ALASKA LEGISLATURE COMMITTEE FILES 1983-1984 8672

2219 HHESS HB 19 709

AWH: 53RD ANNUAL CONVENTION

Industry professionals from hospitals, hospital associations, and other health care organizations from throughout the West will be meeting at the 1983 Association of Western Hospitals annual convention in Anaheim, California, April 24-27.

"Essentials for Excellence: New Directions in Health Care" is the theme of the 52rd annual convention and participants will be able to explore new directions in health care through a wide variety of educational programs. The 74 Western Instructional Conferences (WICs) offer an opportunity for in-depth examination of a broad range of health care issues including financial management, education and training, fund development, marketing, information systems, reimbursement, organizational models, planning and ambulatory care.

The $25. general registration fee admits participants to the opening and closing general assemblies and two special sessions, as well as the exhibit floor. Additional fees of $45., $65. and $100. cover the cost of attending WICs. Convention registration catalogs and additional information may be obtained by contacting the Association of Western Hospitals, 850 Market Street, CA 94102, (415) 421-8810.

THIS N' THAT

Humana Hospital Alaska has elected its medical staff officers. They are Richard Curtis, president; Robert Bosveld, president-elect; Leo Morresey, vice president; David Anderson, secretary-treasurer; Thomas J. Harrison, member-at-large; and John D. Frost, immediate past president.

Jane Sabes, administrator of Norton Sound Regional Hospital, has been recommended to the Board of Governors of the American College of Hospital Administration as a 1983 Nominee.

A sale of attic treasures was held mid-March to benefit the Wrangell Hospital Auxiliary. Proceeds from the sale will go toward the purchase of Resusic-Annes, used in teaching cardio-pulmonary resuscitation (CPR).

Three members of the Providence Hospital Auxiliary were nominated to receive the Volunteer of the Year Award according to Shirley Shaggs, volunteer manager for Providence. Nominated were Cleo Schoen, Billie Church, and Irene Durrant. The award will be presented at the annual awards luncheon on May 3rd.

The new intensive care unit at Central Peninsula General Hospital in Soldotna, opened on March 14. According to administrator Mike Lockwood, this is the first area of the $5.7 million construction project to be opened. The four-room intensive care unit will have complete monitoring capabilities including three telemetry monitoring units which will double the present hospital capabilities for the critically ill. The ICU will be manned 24 hours a day by specially trained nurses.

NORTHERN CARE

Published By

alaska state hospital association

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

D

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

Sources of $ to hospitals

25% CAPITAL CONST. REIMBURSEMENT

250,000 or 2500/bed operating grant

Capital budget appropriations

Tax free bonding capability via Alaska Medical Facility Authority

30-42% hospital REVENUES ARE from government (STATE & FEDERAL) funds

STATE MEDICAID from 2 million in 1972 to 70 million today.

Alaska State Legislature

House of Representatives

MAR 1 1983

Pouch V
State Capitol
Juneau, Alaska 99811

Official Business

cc to all committee members

MEMORANDUM

TO: Rep. Milo Fritz, Co-Chairman
Rep. Mae Tischer, Co-Chairwoman
House Health and Social Services Committee

FROM: Rep. Jack Fuller, Chairman
House Rules Committee

DATE: March 1, 1983

RE: House Bill 19 - Certificate of Need

Attached for your files and information is back-up information relating to House Bill 19.

The Norton Sound Health Corporation has offered recommendations for consideration to the proposed legislation.

Thank you.

FEB 28 1983

NORTON SOUND
HEALTH CORPORATION

P.O. BOX 966
NOME, ALASKA 99762
(907) 443-5411

February 24, 1983

Representative Jack Fuller
Pouch V
Juneau, Alaska 99811

Dear Jack:

HOUSE BILL 19 - CERTIFICATE OF NEED

OPINION-

ADVANTAGES TO CON

There are distinct advantages to the CON process if those working within the division are truly dedicated to their objective of supplying adequate health care for the area.

(1) The state dept of health planning can gather and supply data relevant for planning to hospitals lacking time and expertise for such essential information prior to a proposed building or equipment acquisition.

(2) In the review process, CON requires and assists hospitals in the formidable steps so necessary but not infrequently overlooked or ignored - public input, avoiding duplicity of services....

DISADVANTAGES TO CON

(1) Public Health Service (federal) hospitals are exempt. ALL health care facilities should be required to participate - or none.

(2) Current lengthy process.

(3) Planning should be for the sake of planning - not tied to funding levels. If improper planning and building (or equipment acquisition) the institution will eventually find the funding not meeting expense.

While the battle wages between the State Hospital Assn and Blue Cross, between Humana and Providence Hospitals of Anchorage I must still maintain that the CON advantages outweigh the disadvantages WITH the following modifications:

(1) Demand the state health planning office to streamline the CON review process-currently lengthy and costly. The entire process should be fashioned after an employee grievance system-three steps, brief periods of time in which to respond back to the employee.

(2) Begin to accept the fact that in this day of Medicare, Medicaid, IHS and even private philanthropic dollar reductions responsible health care providers would be fiscally foolish to act in any other than a judicious way - not adding one additional service, bed, staff, or squre foot that would be "unprofitable" - even to a non-profit establishment. This is where I agree with the President that free enterprise will rule if allowed.

(3) The state health planning agency should establish a long range goal to develop expertise and assistance "in the field" in health planning - assuming more an advocate or assistant rather than an adversary role.

(4) Require ALL hospitals - federal, state, private, etc - to participate in the CON process.

There are my opinions in a nutshell. My prayers are with you that heaven will assist you in this and all your deliberations to cut through subjective opinions and see only what would be best for the people, the state, the country.

Cordially,

Jane Sabes
NORTON SOUND REGIONAL HOSPITAL
Hospital Administrator

ne

PS I'd love to view the legislative process, especially on a health issue. How does one go about that? A response from your secretary will suffice. Thank you.

2-25-83 9:40 AM

MAE-MED:

ENTITLEMENTS OUTSTANDING AS of JULY 1, 1983
(FY84) 25% HOSPITAL REIMBURSEMENT

FAIRBANKS MEMORIAL	1,215,281	1 YR REMAINING
JUNEAU DETOX FACILITY	75,059	3 YRS REMAINING
KENAI - CENTRAL PEN. HOSPITAL	2,167,338	4 YRS REMAINING
	# 3,457,678	

Proposed Amendment to SSHB 19

By Dem. H

Section 4 AS 29.90.010 - 29.90.030 is Repealed

Section 5. Those hospitals or health facilities which are currently receiving funds pursuant to ~~sections~~ AS 29.90.010-29.90.030 shall continue To receive construction AID as Though AS 29.90 were not repealed until its entitlement is satisfied. No new applications shall be received a processed after the effective date of this legislation

Mike Maher
Corrections
Mary Hess

The proposal to ~~establish~~ change the division of corrections within DHSS to ~~a~~ departmental status is one that is supported by the governor's office, correctional professionals and the Health Education and Social Services Committee.

Dealing with the correctional crisis is one of the governor's ~~prime~~ primary objectives for this session, and as responsible legislators, it should be ours too. Knowledge of the crisis — the overcrowding, the mismanagement, the poor conditions, the lack of rehabilitation and the rest ~~are all too well~~ is common. The Clearycase, as you know too well, brings the problem to rest in the laps of both the legislature and the executive departments.

As pointed out by the Governor's task force on Corrections, cooperation between the three branches of government is necessary to solve the problem.

Fortunately, the problem can be solved with proper administration, budgeting, and organization. Correction of the problems identified by the ~~previous~~ task force, begins with proper management. The ~~best~~ solution is to develop a Department of Corrections and establish a Commissioner in charge of that Department who can build a management team dedicated to the solution of Alaska's

Alaska Health Coalition

529 5th Avenue, Suite 8
Fairbanks, Alaska 99701
(907) 456-2553

February 17, 1983

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

Dear Governor Sheffield:

We were dismayed to discover that funding for Alaska'a three Health Systems Agencies (HSAs) was not included in your FY84 budget.

During your campaign, you responded very positively to our "Health Issues Questionnaire." We were greatly encouraged to learn that you strongly supported a formal mechanism for citizen participation in State health program decisionmaking and that you felt that HSAs were an appropriate avenue for that involvement. You answered the questionnaire by saying that you support raising State funding for each HSA "to at least $300,000 to maintain citizen involvement in health care decisions at the local level."

Because of recent Congressional action, each HSA in Alaska will receive $100,000 from the U.S. Department of Health and Human Services in FY84. This is a 63% decrease from FY82. Therefore it is critical that HSAs receive $200,000 in State support to prevent their demise.

I would suggest to you that HSAs have provided the only real means for public involvement in health care decisionmaking at the State, regional, and local levels. HSAs enable effective citizen participation in grant and Certificate of Need reviews, in planning, and in resource ddvelopment. Because of this input, the State has been able to direct its resources to areas of greatest need in efficient and effective ways. Also, the State has been able to avoid unnecessary duplication and to prevent unneeded service expansion, resulting in savings of several million dollars in the last six years. In addition, HSAs provide technical assistance to communities and organizations in ways that improve service effectiveness and continuity of care and promote development of new, needed services and facilities.

The publication I have enclosed, "Public Involvement in Health Care Decisions" summarizes the activities of the three Alaska HSAs. It also describes the important services which would be lost to the public if HSAs do not receive adequate State support. I hope you will take the time to familiarize yourself with the many significant accomplishments

that HSAs have made in the health care system of Alaska. The Alaska Health Coalition believes the Health Systems Agencies have earned a place within the health care system in this State and we urge your support for their continued operation.

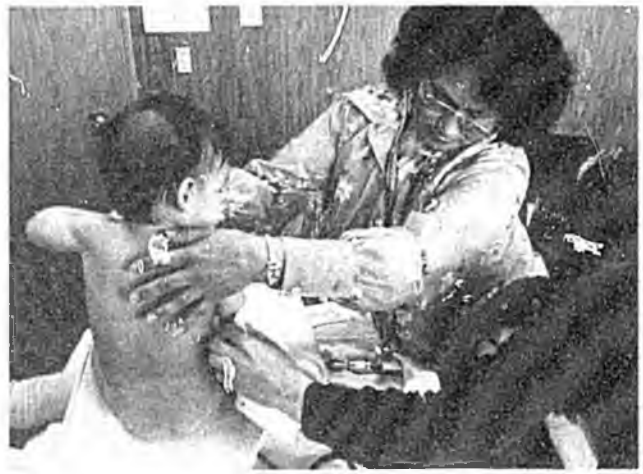
Sincerely,

Charles M. Kaltenbach

Charles M. Kaltenbach, Dr. P.H.
Chairman

CMK:flr

cc: Robert London Smith, Ph.D.
Commissioner, DHSS
Senate HESS Committee
Senate Finance Committee
House Hess Committee
House Finance Committee
Alaska Health Coalition
The Honorable Don Clocksin



Public Involvement in Health Care Decisions

At Risk

Alaska's three Health Systems Agencies, funded by State and Federal dollars since 1976, will cease to exist unless funds are restored to the State budget or appropriated by the Legislature this session.

WITHOUT HEALTH SYSTEMS AGENCIES AT THE REGIONAL LEVEL THERE WILL BE:

* NO opportunity for public discussion at the regional level of the impact of health care programming and funding decisions.
* NO public participation in deciding the future of local health care services. (Decisions will be made in Juneau.)
* NO technical assistance for agencies, organizations, and communities from a non-aligned organization with experienced staff.
* NO regional efforts to promote health.
* NO regional coordination to focus on health-related issues of mutual concern.
* NO independent assessments in the public interest of issues related to health care cost containment.
* NO regional source of information related to health status measurement, health service utilization, health-care quality issues, and health care costs.

THERE WILL BE DUPLICATION OF DATA COLLECTION AND ANALYSIS, RESEARCH, SYSTEMS MANAGEMENT ACTIVITIES, AND PROGRAM DEVELOPMENT.

THERE WILL BE UNNECESSARY EXPANSION OF SERVICES AT EXCESSIVE COSTS TO THE TAXPAYER.

Our Past and Present

Three Health Systems Agencies (HSAs) serve the State of Alaska.

The **Northern Alaska Health Resources Association** serves the North Slope and Fairbanks North Star Boroughs and the areas encompassed by the Arctic Slope, Doyon, and NANA Native regional corporations.

South Central Health Planning and Development serves the Municipality of Anchorage and the areas covered by the Bering Straits, Calista, Bristol Bay, Aleutians, Kodiak, Copper River, North Pacific Rim, and Cook Inlet Native regional corporations.

The **Southeast Alaska Health Systems Agency** serves the Southeastern panhandle.

These HSAs were established by Public Law 93-641 in 1974 to plan for the rational development of health care resources within their regions by providing staff to governing boards composed of a representative cross-section of providers and consumers of health care services. As was the case in other states, the State of Alaska provided funds to supplement the federal grant awards and, consequently, has enjoyed an efficient and mutually beneficial relationship between State officials and planners and their local constituents.

The legal responsibilities of the HSAs are as follows:

A. To improve the health of residents of the health service areas.
B. To increase the accessibility (including overcoming geographic, architectural, and transportation barriers), acceptability, continuity, and quality of health services.
C. To restrain increases in the cost of providing health care.
D. To prevent unnecessary duplication of health care resources.
E. To preserve and improve advantageous competition in the health service area.

These responsibilities are carried out through the development of a long-range health plan and a short-range action plan; reviews of various federal and State grant applications; community assistance with needs assessments, evaluations and plan implementation; and technical assistance to agencies and organizations. These functions are closely coordinated with the respective State agencies which build and expand on our local and regional activities to construct appropriate State-level plans, studies, and policies.

While all this is accomplished on a regular basis by each of the three HSAs, each agency has also recognized the need to tailor its particular work program to the unique requirements and circumstances of its individual health service area.

These activities have helped to:

- **Improve the health status of Alaskans.**
- **Contain the costs of health care.**
- **Improve access to needed health services.**
- **Involve the public in decision-making about the current and future health care delivery system for their communities.**
- **Tailor health service and facility development to the unique needs of each community.**

Our Future

Decreasing support at the Federal level has given Alaska's HSAs a chance to reassess our activities and to discard irrelevant federal requirements. We now have more opportunity to meld our activities to the health systems needs of the regions and communities of Alaska.

The three HSAs have formed the Alaska Health Coalition to encourage responsible participation by the State in health planning and decisionmaking and to support those activities which are vital to the health of Alaska's citizens. The essential program areas are:

COMMUNITY ASSISTANCE

Regional health resources organizations should be available to assist communities and citizen groups in defining health problems in their communities and in identifying solutions to those problems, through:

A. Organizing key individuals for action.
B. Gathering ideas and opinions on identified issues.
C. Analyzing problems and assisting in the development of local strategies for their amelioration.
D. Assisting communities in the implementation of identified strategies.
E. Providing assistance to individuals and organizations in the preparation of funding applications, program development, and evaluation.

HEALTH PROMOTION

Because many of the health problems in the state are related to lifestyle and individual behavior, the resource organizations will seek to improve the health status of Alaskans, by:

A. Determining the prevention and health promotion needs of the regions.
B. Assisting existing programs to improve their effectiveness through coordination and cooperation with other programs.
C. Providing a forum for prevention and health promotion interests.
D. Developing new prevention and health promotion programs to meet the special health needs of Alaskans.

REGIONAL ADVOCACY

To allocate limited resources in a rational and equitable manner, it is necessary to examine individual community needs in relation to the needs of the region and the state as a whole. A framework for providing and communicating this perspective will be accomplished by:

A. Maintaining a regional and local capability to provide current, accurate, health-related data for planning and program development
B. Providing a forum for local grant applications and proposals for new institutional health services and facilities.
C. Providing the Legislature and the Department of Health and Social Services with regional perspectives on health-related issues.
D. Assisting State, local and regional organizations and the Government by conducting research on health-related issues.

HSAs are the forum through which citizens influence the development of health-related services for Alaska. As arenas for participatory democracy, HSAs assist communities, agencies, and individuals to define needs and achieve goals for health resource development. As regional advocates, HSAs bring the concerns of local residents to the attention of the Alaska Legislature and State government. As agents for improving the health of the people, HSAs direct their energies to health promotion and disease prevention, aiming toward increases in the overall health status of the population. **These activities are essential to the continuation of community self-determination in the area of health service development.**

Some of Our Recent Activities

COMMUNITY ASSISTANCE

- SCHPD* assisted the Kenaitze Tribe to establish a clinic.
- NAHRA** helped to establish a patient hostel in Fairbanks.
- SCHPD supported the development of Hospice in Anchorage and Home Health Care, Inc., of Anchorage.
- NAHRA supported development of the Arctic Alliance for People, an association of human service providers in the Interior.
- SCHPD administered a contract for safety week fairs in Sand Point and King Cove.
- NAHRA analyzed the effectiveness and efficiency of Fairbanks Rehabilitation Association's respite care programs.
- SCHPD explored the issues surrounding provision of health care to non-Natives in Bethel.
- SEAHSA*** developed information and assessed the impact of government funding cuts in Ketchikan.
- SEAHSA assessed alternatives for program design and funding sources in Ketchikan.
- NAHRA, SCHPD, and SEAHSA conducted numerous service-specific needs assessments.
- SCHPD trained the Yukon-Kuskokwim Health Corporation Board and staff on health planning, assessment, and management issues.
- NAHRA, SCHPD, and SEAHSA conducted a survey of primary care clinics in rural areas on behalf of DHSS.
- SEAHSA and SCHPD assisted Kake and the Mat-Su Borough to develop community health plans.
- SCHPD provided technical assistance to the Whittier Health Committee.
- NAHRA assessed alcoholism treatment services in Fairbanks and alcohol counselor training in the northern region.

HEALTH PROMOTION

- NAHRA and SEAHSA funded six community-based health education programs.
- SEAHSA developed a boating safety curriculum for grades 7-12.
- SCHPD sponsored a "Health Promotion at the Workplace" conference, with 120 participants.
- SCHPD established a Tel-Med service in Anchorage, with plans to expand to other parts of Alaska.
- NAHRA implemented Alcohol Awareness Week in the Greater Fairbanks area.
- SCHPD developed a resource guide for community health fairs.
- NAHRA published a Health Promotion Resource Directory.
- NAHRA, SCHPD, and SEAHSA wrote a manual for communities to use in establishing health education in their schools.
- NAHRA, SCHPD, and SEAHSA assisted with numerous community health fairs.
- SCHPD established an ongoing Health Promotion at the Workplace working group.
- NAHRA and SCHPD organized child passenger safety groups in Fairbanks and Anchorage.
- NAHRA, SCHPD, and SEAHSA provided information and assistance to various school districts on health education curricula development.
- SCHPD participated in the organization, planning, and leadership of workshops at the Alaska Native Health Board Health Conference.
- NAHRA and SCHPD developed health education legislation.

REGIONAL ADVOCACY

- NAHRA, SCHPD, and SEAHSA developed documents, through public involvement, which identify health problems and health service delivery concerns and propose solutions.
- NAHRA, SCHPD, and SEAHSA provided regional data and evaluation comments for use in the State Health Plan and the Maternal and Child Health Plan.
- NAHRA, SCHPD, and SEAHSA reviewed and commented on proposals for State and federal funding for programs such as mental health, alcohol, and drug abuse (on request of the funding authority).
- NAHRA, SCHPD, and SEAHSA reviewed major capital expenditures by facilities under the Alaska Certificate of Need program, including:
  - Free-standing birthing center in Juneau.
  - Changes in Petersburg Hospital.
  - Re-financing of Alaska Hospital.
  - Expansion of Central Peninsula General Hospital.
  - Replacement of Valley Hospital, Palmer.
  - Replacement and improvement of computer tomography equipment at Alaska Hospital.
  - Free-standing inpatient rehabilitation facility by Alaska Treatment Center.
  - Replacement of Cordova Hospital.
  - Mini-computer system for clinical

lab at Providence Hospital, Anchorage.

- Digital fluoroscopy at Providence Hospital, Anchorage.
- Development of an 80-bed substance abuse/psychiatric facility by Charter Medical Corporation.
- Development of a substance abuse facility by Advanced Health Systems.
- Replacement and expansion of an ambulatory surgery center in Anchorage.
- Expansion of Humana Hospital emergency department.
- Installation of a hospital information system at Providence Hospital, Anchorage.
- Expansion of Fairbanks Memorial Hospital.

* SCHPD — South Central Health Planning and Development, Anchorage
** NAHRA — Northern Alaska Health Resources Association, Fairbanks
*** SEAHSA — Southeast Alaska Health Systems Agency, Ketchikan

HESS —7

What is South Central Health Planning and Development, Inc.(SCHPD)? South Central Health Planning and Development, Inc., like the other two Health Systems Agencies in Alaska, is a non-profit corporation run by a volunteer board of directors established for the purpose of improving the health of residents, increasing the accessibility, acceptability, continuity and quality of health services provided to the population, restraining increases in the cost of providing health services, and preventing unnecessary duplication of health services.

SCHPD serves the 270,000 residents of south central and western Alaska. The service area encompases eight of the twelve Native regional corporation areas: Norton Sound, Yukon-Kuskokwim, Kodiak, Bristol Bay, Copper River, Cook Inlet, North Pacific Rim, Aleutian/Pribilof Islands. The Municipality of Anchorage is designated as a ninth subarea in the total service area.

While all the residents of the area are affected by the decisions of the agency, SCHPD works most closely with: 1) health care providers, including physicians, nurses, representatives from the 16 hospitals in our area, staff from the 8 non-profit health corporations in the area, directors of mental health and alcohol/drug abuse programs, Indian Health Service representatives (on health care cost and health promotion at the workplace issues), community residents who desire technical assistance for the development of proposals for new health services, Boards of health programs who desire training on effective functioning, and others.

The volunteer Board members of SCHPD with help from the staff they hire, provide a process for public involvement in the decisions as to how public money is to be spent in health care. With an ever increasing portion of public (State and Federal) dollars being spent on health services through Medicare, Medicaid, revenue-sharing, mental health and alcoholism programs, risk reduction grants, direct appropriations for capital expenditures (to name a few) public input into the form and organization of those services becomes even more critical.

The public involvement process as implemented by SCHPD has meant:

- -continual coordination with providers and consumers on health care delivery issues in the development of planning documents, on committees and task forces, public meetings;
- -publication, at least annually, of short-range plans listing high priority areas of concern in south central and western Alaska;
- -publication and distribution of periodically updated long-range plan that analyzes health problems and establishes a framework for development of health services by size of community;
- -public review of any Certificate of Need proposals (the only opportunity for the public to review and comment on any analysis of proposals submitted);
- -provision of data to communities, elected officials, health care providers to justify and/or evaluate health care expenditures;
- -public meetings in communities, technical assistance to communities;
- -other involvement in health issues, such as sponsorship and organization of a Health Promotion at the Worksite conference attended by over 200 participants.

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

February 16, 1983

FEB 18 1983

Mae Tischer
House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Representative Tischer:

The Executive Committee of South Central Health Planning and Development, Inc., met on February 14 to consider our future as a regional health planning agency. In order to continue our activities beyond May 31, 1983, the end of our grant year, we need to have some assurance of funding from the State. We are asking that an amount of $200,000 for each of the three Health Systems Agencies be reinstated in the budget.

As we understand it, your subcommittee is now in the process of reviewing the DHSS budget. Alaskan Health Systems Agencies, established in 1976, have received Federal and State grants each year of our operation. Commissioner Beirne told us HSAs were not included in the proposed budget this year for two reasons. First, the Division of Corrections was consuming an increasing portion of the Department's resources. Since then, the new administration has proposed changes in the organization with respect to Corrections services. Second, at the time the budget was drafted, there was no indication Federal money was going to be available. However, Congress has since passed a continuing resolution providing for funding of HSAs at last year's levels.

Continuation of Federal funding at last year's levels means a basic grant of $100,000 plus $15,000 in match (at 30¢ on the dollar for the $50,000 State grant). The chart on the next page shows grant amounts received for the last six years. In addition to the $200,977 in Federal and State money received this last fiscal year, we had approximately $40,000 in carry-over. Therefore, a $200,000 grant from the State would mean a reduction in funding from FY 1980, 1981, 1982 levels. It would mean a slight increase from the latest year. During the past year all staff (except one) are working on a half-time basis due to the budget cuts.

Amount	Federal	State	Total
FY 1983	150,977	50,000	200,977
FY 1982	298,377	100,000	398,377
FY 1981	353,310	100,000	453,310
FY 1980	234,902	125,000	359,902
FY 1979	175,000	125,000	300,000
FY 1978	175,000	125,000	300,000

We urge you to rectify the error made by the Department in excluding funding for the three organizations that provide a forum for public involvement in health care decisions. (See attached page for brief summary of our responsibilities.)

If you have any questions about our organization do not hesitate to call me or the President of the Board, Lillie McGarvey.

Sincerely,

Margaret M. Wilson

Margaret M. Wilson
Executive Director

MMW/ab

Enclosure

In This Issue
- Governors' Health Messages
- The FY 1984 Health Budget

STATE HEALTH NOTES

Number 32
January 1983

Intergovernmental Health Policy Project, George Washington University, Washington, DC 20037

Governors' Health Messages

The governors' state of the state and inaugural messages not surprisingly concentrated on the state of their separate economies. Controlling state budgets is clearly the dominant priority among the states' chief executives. Among the states, deficits for the remainder of their fiscal years are estimated at $1.6 billion in **CALIFORNIA**, $530 million in **NEW YORK**, $260 million in **WISCONSIN**, $164 million in **PENNSYLVANIA**, $150 million in **NEW JERSEY**, and the list continues. Governor Nigh of **OKLAHOMA** reported that a revenue shortfall has occurred for the first time in the state's history.

A recent survey by the National Conference of State Legislatures shows that 19 states are incurring deficits for the current fiscal year and another 13 are operating on very slim margins between revenues and expenditures.

Interestingly, very few governors singled out their Medicaid programs for major reductions or constraints in order to help bring their budgets into balance. Most apparently are reasonably satisfied with the initiatives their states have taken over the past year or two to control the rates of growth in their Medicaid budgets.

GEORGIA'S new Governor Harris specifically pointed to the need for new efforts in Medicaid fraud and abuse control, improved claims review and recovery of overpayments, and a careful study of various alternative reimbursement structures under Medicaid. **NEW YORK** Governor Cuomo intends to recommend a Medicaid Reform Program, which will include major financial and programmatic restructuring. The plan, according to the governor, will enable the state to institute appropriate cost controls, improve access to health care, and strengthen the state's oversight capability through audits and utilization review.

Two governors—Rockefeller of **WEST VIRGINIA** and Lamm of **COLORADO**—made specific references to the need for the regulation of hospital costs. Governor Rockefeller singled out a tripling in state expenditures for public employee health insurance benefits since 1976 as a key reason for his support for a hospital rate setting commission. Governor Lamm referred to the unemployment rate plus increased federal cost containment efforts as reasons for expanding state cost containment measures. In addition to rate regulation, the governor urged the legislature to consider competitive bidding by providers for Medicaid contracts and insurance reform packages.

Acknowledging that hospital costs in **NEVADA** are the highest in the nation—41 percent higher than the national average —Governor Bryan called for several cost containment strategies, e.g., performing day surgery where appropriate and shortening hospital stays. The governor also intends to submit legislation to require understandable billing procedures to reduce the chances of patients being billed for services not received.

Governors Lamm, Anaya (**NEW MEXICO**) and Garrahy (**RHODE ISLAND**) used their inaugural addresses to reconfirm their support for strong certificate of need (CON) legislation. Governor Lamm declared that the state's CON program had saved almost $38 million in health costs over a three-year period, while Governor Garrahy pointed to $42 million in savings to his state over the past decade. Governor Lamm also urged the legislature to consider a limitation on the total yearly amount of capital expenditures made by hospitals.

LESLIE LONGENBAUGH
RESEARCH STAFF

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

POUCH Y, STATE CAPITOL
JUNEAU, ALASKA 99811
PHONE (907) 465-3991

see next pg., too

Governor Cuomo took the opportunity to announce he was ordering a one-year moratorium on the issuance of any new certificates of need. During the one-year moratorium, the Department of Health, in cooperation with other state agencies, is directed to design a new capital budgeting process for hospitals, nursing homes and clinics. The new process is designed to provide the state with the ability to analyze relative need among projects, as well as specific elements in the proposals.

The governors made very little mention of moving away from regulatory strategies and in the direction of containing costs through greater competition. **ARIZONA's** Governor Babbitt was a major exception, however. The governor mentioned the state's repeal of certificate of need legislation in 1982 and deregulation of nursing homes as examples of the state's contribution to removing artificial subsidies in the health care delivery industry. The governor identified three new initiatives he will support on behalf of furthering competition: 1) requiring health care institutions to participate in a uniform billing and discharge data reporting program; 2) prohibiting tax exempt bond issuing bodies from providing tax exempt financing for health care institutions which maintain overall occupancy rates below 85 percent; and 3) creating programs which encourage state employees to be more sensitive about costs in choosing between health care options.

With regard to the state's employee health insurance program, the governor will seek legislative action to establish an employee rebate program for employees selecting lower cost health care insurance plans and to require contracting indemnity insurers to offer plans with varied copayment levels.

Prevention ranked high on the priority list of the governors of **ALASKA, ARIZONA, NEW MEXICO** and **RHODE ISLAND.** Governor Garrahy identified the need to reassess health insurance coverage with a goal of emphasizing coverage for less costly preventive care. Governor Babbitt will seek legislative action to develop health promotion and education programs for state employees and to require contracting indemnity insurers to allow payments for preventive health measures.

The need for expanded alcoholism services received a fair amount of attention. Governor Cuomo will support legislation mandating private health insurance coverage for alcohol treatment. Governor Rockefeller called for an increase in the state tax on alcoholic beverages and a dedication of the revenues to alcohol treatment programs. And Governor Anaya identified alcoholism prevention and services among the top priorities of his administration.

Improving mental health services was a key priority of the governors of **INDIANA, NEW HAMPSHIRE, NEW YORK** and **NORTH DAKOTA.**

A commitment to expanding home and community-based services for the elderly was mentioned by the governors in **NEW MEXICO, MARYLAND, NEW JERSEY,** and **NEW YORK.**

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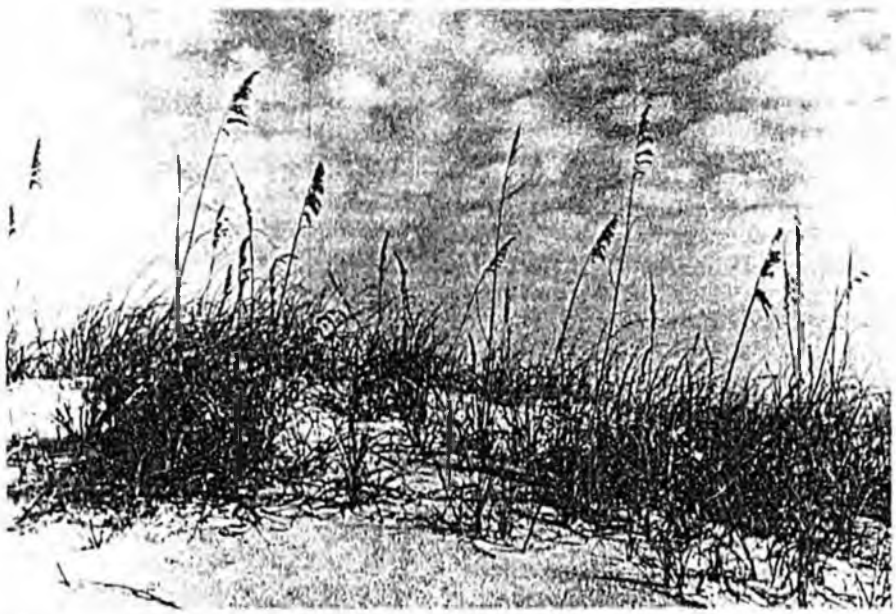

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1) If CERTIFICATE of NEED is REPEALED and HSA funding is cut, ~~what~~ how will STATEwide health planning be implemented.

2) What CONTROL ON health CARE COSTS EXISTS if CON is REPEALED?

3) If prospective RATE setting is proposed, why should it not be included in AN omnibus bill that links CON REPEAL with PRP?

4) ~~Hospital ASSOCIATIONS and STATES~~
NATIONwide trend is toward STRENGTHENING CON REVIEWS - Hospital ASSN's generally support it.

5) What benefit to public by repeal? Loose public INPUT at local level. Loose STATEwide planning perspective at STATE level. Loose Federal health planning $ and MAY loose up to 5 million IN FEDERAL $ for programs. What's the benefit to weigh against that?

What benefits accrue to the public if CON is repealed? The HSA's recommendation will have no authority to support it, the statewide planning perspective will be lost. Alaska may loose up to 5 million dollares in Federal funds and will loose 30% of the Federal Health Planning funds. What is the benefit to public? Health care costs reduced?

2. Will Hospital Assn support an omnibus package that includes repeal of CON with prospective rate program, repeal of 25% Capital reimbursement, in short, a comprehensive health care cost containment package?

3. If CON is unworkable as it is, why not amend it, or work out problems instead of throwing the whole program out?

Law Department
151 Farmington Avenue
Hartford, CT 06156

James E. Brown
Counsel
Government Relations
(203) 273-0343

February 14, 1983

Senator Joe Josephson, Chairman
Health, Education and Social Services Committee
State Capitol
Juneau, Alaska 99811

Dear Senator Josephson:

It is my understanding that your committee will be considering S. B. 85, An Act Repealing the Certificate of Need Program, at a hearing to be held on Wednesday, February 16, 1983. While it is not possible for me to attend in person, I would appreciate your reviewing the enclosed statement in opposition to this bill and entering it into the hearing record.

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

Sincerely,

JEB/jem

Enclosure

STATEMENT OF

ÆTNA LIFE INSURANCE COMPANY

IN OPPOSITION TO

S.B. 85

As a major writer of commercial health insurance, the Ætna Life Insurance Company has for years been deeply concerned about health care cost increases and has consistently supported viable health planning programs. We strongly oppose S.B. 85, An Act Repealing the Certificate of Need Program. We believe that enactment of this legislation would represent a large step backward in Alaska's effort to realize an efficient and effective health care delivery system.

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

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

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

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

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

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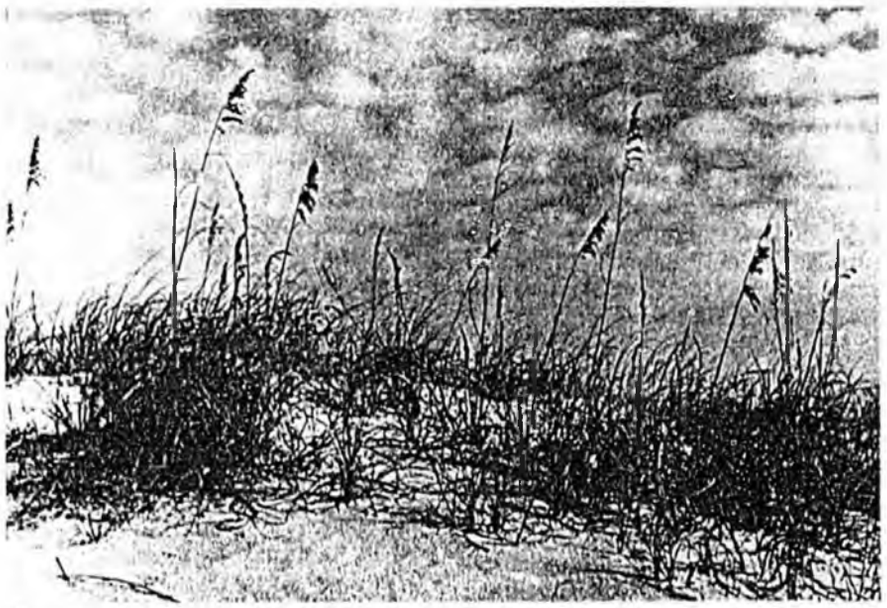

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The FY 1984 Health Budget

STATE HEALTH NOTES

Number 32
January 1983

Intergovernmental Health Policy Project, George Washington University
Washington, DC 20037

Governors' Health Messages

The governors' state of the state and inaugural messages not surprisingly concentrated on the state of their separate economies. Controlling state budgets is clearly the dominant priority among the states' chief executives. Among the states, deficits for the remainder of their fiscal years are estimated at $1.6 billion in **CALIFORNIA**, $530 million in **NEW YORK**, $266 million in **WISCONSIN**, $164 million in **PENNSYLVANIA**, $150 million in **NEW JERSEY**, and the list continues. Governor Nigh of **OKLAHOMA** reported that a revenue shortfall has occurred for the first time in the state's history.

A recent survey by the National Conference of State Legislatures shows that 19 states are incurring deficits for the current fiscal year and another 13 are operating on very slim margins between revenues and expenditures.

Interestingly, very few governors singled out their Medicaid programs for major reductions or constraints in order to help bring their budgets into balance. Most apparently are reasonably satisfied with the initiatives their states have taken over the past year or two to control the rates of growth in their Medicaid budgets.

GEORGIA's new Governor Harris specifically pointed to the need for new efforts in Medicaid fraud and abuse control, improved claims review and recovery of overpayments, and a careful study of various alternative reimbursement structures under Medicaid. **NEW YORK** Governor Cuomo intends to recommend a Medicaid Reform Program, which will include major financial and programmatic restructuring. The plan, according to the governor, will enable the state to institute appropriate cost controls, improve access to health care, and strengthen the state's oversight capability through audits and utilization review.

Two governors—Rockefeller of **WEST VIRGINIA** and Lamm of **COLORADO**—made specific references to the need for the regulation of hospital costs. Governor Rockefeller singled out a tripling in state expenditures for public employee health insurance benefits since 1976 as a key reason for his support for a hospital rate setting commission. Governor Lamm referred to the unemployment rate plus increased federal cost containment efforts as reasons for expanding state cost containment measures. In addition to rate regulation, the governor urged the legislature to consider competitive bidding by providers for Medicaid contracts and insurance reform packages.

Acknowledging that hospital costs in **NEVADA** are the highest in the nation—41 percent higher than the national average —Governor Bryan called for several cost containment strategies, e.g., performing day surgery where appropriate and shortening hospital stays. The governor also intends to submit legislation to require understandable billing procedures to reduce the chances of patients being billed for services not received.

Governors Lamm, Anaya **(NEW MEXICO)** and Garrahy **(RHODE ISLAND)** used their inaugural addresses to reconfirm their support for strong certificate of need (CON) legislation. Governor Lamm declared that the state's CON program had saved almost $38 million in health costs over a three-year period, while Governor Garrahy pointed to $42 million in savings to his state over the past decade. Governor Lamm also urged the legislature to consider a limitation on the total yearly amount of capital expenditures made by hospitals.

see next pg., too

Governor Cuomo took the opportunity to announce he was ordering a one-year moratorium on the issuance of any new certificates of need. During the one-year moratorium, the Department of Health, in cooperation with other state agencies, is directed to design a new capital budgeting process for hospitals, nursing homes and clinics. The new process is designed to provide the state with the ability to analyze relative need among projects, as well as specific elements in the proposals.

The governors made very little mention of moving away from regulatory strategies and in the direction of containing costs through greater competition. **ARIZONA's** Governor Babbitt was a major exception, however. The governor mentioned the state's repeal of certificate of need legislation in 1982 and deregulation of nursing homes as examples of the state's contribution to removing artificial subsidies in the health care delivery industry. The governor identified three new initiatives he will support on behalf of furthering competition: 1) requiring health care institutions to participate in a uniform billing and discharge data reporting program; 2) prohibiting tax exempt bond issuing bodies from providing tax exempt financing for health care institutions which maintain overall occupancy rates below 85 percent; and 3) creating programs which encourage state employees to be more sensitive about costs in choosing between health care options.

With regard to the state's employee health insurance program, the governor will seek legislative action to establish an employee rebate program for employees selecting lower cost health care insurance plans and to require contracting indemnity insurers to offer plans with varied copayment levels.

Prevention ranked high on the priority list of the governors of **ALASKA, ARIZONA, NEW MEXICO** and **RHODE ISLAND.** Governor Garrahy identified the need to reassess health insurance coverage with a goal of emphasizing coverage for less costly preventive care. Governor Babbitt will seek legislative action to develop health promotion and education programs for state employees and to require contracting indemnity insurers to allow payments for preventive health measures.

The need for expanded alcoholism services received a fair amount of attention. Governor Cuomo will support legislation mandating private health insurance coverage for alcohol treatment. Governor Rockefeller called for an increase in the state tax on alcoholic beverages and a dedication of the revenues to alcohol treatment programs. And Governor Anaya identified alcoholism prevention and services among the top priorities of his administration.

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HOSPITAL GROUP WANTS PATIENT FEES IN MEDICARE PAY PLAN

While determined to see Congress pass a prospective payments system, the American Hospital Assn. wants Congress to make some significant changes in HHS' proposed plan. The group's major concern is to have the plan allow hospitals to charge Medicare patients a fee above what Medicare will pay for hospitalization. AHA Vice President Jack Owen urged members at the group's annual meeting to press Congress to give the go-ahead to such payments by Medicare beneficiaries.

The group also will lobby Congress to base the pay plan on each hospital's cost per diagnosis group, rather than use national average costs as proposed by HHS. The association claims this will not raise total costs for Medicare, merely allocate funds more accurately.

AHA also hopes legislators will exempt some small and rural hospitals from the plan. Another area of worry is that the HHS secretary will be the one to decide the actual dollar figure on which payment for each diagnosis will be based (WHCL, Jan. 7, page 1). The non-profit hospital group wants an independent panel of economists to decide this. Owen also urged AHA members to lobby for health planning programs that are locally-run, rather than federally controlled.

CAPITAL COSTS CURBED BY HEALTH PLANNING PROGRAMS

Proponents of the highly criticized health planning program will note with satisfaction a study for the Health Resources Administration which found that certificate-of-need programs have succeeded in curbing increased capital costs. The program in particular averted capital expenditures for acute care services and facilities, said the study(*) prepared by Arthur D. Little, Inc. Health planning programs were studied in six states: N.J., Iowa, Colo., Va., S.C., Wash.

Projects were blocked because they did not meet objectives set forth in state and health systems plans. Review of programs before applications were submitted meant that some programs were stopped early on. Iowa's program of a presubmission conference between the applicant and local health planning staff on the need for a project eliminated the expense of preparation and review for projects which were immediately rejected.

Decisions on certificate-of-need were made on the basis of specific objectives, standards for programs and need estimates. The latter included the volume and utilization of existing and proposed health services. The issue of financial feasibility came into most decisions, particularly at the state level. The effect of new capital spending on operating costs and patient charges was evaluated.

More than two-thirds of the acute care capital expenditures approved were for renovation/replacement and/or conversion of existing capacity. This may be related to the fact that while standards exist for adding acute care capacity, there are no guidelines for renovation and replacement of such services. Many of the new or additional services approved were equipment. Nearly half of N.J.'s new/additional capacity was equipment.

Certificate-of-need programs are especially effective when integrated with state cost containment plans such as rate setting, the study said. It also recommended better standards for long-term care and renovation of acute care facilities.

(*) - Document used in an article is available from our affiliated *Regulatory Watchdog Service* (202) 47[illegible]

POSITION PAPER/Department of Health & Social Services

Position Paper

on

Senate Bill 85

"For an Act repealing the certificate of need program; and providing for an effective date."

Senate Bill 85 repeals those portions of AS 18.07.021 which provide the statutory authority for the Department to administer a certificate of need program and repeals references to certificate of need in other sections of the Statute as well.

The Administration supports Senate Bill 85 as it is currently written.

The Department recommends that the Committee review statutory provisions which relate to health facility development including the following:

Medicaid Programs

The state's participation in the Medicaid program (State dollars fund approximately 52 percent of total program costs) has grown from $1 million in 1972 to nearly $38 million in FY 82 and total costs including federal participation have grown from $2 million to nearly $74 million in this same period. Ninety-two percent of patients in Alaska's long term care facilities are supported by the Medicaid program which means that the state (and federal) government has nearly the full burden of all operational costs for the facility. These Medicaid costs increase when additional beds are added, new equipment is purchased or new services (including new types of manpower) are offered. The Division of Public Assistance must effect a provider agreement with any qualified provider who seeks this agreement.

Capital Budget

Alaska has provided substantial financial assistance in the development of health care facilities. The 12th Legislature provided more than $36.6 million by line item appropriation to expand one hospital; replace two others and provide planning assistance for two rural hospitals. The number of requests for state funding has steadily increased.

Revenue Sharing

Alaska has a revenue sharing program (AS 29.90.010) which provides 25 percent plus interest of hospital construction costs to all non-profit hospitals. This program, administered by the Department of Community and Regional Affairs, provides further support for hospital construction projects in addition to any front-end capital funds provided by the state. This additional health facility construction resource underscores the importance of determining the actual need

for construction, before the State is committed to pay for a major portion of such construction.

Non-profit hospitals each receive a quarter of a million dollars in operating assistance each year through the state's revenue sharing program (AS 29.89.030). Nursing homes and other health facilities also receive assistance based on the number of beds they have. There are no specific requirements as to how such funds are to be expended. Not only are existing health facilities assured of these funds in addition to other state support, but new facilities are encouraged by the availability of these funds.

Recommended by: Phoebe A. Lindsey

Phoebe A. Lindsey, Director
Division of Planning, Policy
and Evaluation

Date: 2/16/83

Approved by: for John R. Smith

Robert London Smith, Ph.D.
Commissioner
Department of Health and
Social Services

Date: 2/16/83

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 Phone: 465-3038
Division: State Health Planning and Development Date: 2-14-83

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

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

Central Peninsula General Hospital

P. O. Box 1268
SOLDOTNA, ALASKA 99669

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

February 14, 1983

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

FEB 18 1983

Subject: House Bill #19

Dear Representative Tischer:

Central Peninsula General Hospital, along with the other hospitals of the Alaska State Hospital Association, would encourage the earliest possible passage of Senate Bill #85.

It is a premise of this organization that the Certificate of Need process is both cumbersome and ineffective in a state such as Alaska. The original purpose was developed to help contain health care costs by discouraging over-building of hospital beds. The State's major health care problem is not over-bedding, but the continuing lack of accessibility to health care programs and facilities due to the rural nature of our state.

I would encourage our legislators to promote the health care agencies in the planning and providing for better health care, and not tying up their time with the fruitless Certificate of Need process.

Please find attached a copy of a letter from the Central Peninsula General Hospital Service Area Board to the Kenai Peninsula Borough Assembly in support of the repeal of the Certificate of Need process.

Again, passage of this legislation at the earliest time is available.

Thank you for your consideration.

Sincerely yours,

Michael J. Lockwood,
Administrator

MJL/pt

enc. (1) Resolution of the Central Peninsula General Hospital Service Area Board for Repeal of the C.O.N.

Central Peninsula General Hospital

P. O. Box 1268
SOLDOTNA, ALASKA 99669

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

February 11, 1983

Kenai Peninsula Borough Assembly

At its regular meeting on February 10, 1983, the Service Area Board of the Central Peninsula General Hospital unanimously endorsed Resolution 83-13 "Urging the Alaska Congressional Delegation to work for Repeal of 42 USC 300 M (D) and Urging the State to subsequently repeal AS18.07 03L-111 which provides for a Certificate of Need program for the Construction, Alteration of Bed Capacity, or Addition or Elimination of a Category of Health Services of a Health Care Facility.

To this end the Service Area Board also endorses House Bill 19 and Senate Bill 85, 2 bills that have been introduced in the 1983 Alaska State Legislature.

Copies of this endorsement have been sent to Senators Stevens, Murkowski and to Congressman Young as well as the Alaska State Legislators.

Robert F. Jensen

ROBERT F. JENSEN
Chairman
Service Area Board

alaska state hospital association

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

REPRESENTING ACUTE, LONG TERM AND OUTPATIENT FACILITIES

Alaska State Hospital Association

Position Paper

Certificate of Need Repeal

The Certificate of Need program in Alaska (AS.07) should be repealed. It is both inequitable and unnecessary. Its basic presumption is that the Department of Health and Social Services can make better decisions for hospitals and nursing homes than can the facilities themselves.

Basic Issues

1. Equity

- While controlling non-state construction of skilled nursing facilities (SNF's) and intermediate care facilities (ICF's), the prgram exempts these beds constructed in Pioneers' Homes. Thus any determination of need based on the current program is flawed because forces external to the program can and have - in Anchorage, Juneau, and Ketchikan - altered the factual situation.

- Alaska Native Health Service and the Armed Forces facilities are also exempt from coverage. Their activities have a direct bearing on many other facilities in terms of both service area and referrals.

- Physician office construction and equipment purchase are also exempt.

The inequities are clearly illustrated in the Anchorage area: Providence Hospital, Humana Hospital, Nakoyia Health Care Center, Hope Cottages and the Alaska Treatment Center are included in the CON program while the Alaska Native Health Service Hospital, Elmendorf AFB Hospital, the Anchorage Pioneers's Home and the Diamond Emergency Center are not included. All of these facilities share the same basic service area.

2. Unnecessary

Market place economics and competition should be the determinant of capital expansion for health facilities. In Anchorage, the Municipal Health Commission as well as open board meetings provide the public input into a facility's planning process. In smaller communities the city council or borough assembly who own the facility provide the public input opportunity.

Alaska is a developing state of many isolated regions without any appeal for duplication of services or need to limit access to health care, which is the basic intent of the CON program.

3. Conformity

42 USC 300 m-(d) requires that states conform to the federal program or face a reduction of specified public health service funds.

- Conformity is not achievable without the inclusion of the Pioneers' Homes.

- There are 30 states, including New York and California as well as Alaska, which are not in conformity.

- The penalties have been deferred every year since passage. In December of 1982 they were deferred until October 1, 1983.

- The Reagan Administration is not supportive of continuing this program. Congress is working to create a state optional program without penalties. Thus the likelihood of imposition of penalties is remote at best and the across the board elimination of CON would not change Alaska's current status.

4. Other States

- Louisiana does not have a certificate of need law.

- According to the American Hospital Association, 30 states currently do not conform.

- At least seven states have termination clauses or specific sunset provisions.

5. Attachments

- Alaska State Hospital Association Policy Paper on Repeal of Certificate of Need

- Providence letter to Mayor Knowles explaining opposition to CON.

- U.S. Department of Health and Human Services letter to Denni[illegible]t discussing Alaska's non-conformity.

(Attachments cont.)

- Alaska Department of Administration letter to Representative Don Clocksin discussing Pioneers' Homes exemption, conformity problem, and potential for penalties.

- 42 USC 300m-(d)

- Alaska Department of Health and Social Services letter to Representative Mike Beirne indicating lack of compliance with federal program.

- Alaska State Medical Association Resolution calling for the repeal of certificate of need.

- Alaska State Hospital Association letter to Stevens on CON repeal.

- Governor Sheffield's response to the Association letter to Senator Stevens.

alaska
state
hospital
association

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

POLICY STATEMENT

CERTIFICATE OF NEED

Position: The Alaska State Hospital Association advocates the repeal of the certificate of need (CON) law, AS 18.07.

Rationale: The CON process has proven costly, wasteful, and unnecessary. The program has become excessively bureaucratic to the point that it undermines economic incentives throughout the decision-making process and so increases the cost of capital projects it takes valuable dollars from patient care. The certificate of need process also removes community control from local jurisdictions in respect to municipally-owned facilities and local advisory boards in respect to corporate ownership.

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

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

#1

bcc Dennis Nesbett

PROVIDENCE
HOSPITAL

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

SISTERS OF
PROVIDENCE

SERVING IN THE WEST SINCE 1856

December 27, 1982

Mayor Tony Knowles
Municipality of Anchorage
Pouch 6-650
Anchorage, Alaska 99502

Dear Mayor Knowles:

Thank you for the opportunity on December 13 to share Providence's plans and some of our concerns with you.

One point came up during our discussion regarding Certificate of Need (CON). I would like to elaborate for you in more detail why the health care providers in Alaska oppose CON and have so strongly supported its repeal.

As you know, the CON law was passed in this and most other states as a requisite to receive Federal funds. The major impetus for the law were:

1. Excess hospital beds in many large cities, and
2. rising health care costs.

The belief was that by controlling the number of beds, capital expenditures and new services, costs would be contained. The results have been much less than desired throughout the country. The law is cumbersome, wasteful and, in fact, costly.

The lack of "success" is especially true in Alaska for some basic reasons:

1. The process which the law sets in place is cumbersome and wasteful. The institution must:
   - submit a letter of intent at least 60 days prior to an application (for no apparent reason);
   - submit an elaborate, repetitive application (most are well over 100 pages). There are 12 separate "criteria" which must be addressed in any application;
   - wait to be declared complete (minimum 20 days; several of our applications were delayed months);
   - then go through a 90-day review process--with three or four public meetings.

2. The costs of CON to the institution are enormous to prepare this cumbersome document (at least 35 copies) and submit to the minimum 110-day process. There are also the institutional costs of delaying implementation and watching the price of a piece of equipment or construction project increase several percent points with inflation.

   The cost to the public is also great in the state, regional and local staff needed to coordinate the program, prepare staff analyses and hold public meetings.

3. The dollar limit for what must be reviewed has been ridiculously low--$150,000. The federal law has allowed that limit to be raised to $400,000 and $600,000 although the Alaska legislature failed in its last session to raise the limits. Some states have raised the limit to $1 million or more. To have a limit of $150,000 or even $600,000 when the hospital's annual operating budget is $75,000,000 (such as Providence's) is overkill.

   In just 1982 alone, Providence has prepared 6 CON applications, including two equipment replacements (for a CT Scanner and a Cath Lab), a $250,000 computer enhancement for an x-ray machine and most absurd, a $167,000 replacement incinerator (25 years old, replacement required by State and EPA codes!). The State did not give final approval on the incinerator until the 90th day.

4. The law itself is overkill in Alaska. Designed for areas of heavy population, excess hospital beds and competition, the law does not work for Alaska for several reasons:

   - The law only covers private facilities--not public health, nor state owned (API or Pioneer Homes), nor military.

   - Alaska has only one city with more than one hospital and only three private ("eligible") hospitals of over 100 beds.

5. The law is reactive to existing decision making processes. Most hospitals in the State already have local public review and approval designed in their own budget review processes. Many hospitals are owned by municipalities, and all have governing or advisory boards of local citizens. These citizens should have control of the expansion and budgetary decisions of their own institutions. Several other layers are unnecessary. Hospitals and their boards are capable of making sound financial and program decisions.

As the attached Policy Statement of the Alaska State Hospital Association (ASHA) notes, we are supportive of state and local planning for the health care needs. The process should be positive and proactive-- encouraging institutions to respond to needs in the community rather than reactive, cumbersome and negative.

We encourage the city to support the ASHA position on repealing the state CON law. Your own Municipal Health Commission is a strong local planning body which helps identify health needs and encourages solutions. It also serves to review public expenditures in health. Those roles are appropriate. It should be freed from the cumbersome CON review.

Thank you for giving me the opportunity to share our concerns with you.

Best wishes for a prosperous 1983.

Sincerely,

Al M. Camosso
Administrator

Enclosure

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Region X
M/S 829 Arcade Plaza Building
1321 Second Avenue
Seattle WA 98101

June 22, 1982

Re: 10P 550016
Alaska SHPDA

Dennis L. DeWitt
President
Alaska State Hospital Association
319 Seward Street
Juneau, Alaska 99801

Dear Mr. DeWitt:

Your letter dated June 11, 1982, requested information about Region X's intentions as a result of the failure of the Alaska Legislature to pass amendments proposed to bring the State Certificate of Need program into compliance with the Federal planning law, as amended. Our course of action is quite clear. We will continue to fullfill our mandated responsibilities guided by actions and time frames specified in the law.

Under the existing provisions of Title XV of the Public Health Service Act, as amended, current law requires (in order to be fully designated) that a SHPDA must meet all requirements for full designation, including that of having a complying Certificate of Need program.

If a SHPDA is not eligible for full designation by a certain date (which for Alaska is January 19, 1983) the Department must invoke the statutory penalty of reducing most Public Health Service grants and contracts to any entity in the State by 25% the first year, 50%, 75%, and 100% over the next three years. Amendments contained in PL 97-35 extended the date by which a State must have a fully designated SHPDA to avoid imposition of the penalty. However, PL 97-35 also amended Section 1521(b)(2)(B) by specifying that a conditional designation agreement could not extend beyond a State's penalty date.

Fully designated SHPDAs (such as Alaska) which do not have complying CON programs but continue to meet other requirements, will be returned to conditional designation. As noted above, PL 97-35 prohibits the conditional designation of any SHPDA from extending beyond its penalty date. Any SHPDA which remains conditionally designated on its penalty date must be terminated. Therefore, we will send a termination notice to any conditionally designated SHPDA 90-days prior to its penalty date, if it still has not demonstrated that it has a complying CON program.

The enclosed copy of a letter to Commissioner Beirne, from the Regional Health Administrator, further emphasizes the critical nature of having a complying CON program in Alaska.

Also the enclosed copy of a 1981 letter addressed to Mr. Ivan Lawner, Esq. concerning Pioneer Homes Certificate of Need review issues, reflects our unchanged position.

I hope the facts in this letter provide the detail of information required to understand the situation. Please call or write, should you need further assistance.

Sincerely,

John D. Whitney
Director
Department of Health
Resources Development
Region X

Enclosures (2)

DEPARTMENT OF HEALTH. EDUCATION. AND WELFARE

829

JUN 21 1982

Re: IOP 550016
Alaska SHPDA

Helen D. Beirne, Ph.D.
Commissioner
Department of Health and
Social Services
Pouch H 01
Juneau, Alaska 99811

Dear Dr. Beirne:

The State of Alaska's Department of Health and Social Services full designation agreement with the Department of Health and Human Services is being extended for three months, until September 30, 1982. As you know, because Alaska's Certificate of Need Program does not comply with Federal requirements, it is necessary that the SHPDA be returned to conditional designation. As required by statute, this 90-day extension of your current designation is being given to allow you to request and prepare for a hearing, if you should want one. Letters from the Bureau of Health Planning to you and to the Governor will further explain this process.

The following conditions are to be considered a part of the extended full designation agreement:

1. If the Agency is unable to retain full designation after September 30, 1982, it will be returned to conditional designation for the period October 1, 1982 to June 30, 1983.

2. The designation of the Agency will automatically terminate when the Agency reaches its penalty date, if the Agency still has not achieved full designation.

You may at any time prior to your penalty date (1-19-83, per PPM 82-12) submit documentation which you believe contains evidence that the State's CON program complies with the minimum Federal requirements, or a certification by the State's Attorney General, attesting to the program's complian

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Please sign both copies of this letter, indicating your acceptance of this extension with conditions. Return one copy to this office. As soon as we receive the signed copy, we will issue a Notice of Grant Award for the extended designation period.

Sincerely,

Dorothy H. Mann, M.P.H.
Regional Health Administrator
Region X

Helen D. Deirne, Ph.D.
Commissioner
Alaska Department of Health

Date

DHRD:ROSS:vw:6/21/82

DEPARTMENT OF HEALTH & HUMAN SERVICES

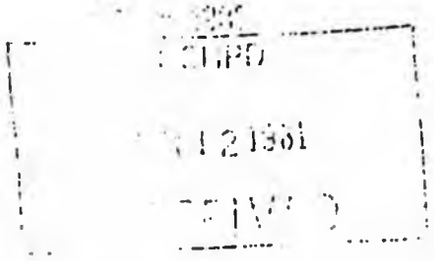
Public Health Service

Pioneer Homes
Lynns Room

Region X
M/S 829 Arcade Plaza Building
1321 Second Avenue
Seattle WA 98101

Re: 10P 550007-05

Mr. Ivan Lawner, Esq.
Hellen & Partnow
524 G Street
Suite 710
Anchorage, Alaska 99501



Dear Mr. Lawner:

This is to respond to your recent letter concerning Certificate-of-Need review of a skilled nursing facility addition to the Pioneer Home in Anchorage. In that correspondence you raised two issues: the need for clarification of our 1978 letter to Howard Gabriel regarding C/N coverage of Pioneer Homes, and the compliance of the Alaska C/N program with federal standards. These matters will be addressed separately.

1. In our September 11, 1978 letter to Howard Gabriel, Director of the Southeast Alaska HSA, we were assuming that Pioneer Homes were only residential or domiciliary care facilities; there was no understanding that inpatient skilled nursing care was provided in these institutions. Given this understanding of the nature and services of Pioneer Homes at that time we were correct in concluding that they would not be included in the federal definition of "health care facilities" which would require coverage under Certificate-of-Need programs. If indeed skilled nursing services are provided in these institutions, they would be considered "health care facilities" as defined by our C/N regulations. The 1978 letter did not consider a Pioneer Home to be such a facility.

2. We have reviewed the Alaska C/N statute and implementing regulations to determine whether Pioneer Homes would be included in the definition of a health care facility. We found that:

   a. The Alaska C/N statute defines a "health care facility" as:

      A private, municipal. . . hospital, psychiatric hospital, turberculosis hospital, skilled nursing facility. . . . (Sec. 18.07.111(7)).

   b. The Alaska C/N regulations, in turn, define "health care facility" as:

      Any of those listed in AS 18.07.111, as defined, where appropriate, in 42 CFR 123.401 (adopted 1/21/77). (7AAC07.130)

c. The State's C/N statute and regulations, taken together and including the cross reference to 42 CFR 123.401, would provide coverage of a distinct part of an institution and would, therefore, meet the federal definition of a skilled nursing facilities, i.e., an institution or a distinct part of an institution which is primarily engaged in providing inpatient skilled nursing care and related services for patients who require medical or nursing care . . . . (42 CFR 123.401)

From the above points, it would appear that the Alaska C/N program adequately defines "heath care facility" and "skilled nursing facility." It is the responsibility of the state to follow its own C/N statute and regulations. If there is an on-going and sustained pattern of not following their statute and regulations, we would certainly assess the state's overall C/N program and then take appropriate action.

Please call us should you have further questions.

Sincerely yours,

John D. Whitney, Director
Division of Health Resources
Development PHS, Region X

cc: Ron Hammett, Director, SCHPD
Howard Gabriel, Director, SEAHSA

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPARTMENT OF ADMINISTRATION

OFFICE OF THE COMMISSIONER

POUCH C
JUNEAU, ALASKA 99811

465-2200

May 29, 1981

Honorable Donald E. Clocksin
Chairman, Health, Education and
Social Services
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Representative Clocksin:

This is in response to your request to put in writing my verbal testimony before your committee on CSSB 225. I will try and confine my remarks to the major issues.

Administration's position is that the Legislature has always implicitly exempted Pioneers' Homes from the certificate of need program. The Senate has concurred with this position as evidenced by CSSB 225. We are asking that the House members be afforded the same opportunity to express their will as the Senate.

There appears to be some confusion existing with the recent State Supreme Court decision of South Central Health Planning and Development, Inc. vs the Department of Administration, on certificate of need. At issue was whether or not the Legislature exempted Pioneers' Homes from certificate of need. The court found that there is no language in State statutes which can reasonably be read as exempting skilled nursing facilities from the certificate of need process when they are contained in Pioneers' Homes. Consequently, whether or not the Legislature intended to exempt Pioneers' Homes now becomes moot. The Legislature's intent can now be established only through the legislative process of amending existing law to allow this exemption.

There has been a substantial amount of discussion centering around the need for proper planning so that health facilities in Alaska are not overbuilt. This is an admirable and worthy objective, and I can assure you that this Department supports health facility planning. However, the existing system under the certificate of need program is fraught with inequities and frustrations; further, it does not represent a comprehensive planning effort.

2-89LH

There are three providers of health facilities; the federal government, the State government, and the "private sector." However, the federal health facilities don't come under the certificate of need program, and in most states this wouldn't pose any problem. The military contingent in California, for instance, would represent a small portion of the state's total population and as such would not greatly impact the planning process for certificate of need. In Alaska, the opposite is true. The federal government is a major provider of health care and facilities. Roughly one-fourth of the state's population are eligible to use federal health facilities (military base, Public Health, Indian Health, etc.). This has a devasting effect on trying to logically plan for state and "private sector" health facilities when a critical component is missing.

In addition, if we look closely at the "private sector" we see that it is not truly private. A substantial portion of the revenues of private nursing homes and health facilities originate through state and federal programs. State and federal rules, regulations, requirements, and laws, guide and govern, in minute detail, the construction and operation of private health facilities. This includes the proper ratios of professional staff to patients, the type of equipment allowed, size of hallways, reporting procedures, and many others. In effect, the "private sector" is part of the "public sector." Consequently, the charge that the State, through the establishment of Pioneers' Homes, is unfairly competing with the private sector is a fallacious argument.

There has also been considerable discussion on the impact of granting Pioneers' Homes an exemption from certificate of need as it relates to federal programs. Mr. Vern Perry, Director of the Division of Pioneers' Benefits spoke with Mr. Jim Egan, Regional Project Officer of the Office of Health Planning, Region X, U. S. Department of Health, Education and Welfare, on Wednesday May 27, regarding the certificate of need program.

QUESTION: What effect would there be on the State of Alaska if Pioneers' Homes were exempted from the certificate of need program?

ANSWER: It would have no effect on medicare, medicaid, AFDC or Indian Health Service. It could only affect categorical programs such as alcoholism, EMS, Neighborhood Health Clinics, Mental Health Clinics, Day Care, etc.

QUESTION: Would the federal government actually discontinue such programs as alcoholism and mental health if Pioneers' Homes were exempted from the certificate of need program?

ANSWER: No! Absolutely not. In his opinion, under the new administration, there would be no federal sanctions whatsoever in health care programs, especially since the responsibility for this is being turned over to the states.

Further, discussions were held with the States of California and Washington regarding their certificate of need programs. In California, Mr. Ken Umbach (916/323-6955) of the Office of Statewide Health Planning and Development was contacted. He stated that California has been out of conformance with the federal certificate of need program since 1969. Their latest date for coming into conformance is October. He stated that if they did not meet the deadline that the feds would probably extend it. Mr. Jim Bettridge of Washington Health Care Facilities Authority (206/753-6185) indicated that the feds were withdrawing total support from the certificate of need program by 1983.

These conversations indicate that:

i. The federal government is not inclined to impose sanctions on a State for nonconformance with the certificate of need program;

ii. There are states which are nonconforming, and have been nonconforming for a number of years, on which federal sanctions have not been imposed; and

iii. The federal government is withdrawing total support for the certificate of need program by 1983. If the state wants to continue a planning process for health facility development it will have to provide for the process by using General Funds monies. Based on the aforementioned problems, now would be the appropriate time to revise this planning process to make it more meaningful.

Finally, a compromise position has been mentioned in which the new nursing wing at the Anchorage Pioneers' Home and the new Pioneers' Home in Ketchikan would be totally grandfathered into law and not made subject to certificate of need. This compromise does not address a truly complex problem.

The Fairbanks Pioneers' Home presently is serving twelve skilled nursing beds in unlicensed beds. Unless a certificate of need is issued which allows licensing of these beds, these twelve pioneers would have to be discharged.

The Fairbanks and Palmer Pioneers' Homes are full to capacity with skilled nursing patients at the present time. If we are to accommodate anticipated need in the near future, additional skilled nursing facilities will have to be constructed within the next few years. This expansion would be impossible unless a certificate of need is issued.

The Department of Health and Social Services, in recent licensing inspections, has advised a significant number of residents in the ambulatory sections of all the Pioneers' Homes should be designated intermediate care patients. Intermediate care requires both a certificate of need and a significant increase in staffing, installation of call buttons or other signalling devices, and closer attention to patients when taking medications, etc. The number of patients which might be considered in need of intermediate care are: thirty at Sitka, twenty at Fairbanks, twenty at Palmer and forty at Anchorage (in the new wing).

Funding to provide intermediate care was not included in the FY 82 operating budget. Although a dollar figure is not available at the present time, a significant increase will be necessary if we must comply with the certificate of need program. Passage of SB 225 would eliminate this situation.

In summary:

1. Administration believes the Legislature had always intended to exclude Pioneers' Homes from certificate of need;

2. The certificate of need process is not appropriate for Alaska;

3. There needs to be planning for health care facilities and a more responsive process needs to be developed;

4. Grandfathering the nursing wing at Anchorage and the new Pioneers' Home at Ketchikan will not solve the complex problems existing at the Fairbanks, Palmer, and Sitka Pioneers' Home; and,

5. Passage of CSSB 225 will eliminate the potential for pain and suffering by allowing Pioneers' Homes residents to remain in their home.

If I can be of any further assistance to you or your committee, please give me a call.

Sincerely,

Frederick B. Muller

Frederick B. Muller
Deputy Commissioner for
Personnel Management

FBM/mjc
cc: Honorable Charles Parr
Honorable Robert Ziegler
Honorable Jalmar Kerttula
Honorable Patrick Rodey
Pioneers' Homes Advisory Board
Dennis Dewitt, Executive Director
Alaska State Hospital Association

accordance with subsection (b)(2), or (b)(3) of this section (as the Secretary determines appropriate), enter into another agreement with the Governor for the designation of a State Agency.

Failure to designate State Agency within specified period; reduction in allotment, grant, loan, loan guarantee, or contract

(d)(1) If an agreement under subsection (b)(3) of this section for the designation of a State Agency for a State is not in effect upon the expiration of—

(A) the fourth fiscal year which begins after 1975; or

(B)(i) if the legislature of the State is in a regular session on December 17, 1980 and the legislature will be in session for at least twelve months from such date, twenty-four months from such date, or

(ii) if the legislature of the State is in session on December 17, 1980, but twelve months do not remain in such session after such date or if the legislature of the State is not in session on such date, twenty-four months after the beginning of the first regular session of the legislature beginning after such date,

whichever occurs later, the Secretary shall take the action prescribed by paragraph (2).

(2) If upon the expiration of the period applicable under paragraph (1) an agreement is not in effect for the designation of a State Agency for a State, the Secretary shall until such an agreement is in effect take the following action:

(A) During the first twelve months after the date of the expiration of the applicable period, the Secretary shall reduce by 25 percent the amount of each allotment, grant, loan, and loan guarantee made to and each contract entered into with an individual or entity in such State during such period under this chapter or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970.

(B) During the second twelve months after such expiration date, the Secretary shall reduce by 50 percent the amount of each such allotment, grant, loan, loan guarantee, and contract.

(C) During the third twelve months after such expiration date, the Secretary shall reduce by 75 percent the amount of each such allotment, grant, loan, loan guarantee, and contract.

(D) After the expiration of thirty-six months after such expiration date, the Secretary may not make or enter into any such allotment, grant, loan, loan guarantee, or contract.

(July 1, 1944, c. 373, Title XV, § 1521, as added Jan. 4, 1975, Pub.L. 93–641, § 3, 88 Stat. 2242, and amended Aug. 1, 1977, Pub.L. 95–83, Title I, § 106(*l*), (m), 91 Stat. 385; Dec. 19, 1977, Pub.L. 95–215, § 6(b), 91 Stat. 1507; July 16, 1979, Pub. L. 96–33, 93 Stat. 86; Oct. 4, 1979, Pub.L. 96–79, Title I, § 123(a), (b)(1)(A), (2), (d), (f), (g)(2), 93 Stat. 624–627; Oct. 17, 1979, Pub.L. 96–88, Title V, § 509(b), 93 Stat. 695; Dec. 17, 1980, Pub.L. 96–538, Title III, § 303(b), 94 Stat. 3190; Aug. 13, 1981, Pub.L. 97–35, Title IX, §§ 902(g)(5), 936(b), 95 Stat. 561, 572.)

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

POUCH H 01
JUNEAU, ALASKA 99811
PHONE: 465-3030

May 10, 1982

The Honorable Mike Beirne
Chairman
House HESS Committee
Alaska State House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Rep..sentative Beirne:

I am enclosing a Program Policy Notice we recently received from the Bureau of Health Planning in the U. S. Department of Health and Human Services. This Notice emphasizes that states which do not have State Health Planning and Development Agencies which fully comply with federal requirements will lose federal support for health planning efforts and will also lose most federal Public Health Service dollars. Alaska currently receives some $5 million annually in such federal funds. Our lack of compliance would result in one quarter of these funds being withheld for four years until certain federal public health service funds are no longer available to Alaska.

We appreciate the hearing you conducted on House Bill 195. We believe this bill, with the amendments we offered, would bring our State Health Planning and Development Agency into full compliance with federal requirements. Your assistance in helping to move this legislation would be very much appreciated.

We appreciate your assistance and support in this matter.

Sincerely,

Helen D. Beirne

Helen D. Beirne
Commissioner

Enclosure

cc: Phoebe A. Lindsey

F38LH

ALASKA STATE MEDICAL ASSOCIATION
4107 Laurel Street • Suite 1 • Anchorage, Alaska 99504 • (907) 277-6891

ADOPTED BY THE ALASKA STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES AT ITS ANNUAL MEETING IN FAIRBANKS, ALASKA JUNE 3, 1982

RESOLUTION NO. 82-23

SUBJECT: Certificate of Need

WHEREAS, the certificate of need process has increased the cost of health care rather than reduced it; and

WHEREAS, the certificate of need process has wreaked havoc upon the orderly development of hospitals in Alaska, therefore

BE IT RESOLVED, the Alaska State Medical Association urges and encourages the Legislature to repeal the certificate of need law.

DISTRIBUTION: Legislature
Alaska State Hospital Association
Press

alaska
state
hospital
association

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

November 4, 1982

The Honorable Ted Stevens
United States Senate
Washington, D.C. 20510

Similar letter sent to:
Senator Murkowski and
Congressman Young

Dear Senator Stevens:

As you are well aware the State of Alaska is not in conformity with the National Health Planning and Development Act and without federal action in 1982 faces penalties in grant monies under the Public Health Service Act and the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970. To avoid this penalty it is imperative that Congress repeal 42 U.S.C. 300m-(d) (copy attached).

This Association as well as the Alaska State Medical Association (resolutions attached) are opposed to the continuation of the state Certificate of Need law. Both are committed to its repeal in 1983. Repeal of 42 U.S.C. 300m-(d) will greatly assist our efforts.

We have communicated our support for various measures considered by this Congress to restructure the federal law. It appears however, that a full reform may be a consideration which must be left to the next Congress. If that is so, it is imperative that you secure repeal of 42 U.S.C. 300m-(d) before the current Congress adjourns in December.

All of those concerned with this issue including Congressman Waxman, the National Governors Conference, the American Hospital Association, etc., agree on removing sanctions against states which do not conform to the federal program. The notion of further delay of the sanctions does not assist anyone, it simply prevents states such as Alaska from dealing with its own law on anything beyond a temporary basis.

For these reasons we urge you to secure the repeal of 42 U.S.C. 300m-(d). This will permit the legislature of the State of Alaska to deal with its law in whatever manner it deems appropriate. Further, we urge that this repeal be secured prior to the adjournment of the 97th Congress.

Sincerely,

Dennis L. DeWitt
President

DLD:lf
cc: Friday Mailing
Alaska State Medical Society
Governer Jay Hammond
Governer Elect Sheffield
Lt. Governer Terry Miller
Lt. Governer Elect McAlpine
American Hospital Association - Lynn Hart
Federation of American Hospitals

BILL SHEFFIELD, GOVERNOR

STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

December 22, 1982

Mr. Dennis L. DeWitt
President
Alaska State Hospital Association
319 Seward Street
Juneau, Alaska 99801

Dear Mr. DeWitt:

Thank you for sending me a copy of your letter to Senator Stevens regarding the state Certificate of Need law.

As you know, I am in agreement with you in your opposition to this law. Please keep me posted as to what I can do to change the law in Alaska.

Best regards.

Sincerely,

Bill Sheffield
Governor

Blue Cross
of Washington and Alaska

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

FEB 18 1983

February 14, 1983

Representative Mae Tischer
Alaska State Legislature
Pouch V (MS 3100)
Juneau, Alaska 99811

Dear Representative Tischer:

I appreciated having the opportunity to discuss with you the legislative proposals which you are addressing in this session and which are of concern to Blue Cross of Washington and Alaska. Martin Tirador will be keeping in close contact with you on these and other issues.

We are continuing to develop information which supports our position for the modification of the certificate of need law. Other organizations such as the Health I[redacted] Much of this information will be presented to the Health Education and Social Services Committee in the hearing on HB 19.

I particularly appreciated the chance to visit with you. I would hope that you will call on either Martin Tirador or me if you feel we can provide you with information on any issue you are considering in the legislative process.

Sincerely,

Joan Gaumer

Joan Gaumer, Director
Government Relations

JHG:pf

Blue Cross
of Washington and Alaska

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

northern alaska health resources association, inc.

FEB 9 1983

February 03, 1983

The Honorable Mae Tischer
Alaska State Legislature
Pouch V (MS 3100)
Juneau, Alaska 99811

Dear Representative Tischer:

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

529 5th avenue, suite 8 fairbanks, alaska 99701 telephone (907) 456-2553

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

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

1. Increase the threshold level which triggers a CON review from $150,000 to at least:
   a. $600,000 for capital expenditures
   b. $400,000 for major medical equipment
   c. $250,000 for operating expenses associated with new services.

2. Exempt all non-clinical capital expenditures. The bill should indicate that non-clinical services which are not subject to review include, but are not limited to: parking, telephone systems, day care, mailrooms, heating and air conditioning, blood bank, dietary/cafeteria, laundry and linen, medical records, business office, housekeeping, central supply, library, reception, and data processing. This exemption would apply only if one of these non-clinical projects was the main purpose of the application. For example, a project proposing a new facility could still include review and consideration of the non-clinical activity if it were part of a larger project.

3. Expedite review of capital equipment replacement.

4. Specify a time limit for a decision by the Commissioner subsequent to a recommendation by the regional health planning agency.

5. Provide that each legislator be informed of all projects in his/her district, especially regarding the outcome of the review.

6. Consider a sunset provision of four or more years to review effectiveness of the CON process.

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

Sincerely,

J. B. Carnahan
President

JBC:flr

cc: William Sheffield
Governor

Robert London Smith, Ph.D.
Commissioner, DHSS

Alaska Health Coalition

Southeast Alaska HSA

South Central Health Planning
and Development, Inc.

FEB 18 1983

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

David, all these type comments need to be made part of the testimony. Please put with our file

February 15, 1983

Dear Alaska Legislator:

The Executive Committee of South Central Health Planning and Development, Inc., yesterday met to discuss the proposed Certificate of Need repeal bill. The Committee asked me to convey to you our support for the attached position paper developed by the Alaska Health Coalition.

The [redacted]

If you have questions on this issue, you might contact Executive Director, Peggy Wilson.

Sincerely,

Margaret McClure Wilson

Margaret M. Wilson
Executive Director

MMW/ab

Alaska Health Coalition

529 5th Avenue, Suite 8
Fairbanks, Alaska 99701
(907) 456-2553

February 11, 1983

TO: Members of the Alaska Legislature

Proposed legislation (HB 19 and SB 85) would repeal Alaska Statute 18.07.031-18.07.111, better known as the Alaska Certificate of Need (CON) law. These bills reflect the position of the Alaska Hospital Association, whose member institutions are subject to the provisions of the CON process. The attached paper, developed by the Alaska Health Coalition, was written to provide legislators and the public with a series of alternatives to consider during discussion of these important bills. The paper summarizes the provisions of the CON law, discusses several of the problems which have been identified with the current process, and reviews the effectiveness of the CON program, both nationally and within Alaska. In addition, a list of recommendations is provided for consideration in revising the current CON law.

The Alaska Health Coalition is a group of interested citizens with memberships from the three Alaska Health Systems Agencies and the Statewide Health Coordinating Council. The primary purposes of the Coalition are to review the need for health planning, development, and promotion activities and to develop goals, describe functions, and recommend structures to achieve optimal health for the citizens of the state. Therefore, we believe that the subject of public review of capital expenditures as currently provided for in the Certificate of Need law is an important issue which deserves a reasonable, objective discussion. We present this paper for the purpose of initiating this discussion.

For additional information, please contact any of the following organizations: Northern Alaska Health Resources Association, Fairbanks (456-2553); South Central Health Planning and Development, Anchorage (278-3631); or, Southeast Alaska Health Systems Agency, Ketchikan (225-9681).

Best regards,

Charles M. Kaltenbach

Charles M. Kaltenbach, Dr. P.H.
Chairman

CMK:sem

Enclosure

CERTIFICATE OF NEED:

REVISION OR REPEAL

Prepared in
the
Public Interest
by
the

ALASKA HEALTH COALITION
February, 1983

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Alaska's Certificate of Need (CON) Law was enacted by the State Legislature in 1976, following passage of Public Law 93-641, the National Health Planning and Resource Development Act of 1974. Provisions in the CON law require that non-federal health care institutions apply for and receive a Certificate of Need from the State of Alaska before proceeding with major capital investments which will result in new construction, alterations or renovations, and/or new services. The Thirteenth Alaska Legislature currently has before it companion bills, HB 19 and SB 85, which provide for repeal of the CON law. The purpose of this paper is to review the data available on the effectiveness of the CON process, both nationally and within the State of Alaska, and to present alternatives for consideration by the Legislature regarding public review of capital expenditures for health care facilities.

Evidence is presented that the CON program has had an effect on limiting the amount of capital expenditures. Furthermore, current economic research has demonstrated that, for every dollar of capital investment made in a health care facility, an accompanying increase in operating costs can be expected amounting to 184% of the original investment in ten years.

Evidence gathered on Alaska's experience with the Certificate of Need program indicated that it has been effective in deterring and/or guiding capital investment within the health care industry and has stimulated improved planning within the health-care institutions themselves. Examples are presented which illustrate how the process created this impact.

Several issues are discussed relating to recognized concerns within the current CON process. These issues include: 1) costs attendant to developing a CON application; 2) delays in the review process; 3) loss of community control; 4) marketplace economics; and, 5) the dollar-threshold limits which require a CON.

The conclusion drawn from this review was that, although there are problems with the current CON process, revision of the law is preferable to outright repeal. Recommendations for revision of the law are provided and include:

1. Raising threshold levels.
2. Exempting non-clinical capital expenditures.
3. Expediting reviews of equipment replacement.
4. Specifying time limits on reviews.
5. Providing legislators with information on the outcome of reviews in their districts.
6. Providing for a sunset review of the process.

CERTIFICATE OF NEED PROGRAM

PURPOSE

The most controversial aspect of the health planning effort, in Alaska and nationwide, has been the Certificate of Need (CON) program. Borrowed from public utility regulations, the earliest CON program was enacted by New York in 1964. Twenty-six other states instituted CON programs in the next ten years, and, with the passage of Public Law 93-641, CON was mandated for all states. Alaska's Certificate of Need statute (18.07.031-.111) was enacted by the State Legislature in 1976 and amended in 1981.

As originally designed, the CON program was implemented to curb rapidly escalating costs of health care by stemming uncontrolled capital investments in new health-care facilities, services, and high-technology equipment. To accomplish this goal, the CON program had several primary objectives: 1) to prevent unnecessary duplication of services and facilities; 2) to reduce the number of available hospital beds or at least not allow the growth of hospital beds to exceed guidelines established in the State Health Plan; 3) to promote an equitable and efficient allocation of resources; and 4) to determine if less costly alternatives to expensive capital expenditures were available to accomplish the same purpose.

WHO MUST APPLY

The State of Alaska requires approval of capital expenditures for projects which meet or exceed certain thresholds:

1. Capital expenditures in excess of $150,000 toward building, improving, or purchasing a health care facility, including lease or purchase of equipment, costs of any study surveys, designs, and site acquisitions and preparations.

2. Any change within a two-year period in the licensed bed capacity of a health care facility amounting to 10 beds or 10 percent, whichever is the lesser, which increases or decreases the number of beds or redistributes beds among different categories of service.

3. Any addition or elimination of a major type of service offered in or through the health care facility.

A project meeting or exceeding these thresholds is required to obtain a Certificate of Need from the State of Alaska prior to implementation.

THE PROCESS

An applicant enters the CON review process by submitting a "Letter of Intent" to the Department of Health and Social Services (DHSS) and to the appropriate health systems agency describing briefly the scope of the proposed activity. If the DHSS determines that the project is subject to CON review, the applicant develops a formal application and submits it to the State agency and the regional health systems agency. In most cases, a pre-application conference is scheduled with the applicant to minimize any potential misunderstandings and to achieve an agreement on what would represent a successful application. Once the State agency certifies that the application is "complete" -- that it contains sufficient information necessary to conduct an objective review -- the agency has 90 days to review the application and to submit an analysis to the Commissioner of DHSS for final action. Within the 90-day review period, the regional health planning agency has 60 days to review and seek public comments on the appropriateness of the proposed application. The HSA submits its findings and recommendations to the Commissioner. Once the Commissioner has considered the information that has been submitted, he decides whether or not to issue a Certificate of Need to the applicant. The Commissioner notifies the applicant in writing of the decision. Copies of the decision are sent to the Health Systems Agency and are published in regional newspapers.

EFFECTIVENESS

Nationwide

Nationally, credible information is just beginning to emerge regarding the effect of capital expenditures review. Although this topic has been of interest for many years, much of the early literature is of little value because of a basic lack of understanding about the process and outcome of capital expenditure review programs.[1] Two recently completed studies in the State of Massachusetts have reported CON impacts.[2,3] The first analyzed hospital capital investment among short-term general voluntary hospitals between 1967-1976. The results were that, by 1976 and beyond, CON review reduced all dimensions of project scale and cost by as much as two-thirds of that originally proposed. The second study found that the formal and informal actions of the CON agency from 1972-1976 resulted in small, but statistically significant, reductions in the rate of hospital investment.

Two studies conducted in 1982 by Arthur D. Little, Inc., shed additional light on the potential impact of capital expenditures review.[4,5] The first study analyzed the effect of capital expenditures review decisions in five states: Colorado, Florida, Maryland, Massachusetts, and Oregon (chosen for their geographical and regulatory differences). Based on their analysis, CON programs appeared to be effective in limiting the amount of capital expenditures undertaken. Furthermore, they discovered that, for every dollar of capital investment, there was a definite increase in operating costs. They projected that, over a ten-year period, a dollar of capital investment generates additional operating costs with a present value of $1.84 (exclusive of

depreciation and debt service). They concluded from these results that CON programs have the potential to play an important role in curbing hospital cost inflation.[4]

A second report by Arthur D. Little, Inc., involved an analysis of information from a six-state study.[5] For the states of Virginia, South Carolina, Washington, New Jersey, Iowa and Colorado, Arthur D. Little undertook a review of Certificate of Need programs for the twelve-month period beginning July 1, 1979 to June 30, 1980. Three significant findings were reported: 1) certain capital costs were not incurred as a result of the CON review program; 2) the objectives contained in individual state plans and health systems plans tended to deter capital expenditure projects; and, 3) pre-application conferences -- health planners and providers working together to avoid project denial -- were effective means of reducing the "administrative costs" of the review process as well as excessive capital expenditures.[6]

Alaska

Currently (February 1983) there are five projects under review by the Department of Health and Social Services that total $106,000,000. Two additional applications are anticipated, totalling $20,820,000. These seven applications ($126.8 million) provide an interesting contrast with the more than 30 projects which were approved for $149,000,000 in the previous five years (1977-1982).

Two projects with a combined total of $12,400,000 have been denied during the past five years. In addition, several other Letters of Intent have been received by the Department for which applications were never received. It is impossible to estimate how many applications or letters of intent were never submitted because of the presence of the CON law.

The Alaska CON Program has been effective in accomplishing three things. First, it seems reasonable to expect that CON has deterred misdirected projects that could not withstand the test of public scrutiny. It has, therefore, acted to uphold existing plan standards. Secondly, it has guided institutional actions into areas which are compatible with the goals and objectives of the State as reflected in State and regional health plans. Thirdly, the presence of the CON program has promoted better planning on the part of the health care institutions throughout the State.

Deterrent Effects

Although the deterrent effect of Certificate of Need is admittedly difficult to demonstrate, there is evidence from the number of "Letters of Intent" which never resulted in an application that CON is a deterrent. A specific example of this phenomenon was observed during a recent effort by four different applicants to provide inpatient alcoholism treatment services in and around Anchorage. The Department of

Health and Social Services and the local health systems agency identified a need for 40-80 alcohol-treatment beds in the area. Due to pre-application planning, only two of the four applications were completed for final consideration. Both were subsequently approved.

Improved Institutional Planning

Situations in which the CON process provides expert guidance and stimulates better institutional planning do not always result in smaller, less-expensive projects. For example, Valley Hospital in Palmer submitted an application to complete a minimal and temporary renovation of their 30-year old facility at a cost of $2,000,000. Part of the renovation included additional insulation to prevent heat loss through the roof. At the suggestion of the Department, a structural engineer was asked to study the ability of the roof to withstand the increased load of snow which would not be melted because of the insulation. The Department also requested a life-cycle cost analysis which would determine the cost of a temporary renovation as opposed to costs of major renovation. The results of these inquiries demonstrated that the roof was not designed to withstand the extra load of snow and that, when total operating expenses and capital costs were considered for a 25-year period, it would be less expensive to forgo the minimal renovation and proceed with a major renovation. The result of this review was an approval for a major renovation project -- at a long-term cost savings.

Petersburg General Hospital filed a letter of intent for $3,400,000 to renovate an existing acute care facility. Following an architectural assessment of the facility and a life-cycle cost analysis requested by the State, it was determined that the cost of new construction would be preferable to renovation. Subsequently, a CON was approved for $7,150,000. Obviously, the CON process is not punitive, but rather seeks to use health care resources to gain the maximum benefit for the community.

Hospitals in Homer and Fairbanks submitted proposals for review which contained "shelled-in" space for which no use was intended for the immediate future. In Homer, the Department requested further assessment of the situation to identify a solution to future use of the shelled-in space. As a result the plans were redrawn for the renovation and expansion and included the proposed use of the shelled-in space.

Better Conformance with Identified Community Needs

In Fairbanks, the CON process stimulated a community discussion of the need for inpatient psychiatric services and a concern for approving the construction of two shelled-in floors that did not have an identified use. Because of discussions at the local level during the review by the health systems agency, the hospital agreed to specify the intended use of the shelled-in space and, furthermore, to enter into a planning process with the community during the following year to determine the most appropriate configuration for the proposed services.

Summary

Although it is difficult to place a dollar figure on the impact of the Certificate of Need program over the past six years, it appears that Alaska's program has effectively deterred and guided capital investment within the health care industry and has stimulated improved planning within the institutions themselves. Because of the CON program, Alaskans have saved millions of dollars in operating costs which would have resulted from unneeded expansion of facilities and services. Moreover, the State Legislature and the Administration should feel some measure of assurance that, because of the CON process, the millions of dollars in public funds that have flowed from the State to health care facilities for construction and operation are being used for projects which meet an identified need, do not duplicate existing services, and are financially feasible.

PROBLEMS WITH THE CON PROCESS AND RECOMMENDATIONS FOR IMPROVEMENT

INTRODUCTION

Proponents and opponents of the Certificate of Need program agree that the current CON process requires substantial changes. Opponents cite several reasons for their decision to push for repeal of the current law. Among the reasons are: 1) significant costs are involved in developing a CON application and proceeding through the review; 2) delays in implementation are caused by an extended review period; 3) the CON process removes community control; 4) market-place economics should control capital investment; and 5) threshold limits which trigger a CON review are too low.

COSTS

No one denies that there are costs attendant to developing a CON application. The majority of those costs, which have been estimated to run as high as $40,000 for the more complex projects, can be attributed to personnel costs. Most of these costs would continue in the absence of CON if a facility did a credible job of planning for future services. In order to gain public support, justify the financial feasibility of a construction project, and obtain adequate architectural designs, planning still must occur. The costs of institutional planning will not disappear in the absence of CON.

DELAYS

Extended review schedules have in some cases resulted in delays in construction start-up time which have been not only frustrating but also costly. It seems reasonable that the cause for these delays can be identified and corrected by revising the regulations regarding CON review. For example, provisions could be made to expedite review of capital equipment replacement and to set a time limit for a decision by the Commissioner subsequent to a recommendation by a regional health planning agency. Also, by raising the threshold limits which require a CON, there will be approximately 25% fewer reviews to do. This should improve the efficiency of the review process.

COMMUNITY CONTROL

Concern has been expressed that the CON process removes community control from local jurisdictions in the case of municipally-owned facilities and local advisory boards with respect to corporately-owned facilities. However, local governments and advisory boards do not necessarily maintain a regional or statewide perspective when it comes to considering new services and facilities. In other words, persons who

serve on local hospital advisory boards are chosen for their expertise and dedication in local issues; often, however, a project will have regional or statewide implications that cannot be properly addressed at the local level. The CON process, at the very least, offers local, regional and statewide perspectives on the need and appropriateness of a proposed project. Instead of removing community control, the CON process bestows some control on the community at large.

In addition, a trend is evident that an increasing amount of public funds are being appropriated by the legislature for construction and renovation. It seems reasonable that in a time of decreasing state revenues, citizens should have an opportunity to influence the distribution of these funds so that they meet state and regional needs instead of local demand. The CON process ensures public participation in these decisions.

MARKETPLACE ECONOMICS: COMPETITION vs. "REGULATION"

In recent years, there has been a popular theory that the problems in U.S. health services can be blamed on excessive government intervention and regulations. It has been argued that high costs and related problems could be solved by a "return to the free market and competition."[6] Two recent articles argue to the contrary.[7,8]

Roemer and Roemer, well-known health-economics experts, examined the past and present operations of free trade and competition in the health care system and found that not one of at least five conditions necessary for competition existed.[7] In addition, they found that the free market created a geographic maldistribution of health manpower, causing serious problems for rural populations. Furthermore, they discussed the paradoxical problem which has been demonstrated for every component of the health care industry of "supply creating demand" rather than the reverse, which is true in an effectively operating market. Supply creates demand in the health care industry fundamentally because the seller (doctor) rather than the buyer (patient) makes most of the decisions on what health services are to be obtained.[7]

Needlemen, another health economist, expressed a similar opinion.[8]

> An effective market is one in which there is competition on the basis of both price and quality, and in which those who sell services are limited in their ability to influence the volume of services they sell and are constrained in the prices they set by competitive pressures. By this definition, an effective market for health care services does not exist in most communities. Competition exists but it is rarely price competition; indeed the nature of current competition based on scope of services, amenities, and convenience is to encourage price increasing behavior. (Emphasis added).[8]

Arthur D. Little, Inc., summarized the policy implication of the debate surrounding competition and regulation. They reported that, in the absence of Certificate of Need regulations, hospitals will compete more vigorously by offering improved facilities to recruit physicians and patients. The resulting "building boom" will drive up operating expenditures over the next ten years by $1.84 for every dollar invested, exclusive of depreciation and debt service.

THRESHOLD LIMITS

Alaska regulations specify that a CON is required for any capital expenditure in excess of $150,000. There is general agreement that this threshold is far too low. Federal regulations have already changed to accomodate a significant increase in CON thresholds. The threshold levels which trigger a CON review should be increased from $150,000 to at least $600,000 for capital expenditures; $400,000 for major medical equipment; and $250,000 for operating expenses associated with new services.

CONCLUSIONS

Recent evidence nationally and available information from the Certificate of Need Program in Alaska indicate that the program has been effective in deterring unjustified projects, guiding capital investment projects, and stimulating improved institutional planning. Together these effects have served to meet the health care needs of the public, prevent duplication of costly services, and restrain the increasing costs of health care. Acute problems with the CON process are correctable by amending the law.

Options available to the Legislature can be placed into three categories: 1) keep the law as it is and maintain the status quo; 2) repeal the law in its entirety; or, 3) revise the law to correct recognized problems.

MAINTAIN CURRENT CON PROCESS

The State would continue to operate the program in its current form. This option assumes the CON process is working efficiently and requires only minor changes.

Because of recognized problems, this option appears to have little merit. Threshold levels are too low, most non-clinical expenditure reviews are a nuisance for applicants and reviewers, and delays in the review process are unacceptable.

REPEAL THE CON LAW

This option assumes that the Certificate of Need process has been entirely ineffective and that marketplace incentives will arise to control capital investments and health care costs.

It also assumes that public review of health care capital expenditures are unimportant and that health care consumers should not have a voice in determining the appropriateness of services in their community.

A competitive pricing market does not exist within the health care services industry of any community in Alaska. In addition, the State of Alaska did not renew its Section 1122 agreement with the federal government in 1981 because the Certificate of Need law was in place. (Section 1122 of PL 92-603 required that health care facilities, which received federal monies under Titles XVIII and XIX, be subject to review to ensure consistency with state health plans.) Repeal of the CON law would leave the State entirely without a capital expenditure review process for health care facilities; therefore, the State would have to rely principally on either the competitive market or incentives established under some kind of a prospective reimbursement system to control costs and allocate resources. (Hospitals are currently reimbursed by the federal government under Medicare and Medicaid on a retrospective basis; that is, after the costs have already occurred. Under this