

ALASKA LEGISLATURE COMPLETES 1903-1904 80/2

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The relationship of the proposed project to the applicable local and State Health Plans as well as any long-range plans (if any) for the health facility;

The need that the population to be served has for the proposed project;

The availability of less costly or more effective alternatives;

The immediate and long-term financial feasibility of the proposal, as well as the probable impact of the proposal on the costs of and charges for providing health care services;

The relationship of the purposes proposed to be provided to the existing health care system;

The availability of resources (including health manpower, management personnel, and funds for capital and operating needs) for the provision of the services proposed;

The relationship, including the organizational relationship, of the health services proposed to be provided to ancillary or support services; and

The costs and methods of the proposed construction, including the costs and methods of energy provision.

These eight standards would, presumably have to be justified anyway in any attempt to receive financing through an institution, and would appear to be good planning policy. The most expensive plan ever submitted to the state of Alaska reportedly cost \$25,000, although consultants and planners need not be hired. Most hospitals in the state have done C.O.N. applications internally or have borrowed planners from other facilities (Soldotna, Kenai and Valdez use resources of the Fairbanks Memorial Hospital). Many hospitals have also used their proposals for bid applications for construction. C.O.N. also includes public input locally through a hearing process which may not be available otherwise.

Marketplace competition does not work in the health care industry, and would be particularly ineffective in Alaska since all locations except Anchorage have no alternative institutions. The basic premise of market place economics assumes a willing, competent and knowledgeable buyer who is offered a reasonable opportunity to make a choice for competitive pricing to occur. Since physicians have relationships to one particular hospital where they have privileges, and refer their patients there for treatment, this line of thinking will not support such a statement. Small hospitals in this state are moving in the direction of more regional care through expansion to more specialized services within the community. Planning for the inter-relationship of these services with large facilities may not be accomplished without a unified state planning function (It should be noted here that the state health planning agency has been defunded in the FY 84 Executive budget)

Current expansion plans in Anchorage support the fact that marketplace economics is not a viable solution. Even though the Municipal Health Commission in Anchorage has projected that Anchorage will need only 456 to 514 beds in 1990, plans by Humana and Providence, if allowed to proceed unheeded would add 178 to 236 unnecessary beds to the community. Competition in this case seems to apply to construction and not to fair pricing.

The two Certificate of Need applications currently being considered for the Anchorage area are:

Humana - 93 beds - \$20 million (\$56 million with interest) 65% occupancy
Providence - 150 beds - \$80 million (\$185.6 million with interest) 90% occupancy.

(These do not include any reference to the approved Certificate of Need for the Lake Otis Hospital - 125 beds)

What effect do these proposals have on state revenues, and what would be the further effect if the Certificate of Need program were repealed allowing facilities to build at will?

Revenue Sharing for Hospitals AS 29.90 provides a yearly amount of \$250,000 or \$1,000 per bed to hospitals for operating expenses.

C & RA Hospital Construction Assistance provides for repayment of a quarter of the construction costs (including interest) within the first five years, with no repayment clause for situations like the sale of the Teamster Hospital to Humana.

How will insurance premiums be affected by repeal?

The Medicaid Program (52% state funds) and the General Relief Medical Program (100% state funds) will also be affected by any construction, since the Medicare guidelines allow a percentage of construction costs related to applicable patient caseload to be added to reimbursable costs. The state's Medicaid program alone has risen from \$4 million in 1972 to almost \$70 million in 1984 (projected, but due to an additional increase through added caseload of up to 2,000 from withdrawal of Indian Health Service non-native dependents).

When visiting Providence Hospital last year with the Senate HESS Committee, we were told that the percentage of Medicaid clients was 13, even considering a 10% client caseload, this will add over \$18 million to the Medicaid budget for Providence proposed construction alone. If the Federal "CAP" on Medicaid goes into effect, these costs will simply be shifted to other third party payors and not absorbed by the hospitals, whether or not the beds remain unused.

The health insurance industry and the Municipal Health Planning Commission of Anchorage are opposed to the repeal of Certificate of Need, and the Legislature must ask itself if we can afford to give up the only control on health expenditures available to the state.

*The medical
↓ hospital industry
was owned & granted
by the govt, it
appears*

*Nancy Dietrich
Don't mess with
not objection
the woman
is strong
opponent*

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF STATE HEALTH PLANNING & DEVELOPMENT

BILL SHEFFIELD, GOVERNOR

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

DOCUMENT NO. 83-35

February 2, 1983

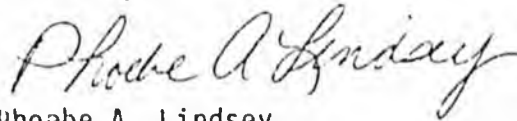
FEB 7 1983

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

Dear Mr. Palmer:

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

Sincerely,



Phoebe A. Lindsey
Director

Enclosure



Region X
M/S 229 Arcade Plaza Building
1321 Second Avenue
Seattle WA 98101

RECEIVED
MAR 22 1982

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

DSMFD

Dear Phoebe:

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

<u>PROJECT GRANTS</u> <i>Federal</i>	<u>NUMBER</u>	<u>AMOUNT AWARDED</u>
Health Systems Agencies	3	\$ 980,836
State Health Planning & Development Agencies	1	\$ 442,551
Immunization, Financial Assistance	1	\$ 130,188
Direct Assistance		\$ 38,853
Venereal Disease, Financial	1	\$ 155,392
Direct		\$ 72,229
Community Health Centers	1	\$ 560,535
General Community Health	1	\$ 120,000
Family Planning	2	\$ 310,239
Maternal & Child Health R/B	1	\$ 422,012
Crippled Children's Services R/B	2	\$ 141,000
Community Mental Health; Initial Oper.	1	\$ 787,229
TOTAL PROJECT GRANTS	14	\$4,161,064
 <u>FORMULA GRANTS</u>		
Alcohol Formula	1	\$ 182,238
Health Incentive	1	\$ 38,300
Maternal & Child Health A Funds	1	\$ 364,000
B Funds	1	\$ 70,000
Crippled Children's A Funds	1	\$ 175,100
B Funds	1	\$ 70,000
TOTAL FORMULA GRANTS	6	\$ 809,638
 TOTAL OF ALL GRANTS	 20	 \$5,060,702

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

Sincerely,
Rebecca J. Dyer
Rebecca J. Dyer, Director
Office of Grants Management

cc: Jack Whitney

FY 1981 MUNICIPAL REVENUE SHARING ENTITLEMENTS (112)

FEBRUARY 22, 1982

1982

TOTAL ENTITLEMENT = \$55,707,600

KEY	COMMUNITY	PUBLIC ROAD MILES	ICE ROAD MILES	HOSPITAL ENTITLEMENT	HEALTH FACILITIES ENTITLEMENT	HOSPITAL CONST. AID
BOROUGH AND SERVICE AREAS						
0010	ANCHORAGE A.W.	400.60	0.00	\$463,825	\$688,405	\$5,483,870
0020	CITY S.A.	0.00	0.00	\$0	\$0	\$0
0030	EAGLE RIVER	25.99	0.00	\$0	\$0	\$0
0040	CHUGIAK	0.00	0.00	\$0	\$0	\$0
0060	GIRDWOOD	10.54	0.00	\$0	\$0	\$0
0070	GLEN ALPS	10.59	0.00	\$0	\$0	\$0
0080	FIRE S.A.	0.00	0.00	\$0	\$0	\$0
0090	ROADS & DRAINAGE	0.00	0.00	\$0	\$0	\$0
0095	LIMITED ROAD S.A.	0.00	0.00	\$0	\$0	\$0
0100	POLICE S.A.	0.00	0.00	\$0	\$0	\$0
0110	PARKS & REC	0.00	0.00	\$0	\$0	\$0
0120	P & R/CHUGIAK	0.00	0.00	\$0	\$0	\$0
0130	SOLID WASTE S.A.	0.00	0.00	\$0	\$0	\$0
0140	CHUGIAK/SOLID WASTE	0.00	0.00	\$0	\$0	\$0
0150	BUILDING SAFETY	0.00	0.00	\$0	\$0	\$0
0160	CITY SA ROADS & DRAINAGE	0.00	0.00	\$0	\$0	\$0
0170	SERVICE AREA 35	0.00	0.00	\$0	\$0	\$0
0175	UPPER O'MALLEY	14.60	0.00	\$0	\$0	\$0
0180	PORT OF ANCH.	0.00	0.00	\$0	\$0	\$0
0185	ROADS	58.16	0.00	\$0	\$0	\$0
0190	AIRPORT S.A.	0.00	0.00	\$0	\$0	\$0
0195	PUBLIC TRANSIT	0.00	0.00	\$0	\$0	\$0
0200	PARKING S.A.	0.00	0.00	\$0	\$0	\$0
0210	BRISTOL BAY BOROUGH	6.87	0.00	\$0	\$38,414	\$0
0230	FAIRBANKS BOROUGH	93.60	0.00	\$0	\$0	\$0
0240	ESTER F.P.	0.00	0.00	\$0	\$0	\$0
0250	NORTH STAR F.P.	0.00	0.00	\$0	\$0	\$0
0260	UNIVERSITY F.P.	0.00	0.00	\$0	\$0	\$0
0270	HAINES BOROUGH	0.00	0.00	\$0	\$0	\$0

FY 1981 MUNICIPAL REVENUE SHARING ENTITLEMENTS (112)

FEBRUARY 22, 1982

TOTAL ENTITLEMENT = \$55,707,600

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

FY 1981 MUNICIPAL REVENUE SHARING ENTITLEMENTS (#2)

FEBRUARY 22, 1982

TOTAL ENTITLEMENT = \$55,707,600

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

FY 1981 MUNICIPAL REVENUE SHARING ENTITLEMENTS (112)

FEBRUARY 22, 1982

TOTAL ENTITLEMENT = \$55,707,600

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

FY 1981 MUNICIPAL REVENUE SHARING ENTITLEMENTS (#2)

FEBRUARY 22, 1982

TOTAL ENTITLEMENT = \$55,707,600

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

FY 1981 MUNICIPAL REVENUE SHARING ENTITLEMENTS (#2)

FEBRUARY 22, 1982

TOTAL ENTITLEMENT = \$55,707,600

KEY	COMMUNITY	PUBLIC ROAD MILES	ICE ROAD MILES	HOSPITAL ENTITLEMENT	HEALTH FACILITIES ENTITLEMENT	HOSPITAL CONST. ADJ.
5610	NAPASKIAK	0.00	0.00	\$0	\$9,964	\$0
5620	NEWHALEN	0.00	0.00	\$0	\$9,603	\$0
5630	NEW STUYAHOK	0.00	0.00	\$0	\$9,603	\$0
5640	NEWTOK	0.00	0.00	\$0	\$9,964	\$0
5650	NIGHTMUTE	0.00	0.00	\$0	\$9,964	\$0
5660	NIKOLAI	0.00	0.00	\$0	\$0	\$0
5670	NONDALTON	1.50	0.00	\$0	\$9,603	\$0
5680	NOORVIK	2.42	0.00	\$0	\$10,337	\$0
5690	NULATO	5.80	0.00	\$0	\$10,337	\$0
5700	NUIGSUT	0.00	0.00	\$0	\$0	\$0
5710	OLD HARBOR	4.45	0.00	\$0	\$0	\$0
5720	OUZINKIE	3.10	0.00	\$0	\$0	\$0
5730	PILOT STATION	2.00	0.00	\$0	\$0	\$0
5740	PLATINUM	0.00	0.00	\$0	\$0	\$0
5750	POINT HOPE	0.00	0.00	\$0	\$0	\$0
5760	PORT ALEXANDER	0.00	0.00	\$0	\$0	\$0
5770	PORT HEIDEN	26.60	0.00	\$0	\$9,603	\$0
5780	PORT LIONS	3.39	0.00	\$0	\$0	\$0
5790	QUINHAGAK	1.25	0.00	\$0	\$9,964	\$0
5800	RUBY	0.00	0.00	\$0	\$0	\$0
5810	RUSSIAN MISSION	0.00	0.00	\$0	\$0	\$0
5820	SAINT MICHAEL	0.00	0.00	\$0	\$10,337	\$0
5830	SAINT PAUL	37.50	0.00	\$0	\$0	\$0
5840	SAVOONGA	0.00	0.00	\$0	\$10,337	\$0
5850	SAXMAN	3.20	0.00	\$0	\$0	\$0
5860	SCAMMON BAY	1.25	0.00	\$0	\$0	\$0
5870	SELAWIK	0.00	0.00	\$0	\$0	\$0
5880	SHAGELUK	2.00	0.00	\$0	\$0	\$0
5890	SHAKTOOLIK	3.50	18.00	\$0	\$10,337	\$0
5900	SHELDON POINT	0.00	0.00	\$0	\$9,964	\$0
5910	SHISHMAREF	1.98	0.00	\$0	\$0	\$0
5920	SHUNGNAK	0.00	0.00	\$0	\$10,337	\$0
5930	STEBBINS	0.00	0.00	\$0	\$10,337	\$0
5940	TANANA	31.69	0.00	\$0	\$0	\$0
5950	TELLER	2.69	0.00	\$0	\$10,337	\$0
5980	TENAKEE SPRINGS	2.00	0.00	\$0	\$7,700	\$0

FY 1981 MUNICIPAL REVENUE SHARING ENTITLEMENTS (#2)

FEBRUARY 22, 1982

TOTAL ENTITLEMENT = \$55,707,600

KEY	COMMUNITY	PUBLIC ROAD MILES	ICE ROAD MILES	HOSPITAL ENTITLEMENT	HEALTH FACILITIES ENTITLEMENT	HOSPITAL CONST. AI
3990	TOGIAK	5.00	0.00	\$0	\$9,603	\$
3000	TOKSOOK BAY	0.00	0.00	\$0	\$9,964	\$
3010	TULUKSAK	9.50	43.00	\$0	\$9,964	\$
3015	TUNUNAK	0.00	0.00	\$0	\$9,964	\$
3020	UNALAKLEET	9.52	0.00	\$0	\$10,337	\$
3030	UPPER KALSKAG	1.50	16.50	\$0	\$0	\$
3040	WAINWRIGHT	0.00	0.00	\$0	\$0	\$
3050	WALES	0.00	0.00	\$0	\$0	\$
3050	WASILLA	45.14	0.00	\$0	\$15,400	\$
3070	WHITE MOUNTAIN	1.52	0.00	\$0	\$9,603	\$
3080	WHITTIER	6.00	0.00	\$0	\$0	\$
3090	EXT FIRE AREAS	0.00	0.00	\$0	\$0	\$61,810
3100	NATIVE VILLAGE GOVT	0.00	0.00	\$0	\$0	\$1,141,850
		TOTAL		\$4,028,354	\$2,476,985	\$7,943,270

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

RECEIVED

JAN 4 1983

DEHPD

A. CERTIFICATE OF NEED REVIEWS COMPLETED

1. Lake Otis Clinic, Anchorage -- "Grandfathered CON" for 125 general acute care hospital; (issued 7/27/77)
2. Sitka Community Hospital, Sitka -- Review status of "Grandfathered CON" for new facility; (six-month extension issued 12/31/78)
3. Lake Otis Clinic, Anchorage -- Review of status of "Grandfathered CON" for new facility; (six-month extension issued 12/31/78)
4. Fairbanks Memorial Hospital, Fairbanks -- Purchase and installation of laboratory information system; (information in archives)
5. Fairbanks Memorial Hospital, Fairbanks -- Application to Medical Facility Authority for bond sale; (information in archives)
6. Alaska Hospital and Medical Center, Anchorage -- Provide 21 bed chemical dependency unit; (information in archives)
7. Juneau Regional Rehabilitation Facility, Juneau -- Construction of a 16 bed drug abuse/detoxification and rehabilitation facility; \$654,000. (issued 6/7/79)
8. Providence Hospital, Anchorage -- Purchase and installation of a simulator for radiation therapy; \$195,365. (issued 9/4/79)
9. Providence Hospital, Anchorage -- Purchase and installation of a G.E. fluoriscan system; \$285,000. (issued 2/14/80)
10. Lake Otis Clinic, Anchorage -- Review to determine status of "Grandfathered C/H"; (Grandfathered certificate status continued 3/10/80)
11. Fairbanks Memorial Hospital, Fairbanks -- Remodel of labor, delivery, and nursery areas; \$540,000. (issued 2/26/80)
12. Central Peninsula Hospital, Soldotna -- expansion and improvement of facility (phase one); \$6,762,646. (issued 4/2/80)
13. Providence Hospital, Anchorage -- Purchase and installation of a linear accelerator; \$1,785,000. (issued 5/15/80)
14. Valdez Community Hospital, Valdez -- Purchase and installation of replacement radiology room; \$150,000. (issued 5/15/80)

15. Seward General Hospital, Seward -- several energy saving construction projects; \$286,113. (issued 10/6/80)
16. Valley Hospital, Palmer -- Minimal expansion and remodeling of facility; \$2,000,000. (issued 6/9/80)
17. South Peninsula Hospital, Homer -- expansion and improvement of facility; \$6,472,300. (issued 10/28/80)
18. Faith Hospital, Glennallen -- Expansion of outpatient areas of facility; \$700,000. (issued 11/3/80)
19. Providence Hospital, Anchorage -- "Grandfathered C/N" for 250 bed acute care facility; (issued 5/1/81)
20. Alaska Hospital and Medical Center, Anchorage -- "Grandfathered C/N" for 199 bed acute care facility; (issued 12/4/81)
21. Sitka Community Hospital, Sitka -- 1122 review of diagnostic ultrasound services; \$79,320. (five year lease with option to purchase) (issued 11/5/80)
22. Providence Hospital, Anchorage -- Replacement of radiology room; \$236,000. (issued 12/26/80)
23. Juneau Regional Rehabilitation Facility, Juneau -- Remodel facility to meet hospital standards; \$250,000. (issued 2/21/81)
24. Central Peninsula Hospital, Soldotna -- Purchase and installation of radiographic and fluoroscopic imaging system; \$305,899. (issued 5/21/81)
25. Wrangell General Hospital, Wrangell -- Renovation and Expansion of facility; \$6,870,000. (issued 7/13/81)
26. Providence Hospital, Anchorage -- Purchase of replacement radiology room; \$230,000. (issued 7/20/81)
27. Providence Hospital, Anchorage -- Construction of hostel for outpatients and family of inpatients; \$900,000. (issued 7/29/81)
28. Petersburg General Hospital, Petersburg -- Renovation and expansion of facility; \$7,150,000. (issued 8/11/81)
29. Alaska Hospital and Medical Center, Anchorage -- Purchase adjacent professional office building for expansion of chemical dependency unit and other hospital areas; \$15,236,000. (issued 9/24/81)
30. Central Peninsula Hospital, Soldotna -- Expansion of surgery and other areas of facility (phase two); \$5,849,000. (issued 11/10/81)
31. Family Centered Birth, Juneau -- Construction of a birthing center; Review terminated following a Department of Law Opinion regarding applicability of C/N statute to birthing centers; (review terminated 12/22/81)

32. Alaska Treatment Center, Anchorage -- Construction of a new free-standing inpatient rehabilitation facility; \$11,400,000. (denied, 1/22/82)
33. Valley Hospital, Palmer -- Construction of a new hospital adjacent to existing facility; \$10,570,000. (issued 2/19/82)
34. Cordova Hospital, Cordova -- Construction of a new hospital at a new site; \$15,075,000. (issued 4/13/82)
35. Providence Hospital, Anchorage -- Purchase and installation of a laboratory computer; \$440,000. (issued 4/23/82)
36. Petersburg General Hospital, Petersburg -- Modification of previously issued CON, increase in space and expenditure; \$2,005,000. (issued 5/18/82)
37. Fairbanks Memorial Hospital, Fairbanks -- Construction of new 5 floor patient tower, increase in acute care beds; \$26,200,000. (issued 6/2/82)
38. Humana Hospital, Anchorage - Application for temporary certificate for expansion of chemical dependency unit; \$1,000,000. (denied 6/28/82)
39. Providence Hospital, Anchorage -- Purchase and install replacement hospital incinerator; \$200,000. (issued 7/20/82)
40. Humana Hospital Alaska, Anchorage -- Purchase and install CT full body scanner to replace CT head scanner; \$848,000. (issued 10/1/82)
41. Advanced Health Systems, Anchorage -- Construct new free-standing Raleigh Hills alcoholism treatment hospital; \$3,700,000. (issued 11/16/82)
42. Charter Medical Corporation -- Construct new free-standing psychiatric and substance abuse hospital; \$12,248,000. (issued 11/16/82)
43. Providence Hospital, Anchorage -- Purchase and install replacement CT full body scanner; \$832,000. (issued 11/16/82)
44. Providence Hospital, Anchorage -- Purchase and install new digital fluorography system; \$256,000. (issued 11/30/82)

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

1. Providence Hospital, Anchorage -- Purchase and install new hospital information system; \$2,698,000.
2. Providence Hospital, Anchorage -- Construct new 160 bed patient tower, increase acute care beds, add inpatient rehabilitation program, expand ancillary departments; \$79,754,000.
3. Surgery Center, Inc., Anchorage -- Construct new free-standing ambulatory surgery center to replace current facility; \$2,698,000.

4. Humana Hospital Alaska, Anchorage -- Renovation and expansion of emergency department; \$1,012,200.
5. Humana Hospital Alaska, Anchorage -- Construction of new patient tower adjacent to existing hospital, 73 bed increase in acute care beds, addition of 20 bed inpatient rehabilitation program; \$20,000,000.
6. Lake Otis Hospital, Anchorage -- Hearing to determine whether CON should be revoked; cost of project not identified. Decision - pending.

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

1. Valley Hospital, Palmer -- Termination of skilled nursing services. No further action by VH. (LOI dated 12/13/79)
2. Metlakatla Indian Community, Metlakatla -- construction of long term care facility. \$200,000. No further action by MIC. (LOI dated 12/26/79)
3. Lake Otis Clinic, Anchorage -- Construction of 265 bed acute care/chemical dependency hospital. \$7,000,000.+ No further action by LOC. (LOI dated 2/14/80)
4. Providence Hospital, Anchorage -- Construction of 132 bed addition and expansion of services. \$25,400,000. No further action by Providence. (LOI dated 3/31/80)
5. Health Care Services - Alaska, Anchorage -- Sale of Nakoyia Health Care Center. \$14,200,000. No further action by HCS. (LOI dated 6/6/80)
6. Alaska Kidney Foundation, Anchorage -- Construction of a new facility for Alaska Kidney Center. Capitalized five year lease = \$200,000. No further action by AKC. (LOI dated 6/23/80)
7. Horton Sound Regional Hospital, Nome -- Provision of family services unit. No further action by HSRH. (LOI dated 9/25/80)
8. Kodiak Island Hospital, Kodiak -- Offering of diagnostic ultrasound services. Decision - diagnostic radiology is a part of radiology department and not a new service; therefore, is not subject to CON review. (LOI dated 10/14/80)
9. Alaska Hospital and Medical Center, Anchorage -- Addition of 21 beds to chemical dependency unit. No further action by AHMC. (LOI dated 10/21/80)
10. Alaska Hospital and Medical Center, Anchorage -- Purchase of professional office building for facility expansion; \$10,000,000. (LOI dated 12/28/80)

11. Ketchikan General Hospital, Ketchikan -- Replacement of computer system. \$103,000. Decision - not subject to CON review. (LOI dated 2/11/81)
12. Ketchikan General Hospital, Ketchikan -- provision of recompression chamber. \$55,000. Decision - not subject to CON review. (LOI dated 7/21/81)
13. Akeela House, Anchorage -- new building for residential drug abuse therapy program. \$460,000. Decision - not subject to CON review. (LOI dated 8/4/81)
14. Ketchikan General Hospital, Ketchikan -- Offering of diagnostic ultrasound services. \$70,000. Decision - not subject to CON review. (LOI dated 8/19/81)
15. Providence Hospital, Anchorage -- Predevelopment application for large construction project; \$4,000,000. (withdrawn 10/8/81)
16. Humana, Anchorage -- Purchase of Alaska Hospital and Medical Center by Humana. \$65,000,000. Decision - not subject to CON review. (LOI dated 11/13/81)
17. Comprehensive Care Corporation, Anchorage - Establishment of a 50 bed alcoholism and chemical dependency hospital in Anchorage. Letter of intent still valid through 2/16/83, however letter received from applicant indicates that application was not expected to be submitted. (LOI dated 2/17/82)
18. Providence Hospital, Anchorage -- Offering of home health services; cost uncertain. Decision - subject to CON review. (LOI dated 1/19/92)
19. Kodiak Island Hospital, Kodiak - Purchase of gamma camera, \$90,000. Decision - not subject to CON review. (LOI dated 2/10/82)
20. Humana Hospital, Anchorage - Relocation and expansion of chemical dependency unit, increase CDU from 21 beds to 36 beds; \$1,000,000. Letter of intent withdrawn. (LOI dated 5/10/82)
21. Anchorage Community Mental Health, Anchorage - Establishment of residential transitional facility. Decision - not subject to CON review. (LOI dated 6/14/82)
22. Humana Hospital, Anchorage, Purchase of hospital data processing services; Decision - not subject to CON review. (LOI dated 10/11/82)
23. Peninsula Addiction Center, Inc., Soldotna - Establishment of new freestanding 12 to 24 bed substance abuse treatment facility; cost undetermined. Application anticipated. (LOI dated 5/14/82)
24. Bartlett Hospital, Juneau -- Construction of new patient tower, increase in acute care beds; \$20,000,000. Application anticipated. (LOI dated 7/21/82)

25. Providence Hospital, Anchorage -- Purchase of new cardio-vascular imaging system; \$820,000. Application anticipated. (LOI dated 10/1/82)
26. Providence Hospital, Anchorage - construction of employee child care center; \$1,400,000. Decision - not subject to CON review. (LOI dated 10/14/82)
27. Sisters of Providence, Inc. Seattle - Purchase of Nakoyia Health. Care Center Applicability of certificate of need requirement under review by Department of Law. (LOI dated 12/10/82)



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

February 7, 1983

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

Dear Mr. Palmer:

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

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

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

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

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

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

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

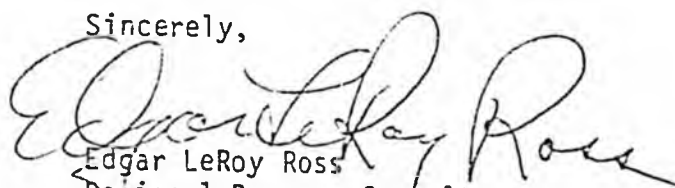
You may find several of our observations relevant to your current task:

- 1) Many States are---as is usual---revising their planning statute and rules to better meet their own environment and to make the State Planning less dependent on Federal support, or in anticipation of future block grant funding for Planning.
- 2) Several States that had requested and received 1536 designation, such as Alabama and Texas, apparently wish to regain their former planning status and reconstitute their Health Systems Agencies and local planning. (While a final program decision has not been made on this issue, the current perception is that once done, it probably cannot be undone under existing rules.)
- 3) Because the free-market elements do not yet exist in order to allow competition to be the major controlling factor for health care costs, most States intend to strengthen their CON and health facility rate review regulation mechanisms to cover the next few years. Highly populous States, such as New York, as can be noted by the recent report of the Health Care Capital Policy Advisory Committee" which is attached, see CON and rate review as critically important tools of planning and cost management. Other States, such as Washington, while having one of the nation's most effective programs, perceive CON and rate review as an essential but perhaps intermediate range solution to health costs management over the next few years.

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

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

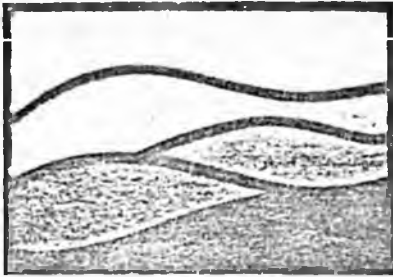
Sincerely,

A handwritten signature in cursive script, appearing to read "Edgar LeRoy Ross". The signature is written in dark ink and is positioned above the printed name and title.

Edgar LeRoy Ross
Regional Program Consultant
for Regulatory Activities

Enclosure

cc: William R. Berry



Transition Briefing Memo

21

October 28, 1982



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

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

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

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

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

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

Western Center for Health Planning

703 MARKET STREET - SUITE 535 · SAN FRANCISCO, CALIFORNIA 94102 · (415) 546-7601

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

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

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

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

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

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

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

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

3. SPECIAL PLANS AND PROJECTS

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

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

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

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

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

This project has been funded with Federal Funds from the Health Resources Administration, Department of Health and Human Services, under contract HRA 232-79-0037. The contents of this publication do not necessarily reflect the view or policies of the Department of Health and Human Services, nor does mention of trade names, commercial products, or organizations imply endorsement by the U.S. Government.

PROVIDENCE
HOSPITAL

JAN 31 1983



SISTERS OF
PROVIDENCE

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

SERVING IN THE WEST SINCE 1856

January 26, 1983

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

H/ESS

Position: Paper on HB 19 and a companion bill being submitted to the Senate -- pertaining to an "Act repealing the certificate of need program."

Dear Representative Tischer:

Providence Hospital joins the rest of the hospitals in this state in requesting the repeal of the certificate of need law and endorsing House Bill 19 (Fritz and Hayes) and the companion bill about to be submitted to the Senate. The process which this law sets in place is cumbersome and wasteful and totally inappropriate for Alaska.

The major impetus for the law was to control excess hospital beds in many large cities and to help control rising health care costs. The belief was that by controlling the number of beds, capital expenditures and new services, costs would be contained. The results have been much less than desirable throughout the country, and, in Alaska, have been needless, wasteful, cumbersome and costly.

The lack of success in Alaska is better termed overkill. Designed for areas of heavy population, excess hospital beds and competition, the law does not work and is inappropriate for our small state for several reasons:

- The law only covers private facilities, and does not cover public health, military or state owned institutions.
- Alaska has only one city with more than one hospital, and there are only three hospitals in the whole state (eligible for review) of over 100 beds.
- The law is reactive to existing decision making processes. Hospitals in Alaska already have local public review and approval designed in their own budget review processes. Many hospitals are owned by

municipalities, and all have governing boards or advisory boards of local citizens. These citizens and municipalities should have control of the expansion and budgetary decisions of their own institutions. Several other layers of bureaucracy and review are cumbersome, costly and inefficient. For our Certificate of Need, the following is an actual review cycle showing the different bureaucratic levels we had to go through just to have a decision made on one project.

Letter of intent to file certificate of need

Pre-application conference (HSA, Municipal Health Commission, State)

Public Hearing on Certificate of Need Application (State)

Joint Project Review (HSA and Municipal Health Commission)

Concurrent Review (HSA and Municipal Health Commission)

Board Review (Municipal Health Commission)

Board Review (HSA and Southcentral Health Planning & Development Agency)

Commissioner's Review (State)

From the time of holding the application conference to the ultimate decision by the Commissioner, the process has taken over a year.

- The law places a costly burden on all institutions who have to prepare and submit Certificates of Need. The documents which need to be prepared are massive, require hundreds of hours of preparation and at least 35 each need to be produced for the review boards and other parties. The 110 day minimum time period for a review is unrealistic, and often times, the institutional cost of delaying implementation means an eventual increase in price of the piece of equipment or construction project due to inflation.
- The law also passes on a cost to the public in that state, regional and local staff are needed to coordinate the program, prepare staff analyses and hold public meetings. We are estimating that the cost of state, regional and local staffs have increased the cost of health care by at least \$8,000,000 in the last six years.

- The dollar limit for what must be reviewed is absurdly low. In 1982 alone, Providence spent hundreds of man hours and other monies preparing six CON applications for such things as a \$167,000 replacement incinerator (the old one being 25 years old was required to be replaced by both State and EPA codes!); a CT scanner and Cath lab replacement; and a \$250,000 computer enhancement for an x-ray machine. Believe it or not, the STATE did not give approval on the incinerator until the 90th and final day for a decision to be made.

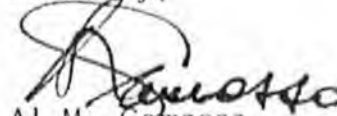
The Alaska State Hospital Association is unanimous in endorsing the repeal of the CON law. We have also received indications from several legislators and the Alaska Medical Association that repeal of the CON law would be best for a growing state such as Alaska.

We are supportive of local planning for Alaska's health care needs. The process, however, should be positive and proactive -- encouraging institutions to respond to needs in the community -- not negative, reactive and cumbersome.

Your support in repealing the certificate of need law in Alaska would be appreciated. With an early response and passage of HB 19 or the companion bill in the Senate, a tremendous and costly burden will be lifted from Alaska's hospitals.

Thank you for your consideration.

Sincerely,


Al M. Camosso
Administrator



Official Business

Alaska State Legislature

House of Representatives Committee on Health, Education & Social Services

Pouch V
State Capitol
Juneau, Alaska 99811

January 28, 1983

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

Dear Mr. Whitney:

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

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

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

Sincerely,

David R. Palmer

Historical Note

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

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

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

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

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

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

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

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

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

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

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

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

Health Systems Agencies, State Health Planning and Development Agencies, and Statewide Health Coordinating Councils; Organizational and Related Changes; Changes in Functions. Effective on or after Oct. 4, 1979, health systems agencies, State health planning and development agencies, and

Statewide Health Coordinating Councils may make the organizational and related changes required by the amendments to this section by Pub.L. 96-79 and may act in accordance with the changes in their functions made by the amendments to this section by Pub.L. 96-79, see section 129(a)(2) and (3) of Pub.L. 96-79, set out as an Effective Date of 1979

Amendment in title.

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

Library References

States — 4.10.

C.J.S. States § 24.

Notes of Decisions

1. Exhaustion of administrative remedies

Health systems agency's petition for judicial review of the state board of health's recommendation to the secretary that defendant hospital be reimbursed with federal funds for certain expenses related to a proposed expenditure was properly dismissed for petitioner's failure to exhaust its administrative remedies, since the review mechanism of this subchapter requires that health systems agency

whose recommendation has been rejected by a state agency request a review by an agency of the state, since petitioner did not even allege that it made any request for such a review, and since it was entitled to a review, it was not shown that a request for review would have been futile. Southern Indiana Health Systems Agency, Inc. v. State Bd. of Health, Ind.App.1979, 391 N.E.2d 845.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Performance by other State agencies

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

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

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

Statement

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

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

Historical Note

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

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

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

tion 300m-3(c)(2) of this title", and added subpar. (B).

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

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

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

PAGE 0001

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

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

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

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

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

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

PAGE 0002

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

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

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

My questions, general and specific:F

1. What are the chances that the sanctions may again be suspendedF
as in 97-377. In short, what does the mood of congress seem to be regardingF
certificate of need (how's that for a wide open questions?).F

2. Can you find out what response the Health and Human ServicesF
Dept. would have to a repeal of certificate of need here?F

3. Would an exemption via B1536 of PL 932641 for Alaska to theF
health systems agency requirement do the same thing as a repeal of theF
certificate of need? Authority is supposedly in an amendment to the F
Omnibus Budget Reconciliation Act of 1981.F

4. If certificate of need were repealed, and sanctions invoked,F
how much money would Alaska loose?F

F

I'll appreciate any help. Send answer to the LIO office in Juneau.F
I am in rm. 112 at the capitol. The phone is 46523777. Thanks.

MORE
MSG326 MSG WITH THIS NUMBER ALREADY EXISTS

5404 p. 2

MSG1-5 to ing



ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

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

February 25, 1982

MEMORANDUM

TO: Representative Mike Beirne
FROM: Leslie Longenbaugh, Research Staff
RE: Health Care Planning Agencies
Research Request Number 82-32

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

The §1536 designation derives from Section 1536 of PL 93-641, the National Health Planning and Resources Development Act of 1974. The Act required that governors designate health systems agencies in local health care service areas; these agencies assess the health care needs of their local populations and make recommendations regarding certificates of need, which must be obtained by providers who plan to make capital improvements costing more than \$600,000 or purchase equipment at a cost of more than \$400,000.¹ The State Health Planning and Development Agency (SHPDA) and Statewide Health Coordinating Council (SHCC), also required and partially funded under the Act, use the health systems agencies' recommendations in issuing certificates of need to health care providers.

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

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

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

Representative Beirne
February 25, 1982
Page 2

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

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

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

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

Representative Beirne
February 25, 1982
Page 3

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

In addition to amending the conditions of eligibility for the §1536 designation, Congress, at the request of President Reagan, in 1981 reduced substantially the level of federal funding for the state health care planning agencies that are required under PL 93-641. The President has been said to feel that health care costs can best be reduced through free market competition, achieved through deregulation of the industry. This philosophy was reflected in Ohio, according to Ms. Williamson, where the governor and legislature chose limited deregulation of health care over continued local planning. According to staff at the State Health Planning and Development Agency³, the federal funding for Alaska's three health systems agencies has been reduced by almost 40%, to approximately \$165,000 per agency; the Legislature has allocated \$100,000 to each of the health systems agencies for the present fiscal year.

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

LL/bf

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

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

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

* * *

STATUS REPORT

Health Planning Odyssey Continues

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MSG 83-00005404 PRTY 1 /01/83 15:47:18 ORIG: 40 IN= 0002

FROM: DAVE PALMER

TO: KIM

TARGET: LJ40 SUBJ: CERTIFICATE OF NEED..PAGE 2

PAGE 0001

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

MY QUESTIONS:

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

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

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

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

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

NXT MSG U/R/S

PREV MSG U/R/S

RESEND

CANCEL

2-4-83

Phone call from JACK Whitney, Ed Ross
206-442-0215

Public Health - send copy of SSHB19 - omitted from letter

1. STATE is on "CONDITIONAL" STATUS.
PIONEER HOME exemption NOT as big an issue
w/ PHS as w/ STATE HOSP. ASSN.
NOTIFICATION, REQUIREMENTS, etc
2. Attempt by STATE to REPEAL CON does NOT change
^{FED} STATE LAW. REQUIRING CON. PUT STATE further & out
of COMPLIANCE
3. MOST STATES ARE STRENGTHENING CON PROCESS
4. SANCTIONS don't apply until OCTOBER.
5. 1536 EXEMPTION is from PUBLIC HEALTH PLANNING AGENCIES.
STATE MUST do SAME functions w/o FED MONEY
STATES that HAVE TAKEN to exemption can't get
BACK OUT
6. LOOK AT ARTHUR LITTLE REPORT - please

2-4-87
%LOOKUP ALL WHILE TOPIC IS "CERTIFICATE OF NEED". 15 ENTRIES WERE
DETECTED 7 ARTICLES DETECTED 8 REPORTS DETECTED %SHOW ABSTRACTS

***** ARTICLES *****

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

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

SCOPE
GE

ABSTRACT

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

✓ NCSL IDENTIFICATION NUMBER: ART7900119

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

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

SCOPE
WI MD WA NJ PA NY MI FE

ABSTRACT

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

NCSL IDENTIFICATION NUMBER: ART8000346

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

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

SCOPE
MI

ABSTRACT

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

NCSL IDENTIFICATION NUMBER: ART8000445

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

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

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

ABSTRACT

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

NCSL IDENTIFICATION NUMBER: ART8000462

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

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

SCOPE
FE

ABSTRACT

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

NCSL IDENTIFICATION NUMBER: ART8100530

TITLE: HEALTH PLANNING.
AUTHOR: AUTHOR UNLISTED.

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

SCOPE
FE

ABSTRACT

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

NCSL IDENTIFICATION NUMBER: ART8101052

TITLE: CERTIFICATE OF NEED.
AUTHOR: AUTHOR UNLISTED.

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

SCOPE

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

ABSTRACT

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

NCSL IDENTIFICATION NUMBER: ART8101053

***** REPORTS *****

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

SOURCE

STATE AGENCY
OK LEGIS. COUNCIL.

PUBLISHED 03/15/78, 2 PAGES

SCOPE
OK FE

ABSTRACT

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

NCSL IDENTIFICATION NUMBER: RCH7802604

TITLE: CERTIFICATE OF NEED: ASSESSMENT OF CURRENT PROGRAMS AND POLICY ISSUES.

AUTHOR: HEANEY, C.

SOURCE

STATE AGENCY

WA WA UNIV.

PUBLISHED 03/13/78, 72 PAGES

SCOPE

50 FE

ABSTRACT

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

NCSL IDENTIFICATION NUMBER: RCH7802620

TITLE: CERTIFICATE OF NEED.

AUTHOR: GODFREY, B.

SOURCE

STATE AGENCY

LA LEGIS. COUNCIL.

PUBLISHED 04/16/79, 92 PAGES

SCOPE

LA FE GE

ABSTRACT

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

NCSL IDENTIFICATION NUMBER: RCH7903624

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

SOURCE
STATE AGENCY
CA ASSEM. OFC. OF RES.

PUBLISHED 11/01/79, 13 PAGES

SCOPE
CA FE

ABSTRACT

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

NCSL IDENTIFICATION NUMBER: RCH8004110

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

SOURCE
STATE AGENCY
OR LEGIS. RESEARCH.

PUBLISHED 02/08/80, 6 PAGES

SCOPE
OR FE

ABSTRACT

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

NCSL IDENTIFICATION NUMBER: RCH8004346

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

SOURCE
STATE AGENCY
CT LEGIS. RESEARCH.

PUBLISHED 02/21/80, 3 PAGES

SCOPE
CT

ABSTRACT

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

NCSL IDENTIFICATION NUMBER: RCH8004438

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

SOURCE
STATE AGENCY
WI LEGIS. COUNCIL.

PUBLISHED 01/01/81, 32 PAGES

SCOPE
WI FE

ABSTRACT

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

NCSL IDENTIFICATION NUMBER: RCH8104934

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

AUTHOR: AUTHOR UNLISTED.

SOURCE

STATE AGENCY
ND LEGIS. COUNCIL.

PUBLISHED 09/01/81, 6 PAGES

SCOPE

FE ND

ABSTRACT

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

NCSL IDENTIFICATION NUMBER: RCH8205416

SEWARD GENERAL HOSPITAL

P.O. BOX 365

SEWARD ALASKA 99664

PHONE (907) 224-5205

January 26, 1983

JAN 31 1983

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

Dear Bette:

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

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

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

Thank you for your attention to this matter.

Yours truly,

C. Keith Campbell
C. Keith Campbell, Administrator

CKC:ecb

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

Bette:

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

Bette

FEB 9 1983

February 03, 1983

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

Dear Representative Cato:

The Board of Directors of the Northern Alaska Health Resources Association has discussed the issue of repeal of the ~~Certificate-of-Need~~ (CON) law as currently proposed in HB 19. ~~We reached agreement that a modified CON process is preferable to repeal.~~ Although we recognize that there are problems with the current process, we believe that they can be solved by making major revisions in the regulations rather than by repealing the law. There is little disagreement that the threshold limits that trigger CON review are too low or that review of many non-clinical expenditures is a nuisance. Moreover, the process should be tightened up so that reviews are completed in a timely and efficient manner.

There are several reasons why we believe the CON process should be retained; however, the most important reason has to do with citizen participation in deciding what health care services and facilities are most appropriate and affordable for a specific community or region of the state. The issue has not been whether a CON should be approved or denied but rather that a discussion or negotiation has taken place between the community and health-care facility regarding local, regional and statewide needs. The Certificate-of-Need process has been a forum for these discussions and has served to guide the appropriate development of health care services and facilities throughout the state.

A recent trend has been to appropriate increasing amounts of public funds for construction or expansion of health care facilities in Alaska (i.e., \$31,500,000, FY 81-82). Moreover, we are seeing the cost of health care increasing at a rate which has been consistently higher than the general rate of inflation. It has been demonstrated that capital investment contributes significantly to the growth of total hospital expenditures. Although it is true that general inflation, sophisticated technology, and increasing staff requirements also contribute to rising costs of hospital care, hospital capital investments add to the operating costs by an amount in excess of the value of the investment. In April, 1982, Arthur D. Little, Inc., a health economics consulting firm under contract with the National Center for Health Services Research, estimated that the present value of additional operating expenditures in the next ten years is \$1.84 for every dollar invested in capital improvements, exclusive of depreciation and debt service. Uncontrolled

capital expenditures for more or bigger health care facilities can only serve to drive up operating costs at an accelerated rate. These increased costs are ultimately passed on to the patient or community. We believe that people must continue to have the opportunity and responsibility through the CON process to determine what level of health services they are willing to pay for. Competition in the health care field essentially does not exist, especially in Alaska where most communities cannot afford more than one health care facility; therefore, the only way that we can keep a lid on overbuilding is through a capital expenditures review program similar to the current Certificate-of-Need program.

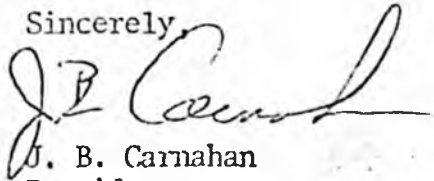
Several states have already revised their CON process (among them Colorado and New Mexico) with full support of their respective state hospital associations. Revision of Alaska's CON process must occur if we expect to see the process work as it was designed to do. The following revisions are offered for consideration:

1. Increase the threshold level which triggers a CON review from \$150,000 to at least:
 - a. \$600,000 for capital expenditures
 - b. \$400,000 for major medical equipment
 - c. \$250,000 for operating expenses associated with new services.
2. Exempt all non-clinical capital expenditures. The bill should indicate that non-clinical services which are not subject to review include, but are not limited to: parking, telephone systems, day care, mailrooms, heating and air conditioning, blood bank, dietary/cafeteria, laundry and linen, medical records, business office, housekeeping, central supply, library, reception, and data processing. This exemption would apply only if one of these non-clinical projects was the main purpose of the application. For example, a project proposing a new facility could still include review and consideration of the non-clinical activity if it were part of a larger project.
3. Expedite review of capital equipment replacement.
4. Specify a time limit for a decision by the Commissioner subsequent to a recommendation by the regional health planning agency.
5. Provide that each legislator be informed of all projects in his/her district, especially regarding the outcome of the review.
6. Consider a sunset provision of four or more years to review effectiveness of the CON process.

The Honorable Belle Cato
February 03, 1983
Page 3

In summary, there is little disagreement that there are problems with the current CON process; however, the forum that the CON process provides for community discussion about the relative merits of a proposed project far outweigh what we perceive to be correctable problems. We recommend revision of the CON process rather than repeal.

Sincerely,



J. B. Carnahan
President

JRC:flr

cc: William Sheffield
Governor
Robert London Smith, Ph.D.
Commissioner, DHSS
Alaska Health Coalition
Southeast Alaska HSA
South Central Health Planning
and Development, Inc.



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

February 4, 1983

POLICY STATEMENT

Blue Cross of Washington and Alaska supports the retention of Certificate of Need. That process should, however, be modified as follows:

1. The dollar threshold should be increased to \$1,000,000 per application.
2. Modifications which are necessary to reduce health and safety hazards should be exempted.
3. The State Health Planning and Development Agency should become the sole health planning body for the State and should be charged with health planning for all Alaskans. A provision should be included allowing municipalities to establish local health councils to the State Health Planning and Development Agency, who may make recommendations on planning matters.

JHG:pf

Alaska State Legislature

COMMITTEES

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House of Representatives

M E M O R A N D U M

TO: Dave Palmer
FM: Edie Russel *Edie*
RE: HB 19
DT: February 14, 1983

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

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

Municipal Revenue Sharing

Hospital entitlement \$1,000/BED or \$250,000 or \$50,000/hospital
1981 = \$14,620,000

Hospital Construction 25% REIMBURSEMENT
1981 = \$6,000,000

Public Roads \$2500/mile

~~Nation Villages \$25,000 each~~

Volunteer fire depts in unorganized borough
10⁰⁰ /PER capita

In This Issue

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

STATE HEALTH NOTES

Number 19
June 1981

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

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

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

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

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

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

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

Certificate of Need

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

for both hospitals and nursing homes.

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

Health Planning

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

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

A recent telephone survey by IHPP of various state officials revealed very little optimism for the survival of local health systems agencies in the event federal financial support is withdrawn. With the exception of a few places where local business and labor coalitions or

Blue Cross-Blue Shield associations have indicated a willingness to support local health planning, most state officials contacted felt that neither public nor private support would be forthcoming for their continuation. Significantly, many of the same officials expressed the view that, even if the Federal Health Planning law is repealed, their state would probably retain some degree of certificate-of-need authority, as well as some health planning functions at the state level.

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

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

Health Planning and Antitrust

In a major decision affecting health planning, the U.S. Supreme Court ruled that actions taken by providers under the general authority of the Health Planning Act are not necessarily immune from federal antitrust laws. In a specific case, the Court refused to extend immunity from antitrust to Blue Cross of Kansas City for its refusal to enter into a reimbursement contract with a hospital because the hospital failed to obtain approval from the local HSA before beginning construction (National Gerimedical Hospital and Gerontology Center v. Blue Cross of Kansas City). Blue Cross

contended that its action was pursuant to the local HSA plan and was furthering the purposes of the National Health Planning Act. The Court, however, rejected the argument that the Health Planning Act immunizes all private conduct undertaken in response to the health planning process. The decision suggests that immunity from antitrust should be granted only in cases where Congress has explicitly indicated its preference. And, in the Court's opinion, "There is no reason to believe that Congress specifically contemplated 'enforcement' of advisory decisions of an HSA

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

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

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

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

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

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

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

vised by a physician.

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

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

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

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

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

Emergency Medical Services

Public Employees—A FLORIDA bill (327)

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

Cost Containment—A WEST VIRGINIA bill (HB 1518) would require a demonstrated "good faith effort" to control costs on the part of all accident and health insurers before the insurer could increase its rates or lessen its benefits or coverage. The bill defines a good faith effort as a vigorous attempt by the insurer through a combination of education, persuasion, and financial incentives and disincentives to control costs and to encourage health care pro-

viders to also control costs by 1) eliminating duplicative or unnecessary services or facilities; 2) promoting alternative forms of care; 3) engaging in such experiments as incentive reimbursement and utilization review; 4) encouraging consumer involvement; and 5) promoting sound management practices by health care providers. A NEW YORK bill (A 4154) would require health insurance plans filing for rate changes to submit an economic impact statement indicating the effect of such increased rate on the elderly, the handicapped, the unemployed and on persons living on marginal fixed incomes.

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

Health Insurance

IHPP recently completed a fifty state survey of current Medicaid cost containment strategies. The survey identifies all legislative and executive proposals affecting services, eligibility and reimbursement, as well as strategies for improving the administration and management of the program. A brief summary of the survey indicates that over one half of the States have proposed some degree of benefit reduction, from limits on the number of covered hospital days to the elimination of some or all optional services. Twenty-one States have proposed either increases in current copayments on some optional services or new copayment requirements

on optional services. Almost half of the States are considering significant changes in provider reimbursement, from decreasing or freezing physician payment levels to restructuring nursing home reimbursement methodologies. Most significant, 14 States are proposing significant changes in their eligibility standards. Such proposals range from more restrictive criteria for the medically needy to eliminating 18 to 21 year old students to eliminating coverage altogether for the medically needy and the AFDC-U populations.

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

Medicaid Survey

• A publication entitled, Role of State and Local Governments in Relation to Personal Health Services, is now available from the American Public Health Association for \$4.00 a copy. The volume, a collection of presenta-

tions made at a symposium in 1980, examines the involvement of state and local governments in the financing, organizing and delivery of health care services.

Publications and Reports

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

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

• The Office of Research, Demonstrations and Statistics, HCFA, HHS, recently released a briefing paper entitled, "HMO's: Issues and Alternatives for Medicare and Medicaid." The paper provides a comprehensive overview of

the major issues and alternatives which need to be addressed if public payer involvement with HMOs is to expand. The report focuses on current legislative barriers to HMO enrollment, reimbursement problems, benefits and liabilities, marketing strategies, and quality assurance. To order, request HCFA Pub. No. 03107.

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

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

State Health Highlights

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

• The **NEW YORK** Department of Health has released an information kit which explains in detail the rights and responsibilities of employers and employees under the State's new "Right to Know"

law. The "Right to Know" law requires employers to notify employees what information is available concerning the toxic effects of chemical substances; to provide all requested information; and to provide education and training to employees in the safe and proper handling of such substances.

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

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

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

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

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

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

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

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

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

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

STATE HEALTH NOTES



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February 14, 1983

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

Dear Representatives Fritz and Tischer:

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

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

Sincerely,



JEB/jem

Enclosure

STATEMENT OF
ÆTNA LIFE INSURANCE COMPANY
IN OPPOSITION TO
H.B. 19

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

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

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

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

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

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

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

THIS QUESTION IS GOING TO DEPEND ON WHAT THE 98TH CONGRESS CHOOSES TO DO. THE CONTINUING RESOLUTION WILL STAND UNLESS CONGRESS TAKES SOME ACTION BEFORE THE END OF THE FISCAL YEAR. IF CONGRESS DOES NOT ACT BEFORE JUNE 30TH, THE DEPARTMENT WILL HAVE TO AT LEAST FUND STATES THROUGH THE FIRST QUARTER OF FY84. H.H.S. IS POWERLESS TO IMPOSE THE SANCTIONS MANDATED BY LAW AND IS WAITING FOR SOME DIRECTION FROM CONGRESS.

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

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

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

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

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

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

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

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

SELECT A BILL NUMBER AND HIT ENTER BILL NUMBER *B 19 STATUTE 1826220
RETURN TO MAIN MENU ?

2/23
HEARING

2/23

Fbks Tom Mingen Administrator Fairbanks Memorial

1) Duplication of services

2) COST TO PREPARE CON

5 people @ 60 days work

hired organization \$24,000 to review NEED projections

3) Public input: LAY BOARDS citizens

BOARD of directors

4) increased costs if CON repealed -

N/A in ALASKA

CONSTRUCTION costs hold up - 1%/yr inflation

CON process difficult to time review to

CONSTRUCTION SEASON.

5) Denied only 1 - NO SAVINGS

"No major proposal waiting in the wings"

⇒ 6) Medicaid - population NO INCREASE significantly
in Medicaid \$ benefits increased

INCREASING limits of CON threshold not addressing
Problem.

? \$ \$ RETAINED in FED'S STATE 60% STATE GRANT
process funds capital construction,
Funds

Anchorage

DR. BEIRNE

FAVOR modification of law

CHANGE threshold 750,000 to 1,000,000

- 1) MONITOR hospital, since STATE FUNDS constitute major investments.

Art Willman - SITKA President SE AK Health System
Agency - Pub. Health Service

LAW needs work, don't REPEAL
opportunity REGIONAL & local groups. to REVIEW
Limits too low - 1,000,000 - 1.5M
COSTLY PROCESS \$100,000?

Martin Tirador BLUE CROSS

RETAIN CON REPEAL could affect ability
to provide coverage. 100% of capital = 30% in
operation Need to change law.

Limit to \$1,000,000 min CAP expend &
major equip REMOVE items from CON review /
items subject to review & regulation. Streamline
process. ONE AGENCY - SHPDA in DHSS
to review.

WRITTEN REMARKS? - YES

TRUMAN
Dorothy ~~TRUMAN~~ - FAIRBANKS - CITIZEN
Supports CON. Recommend changes
Work for commission on handicapped

Dennis Dewitt Nursing homes & Hospitals
• MEDICAID - CON NO RELATIONSHIP
Agency can only stop projects

• HB112 is option to CON
COST of HEALTH CARE NOT relevant to COST of
CARE

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

Peggy Wilson - HSA - ANCHORAGE
CON work gets done anyway.
Public involvement - hundreds of people - testimony on
controversial issues INCREASES. Overall health planning

STATE planning - REGIONAL PLANS
AK: 409⁰⁰/day 262⁰⁰/wash 245⁰⁰/USA Aug.
UTILIZATION MORE AVAILABLE = MORE USE

John Pugh Support repeal - ... BUT LOOK AT
AREAS THAT INCREASE HEALTH CARE COSTS:

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

Capital Budget 36.6 million for const or
renovation in budget.

Revenue Sharing AS 29.90 CAPITAL REV. SH.
Reimbursement 25%

Capital Review AB 112 IF CON REPEALED,
then some review is required to look at
feasibility - STATE AS BANKER, NEED fiduciary
responsibility, REVIEW

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

2. Q-

Implied in position paper - NEED
PROCESS TO REVIEW CONSTRUCTION COSTS

Repeal ~~is~~ in conjunction w/ REVIEW

P. Good - CAPITAL PORK BARR - CAP. REVIEW NOT
BASED ON REASON. IS CRIA RELEVANT TO
REVIEW?

Why REPEAL CON? by GOVERNOR - MARKETPLACE
ECONOMY WILL WORK IN ANCHORAGE.

PRELIMINARY STATEMENT OF FISCAL IMPACT

4185

Bill No: Senate Bill 85 Date on Bill: 1/27/83
 Title: An Act repealing the certificate of need program; and providing for an effective date
 Sponsor: Senators Faiks, P. Fischer, and Pettyjohn
 Requestor: _____

1. Estimated fiscal impacts on:

a. Expenditures:

			FY 83	FY 84	FY 85	FY 86			
Capital			0	0	0	0			
Operating			0	0	0	0			
Total			0	0	0	0			

b. Revenues:

Revenue			0	0	0	0			
---------	--	--	---	---	---	---	--	--	--

2. Source of funds to offset fiscal impact of bill:

3. Assumptions:

4. Disclaimer:

This statement has not been reviewed by the OMB in the Office of the Governor. It does not represent the policy of the Sheffield Administration or the final estimate of fiscal impact.

Prepared By: Dave W. Williams *DW* *HHS* Phone: 465-3038
 Division: State Health Planning and Development Date: 2-14-83

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

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

SPONSOR: House Hess Committee
 SUBJECT: HR 19 - Certificate of Need Repeal
 MAILING ADDRESS: Info: Invitational only

TAKEN BY: Quil 2/18
 T/C DATE/DAY: Wed
 TIME: 1-3 PM Pacific
11-12:00 PM Alaska
10-12 Noon Bering

PHONE: 3777 CONTACT: Dave Palmer ZIP

T/C DURATION: 2 hour

SITES PARTICIPATING: 2 Wnie TV

ALL ALASKAN	<u>Anchorage</u>	Dillingham	<u>Juneau</u> *	Mat-Su	Sitka
	Barrow	Fairbanks	Ketchikan	Nome	Seward
WASHINGTON DC	Bethel	Haines	Kodiak	*Petersburg	Soldotna (Kenai)
	Delta Junction	Homer	Kotzebue	Sand Point	Valdez
					*Wrangell

Sen. Stevens
 Sen. Murkowski
 Congressman Young

SPECIAL OFF-NET*
 LOCATIONS/PHONE
 NUMBERS: ~~XXXXXXXX~~

Chairing Site/Person *JNO - Rep Fasting*
Dave Palmer
 Signature of Sponsor/Contact Person

2/18/83
 Date

<u>SUSAN Callan</u>	To testify
<u>278-3631</u>	From Anchorage
	<u>CIO office</u>

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

MODERATOR NOTES

Special backup, publicity
 or technical considerations.

JUNEAU Room Location
H. Hess Committee Room
112 schedule 12:20pm
W 3:00 pm

POST TELECONFERENCE NOTES

SITE/LOCATION: _____
 LOCAL MODERATOR: _____
 T/C Started: _____
 T/C Ended: _____
 Was T/C Recorded? _____
 Was T/C Broadcast on RADIO or TV?
 (If yes, what stations?) _____
 TESTIFIED/PARTICIPATED: _____
 UNABLE TO TESTIFY: _____
 OBSERVORS: _____
 TOTAL #: _____

BILLING INFORMATION

Billing Address: _____

 _____ zip
 Phone Charges To: _____
 (area code) (phone number)
 CATEGORY: Legislative ___ Non-Legislative ___
 AMOUNT PAYABLE: _____

ALASKA

STATE LEGISLATURE

MEMORANDUM

Art Willman

SITKA 966-8333

1 pm SITKA L.I.O.



PRES. SE H.S.A.
Pub Health Health Service



HB 19

2/21

GOVERNOR'S POSITION TODAY PER EMIL:

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

HEALTH CARE - NOT FREE MKT

1) CONSUMER NOT RESPONSIBLE FOR COSTS

3rd PARTY PAYS

2) - supply induced demand 80-90% physician's influence

3) high cost of technology

4) LACK of information - choices ^{AVAILABLE} to patient

Non competitive - non profit - public funds

ROLE of CON

1) REPEAL of LAWS - SUNSET - NOT REPEALED

2) Cost of CON. \$250,000 for FY84

COST to hospitals - have them support costs?

STUDIES - Arthur Little - 6 STATE REVIEW - DOCUMENTS

SAVINGS due to CON

- MASSACHUSETTS - ROEMER?

IN ALASKA = NOT applicable only Anchorage

Proposal presented. Altered by CON PROCESS - benefit in small RURAL AREAS too.

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

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

COST COMPARISONS

Providence	250 beds	\$ 186,000,000	223 ⁶¹ 47	396,000 Per bed
Hum	200 "	\$ 56,000,000	161 ⁶³ 47	150,000 Per bed

clocksin

Medical Care FY 80 81 82 \$153,000,000
Health Care covered by programs covered by CON.
Entitlement 23
Per Operate 36
7.5

Medical GRM, corrections operating funds
COST TO CONSTRUCT - RELATED TO COST TO OPERATE

Amend:

INCREASE: Threshold to \$600,000
750,000 or more
400,000

EXEMPT: REPLACEMENT EQUIPMENT
New medical construction
Remodeling due to CODE CONFORMANCE

STREAMLINE process

- 1) Simplify application for smaller projects
- 2) deadline on commissioner's time to approve
- 3) Review whether HSA's ARE NECESSARY
- 4) PROSPECTIVE RATE SETTING commission
eliminate full reimbursement w/o careful
Review
- 5) tie capital cost \$ to CON.

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

occupancy rate on WEST COAST less than EAST COAST
Dentistry; ultrasound
New Mexico

"ASSN supports planning process"
ERROR factor $16\% \pm$ for Humana {Providence}

DAVIS
"

PROV - Humana - difference between two - ?

HB 112

FED \$ lost if CON? 25%

OCCUPANCY RATE - Humana
Providence 95%

P. Groll

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

Mild - equipment VERY EXPENSIVE - MAKES COST A different.

- DELAY in CON limits ACCESS to HEALTH CARE

ALAN BLUME

GOV-

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

Human & Providence - CON REPEAL

ALAN BLUME 2/23

1) Marketplace Economics

John Pugh

- 1) Fritz - Reconsider - mention to gov.
- 2) CAP other aspects of capital construction
- 3) - Prospective R system +
ANHS - Medicaid

Comprehensive health care cost containment

Would NOT oppose Amendment or omnibus
bill to ~~care~~

Vol. 6 April 1985 No. 4

CON REPEAL STUMBLES

DATES TO REMEMBER

April 20 - 25, 1985
Medical Technology Association
of Alaska Annual Meeting
Sheraton Hotel, Anchorage

April 24 - 27, 1985
AWH Convention
Anaheim, California

April 25 - 26, 1985
Rehabilitation Workshop
Cordova Community Hospital

May 8 - 14
National Hospital Week
National Nursing Home Week

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

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

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

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

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

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

CAPITAL BUDGET BLEAK

In early April Governor Sheffield released his revised capital budget which failed to receive rave reviews. For health facilities the picture was extremely bleak. While Fairbanks Memorial Hospital received \$5.4 million and Valley Hospital in Palmer received \$1 million in the supplemental appropriation bill which emerged from the legislature to complete their projects, there was little in the way of commitment to new projects. In the revised budget Cordova Hospital was listed for a \$2 million grant towards its \$15 million project but Wrangell's \$9 million project received no mention. The Association will continue to work with legislative leadership in an attempt to augment the appropriations to hospitals.

FEDS PASS PROSPECTIVE PAYMENT

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

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

The measure passed by Congress (HR 1900) creates a three year phase-in period moving from the current system based on 225 limitations through a phase of nine regional urban and rural rates to national urban and rural rates. During the three year phase-in period payments will be a blend of hospital specific average Medicare costs per discharge and a combination of national and regional payment rates based on DRG's. In the fourth year payments will be based totally on national urban and rural DRG based rates.

Capital costs are passed through until October 1, 1986. In the interim, Congress must determine how to pay capital costs and if it wishes to differentiate between capital costs incurred before and after March 1, 1985. If Congress fails to act on the capital cost question by October 1, 1986 states will be mandated to perform a review of all capital expenditures over \$600,000 under Section 1122. The return on equity is reduced one third and appears to be eliminated on October 1, 1986.

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

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

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

The marathon fundraiser traditionally features individuals rocking in rocking chairs and rolling in wheelchairs for donations pledged to them by members of the community. Each nursing home in Alaska, through their resident councils, elected to add to or "dress-up" the original idea of rocking and rolling. 1985 Jamboree activities in our state included a raffle for roundtrip airfare Outside, bake sales, guessing contests, costumes, and the election of Jamboree royalty. Entertainment for the rock n' rollers ranged from belly dancing and bagpipes to a dog sled demonstration. Residents sold (and ate) chili dinners, homemade pies and sweetbreads and the ever-popular Big Mac. We received one report of a long term care resident who swam to benefit charity.

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

Governor Bill Sheffield has set aside May 8 - 14, 1985 as the special week this year to honor nursing homes and their residents. The theme "Memories Were Made To Be Shared" emphasizes the fact that nursing home residents have contributed much to the history of our state and have many personal memories to share about the early life of Alaska. Many of our convalescing aged and chronically ill friends and relatives need contact with the community. Members of the Alaska State Hospital Association are sponsoring many activities during the week of May 8 - 14 to ensure that this important contact is reinforced. The primary focal point is the nursing home resident and National Nursing Home Week is a good time to visit the facility in your community and share with a friend.

NATIONAL NURSING HOME WEEK

JAMBOREE WRAP-UP

NORTON SOUND HOSPITAL AWARDED RURAL GRANT

NATIONAL HOSPITAL WEEK MAY 8 - 14

WESTERN NETWORK INST. FOR NURSE EXECUTIVES

EXAMS FOR CLINICAL LAB TECHS

FELLOWSHIP SITE AT BRISTOL BAY HOSPITAL

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

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

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

The Western Network for Education in Health Administration has announced the second annual Western Network Institute for Nurse Executives to be held at the University of California, Berkeley, from July 23 - 30, 1985.

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

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

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

The Health & Human Services' (HHS) Proficiency Examination for Clinical Laboratory Technologists will be held October 7, 1985 in Fairbanks and Anchorage. The exact locations have not yet been determined. Applications for the exam may be obtained from the Division of State Health Planning & Development, Health Facilities Certification & Licensing in the Frontier Building, 36th and C Streets, Anchorage, Room 508 or by writing the same at 3601 C Street, Pouch 6535, Anchorage, 99502-0535, phone: (907) 561-4550. A \$35. fee must accompany the application.

The examination will be conducted by Professional Examination Services, 475 Riverside Drive, New York, New York 10115 and the applications must be submitted to them before June 30, 1985.

The Bristol Bay Area Hospital at Dillingham has been selected by the Association of Western Hospitals as one of two sites for the 1985 Kellogg Rural Post-Graduate Fellowship Program. The other site selected is Delta County Memorial Hospital in Delta, Colorado.

The fellowship program provides rural hospitals an opportunity to obtain management assistance from a well-trained individual who has expressed interest in rural health and who is evaluating alternatives for placement in the field. John Dumbolton, administrator of the Bristol Bay hospital, will participate with AWH in the selection of an exceptional hospital/health graduate to assume a staff management position in the Dillingham hospital for one year beginning September, 1985. Dumbolton and the Kellogg Fellow will develop specific objectives and one or more special projects achievable within the year period of the fellowship.

Funding for the project is provided through a Kellogg Foundation grant, the AWH Educational & Research Foundation and the participating hospital. AWH advises they received 15 excellent site applications from throughout the western states. "We feel that both facilities ultimately selected offer a unique and valuable fellowship experience focusing on rural health concerns," the announcement stated.