

ALASKA LEGISLATURE COMMITTEE FILES 1983-1984 86/2

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HHESS HB 19

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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.^{2,5} 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. (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.

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.

REFERENCES CITED

- 1 U.S. Congress, Congressional Budget Office. Health Planning Issues for Reauthorization. Washington, D.C. March 1982.
- 2 Howell, Julianne. Regulating Hospital Investment: The Experience in Massachusetts. Hyattsville, Maryland. DHHS/Health Resources Administration, (DHS) 81-8298. March 1981.
- 3 Headen, A. "The Impact of Certificate of Need Regulation on Hospital Investment: New Evidence." Presented at American Economic Association Health Economics Research Organization. Washington, D.C. December 1981.
- 4 Arthur D. Little, Inc. Development of an Evaluation Methodology for Use in Assessing Data Available to the Certificate of Need (CON) and Health Planning Programs. Final report prepared for DHHS/Office of Assistant Secretary for Health. Contract #233-79-4003. April 1982.
- 5 Arthur D. Little, Inc. A Study of Intermediate Outcomes of the CON Review Process. DHHS/Health Resources Administration. Contract #232-81-0018, Task Order #2. March 1982.
- 6 Enthovan, A.C. Consumer Choice Health Plan (in two parts). *New England Journal of Medicine*. 298:650-658, 709-720. March 1978.
- 7 Roemer, M.I. and John E. Pomer. The Social Consequences of Free Trade in Health Care: A Public Health Response to Orthodox Economics. *International Journal of Health Services*. 12(1):111-129. November 1982.
- 8 Needleman, Jack. Competition and State Health Planning Programs: Options for State Action. Alpha Center for Health Planning. Bethesda, Maryland. DHHS/BHP. HRA Contract #232-79-0035. June 1982.

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 majority. 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.

Position Paper

Tischer

on

Senate Bill 85 ~~HB~~ 17

93

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

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

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

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

Medicaid Programs

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

Capital Budget

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

Revenue Sharing

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

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

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

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

Date: 2/16/83

Approved by: John R. Boy
for Robert London Smith, Ph.D.
Commissioner
Department of Health and
Social Services

Date: 2/16/83

Bill No: Senate Bill 85

Date on Bill: 1/27/83

Title: An Act repealing the certificate of need program; and providing for an effective date

Sponsor: Senators Faiks, P. Fischer, and Pettyjohn

Requestor: _____

1. Estimated fiscal impacts on:

a. Expenditures:

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

b. Revenues:

Revenue	0	0	0	0				
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2. Source of funds to offset fiscal impact of bill:

3. Assumptions:

4. Disclaimer:

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

Prepared By: Dave W. Williams DW

Phone: 465-3038

Division: State Health Planning and Development

Date: 2-14-83

Approved by Commissioner: 

Date: 2/16/83

Department: Health and Social Services

Date: _____

6. Distribution:

Original to Legislative Finance

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Copy to Sponsor

Central Peninsula General Hospital

P. O. Box 1268
SOLDOTNA, ALASKA 99669

David

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

February 14, 1983

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

FEB 18 1983

Subject: House Bill #19

Dear Representative Tischer:

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

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

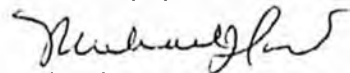
I would encourage our legislators to promote the health care agencies in the planning and providing for better health care, and not tying up their time with the fruitless Certificate of Need process.

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

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

Thank you for your consideration.

Sincerely yours,



Michael J. Lockwood,
Administrator

MJL/pt

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

Central Peninsula General Hospital

P. O. Box 1268

SOLDOTNA, ALASKA 99669

OPERATED BY
LUTHERAN HOSPITALS AND HOMES SOCIETY
FARGO, NORTH DAKOTA 58103

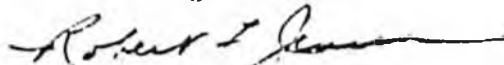
February 11, 1983

Kenai Peninsula Borough Assembly

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

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

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



ROBERT F. JENSEN
Chairman
Service Area Board



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

REPRESENTING ACUTE, LONG TERM AND OUTPATIENT FACILITIES

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Hospital
Cordova

Delegate to the American
Hospital Association
Al M. Camosso
Providence Hospital
Anchorage

Alternate Delegate to the
American Hospital Assoc.
Michael Lockwood
Central Peninsula Hospital
Soldotna

Delegate to the American
Health Care Association
Jack Buck
St. Ann's Nursing Home
Juneau

Alternate Delegate to the
American Health Care
Association
Emma G. Ivy
Wrangell General Hospital
Wrangell

Delegate to the Association
of Western Hospitals
Michael Herring
South Peninsula Hospital
Homer

Alternate Delegate to the
Association of Western
Hospitals
Daniel Van Wieringen
Kodiak Island Hospital
Kodiak

Trustee Delegate to the
American Hospital Assoc.
Moe Kadish
Trustee, Providence
Hospital
Anchorage

Alternate Trustee Delegate
to American Hospital
Association
Robert Jensen
Central Peninsula Hospital
Soldotna

Physician Member of
the Board
Keith Brownsberger, M.D.
Anchorage

President
Dennis L. DeWitt
Juneau

Alaska State Hospital Association

Position Paper

Certificate of Need Repeal

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

Basic Issues

1. Equity

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

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

- Physician office construction and equipment purchase are also exempt.

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

2. Unnecessary

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

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

3. Conformity

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

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

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

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

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

4. Other States

- Louisiana does not have a certificate of need law.

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

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

5. Attachments

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

- Providence letter to Mayor Knowles explaining opposition to CON.

- U.S. Department of Health and Human Services letter to Dennis DeWitt discussing Alaska's non-conformity.

Position Paper
Certificate of Need Repeal
Page Three

(Attachments cont.)

- Alaska Department of Administration letter to Representative Don Clocksin discussing Pioneers' Homes exemption, conformity problem, and potential for penalties.
- 42 USC 300m-(d)
- Alaska Department of Health and Social Services letter to Representative Mike Beirne indicating lack of compliance with federal program.
- Alaska State Medical Association Resclution calling for the repeal of certificate of need.
- Alaska State Hospital Association letter to Stevens on CON repeal.
- Governor Sheffield's response to the Association letter to Senator Stevens.

Chairman of the Board
Ronald A. Pavellas
Humana Hospital Alaska
Anchorage

Chairman-Elect
Mark Hawkins
Sitka Community Hospital
Sitka

Immediate Past Chairman
Tom Mingen
Fairbanks Memorial
Hospital
Fairbanks

Secretary/Treasurer
Edward Zeine
Cordova Community
Hospital
Cordova

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Al M. Camosso
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Anchorage

President
Jenna L. DuWitt
Juneau

POLICY STATEMENT

CERTIFICATE OF NEED

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

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

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

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

4-1

Dr. C. Dennis Melville

PROVIDENCE HOSPITAL



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

SERVING IN THE WEST SINCE 1858

December 27, 1982

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

Dear Mayor Knowles:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mayor Tony Knowles
Page Three
December 27, 1982

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

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

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

Best wishes for a prosperous 1983.

Sincerely,


Al M. Camosso
Administrator

Enclosure



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

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

June 22, 1982

Re: 10P 550016
Alaska SHPDA

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

Dear Mr. DeWitt:

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

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

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

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

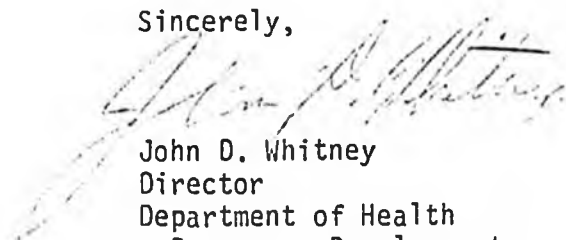
Page 2 - Dennis L. DeWitt

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

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

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

Sincerely,



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

Enclosures (2)

JUN 21 1982

Re: IOP 550016
Alaska SHPPA



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

Dear Dr. Beirne:

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

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

1. If the Agency is unable to retain full designation after September 30, 1982, it will be returned to conditional designation for the period October 1, 1982 to June 30, 1983.
2. The designation of the Agency will automatically terminate when the Agency reaches its penalty date, if the Agency still has not achieved full designation.

You may at any time prior to your penalty date (1-19-83, per PPI 22-12) submit documentation which you believe contains evidence that the State's CON program complies with the minimum Federal requirements, or a certification by the State's Attorney General, attesting to the program's compliance.

ALASKA DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

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

Sincerely,

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

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

Date

DHRD:ROSS:vw:6/21/82



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Pioneer Home - S

Region X *Lynn's Room*
M/S 829 Arcade Plaza Building
1321 Second Avenue
Seattle WA 98101

Re: 10P 550007-05

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

124
1121381
11/17/77

Dear Mr. Lawner:

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

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

A private, municipal. . . hospital, psychiatric hospital, tuberculosis hospital, skilled nursing facility. . . .
(Sec. 18.07.111(7)).
 - b. The Alaska C/N regulations, in turn, define "health care facility" as:

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

Page 2 - Mr. Ivan Lawner, Esq.

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

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

Please call us should you have further questions.

Sincerely yours,

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

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

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPARTMENT OF ADMINISTRATION

OFFICE OF THE COMMISSIONER

POUCH C

JUNEAU, ALASKA 99811

465-2200

May 29, 1981

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

Dear Representative Clocksin:

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

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

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

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

Honorable Donald E. Clocksin
Chairman, Health, Education and
Social Services

Page 2

May 29, 1981

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

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

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

Honorable Donald E. Clocksin
Chairman, Health, Education and
Social Services

Page 3

May 29, 1981

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

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

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

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

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

Honorable Donald E. Clocksin
Chairman, Health, Education and
Social Services

Page 4

May 29, 1981

These conversations indicate that:

- i. The federal government is not inclined to impose sanctions on a State for nonconformance with the certificate of need program;
- ii. There are states which are nonconforming, and have been nonconforming for a number of years, on which federal sanctions have not been imposed; and
- iii. The federal government is withdrawing total support for the certificate of need program by 1983. If the state wants to continue a planning process for health facility development it will have to provide for the process by using General Funds monies. Based on the aforementioned problems, now would be the appropriate time to revise this planning process to make it more meaningful.

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

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

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

Honorable Donald E. Clocksin
Chairman, Health, Education and
Social Services

Page 5

May 29, 1981

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

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

In summary:

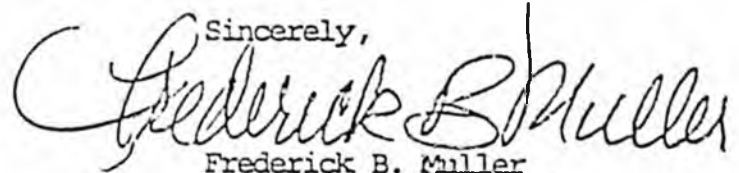
1. Administration believes the Legislature had always intended to exclude Pioneers' Homes from certificate of need;
2. The certificate of need process is not appropriate for Alaska;
3. There needs to be planning for health care facilities and a more responsive process needs to be developed;
4. Grandfathering the nursing wing at Anchorage and the new Pioneers' Home at Ketchikan will not solve the complex problems existing at the Fairbanks, Palmer, and Sitka Pioneers' Home; and,
5. Passage of CSSB 225 will eliminate the potential for pain and suffering by allowing Pioneers' Homes residents to remain in their home.

Honorable Donald E. Clocksin
Chairman, Health, Education and
Social Services

Page 6

May 29, 1981

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

Sincerely,

Frederick B. Muller
Deputy Commissioner for
Personnel Management

FBM/mjc

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

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

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

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

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

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

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

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

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

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

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

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

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

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

RECEIVED JAN 11 1981

Rel: Alcoh Treatment referre 91-616 amend chapte For co ode tion 25 1981 L 97- setting tendin (1)(B) forth ; beyond agreem thority Subs (1), in for "da "date, Subs (3), str Mental Abuse 1980 Pub.L 1980" 1979 96-79, precede "this p Subs inserted extend ditional igrated effort: tion 30 Pub l agreeme shall n thirty-s been en "The ; subpara months Subs (A), (2) subpar. nated, els (i) ceding for "the pertain

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

JAY S. HAMMOND, GOVERNOR

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

May 10, 1982

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

Dear Representative Beirne:

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

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

We appreciate your assistance and support in this matter.

Sincerely,



Helen D. Beirne
Commissioner

Enclosure

cc: Phoebe A. Lindsey



ALASKA STATE MEDICAL ASSOCIATION

1107 Laurel Street • Suite 1 • Anchorage, Alaska 99504 • (907) 277-6891



ADOPTED BY THE ALASKA STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES AT ITS ANNUAL MEETING IN FAIRBANKS, ALASKA JUNE 8, 1982

RESOLUTION NO. 82-23

SUBJECT: Certificate of Need

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

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

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

DISTRIBUTION: Legislature
Alaska State Hospital Association
Press

alaska
state
hospital
association

319 Seward St., Juneau, Alaska 99801 • (907) 586-1790
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Physician Member of
the Board
Keith Brownsberger, M.D.
Anchorage

President
Jennie L. DeWitt
Juneau

November 4, 1982

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

Similar letter sent to:
Senator Murkowski and
Congressman Young

Dear Senator Stevens:

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

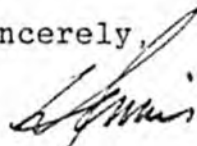
This Association as well as the Alaska State Medical Association (resolutions attached) are opposed to the continuation of the state Certificate of Need law. Both are committed to its repeal in 1983. Repeal of 42 U.S.C. 300m-(d) will greatly assist our efforts.

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

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

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

Sincerely,



Dennis L. DeWitt
President

DLD:lf

cc: Friday Mailing

Alaska State Medical Society

Governor Jay Hammond

Governor Elect Sheffield

Lt. Governor Terry Miller

Lt. Governor Elect McAlpine

American Hospital Association - Lynn Hart

Federation of American Hospitals

BILL SHEFFIELD, GOVERNOR



STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

December 22, 1982

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

Dear Mr. DeWitt:

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

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

Best regards.

Sincerely,

A handwritten signature in cursive script that reads "Bill Sheffield".

Bill Sheffield
Governor

Blue Cross
of Washington and Alaska



FEB 18 1983

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

February 14, 1983

David

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

Dear Representative Tischer:

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

We are continuing to develop information which supports our position for the modification of the certificate of need law. Other organizations such as the Health [REDACTED] Please [REDACTED] the necessity [REDACTED]

[REDACTED] Much of this information will be presented to the Health Education and Social Services Committee in the hearing on HB 19.

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

Sincerely,

Joan Gaumer, Director
Government Relations

JHG:pf

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

February 4, 1983

POLICY STATEMENT

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

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

northern alaska health resources association, inc.

FEB 9 1983

February 03, 1983

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

Dear Representative Tischer:

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

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

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

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

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

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

The Honorable Mae Tiller
February 03, 1983
Page 3

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

Sincerely,



J. B. Carnahan
President

JBC:flr

cc: William Sheffield
Governor

Robert London Smith, Ph.D.
Commissioner, DHSS

Alaska Health Coalition

Southeast Alaska HSA

South Central Health Planning
and Development, Inc.

FEB 18 1983



**South Central
Health Planning and Development, Inc.**

1135 West Eighth Avenue • Suite 1 • Anchorage, Alaska 99501
(907) 278-3631

February 15, 1983

Dear Alaska Legislator:

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

The ~~name of the organization~~

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

Sincerely,

Margaret McClue Wilson

Margaret M. Wilson
Executive Director

MMW/ab

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

Alaska Health Coalition

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

February 11, 1983

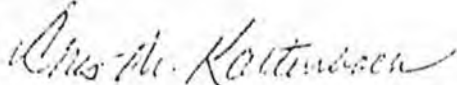
TO: Members of the Alaska Legislature

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

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

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

Best regards,



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

CMK:sem

Enclosure

Coalition Member

J. B. Carnahan, Fairbanks; Joseph Chelimo, Juneau;
Charles Kaltenbach, Dr. P.H., Fairbanks; Steve Jenko, Anchorage;
Jola Manning, Ketchikan; Lillie McFarvey, Anchorage; Art Williams, Girda; Margaret Wilson, Anchorage

CERTIFICATE OF NEED:

REVISION OR REPEAL

Prepared in
the
Public Interest
by
the

ALASKA HEALTH COALITION
February, 1983

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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 55, 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.

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.

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."⁵ 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. 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.

Needlemen, another health economist, expressed a similar opinion.⁹

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).⁹

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 accommodate a significant increase in CON thresholds. The threshold levels which trigger a CON review should be increased from \$150,000 to at least \$600,000 for capital expenditures; \$400,000 for major medical equipment; and \$250,000 for operating expenses associated with new services.

CONCLUSIONS

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

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

MAINTAIN CURRENT CON PROCESS

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

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

REPEAL THE CON LAW

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

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

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

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.

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. I [REDACTED] from \$500,000 to at least: [REDACTED]

[REDACTED]
[REDACTED]
[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. C [REDACTED] e [REDACTED] effectiveness of the CON process.

REFERENCES CITED

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- 2 Howell, Julianne. Regulating Hospital Investment: The Experience in Massachusetts. Hyattsville, Maryland. DHHS/Health Resources Administration, (DHS) 81-8298. March 1981.
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- 4 Arthur D. Little, Inc. Development of an Evaluation Methodology for Use in Assessing Data Available to the Certificate of Need (CON) and Health Planning Programs. Final report prepared for DHHS/Office of Assistant Secretary for Health. Contract #233-79-4003. April 1982.
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- 6 Enthovan, A.C. Consumer Choice Health Plan (in two parts). New England Journal of Medicine. 298:650-658, 709-720. March 1978.
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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-Durton, 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 majority. 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 Aetna Life Insurance Company has for years been deeply concerned about health care cost increases and has consistently supported viable health planning programs. We strongly oppose H.B. 19, An Act Repealing the Certificate of Need Program. We believe that enactment of this legislation would represent a large step backward in Alaska's effort to realize an efficient and effective health care delivery system.

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

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

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

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

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

Alaska Health Coalition

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

February 11, 1983

FEB 16 1983

TO: Members of the Alaska Legislature

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

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

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

Best regards,



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

CMK:sem

Enclosure

Coalition Members

J. B. Carnahan, Fairbanks; Joseph Cladouhos, Juneau;
Charles Kaltenbach, Dr. P.H., Fairbanks; Steve Lesko, Anchorage;
John Manning, Ketchikan; Lillie McGarvey, Anchorage; Art Willman, Sitka; Margaret Wilson, Anchorage

northern alaska health resources association, inc.

FEB 9 1983

original MS

February 03, 1983

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

Dear Representative Tischer:

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

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

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

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

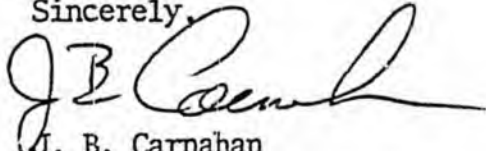
Several states have already revised their CON process (among them Colorado and New Mexico) with full support of their respective state hospital associations. Revision of Alaska's CON process must occur if we expect to see the process work as it was designed to do. The following revisions are offered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

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

The Honorable Mae Tischer
February 03, 1983
Page 3

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

Sincerely,


J. B. Carnahan
President

JBC:flr

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

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U.S. House of Representatives
 Committee on Energy and Commerce
 Room 2125, Rayburn House Office Building
 Washington, D.C. 20515

February 2, 1983

FRANK M. POTTER, JR.
 CHIEF COUNSEL AND STAFF DIRECTOR

Pierre Howard, Chairman
 Senate Human Resources Committee
 The State Senate
 Atlanta, Georgia 30334

Dear Senator Howard:

Thank you for your letter concerning the consideration of Certificate of Need legislation by the Georgia Senate.

I can appreciate your interest in CON legislation. It is clear that without a strong health planning program, hospital and nursing home expansion will wildly inflate State and private, as well as Federal, health care payments. I suspect that Georgia, and Georgia's employers and employees, can ill afford to waste their resources on unnecessary or over-priced health services.

I am pleased to report to you that there is a firm Federal commitment to support a health planning system throughout the nation. A bill to extend Federal assistance to State and local health planning agencies was passed by the House of Representatives last year by a vote of 302 to 14. Although it was not possible to work out an agreement with the Senate in this regard at the end of the 97th Congress, the program was extended through FY 1983 by the Continuing Resolution.

As the 98th congress begins its work, I am sure that health planning legislation will again be on the agenda. While it is not possible to predict what the exact result of the legislative process will be, I think it is reasonable to assume:

1. The Federal government will continue to provide substantial funds to the States and local agencies to support health planning activities; and
2. In order to be eligible to receive such funds, States and local agencies will have to meet certain standards of organization and operation necessary to ensure their effectiveness.

3. States will be required to conduct a certificate of need program which covers hospital and nursing homes and otherwise complies with Federal law.

In this context, I would suggest that the prudent course for Georgia, or any other State, at this time is to maintain the current program without any major change. This will insure that both State and local agencies remain eligible for Federal support this year under the FY 1983 Continuing Resolution. It will also mean that, once all of the details of the Federal legislation are settled, Georgia can, in a single step, make changes in its CON program with a clear understanding of what its effect on eligibility for Federal support may be. If Georgia revises its CON program this year, further revisions, even contradictory changes, may be necessary next year or the year after.

With specific regard to the provisions of SB 121, I can report that they are not consistent with the current requirements of the Federal statute. I cannot guess whether these provisions will or will not be consistent with that legislation that will be developed this year. I can point out, by way of example, that the legislation endorsed by the House last year did include detailed requirements for State CON programs and that the provisions of SB 121 are not consistent with all of the provisions of that bill.

Again, I appreciate your interest in the future of the health planning program. As a Federal-State partnership, planning can only be successful with the understanding and support of State officials throughout the nation.

My best regards to you and your colleagues in the Georgia Senate.

Sincerely,

HENRY A. WAXMAN
Chairman, Subcommittee on
Health and the Environment

HAW/bbg

Blue Cross
of Washington and Alaska



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

FEB 18 1983

February 14, 1983

David

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

Dear Representative Tischer:

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

We are continuing to develop information which supports our position for the modification of the certificate of need law. Other organizations such as the Health Insurance Association of America and the American Health Planning Association have also researched the subject and have documented the necessity to retain CON if costs are to be contained in the health delivery system. Much of this information will be presented to the Health Education and Social Services Committee in the hearing on HB 19.

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

Sincerely,

Joan Gaumer

Joan Gaumer, Director
Government Relations

JHG:pf

MAE -

New Mexico, ARIZONA, MINNESOTA, Colorado
HAVE SUNSET provisions that provide for
CERT. of Need laws to expire on future dates -
like ALASKA'S sunset on topics like parole board,
psychological examiners board, etc. REPEAL HAS
NOT BEEN PASSED by ANY legislature of FOR
CON.

DAVE

Alaska State Legislature

Representative Mae Tischer
District 11
3305 Oregon Drive
Anchorage, Alaska 99503



White In Juneau
Pouch V
Juneau, Alaska 99811
(907) 465-3759

House of Representatives

MAE TISCHER

15 March 1983

Dr. Mike Beirne
President, Lake Otis Clinic
P. O. Box 4-1539
Anchorage, AK. 99509

Dear Mike:

Thank you for your March 2 update regarding CON. The Bill has passed out of my committee but has a long way to go before final passage, as you know. Presently in House Finance, I will copy your attachments and personally present them to the Finance Committee for their perusal. Many of the points in the February 23, 5-page letter to Commissioner Smith are pertinent facts for deliberation.

Sincerely,

Representative Mae Tischer
District 11



MAR 7 1983

LAKE OTIS CLINIC, INC. P.O. BOX 4-1539 ANCHORAGE, ALASKA 99509

(907) 276-3166

THE LAKE OTIS COMMUNITY HOSPITAL

March 2, 1983

file in my HESS CON file

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

Dear Representative Tischer:

I know you are in the process of reviewing the Certificate of Need (CON) law. And, you are probably aware of the latest developments regarding the applications for CONs by Providence and Humana Hospitals.

Therefore, the attached materials are simply for your review. Should you have any questions, please let me know.

Sincerely,

Mike
Dr. Mike Beime
President
Lake Otis Clinic

MB/nc

attachments

*Mike -
Please don't repeal that law!
modify it - one million
threshold, but keep the law.
The only thing you need a
CON for is new beds. Thanks.
- Mike*

LAW OFFICES OF
DAVIS, WRIGHT, TODD, RIESE & JONES
510 L STREET
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1050 THOMAS JEFFERSON STREET N.W.
WASHINGTON, D. C. 20007
(202) 805-0484
TELECOPIER: (202) 342-1922

PLEASE REPLY TO ANCHORAGE OFFICE

February 23, 1983

The Honorable Robert L. Smith
Commissioner
Department of Health and Social Services
Pouch H 01
Juneau, AK 99811

Re: In the Matter of the Revocation of the Certificate of
Need for Lake Otis Hospital

Dear Commissioner Smith:

Thank you for your letter of January 31, 1983 regarding the status of the above-referenced administrative proceeding. We am writing to you today on behalf of our client, Lake Otis Clinic, Inc., because of recent developments we believe should be brought to your attention. Counsel for petitioner, South Central Health Planning and Development, Inc. ("South Central") has been provided with a copy of this letter and its attachments so he may respond to the letter if he wishes.

As you are no doubt well aware, the principal issues in this case are whether there are grounds for revoking Lake Otis Clinic's certificate of need, and if so, whether the certificate should or should not be revoked. The revocation proceeding was filed and prosecuted by South Central, the regional health systems agency which acts in an advisory capacity to DHSS. Since 1977, South Central has opposed the certificate of need issued to Lake Otis Clinic by DHSS essentially on the grounds (1) that the certificate was never submitted to South Central's review and recommendations and (2) that there is no need for the 125 acute care hospital beds Lake Otis Hospital would put into operation in Anchorage. The Anchorage Municipal Health Commission ("MHC") has taken a similar position. It filed a lawsuit challenging Lake Otis' certificate of need in 1979 which was dismissed late that year. South Central filed the instant administrative action in 1980. Lake Otis has consistently taken the position that it is

CB
2/24/83

The Honorable Robert L. Smith
February 23, 1983
Page 2

not required to submit its hospital proposal to review by South Central and MHC since its certificate was "grandfathered" and that there was or would be need for the additional 125 acute care beds when they are constructed.

Disturbing recent developments indicate that South Central and MHC may be radically altering their position on bed need in Anchorage, after having effectively embroiled Lake Otis' certificate of need in litigation since mid-1979. Providence Hospital has filed an application for a certificate of need authorizing it to undertake a \$97 million construction project to increase its bed capacity from 250 to 410 beds. Humana Alaska Hospital also has filed an application for a certificate of need authorizing it to spend \$21.5 million to add 93 beds to its 199 bed hospital. The two proposals together would add 243 new hospital beds in Anchorage, slightly less than twice as many beds authorized under the Lake Otis Clinic certificate of need.

Based on the firm position taken by South Central and MHC in opposition to the Lake Otis certificate of need over the last several years and those agencies' current bed-need projections for Anchorage, an impartial observer could reasonably anticipate rejection of the Providence and Humana applications on lack-of-need grounds. For example, in September, 1977 the Municipal Health Commission formally came out in opposition to the Lake Otis certificate of need under a resolution which states:

The Municipal Health Commission recommends to the regional health systems agency, Mayor Sullivan, and the Municipal Assembly that there be a moratorium on the construction of civilian non-native acute care hospital beds within the Municipality of Anchorage for a five-year period or until civilian population reaches 270,000, whichever is sooner.

Exhibits R-55 and R-68, Lake Otis Revocation Proceedings (copy attached). Shortly thereafter, South Central's board of directors adopted a similar resolution finding "need for no additional civilian non-native acute care beds for the Municipality of Anchorage," and opposing the Lake Otis certificate of need. Exhibit R-56, id. (copy attached). Based upon these and other exhibits and testimony in the Lake Otis

The Honorable Robert L. Smith
February 23, 1983
Page 3

revocation proceedings, Hearing Officer Joan Katz concluded that neither agency would have found any need for Lake Otis' 125 hospital beds had the project been submitted for review. Hearing Officer Katz expressly found:

Beirne's refusal to submit to agency review was predicated on a realistic assessment that the agencies would not find bed need sufficient to support LOC's respective applications. (Emphasis added.)

Proposed Decision of Joan M. Katz, Ultimate Findings of Fact at page 32 (June 25, 1982). Beirne, of course, is Dr. Michael F. Beirne, president of Lake Otis Clinic, Inc.

South Central and MHC have both adopted health systems plans, as required by their enabling statutes, which are consistent with their position that there is essentially no need for additional hospital beds in Anchorage. The Municipality of Anchorage Health Systems Plan (1982-84), attached hereto as Exhibit B, projects total acute care bed-need at 480 in 1985 and 511 in 1990 as against the 449 beds currently licensed and in operation. The addition of Lake Otis' 125 beds would, according to that plan, exceed projected bed need until 1995. Similarly, the South Central bed need projection for Anchorage, Exhibit C (copy attached), projects "high" bed needs of 481 and 513 in 1985 and 1990 respectively. Although we understand that one or both of these health plans have been revised upwards slightly this year, neither revision projects additional bed needs beyond the 125 beds authorized for Lake Otis Clinic.

In these circumstances, it is anomalous that the joint South Central/MHC project review committee assigned to review the Providence and Humana expansion applications has recommended approval of not one, but both hospital applications! The February 13, 1983 Anchorage Times article attached hereto as Exhibit A describes the action taken by the project review committee. The committee apparently has abandoned the MHC moratorium on construction of additional hospital beds "until civilian population [of Anchorage] reaches 270,000." It also has abandoned the health systems plans which - even disregarding Lake Otis' 125 beds - show no need for the number of beds proposed by Providence and Humana Hospitals until some time between 1995 and the year 2000, or later. According to the newspaper article, which our client believes

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accurately reflects the actions taken by the committee, justification for approval of both applications is predicated on projections of bed need in 1995, some twelve years in the future, and the committee's "instinctive" or "gut" feeling that the 1995 projections are too low. If these recommendations are adopted by MHC and South Central in their February 23 and March 5, 1983 hearings, the agencies will have taken a position completely inconsistent with their long-running opposition to construction of the Lake Otis Hospital.

These developments have a direct impact on the case pending before you. Lake Otis Clinic believes that it has demonstrated good cause for not having completed its hospital project. Even assuming for the sake of argument that good cause were not shown, revocation of its certificate is permissive, not mandatory, under AS 18.07.081(d). Whether revocation is justified depends upon a careful weighing of equitable considerations such as Lake Otis' investment in and desire to complete its project and the public's interest in containing hospital cost escalations through prevention of unnecessary construction and equipment acquisitions. We believe it would be fundamentally unfair for the Department to revoke Lake Otis' certificate of need in the present circumstances. If South Central adopts the project review committee's recommendations, it will have effectively swung one hundred and eighty degrees from a position that there is no need for Lake Otis' 125 acute care beds to a position supporting the construction of 243 beds. The irony of South Central's revocation petition is that if it is granted by DHSS, Lake Otis's 125-bed certificate would be eliminated at precisely the same time the two major Anchorage hospitals are aggressively moving ahead with their own expansion plans which will have a substantially greater impact on bed availability than Lake Otis' project. In fairness, South Central cannot have it both ways: either there is no need for additional beds in Anchorage and all expansion applications should be resisted or there is need and Lake Otis should be permitted a reasonable time free of debilitating litigation against its certificate of need to complete construction of its hospital. The inequities inherent in these recent developments are clear.

We respectfully request that you consider the recent and pending actions by South Central and MHC in connection with the