Patricia Nault (907-465-8617), Health Program Manager II, who serves as the state's coordinator for the project.

challenges in public health, specifically the system's capacity to work with people from many sectors to improve the health status of all people in a community.

Turning Point's underlying philosophy was that public health agencies and their partners can be strengthened by linking to other sectors (not just the private health care sector, but education, criminal justice, faith communities, business, and others) because the underlying causes of poor health and quality of life are tied closely to social issues that are too complex to be approached by disease models of intervention.

Turning Point specifically collaborated with its 23 state partners to pursue the following overarching actions:

- Influence good public health policy
- Expand information technology so data is available to local communities for addressing health concerns
- Stimulate state agencies and organizations to develop comprehensive state health plans

The state's involvement with Turning Point resulted in the formulation of the Alaska Public Health Improvement Process (APHIP), which the DHSS describes as follows:

> APHIP is a planning process implemented to develop a better understanding of Alaska's public health system and infrastructure, to identify weaknesses in the system, and to set goals and develop strategies for strengthening the state's public health infrastructure. This process was supported by a grant from the Robert Wood Johnson Foundation from April 1997-March 1999. It resulted in a successful application to the Foundation for subsequent implementation funds to support creation of an Alaska Public Health Information System, to lead a national initiative to modernize state public health law, and to participate in a national initiative to promote performance management in public health. Other goals identified through the public health improvement process, such as assurance of a well trained, competent public health workforce, are also currently being addressed by a number of public health system partners.[4]

HEALTHY ALASKANS 2010

Emerging out of the APHIP process, "Healthy Alaskans 2010" is the state-focused adaptation of "Healthy People 2010," the current national public health guidelines and objective developed by the U.S. Department of Health and Human Services.[5] According to the DHSS, Healthy People

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[4] *http://hss.state.ak.us/dph/improving/aphip/default.htm*

[5] In 1994, DHSS published a plan to assess the health status of Alaskans and to identify key actions to be taken in order to make progress on certain health indicators based on the framework provided by the national Healthy People 2000 program. The data from these assessments serve as the baseline health status indicators upon which the updated goals and new measures of Healthy People 2010 seek to improve. More information on Healthy People 2010 is available on the program's website at *http://www.healthypeople.gov/About/*.

2010 was "developed through a broad consultation process" and is "built on the best scientific knowledge" and is designed to measure health trends over time. The program has two-overarching goals, as follows:

- To help individuals of all ages increase life expectancy and improve their quality of life; and
- To eliminate health disparities among different segments of the population.

Numerous states have followed the federal Healthy People framework in formulating their health plans and policies. This circumstance will likely continue, as grants from the Centers for Disease Control—on which many state public health programs depend—are often tied to meeting the priorities and objectives of the program.

The development of Healthy Alaskans 2010 was guided by the Healthy Alaskans Partnership Council (formerly the APHIP Steering Committee). The Council was comprised of representatives of at least 32 organizations including state agencies, health care associations, the state university system, the military, Native health organizations, private health provider agencies, and the legislature. Under the Council's guidance three volumes were produced under the Healthy Alaskans 2010 title. Volume I is comprised of twenty-six "problem-area" chapters, authored primarily by DHSS staff, that each provide information, objectives and targets for a unique public health issue area.[6] Volume II is the strategic plan for the project; however, the volume employs the novel approach of using anecdotes and stories from communities across Alaska to impart the importance and relevance of each of the volume's chapters and issue areas.

Whereas volumes I & II of Healthy Alaskans provide the framework for the state's public health regime, volume III contains at least 38 specific program plans that are currently in effect in the state. Each of these plans relates to the objectives, targets and strategies of one or more of the issue areas delineated in volumes I & II of the series.[7]

COMPREHENSIVE INTEGRATED MENTAL HEALTH PLAN

The DHSS, in conjunction with the Alaska Mental Health Trust Authority (AMHTA), is required by AS § 47.30.660 to "prepare, and periodically revise and amend, a plan for an integrated comprehensive mental health program." The current plan, "Moving Forward," covers the years 2006-2011, and was "coordinated with federal, state, regional, local, and private entities involved in mental health services," as is required by statute.[8] The DHSS and the AMHTA specifically acknowledge the contributions to the report of the Alaska Commission on Aging, the Governor's Council on Disabilities and Special Education, the Governor's Advisory Board on Alcoholism and Drug Abuse, and the Alaska Mental Health Board. In the view of the authors, the involvement of these groups "assures that the Comprehensive Integrated Plan is consistent with the planning

[6] We include copies of Healthy Alaskans Volumes I & II as Attachment A. Volume III is available online at *http://hss.state.ak.us/dph/targets/ha2010/volume3/default.htm*

[7] The DHSS maintains a table for cross-referencing individual program plans to the 26 chapters of Healthy Alaskans volume I online at *http://hss.state.ak.us/dph/targets/ha2010/volume3/chapters.htm*

[8] We include a copy of "Moving Forward" as Attachment B. Additional information and electronic copies of the plan are available at *http://www.hss.state.ak.us/commissioner/healthplanning/movingforward/default.htm*. More information on the Alaska Mental Health Trust Authority is available online at *http://www.mhtrust.org/*

efforts" of statutory advisory and advocacy boards." According to the authors, the intent of the plan is as follows:

> . . . to guide resource allocation decisions in the development of services, workforce, and facilities to meet the needs of Trust beneficiaries. The overall goal is a service system that quickly meets the needs of each individual, where highly qualified staff from state, federal, tribal and private agencies have the resources necessary to work together to provide seamless care for the best outcome possible for each person. Another goal is to reduce the incidence of Trust beneficiaries' disabling conditions through prevention and early intervention, to the extent possible.

ALASKA HEALTH CARE STRATEGIES PLANNING COUNCIL

On February 15, 2007, Governor Palin issued Administrative Order 232, establishing the Alaska Health Care Strategies Planning Council. In the order, the Governor states that the provision of adequate health care is among the "most pressing domestic issues" for the country. She further states that providing health care in Alaska is complicated by the state's "unique demographic characteristics, including our small and geographically disbursed population." The Council is tasked with addressing these complexities by synthesizing and building upon past health care planning efforts in order to fulfill the following objectives:

> . . . develop a statewide plan to identify short-term and long-term strategies to effectively address the issues of access to, and cost and quality of, health care for Alaskans. The council's development of a health care action plan should serve to educate all Alaskans about the myriad of public policy choices regarding health care issues and should engage both governmental agencies and the private sector in finding solutions to these problems.[9]

On May 8, 2007, the Governor appointed fourteen Alaskans to serve on the Council. These members include health care providers; administrators of hospitals, nursing homes, tribal and community health organizations; and current and former policymakers including non-voting ex-officio members Senator Bettye Davis and Representative Peggy Wilson, the respective chairs of the Senate and House Health Education and Social Services Committees. The group, under the guidance of DHSS Commissioner Karleen Jackson, held a "health care conference" and a total of seven public meetings between June and December, 2007, to gather public testimony on health care access, cost, and quality, and to educate Alaskans on health care issues in the state. The meetings were held at various locations in Anchorage, and were available via streaming live video online.

The Council submitted its final report and recommendations to the Governor and the Legislature on December 23, 2007. The order establishing the Council directed that the report include the following:

> (1) a description of the current health care system in Alaska;

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[9] Many of the state's various health plans are available through the "publications" section of the website of the Department of Health and Social Services at the following URL: *http://www.hss.state.ak.us/commissioner/Healthplanning/publications/default.htm*.

(2) an inventory and analysis of all existing private and public health care plans, reports, and Initiatives in Alaska;

(3) short-term and long-term statewide strategic plans designed to improve health care access, cost, and quality within the next ten years; each strategy should

(A) include estimates of cost and potential funding sources;

(B) involve non-traditional stakeholders, including business, philanthropic, faith-based, and other community organizations; and

(C) promote integration across public and private health care delivery systems; and

(4) performance measures and accountability mechanisms to provide policy makers with tools to assess the success of the strategic plans over time.[10]

According to the Council's report, however, the short operational time frame did not allow the group to address the Governor's directive to present fiscal information to accompany each of the strategies outlined in the report. The Council further indicates that implementation plans were beyond the scope of its report, but that its recommendations nonetheless present a "real and actionable foundation" for meeting the long-term goals and strategic directions articulated in its report. The first of these recommendations, as listed in Appendix A of the final report, is to create an "ongoing and quasi-independent" Alaska Health Care Commission.[11]

ASSESSING OTHER STATES' HEALTH PLANNING PROCESSES

Due to the limited timeframe allowed for this request, we were unable to conduct an extensive assessment of other states' planning processes. Our research does indicate, however, that the success of a given planning process is ultimately determined largely by the success of the plan once implemented. That is, a plan may only be considered a success if it achieves the goals and outcome targets articulated by the plan. With that in mind, there are a number of organization that have sought to identify the important aspects of successful planning in cross-disciplinary, collaborative circumstances such as those necessarily encountered in large-scale public health planning. One such organization, the National Charrette Institute (NCI), has published a "best practices" report on collaborative, community-based planning.[12]

Additionally, the Turning Point Collaborative, of which Alaska is a member, has a number of publications that identify the efforts and successes of its member-states. We include two of these

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[10] Further information, including meeting schedules, minutes and presentations from the meetings, live web stream links, numerous links to online healthcare resources and reports, and general information about the Council is available online at *http://www.hss.state.ak.us/hspc/meetings.html*

[11] We include the Alaska Health Care Strategies Council, "Final Report: Summary and Recommendations," as Attachment C.

[12] The report and more information on planning processes are available on the NCI website at *http://www.charretteinstitute.org/resources/NCI_RWJF_Forum.html*. The National Charrette Institute describes itself as a nonprofit educational institution that teaches the transformative process of dynamic planning to create healthy community plans.

publications as Attachment D.[13] In addition, synopses of the experiences and successes of specific states' activities in various areas of public health planning are available through the search function of the Robert Wood Johnson Foundation website at *http://www.rwjf.org/*.

I hope you find this information to be useful. Please do not hesitate to contact us if you have questions or need additional information.

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[13] Specifically, we include "Transforming Public Health State by State" and "States of Change: Stories of Transformation in Public Health." Additional Turning Point publications, including recommended statutory changes, performance management, and social marketing, as they relate to public health, are available on the group's website at *http://www.turningpointprogram.org/Pages/archives.html#reports*.

Attachment A

Alaska Department of He. "h and Social Services, Division of Public Health, "Healthy Alaskans 2010," Volumes I & II, November 2005; online at *http://hss.state.ak.us/dph/targets/ha2010/default.htm*

Attachment B

Alaska Department of Health and Social Services, "Moving Forward: Comprehensive Integrated Mental Health Plan, 2006-2011;" available online at http://www.hss.state.ak.us/commissioner/healthplanning/movingforward/default.htm

Comprehensive Integrated Mental Health Plan: 2006-2011

WEBSITE UPDATE

2007

http://hss.state.ak.us/commissioner/healthplanning/movingforward

Index

Email: compMHplan@health.state.ak.us

Executive Summary

Moving Forward, Comprehensive Integrated Mental Health Plan 2006-2011 is the work of the Alaska Department of Health and Social Services, the Alaska Mental Health Trust Authority and other state agencies, boards and commissions. This plan is a response to a statutory requirement that such a plan be developed (AS 47.30.660).

The Comprehensive Integrated Mental Health Plan has a vision of optimal quality of life for Alaskans, especially those Alaskans who receive services under the Comprehensive Integrated Mental Health Program. By law, these recipients (also called beneficiaries) are Alaskans who have a mental illness, a developmental disability, experience chronic alcoholism, or suffer from Alzheimer's disease or a related dementia. Also included are individuals at risk of developing these conditions — for example, children who exhibit behaviors or symptoms suggesting they may develop a mental disorder.

The Comprehensive Integrated Mental Health Plan 2006-2011 looks at the status of Trust beneficiaries in four areas: health, safety, quality of life and economic security. Data are used to show long-term changes in these four areas. Another section of the Plan examines current service delivery and gaps in service. The Plan highlights current efforts to improve health, safety, living with dignity, and economic security for Trust beneficiaries and indicates future avenues for further efforts.

Abbreviations Used in this Plan

CIMHP	Comprehensive Integrated Mental Health Plan
DHSS	Alaska Department of Health and Social Services
AMHTA	Alaska Mental Health Trust Authority
AS	Alaska Statutes
AMHB	Alaska Mental Health Board
ABADA	Advisory Board on Alcoholism and Drug Abuse
ACoA	Alaska Commission on Aging
GCDSE	Governor's Council on Disabilities and Special Education

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I. Introduction

Plan Vision

The vision of the Comprehensive Integrated Mental Health Plan is optimal quality of life for all Alaskans, especially those experiencing mental and emotional illness, cognitive and developmental disabilities, alcoholism and substance use disorders, and Alzheimer's disease or similar dementia.

Authority for Plan

Alaska Statute 47.30.660 requires the Department of Health and Social Services, in conjunction with the Alaska Mental Health Trust Authority, to develop and revise a plan for a comprehensive integrated mental health program for Alaska. Under the statute, the preparation of this plan is to be coordinated with federal, state, regional, local, and private entities involved in mental health services.

Purpose of Plan

The purpose of this Comprehensive Integrated Mental Health Plan (Comp MH Plan) is to guide resource allocation decisions in the development of services, workforce, and facilities to meet the needs of Trust beneficiaries. The overall goal is a service system that quickly meets the needs of each individual, where highly qualified staff from state, federal, tribal and private agencies have the resources necessary to work together to provide seamless care for the best outcome possible for each person. Another goal is to reduce the incidence of Trust beneficiaries' disabling conditions through prevention and early intervention, to the extent possible.

Moving Forward: Comprehensive Integrated Mental Health Plan is coordinated with plans developed by the Alaska Mental Health Board, the Governor's Council on Disabilities and Special Education, the Governor's Advisory Board on Alcoholism and Drug Abuse and the Alaska Commission on Aging, collectively called the beneficiary planning and advocacy boards, and by the Department of Corrections' 1999 plan. This plan is also linked with such DHSS plans as Healthy Alaskans 2010 and other planning initiatives. (hyperlink to http://hss.state.ak.us/commissioner/Healthplanning/publications/assets/stateHealthPlans.pdf

Target Population of Plan

Moving Forward: Comprehensive Integrated Mental Health Plan has a vision of optimal quality of life for Alaskans, especially those Alaskans who receive services under the Comprehensive Integrated Mental Health Program (AS 47.30). By law, these service recipients (also called Trust beneficiaries) are Alaskans who have a mental illness, a developmental disability, experience chronic alcoholism or Alzheimer's disease or a related dementia. Efforts include prevention, to the extent possible, of these disabling

conditions. Those who may need services in the future are included in this plan since prevention is the surest way to limit human suffering and is usually the least costly strategy.

Extent of the Problem

With Alaska data and national prevalence data, we can estimate that there are currently up to 90,000 Trust beneficiaries in Alaska. (This number may include duplications due to the nature of the data available). If those with substance use disorders were counted instead of just those who are alcohol dependent, the number of Trust beneficiaries would rise to 120,000.

- Chronic mental illness (adults): 27,600
- Serious Emotional Disturbance (youth): 17,000
- Alzheimer's Disease (adults over age 65): 4,900
- Brain injured: 10,000
- Developmentally disabled: 11,500
- Alcohol dependent: 19,000

Mental Illness:

Approximately 27,600 Alaskan adults experience chronic mental illness. These are adults who have a diagnosable mental disorder that has resulted in functional impairment which substantially interferes with or limits one or more major life activities such as the ability to perform self care, personal relations, living arrangements, or work.[1]

It is estimated that 17,000 young Alaskans (12 percent of the population under age 18) experience Serious Emotional Disturbance (SED). These are children and youth who have a diagnosable mental disorder that substantially interferes with or prevents them from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills such as completing their education.[2]

Alzheimer's Disease and Related Dementia:

An estimated one in eight Americans over age 65, and nearly half of those 85 or older, have Alzheimer's disease. From 2000 to 2004, deaths from Alzheimer's disease increased 33 percent, while deaths from heart disease, breast and prostate cancers and stroke declined.[3] Although Alzheimer's disease is not a normal part of aging, the risk of developing the illness rises with age.

Using national prevalence rates, the Alaska Commission on Aging estimates that as of 2006, there were 4,916 Alaskans aged 65 and above with Alzheimer's. As of January, 2007, 57 percent of residents in Alaska Pioneer Homes had a dementia diagnosis.[4]

It is estimated that one to four family members act as caregivers for each individual with Alzheimer's disease. Nearly 10 million Americans care for a person with Alzheimer's or other dementia, and about one-third of the caregivers are aged 60 and older.[5]

It is estimated that at least 10,000 Alaskans are living with brain injury today. Every year the Alaska Department of Health & Social Services reports about 800 traumatic brain injury (TBI) cases resulting in hospitalization or fatality. The Alaska TBI rate is 28 percent higher than the national average.[6]

Developmental Disabilities:

According to national prevalence data, 1.8 percent of the national population has a developmental disability. At this rate, it is estimated that 11,500 Alaskans have developmental disabilities.[7]

According to the U.S. Department of Education and other agencies, autism is the fastest-growing developmental disability. It is the most common of the Pervasive Developmental Disorders, affecting an estimated one in 150 births.[8] From 1993 to 2004, autism cases in ages 6-22 increased 522 percent nationwide and 685 percent in Alaska.[9]

Chronic Alcoholism:

Rates of heavy and binge drinking are consistently higher in Alaska than in the United States as a whole. In 2006, the highest prevalence of heavy and binge drinking was among young adults aged 25 to 34.[10]

In 2005, approximately 19,000 Alaskans were alcohol dependent and 49,000 had substance use disorders. Almost 27% of young Alaskans between the ages of 12 and 17 used alcohol in the last month, according to 2004 and 2005 statistics.[11] This is a significant concern, because research shows that young people who begin drinking before the age of 15 are four times more likely to develop dependence.[12]

II. Results Areas

Health

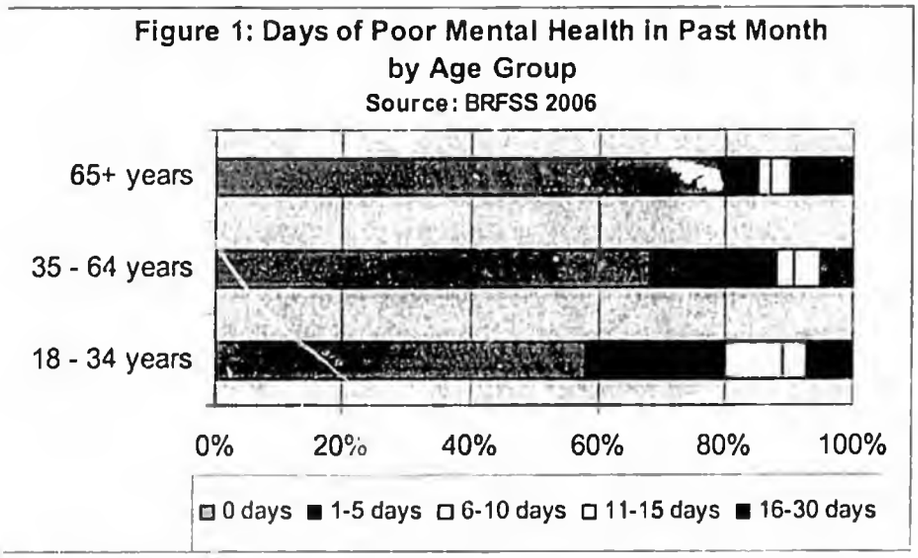
When someone is born as or becomes a Trust beneficiary, the individual and the family want the best care possible—the most helpful services close to home. Accessing behavioral health care can be difficult for Alaskans in small communities, for those who have inadequate or no health insurance, or whose access to information is limited. Not all communities, even larger ones, have a range of treatment programs and other needed supportive services. Without strong support and treatment services, people may not get the services they need, may become homeless, or become involved with the justice system.

Health Goal #1: Enhance quality of life through appropriate services for people with mental and cognitive disabilities and substance use disorders

Good physical and mental health is a common measure of an individual's well being. One way to assess a population's overall health is with a set of measures known as "Healthy Days."[13] Developed by the National Center for Disease Control, Healthy Days is one of the few population-based surveys of mental health status. It measures individuals' self-evaluation of their physical and mental health within the past 30 days.

Figure 1 — Days of Poor Mental Health in Past Month by Age Group

Data from the Behavioral Risk Factor Surveillance Survey[9] show the percent of Alaskans surveyed who self-report the number of days in the prior month that they experienced "poor mental health." Fourteen percent of survey respondents reported more than five days of poor mental health during the previous month. The percentage of young adults who report that they experienced between six and 10 days of poor mental health was three times higher than other age groups.

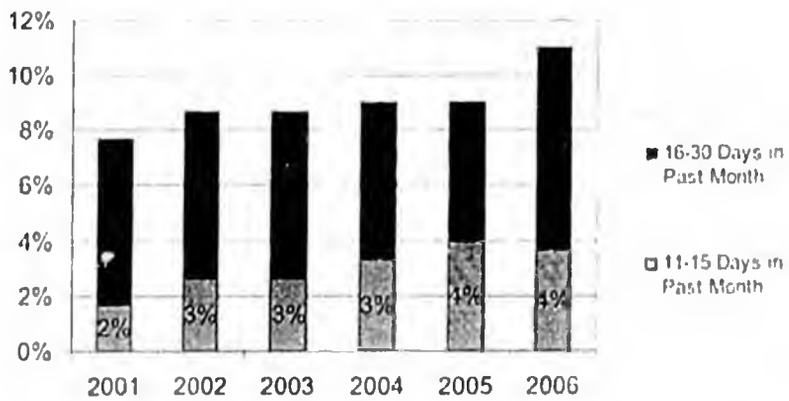


AK DHSS Division of Public Health, Behavioral Risk Factor Surveillance System

Figure HM-1 - Percent of Alaskans Reporting 11-15 Days and 16-30 Days of Poor Mental Health in Past Month, 2001-2006

The number of Alaskans in all age groups reporting poor mental health for more than half of the past month increased in 2006. The number reporting only 11 to 15 days of poor mental health in the past month has increased gradually during the last six years.

Figure HM-1
Percent of Alaskans Reporting 11-15 Days and 16-30 Days of Poor Mental Health in Past Month, 2001-2006



AK DHSS Division of Public Health, Behavioral Risk Factor Surveillance System

Health Goal #2: Reduce the abusive use of alcohol and other drugs to protect Alaskans' health, safety, and quality of life.

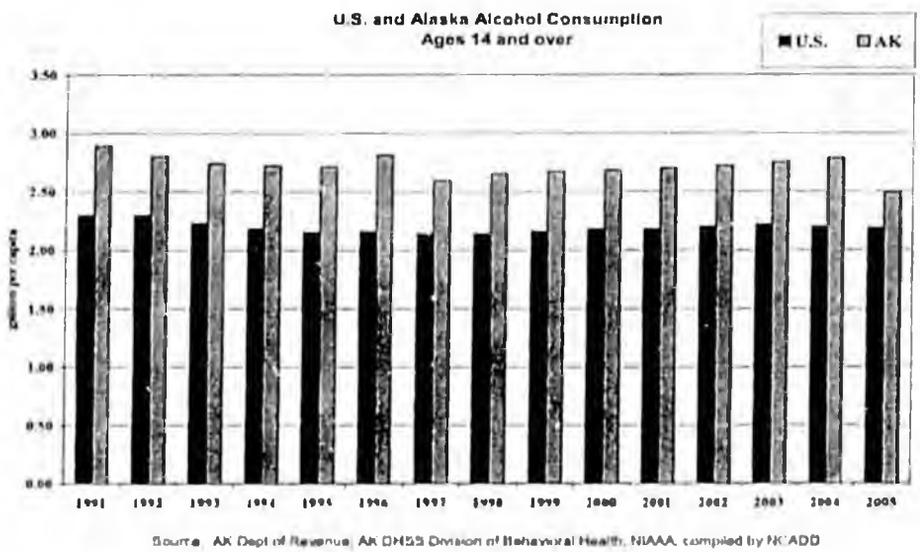
Alcoholism and chemical dependency have long been recognized as Alaska's number one behavioral health problem. Alcoholism and other addictive diseases not only compromise individuals' health but also create profound social problems. The social cost of alcohol abuse is seen in rates of related injuries, chronic disease, and deaths. National research shows that substance abuse has been implicated in 70 percent of all cases of child abuse and that 80 percent of the men and women behind bars are there because of drug or alcohol related crime.[14]

Figure 2 — U.S. and Alaska Alcohol Consumption Comparisons

Alcohol consumption rates reflect the prevalence and severity of alcohol related problems. The alcohol consumption rate in Alaska has been higher than the rate in the rest of the nation during each of the last 14 years, and is well above the *Healthy Alaskans 2010* goal of 2.2 gallons or less per person per year.

Data from the National Institute on Alcohol Abuse and Alcoholism (NIAAA) indicates that Alaska remains in the highest group for alcohol consumption in the nation (per capita ethanol consumption per 10,000 people aged 14 and over). Consumption rates are calculated with in-state sales of alcoholic beverages and the state population of persons 14 years and older.

Figure 2

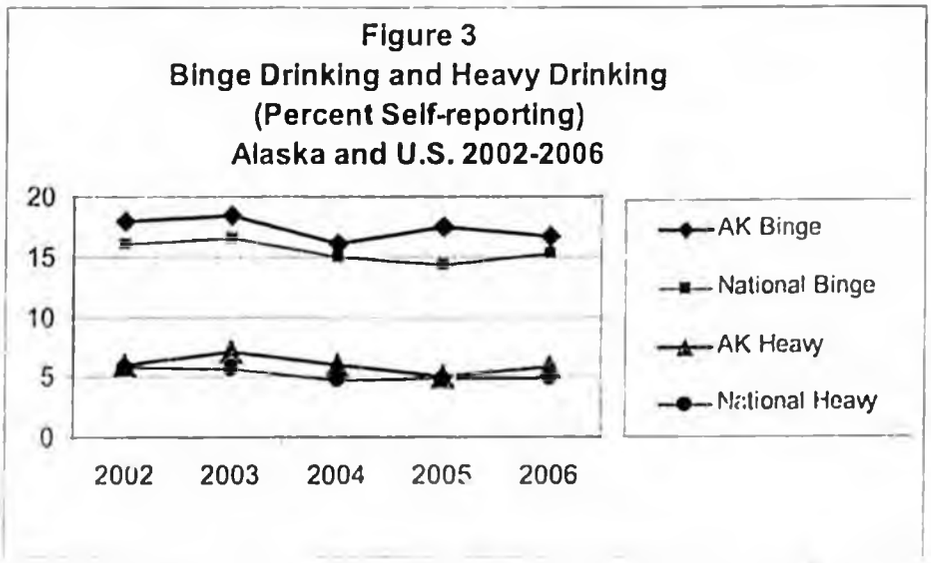


Source: AK Dept of Revenue, AK DHSS Division of Behavioral Health, NIAAA, compiled by NCADD

Figure 3 — Heavy and Binge Drinkers, Alaska and U.S.

Another indication of the pervasiveness of alcohol abuse is the percentage of Alaskans who report acute (binge) and chronic (heavy) drinking. The Behavioral Risk Factor

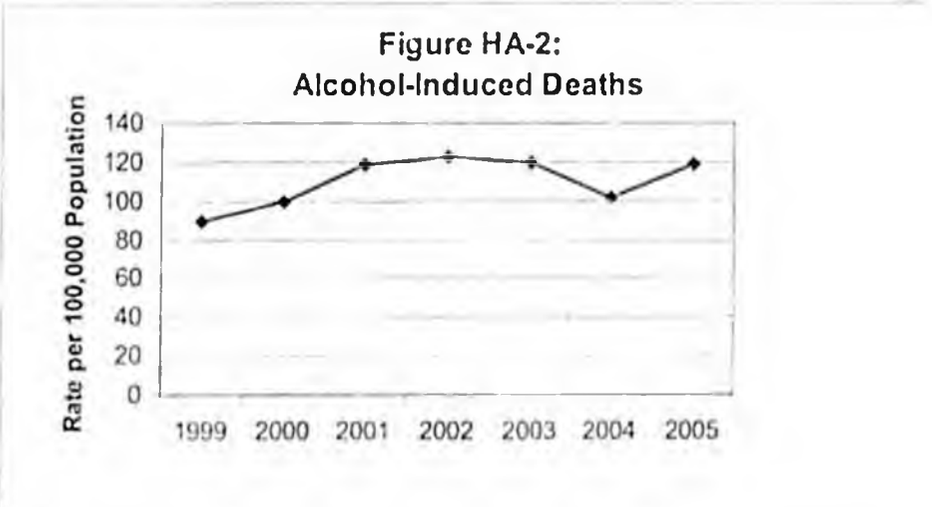
Surveillance Survey[9] shows that binge drinking is more prevalent than heavy drinking, and each year Alaskan adults report more binge and heavy drinking than in the rest of United States. In 2006, the highest prevalence of binge (31%) and heavy (7 %) drinking in Alaska was among young adults aged 18 to 24. Overall, heavy drinking in Alaska rose slightly between 2005 and 2006.



AK DHSS Division of Public Health, Behavioral Risk Factor Surveillance System

Figure HA-2 — Alcohol Induced Deaths

Data for alcohol-induced deaths includes fatalities from alcoholic psychoses, alcohol dependence syndrome, non-dependent abuse of alcohol, alcohol-induced chronic liver disease and cirrhosis, and alcohol poisoning. It does not include deaths due to traumatic injury, such as motor vehicle crashes. There were 119 alcohol-induced deaths in Alaska in 2005.



Source: DHSS Division of Public Health, Bureau of Vital Statistics

On average, 16.7 years of productive life were lost for each alcohol-induced death. The rate of alcohol-induced deaths for Natives was nearly six times higher than that for whites. Alaska males were over 25 percent more likely than females to die from alcohol-induced causes, but this disparity is less than in the U.S. as a whole.[15]

Health Goal #3: Promote healthy births and encourage early childhood interventions to reduce the risk of disability

Alaska families, like those everywhere, strive to have healthy babies and provide good homes for their children. The first three years of a child's life are a time of extraordinary growth physically, mentally, emotionally, and socially. We know that environmental factors have a profound influence on the brain. Research confirms that many children's mental health problems are related to family violence, parents' chemical addiction, mental illness, and poverty.[16] Often a number of identifiable stresses combine to create family dysfunction and to compromise the children's development and health.

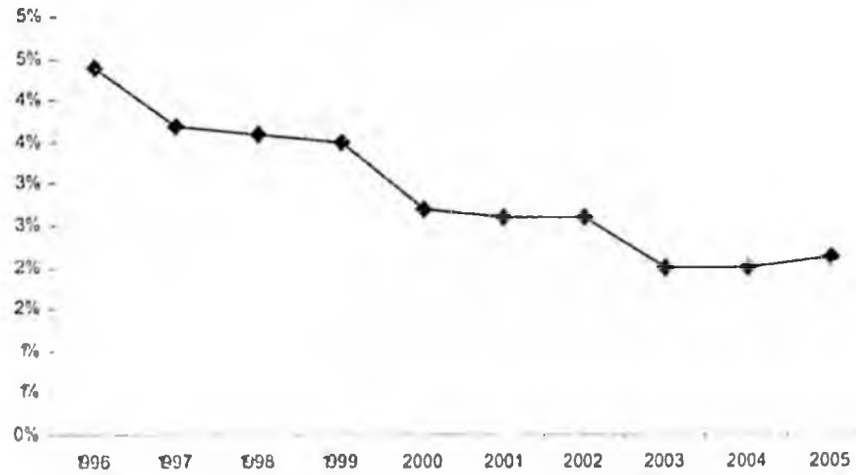
Figure 4 — Percentage of Women Self-reporting Alcohol Consumption During Pregnancy, Alaska 1996-2005

The U.S. Substance Abuse and Mental Health Services Administration estimates the prevalence of FASD at about 100 per 10,000 live births. Brain damage can occur when alcohol crosses the placenta and damages developing tissues. The result may be mild to severe cognitive impairment, mental retardation, social and emotional problems, learning disabilities, visual impairment, neurobehavioral problems and other structural birth defects.. Approximately 126 infants are born each year in Alaska who have been affected by maternal alcohol use during pregnancy.[17]

Alaska Bureau of Vital Statistics birth data indicates an overall decrease in self-reported alcohol use during pregnancy between 1996 and 2005 and a slight increase from 2004 to 2005 (Figure 4). It is generally acknowledged that this data, self-reported by women at the time of delivery, is underreported. However, it is agreed that over the last decade, there has been a significant decline in prenatal alcohol use in Alaska.[18]

For more information about efforts to prevent FASD, see Initiatives section.

Figure 4: Percentage of Women Self-reporting Alcohol Consumption During Pregnancy Alaska 1996-2005



Source: DHSS Div of Public Health, Vital Statistics

Health Goal #4: Reduce the number of suicides in Alaska.

In 2004, the latest year for which official data are available nationally, Alaska's suicide rate was the highest in the nation. Alaskans aged 20-29 years had the highest rate, followed by the 30-39 year old group. The estimated years of potential life lost due to suicide in Alaska was 4,686.[19]

Figure 5 — Alaska Suicide Rates per 100,000 Population by Area, Alaska 1996-2005

Figure 5 shows Alaska's age-adjusted suicide rates per region for the years 1996 through 2005. The regions with the lowest rates of suicide were Kodiak and the Aleutians, while the highest rates were in Nome and the Northwest Arctic.

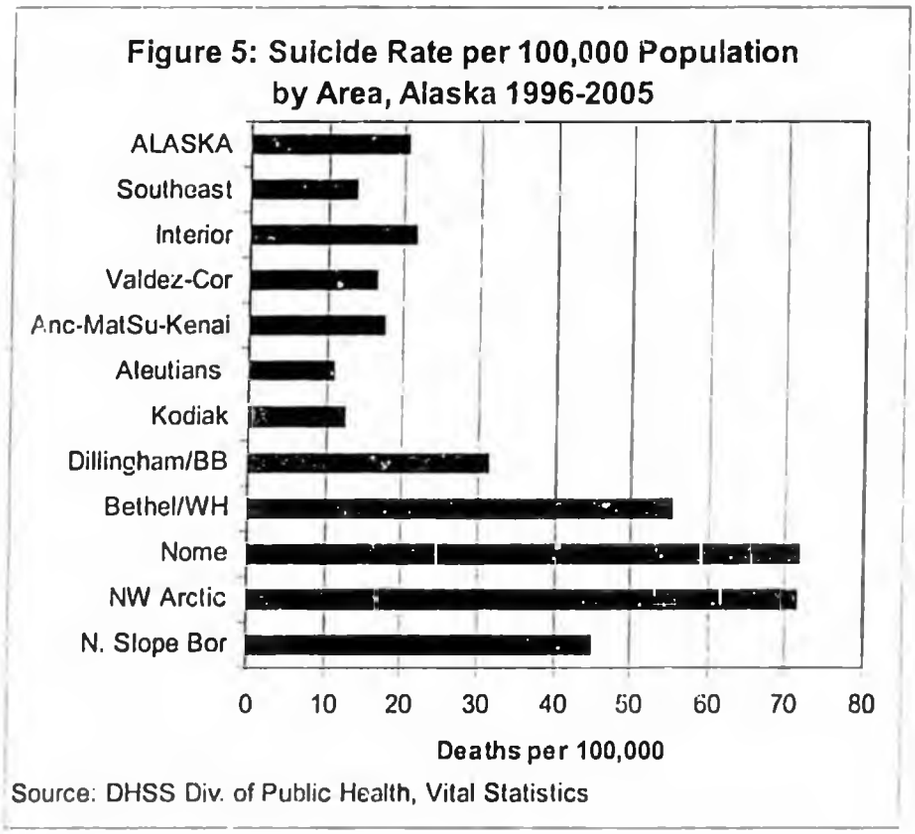
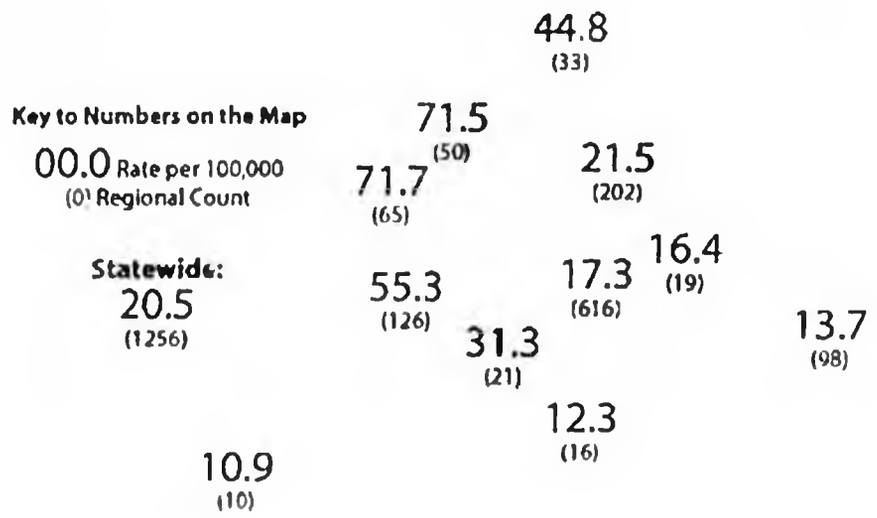


Figure 6: Alaska Suicide Rates (and Numbers) by Region, 1996-2005



Source: DHSS Div. of Public Health, Vital Statistics, compiled by Health Planning and Systems Development

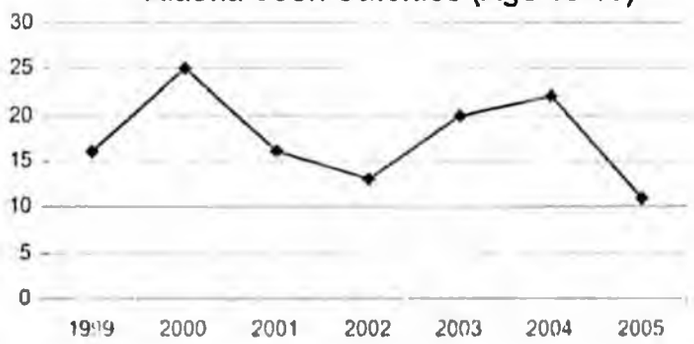
The *Alaska Suicide Follow-back Study* contains information from interviews with the families of some of Alaska's suicide victims from 2003 to 2006. According to the interviews, more than half (54%) of the decedents had a disability or illness that made it difficult for them to take care of normal daily activities. Almost two-thirds (62%) of decedents were reported to have had current prescriptions for mental health medications at the time of their death but many were not taking the medications as prescribed.[20]

Among the suicide cases that had a follow-back interview, a binge drinking rate of 43 percent was reported, which is 2.5 times higher than the Alaska rate and three times higher than the national estimated rate according to the 2005 BRFSS. 43percent of the interviewees said the decedents drank alcohol daily. The interviews indicated that 54 percent of the decedents had smoked marijuana within the past year. The reported rate for alcohol and drug use by Alaska Natives was exactly the same as for non-Natives. Although Alaska Natives comprise only 16 percent of the population, they accounted for 39 percent of the suicides.[21]

Figure HS-1 — Alaska Teen Suicides

Among Alaskans aged 15 to 19, there were 22 suicides in 2004 and 11 in 2005.

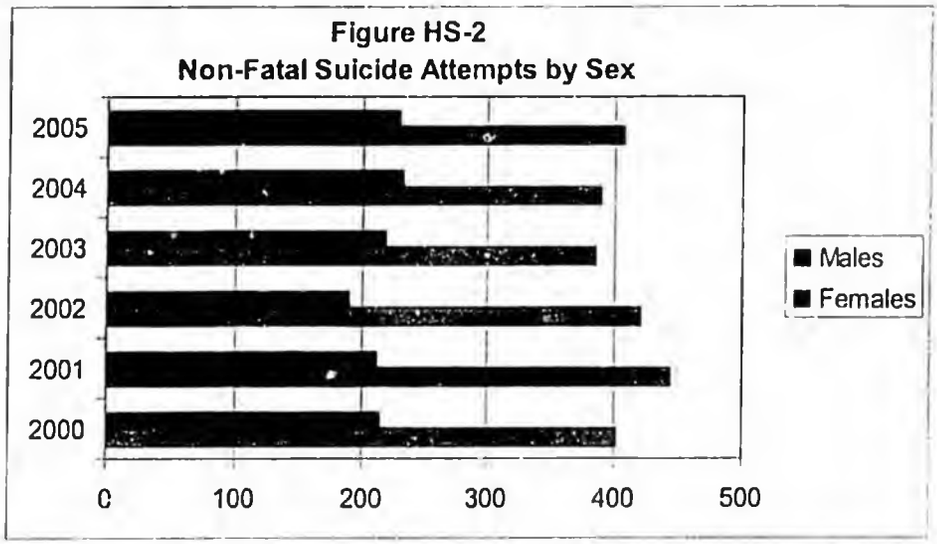
Figure HS-1
Alaska Teen Suicides (Age 15-19)



Source: DHSS Division of Public Health, Bureau of Vital Statistics, Health Profiles

Figure HS-2 — Non-fatal Suicide Attempts by Sex

Between 2000 and 2005, non-fatal suicide attempts were almost twice as high among Alaskan women as compared to men.



Source: Alaska Trauma Registry, 2000-2005, Alaska residents (hospital admissions of 24 hours or more); DHSS DPH Section of Injury Prevention and EMS staff.

Suicidal ideation/attempts from 2003 Youth Risk Behavior Survey (YRBS[22])

- Percentage of students who actually attempted suicide one or more times during the past 12 months: 8.1 %
- Percentage of students who seriously considered attempting suicide during the past 12 months: 16.7 %

Protective Factors

Measures that enhance resilience or protective factors are as essential as risk reduction in preventing suicide. Positive resistance to suicide is not permanent, so programs that support and maintain protection against suicide need to be ongoing.

Protective factors include:

- Effective and appropriate clinical care for mental, physical, and substance abuse disorders
- Easy access to a variety of clinical interventions and support for help seeking
- Restricted access to highly lethal methods of suicide
- Family and community support
- Support from ongoing medical and mental health care relationships
- Learned skills in problem solving, conflict resolution, and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self-preservation instincts[23]

The Current Initiatives section reflects projects to prevent suicide in Alaska.

Health Goal #5: Access: ensure high quality treatment, recovery and support services are provided as close to one's home community as possible.

The Department and The Trust aim to provide sustainable, comprehensive behavioral health services that are based in local communities so that residents can be served as close to their home as possible. Some of the current initiatives that address this goal are the Bring the Kids Home Initiative, the Community-based Suicide Prevention and Rural Human Services project, the Comprehensive Fetal Alcohol Syndrome Project, and Workforce Development.

Estimated Number of Alaska Mental Health Trust Beneficiaries Served by DHSS Divisions (Figure HC-1)

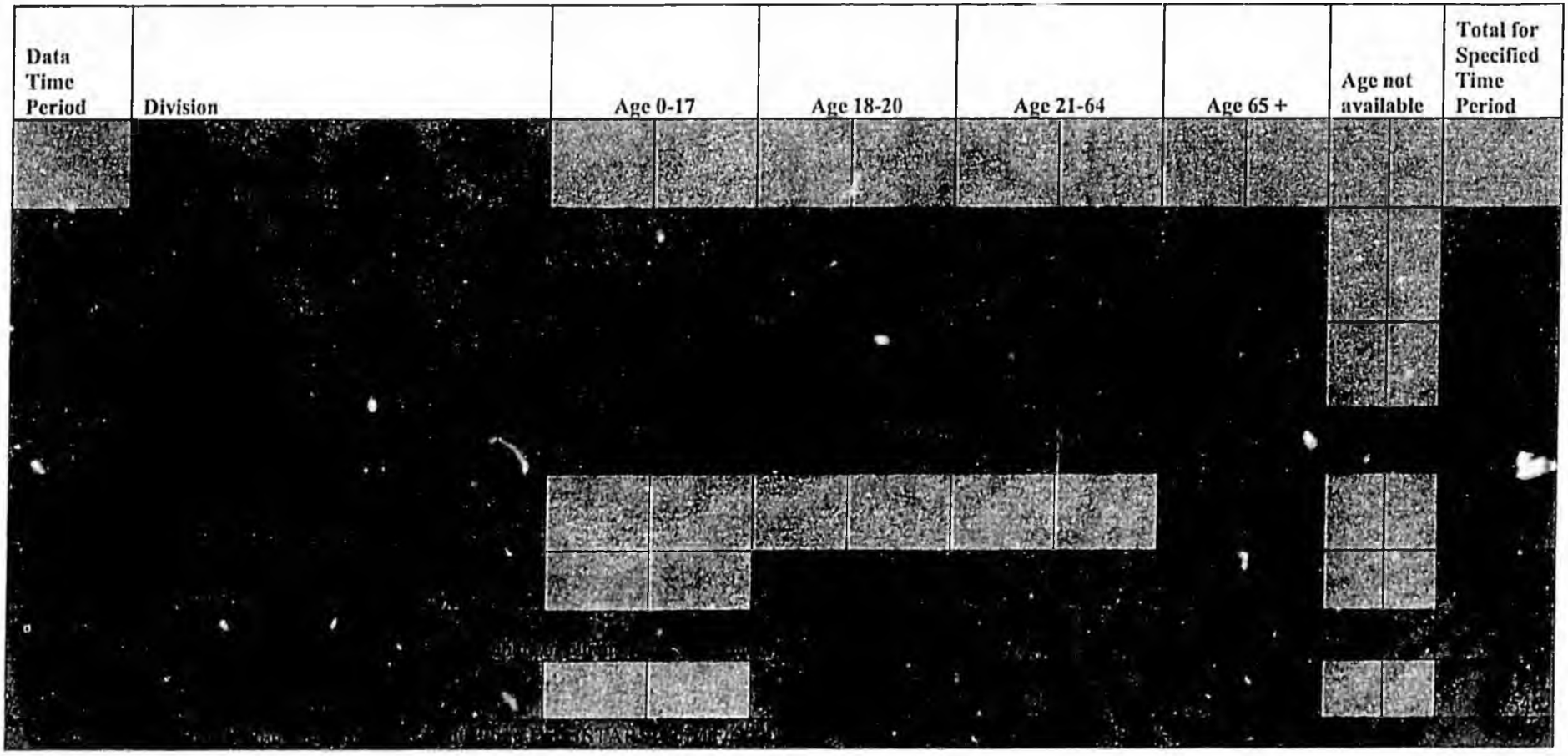
The Department of Health and Social Services serves many Trust beneficiaries in its various programs throughout the state. An estimate of the number of Trust beneficiaries served by each division within the Department is shown in Figure HC-1. Since people served remain anonymous, and the same person may have been served by more than one program or division during the same year, there is not a way to avoid duplication in the numbers in all divisions.

Figure HC-1

Estimated Number* of Alaska Mental Health Trust Beneficiaries Served by DHSS Divisions
***Actual number may be lower - there is duplication in some of the data reported.**

Data Time Period	Division	Age 0-17		Age 18-20		Age 21-64		Age 65 +		Age not available		Total for Specified Time Period
		Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	
FY 2005	Behavioral Health (DBH) - Mental health	3397	4271	247	243	2614	1782	69	29	3	5	12,660
Source:	*These are state community mental health settings, state psych hospitals, and other settings. Some clients may have been served in more than one setting so would be counted twice.* Source: CMHS FY 2005 Uniform Reporting System, Basic Table 3A and B.											
April - Dec., 2005	DBH - FASD Diagnostic team	91		8								99
Source:	*This is the number of clients referred to and screened by the FASD Multidisciplinary Community Diagnostic Teams between April and December 2005. Of those screened, 3% were diagnosed with FAS or atypical FAS; 51% with static encephalopathy; 39% with neurobehavioral disorder; and 7% were found to have no evidence of organic brain damage.* Source: Behavioral Health Research & Services FAS Evaluation Summary Report of the Alaska Multidisciplinary FASD Diagnostic Team Data, UAA (DHRS FAS-Related Technical Report No. 35)											
FY 2005	DBH - Chronic Alcoholism			776								776
Source:	*Estimates drawn from State grantee residential substance abuse treatment facilities quarterly reports to DBH. Excluded from these numbers are youth and women with children.*											

Data Time Period	Division	Age 0-17	Age 18-20	Age 21-64	Age 65 +	Age not available	Total for Specified Time Period
1/1/07 to 4/30/07	Juvenile Justice (DJJ) - Age 0-21						841
	Female	142					
	Male	699					
	Numbers represent youth on supervision with DJJ who had at least one Axis 1 diagnosis, under DSM-IV-TR (clinical disorders & other conditions that may be a focus of clinical attention). Most were 17 years of age or younger. Of the total, 39% also had a co-occurring disorder (substance related disorder accompied by a mental health disorder). Alaska Native youth had more Axis 1 primary diagnoses than any other group. Source: *DHSS Div. of Juvenile Justice*						
One-day snapshot, 5/1/07	**Pioneer Homes**				263		263
Source:	*Total Pioneer Home residents with a dementia diagnosis (sorted for "dementia" in ICD-9 code).* Source: *Division of Pioneer Homes, Accu-Med Electronic Medical Records System*						
One month - April, 2007	**Public Assistance (DPA)** -Alaska Temporary Assistance Program (ATAP) (4/05)	3381					4,784
April, 2007	DPA- Adult Public Assistance (APA)	16,568					16,104
April, 2007	DPA - Food Stamps	22,491					21,477
Source:	*These figures reflect a one-month caseload for all Alaskans; this data does not break out the number of Trust beneficiaries. Not counted are the customers whose cases are managed by the tribal system.* Source: *DPA*						


Data Time Period
Division
Age 0-17
Age 18-20
Age 21-64
Age 65 +
Age not available
Total for Specified Time Period

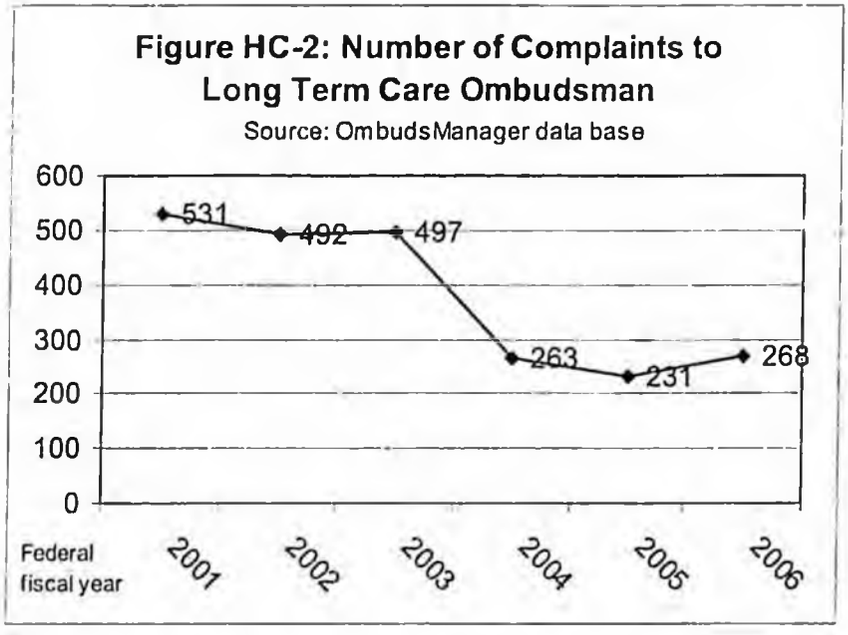
Public perceptions of care

The public behavioral health system is responsible for providing safe and effective care. The system has changed with consumers' increasing involvement in choosing the types of treatment and other services they receive. Today, many agencies include consumers on their boards of directors. Consumers participate in quality assurance reviews for mental health, developmental disabilities, and early intervention/infant learning programs. Consumer satisfaction surveys are included in most provider reviews conducted by the Department of Health and Social Services.

Public perceptions of care as indicated through number of complaints to the Long-Term Care Ombudsman (Figure HC-2).

In 1978, the federal Older Americans Act began requiring every state to have a Long Term Care Ombudsman Program to identify, investigate and resolve complaints and advocate for seniors. The ombudsman investigates complaints about nursing homes, assisted living homes, and senior housing units as well as concerns about individuals' care and circumstances. Consumers, family members, administrators, and facility staff can make complaints regarding the health, safety, welfare, or rights of a long-term care resident. The Alaska ombudsman's office is administratively managed by and resides in the office of the Alaska Mental Health Trust Authority. The majority of funding for the office comes from grants through the federal Administration on Aging.

Figure HC-2 shows the number of complaints that Alaska's Office of the Long-Term Care Ombudsman received from consumers each year. Most of the complaints were against assisted living homes and nursing homes. Beginning with fiscal year 2004, fewer complaints were recorded in this data base because at that time they began counting only cases that their office was actively investigating. Before 2004 the cases they counted also included ones that they were monitoring and that were being investigated by other state agencies such as Adult Protective Services and Certification and Licensing. There have been about 250 complaints actively investigated during each of the last three years.



Alaska has one of the fastest-growing senior populations of all the states, with the number of seniors expected to more than double by 2030. While Alaska seniors have a higher mean and median income than U.S. seniors as a whole, higher living costs may consume much of that additional income. Incomes of senior households located in rural areas and those headed by Alaska Natives have substantially lower incomes. The poorest group is seniors age 85 and over, which is also the fastest-growing sub-group of the senior population. By 2030, the number of Alaskans in this age group is expected to triple. [23]

Consumers Satisfied with Public Mental Health and Substance Abuse Services (Figures HC-3a and HC-3b).

Figures HC-3a and b show the results of a cooperative effort between the DHSS Division of Behavioral health and providers to ask consumers to evaluate services. Questions were asked about satisfaction with services, quality and outcomes, participation in treatment outcomes, access to services, and cultural sensitivity. For interviews in fiscal year 2006, satisfaction ranged from 70 to 82 percent.

Figure HC-3a - Adults

Consumers Satisfied with Public Mental Health and Substance Abuse Services

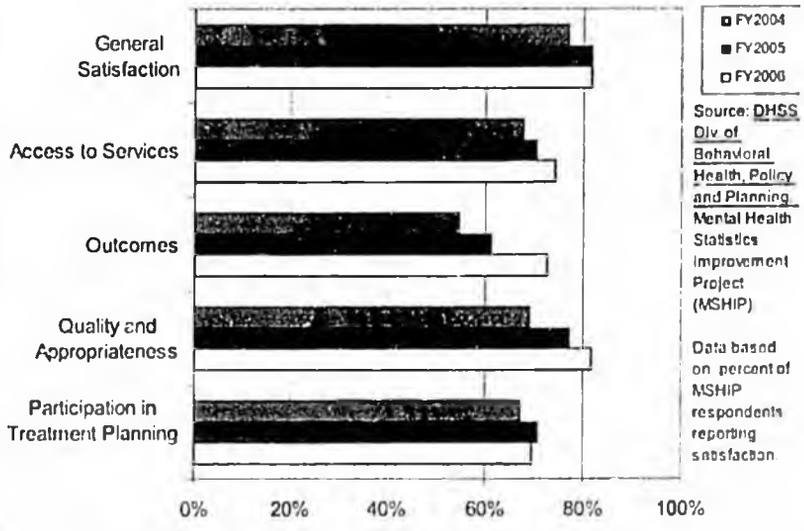
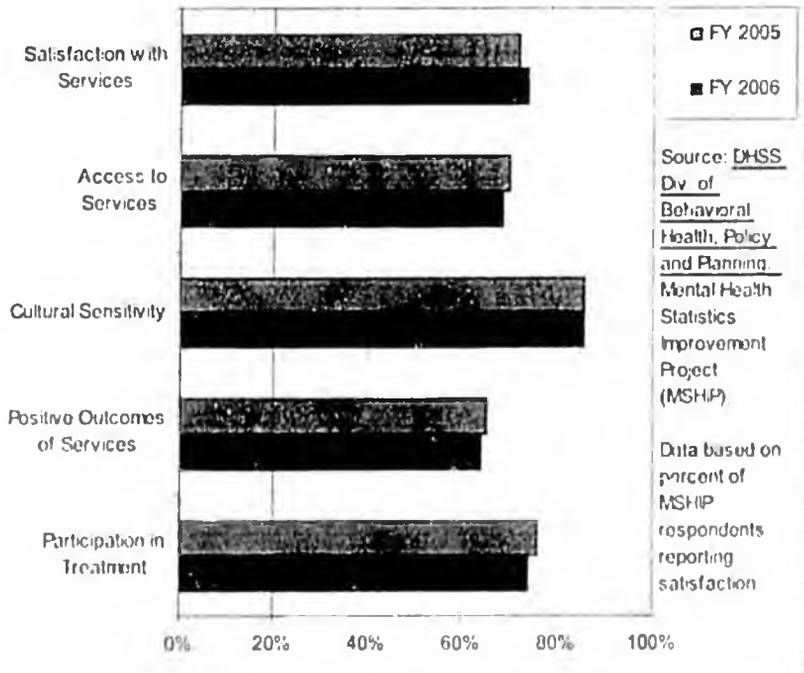


Figure HC-3b - Youth / Families with Youth

Consumers Satisfied with Public Mental Health and Substance Abuse Services



Public perceptions of care as indicated through agencies with family members or consumers on governing/advisory boards

A majority of the behavioral health and developmental disability agencies now include consumers on their governing boards. All 84 agencies providing behavioral health services met the review standard of having consumers or family members in sufficient numbers on the agency governing body or board to ensure their meaningful participation. Consumers of publicly funded behavioral health and developmental disabilities services demand increased involvement in their treatment and care. Consumers or family members of consumers also sit on each of the four statewide advocacy boards and commission.

Safety

Thousands of Alaskans with mental and developmental disabilities are incarcerated each year because they do not get the services they need through Alaska's treatment and support systems. Police and court responses are often the only available resolution to crises or to public displays of untreated mental health problems, when appropriate treatment to prevent or respond to these situations was either unavailable or inaccessible.

Alaska has a high rate of child abuse and domestic violence. Experiencing or even witnessing violence may result in developmental delays, emotional disorders and substance use disorder.[24] Adults with cognitive or developmental disabilities are also vulnerable to neglect and abuse. State programs can assist in strengthening and re-building families, providing treatment, and providing guardianship for adults with mental impairments.

Filling the gaps in treatment and support services, both in communities and within the correctional system, can prevent crises that bring people with mental and developmental disabilities into contact with the criminal justice system and contribute to their repeated incarceration. Training for police, court and prison personnel can help divert many people into appropriate treatment in communities or provide effective treatment when people with mental health problems or developmental disabilities are unavoidably or necessarily incarcerated.

Safety Goal #1: Protect children and vulnerable adults from abuse, neglect, and exploitation

Childhood maltreatment has been linked to a variety of changes in brain structure and function and stress-responsive neurobiological systems.[25] The Adverse Childhood Experiences (ACE) Study provided evidence that adverse childhood experiences cast a major shadow on health and well-being in peoples' lives even 50 years later. "Adverse childhood experiences" include repeated physical abuse; chronic emotional abuse; and growing up in a household where someone was alcoholic or a drug user; a member was imprisoned; a mother was treated violently; someone was mentally ill, chronically depressed, or suicidal; or parents were separated or divorced during childhood.[26]

Figure WS-1 — Unduplicated Count of Children with Reports of Harm

Figure WS-1 shows the unduplicated count of Alaska's children for whom a report of harm was received by the Alaska Department of Health and Social Services Office of Children's Services. Each child is counted only once regardless of the number of reports received. Generally, it indicates the number of children for whom individuals reported some safety concerns to the Office of Children's Services. OCS did not investigate all reports of harm received; some did not meet OCS criteria for investigation and some were referred for another type of response. The number of children with reports of harm increased from 9,531 in state fiscal year 2004 to 12,491 in state fiscal year 2006.

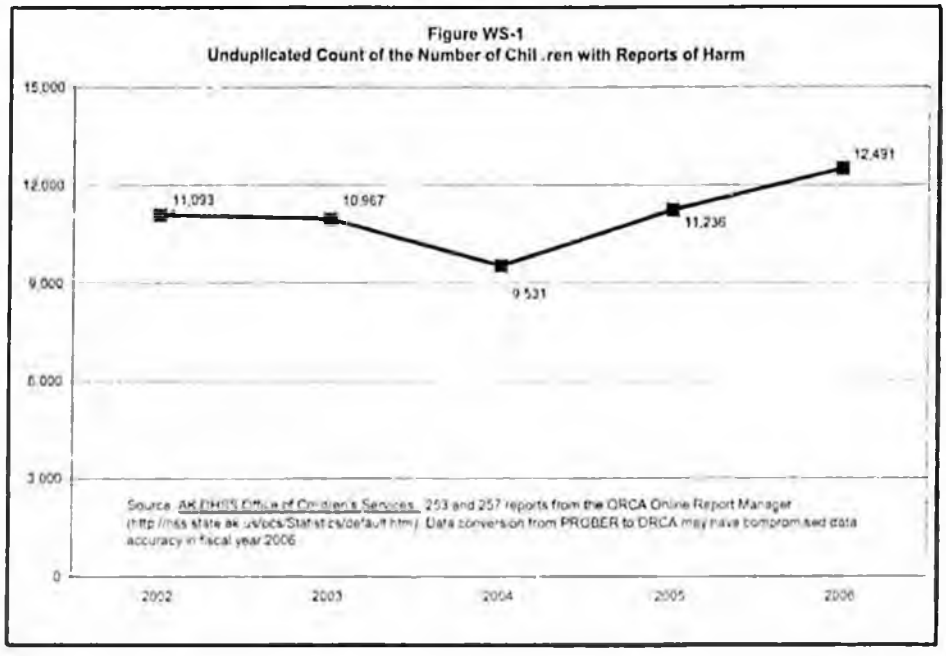


Figure 7 — Safety of Children: Number of Children with a Substantiated Report of Harm by Type of Harm

Figure 7 represents the number of Alaska's children who were substantiated as victims of child abuse and neglect. It counts children who had a report of harm which was investigated and harm substantiated. Each child is counted once for each type of harm substantiated. Types of harm reported and substantiated include neglect, physical abuse, sexual abuse, mental injury, and abandonment. The number of substantiated reports of harm increased between state fiscal year 2005 and state fiscal year 2006.

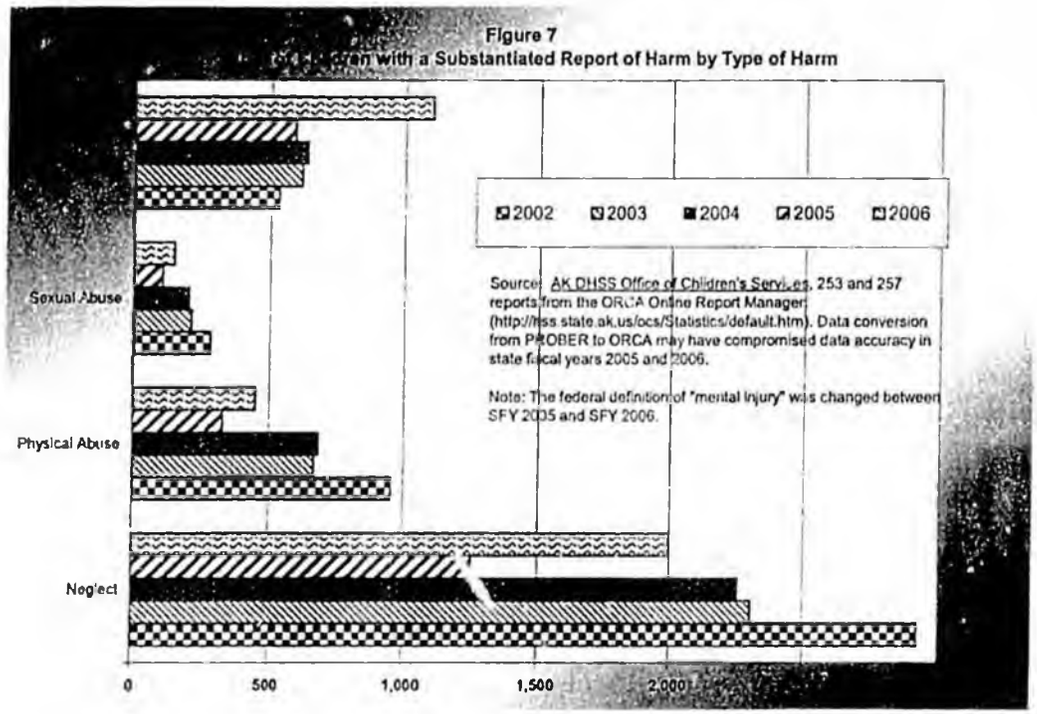
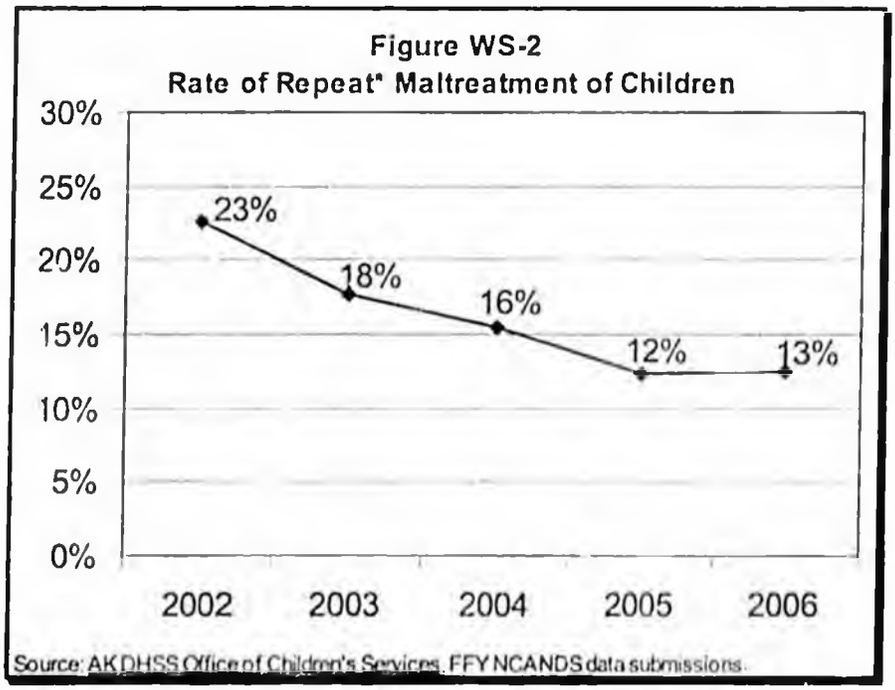


Figure WS-2 Rate of Repeat Maltreatment of Children

Figure WS-2 shows the percentage of all children who were subjects of substantiated or unconfirmed reports of harm during the first 6 months of the year and who had another substantiated or unconfirmed report of harm within 6 months. In state fiscal year 2006, the rate of repeat maltreatment was 13 percent.



Reports of physical injury, sexual assault, and threats/injuries by weapon at school from Youth Risk Behavior Survey [22]

According to the Youth Risk Behavior Survey, the number of high school students reporting threats and sexual abuse has increased since 2003.

- **2003 Youth Risk Behavior Survey**
    - 4.1 percent of students did not go to school on one or more of the past 30 days because they felt unsafe at school or on their way to or from school.
    - 8.1 percent of students have been physically forced to have sexual intercourse when they did not want to

- **2007 Youth Risk Behavior Survey**
    - 5.5 percent of students did not go to school on one or more of the past 30 days because they felt unsafe at school or on their way to or from school.
    - 9.2 percent of students have been physically forced to have sexual intercourse when they did not want to

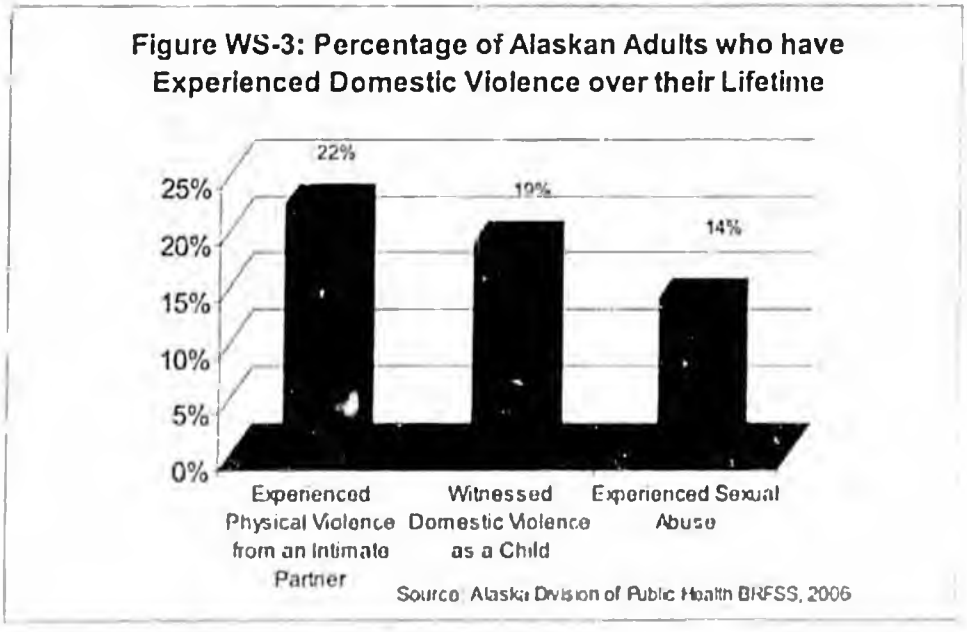
Table S-1: Domestic Violence and Sexual Assault Fiscal Year 2006 Statistics

During fiscal year 2006, Alaska shelters provided services to 8,140 clients. 25% of the clients were children. Services include safe shelter, crisis intervention, food and clothing, referrals and many other services. Table S-1 aggregates the field reports from victim service providers and shows the types of incidents experienced by the clients. The top three types of incidents were domestic violence, sexual abuse of children, and sexual assault toward adults.

Adult Molested as a Child Count	59
Assault Count	195
Child Physical Abuse Count	109
Child Sexual Abuse Count	898
Domestic Violence Count	5,257
DWI / DUI Victim Count	14
Elder Abuse (victim 60+ years of age) Count	11
Other Violent Crime Count	79
Robbery Count	13
Sexual Assault (adult) Count	653
Stalking Count	139
Survivor of Homicide Victim Count	37
Grand Count	7,464

Figure WS-3: Percentage of Alaskan Adults who have Experienced Domestic Violence over their Lifetime

Figure WS-3 shows the percentage of participants in the most recently-available Behavioral Risk Factor Surveillance Survey (BRFSS)[14] who responded that they had witnessed domestic violence in their family as a child, experienced physical violence from an intimate partner, or been sexually abused during their lifetime. In 2006, twenty-two percent of Alaskan adults had experience physical violence from an intimate partner; fourteen percent had witnessed domestic violence as a child; and fourteen percent had experienced sexual abuse.



Adult Protective Services Reports of Harm

Alaska law defines vulnerable adults as persons 18 years of age or older who, because of a physical or mental impairment or condition, are unable to meet their own needs or to seek help without assistance.[27] Adult Protective Services in the Department of Health and Social Services receives and investigates reports of harm. Harm includes abandonment, abuse, exploitation, and neglect (the most common report). More than half of the clients are female.

Adult Protective Services Investigations:

Total investigations FY 04: 1173
Total investigations FY 05: 1497
Total investigations FY 06: 1427[28]

In fiscal year 2006, the Department of Health and Social Services was contacted about 1666 people (unduplicated) for whom an investigation was possibly warranted; 86% of these intakes were investigated.

Safety Goal #2: Prevent and reduce inappropriate or avoidable arrest, prosecution, incarceration and recidivism of persons with mental health problems or developmental disabilities through appropriate treatment and supports.

Jail Diversion — Arrest History:

The Alaska Mental Health Board, the Alaska Mental Health Trust Authority, the Department of Corrections, the Court System, prosecutors, defense attorneys and community treatment providers have collaborated to implement Jail Alternative Services (JAS) and a therapeutic mental health court. JAS diverts voluntary low risk offenders to treatment instead of jail and monitors compliance with treatment.

The JAS program annually refers up to 40 eligible individuals to community treatment providers and monitors compliance with court-ordered treatment conditions. JAS is operated by the Department of Corrections for individuals sentenced through the Anchorage District Court Coordinated Resources Project "CRP" (Mental Health Court) to the JAS program.

Between July, 1998 and June, 2003, the JAS program served a total of 103 unduplicated clients. Of the 103 clients, 36 completed the program, 37 were vacated or opted out of the program after entry, and 30 were still active on the caseload. , These 103 clients had had a total of 197 misdemeanor arrests and 20 felony arrests during the 12 months prior to participation in Jail Alternative Service. During participation in JAS, arrests decreased sharply to 86 misdemeanor arrests and two felony arrests. In terms of total days of incarceration, there was a reduction of 4,468 inmate days related to JAS clients between the 12-month period before entry into JAS and the period while active in JAS — more than 12 years.

Once clients are no longer active in JAS, whether or not they have completed the program, there is no longer any legal leverage to require them to receive services. A measure of the effectiveness of the JAS program, therefore, is the extent to which these clients are able to maintain the gains that were so evident while active in JAS. Table 1 clearly shows that clients who successfully complete the JAS program fare considerably better after leaving JAS than those who do not complete the program.

Table 1 and Figures 8A and 8B show a reduction in legal recidivism as a result of the JAS program.

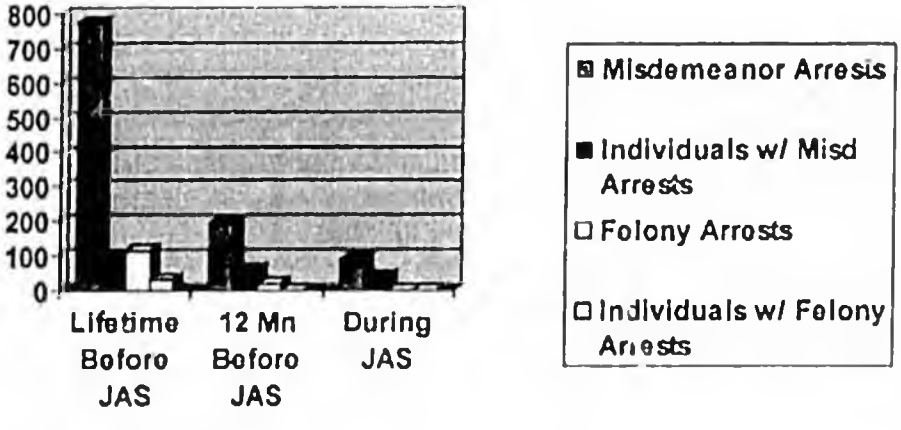
Table 1: Arrest Data for Clients not active in Jail Alternative Service (JAS)

Metric N=103	Lifetime Total Before JAS	12 Months Before JAS	During JAS
# Misdemeanor Arrests (New Charges)	773	197	86
# Individuals with Misd meanor Arrests	(100%) 103	(55%) 57	(45.2%) 40
# Felony Arrests	113	20	2
# Individuals with Felony Arrests	(29.1%) 30		2
Average Number of Arrests/per JAS Participant		2.1	0.9
Total Days in Custody for All JAS Participants	42,720	7,732	3,264

The length of time for JAS client participation ranged from 14 days to 1,742. The median length of time under JAS supervision was 402 days.

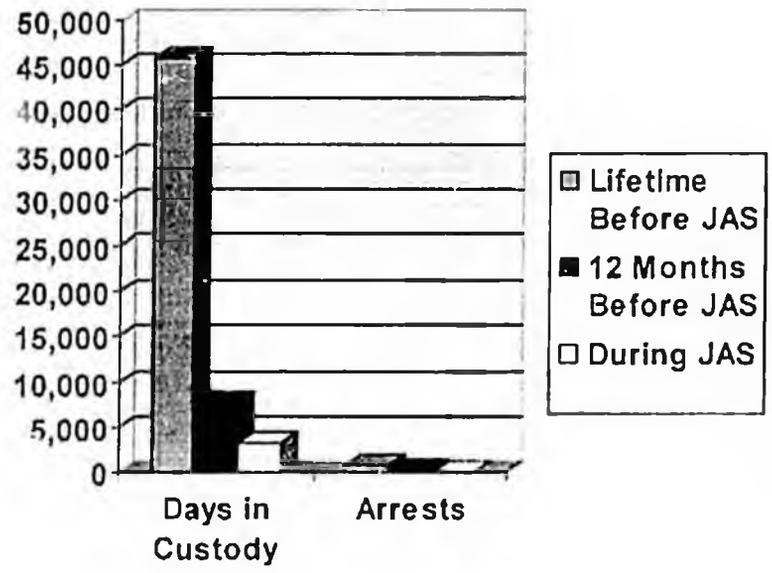
Sources: Jail Alternative Service Program Evaluation July 1, 1998 – June 30, 2003, C&S Management Associates, 2004. Alaska Mental Health Trust Authority Status Report, Jail Alternative Services, which included data from program inception July 1, 1998 through June 30, 2003, dated April 12, 2004, by Colleen Patrick-Riley, Department of Corrections Mental Health.

Figure 8A: Arrest Data for Individuals Who Participated in Jail Alternative Services (JAS)



(Revised February, 2007)
Source: JAS Program Evaluation, July 1, 1998-June 30, 2003; C&S Management Associates, 2004

Figure 8B: Days in Custody and Arrest Data for Individuals Who Participated in Jail Alternative Services (JAS)



(Revised February, 2007)
Source: JAS Program Evaluation, July 1, 1998-June 30, 2003; C&S Management Associates, 2004

Living with Dignity

Living with dignity can be defined as being valued and appreciated by others for the choices and contributions one makes and being able to take advantage of the opportunities available to all Alaskans. The Comprehensive Plan focuses on three issues related to life with dignity: community participation, housing, and education and training.

To be part of a neighborhood, live in acceptable housing and attend the public school are marks of community membership. Alaskans experiencing mental illness, substance use disorders, developmental disabilities, and age-related dementia need to engage with family, friends, and neighbors and participate in their communities. Social contributions can include volunteer or paid work, subsistence activities, active membership in spiritual and other community organizations, and successful school attendance. People with cognitive or developmental disabilities may need support and assistance to connect with and become contributing members of their communities. Prejudice may limit social acceptance in school, religious organizations and volunteer activities. In some communities, unavailability of transportation services can limit participation in community life.

While many Alaskans struggle to find decent, affordable housing, people with cognitive or developmental disabilities and their families often find it especially difficult to obtain appropriate housing because they are more often poor and because they face discrimination. Poverty makes a person particularly vulnerable to homelessness: an individual may be less than a paycheck away from losing shelter. Many of Alaska's homeless are people with mental, developmental or cognitive disabilities or addictive diseases. Once people are homeless, finding and keeping a treatment schedule becomes even more difficult.

Gaining new skills and experiences in supported environments can prepare adolescents and adults with cognitive or developmental disabilities for jobs and participation in community life. All children are entitled to a public school education where they learn the social, academic and practical skills needed to become adults who are as independent as possible. Children can progress further when developmental delays are identified and addressed early. Schools can also help in identifying students with emotional disturbances and referring them to behavioral health care providers. Schools can educate all children about addictive disorders and healthy lifestyles.

Dignity Goal #1: Make it possible for Trust beneficiaries to be productively engaged in meaningful activities throughout their communities.

The Client Status Review (CSR) tracks the quality of life of consumers of the Alaska behavioral health treatment system. When clients enter the system they are asked a series of questions about their "life domains" such as thoughts of self-harm, feelings of

connectedness, productivity, etc. For comparison, they are asked the same questions at different intervals during treatment, and at discharge. Figures 9A and 9B show the percentage of consumers who reported that their conditions were the same or better than they had been when they entered the system. Included are 1,688 consumers (419 children and 1,269 adults) in state fiscal year 2006.

Figure 9A: Positive Outcomes in Life Domains – Adults (Percentage of Adult Behavioral Health Consumers Improving or Maintaining Quality of Life)

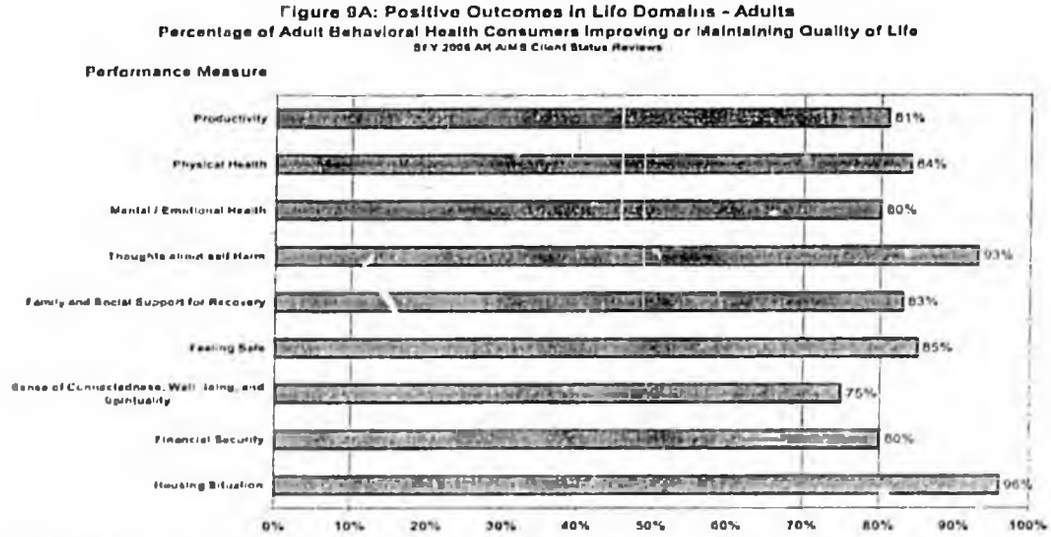
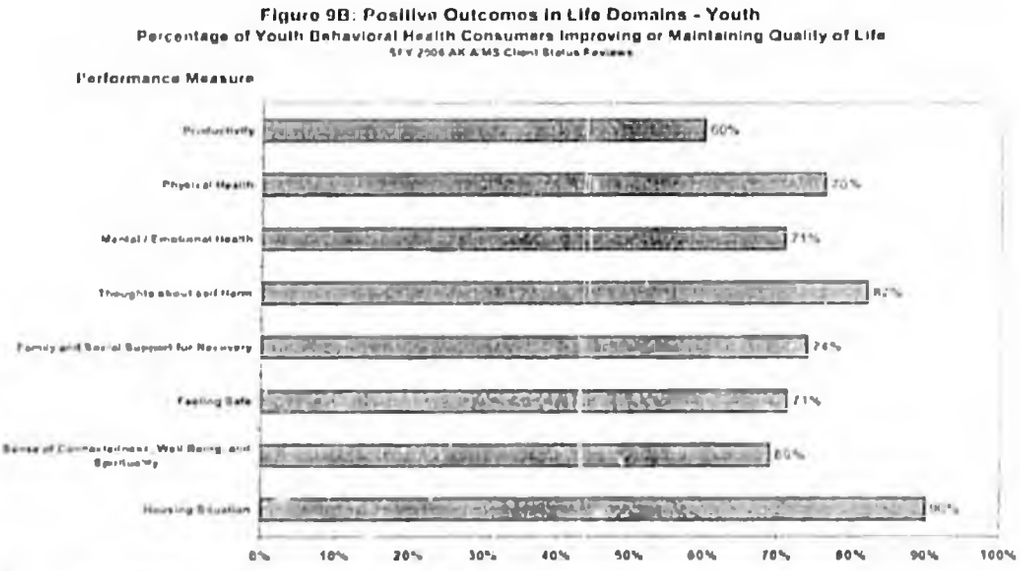


Figure 9B: Positive Outcomes in Life Domains – Youth (Percentage of Youth Behavioral Health Consumers Improving or Maintaining Quality of Life)



Youth connectedness at levels of family, school, and community - Youth Risk Behavior Survey 2003 Report [22]

Connectedness is a key protective factor correlated with a decrease in youth risk behaviors (use of tobacco, alcohol and other drugs, suicide ideation, violence and early sexual activity).[29] The term "connectedness," in this context, refers to the feeling of support and connection youth feel from their school and their community. Youth who help others or who are engaged in community service activities are less likely to be involved in anti-social behaviors, to be suspended from school or to become pregnant.[30] Service activities also provide an opportunity for youth to form close relationships with caring adults.

The 2003 Youth Risk Behavior Survey[22] shows that among Alaska high school students:

- 79.3 percent of boys and 78.1 percent of girls report they don't feel alone in life.
- Most Alaska high school students, 71.0 percent of boys and 74.6 percent of girls, believe they matter to people in their community.
- The majority of boys (60.0 percent) and girls (55.0 percent) report they have teachers who care about them and give encouragement.
- Forty-eight percent of students agree or strongly agree that in their community they feel they matter to people.

Dignity Goal #2: Enable Trust beneficiaries to live in appropriate, accessible and affordable housing in communities of their choice.

On any given night in Alaska, there are an estimated 3,500 homeless Alaskans. Of these, 35 percent suffer from chronic substance abuse problems, 21 percent are severely mentally ill, 19 percent have a dual diagnosis, and 36 percent live with a disability.[31] At least 3000 children were homeless or inadequately housed during the 2005-2006 school year. [32] These children are more likely to experience conditions of anxiety, withdrawal, depression, hunger, asthma, ear infections, stomach problems and speech problems than their peers.

Homelessness results from a complex set of circumstances that require people to choose between food, shelter, and other basic needs. Contributing factors include:

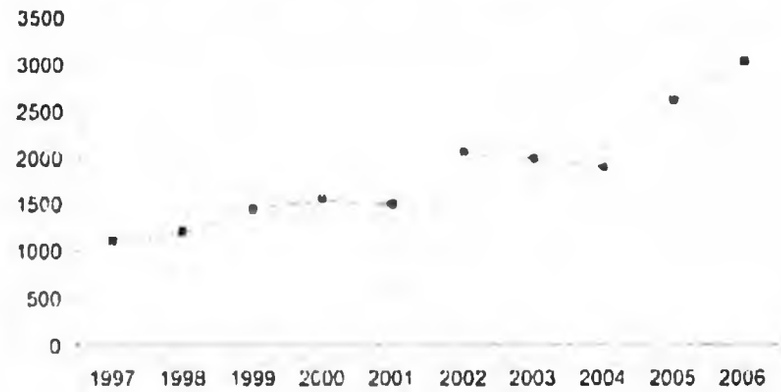
- **Inadequate income.** A 2001 study found 57% of Alaska households could not afford a median-priced home and 46% could not afford the average rent.[33] In Anchorage, a person needs to earn $18.12 per hour to afford a modest two-bedroom apartment at the average fair market rent of $942.[34] (For more information about rent-wage disparities in Alaska, please see Table E-1.)
- **Inadequate supply of affordable housing.** The private housing market alone cannot supply enough affordable housing because of high land prices and other costs. The waiting list in Alaska for publicly financed housing is over 3,000 households.[35]

- **Catastrophic events and destabilizing forces.** A sudden economic downturn caused by illness, injury, divorce or job loss may push people into homelessness. Mental illness and addiction disorders are also destabilizing forces that can cause homelessness.

Insufficient support'e services. In Alaska, homeless prevention services, case management services, after-hours mental health counseling and other housing retention services are not widely available. Once special needs clients have been placed in housing, there is a great need for "house calls" by occupational therapists or other providers to help the client retain the housing.[37]

Figure 10 — Estimated number of homeless Alaskans: Alaska Housing Finance Corporation Statewide Winter Homeless Survey Reports

Estimated Number of Homeless Alaskans: Alaska Housing Finance Corporation Statewide Winter Homeless Survey Reports



Source: Alaska Housing Finance Corporation Homeless Service Providers Survey Reports
Data reflects total homeless numbers reported by agencies, with duplicates removed

Figure 10 shows that the estimated number of homeless Alaskans doubled between 2001 and 2006. The AHFC survey is completed semiannually on a predetermined day by providers of services for homeless people. Although the survey has many limitations, including low survey return rates, it does provide some idea of the number of homeless Alaskans and their characteristics.

Section 8 Public Housing

Over 4,000 Alaska residents currently are using Section 8 public housing vouchers, which are allocated from the U.S. Department of Housing and Urban Development to the Alaska Housing and Finance Corporation's Public Housing Division. In addition, as of July 2, 2007, there were 3,020 households still waiting for Section 8 vouchers. The number of vouchers allocated from HUD to AHFC is currently limited to 4,183, thus the need is greater than the supply.[35]

Homeless Bed Inventory

According to the Alaska Housing and Finance Corporation, the 2007 Homeless Bed Inventory showed 1,265 emergency shelter beds and 690 transitional housing beds for a total of 1,955 temporary beds in Alaska.[36]

Supportive Housing

There are approximately 538 supportive housing units statewide. These units, designed for those who are homeless with special needs, enable people to live as independently as practicable.[37] In supportive housing, residents have their own housing units and lease agreements.

Assisted Living

Throughout Alaska there are 2702 assisted living beds in 506 licensed facilities.[38] Assisted living is a more structured and regulated form of special needs housing. More often than not, the landlord and service provider are the same and housing tenancy is tied to using the services provided. Many of these required services are related to activities of daily living. In Alaska, virtually all of the special needs housing for persons with developmental disabilities are licensed assisted living homes.

Number of individuals discharged to homeless situations from Alaskan institutions: Alaska Psychiatric Institute (API)

When Alaska Psychiatric Institute patients return to their home community, staff works to identify appropriate living arrangements whenever possible. Those who are homeless at discharge are typically referred to shelters in the community. Over the last six years, an average of 88 discharges a year have led to homeless status.[39]

Alaska Department of Corrections

A 2005 Department of Corrections Homeless Offender survey found that 35% of offenders did not know where they would live upon release or planned to live in a shelter or on the street.[40]

Dignity Goal #3: Assist Trust beneficiaries to receive the guidance and support needed to reach their educational goals.

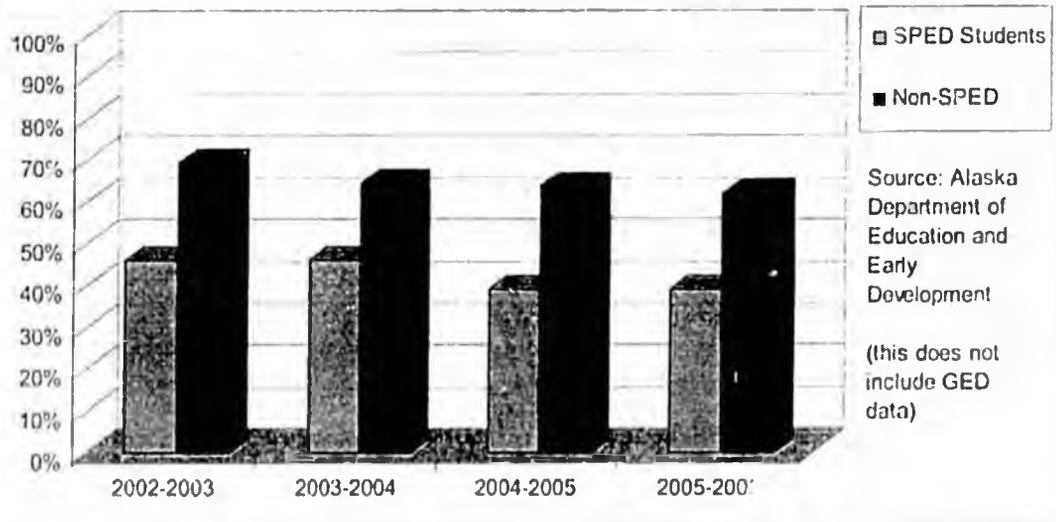
The federal Individuals with Disabilities Education Act (IDEA)[19] is the primary law that entitles children with disabilities to a free and appropriate education. IDEA requires states to provide special education and related services to students who meet eligibility requirements. To be eligible, a student must meet criteria established in the law and the condition must adversely affect his or her educational performance. Children with disabilities must be taught in the least restrictive environment and among non-disabled children to the maximum extent appropriate.

IDEA requires schools to provide necessary accommodations, as identified in each student's required Individual Education Plan, for special education students to participate in the high school exit examination. This accommodation includes development of an alternate assessment for students with significant disabilities. It is critical for children to participate in school and complete a high school course of study as part of their preparation for a life as independent as possible.

Figure 11 — High School Graduation Rates for Students Receiving Special Education Compared with Students Not Receiving Special Education

Figure 11 shows the rate of students who graduated from Alaska's public high schools with a regular diploma. Between 2002 and 2006 there was a slight decline in graduation rates among all students. During that time the graduation rates for Alaskans who received special education services were 18 to 23 percent lower than the rates for those who did not receive special education services.

Figure 11: High School Graduation Rates for Youth Receiving Special Education Compared with Youth not Receiving Special Education



Alaska loses a significant number of students over their four years of high school. Reasons for discontinuing school include pursuing a GED, entering the military, becoming employed, facing family problems, illness, pregnancy, or alcohol/drug dependency, failing, truancy, being expelled due to behavior, transferring to non-district sponsored home schooling, or leaving for unknown reasons without a formal request for transfer of records. Part of the recent decline in overall graduation rates may be tied to better record keeping and reporting in the districts.

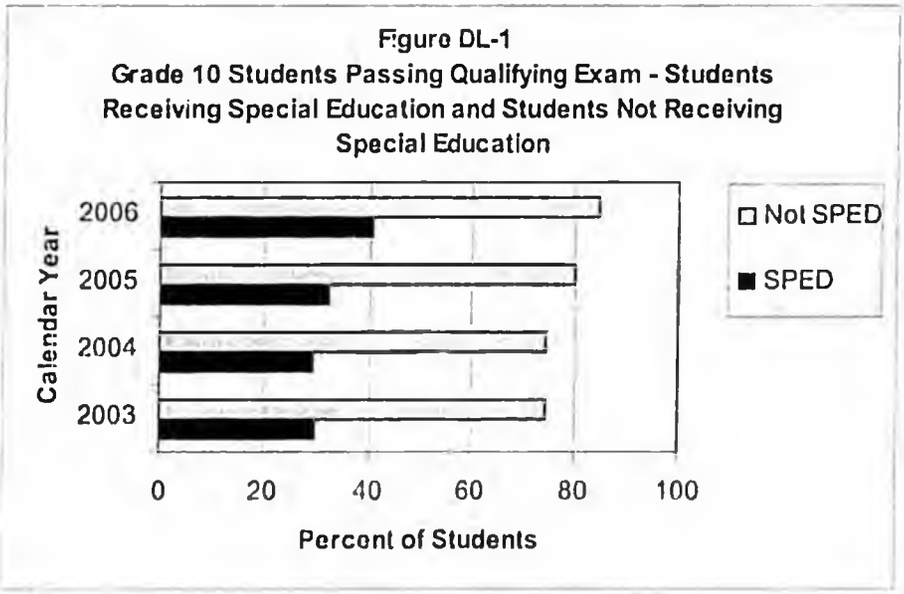
The data used to generate the graduation rate is the same for all students, whether or not they are on an Individual Education Plan. The actual yearly graduation rate is computed by determining the total number of graduates divided by the sum of the continuing 12th

grade students plus the total of yearly "drop-outs" for each of the four preceding years (i.e., a cohort model).

In the 2003-04 school year, the state offered a one-year waiver to all special education students so that if they met all other graduation requirements in their district, they were granted a diploma without having passed the High School Graduate Qualifying Exam (HSGQE- high school exit exam). This caused a one -year spike in the Special Education graduates. The 2004-05 graduate counts returned to the historical norm.

Figure DL-1 - Grade 10 Students Passing Qualifying Exams – Students Receiving Special Education Services and Students Not Receiving Special Education Services

Figure DL-1 shows the percentage of 10th Grade students enrolled in special education who scored above proficiency in reading, writing, and math on the High School Graduate Qualifying Exam, as compared to the students not receiving special education who also scored above proficiency. Overall, more students passed the exams in 2006 than in 2005. The rate of passage for those receiving special education is consistently less than half the rate for those not receiving special education. These percentages are statewide and include only the students who participated in the exams.



Economic Security

"Economic security" means that people are able to provide basic necessities for themselves and their families. Many Trust beneficiaries must rely on public assistance to meet basic needs because they are unable to work or engage in subsistence activities.. Unfortunately, public assistance has not kept pace with the cost of living, and poverty is common among Trust beneficiaries and their families. Alaskans living with mental health problems and developmental or cognitive disabilities who are able to work can be helped in this effort by continued Medicaid and assistance with expensive medications needed for the treatment of their illness.

Economic Security Goal #1: Make it possible for Trust beneficiaries most in need to live with dignity, ensuring they have adequate food, housing, medical care, work opportunities, and consistent access to basic resources.

Figure 12 — SSI/APA Payment Compared to Alaska Poverty Level

The Supplemental Security Income (SSI)/Adult Public Assistance (APA) cash benefit for people with disabilities has eroded over the years in relation to the Alaska poverty level. In Alaska, the SSI/APA programs combine to provide minimal cash assistance of $985 dollars a month to elderly, blind, or disabled individuals. While the SSI payment is adjusted every year for inflation, the APA payment is legally capped and therefore diminishes in value every year due to inflation

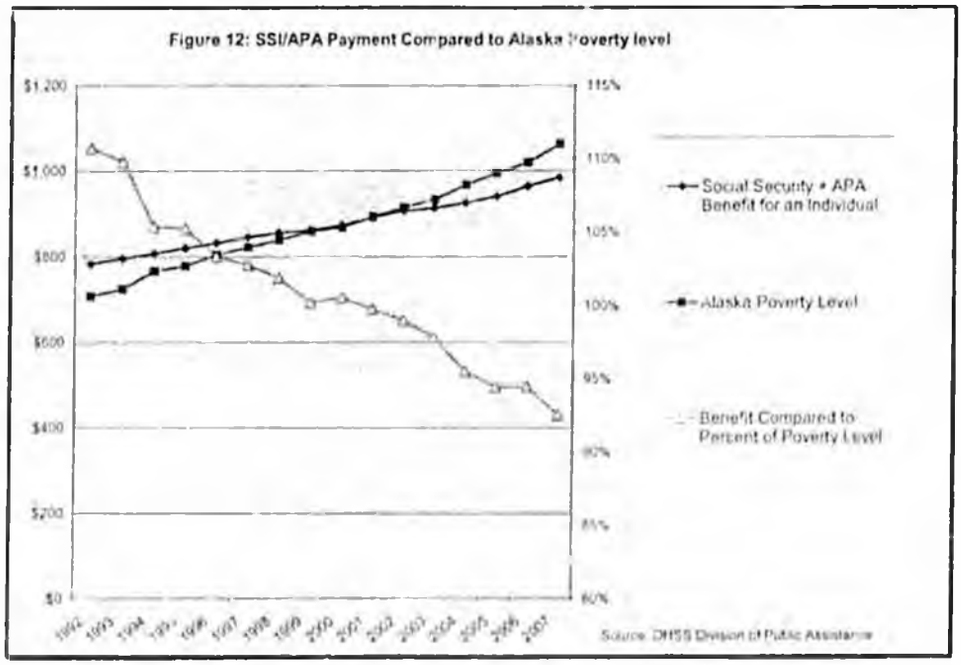


Figure 13 — Alaska Population 18 and Over by Income Level and Disability Status, 2005-2006

Behavioral Risk Factor Surveillance Survey data from 2005 and 2006 show that Alaskans experiencing a disability (i.e., limited in any way in any activities because of physical, mental or emotional problems) have a significantly lower annual income than those not experiencing a disability.

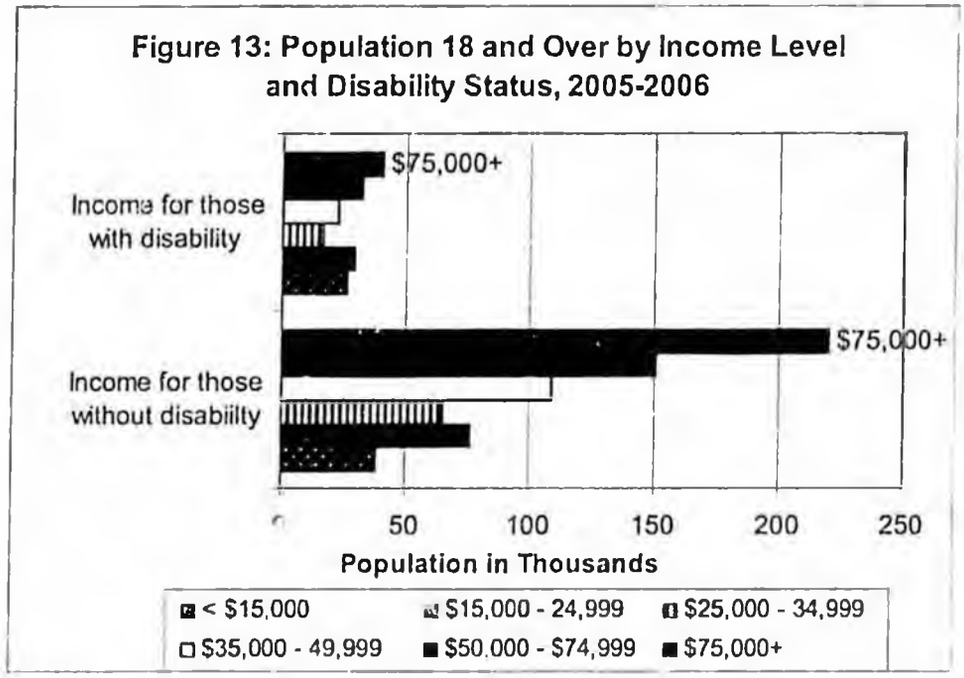
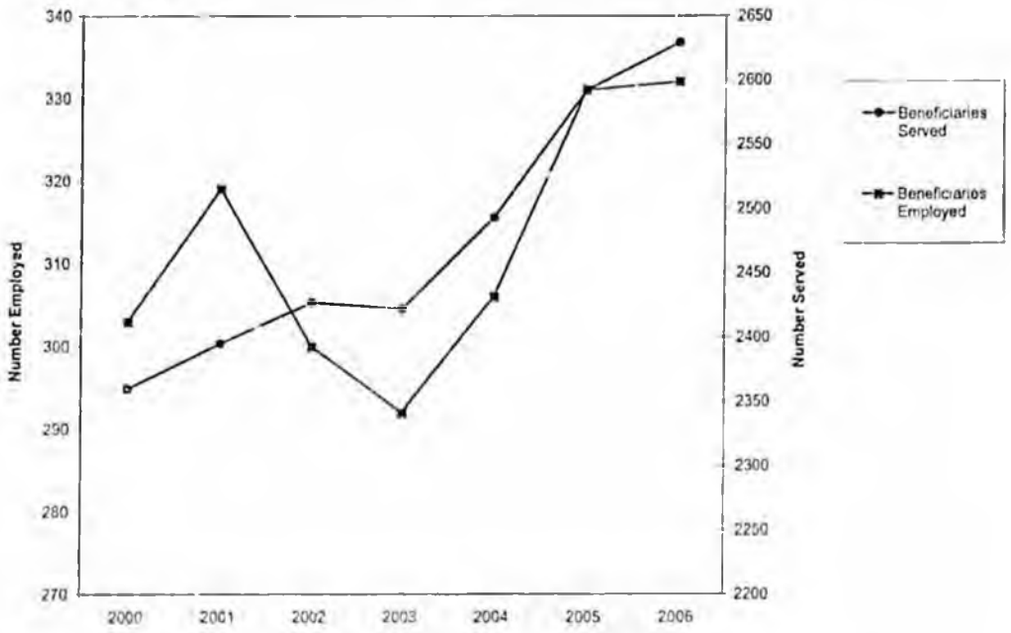


Figure 14 — Number of Trust Beneficiaries Receiving Support through Division of Vocational Rehabilitation versus Number Employed

The Division of Vocational Rehabilitation (DVR) assists individuals with a disability to obtain and maintain employment. With the proper services and supports, such as education, on-the-job training, job search, and placement services, people with disabilities can be employed. Of the total clients served by DVR in 2006, 68 percent were Trust beneficiaries. Trust beneficiaries comprised 61 percent of the total clients receiving training, and 63 percent of the total becoming employed.

Figure 14 shows that over the last six years, the number of Trust beneficiaries served by DVR has steadily grown by over 11 percent and the number who became employed grew approximately 8.5 percent. Although DVR has increased community outreach, cases can take years to reach a successful outcome, thus outcomes lag behind the number served.

Figure 14
Number of Trust Beneficiaries Receiving Support through
Division of Vocational Rehabilitation vs. Number Employed



Source: AK Department of Labor and Workforce Development, Division of Vocational Rehabilitation

Employment initiatives of DVR with a focus on Trust beneficiaries include the Customized Employment Grant (CEG), supported employment services, and micro-enterprise grants from The Trust. The goal of the CEG is to build the capacity in Job Centers in Juneau, Kenai, Anchorage, Wasilla and Fairbanks to better serve people with severe disabilities so that they have a more responsive and individualized employment relationship based on their strengths, needs and interests, while meeting the needs of the employer. The micro-enterprise grants require DVR to match the funds and focus on self-employment ventures. Supported employment is a service delivery system within the vocational rehabilitation program to provide employment opportunities to individuals who require intensive services to gain employment and extended services to maintain employment.

Figure ES-1: MR/DD Waiver Recipients who Receive Supported Employment Services

Figure ES-1 shows that approximately 320 MR/DD waiver recipients have received supported employment services annually for the last five years. "Supported employment" is paid employment for persons with developmental disabilities for whom competitive employment at or above the minimum wage is unlikely and who, because of their disabilities, need intensive ongoing support, including supervision and training, to perform in a work setting. Medicaid covers the costs of supported employment for people with developmental disabilities, allowing participants to contribute to the community and to their own sense of self-esteem through work.

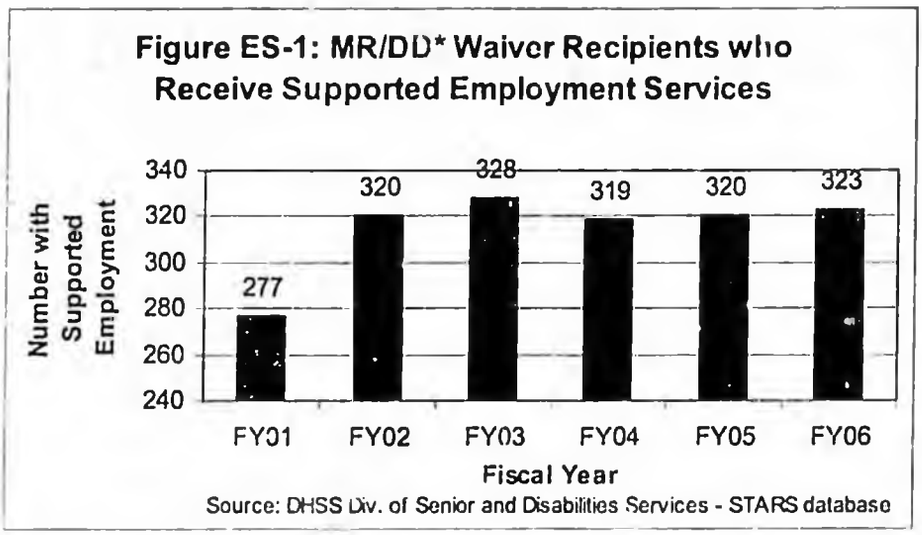
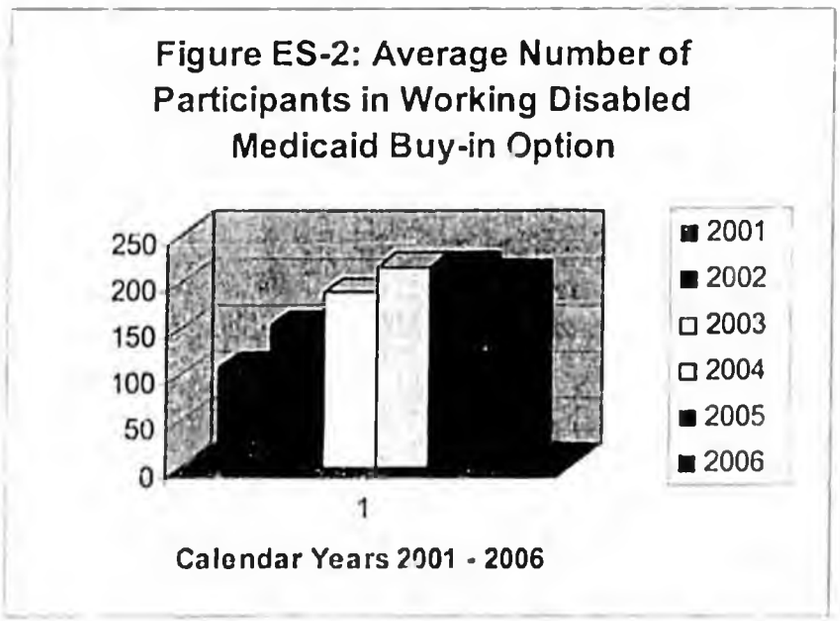


Figure ES-2 - Average Number of Participants in the Medicaid Buy-in Option

The Working Disabled Medicaid Buy-in is a category of Medicaid intended to encourage an individual with a disability to work (if they are able) by giving or extending their access to health coverage. Alaska was the first state to pass legislation that provides for this program and participation has doubled since 2001. To participate in the buy-in program, family income cannot exceed 250 percent of federal poverty guidelines for Alaska, and the individual's monthly unearned income must be less than $1156 ($1390, if married) and countable assets of less than $2000 ($3000, if married).



Source: AK DHSS Div. of Public Assistance Eligibility Information System

Affordability of Housing

Many Alaskan families cannot afford adequate housing. A minimum wage worker in Alaska earns $7.15 per hour. The average Fair Market Rent (FMR) for a two-bedroom apartment in Alaska is $931. For this level of rent and utilities to be considered affordable, a minimum wage earner must work 100 hours per week, 52 weeks per year. Or, a household must include 2.5 minimum wage earner(s) working 40 hours per week year-round. A housing unit is considered affordable if it costs no more than 30 percent of one's income.

The following chart shows how much money a person in each Alaska census area would need to earn in order for them to be spending only the recommended 30 percent of their income on a typical two-bedroom rental. For instance, a person renting a two-bedroom apartment in Mat-Su would need to earn $15.33 per hour working fulltime. But if they were only able to earn minimum wage, they would need to work 86 hours per week.

An Alaskan household must earn $3,103 monthly or $37,235 annually to afford the average unit. This translates into an hourly wage of $17.90, based on a 40-hour work week, 52 weeks per year.
For more information about homelessness, please see the Living with Dignity section

TABLE ES-1
Alaska Rent-Wage Disparities

Community	Affordable Rent*	SSI/APA Affordable Rent	2-BR FMR	Wage Needed to Afford 2-BR FMR	Hrs pr wk @ Min Wage**
			Fair Market Rent	Per Hour	
Anchorage	$577	$290	$942	$18.12	101
Barrow	$588	$290	$1,104	$21.23	119
Bethel	$339	$290	$1,213	$23.33	131
Dillingham	$420	$290	$1,004	$19.31	108
Fairbanks	$526	$290	$859	$16.52	92
Juneau	$652	$290	$1,096	$21.08	118
Kenai	$499	$290	$732	$14.08	79
Ketchikan	$545	$290	$962	$18.50	103
Kodiak	$547	$290	$1,034	$19.88	111
Mat-Su	$528	$290	$797	$15.33	86
Nome	$407	$290	$1,030	$19.81	111
Sitka	$578	$290	$920	$17.69	99
Unalaska	$458	$290	$1,004	$19.31	108
Valdez	$559	$290	$907	$17.44	98

Source: National Low Income Housing Coalition www.nlihc.org "Out of Reach" 2006 report

*Affordable rent means monthly rent affordable to a household earning 30% of Annual Median Income, applying the generally accepted standard of spending not more than 30% of income on housing costs

** Minimum wage of $7.15 hr, effective 1/1/03

FMR-Fair Market Rent as issued by HUD 10/1/2006