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reimbursement mechanism, there is no real incentive for containing costs. Prospective reimbursement, on the other hand, would require that hospitals negotiate the rate or cost of a service a year in advance. The government and other third-party insurers would reimburse the hospital only at the negotiated rate; therefore, costs exceeding the rate would be borne by the hospital, and, conversely, the hospital would make money if costs were kept below the negotiated rate.)

Because a competitive pricing market does not exist anywhere in Alaska, eliminating the CON program will likely lead to new, unneeded services and facilities which will result in increased operating costs. These costs are passed directly on to the buyers (patients and taxpayers).

Prospective reimbursement, on the other hand, comes in various forms and generally has been found to be more difficult to enact and implement than Certificate of Need. Generally speaking, prospective reimbursement is likely to be successful only where there has been political support for Certificate of Need.[3]

Finally, repeal of CON serves the interests of the health services establishment only. Those who control health-care costs would also be controlling capital investments. Consumers could not have a voice in determining the most appropriate and affordable level of service for their community or region.

MODIFY THE CON PROCESS

This option assumes that the CON program has been effective and can be modified to make it more efficient. The scope of the CON program could be scaled back by raising threshold levels and exempting certain non-clinical capital expenditures. Under this option, the CON program could be reduced further if a market capable of insuring an appropriate allocation of services emerged or to complement a prospective reimbursement system.

RECOMMENDATIONS

The Alaska Health Coalition recommends that negotiations take place among members of the Alaska State Hospital Association, the Legislature, and the Administration to work out revised CON regulations.

[redacted]

1. [redacted] to at least:

[redacted]

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. [redacted]

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

6. [redacted] the CON process.

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APPENDIX

NATIONAL HEALTH PLANNING AND DEVELOPMENT ACT OF 1974

INTRODUCTION

Public Law 93-641, (National Health Planning and Resource Development Act), passed by the U.S. Congress in 1974, established a national health planning program which was implemented in each state and several American territories. The intent of Congress was to integrate previously sponsored programs (Hill-Burton, Regional Medical Program, Comprehensive Health Planning), retain the best features of each, and address major national, state, and local concerns about the current planning, development, and operation of the nation's health care system. To address these concerns, the Act authorized the designation and funding of state and regional health planning agencies and set forth several functions these agencies had to perform in order to further the "achievement of equal access to quality health care at a reasonable cost."

HEALTH SYSTEMS AGENCIES

Health Systems Agencies (HSAs) were designated as local or regional bodies with the responsibility for preparing and implementing plans designed to improve the health of the residents of its health service area; to increase the acceptability, accessibility, continuity and quality of health services of the area; to restrain increases in the cost of providing health services; and, to prevent unnecessary duplication of health resources. These functions were carried out by interested consumers and providers working together to identify community and regional problems and to develop strategies and recommendations to help alleviate those problems.

HSAs were established as either private, non-profit corporations or public entities governed by boards that had to have a consumer majorities. Operational funds have been awarded through both Federal (PHS) and State (DHSS) sources. In Alaska, the Governor designated three health service areas which were each to be served by an HSA. Alaska's three HSAs are: Northern Alaska Health Resources Association, Inc. (Fairbanks), serving northern Alaska; South Central Health Planning and Development, Inc. (Anchorage), serving south central Alaska, including the Aleutian chain; and Southeast Alaska Health Systems Agency (Ketchikan), serving Alaska's panhandle.

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

The Governor designated a State Health Planning and Development Agency (SHPDA) as a unit of State government. The SHPDA has the responsibility to conduct the health planning activities of the State, including preparation and implementation of the State Health Plan, and to provide coordination of the HSAs. The SHPDA also supports the function of the Statewide Health Coordinating Council and is responsible for administration of the Certificate of Need program. In Alaska, the SHPDA resides within the Department of Health and Social Services. It currently occupies division-level status.

STATEWIDE HEALTH COORDINATING COUNCIL

The Alaska Statewide Health Coordinating Council (SHCC) is the third entity involved in the State health planning network. The SHCC is a group of citizens appointed by the Governor who oversee the health planning activities within the State. Specifically, they have responsibility for preparation of the State Health Plan. The State Health Plan forms the basis upon which Certificate of Need applications are reviewed. Both the SHPDA and SHCC are supported with a mix of Federal and State funds.

STATEMENT OF

ÆTNA LIFE INSURANCE COMPANY

IN OPPOSITION TO

H.B. 19

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 H.B. 19, An Act Repealing the Certificate of Need Program. We believe that enactment of this legislation would represent a large step backward in Alaska's effort to realize an efficient and effective health care delivery system.

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

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

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

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

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

CERTIFICATE OF NEED:

REVISION OR REPEAL

Prepared in
the
Public Interest
by
the

ALASKA HEALTH COALITION
February, 1983

Alaska Health Coalition

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

February 11, 1983

FEB 15 [illegible]

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,

Chas M. Kaltenbach

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

CMK:sem

Enclosure

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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.[5]

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.[9] (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

reimbursement mechanism, there is no real incentive for containing costs. Prospective reimbursement, on the other hand, would require that hospitals negotiate the rate or cost of a service a year in advance. The government and other third-party insurers would reimburse the hospital only at the negotiated rate; therefore, costs exceeding the rate would be borne by the hospital, and, conversely, the hospital would make money if costs were kept below the negotiated rate.)

Because a competitive pricing market does not exist anywhere in Alaska, eliminating the CON program will likely lead to new, unneeded services and facilities which will result in increased operating costs. These costs are passed directly on to the buyers (patients and taxpayers).

Prospective reimbursement, on the other hand, comes in various forms and generally has been found to be more difficult to enact and implement than Certificate of Need. Generally speaking, prospective reimbursement is likely to be successful only where there has been political support for Certificate of Need.[8]

Finally, repeal of CON serves the interests of the health services establishment only. Those who control health-care costs would also be controlling capital investments. Consumers could not have a voice in determining the most appropriate and affordable level of service for their community or region.

MODIFY THE CON PROCESS

This option assumes that the CON program has been effective and can be modified to make it more efficient. The scope of the CON program could be scaled back by raising threshold levels and exempting certain non-clinical capital expenditures. Under this option, the CON program could be reduced further if a market capable of insuring an appropriate allocation of services emerged or to complement a prospective reimbursement system.

RECOMMENDATIONS

The Alaska Health Coalition recommends that negotiations take place among members of the Alaska State Hospital Association, the Legislature, and the Administration to work out revised CON regulations.

The Coalition further recommends that the following revisions be considered as a starting point for the negotiations.

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.

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APPENDIX

NATIONAL HEALTH PLANNING AND DEVELOPMENT ACT OF 1974

INTRODUCTION

Public Law 93-641, (National Health Planning and Resource Development Act), passed by the U.S. Congress in 1974, established a national health planning program which was implemented in each state and several American territories. The intent of Congress was to integrate previously sponsored programs (Hill-Burton, Regional Medical Program, Comprehensive Health Planning), retain the best features of each, and address major national, state, and local concerns about the current planning, development, and operation of the nation's health care system. To address these concerns, the Act authorized the designation and funding of state and regional health planning agencies and set forth several functions these agencies had to perform in order to further the "achievement of equal access to quality health care at a reasonable cost."

HEALTH SYSTEMS AGENCIES

Health Systems Agencies (HSAs) were designated as local or regional bodies with the responsibility for preparing and implementing plans designed to improve the health of the residents of its health service area; to increase the acceptability, accessibility, continuity and quality of health services of the area; to restrain increases in the cost of providing health services; and, to prevent unnecessary duplication of health resources. These functions were carried out by interested consumers and providers working together to identify community and regional problems and to develop strategies and recommendations to help alleviate those problems.

HSAs were established as either private, non-profit corporations or public entities governed by boards that had to have a consumer majorities. Operational funds have been awarded through both Federal (PHS) and State (DHSS) sources. In Alaska, the Governor designated three health service areas which were each to be served by an HSA. Alaska's three HSAs are: Northern Alaska Health Resources Association, Inc. (Fairbanks), serving northern Alaska; South Central Health Planning and Development, Inc. (Anchorage), serving south central Alaska, including the Aleutian chain; and Southeast Alaska Health Systems Agency (Ketchikan), serving Alaska's panhandle.

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

The Governor designated a State Health Planning and Development Agency (SHPDA) as a unit of State government. The SHPDA has the responsibility to conduct the health planning activities of the State, including preparation and implementation of the State Health Plan, and to provide coordination of the HSAs. The SHPDA also supports the function of the Statewide Health Coordinating Council and is responsible for administration of the Certificate of Need program. In Alaska, the SHPDA resides within the Department of Health and Social Services. It currently occupies division-level status.

STATEWIDE HEALTH COORDINATING COUNCIL

The Alaska Statewide Health Coordinating Council (SHCC) is the third entity involved in the State health planning network. The SHCC is a group of citizens appointed by the Governor who oversee the health planning activities within the State. Specifically, they have responsibility for preparation of the State Health Plan. The State Health Plan forms the basis upon which Certificate of Need applications are reviewed. Both the SHPDA and SHCC are supported with a mix of Federal and State funds.

Phoebe Lindsey

1122 PROGRAM

CERTIF ON NEED 18.07.111 (7)

hospitals, licensed, care facilities

PROCESS:

60 days from letter of intent to Application date

0-60 DAYS Application

15 DAYS - Dept Determines APP is OK

90 DAYS - TO MAKE RECOMMENDATION to COMMISSIONER

APPEAL

REQUEST for HEARING

PL 97-377 CONTINUING RESOLUTION through Sept 83

- 93-641 HEALTH PLANNING ENABLING LAW

If current 97-377 is REPLACED then FED MAY REQUIRE inspections, etc

1) Medicaid FED & STATE SUPPORT- 60 million

REPEAL OPENS option

PER DAY RATE to different facilities based on operating EXPENSES

PROSPECTIVE not Retrospective Reimbursement system

2) Revenue Sharing 25% cost of non profit capital construction

HOSPITALS —

Operating expenses - $250,000 to each non prof. Hospital

Nursing homes get $2000 per bed

TRACK RECORD

Dave Williams 305 Assembly Bldg.

└ heads staff

INSURANCE companies support CERT. of NEED

HEALTH INSURANCE CORP of America favors cert of need

HB 19

1/21

BLUE CROSS COBBLEST —

QUESTIONS
- tie to STATE AID
- COST of SERVICE if EXTRA BEDS
- Why ~~RE~~ SET PRIORITY for HEALTH CARE FACILITIES if REGIONAL CERT. of NEED. Bette Cato may into 6.11 setting up PRIORITY

SEARCH
ALL

SELECT
ALL CHAPTER EQ 18.07

Summary:

PL 93-641 is FED. ENABLING ~~STEP~~ Authority RE: HEALTH PLANNING

PL 97-377 is A CONTINUING RESOLUTION effective through Sept 83. The "1122" PROGRAM 1122 SEC of Soc. Sec. Act REQUIRES SOME SORT of CERT. of NEED ANALYSIS - that is not REQUIRED under current temporary law.

Until Sept 83, REPEAL of CERT of NEED would have NO other Federally mandated counterpart. ~~IF~~ FEDERAL action could supercede the REPEAL. All 50 STATES have "CON" PROCESS.

1) Reimbursements for Medicaid ± 60 million

All CERTIFIED FACILITIES ARE ELIGIBLE for REIMBURSEMENT REPEAL could MEAN MORE OPTIONS. PER DAY REIMBURSEMENT VARIES with individual facility

Change to PROSPECTIVE, NOT REIMBURSEMENT method might help

2) State Rev. Sharing funds available for 25% cost of CAPITAL CONSTRUCTION - more facilities built, greater demand

- Why Hospital Assn support for this bill? Acts as controlling factor to competition.

THE CERTIFICATE of NEED

1. OUTLINE BASIC PROCESS - FED MANDATE, STATE LAW
   STATE AGENCY. ATTACH CON ACTIVITY REPORT
   CURRENT THRESHOLD LIMITS 7AAC 07.010 - $150,000 CAP 600,000 EQUIP. 400,000
2. SUMMARIZE VIEWPOINTS
   A. REPEAL - UNNECESSARY CONTROL ~~FOR~~ ON AN ENTERPRISE. MOST FACILITIES COVERED BY CON
      REQUIRE PUBLIC FUNDS - ALLOCATION & BUDGET REVIEW
   B. A FREE ENTERPRISE
      B. B ESPECIALLY NOT SUITED FOR RURAL AK
      C. C SANCTIONS NOT IN EFFECT. TIME TO ACT IF SANCTIONS ARE IMPOSED
      D. D CHANGE IN RETROSPECTIVE TO PROSPECTIVE FEE
      E. E SCHEDULE FOR MEDICAID WOULD ~~BE~~ PROVIDE RATE REVIEW
   C. RECURRENT THRESHOLD LIMITS UNREALISTICALLY LOW.
2. B. MAINTAIN OR AMEND
   1. REQ'D BY FED LAW
   2. MANDATES COULD MEAN LOSS OF $
   3. PROVIDES PLANNING ON STATEWIDE BASIS
   4. RESTRICTS FRIVOLOUS EXPENDITURES
   5. FREE ENTERPRISE DOESN'T EXIST IN HEALTH CARE

Repeal will have effects on 4 major four topics:

4 issues appear prominently when considering Repeal of Certificate of Need:

1. ~~Effect~~ Demand on State Revenue Sharing funds
2. Effect on State Medicaid payments
3. Free Enterprise vs. Regulation
4. Federal mandates and potential loss of funds.

Tierney, et al

The Certificate of Need Program was established in 1974 by federal law (PL 93-641). It is intended to serve as a cost control aid and planning review process. It acts as a check to frivolous or misdirected projects. It directs capital (construction) investment to be compatible with the goals and policies of the reviewing agency. The certificate of need was designed to avoid unnecessary duplication which results in underutilization and inflated costs in a cost based reimbursement system.

- Sanctions "Any allotment, grant, loan and loan guarantee made to and each contract entered into with an individual or entity in such State ... under this Act (Public Health Service Act), the Community Mental Health centers Act, the Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment and Rehabilitation Act of 1970 and the Drug Abuse Office and Treatment Act of 1972."

  Sanctions begin at 25% and continue annually in 25% increments.

1979 Amendments to Health Planning 96-79

7 AAC 07.010 PL - 93-641

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AMER HOSP ASSN
APPROPRIATENESS REVIEW of Health Care Services

7 AAC 07.010 - SETS level of construction amount REQ CON at $150,000.

FED LAW allows CAP imp $600,000
EQUIP 400,000

Federal Mandates

The 1974 law, 93-641 established the requirement for states to develop the certificate of need review. The law was amended by 96-79 in 1979. The sanctions imposed against states for non compliance with the CON (certificate of need) process have been temporarily lifted by P.L. 97-377, which expires September 30, 1983. So, until Sept 30, 1983, a repeal of CON would impose no threat of loss of federal funds. Federal funds that are subject to sanction action IF the sanctions are allowed total just over 5 million dollars. See letter of Rebecca Dyer attached.

Attach $ letter

The most recent word from the Legislative information office in Wash D.C. is that the continuing resolution (that suspends sanctions) will stand unless congress takes action before the end of the fiscal year. If congress does not act before June 30th, the Dept. will have to fund at least the first quarter of FY84. The Dept of H.H.S. is waiting for congressional direction. Repeal of CON would probably result in loss of some planning review regardless of sanctions.

Attach 1 & 2 from Omnicom

Alaska, and several other states are out of compliance now and have been placed on "conditional" status by D.H.H.S. Should sanctions be imposed, the state is given notice that funds may be withheld.

STATE REVENUE SHARING to MUNICIPALITIES

Don't GRIFFIN

STATE AID through Title 29 REVENUE SHARING ~~GRANTS~~ FUNDS ~~ARE~~ FOR HOSPITAL ENTITLEMENT GRANTS, & HOSPITAL CAPITAL CONSTRUCTION, PUBLIC ROADS, AND VOLUNTEER FIRE DEPTS IN THE UNORGANIZED BOROUGH ARE ISSUED by PRORATING THE TOTAL REQUESTS ~~by the amounts~~ within the ALLOCATIONS.

ASK GINNY

If REPEAL on CERTIFICATE of NEED MEANS AN INCREASE in CAPITAL CONSTRUCTION, AND, therefore, AN INCREASE in demand for STATE AID, THERE will be A REDUCED AMOUNT of funds AVAILABLE to individual RECIPIENTS for those CATEGORIES listed — ~~hospital~~ GRANTS, PUBLIC ROADS, VOLUNTEER FIRE DEPARTMENT.

ATTACH FY81,82 ENTITLEMENTS C&RA

5437

Public Health Service in Seattle for his AGENCY's Retention to a Repeal of the certificate of NEED. IN PRACTICE, it APPEARS that the Federal government has not instituted SANCTIONS - EVEN though STATES (like CALIFORNIA) have been out of compliance for YEARS. IN FACT, SANCTIONS WERE SUSPENDED by PL 97-377. A continuing RESOLUTION suspends SANCTIONS through September 1983.

My QUESTIONS for you - GENERAL ONES which you MAY not be able to address EASILY and then SPECIFIC ONES:

1) What ARE the CHANCES that the SANCTIONS MAY AGAIN BE SUSPENDED AS in 97-377? - MOOD of CONGRESS?

2) CAN you find out what ~~the~~ response the Health and Human Services Dept would have to a Repeal of certificate of need process here?

3) Would AN EXEMPTION (§1536 of PL 93-641) for ALASKA to the ~~the~~ HEALTH SYSTEMS ~~AGENCY~~ AGENCY REQUIREMENT do the SAME thing AS Repeal of C/N PROCESS? (FOUND IN AN AMENDMENT to the Omnibus Budget RECONCILIATION Act of 1981).

4) If C/N were REPEALED and SANCTIONS WERE INVOKED, how much Federal money would ALASKA loose.

FY 1981 MUNICIPAL REVENUE SHARING ENTITLEMENTS (#2) april 27, 1981

TOTAL ENTITLEMENT = $51,900,000 14,6200,000 6 million

KEY	COMMUNITY	PUBLIC ROAD MILES	ICE ROAD MILES	HOSPITAL ENTITLEMENT	HEALTH FACILITIES ENTITLEMENT	HOSPIT CONST. A
BOROUGHS AND SERVICE AREAS						4,885,65
0010	ANCHORAGE A.W.	0.00	0.00	$423,674	$355,886	$4,885,6
0020	CITY S.A.	0.00	0.00	$0	$0	
0030	EAGLE RIVER	0.00	0.00	$0	$0	
0040	CHUGIAK	0.00	0.00	$0	$0	
0060	GIRDWOOD	0.00	0.00	$0	$0	
0070	GLEN ALPS	0.00	0.00	$0	$0	
0080	FIRE S.A.	0.00	0.00	$0	$0	
0090	ROADS & DRAINAGE	402.95	0.00	$0	$0	
0100	POLICE S.A.	0.00	0.00	$0	$0	
0110	PARKS & REC	0.00	0.00	$0	$0	
0120	P & R/CHUGIAK	0.00	0.00	$0	$0	
0130	SOLID WASTE S.A.	0.00	0.00	$0	$0	
0140	CHUGIAK/SOLID WASTE	0.00	0.00	$0	$0	
0150	BUILDING SAFETY	0.00	0.00	$0	$0	
0160	SPECIAL ASSESSMENT	0.00	0.00	$0	$0	
0170	SERVICE AREA 35	63.37	0.00	$0	$0	
0180	PORT OF ANCH.	0.00	0.00	$0	$0	
0190	AIRPORT S.A.	0.00	0.00	$0	$0	
0200	PARKING S.A.	0.00	0.00	$0	$0	
0210	BRISTOL BAY BOROUGH	0.00	0.00	$0	$0	
0220	SOUTH NAKNEK S.A.	4.42	0.00	$0	$0	
0230	FAIRBANKS BOROUGH	74.31	0.00	$0	$0	
0240	ESTER F.P.	0.00	0.00	$0	$0	
0250	NORTH STAR F.P.	0.00	0.00	$0	$0	
0260	UNIVERSITY F.P.	0.00	0.00	$0	$0	
0270	HAINES BOROUGH	0.00	0.00	$0	$0	
0280	FIRE DISTRICT	0.00	0.00	$0	$0	

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0290	JUNEAU BOROUGH A.W.	0.00	0.00	$74,766	$89,719	
0300	S.A. 1	14.23	0.00	$0	$0	
0310	S.A. 2	4.84	0.00	$0	$0	
0320	S.A. 3	38.17	0.00	$0	$0	
0330	S.A. 4	0.00	0.00	$0	$0	
0340	S.A. 5	0.00	0.00	$0	$0	
0350	S.A. 6	0.00	0.00	$0	$0	
0360	S.A. 7	0.00	0.00	$0	$0	
0370	S.A. 8	0.00	0.00	$0	$0	
0380	KENAI PENINSULA BOROUGH	2.79	0.00	$160,956	$0	
0390	NIKISKI F.P.	0.00	0.00	$0	$0	
0400	NORTH KENAI REC.	0.00	0.00	$0	$0	
0410	BEAR CREEK F.P.	0.00	0.00	$0	$0	
0420	KETCHIKAN BOROUGH	0.00	0.00	$0	$0	
0430	SHOREL INE S.A.	0.00	0.00	$0	$0	
0440	KODIAK ISLAND BOROUGH	0.00	0.00	$80,478	$67,601	
0450	FIRE DISTRICT I	0.00	0.00	$0	$0	
0460	ROAD DISTRICT	15.00	0.00	$0	$0	
0470	MAT-SU BOROUGH	286.12	0.00	$0	$0	
0480	WASILLA F.P.	0.00	0.00	$0	$0	
0490	BUTTE F.P.	0.00	0.00	$0	$0	
0500	GREATER PALMER F.P.	0.00	0.00	$0	$0	
0510	SUTTON F.P.	0.00	0.00	$0	$0	
0520	NON AREA-WIDE	0.00	0.00	$0	$0	
0525	TALKETNA FLOOD S.A.	0.00	0.00	$0	$0	
0530	TALKEETNA F.P.	0.00	0.00	$0	$0	
0540	GARDEN TERRACE	0.00	0.00	$0	$0	

0550 LAKES F.P.	0.00	0.00	$0	$0	

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KEY	COMMUNITY	PUBLIC ROAD MILES	ICE ROAD MILES	HOSPITAL ENTITLEMENT	HEALTH FACILITIES ENTITLEMENT	HOSPI CONST.
0560	NORTH SLOPE BOROUGH	51.94	0.00	$0	$38,876	
0570	SITKA BOROUGH	16.05	0.00	$77,569	$16,548	
	FIRST CLASS CITIES					
1000	BARROW	0.00	0.00	$0	$0	
1010	CORDOVA	8.30	0.00	$86,631	$13,861	
1020	CRAIG	4.50	0.00	$0	$3,987	
1030	DILLINGHAM	6.81	0.00	$0	$0	390,934
1040	FAIRBANKS	87.20	0.00	$179,038	$90,096	$1,380,9
1050	GALENA	5.58	0.00	$0	$5,553	
1060	HAINES	10.44	0.00	$0	$0	
1070	HOMER	10.63	0.00	$0	$8,584	
1080	HOONAH	4.00	0.00	$0	$0	
1090	HYDABURG	3.17	0.00	$0	$3,987	
1100	KAKE	5.17	0.00	$0	$0	
1110	KENAI	45.12	0.00	$0	$8,584	261,2
1120	KETCHIKAN	16.60	0.00	$91,713	$19,937	$261,2
1140	KING COVE	0.00	0.00	$0	$5,159	
1150	KLAWOCK	1.69	0.00	$0	$3,987	
1160	KODIAK	14.68	0.00	$0	$0	
1170	NENANA	11.28	0.00	$0	$0	
1180	NOME	13.45	0.13	$104,134	$11,107	
1190	NORTH POLE	10.72	0.00	$0	$0	
1200	PALMER	19.36	0.00	$77,569	$0	
1210	PELICAN	1.10	0.00	$0	$4,292	
1220	PETERSBURG	9.48	0.00	$77,569	$8,274	
1230	SAND POINT	8.34	0.00	$0	$5,159	
1240	SAINT MARY'S	7.93	10.21	$0	$5,353	
1250	SELDOVIA	6.48	0.00	$0	$4,292	
1260	SEWARD	18.35	0.00	$80,478	$77,259	
1270	SKAGWAY	9.50	0.00	$0	$4,292	
1280	SOLDOTNA	24.78	0.00	$0	$0	
1290	UNALASKA	38.42	0.00	$0	$5,159	

1320 ZONE II	0.00	0.00	$0	$0

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1330	WRANGELL	7.04	0.00	$77,569	$4,137	
1340	ZONE II	0.00	0.00	$0	$0	
1350	ZONE IV	0.00	0.00	$0	$0	
1360	YAKUTAT	3.31	0.00	$0	$4,292	
SECOND CLASS CITIES						
5000	AKHIOK	0.00	0.00	$0	$0	
5010	AKIACHAK	2.00	11.00	$0	$0	
5020	AKIAK	0.00	0.00	$0	$5,353	
5030	AKOLMIUT	0.00	44.75	$0	$10,706	
5040	AKUTAN	0.00	0.00	$0	$0	
5050	ALAKANUK	4.00	4.00	$0	$5,353	
5060	ALEKNAGIK	0.00	1.50	$0	$5,159	
5070	ALLAKAKET	0.00	0.00	$0	$5,553	
5080	AMBLER	5.22	0.00	$0	$5,553	
5090	ANAKTUVUK PASS	0.00	0.00	$0	$0	
5100	ANDERSON	5.00	0.00	$0	$0	
5110	ANGOON	5.18	0.00	$0	$4,137	
5120	ANIAK	8.00	24.00	$0	$11,107	
5130	ANVIK	1.50	0.00	$0	$0	
5140	ATMAUTLUAK	0.00	15.00	$0	$5,353	
5150	BETHEL	10.85	48.00	$0	$66,915	
5160	BREVIG MISSION	0.00	0.00	$0	$5,553	
5170	BUCKLAND	0.00	0.00	$0	$0	
5180	CHEFORNAK	0.00	0.00	$0	$5,353	
5190	CHEVAK	0.50	00	$0	$5,353	
5200	CHUATHBALUK	4.00	00	$0	$5,553	
5210	CLARK'S POINT	0.00	00	$0	$5,159	
5220	DEERING	0.00	0.00	$0	$5,553	
5230	DELTA JUNCTION	10.88	0.00	$0	$4,620	
5240	DIOMEDE	0.00	0.00	$0	$0	

KEY	COMMUNITY	PUBLIC ROAD MILES	ICE ROAD MILES	HOSPITAL ENTITLEMENT	HEALTH FACILITIES ENTITLEMENT	HOSPI CONST.
5300	FORT YUKON	16.48	0.00	$0	$0	
5310	FORTUNA LEDGE	5.00	0.00	$0	$5,353	
5320	GAMBELL	0.00	0.00	$0	$0	
5330	GOLOVIN	0.00	0.00	$0	$5,553	
5340	GOODNEWS BAY	0.00	0.00	$0	$0	
5350	GRAYLING	0.00	0.00	$0	$0	
5360	HOLY CROSS	4.00	0.00	$0	$5,553	
5370	HOOPER BAY	0.00	0.00	$0	$0	
5380	HOUSTON	30.75	0.00	$0	$0	
5390	HUGHES	5.00	0.00	$0	$0	
5400	HUSLIA	17.70	0.00	$0	$5,553	
5410	KACHEMAK	0.00	0.00	$0	$0	
5420	KAKTOVIK	0.00	0.00	$0	$0	
5430	KALTAG	2.00	0.00	$0	$0	
5440	KASAAN	0.00	0.00	$0	$0	
5460	KIANA	0.00	0.00	$0	$0	
5470	KIVALINA	0.00	0.00	$0	$0	
5480	KOBUK	4.00	0.00	$0	$0	
5490	KOTLIK	0.00	0.00	$0	$5,353	
5500	KOTZEBUE	15.52	3.50	$0	$0	
5510	KOYUK	0.00	0.00	$0	$0	
5520	KOYUKUK	1.50	0.00	$0	$5,553	
5530	KUPREANOF	0.00	0.00	$0	$0	
5540	KWETHLUK	0.00	0.00	$0	$5,353	
5550	LARSEN BAY	0.00	0.00	$0	$0	
5555	LOWER KALSKAG	2.60	40.00	$0	$5,553	
5560	MANOKOTAK	0.43	0.00	$0	$5,159	
5570	MCGRATH	10.95	0.00	$0	$5,553	
5580	MEKORYUK	0.00	0.00	$0	$5,353	
5590	MOUNTAIN VILLAGE	0.00	0.00	$0	$0	
5600	NAPAKIAK	2.48	0.00	$0	$5,353	
5610	NAPASKIAK	0.00	0.00	$0	$5,353	
5620	NEWHALEN	0.00	0.00	$0	$5,159	
5630	NEW STUYAHOK	0.00	0.00	$0	$5,159	
5640	NEWTOK	0.00	0.00	$0	$5,353	
5650	NIGHTMUTE	1.00	0.00	$0	$5,353	

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5660	NIKOLAI	0.00	0.00	$0	$0	
5670	NONDALTON	1.80	0.00	$0	$0	
5680	NOORVIK	2.20	0.00	$0	$5,553	
5690	NULATO	4.80	0.00	$0	$5,553	
5700	NUIGSUT	0.00	0.00	$0	$0	
5710	OLD HARBOR	4.45	0.00	$0	$0	
5720	OUZINKIE	0.00	0.00	$0	$0	
5730	PILOT STATION	2.00	0.00	$0	$0	
5740	PLATINUM	0.00	0.00	$0	$0	
5750	POINT HOPE	0.00	0.00	$0	$0	
5760	PORT ALEXANDER	0.00	0.00	$0	$0	
5770	PORT HEIDEN	26.60	0.00	$0	$5,159	
5780	PORT LIONS	2.44	0.00	$0	$0	
5790	QUINHAGAK	1.25	0.00	$0	$5,353	
5800	RUBY	0.00	0.00	$0	$0	
5810	RUSSIAN MISSION	0.00	0.00	$0	$5,353	
5820	SAINT MICHAEL	0.00	0.00	$0	$5,553	
5830	SAINT PAUL	37.50	0.00	$0	$0	
5840	SAVOONGA	0.00	0.00	$0	$0	
5850	SAXMAN	2.90	0.00	$0	$0	
5860	SCAMMON BAY	1.25	0.00	$0	$5,353	
5870	SELAWIK	0.00	0.00	$0	$0	
5880	SHAGELUK	0.00	0.00	$0	$0	
5890	SHAKTOOLIK	3.50	18.00	$0	$5,553	
5900	SHELDON POINT	0.00	0.00	$0	$5,353	
5910	SHISHMAREF	0.00	0.00	$0	$0	
5920	SHUNGNAK	0.00	0.00	$0	$5,553	
5930	STEBBINS	0.00	0.00	$0	$5,553	
5940	TANANA	29.35	0.00	$0	$0	
5950	TELLER	2.69	0.00	$0	$5,553	
5980	TENAKEE SPRINGS	2.00	0.00	$0	$0	
5990	TOGIAK	5.00	0.00	$0	$5,159	
6000	TOKSOOK BAY	0.00	0.00	$0	$5,353	
6010	TULUKSAK	9.50	18.00	$0	$5,353	
6015	TUNUNAK	0.00	0.00	$0	$0	
6020	UNALAKLEET	9.22	0.00	$0	$5,553	

6020 DNALAKLEET 9.22 0.00 $0 $5,553

FY 1981 MUNICIPAL REVENUE SHARING ENTITLEMENTS (#2) april 27, 1981

TOTAL ENTITLEMENT = $51,900,000

KEY	COMMUNITY	PUBLIC ROAD MILES	ICE ROAD MILES	HOSPITAL ENTITLEMENT	HEALTH FACILITIES ENTITLEMENT	HOSPI CONST.
6030	UPPER KALSKAG	1.50	1.50	$0	$0	
6040	WAINWRIGHT	0.00	0.00	$0	$0	
6050	WALES	0.00	0.00	$0	$0	
6060	WASILLA	44.96	0.00	$0	$4,137	
6070	WHITE MOUNTAIN	0.00	0.00	$0	$0	
6080	WHITTIER	10.50	0.00	$0	$4,620	~~74,357~~
6090	EXT FIRE AREAS	0.00	0.00	$0	$0	~~$74,~~
6100	NATIVE VILLAGE GOVT	0.00	0.00	$0	$0	~~$1,~~470,
	TOTAL			$1,682,026	$1,241,800	~~$8,~~072,5

1,470,402

8,072,574

NV6= $24,574 ea.

SUMMARY OF MAJOR CHANGES IN

THE NATIONAL HEALTH PLANNING AND RESOURCES DEVELOPMENT PROGRAM

FROM ENACTMENT OF THE HEALTH PLANNING AND RESOURCES DEVELOPMENT AMENDMENTS

OF 1979 (Public Law 96-79) ON OCTOBER 4, 1979

The Health Planning and Resources Development Amendments of 1979 amend Titles XV and XVI of the Public Health Service Act and extend for 3 years the health planning program begun by P.L. 93-641 enacted on January 4, 1975. The amendments authorize appropriations of $267 million in fiscal 1980, $354 million in 1981 and $416 million in 1982, a total of $1.04 billion.

Title XV (National Health Planning and Development) is administered by the Bureau of Health Planning, Health Resources Administration, and Title XVI (Health Resources Development) by the Bureau of Health Facilities, HRA. The Administration is one of the six agencies of the Public Health Service of the U.S. Department of Health, Education, and Welfare. The two bureaus are located at 3700 East-West Highway, Hyattsville, Maryland 20782.

Contacts:

Title XV, Bureau of Health Planning, Frances Dearman (301) 436-6110
Title XVI, Bureau of Health Facilities, Dorothy Bailey, (301) 436-8988

October 11, 1979

TITLE XV NATIONAL HEALTH PLANNING AND DEVELOPMENT

ADMINISTERED BY BUREAU OF HEALTH PLANNING

National Guidelines for Health Planning (Section 1501)

The Department of Health, Education, and Welfare (HEW) must annually review the goals and standards of the National Guidelines for Health Planning as well as the plans of the Health Systems Agencies (HSA) and State Health Planning and Development Agencies (SHPDA) and on the basis of the findings, revise the National Guidelines. The HSAs, SHPDAs and Statewide Health Coordinating Councils (SHCC) must be consulted at least 45 days prior to their issuance or revision. Relying on data HSAs and SHPDAs must supply, HEW may collect and make public data on whether the health care delivery systems are changing to meet the standards and goals in the Guidelines and the resources required to meet the goals.

The standards promulgated as part of the National Guidelines must reflect the unique circumstances and needs of medically underserved populations including isolated rural communities.

National Health Priorities, National Council (Section 1502)

The list of National Health Priorities is lengthened from 11 to 17, more emphasis is placed on cost containment and a new section is added on the role of competition in the allocation of health services. New priorities concern:

--identification and discontinuance of unneeded or duplicate services and facilities;

--cost containment through technology, more appropriate use of resources and increased efficiency;

--deinstitutionalization of improperly placed mental patients and improved care for the institutionalized;

--emphasis on outpatient mental health care;

--promotion of health prevention and treatment including emotional and psychological components of care; and

--development and use of cost-saving technology.

Also added as a priotity is strengthening of competition where it can appropriately advance quality assurance, cost effectiveness and access to care.

Council: The National Council on Health Planning and Development is expanded from 15 to 20 members. The number of nonprovider members is increased from 5 to 8 and the representation of urban and rural medically underserved populations is required. At least one hospital representative is required. The Assistant Secretary of Agriculture for Rural Development is added as a nonvoting, ex-officio member.

Health Service Areas (Section 1511)

Procedures for review and revision of health service area boundaries are changed. A review can be initiated by HEW, a Governor or HSA. The boundaries may be revised if HEW finds they no longer meet the requirements of the law or that the proposed boundaries meet them more appropriately. Within one year of enactment of the amendments, HEW must publish regulations listing criteria for revisions.

The Commonwealth of Puerto Rico is added to the jurisdictions where the State agency, under Section 1536, may perform the functions of the HSA.

Health Systems Agency Governing Body (Section 1512)

The amendments provide that the governing board of a public HSA must appoint the members of its governing body for health planning. Under the amendments the governing board of a public HSA rather than the separate governing body for health planning is responsible for personnel policies and budget unless it specifically delegates the responsibility.

Consumer members of an HSA governing board no longer are required to have been consumers for 12 months prior to appointment. The language requiring them to be "broadly representative" of the composition of the area's population has been deleted. The new language requires consumers to be "broadly representative of the health service area" and to include representatives of the principal social, economic, linguistic, handicapped and racial populations and of geographic areas of the health service area.

Providers can now serve on HSA governing bodies where they live or where they work. The proportion of direct providers among the provider minority is increased from one-third to one-half and at least one direct provider must be engaged in the administration of a hospital.

Governmental representatives other than elected officials must be appointees of units of general purpose local government.

The proportion of nonmetropolitan representation must be "at least equal to the nonmetropolitan proportion of the population of the area." Persons knowledgeable about mental health must be included on the governing body.

A consumer majority is required for all subcommittees or advisory bodies appointed by an HSA governing board or executive committee.

A new section requires broad participation in governing body selection by residents of the area served. The process developed by each agency must prohibit selection of more than one-half of the members by the governing body itself. The same requirements apply to subarea council selection if the subarea council selects one or more members of the governing body.

If a governing body has more than 30 members, the required size of its executive committee is changed from "not more than 25" to "not less than 10 nor more than 30."

A new section requires each HSA to have a program of technical support of governing body members, executive committee members and members of entities appointed by these groups. At least one staff person is to be responsible for providing information and technical assistance to governing body members particularly consumers. Minimum areas of staff expertise are expanded to include financial and economic analysis, prevention of disease and other health matters, and development and use of health and mental health resources.

A new subsection deals with conflict of interest for members of governing bodies, executive committees or other HSA entities. They are prohibited from voting on matters involving any individual or entity with which a member has had "any substantial ownership, employment, medical staff, fiduciary, contractual, creditor or consultative relationship" currently or in the preceding 12 months. Written disclosure and public announcement of conflicts are required at meetings during which actions are taken.

Revised language absolves an HSA from liability for damage when a governing body member or employee acts within the scope of his duty with reasonable care and without malice.

Provisions are changed to allow closed meetings and records when the board determines that discussions about an employee's performance or salary would constitute an unwarranted invasion of personal privacy. Meetings also may be closed when information relating to a judicial proceeding involving the agency might be disclosed.

HSA governing body membership must now include individuals who are knowledgeable about mental health services (including substance abuse).

Health Systems Plan, Annual Implementation Plan, PUFF, (Section 1513)

Lobbying: New language prohibits an HSA from hiring a lobbyist.

Health Systems Plan and Annual Implementation Plan: The review and revision of the Health Systems Plan are changed from an annual to a triennial process, allowing more time for implementation. An HSA must establish the Health Systems Plan in a format determined by the SHCC in consultation with the State agency and HSAs. The description of a "healthful environment" is to be "primarily with regard to health care equipment and to health services provided by health care institutions, health care facilities and other providers of health care and other health resources."

The Health Systems Plan must include goals for the delivery of mental health services.

The goals of the Health Systems Plan are to be responsive to statewide needs but no longer are required to be consistent with the National Guidelines. The plan must describe the institutional health services needed to provide for the well-being of persons in the area and must also describe the number and type of resources needed to meet the plan goals plus the extent to which new facilities need to be constructed or existing ones need modernization, discontinuance or conversion.

The procedural requirements for the Health Systems Plan also apply to the establishment, review and amendment of the Annual Implementation Plan.

Coordination: Examples of other regional planning bodies with which an HSA must coordinate activities are agencies concerned with aging, alcohol abuse, drug abuse and mental health. Coordination is required with rate review bodies.

New language describes coordination among HSAs within a Standard Metropolitan Statistical Area and requires HEW to issue regulations for sharing of HSA data with Indian Tribes.

Proposed Uses of Federal Funds: A number of changes are made in the review of Proposed Uses of Federal Funds (PUFF). Direct funding of entities other than State government is usually subject to HSA review while direct funding to State government is reviewed only if its impact on health resources occurs solely in the Agency's health service area. Federal funds made available by a State to a third party are now reviewable not only under the allotment programs but also under grants or contracts to State government.

An attempt is made to clarify HSA review of research and training funding. Training funds would be reviewed only if they made a significant change in health services available in the health service area. Research funds would be reviewable only if they would change significantly the delivery of health services or the distribution of available health resources in the area.

In the case of Federal funds made available by a State to a third party, a Governor must allow 60 days for HSA review. If the Governor decides to make funds available despite a negative HSA finding, the HSA and SHPDA must be provided with a detailed statement of the reasons.

Appropriateness: The requirement for review of appropriateness of "all institutional health services" is narrowed to "at least" those institutional and home health services for which goals have been set in the State Health Plan. In an appropriateness review, the minimum considerations are "accessibility and availability, financial viability, cost effectiveness, and quality of service provided."

Hospital Charges: To aid consumers in making informed choices, a new provision requires each HSA to collect annually on forms developed with the State the charges for the State's 25 most frequently used hospital services. The charges must include average rates for private and semiprivate rooms. The information must be made available in easily understandable form for public inspection and copying.

Designation of Health Systems Agencies (Section 1515)

The maximum duration of a full designation agreement is extended from 12 months to 36 months. HEW may terminate the agreement with a nonperforming HSA but must first consult with the Governor and the SHCC; give notice of intent to terminate, listing steps that could be taken to comply; provide an opportunity for a hearing; and consult with the National Council.

HEW may return a nonperforming HSA to conditionally designated status for not more than 12 months if the agency is given notice and an opportunity for a hearing. Before renewing a full designation agreement, HEW must provide the State agency with an opportunity to comment on the HSA's performance and to recommend whether or not the HSA should be renewed as well as stating any conditions the State agency believes should be attached to the renewal.

In terminating an HSA, HEW may choose to continue its operation until a new designation agreement is in effect. It must provide the terminating agency an opportunity to settle its affairs.

HSA Planning Grants (Section 1516)

The amendments provide for carryover of grant funds for one more year beyond that in which they are made available. The funding formula is changed in several respects. The maximum base grant is the lesser of $0.60 per capita or $3,750,000. The minimum base grant is a sliding scale of $225,000 for fiscal 1980; $245,000 for fiscal 1981; and $260,000 for a succeeding year.

HEW is authorized to retain an amount not to exceed 5 percent of the appropriation to supplement grants to meet extraordinary expenses, such as those related to bi-State status, large underserved populations and large geographic areas or to assist an agency in improving its performance as a result of the development and implementation of innovative planning mechanisms. The grant amount may be reduced if not needed by the Agency.

Non-Federal funds may be matched by: (1) an amount equal to the non-Federal funds (2) $200,000 or (3) $0.25 per capita, whichever is less.

State Agency Designation (Section 1521)

The period of conditional designation may be extended beyond 36 months if HEW finds the State agency is making "a good faith effort" to comply with its required functions.

The penalties for a State failing to have its agency qualify for full designation have been extensively revised and the effective dates changed. During the first year of noncompliance, HEW will withhold 25 percent of Federal funds. The percentage rises to 50 percent in the second year, and 75 percent in the third with a complete cutoff in the fourth year.

September 30, 1980, is the earliest date for compliance but the deadline will be later for many States depending on when their legislatures meet.

The period of a full designation agreement is extended from 12 to 36 months. If HEW decides to terminate a State agency agreement, the Department must consult with the SHCC; notify the agency, explaining the decision and listing corrective actions required; provide an opportunity for a hearing; and consult with the National Council.

Before renewing a State agency designation agreement, HEW must provide each HSA and the SHCC with an opportunity to comment and recommend renewal or nonrenewal. If it is not performing satisfactorily, a State agency may be returned to conditionally designated status for up to 12 months.

State Health Planning and Development Functions (Section 1523)

A new function, the determination of statewide health needs, is given to the State agency. In developing these needs, the agency is to consult with the SHCC and to solicit written recommendations from the State health authority, the State mental health authority and other agencies designated by the Governor.

The development of the preliminary State Health Plan and review of the Health Systems Plan is changed from an annual to a triennial process. In reviewing Health Systems Plans, the State agency is required to make them available to

the State health authority, the State mental health authority and other State agencies specified by the Governor. It also is to solicit written recommendations concerning the goals and resource requirements in Health Systems Plans.

As another new function, the State agency must prepare an inventory of health care facilities, evaluate their physical condition and report the results to HSAs for their use. The requirement for a separate State Medical Facilities Plan is deleted.

Statewide Health Coordinating Council (Section 1524)

HSA representation required on the SHCC will vary with the number of HSAs in the State. If there are ten or fewer HSAs, each is entitled to two representatives. If there are more than ten, each is entitled to one representative. Each HSA is to submit to the Governor a list of at least twice as many representatives as it is entitled to. In the case of bi-State HSAs, representation on the SHCC will be based on the proportion that the population of the bi-State area living in the State bears to the population of the largest health service area in the State, with a minimum of one representative assured.

Not less than one-half the providers on the SHCC must be direct providers. If there are rural and urban medically underserved populations in a State, they must be represented on the SHCC. The Governor is given the option of selecting, with legislative advice and consent, the chairman of the SHCC from among its members. If the Governor does not act, the SHCC can select its own chairman.

The SHCC is given responsibility for establishing in consultation with the HSAs and the State agency, a uniform format for the Health Systems Plan. It also reviews and coordinates the Health Systems Plans triennially and the Annual Implementation Plans annually. The State Health Plan also is prepared triennially. It must include a description of the institutional health services needed in the State, describe the number and type of resources available and those in need of modernization, closure and conversion.

New language seeks to integrate mental health, alcohol and drug abuse into the State health planning process and requires the health plans in these areas to be consistent with the State Health Plan.

As approved by the SHCC, the State Health Plan does not become effective until it is approved by the Governor. The Governor can disapprove the plan only if he determines it does not effectively meet the statement of health needs as developed by the State agency.

In a change in the review of uses of Federal funds function, the SHCC is given authority to review and recommend approval or disapproval of applications for certain Federal health funds submitted by the State government which is carried out in more than one health service area. If the SHCC recommends disapproval of a plan or application, HEW, after finding that the proposed use is not in conformity with the State Health Plan, may not make funds available. The Governor must be allowed 30 days to submit a revised plan or application that conforms with the State Health Plan.

The SHCC is extended the same immunity from damages as the HSA board and placed under the same conflict of interest requirements.

Grants for State Health Planning and Development (Section 1525)

Amendments permit one year carryover of grant funds.

Grants for Rate Regulation (Section 1526)

New language removes the limitation on the number of rate regulation demonstration grants to States, allows entities of State government other than the State agency to administer the rate regulation program, and allows rate regulation grant funds to remain available for one fiscal year after that in which they are awarded.

Certificate of Need (Section 1527)

A new section broadens and further defines certificate of need programs. Certificate of need decisions must be consistent with the State Health Plan except for emergency situations. In reviewing applications, a SHPDA must make its determination before major equipment is purchased, institutional health services are offered or capital expenditures obligated.

The amendments limit the type of conditions that can be placed on awarding a certificate of need. States are prohibited from attaching any condition not related to criteria in the law or in State or Federal regulations in force before the amendments took effect.

A State agency is authorized to withdraw a certificate of need if the applicant is not adhering to its timetable or making a good faith effort.

Each certificate must specify the maximum amount of money that can be spent on an approved project.

HMOs: Health maintenance organizations (as defined in this section or as qualified under Section 1310 of the Public Health Service Act) are exempt from certificate of need requirements under specified conditions. The State may not require a certificate of need for the offering of an inpatient health service, the acquisition of major equipment, or obligation of capital expenditures by health maintenance organizations if:

--the HMO meets the definition under this law;

--the HMO (or a combination of HMOs) has an enrollment of at least 50,000 individuals;

--the facility in which the service will be provided is reasonably accessible to members; and

--at least 75 percent of the patients who can be reasonably expected to receive the service will be individuals enrolled with the HMO (or combination of HMOs).

Certificate of need applications from other health maintenance organizations must be approved if the State agency finds that approval is required to meet the needs of enrollees and the health maintenance organization cannot obtain these services or facilities within the area in a manner consistent with the health maintenance organization concept.

The establishment of and the outpatient facilities and services of an health maintenance organization are exempt from certificate of need review in any case.

Safety Hazards, Licensure, Accreditation: Automatic approval is required of any certificate of need application to comply with building and safety codes, State licensure standards or Medicare/Medicaid certification unless the SHPDA finds the facilities or services are unneeded or inconsistent with the State Health Plan.

Simple Acquisitions: Special treatment also is provided for simple acquisitions of health facilities or major medical equipment for noninstitutional uses. In both cases, a notice stating intent to acquire and expected uses must be filed with the SHPDA 30 days before contracts are signed. These acquisitions are exempt from certificate of need coverage unless notice is not given or the State agency finds that the acquisition will provide inappropriate bed capacity or services.

Definitions of "capital expenditure" and "major medical equipment" are added. "Major medical equipment" excludes the equipment of independent clinical labs. Congress wanted to make clear that this provision is a minimum requirement of an acceptable certificate of need program, and that a State is permitted to cover medical equipment acquired for use in other than inpatient settings, which costs less than $150,000, or which is acquired by a clinical laboratory. Although States would be prohibited from changing their law to go beyond the minimum requirements after September 30, 1982, no State which had imposed additional requirements before that date would be required to alter those requirements.

Definitions (Section 1531)

"Indirect provider" is no longer a separate category but included under "direct providers." This term is broadened to include persons who: have a fiduciary interest in health care delivery, research, health manpower instruction and drug production; receive directly or through their spouse more than 20 percent of their gross income from health care; or are members of the immediate families of persons in these categories. An individual will not be considered a provider solely because of membership on the governing board of a health care institution or drug or equipment producer.

The definition of "institutional health services" is altered to include services which are provided through designated facilities and those to be defined in HEW regulations and which entail an annual operating cost of at least $75,000. The $75,000 figure may be adjusted upward after 12 months at the discretion of a State to reflect inflation.

Criteria and Procedures for Reviews (Section 1532)

Extensive statutory requirements relating to review procedures are added. They include requirements for administrative and judicial reviews, timely notification and those related to failure to complete review in a timely manner.

"Batched review" of all similar certificate of need applications is required at both the State agency and HSA level at least twice a year. Batching enables planning agencies to review simultaneously applications proposing similar services and to evaluate them on the basis of relative need.

Factors to be considered in the development of criteria for review are expanded to include: the effects of the service on the needs for clinical training in the area; the access that health profession schools will have to services for teaching; and the accessibility of the services to all residents of the service area. Other factors include the efficiency and appropriateness of the use of existing services and facilities, and quality of care provided by the applicant in the past.

TITLE XVI HEALTH RESOURCES DEVELOPMENT

ADMINISTERED BY THE BUREAU OF HEALTH FACILITIES

State Allotments and State Medical Facilities Plans

In amending Title XVI, Congress targeted resources to meet special needs ranging from excess inpatient hospital capacity to the unmet primary care needs of the urban and rural poor. These needs are defined by conditions, not by State or other geographic boundary lines. Thus, Congress repealed the allotment grants to States which originally existed in Title XVI to aid facilities construction. Congress also repealed the requirement for a separate, HEW-approved State Medical Facilities Plan. Previously, the State Medical Facilities Plan existed as a framework which had to be approved before allotments could be made for facility construction and aid. In the amendments, Congress intends to integrate facilities planning as part of the State Health Plan produced by each State's SHCC.

Loan and Loan Guarantee Program (Sections 1601-2)

Congress centralized the loan and loan guarantee program by requiring that all applications under this program be submitted directly to HEW for approval. Direct loans, previously limited to public facilities, have been expanded to nonprofit private facilities. Loan guarantees, limited before to nonprofit private facilities, may now go to public entities as well.

Authority for loans and loan guarantees had been limited to projects for: (1) modernization; (2) construction of new outpatient medical facilities; (3) construction of new inpatient medical facilities in areas where population growth has been recent and substantial; and (4) conversion projects. Now loan and loan guarantees are also authorized for: (1) projects which will discontinue unneeded hospital services or facilities, and (2) modernization projects which before had been eligible only for special project grant money to correct safety hazards and avoid noncompliance with licensure or accreditation standards.

Interest Subsidy: HEW may now pay up to one-half the net effective interest rate on guaranteed loans for projects located in poverty areas. Formerly this subsidy was limited to three percent and was not targeted to any special need areas.

Default Authority: Under the previous law, HEW did not have authority to act on behalf of loan or loan guarantee projects which were in danger of default. Default funds were limited to actual default procedures. The amended law permits HEW to spend money on technical and consultative assistance to prevent such defaults. In addition to taking title to assets used to secure loans HEW may now take "any other actions needed" to protect the government's interests.

Project Grants For Construction Modernization (Section 1610)

The amended law allows facilities to apply for loan and loan guarantees for construction to correct safety hazards or to avoid licensure or accreditation noncompliance. The law also now allows private nonprofit facilities to apply for grant aid. Formerly only public facilities were eligible. To be eligible, however, the private nonprofits must serve the same patient population as would public facilities (i.e., the same proportion of patients unable to pay for services) and, further, must show that without a grant there would be a disruption of health care services to low income individuals.

New Project Grants: Congress addressed the special needs of medically underserved areas by establishing a new grant program. The grants would be available to public or private nonprofit facilities for construction of outpatient facilities or conversion of inpatient to outpatient or long-term care facilities in underserved areas.

Funds for this program are authorized starting in fiscal 1981.

Discontinuance and Conversion (Sections 1641-2)

A new program of grants for voluntary discontinuance and conversion of unneeded hospital services is authorized effective April 1, 1980. Congress intended it to be a demonstration program to help combat the escalating cost of inpatient hospital care. It also is intended to strengthen health care delivery through conversion of hospital capacity to less expensive and more appropriate services.

Grants may be awarded for liquidation of debt in case of closure; planning, development and delivery of another service in case of conversion; termination pay and retraining and re-employment costs for displaced hospital personnel.

Applications for grants must be reviewed by the local HSA, which recommends approval or disapproval, and forwarded to the State agency which reviews and makes its recommendation to HEW. The HSAs and SHPDAs are to determine the need for discontinuance or conversion of a service or facility and give special attention to needs and access patterns of poverty populations. HEW may not override a State agency recommendation for disapproval but may disapprove a recommendation for discontinuance or conversion if it determines the project would not reduce health care costs.

The Department of Labor must review applications and certify that any proposed project protects the rights and vested interests of affected employees of the hospital.

Grants also are authorized to SHPDAs to assist in the reduction of excess hospital capacity. Funds are authorized to assist State agencies in: identifying excess hospital capacity; developing programs to reduce excess capacity to lower health care costs; developing means to overcome barriers to reduction of excess capacity; and carrying out programs to decertify nonappropriate facilities serving densely populated areas and for poverty area outpatient services.

Enforcement of Assurances: The amendments reinforce the intent of Congress that facilities adhere to the uncompensated care and community service parts of the law. Facilities which received Federal aid under either Title VI (Hill-Burton) or XVI were required to give assurances that they would provide a certain amount of uncompensated care to those unable to pay and to provide care without discrimination to community residents. The obligations apply to more than 5,000 hospitals, nursing homes and other medical facilities.

Periodic reports by facilities of compliance with the law are required under the amendments.

AUTHORIZATIONS FOR APPROPRIATIONS ($ MILLIONS)

HEALTH PLANNING AND RESOURCES DEVELOPMENT AMENDMENTS OF 1979

	FY 1980	FY 1981	FY 1982
HSA Planning Grants (Sec. 1516)	$150	$165	$185
State Agency Grants (Sec. 1525)	35	40	45
Technical Assistance/Health Planning Centers (Sec. 1534)	6	8	10
Rate Reviews (Sec. 1526)	6	6	6
Area Development Funds (Sec. 1640)	-	20	30
Facilities Project Grants (Sec. 1610)	40	50	50
Outpatient Facilities (Sec. 1610)	-	15	15
Closure/Conversion Grants (Sec. 1643-44)	30	50	75
TOTALS	$267	$354	$416

HEALTH PLANNING AND DEVELOPMENT BUDGET HISTORY

FY 1978-80

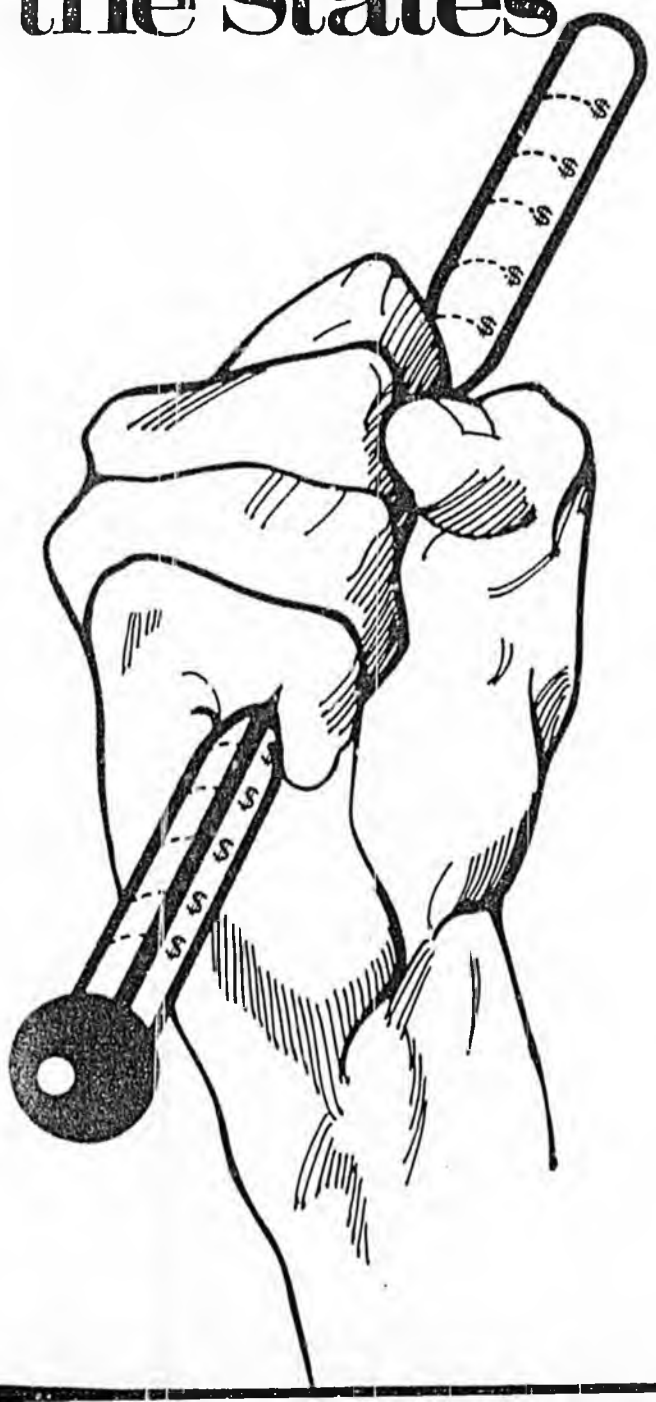
(Millions)

	Appropriations		
	1978	1979	1980
HSA Planning Grants (Sec. 1511)	107.0	107.0	124.7
State Agency Grants (Sec. 1525)	29.5	29.5	32.0
Technical Assistance/Health Planning Centers (Sec. 1534)	6.5	6.5	1.0
Rate Reviews (Sec. 1526)	2.0	2.0	-
Area Development Funds (Sec. 1640)	-	-	-
Facilities Project Grants (Sec. 1625)	-	-	-
Outpatient Facilities (Sec. 1625)	-	-	-
Closure/Conversion Grants (Sec. 1644 & 1643)	-	-	30.0

Russ Hereford

Controlling Health Care Costs: Strategies from the States

With Congress divided over how—and whether—to address the rising cost of health care, states have taken the lead in fashioning solutions.



The defeat of President Carter's hospital cost containment legislation in the House of Representatives underscores the difficult task facing those who seek to curb the high rate of inflation in health care. It also reemphasizes the key role which states must continue to play in the nation's health cost crisis. The role is not a new one for the states; in fact, they have taken the lead in developing solutions to the problem.

Although the health care cost problem has not disappeared (during the 12 months ending last March, the nation's health expenditures rose 13.3 percent to 198.6 billion dollars), actions undertaken in some states appear to have had a major impact on health expenditures. For example, in the eight states that would have been exempted from federal controls under the Administration's bill—because they were already operating mandatory hospital cost containment programs—1978 hospital expenses per admission increased at a rate less than three-fourths that of the other 42 states.

Why States?

States appear to be the most appropriate level at which rising health costs can be controlled. State legislators and state government are affected by rising health costs in a variety of ways. As purchasers of health care for the needy through Medicaid, states (and, in nine states, local government) contributed over $8 billion to this joint federal-state program in 1978. States spent another $1 billion for the poor who are not eligible for Medicaid and for benefits not covered by federal matching funds. In addition, state governments are major employers who contribute to the cost of health insurance premiums for their employees. The growing burden placed on constituents to finance the increased cost of health programs leaves legislators with the unpleasant dilemma of either raising taxes to cover increased costs or reducing services to keep health costs within budget.

Having responsibility for the state's economic environment, legislators face demands from both industry and labor. Businesses express concern over their ability to remain competitive and still generate sufficient profits for future capital investment in the face of the growing costs of health benefits for their workers. At the same time, workers are increasingly frustrated as they forego real increases in their standard of living, or improvements in health benefit coverage, merely to maintain their current level of benefits.

State level control of health care costs should be encouraged for a number of reasons. The protection of

public health has traditionally been within the recognized police powers of the states. (It is interesting to note that the U.S. Department of Health, Education and Welfare was not established until 1953.) As financiers and regulators of health care, and through the delivery of public health services, state government has a long history of involvement in health activities.

"States have responded to the problem with a number of innovative programs. Some particularly interesting ones are in the fields of hospital cost containment, alternatives to institutional care, and health planning."

States are in the best position to view the operation of health programs within the context of statewide priorities and resources. The ability to consider the unique features of a particular state, especially its health care delivery system, when designing a cost containment program best assures that the legitimate concerns of all interested parties will be addressed.

It is at the state level that many health-related programs are regulated. The complementary nature of these activities can give extra clout to cost containment efforts: Certificate of need programs are operated by the states; states administer the Medicaid program; health care providers, such as physicians, nurses, and hospitals, are licensed by state government; the insurance industry is regulated at the state level. Through coordination of these and other regulatory programs, a comprehensive, system-wide cost containment approach can be implemented.

At the same time, states offer the opportunity for experimentation on various approaches to health care cost control. Cost containment is a new art, not an established science. States have the opportunity to develop and implement innovative approaches to health care cost containment which may later be adopted by other states or the federal government.

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Finally, given their major financial stake as a health care financing agency, states have a vested interest in seeing that cost containment programs work.

State Responses

States have responded to the problem of rapidly rising health care costs with a number of innovative programs. Some particularly interesting approaches are in the fields of hospital cost containment, alternatives to institutional care, and health planning.

Hospital Cost Containment Programs: Eighteen states have enacted some type of legislation designed to control hospital costs. These programs vary widely in scope, structure and procedure, from simple disclosure statutes to programs requiring state review and approval of hospital rates and charges.

The programs regulating rates and charges appear to have been quite successful in controlling hospital cost increases. For example, the effectiveness of the mandatory state programs was recognized by the Carter Administration when it chose to exempt them from federal controls under the Administration's proposed cost containment bill.

State rate review programs have one major feature in common. They revise one of the inflationary incentives built into the hospital payment system: retrospective reimbursement. Under the Medicare and Medicaid programs in most states, and under many Blue Cross plans, hospitals are paid after the fact on the basis of costs incurred in treating a patient. This retrospective, cost-plus system contains no incentives to hospitals for cost control. In reality, the incentive is to increase costs, since higher costs will result in increased hospital revenue. Even unnecessary services will lead to additional income.

To counter this inflationary incentive, state rate-setting programs determine ahead of time the rates which hospitals may charge. Under such a prospective reimbursement system, hospitals know in advance the amount of money they will receive for treating patients. In effect this requires hospitals to hold their costs within a predetermined budget, and instills an element of financial management into hospital operations.

Maryland established one such program in 1971. After an initial developmental period, the Maryland Health Services Cost Review Commission began setting rates in 1974. In 1977, HEW's Health Care Financing Administration, on an experimental basis, agreed to permit the Maryland Commission to set rates for the Medicare program—an agreement that made Maryland the first state agency in the country to set rates for all payers. More recently, Medicare waivers have also been granted for experimental programs in Washington, New Jersey and western Pennsylvania. Senate Majority Leader Rosalie Abrams played a key role in the enactment of the legislation and continues to be pleased with the law. According to Senator Abrams, "The commission has demonstrated its effectiveness in containing the rise in hospital costs in Maryland, where the rate of

increase is certainly more rational than in the rest of the country. It is not state rate review alone, however, that is achieving this effect. One essential ingredient of the legislation was a requirement that a uniform accounting system be adopted. This has forced hospitals to examine their own budgets and has made them more cost conscious."

While a state body sets rates in Maryland, Wisconsin has vested rate review authority in a 20 member committee composed of representatives of the State, the Wisconsin Hospital Association, and Blue Cross of Wisconsin. The

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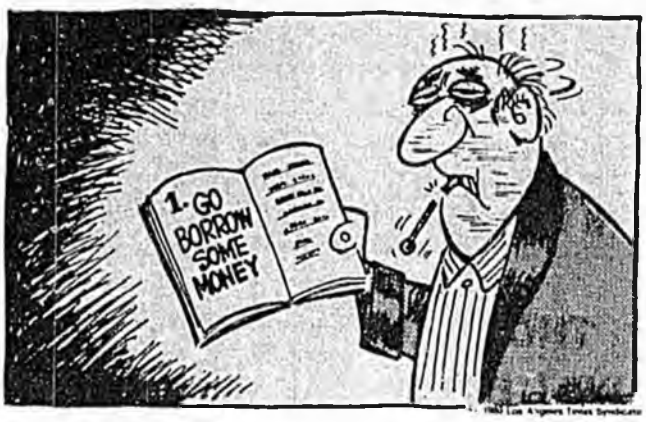
methodology for rate setting was developed by the Department of Health and Social Services, but actual analysis is performed by Blue Cross. Representative Joseph Czerwinski, Chairman of the Assembly Health and Services Committee reports that, "The rate review process appears to be working well, although we are still only in the developmental stage." Representative Czerwinski agrees with Senator Abrams that hospitals have become more cost conscious since the program began. "We do have to be satisfied that any one making a decision on hospital costs —a hospital administrator talking to a dietary expert or to a physician who wants a CAT scanner—is thinking about the fact that he will have to go before a rate review committee, and justify that position in public," Czerwinski says. "That exercise makes hospital administrators much more conscious of the cost implications of their decisions."

Alternatives to Institutional Care: While much attention nationally has been focused on controlling hospital costs, an even more serious problem for the states is long-term care. This segment now takes the largest portion of the average state's Medicaid budget—39 percent, or over $7 billion nationally.

It appears that long-term care will continue to be a major financial burden on state governments. The size of the nation's elderly population will continue to grow. It is estimated that by the year 2015, almost 40 million people will be over 65 versus 24 million in 1978. And it appears that relief will not be forthcoming should a national health insurance plan be enacted: No national health insurance proposal now under consideration in Congress would reduce the states' role in financing long-term care. A number of the proposals would place additional funding responsibilities on state government.

One cannot consider alternatives to institutional care as a purely fiscal issue. Few people disagree that patients are happier when they are able to remain at home with family or friends rather than be placed in a nursing home. Unfortunately, the long-term care funding programs—primarily Medicaid—are heavily biased towards expensive insitutions rather than at-home care. At the same time, community-based delivery systems are lacking or woefully inadequate in many places. Several states, however, have initiated actions to rectify this situation.



One such effort has recently been undertaken in New York through the enactment of the "Nursing Home without Walls" program in 1977. The author of the legislation establishing the program, Senate Health Committee Chairman Tarky Lombardi, Jr., explains, "This program is designed to provide nursing-home level care to persons in their own home. We expect it to have several benefits: We should find happier patients recovering more rapidly under a managed, coordinated program of care provided at home. This program will also obviate the need for construction of more long term care facilities. It should free acute hospital beds for sicker patients, or permit the closing of excess hospital beds that had been filled with patients who need nursing home—not acute hospital—care. We have found that almost 4,000 Medicaid beneficiaries are in our hospitals awaiting long term care placement at an average monthly cost in excess of $6,000. We have been able to serve patients under the Nursing Home without Walls program for an average of $785 per month." Senator Lombardi is also quick to emphasize that the program has an important quality of life aspect. "As just one example, one of the persons served under this program is a 93-year-old woman with a heart condition who is able to stay home and supervise her 72-year-old mentally retarded daughter."

Health Planning: An oversupply of hospital beds and inefficient utilization of available services have also been major contributors to health inflation. The problem is not a small one. The Department of Health, Education and Welfare has estimated that approximately 130,000 hospital beds could be eliminated without affecting quality of care. An analysis of health costs in Michigan determined that over 16 percent of the state's bed supply was surplus.

Excessive supply contributes to high costs in at least two major ways. First, empty beds are expensive to maintain. Although the exact cost has never been determined, estimates place it between 50 and 75 percent of the cost of a full bed. Second, given the expense of maintaining an empty bed, physicians and hospitals are encouraged to fill empty beds in order to generate revenue. This can result in unnecessary admissions and excessive stays in the hospital.

"Obviously, the interest of state legislators in health care issues extends beyond cost containment. Other unmet needs are readily apparent . . . Resolution of these problems, however, is intimately related to cost containment. Few public officials will look favorably at efforts to expand government's financial stake in the health care delivery system until they rest assured that the high rate of inflation in that system is under control."

To deal with the problem of oversupply of beds and services, and to prevent future unnecessary construction, New York enacted legislation in 1964 to establish the nation's first certificate of need program. Certificate of need is a mechanism to require prior state approval of hospital capital expenditures and construction; the primary determining factor in the approval process is the need for a proposed new service or facility. By the early 1970's, more than half of the state legislatures had enacted laws establishing a certificate of need program. Ten years after New York's action, the federal government adopted the concept in the National Health Planning and Resources Development Act, requiring that states must have an approved certificate of need program in order to be eligible for federal funds under such programs as the Public Health Service Act.

Some states, however, have gone beyond a simple certificate of need program. In 1978, Michigan enacted legislation establishing a mechanism for reducing that state's surplus of hospital beds. The legislation, which grew out of a joint public/private cost containment coalition, identifies health service areas with surplus beds. The local Health Systems Agency is responsible for developing a hospital specific plan for closing the excess beds. After the state has approved the HSA's bed reduction plan, the State Department of Public Health is prohibited from issuing a certificate of need inconsistent with the bed reduction plan, or to a facility out of conformity with the plan. Michigan hopes to eliminate 3,800 excess beds during the first five years of the law.

In addition to controlling the supply of hospitals and institutions, certificate of need provides a mechanism for assuring that expensive new technologies, such as kidney dialysis or open heart surgery, are distributed according to need. An example of a high cost technology that has recently been introduuced is computerized axial tomography, or CAT scanning. This process represents a tremendous advance in medical diagnostic capability; it is so significant that its inventors were awarded the 1979 Nobel Prize for Medicine. While virtually every hospital might like its own CAT scanner, and every patient might like to have one in the the local hospital, the machine costs between one-half and three-quarters of a million dollars. In addition a CAT scan is not administered to most hospital patients. The high price of such a technology and its relatively restricted use dictate that if it is to operate in a cost effective manner, the supply should be limited and distributed on the basis of the public need for the service. Accordingly, a certificate of need program might require that the equipment perform at least 2,000 CAT scans annually in order to be approved.

Wisconsin has gone even further. As Representative Czerwinski said, "Certificate of need is reactive only to new development. In Wisconsin, we thought it important to look at existing services and institutions available to our citizens. So along with certificate of need, Wisconsin has the ability to decertify existing services which do not meet minimum usage criteria in such areas as heart catheterization, radiation therapy, chemo-dialysis, renal transplants, high risk maternal and neonatal care, and computer tomography." In order to permit the effective and planned reduction of services without placing an institution in extreme financial hardship, the Wisconsin Rate Review Committee "has the ability to negotiate with the hospital to increase its daily rate to amortize the costs of deleting that service. While this may raise short run costs, in the long run it should prove cost effective."

Obviously, the health interests of state legislators extend beyond cost containment. Even in the relatively narrow field of health financing other unmet needs are readily apparent: expanded access to care for rural residents; protection against the catastrophic costs of a major illness; and funding health services for the poor not covered under existing programs are among the other urgent concerns. Resolution of these problems, however, is intricately related to cost containment. Few public officials will favorably view efforts to further expand government's financial stake in the health care delivery system until they rest assured that the high rate of inflation in that system is under control. Accordingly, it appears that cost containment will retain its place at the top of the nation's health agenda.

Russ Hereford is director of the Health Care Cost Containment project of the National Conference of State Legislators.

Chapter 88. Municipal Tax Resource Equalization.

Effective date of chapter. — Section 17, ch. 155, SLA 1980, provides that §§ 1 — 12 of the act take effect on the first day of the fiscal year for which $33,400,000 or more is appropriated and allowed by the governor for distribution to municipalities and other recipients under the provisions of §§ 1 — 12 of this act or on July 1, 1983, whichever is earlier. A total of $33,500,000 was appropriated for the programs for the fiscal year beginning July 1, 1980. The appropriations were made in §§ 51 and 52, ch. 120, SLA 1980, and § 6, ch. 165, SLA 1980.

Editor's note. — Section 1, ch. 155, SLA 1980, effective on the same day as this chapter, provides: "It is the purpose of sec. 2 of this act [this chapter] to (1) improve the revenue raising and distribution system for the benefit of residents of home rule and general law municipalities by providing for more equitable allocation of financial resources among municipalities to improve their fiscal capacities; and (2) assure that no municipality suffers impoverishment of necessary public services, relative to other municipalities, because of the chance location of taxable wealth in the state."

Section 12, ch. 155, SLA 1980, effective on the same day as this chapter, provides: "(a) Notwithstanding other provisions of secs. 1 — 11 of this act, (1) a municipality may not receive less than $25,000 plus an area cost-of-living differential during the first fiscal year in which this act is effective; and (2) a municipality which would receive under AS 29.88, added by sec. 2 of this act, less than 125 percent of the amount which it received for the last fiscal year under AS 43.18.010 — 43.18.045, repealed by sec. 11 of this act, is, for each of the first five fiscal years during which secs. 1 — 10 of this act are effective, entitled to receive an amount equal to 125 percent of the amount which it received for the last fiscal year under the former provisions of AS 43.18.010 — 43.18.045 in accordance with those provisions. (b) For the first five fiscal years during which secs. 1 — 10 of this act are effective, in order to pay the amounts required by (a) of this section, the allocations made by the Department of Community and Regional Affairs to the accounts established in AS 29.88.035, AS 29.89.080, and AS 29.90.020 shall be prorated by an amount which reduces the allocation to each account in equal proportion, and the prorated amounts shall be allocated to these accounts. (c) For the first five fiscal years during which secs. 1 — 10 of this act are effective, payment of an entitlement to a borough under AS 29.88 may be made to a borough only if the borough assembly agrees to allocate to each borough service area in the borough at least the amount of money that the service area received during the last fiscal year under the former provisions of AS 43.18.010 — 43.18.045, in accordance with those provisions."

Sec. 29.88.010. State equalization of tax resources for local government services. (a) During each fiscal year the department shall compute an equalization entitlement for local government services provided by a taxing unit.

(b) The equalization entitlement computed for a taxing unit is based on the population, relative ability to generate revenue, and local tax burden of the taxing unit and is determined by the application of the

formula

Entitlement = P x R

where P = population, and

R = millage rate equivalent, determined by dividing the sum of the locally generated revenue of the taxing unit by one-tenth of one percent (0.1) of the full and true value of assessed property of the taxing unit determined under AS 29.88.020(d); however, the property value used under this subsection may not be less than 15 percent of the statewide average per capita full and true assessed property value.

(c) For purposes of this section, locally generated revenue

(1) includes

(A) the actual revenue derived from the levy and collection of local taxes in the taxing unit for local government services during the preceding fiscal year of the taxing unit;

(B) motor vehicle payments received by the municipality during the preceding fiscal year under AS 28.10.431;

(C) revenue from fees, rentals, leases, penalties, licenses or permits received during the preceding fiscal year by the municipality for a function or service over which it has control, including revenues derived from parks and recreation services, mass transit, offstreet parking, and garbage and solid waste disposal services;

(D) special assessments received during the preceding fiscal year; and

(E) payments received by a municipality from a utility which are in place of taxes levied and collected by the municipality;

(2) excludes

(A) revenue derived from the levy and collection of municipal taxes and appropriated for the operating expenses and debt service of utilities;

(B) revenue from interest earned on investments and from the sale and lease of land or equipment; and

(C) all other revenue from whatever service derived. (§ 2 ch 155 SLA 1980)

Sec. 29.88.015. Determination of population. (a) For purposes of this chapter, the population of a taxing unit shall be determined annually by the latest figures of the United States Bureau of the Census or other population data which, in the judgment of the department, is reliable.

(b) The population of the taxing unit includes the population of any military reservation which is a part of the taxing unit. (§ 2 ch 155 SLA 1980)

Sec. 29.88.020. Determination of millage rate equivalent. (a) The department may require a municipality to return a certification, signed by the municipal treasurer or manager and the mayor, which provides an estimate of the locally generated revenue received by the municipality during the preceding fiscal year.

(b) By October 15 of each year, the department shall make an initial determination of the millage rate equivalent of each taxing unit to be used for computing and distributing equalization entitlements for the current fiscal year under this chapter. The department shall base the initial determination on the estimates in the certification returned by a municipality under (a) of this section.

(c) As early as possible, but not later than December 15 of each year, the department shall make a final determination of the millage rate equivalent of each taxing unit to use to compute and distribute equalization entitlements under this chapter. The department shall base the determination on audits, financial statements and other financial reports prepared and submitted by a municipality. The department shall adjust the locally generated revenue reported by a municipality to exclude the municipal revenue claimed by the municipality which does not qualify for inclusion in or recognition as locally generated revenue for local government purposes under AS 29.88.010(c)(1). The adjustment shall be made by deducting from total revenue claimed by the municipality the amount of the department's estimate of revenue which is not recognized for local government purposes.

(d) The full and true assessed property value shall be determined by the department in the manner provided for the computation of state aid to education under AS 14.17.140. When the determination of locally generated revenue includes revenue of a utility received under AS 29.88.010(c)(1)(E), the full and true assessed property value shall include the computed assessed value of the utility, determined by dividing the amount of the payment in place of taxes made by the utility by the millage rate which would apply to the utility if the utility were subject to levy and collection of taxes under AS 29.53.

(e) In addition to the computation for municipalities which levy and collect a property tax, the department shall determine an estimated full and true assessed property value under (d) of this section for

(1) each municipality which is a school district and which does not levy and collect a property tax;

(2) each second class city with a population of 750 or more persons; however, a computation is not required under this paragraph more often than once during a period of three successive calendar years; and

(3) all other second class cities, by determining the average per capita full and true assessed property value of all cities having a population of less than 750 persons in which an assessment has been completed by a municipality or for which a determination is not made under (1) or (2) of this subsection.

(f) The department shall annually compute a statewide average per capita full and true assessed property value. (§ 2 ch 155 SLA 1980)

Sec. 29.88.025. Reports. A payment of an equalization entitlement may not be made to a municipality under this chapter until the municipality has submitted its certificate of estimated revenue and its financial report to the department for the fiscal year preceding the year for which the equalization entitlement is sought, together with a budget for the municipality's current fiscal year. The financial report shall include a listing of general revenue collected from taxes levied and assessed by the municipality and any other revenue which, in the opinion of the municipal officials, is eligible for inclusion in computations of the locally generated revenue of the taxing unit. (§ 2 ch 155 SLA 1980)

Sec. 29.88.030. Limitation on computation and use of payments. (a) An equalization entitlement generated by the general tax levy of a taxing unit may be used only for authorized expenditures of that taxing unit, but up to 15 percent of the payment of an equalization entitlement generated by areawide revenue of a municipality may be used by the municipality for areawide or nonareawide purposes at the discretion of its assembly or council.

(b) An equalization entitlement determined with reference to revenue other than revenue obtained from the levy and collection of taxes may be used for areawide or nonareawide purposes, at the discretion of the assembly or council. (§ 2 ch 155 SLA 1980)

Sec. 29.88.035. Tax equalization account. The tax equalization account is established. Money to carry out the provisions of this chapter shall be allocated by the department to the account. The amount allocated to the account shall be fully distributed by the department as payments to municipalities to fulfill each municipality's share authorized under AS 29.88.010. The amount allocated to the account shall be distributed by the department pro rata among eligible municipalities. (§ 2 ch 155 SLA 1980)

Sec. 29.88.040. Administration. (a) The department may adopt regulations necessary to implement this chapter. The regulations shall include, among other provisions,

(1) procedures and filing dates for submitting certification and financial reports;

(2) procedures for obtaining information required to compute and determine the municipality's millage rate equivalent; and

(3) procedures by which the department shall notify a municipality in writing of the reasons for a proposed disallowance or adjustment of any factor bearing upon the determination of the municipality's entitlement and by which the municipality will be provided reasonable time in which to respond or to challenge the department's determination.

(b) The department shall make reasonable efforts to advise and assist municipalities in collecting information and completing reports necessary for the determination of entitlements under this chapter.

(c) The department shall, by regulation, classify for inclusion or exclusion as a component of a municipality's millage rate equivalent under AS 29.88.010 any tax revenue appropriated for a utility not included in the definition set out in AS 29.88.045(4). (§ 2 ch 155 SLA 1980)

Sec. 29.88.045. Definitions. In this chapter

(1) "department" means the Department of Community and Regional Affairs;

(2) "municipality" means a city, borough or unified municipality incorporated under the laws of the state;

(3) "taxing unit" means a municipality and

(A) in a borough or unified municipality, a service area or the entire area outside cities;

(B) in a city, a differential tax zone;

(4) "utilities" means electricity, water, sewer, gas, heat, or telephone services, and refuse and garbage collection services. (§ 2 ch 155 SLA 1980)

Chapter 89. State Aid for Miscellaneous Municipal Purposes.

Effective date of chapter. — Section 17, ch. 155, SLA 1980 provides that §§ 1 — 12 of the act take effect on the first day of the fiscal year for which $33,400,000 or more is appropriated and allowed by the governor for distribution to municipalities and other recipients under the provisions of §§ 1 — 12 of this act or on July 1, 1983, whichever is earlier. A total of $33,500,000 was appropriated for the programs for the fiscal year beginning July 1, 1980. The appropriations were made in §§ 51 and 52, ch. 120, SLA 1980, and § 6, ch. 165, SLA 1980.

Editor's note. — Section 12, ch. 155, SLA 1980, effective on the same day as this chapter, provides: "(a) Notwithstanding other provisions of secs. 1 — 11 of this act, (1) a municipality may not receive less than $25,000 plus an area cost-of-living differential during the first fiscal year in which this act is effective; and (2) a municipality which would receive under AS 29.88, added by sec. 2 of this act, less than 125 percent of the amount which it received for the last fiscal year under AS 43.18.010 — 43.18.045, repealed by sec. 11 of this act, is, for each of the first five fiscal years during which secs. 1 — 10 of this act are effective, entitled to receive an amount equal to 125 percent of the amount which it received for the last fiscal year under the former provisions of AS 43.18.010 — 43.18.045 in accordance with those provisions. (b) For the first five fiscal years during which secs. 1 — 10 of this act are effective, in order to pay the amounts required by (a) of this section, the allocations made by the Department of Community and Regional Affairs to the accounts established in AS 29.88.035, AS 29.89.080, and AS 29.90.020 shall be prorated by an amount which reduces the allocation to each account in equal proportion, and the prorated amounts shall be allocated to these accounts. (c) For the first five fiscal years during which secs. 1 — 10 of this act are effective, payment of an entitlement to a borough under AS 29.88 may be made to a borough only if the borough assembly agrees to allocate to each borough service area in the borough at least the amount of money that the service area received during the last fiscal year under the former provisions of AS 43.18.010 — 43.18.045, in accordance with those provisions."

Sec. 29.89.010. Revenue sharing payable. In addition to the equalization entitlements paid under AS 29.88, during each fiscal year the department shall pay aid

(1) to a municipality or other eligible recipient which has the power to provide the services described in AS 29.89.020 — 29.89.040 and exercises the power in the manner required by this chapter;

(2) to a Native village government under AS 29.89.050. (§ 3 ch 155 SLA 1980)

Sec. 29.89.020. State aid to municipalities for roads. (a) The department shall pay to a municipality which has power to provide for road maintenance and exercises that power, $2,500 a mile for each mile of road, street or highway maintained by the local government, excluding (1) the official state highway system, (2) roads, streets or highways not dedicated to public use, (3) roads, streets or highways maintained under the local service road program (AS 19.30.111 —

19.30.251), and (4) alleyways, in accordance with regulations adopted by the Department of Transportation and Public Facilities. A payment may not be made under this subsection for maintenance of a road which is not used by automotive equipment.

(b) A frozen waterway and a connection from an inhabited area to a waterway which may be safely used for public transportation by automotive equipment and is so used during a portion of a year is eligible for a payment of $1,500 per mile if the waterway and connection are maintained during the period of use by a municipality or combination of municipalities. The department, after consultation with the Department of Transportation and Public Facilities, shall determine which waterways and connections qualify and, where the waterways or connections lie outside the corporate limits of a municipality, which municipalities shall receive the payments under this subsection, unless the municipalities involved have agreed in writing to a particular distribution. (§ 3 ch 155 SLA 1980)

Sec. 29.89.030. State aid to municipalities and other eligible recipients for health facilities and hospitals. (a) The department shall pay

(1) to a municipality which has the power to provide hospital facilities and services and which exercises that power, $1,000 per bed for each bed actually used for patient care, limited to the number of beds provided for in the construction design of the hospital, or $250,000 a hospital for those hospitals with 10 or more beds, or $50,000 a hospital for those hospitals with less than 10 beds, as the municipality may elect; money received under this paragraph may be used only for hospitals and shall be apportioned among qualifying hospitals as the municipality determines;

(2) on the basis set out in (1) of this subsection to a municipality for a nonprofit hospital not operated by a municipality if the municipality first certifies to the department that the nonprofit hospital is in compliance with all standards for hospitals which have been adopted by the municipality; money may not be paid on behalf of a nonprofit hospital without this certification; payments to the municipality shall be transferred to the nonprofit hospital in accordance with the basis by which the payment was generated by the hospital, and shall be applied to the annual cost of operation and maintenance of the hospital or for the provision of health care service at the hospital as the directors of the hospital determine;

(3) to a municipality in which a health facility is operated, $2,000 per bed for each bed actually used for patient care, limited to the number of beds provided for in the construction design of the health facility, or $8,000 per health facility as the municipality determines.

(b) A hospital may not receive payment under both (a)(1) and (a)(2) of this section.

(c) Money received by a municipality under (a)(3) of this section shall be used for expenses of health services or operation and maintenance of health facilities as the municipality determines.

(d) Before money may be distributed under this section, the commissioner of health and social services shall certify to the commissioner of community and regional affairs that any accumulation of assets by nonprofit corporations or other recipients under this section is dedicated irrevocably to a public purpose. (§ 3 ch 155 SLA 1980; am §§ 1, 2 ch 103 SLA 1981)

Cross reference. — As to state aid for hospital construction, see AS 29.90.

Editor's note. — As to reports by Department of Health and Social Services and Department of Community and Regional Affairs and commissioner of health and social services, see § 14, ch. 155, SLA 1980, effective July 1, 1980, in the 1980 Temporary and Special Acts and Resolves.

Sec. 29.89.040. State aid to volunteer fire departments in the unorganized borough. (a) The department shall pay to a volunteer fire department registered with the state fire marshal and serving an area not in an organized borough or city a sum for protection purposes equal to $10 per capita for the population served by the department, as determined by the state fire marshal.

(b) A grant shall be made under (a) of this section to facilitate the organization of a volunteer fire department in an area not in an organized borough or city, upon application of the proposed fire protection group to the state fire marshal and upon approval of applications according to standards of organization and service prescribed by regulations adopted by the state fire marshal. (§ 3 ch 155 SLA 1980)

Sec. 29.89.050. State aid to Native village governments. The state shall pay $25,000 to a Native village government for a village which is not incorporated as a city under this title. In this section, "Native village government" means

(1) a local governing body organized by authority of the Act of Congress of June 18, 1934 (25 U.S.C. § 476); or

(2) a traditional village council or, if there is no traditional village council, the paramount chief or other governing body of a Native village which meets the requirements of the Alaska Native Claims Settlement Act (43 U.S.C. §§ 1601 — 1628). (§ 3 ch 155 SLA 1980)

Sec. 29.89.060. Population determination. For purposes of this chapter, population shall be determined by the latest figures of the United States Bureau of the Census or other reliable population data, including but not limited to public school enrollment figures, public utility connection, registered voters or certified employment payrolls. (§ 3 ch 155 SLA 1980)

Sec. 29.89.070. Area cost-of-living differential. (a) Payments to a municipality or other eligible recipient under AS 29.89.020 — 29.89.030 shall reflect area cost-of-living differentials. Payments shall be based upon the sum of per capita, per mile and per bed or facility grants due each municipality or other recipient multiplied by the appropriate area cost-of-living differential. The area cost-of-living differential for each recipient shall be determined annually by election district under the provisions of AS 39.27.030. Application of the area cost-of-living differential may not result in distribution of an amount less than the amount of the payment determined without application of this section.

(b) The election districts used to establish area cost-of-living differentials under (a) of this section are those designated by the proclamation of reapportionment and redistricting of December 7, 1961, and retained for the house of representatives by proclamation of the governor September 3, 1965. (§ 3 ch 155 SLA 1980)

Sec. 29.89.080. Miscellaneous services account. The miscellaneous services account is established. Money to carry out the provisions of this chapter shall be allocated by the department to the account in accordance with AS 29.95.010. If amounts in the account are insufficient to pay each municipality's or other recipient's share authorized under this chapter, the amounts which are available shall be distributed pro rata among eligible municipalities and other recipients. (§ 3 ch 155 SLA 1980)

Sec. 29.89.090. Regulations. The department shall adopt regulations necessary to carry out the purposes of this chapter. The regulations shall include minimum standards required to qualify a municipality or other recipient for payments for each service. The department may require a municipality or other recipient to submit a performance report adequate to demonstrate to the department that a service for which payment is requested under this chapter was performed by the municipality or other recipient and meets minimum standards of service prescribed by regulation. (§ 3 ch 155 SLA 1980)

Sec. 29.89.100. Definitions. In this chapter

(1) "department" means the Department of Community and Regional Affairs;

(2) "health facility"

(A) means a facility which is licensed, when required, by the state under AS 18.20.010 — 18.20.130 and which is owned or operated or both by a municipality or by a nonprofit corporation or other nonprofit sponsor;

(B) includes a public health center, maternity home, community mental health center, facility for the mentally or physically handicapped, nursing home or convalescent center;

(C) excludes a facility operated or wholly supported by the state or the federal government;

(3) "hospital" means a licensed hospital determined by the Department of Health and Social Services to be a general hospital; the term excludes a facility operated or wholly supported by the state or the federal government. (§ 3 ch 155 SLA 1980)

Chapter 90. State Aid for Hospital Construction.

Section

10. State aid for hospital construction
20. Hospital construction assistance account
30. Definitions

Cross reference. — As to state aid to municipalities and other eligible recipients for health facilities and hospitals, see AS 29.89.030.

Effective date of chapter. — Section 17, ch. 155, SLA 1980, provides that §§ 1 — 12 of the act take effect on the first day of the fiscal year for which $33,400,000 or more is appropriated and allowed by the governor for distribution to municipalities and other recipients under the provisions of §§ 1 — 12 of this act or on July 1, 1983, whichever is earlier. A total of $33,500,000 was appropriated for the programs for the fiscal year beginning July 1, 1980. The appropriations were made in §§ 51 and 52, ch. 120, SLA 1980, and § 6, ch. 165, SLA 1980.

Editor's note. — Section 12, ch. 155, SLA 1980, effective on the same day as this chapter, provides: "(a) Notwithstanding other provisions of secs. 1 — 11 of this act, (1) a municipality may not receive less than $25,000 plus an area cost-of-living differential during the first fiscal year in which this act is effective; and (2) a municipality which would receive under AS 29.88, added by sec. 2 of this act, less than 125 percent of the amount which it received for the last fiscal year under AS 43.18.010 — 43.18.045, repealed by sec. 11 of this act, is, for each of the first five fiscal years during which secs. 1 — 10 of this act are effective, entitled to receive an amount equal to 125 percent of the amount which it received for the last fiscal year under the former provisions of AS 43.18.010 — 43.18.045 in accordance with those provisions. (b) For the first five fiscal years during which secs. 1 — 10 of this act are effective, in order to pay the amounts required by (a) of this section, the allocations made by the Department of Community and Regional Affairs to the accounts established in AS 29.88.035, AS 29.89.080, and AS 29.90.020 shall be prorated by an amount which reduces the allocation to each account in equal proportion, and the prorated amounts shall be allocated to these accounts. (c) For the first five fiscal years during which secs. 1 — 10 of this act are effective, payment of an entitlement to a borough under AS 29.88 may be made to a borough only if the borough assembly agrees to allocate to each borough service area in the borough at least the amount of money that the service area received during the last fiscal year under the former provisions of AS 43.18.010 — 43.18.045, in accordance with those provisions."

As to reports by Department of Health and Social Services and Department of Community and Regional Affairs and commissioner of health and social services, see § 14, ch. 155, SLA 1980, in the 1980 Temporary and Special Acts and Resolves.

Sec. 29.90.010. State aid for hospital and health facility construction. If construction of a hospital began after January 1, 1968, or if construction of a health facility began after January 1, and before July 1, 1980, and state matching aid for construction approved for payment to the municipality or other hospital or health facility sponsor constitutes less than 25 percent of the total project cost, the department shall pay to the municipality or other hospital or health facility sponsor each fiscal year $2,500 a bed for the maximum number of beds provided for in the construction design of the hospital or health facility or five percent of the total project cost, whichever is greater. State aid provided for in this section shall continue until the municipality or other hospital or health facility sponsor has received an amount which, combined with state matching money for construction of the hospital or health facility, equals 25 percent of the total project cost. Money received for construction may not be used for any other purpose. (§ 4 ch 155 SLA 1980; am § 3 ch 103 SLA 1981)

Sec. 29.90.020. Hospital and health facility construction assistance account. The hospital and health facility construction assistance account is established. Money to carry out the provisions of this chapter shall be allocated by the department to the account in accordance with AS 29.95.010. If amounts in the account are insufficient to pay each recipient's share authorized under this chapter, the amounts which are available shall be distributed pro rata among eligible recipients. (§ 4 ch 155 SLA 1980; am § 4 ch 103 SLA 1981)

Sec. 29.90.030. Definitions. In this chapter

(1) "department" means the Department of Community and Regional Affairs;

(2) "hospital" means a licensed hospital determined by the Department of Health and Social Services to be a general hospital; the term excludes a facility operated or wholly supported by the state or the federal government;

(3) "total project cost" means

(A) costs directly related to the project; and

(B) the total of all costs of financing and carrying out the project, including but not limited to,

(i) the costs of all necessary studies, surveys, plans and specifications, architectural, engineering or other special services, acquisition of real property, site preparation and development, purchase, construction, reconstruction and improvement of real property, and the acquisition of machinery and equipment as may be necessary in connection with the project;

(ii) an allocable portion of the administrative and operating expenses of the municipality or other hospital sponsor;

(iii) the cost of financing the project, including interest on bonds issued to finance the project; and

(iv) the cost of other items, including any indemnity and surety bonds and premiums on insurance, legal fees, fees and expenses of trustees, depositaries, financial advisors, and paying agents for the bonds issued as the issuer considers necessary.

(4) "health facility"

(A) means a facility that is licensed, when required, by the state under AS 18.20.010 - 18.20.130 and that is owned or operated or both by a municipality or by a nonprofit corporation or other nonprofit sponsor;

(B) includes a public health center, maternity home, community mental health center, facility for the mentally or physically handicapped, nursing home, or convalescent center;

(C) excludes a facility operated or wholly supported by the state or the federal government.

(§ 4 ch 155 SLA 1980; am § 5 ch 103 SLA 1981)

Chapter 95. Administration of Municipal Financial Assistance Programs.

Section

Effective date of chapter. — Section 17, ch. 155, SLA 1980, provides that §§ 1 — 12 of the act take effect on the first day of the fiscal year for which $33,400,000 or more is appropriated and allowed by the governor for distribution to municipalities and other recipients under the provisions of §§ 1 — 12 of this act or on July 1, 1983, whichever is earlier. A total of $33,500,000 was appropriated for the programs for the fiscal year beginning July 1, 1980. The appropriations were made in §§ 51 and 52, ch. 120, SLA 1980, and § 6, ch. 165, SLA 1980.

Editor's note. — Section 12, ch. 155, SLA 1980, effective on the same day as this chapter, provides: "(a) Notwithstanding other provisions of secs. 1 — 11 of this act, (1) a municipality may not receive less than $25,000 plus an area cost-of-living differential during the first fiscal year in which this act is effective; and (2) a municipality which would receive under AS 29.88, added by sec. 2 of this act, less than 125 percent of the amount which it received for the last fiscal year under AS 43.18.010 — 43.18.045, repealed by sec. 11 of this act, is, for each of the first five fiscal years during which secs. 1 — 10 of this act are effective, entitled to receive an amount equal to 125 percent of the amount which it received for the last fiscal year under the former provisions of AS 43.18.010 — 43.18.045 in accordance with those provisions. (b) For the first five fiscal years during which secs. 1 — 10 of this act are effective, in order to pay the amounts required by (a) of this section, the allocations made by the Department of Community and Regional Affairs to the accounts established in AS 29.88.035, AS 29.89.080, and AS 29.90.020 shall be prorated by an amount which reduces the allocation to each account in equal proportion, and the prorated amounts shall be allocated to these accounts. (c) For the first five fiscal years during which secs. 1 — 10 of this act are effective, payment of an entitlement to a borough under AS 29.88 may be made to a borough only if the borough assembly agrees to allocate to each borough service area in the borough at least the amount of money that the service area received during the last fiscal year under the former provisions of AS 43.18.010 — 43.18.045, in accordance with those provisions."

Sec. 29.95.010. Allocation and distribution. (a) Each year, the Department of Community and Regional Affairs shall allocate money appropriated to the accounts established in AS 29.88, AS 29.89, and AS 29.90 in the amounts determined by the legislature.

(b) Money in the miscellaneous services account established in AS 29.89.080 which exceeds the amount required to fully fund distributions authorized by AS 29.89 shall be reallocated to the tax equalization account established in AS 29.88.035 and distributed according to the provisions of AS 29.88.

(c) Money in the hospital construction assistance account established in AS 29.90.020 which exceeds the amount required to fully

fund distributions authorized by AS 29.90 shall be reallocated to the tax equalization account established in AS 29.88.035 and distributed according to the provisions of AS 29.88. (§ 5 ch 155 SLA 1980)

Sec. 29.95.020. Qualification for minimum payment. (a) A municipality qualifying for an entitlement under AS 29.88 or AS 29.89 shall receive a minimum payment of $25,000 plus an area cost-of-living differential for each fiscal year if:

(1) the municipality has conducted a regular election under AS 29.28.010 — 29.28.050 during the fiscal year preceding the year for which payment of an entitlement is authorized by AS 29.88 or AS 29.89 and has reported the results of the election to the commissioner of the Department of Community and Regional Affairs;

(2) regular council meetings are held in the municipality in accordance with the requirements of AS 29.23.210 during the fiscal year preceding the year for which payment of an entitlement is authorized by AS 29.88 or AS 29.89 and a record of the proceedings is maintained;

(3) a municipal budget has been adopted for the fiscal year during which payment of an entitlement is authorized by AS 29.88 or AS 29.89 and an audit or financial statement for the preceding fiscal year has been prepared and furnished to the Department of Community and Regional Affairs in accordance with AS 29.23.560(a); and

(4) local ordinances adopted by the governing body of the municipality have been codified in accordance with AS 29.48.180.

(b) The area cost-of-living differential payable to each municipality under this section shall be determined annually by election district under the provisions of AS 39.27.030. Except as provided in AS 29.95.030, application of the area cost-of-living differential may not result in a payment which is less than the minimum payment determined under (a) of this section. For purposes of this subsection, the election districts used are those designated by the proclamation of reapportionment and redistricting of December 7, 1961, and retained for the house of representatives by proclamation of the governor September 3, 1965.

(c) The Department of Community and Regional Affairs shall pay to each municipality eligible to receive a minimum payment under this section an amount equal to the difference between the minimum payment determined under (a) and (b) of this section and the sum of the amounts payable for the same fiscal year under AS 29.88 and AS 29.89.

(d) A payment under this section may be prorated and reduced under AS 29.95.030.

(e) Payments under this section shall be made from the money allocated to the tax equalization account established in AS 29.88.035. (§ 5 ch 155 SLA 1980)

Sec. 29.95.030. Proration of payments. (a) Payments under AS 29.95.020 and AS 29.88 shall equal the amount allocated to the tax equalization account (AS 29.88.035), adjusted in accordance with AS 29.95.010.

(b) Adjustments of payments shall be determined by prorating amounts payable under AS 29.95.020 and amounts payable under AS 29.88 by a factor which, when applied, reduces all payments in equal proportion so that payments under AS 29.95.020 and payments under AS 29.88 equal the amount allocated to the tax equalization account established in AS 29.88.035. (§ 5 ch 155 SLA 1980)

LEGISLATIVE CHANGES AFFECTING STATE CERTIFICATE OF NEED PROGRAMS

This list summarizes the changes made by the National Health Planning and Resources Development Amendments of 1979 to the requirements for acceptable State Certificate of Need programs. The amendments are grouped according to changes in procedures, in coverage, in criteria, and in definitions. Following the summary of each change are citations for the conference report, the Health Planning Act, and the page in the conference report on which the complete text of the change may be found.

Prepared by Division of Regulatory Activities
Bureau of Health Planning

October 1979

CHANGE IN PROCEDURES

Applications must be submitted according to a timetable established by the reviewing agency. Reviews must be undertaken in a timely fashion, and similar types of applications must be considered in relation to each other, but no less often than twice a year. (Section 116(e) amends 1532(b)(13)(A), see page 24.)

Written notification of the beginning of a review and notification of review status must be made in a "timely" manner. Agencies are required to maintain a mailing list of persons requesting to be notified of reviews. (Section 116(d)(1)(A)&(B) amends 1532(b)(1)&(7), page 22.)

If an agency requests additional information the applicant must be given 15 days to provide the information. (Section 116(d)(2) amends 1532(b)(2), page 22.)

Agencies must establish procedures to assure that only necessary information is requested in an application, and that all "essential" information is accessible to the general public. (Section 116(i)(1)&(2) amends 1532(b), page 25.)

The State Agency must specify a time period for approving or disapproving an application, and for granting an exemption. If additional information is requested of an applicant, the applicant may request that the review period be extended by 15 days. (Section 116(d)(3) amends 1532(b)(12)(C), page 23.)

The following requirements apply to hearings held before the State Agency and before an HSA to which the State Agency has delegated the authority to hold a hearing: Any person may be represented by counsel and may submit arguments and evidence. Any person directly affected may question persons who make factual allegations. A record of the hearing must be maintained. (Section 116(d)(3) amends 1532(b)(12)(A), page 22.)

A State's decision to approve, disapprove, or withdraw a certificate of need must be based solely on a review by the State conducted in accordance with adopted procedures and criteria, and on the record of administrative proceedings. A State's decision to approve or disapprove an exemption is based solely on the record established in administrative proceedings. (Section 116(d)(3) amends 1532(b)(12)(B), page 23.)

An HSA which includes a portion of a single standard metropolitan statistical area will review criteria used for project reviews and certificate of need decisions which affect the area. (Section 121(b) amends 1513(d), page 35.)

Upon the request of any person directly affected, a decision to approve, disapprove, or withdraw a certificate of need must be <u>administratively</u> reviewed under an appeals mechanism consistent with State law governing the practices and procedures of administrative agencies. (Section 116(d)(3) amends 1532(b)(12)(D), page 23.)

After an administrative review, any person adversely affected by a decision may seek judicial review. The Court must affirm the State's decision unless it is found to be "arbitrary, capricious, or not made in compliance with applicable law." (Section 116(d)(3) amends 1532(b)(12)(E), page 23.)

An HSA must be permitted a "timely" appeal. The decision of the reviewing agency must be considered the decision of the State Agency. (Section 117(b)(4) amends 1522(b)(13), page 31.)

A notice of intent is required before any person arranges to acquire an existing health care facility, or arranges to acquire major medical equipment which will not be owned by or located in a health care facility. (Section 117(a) adds 1527(d)(2) and (e)(2), page 29.)

Once a hearing has commenced, ex parte contacts are prohibited between applicants or opponents and any person in the State Agency who exercises responsibility in granting, denying, or withdrawing certificates of need. (Section 116(d)(3) amends 1532(b)(12)(F), page 24.)

If no decision is made within the required time, the applicant may bring an action in the appropriate State Court to require the State Agency to make a decision. (Section 116(d)(3) amends 1532(b)(12)(C)(ii), page 23.)

A governing body member is prohibited from voting on any application in which the member has a conflict of interests. (Section 113(a) amends 1512(b)(3)(F), page 17.)

The State Agency must consider the recommendation of the HSA to approve, disapprove, or withdraw a certificate of need. (Section 117(a) adds 1527(g), page 30.)

The State Agency must monitor the progress of the holder of a certificate in meeting the timetable specified in the application. The State Agency may withdraw a certificate of need if it determines that the holder is not making a good faith effort to meet the timetable. (Section 117(a) adds 1527(a)(3), page 26.)

A certificate of need may only be issued by the State Agency, and must, except in emergency circumstances which pose a threat to public health, be consistent with the State health plan. (Section 117(a) adds 1527(a)(5), page 26.)

When a State issues a certificate of need it must specify a maximum capital expenditure which may be obligated under the certificate. The State program will prescribe the nature of further review if the capital expenditure maximum is exceeded. (Section 117(a) adds 1527(a)(4), page 26.)

HSAs and State Agencies must coordinate the development of procedures and criteria. (Section 116(c) amends 1532(a), page 22.)

Any criterion used to review an application or any condition attached to a certificate of need must be directly related to criteria at section 1532(c), criteria in Federal regulation prior to the date of enactment, or criteria in State regulation. The Secretary may not require the inclusion of criteria other than those at section 1532(c) or those in regulation prior to the date of enactment. (Section 117(a) adds 1527(a)(2), page 25.)

A certificate of need program must provide procedures and penalties to enforce the requirements of the program. (Section 117(b)(2) amends 1523(a)(4), page 30.)

CHANGES IN COVERAGE

A certificate of need program must provide for the review and determination of need for capital expenditures, major medical equipment, and institutional health services. (Section 117(a) adds 1527(a)(1), page 25.)

A certificate of need may not be required for 1) the offering of an inpatient institutional health service 2) the acquisition of major medical equipment for the provision of an inpatient institutional health service or 3) the obligation of a capital expenditure for the provision of an institutional health service by 1) an HMO, 2) combinations of HMOs, 3) health care facilities controlled directly or indirectly by HMOs, or 4) facilities leased by HMOs, if exemption requirements are met. (Section 117(a) adds 1527(b)(1), page 26.)

An HMO or health care facility which meets the requirements must apply for and receive an exemption from coverage. (Section 117(a) adds 1527(b)(2), page 26.)

A certificate of need is required when any major medical equipment or facilities acquired under an exemption are sold, unless the purchaser is an exempted organization. (Section 117(a) adds 1527(b)(3), page 27.)

HMOs and HMO health care facilities may be subject to certificate of need review only to the extent that they are not exempt under the conditions at section 1527(b)(1), and then only for the offering of inpatient institutional health services, the acquisition of major medical equipment, and the obligation of capital expenditures. (Section 117(a) adds section 1527(b)(4), page 28.)

A State Agency must approve an application from an HMO or HMO facility if the Agency finds that the approval is required to meet the needs of enrolled members and new members reasonably expected to enroll, and is required to offer health services in a reasonable and cost effective manner. (Section 117(a) adds 1527(b)(5), page 28.)

A certificate of need must be approved for capital expenditures required to eliminate safety hazards, to comply with State licensure standards, or to comply with accreditation standards required to receive certain reimbursements or payments, unless the State Agency finds that the facility is not needed or the expenditure is not consistent with the State health plan. (Section 117(a) adds 1527(c), page 28.)

A certificate of need is required for the acquisition of a health care facility by any person if a notice of intent is not submitted or if the State Agency finds within 30 days that the acquisition will result in a change of service or bed capacity. (Section 117(a) adds 1527(d)(1), page 29.)

A certificate of need is required for the acquisition of major medical equipment by any person if a notice of intent is not submitted or if the State Agency finds within 30 days that the equipment will be used to provide service to inpatients. A State may require additional coverage of major medical equipment; however, after September 30, 1982, a State may not change its program to include additional requirements. (Section 117(a) adds 1527(e)(1)(A), page 29.)

CHANGES IN COVERAGE

Donations, leases and transfers for less than fair market value (if the fair market value is greater than the capital expenditure threshold) of major medical equipment are subject to review if the acquisition would be subject to review under 1527(e)(1)(A). (Section 117(a) adds 1527(e)(3), page 30.)

Applications from osteopathic and allopathic facilities must be considered on the basis of the needs of osteopathic and allopathic physicians and patients. (Section 117(a) adds 1527(f), page 30.)

CHANGES IN CRITERIA

The State Health plan is added to those plans which must be considered. (Section 116(b)(3) amends 1532(c)(1), page 22.)

Additional criteria concerning the availability of resources and funds, the effect on health professional training programs, alternative uses of the resources involved, and accessibility of the proposed service. (Section 116(f)(3) amends 1532(c)(6), page 24.)

Additional criteria concerning the effects of construction projects on costs and charges, the efficiency and appropriateness of existing services, and the quality of existing services. (Sections 116(g)(1) & (2) amend 1532(c)(6) and add 1532(c)(13) & (14), page 25.)

Adds a consideration of the factors which affect the effect of competition on the supply of the proposed service, and a consideration of improvements or innovations in the financing and delivery of services which foster competition and promote quality and cost effectiveness. (Section 103(c) adds 1532(c)(11) & (12), page 5.)

The criterion on the special needs and circumstances of HMOs is amended to include all HMOs. (Section 117(b)(5) amends 1532(c)(8), page 32.)

DEFINITIONS

"Capital expenditure" is defined as an expenditure which exceeds the minimum, substantially changes the bed capacity, or substantially changes the services of a health care facility. States may adjust the capital expenditure threshold to reflect changes in an index maintained or developed by the Department of Commerce and designated by the Secretary by regulation for purposes of making such adjustments. (Section 117(b)(3) adds 1531(6), page 30.)

"Major medical equipment" means equipment which provides medical and other health services, and which costs in excess of $150,000. (Section 117(b)(3) adds 1531(7), page 31.)

"HMO" is defined as a qualified HMO under section 1310(d), or an organization which satisfies the requirements in existing regulations. (Section 117(b)(3) adds 1531(8), page 31.)

"Institutional health service" is defined as a health service which is provided through the specified facilities, and which entails an annual operating cost of $75,000 (or a figure adjusted as specified by the Secretary by regulation.) (Section 126(a)(1) adds 1531(5), page 40.)

National Conference of State Legislatures

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MEMORANDUM

TO: Interested Legislators and Staff

FROM: Kay Miller, NCSL Health Planning Project Director

SUBJECT: 1979 Congressional Health Planning Amendments (P.L. 96-79): Implications for State Certificate of Need Programs

DATE: December 27, 1979

NCSL Health Planning Project

The National Conference of State Legislatures, through a contract with HEW's Bureau of Health Planning, has a Health Planning Project designed to collect information on state certificate of need (CON) legislation. As part of the project, NCSL is providing interested legislators and staff with information on federal developments which have ramifications for their state certificate of need programs.

NCSL has completed a series of four regional seminars for legislators and their staff which focused in part on the recent amendments to the Health Planning Act and the impact those amendments have on certificates of need. The materials included in this packet are intended to supplement the information provided at the seminars and to give those who did not attend the basic information necessary to understand the implications of the recent amendments.

Finally, the NCSL project can make available necessary technical assistance to state legislatures attempting to develop certificate of need legislation to reflect new changes. Questions regarding the project or requests for technical assistance should be directed to: Kay Miller, Project Director, Health Planning Project, NCSL, Denver, CO 80202 (303) 623-6600.

1979 Amendments to the Health Planning Law

The National Health Planning and Resources Development Act of 1974, P.L. 93-641, established a new nationwide network of health planning agencies. It also mandated that each state establish and administer a certificate of need (CON) program. Certificate of need is basically a method to prevent the construction and other development of unnecessary and inappropriate health care facilities and services. These programs were regarded by many as the regulatory mechanism necessary to give teeth to the planning process.

The Congressional amendments, signed into law October 4, 1979, to the 1974 Act have certain implications for state certificate of need programs. Depending on the latitude which a state's statute permits the state health planning agency in developing a certificate of need program, a legislature may be required to amend (or enact, in a few cases) its CON statute to reflect the significant changes in the federal legislation.

Several examples of the changes in the recent Congressional amendments which may require changes in the state laws are:

I. Health maintenance organizations (HMOs) meeting certain specified criteria outlined in federal law (Section 117 (a), page 26 of the Conference Report, adds 1527 (6)) may not be required to obtain a certificate of need for: 1) the offering of an in-patient institutional health service 2) the acquisition of major medical equipment for the provision of an inpatient institutional health service or 3) the obligation of a capital expenditure for the provision of an institutional health service.

II. A certificate of need is required for the acquisition of major medical equipment by any person if a notice of intent is not submitted or if the state agency finds within 30 days that the equipment will be used to provide service to inpatients. A state may require additional coverage of major medical equipment; however, after September 30, 1982, a state may not change its program to include additional requirements (Section 117 (a) of the Conference Report adds 1527 (e) (1) (A) on page 29.)

There are numerous other changes which may require state statutory changes if state law does not grant liberal rulemaking authority to the state agency. Each state will need to review its legislation in light of the new amendments to determine what legislative action will be necessary to comply. The NCSL Health Planning Project can assist in making this determination and reviewing proposed amendments for compliance.

Timetable for Compliance

Section 123 of the Conference Report, page 38, amends subsection (d) of section 1521 to establish the dates when a state agency must have a final designation agreement is a satisfactory CON program which may require legislation to implement, the dates are tied to legislative sessions. Basically, the amendments state: 1) if the legislature of the state was in session on the date of enactment of the 1979 health planning amendments (October 4, 1979) and will continue to be in session 12 months, the state agency must be fully designated 12 months from that date; 2) if the legislature of a state was in session on the date of enactment but 12 months do not remain in that session, or if the legislature was not in session on the date of enactment, the state agency of that state must be fully designated 12 months after the beginning of the first regular session of the legislature beginning after that date.

NCSL has provided the HEW's Bureau of Health Planning with 1979 adjournment information and 1980 session information on all 50 states. Legislators and staff with questions regarding when their state must have a fully designated State Health Planning & Development Agency should contact their regional office of HEW. If the Regional Office is unable to give a definite answer, contact NCSL, which will obtain a judgment from the Bureau of Health Planning.

Penalties for Failure to have a Fully Designated State Agency

The 1979 amendments also make changes in the penalties that will be imposed on states which do not have final designation agreements in effect on the dates outlined above. These penalties also appear in Section 123 of the Conference Report, page 38, in the amendments to subsection 1521 (d) (2). Basically, the sanctions that HEW must impose