ALASKA LEGISLATURE COMMITTEE FILES 1983-1984 8072

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There is discrepancy between projections for medial/surgical and ICU/PCU/CCU as shown in SCHPD/MHC plans and the Providence application. This reflects the difference in actual use of those beds as compared to optimum use, or that which would have occurred had space in the appropriate type of bed been available. For example, patients needing a general medical/surgical bed might have had to stay longer than necessary in a PCU or ICU bed because the medical/surgical beds were full. The net result of this situation would be an increase in the apparent demand for PCU beds. When calculating patient days by service the PCU days would be higher than under optimum conditions of available medical/surgical beds. Hospitals adjust for this phenomena through a House Convenience Report which shows where patients are actually placed and where they should have been placed under optimum circumstances.

SCHPD & MHC staff did not have access to the house convenience data for use in the plans. However, the medical-surgical subtotal projections are consistent, and are perhaps more useful than the specific service projections for ICU/CCU, PCU and medical-surgical beds.

TABLE I
COMPARISON OF COMMUNITY ACUTE CARE BED NEED PROJECTIONS 1985 - 1995

Service	HSA/MHC Plans[1]	HSA/MHC 1981 Data Update[2]	Providence C/N Application June 82	Humana C/N Application October 82
Medical/Surgical[3]				
Anchorage Use Rate - 1980/Proj.	491	459	561/586	491
Projected Anchorage Use	76.2%	74.5%	75.9%	76.2%
Population - Anchorage CNN				
1985	118,642/141,312	Same as in Plans	-	141,312
1990	135,045/151,132	Same as in Plans	-	151,132
1995	- /168,797	Same as in Plans	172,077	-
Community Bed Need				
1985	247/294	236/281	-	293
1990	281/314	268/300	-	314
1995	- /351	- /336	376[4]	-
ICU/CCU				
Anchorage Use Rate - 1980 Proj.	54	52	-	54
Projected Anchorage Use	76.2%	74.5%	-	76.2%
Community Bed Need				
1985	39/46	38/45	-	47
1990	44/49	43/48	-	48
1995	-/55	-/54	42[5]	-
PCU				
Anchorage Use Rate - 1980 Proj.	52	50	-	52
Projected Anchorage Use	76.2%	74.5%	-	72.2%
Community Bed Need				
1985	30/37	29/34	-	35
1990	34/39	33/37	-	39
1995	-/44	-/41	37[5]	-

COMPARISON OF COMMUNITY ACUTE CARE BED NEED PROJECTIONS 1985 - 1995

Service	HSA/MHC Plans[1]	HSA/MHC 1981 Data Update[2]	Providence C/N Application June 82	Humana C/N Application October 82
Medical/Surgical Subtotal				
1985	316/377	303/360	-	375
1990	359/402	344/385	-	401
1995	-/450	-/431	455[5]	-
Obstetrics				
Anchorage Use Rate - 1980/Proj.	226	259[13]	216/216	/226
Projected Anchorage Use	90.1%	87.0%	91.6%[6]	90%
Population				
1985	42,768/50,940	Same as in Plans	-	50,940
1990	48,681/54,480	Same as in Plans	-	
1995	- /60,848	Same as in Plans	59,753	-
Community Bed Need				
1985	40/47	46/55[13]	-	47
1990	45/50	53/59[13]	-	50
1995	-/56	-/66[13]	52-53[17]	-
Pediatrics				
Anchorage Use Rate - 1980/Proj.	134	132	140	172
Projected Anchorage Use	78.2%	78.3%[14]	79.2%[6]	78.2%
Population				
1985	39,758/47,355	Same as in Plans	-	47,355
1990	45,253/50,646	Same as in Plans	-	50,646
1995	- /56,566	Same as in Plans	58,095	-
Community Bed Need				
1985	29/35	29/34	-	34
1990	33/37	33/36	-	37
1995	- /41	-/41	43-44[11]	-

Table 1 Con't

COMPARISON OF COMMUNITY ACUTE CARE BED NEED PROJECTIONS 1985 - 1995

Service	HSA/MHC Plans[1]	HSA/MHC 1981 Data Update[2]	Providence C/N Application June 82	Humana C/N Application October 82
Thermal				
Anchorage Use Rate - 1980/Proj.	10	11	4[9]	-
Projected Anchorage Use	76.2%	73.7%[11]	-	-
Population	Same as Med/Surg			
Community Bed Need				
1985	9/10	11/12	-	-
1990	10/11	12/13	-	-
1995	-/12	-/14	13	-
Psychiatry				
Anchorage Use Rate - 1980/Proj.	24	27	29.1	-
Projected Anchorage Use	83.1%	83.1%	86.8%[10]	-
Population	Same as Med/Surg			
Community Bed Need				
1985	12/13	13/15	-	-
1990	13/14	14/16	-	-
1995	-/16	-/18	19	-
ACUTE CARE TOTAL[12]				
1985	406/482	403/476[13]	-	464
1990	460/514	456/509[13]	-	496
1995	-/575	-/570[13]	583	-
Neonatal Intensive Care				
Use Rate	470		474	
Live Births				
1985	11,435		-	
1990	13,779		-	
1995	-		16,604	
Community NICU Bed/Need				
1985	30		-	
1990	36		-	
1995	-		43	

Table I Con't

Footnotes to Table I

1. SCHPD Health Systems Plan 1982-86; Anchorage Health Systems Plan, 1982-84.

2. Application of acute care bed need projection methods, as used in the plans, adjusted for 1981 hospital utilization data and 1981 population figures. The following tables include utilization and population data used for calculations in the update column.

1981 Population Data	
Total	187,761
Native	9,876
Military	
Active	11,210
Dependent	16,061
Civilian Non-Native	150,614
Women 15-44 (27%)	40,666
Adults (14+)(74.9%)	112,810
Children (25.1%)	37,804

Source: MOA Community Planning Department

1981 Patient Days and Percent Occupancy

	Providence Patient Days[a]	%Occ	Humana Patient Days[b]	%Occ	Optimum Occupancy[c]
Medical/Surgical	59,773	90.0	23,646	39.7	85%
M/S	47,276	93.8	21,962	39.6	85%
ICU/CCU	5,096	69.8	2,684	40.8	60%
PCU	7,401	92.1	---	--	75%
Obstetrics	4,827	50.8	4,463	81.5	75%
Pediatrics	3,480	52.9	2,591	50.7	65%
Psychiatry	3,586	65.4	---	--	85%
Thermal	1,592	39.6	---	--	50%
Total	72,658	79.6	31,700	43.6	80%

Note: 1. Occupancies calculated using Providence 250 licensed beds, Humana 199 C/N'd beds (See Assumption #10).
2. Humana M/S Occupancy does not include CDU patient days.
3. If assume proportion of L&D days to patient days in HHA are same as in Providence (21.8%), could deduct 973 from OB days to yield 3,490 patient days at 63.7% occupancy of HHA's 15 OB beds.

Sources: [a] Providence Hospital C/N application, p. 114
[b] Humana Hospital Alaska C/N application, p. 58
[c] SCHPD and MIC Plans

Anchorage Patient Days Compared to Total Patient Days for Providence, Humana and the Community in 1981

Service	Providence		Humana		Community		
	Anch.	Total	Anch.	Total	Anch.	Total	%
Med-Surg.	43,122	60,323	19,556	23,808	62,678	84,131	74.5
OB	5,982[1]	7,065[1]	4,509	5,026	10,521	12,091	87.0
Ped	3,912	5,500[2]	2,437	2,880	6,349	8,380	75.8

[1] Labor and delivery day total of 1054 days added to total: 84% (Prov. OB% from Anch. added to Anchorage day total).
[2] Previous total received from Providence for pediatrics was 3,480; the higher figures (3912/5500) include NSCN which cannot be broken out from Peds.

3. Includes orthopedics.

4. See p. 120 of Providence C/N aplication dated June 1982, (Anch. CNN patient days for 1995 divided by total patient days).

5. See p. 194 of Providence C/N aplication (HHA existing beds plus Providence 1995 forecast).

6. See p. 127, p. 130 of Providence C/N (Anchorage CNN patient days forecast for 1995 divided by total patient days).

7. See p. 130 of Providence C/N total patient days (then divide by 365 to get average daily census, and by minimum occupancy of 65%). Alternative method: see p. 194 (HHA beds + Providence 1995 forecast).

8. See p. 127 of Providence C/N, total patient days (then divide by 365 to get average daily census, and by minimum occupancy of 75%).

9. Use rate based on state population.

10. See p. 134 of Providence C/N (Anch. CNN patient days divided by total).

11. Providence medical/surgical Anchorage use rate was used rather than a community-wide proportion.

12. Excluding chemical dependency service at Humana.

13. Use includes labor and delivery days for both hospitals as Humana was unable to separate their labor and delivery days out from OB patient days. Total projections

then include labor and delivery beds which are not included in a total bed count nor as licensed beds.

14. Unable to redo with 1981 patient origin data since Providence Hospital has some NSCN days in pediatric days. (Total in patient origin information provided were not consistent with pediatric service totals.)

Table II: Comparison of Bed Need Projections with Existing Supply of Acute Care Beds

Table II capsulizes the information obtained in Table I and compares the projections completed by the planning agencies (SCHPD and MHC) with current built bed capacity.

The data from the table show that there are currently 449 acute care beds built and/or licensed (250 at Providence and 199 at Humana).

Projections of communitywide need for beds in 1985 ranges from 403 to 432 beds depending on population figures, use rates and methodologies used. Neither Providence's nor Humana's proposed additional beds would be available for use by 1985.

Projections of community need for beds in 1990 range from 456 to 514 beds. By 1990 the combined total of additional beds proposed through Providence's and Humana's C/N's would be 243 (Providence, 150; Humana, 93). The addition of those 243 beds to the existing 449 beds would yield a supply of 692 beds. This level of supply would exceed the projected communitywide demand by 178 to 236 beds.

Projections of community need for beds in 1995 range from 570 to 583 beds. Assuming the addition of 243 proposed new beds (Providence, 150; Humana, 93), to the community, there would still be an excess of 109 to 122 beds beyond demand.

Please note that the derivation of projections of communitywide acute bed need, from the plans or in the 1981 update, does not include consideration of need for inpatient acute rehabilitation beds. However, both C/N proposals of 150 and 93 beds respectively, each include a 20 bed inpatient rehabilitation unit. Therefore, a more accurate comparison of need to proposed supply could be achieved by deducting 20 beds from each hospital's total proposed number, i.e. from 150 to 130 for Providence, and from 93 to 73 for Humana.

TABLE II

COMPARISON OF BED NEED PROJECTIONS WITH EXISTING SUPPLY OF ACUTE CARE BEDS

Service	Existing Acute Beds			Community Bed Need Projections						Beds Proposed Beyond Existing	
				Plans		'81 Update					
	Providence	Humana	Total	HSA	MIC	HSA	MIC	Providence C/N	Humana C/N	Providence C/N	Humana C/N
Medical/Surgical	138	152	290								
1985				247	294	238	281	—	293		
1990				281	314	268	300	—	314	88	31
1995				-	351	-	336	376	—		
ICU/CCU	20	18	38								
1985				39	46	38	45	—	47		
1990				44	49	41	48	—	48	8	10
1995				-	55	-	54	42	—		
ICU	22	—	22								
1985				30	37	29	34	—	35		
1990				34	39	31	37	—	39	6	10
1995				-	44	-	41	37	—		
Obstetrics	26	15	41					—	34		
1985				40	47	46	55	—	34		
1990				49	50	51	59	—	58	12	17
1995				-	56	-	66	52-53	--		
Pediatrics	18	14	32					—	34		
1985				29	35	29	34	—	34		
1990				33	37	33	36	—	37	10	5
1995				-	41	-	41	43-44	—		
Thermal	11	—	11								
1985				9	10	11	12	—	—		
1990				10	11	12	13	—	—	1	
1995				-	12	-	14	13	—		
Psychiatry	15	—	15								
1985				12	13	13	15	--	—		
1990				13	14	14	16	—	—	5	
1995				-	16	-	18	19	—		
TOTAL	250	199	449								
1985				400	482	407	476	—	464		
1990				466	514	456	509	—	496		73
1995				-	575	-	570	583	-	130	
Plus Proposed Inpatient Rehabilitation Beds										20	20
TOTAL PROPOSED ADDITIONS										150	93

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The net result of that adjustment would yield the following comparisons:

	Communitywide Need (Range)	Additional Beds Proposed			Community Bed Supply w/Additions of all Proposed Beds
1985	403 to 482	Proposed beds not available yet			449
		Prov	HHA	Total	
1990	456 to 514	130	73	203	652
1995	570 to 583	130	73	203	652

Therefore, if all beds proposed by Providence (130) and Humana (73) (excluding temporarily the proposed rehabilitation beds) were added to the current community bed supply the comparison of need to supply would be as shown below:

	Communitywide Need (Range)	Supply	Supply Status (Range)
1985	403 to 482	449	excess of 46 to deficit of 33 beds
1990	456 to 514	652	excess of 138 to 196 beds
1995	570 to 583	652	excess of 69 to 82 beds

OTHER CONSIDERATIONS

An important factor is the use of a specific planning horizon. Though projections of bed need are estimated for specified years, it is recognized that services cannot practically be added in small increments. Therefore, beds are planned for and built before all will be used to full capacity. While facilities typically project need for a period three years beyond anticipated opening of a service, a longer horizon might be considered. The impact of improved technology and fluctuations in population numbers and characteristics can significantly alter the trends on which projection assumptions are drawn. Given construction timetables and a usual 3-year post start-up planning horizon, a 1990 projection would be appropriate at a minimum. Taking into account the unknowns with regard to the population of the Municipality of Anchorage and Alaska, as well as the additional factors cited above, a 1995 projection may be the more prudent. The adoption of a specific planning horizon by the Plan Development Committees of the HSA and MHC, would constitute an addition to the assumptions which underly the projections (See page 1).

An additional consideration in the determination of future need for acute care beds, is the presence of 125 general acute care beds, considered by the State to be existing by virtue of a grandfathered C/N held by Lake Otis Hospital, Inc.

In order to show the impact of those 125 beds on the local need and supply status one must recognize that those 125 beds are not yet built. It typically takes about three years to build and open hospital beds. If one assumed construction to begin in early 1983, it would be at least 1986 before the beds would be open and available for use. (As of this time LOH has not indicated when those beds would be open and available.) Therefore, the comparison of needs and supply, not considering the beds proposed by Providence and Humana, would be as shown below:

Community Need (Range)		Bed Supply	Supply Status
1985	403 to 482	449	excess of 46 to deficit of 33 beds
1990	456 to 514	574	excess of 60 to 118 beds
1995	570 to 583	574	excess of 23 to deficit of 4 beds

NOTE: MHC need figures from the 1982-84 HSP are:

	Beds Needed
1985	482
1990	514
1995	575

If MHC:PDC were to use their HSP need figures only, the Bed Supply Status would be:

1985	deficit of 33 beds
1990	excess of 60 beds
1995	deficit of 4 bed

SUMMARY

In summary, by 1985 the Anchorage community may experience either a small excess (46 beds) or an even smaller deficit (33 beds), of hospital beds depending on the assumptions and figures used for projecting need. By 1990, assuming the approved 125 LOH beds are built and opened, the community may experience an excess of beds ranging from 60 to 118, again depending on projection methodologies used. By 1995, with 125 LOH beds in place, there may be either an excess of 23 beds or a small deficit of 4 beds.

If one considers the supply not to include LOH, then the resultant need for beds will vary depending on the number of beds contributed to the supply through either or both the Providence and/or Humana proposals.

Therefore, it appears that the ability of the health care system to meet projected demand for acute care beds between 1985 and 1995 is largely dependent upon (1) the date by which and the specific type of beds Lake Otis Hospital will open within the 125 bed facility, or (2) the ability of other providers to somehow meet the community's needs.

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PLEASE NOTE: THE PRECEDING PAGES WERE TREATED AS A UNIT IN THE ORIGINAL DOCUMENT.

BRIEFING PAPER
PROSPECTIVE PAYMENT VS. RETROSPECTIVE REIMBURSEMENT

I. General Overview

Hospital and Nursing home rates have traditionally been established retrospectively, that is, costs are estimated at the beginning of a fiscal year and an "interim payment" determined. At the end of the fiscal year, the total of interim payments made is compared to the allowable costs of the facility. The difference is either collected from or paid to the facility. This process is referred to as "cost settlement".

Prospective payment, on the other hand, provides for establishment of the payment rate prior to the fiscal year, and the facility must operate and provide care at this predetermined rate.

The retrospective approach is advantageous to providers in that reimbursement for their allowable costs of operation is assured. This is a fundamental weakness of retrospective systems as it is completely devoid of incentives for efficiency and cost control. This method provides no incentives for control over staffing levels, equipment purchases, wage increases, service expansion, etc.

II. Problems with Retrospective Cost-Based Reimbursement Systems

- Tendency toward ineffective cost containment -- The key problem with a retrospective system is the lack of incentives to control expenditures so that unnecessary costs are not incurred.

- Dependence upon auditing and monitoring procedures -- A retrospective cost-based reimbursement system must have a tight, effective auditing system to monitor numerous categories of reported costs and statistical information, and auditing procedures must be constantly analyzed and up-dated. This is crucial to curb the inherent abuses of the system, but is very costly, complex and time-consuming.

- Tendency of the system to become static and inflexible -- Decisions are often made by accountants based on "generally acceptable accounting principles" rather than on the merits of each individual situation.

- Providers incur costs that are non-allowable but do not realize this until the fiscal year is complete and final cost reports are reviewed by the Department.

- Uncertainty of the program costs until the fiscal year is well over -- Final cost figures may not be known to the State until 6 months after a fiscal year ends.

- Cost Shifting occurs to the extent that unallowable costs under Medicaid are borne by other payors (insurance and private payors).

III. Advantages of a Prospective Payment System

- Based on the principle that predetermined rates will result in lower costs.
- Predictability of costs to the State.
- Predictability of revenues to the facilities.
- The technique encourages development of more sophisticated budgeting and cost monitoring capabilities, which are desirable management tools. The State is able to see how a facilities' budget is built and discuss the assumptions in each of the major cost categories.

IV. Disadvantages of a Prospective Payment System

- A potential disadvantage of the prospective determination of rates is that the staff time and other resources required for administration of the system are generally greater than those of a retrospective system. However, administrative costs vary greatly according to the design of the system, and as such, this factor is not necessarily of significant concern.
- ~~Artificial~~ Arbitrary (Caps, freezes, Lids etc) cost limiters may be introduced into the prospective system to balance costs versus revenues. This eventually places hospitals and nursing homes in a no win situation since the rates do not fairly reflect efficiently run facilities' costs.
- If rates are not applied industry wide, cost shifting can still occur if Medicaid rates are set unrealistically low by the State.

V. Operation of a Prospective Payment System

There are a wide variety of prospective payment systems operated in the acute-care and long-term care sectors.

A common element of a prospective rate payment setting mechanism is an allowable rate of increase in per diem cost for the following year. This percentage is normally calculated through application of economic indicates such as U.S. Department of Labor wholesale and consumer price

indexes. The percentage is then routinely applied to actual cost from the previous period to arrive at the prospective rate. Determination of allowable rates of increase can be undertaken for individual facilities or groups of facilities.

Another aspect of a prospective payment system is the degree of specificity in the use of cost categories and associated economic indicators combined with uniform reporting costs to the State. A breakdown of total cost into components presumably increases the accuracy of inflation forecasts. An obvious breakdown would be labor/non-labor and further categorization is possible within these areas. The advanced example which follows uses "natural" expense categories in contrast to cost centers normally found in facility accounting.

- Labor expenses
  - physician's fees
  - management
  - clerical
  - technical (e.g., LPNs', therapists)
  - registered nurses
  - household services (e.g., dietary, housekeeping workers)

- Non-labor expenses
  - food
  - utilities
  - drugs and supplies
  - maintenance of personnel
  - other

Some level of categorization is necessary to assure accuracy of prediction. While an approach such as that outlined above may be elected, it should be stressed that a requirement for facilities to prepare both historical and budget costs in this fashion requires a significant level of accounting time and expertise. The compromise approach shown below may often suffice:

- Salaries and fringe benefits

- Non-labor expenses
  - administrative and general
  - household and maintenance
  - dietary
  - professional care

There is precedent either to include or exclude "cost settlement" in a prospective payment system. The justification for cost settlement is that factors beyond the control of hospitals and nursing homes may adversely influence costs in relation to the prospective rate. These factors include changes in the general level of inflation, natural disasters and loss of patient volume. The major argument against allowing adjustment is that it may return the burden of cost increases possibly caused by poor management or budget procedures to the third-party payor, which is counter to the original objective of the

prospective payment concept. This matter has to be addressed by each state; however, an automatic adjustment is not recommended. Any adjustment mechanism should require written appeals, and defined criteria should be published as to the conditions under which an appeal will be considered.

VI. State Reimbursement Trends

To date, approximately thirty-four states have instituted a prospective system of reimbursement for nursing home services under Medicaid, and sixteen states have instituted a prospective system of reimbursement for hospital services under Medicaid. These prospective systems have taken many forms, each state's structure is a little different. However, they share the same philosophical purposes: "to encourage economy and efficiency, and to establish a uniform system of accounting, budgeting, and reporting in determining a health facility's future reimbursement".

VII. Why Alaska Needs Prospective Payment Now

* Total spending is growing at 20% each year in Medicaid/GR Medical.

In any period, total spending is always a function of, 1) the number of recipients, the volume of services used, and the unit price of service. With an automatic cost-of-living increase that expands Alaska's eligible population, coupled with no unit price control or volume limits, Alaska currently has no ability to effectively control growth in medical costs.

According to a recent study by THE URBAN INSTITUTE, Medicaid payments rose at an annual rate of 15.5 percent from FY73 to FY79 nationally. Alaska had the highest annual rate of increase at 41.8 percent during this same period. Since FY79, costs have increased in excess of 20% annually in Alaska.

These three factors (recipients, volume, and unit price) need to be considered collectively in any fiscal year.

Breakdown of FY84 Total Spending Increase

- Unit Price
- Increased Eligibles
- Services Utilization

_____ %

This clearly presents a serious problem in a retrospective environment as critical decisions concerning eligible populations, service coverages and unit price are handled independent of each other and do not produce a final cost figure until the fiscal year is past. If total spending is to be contained at a level below 20%, these choices must be made before each fiscal year starts.

- Federal funding for Medicaid is being reduced for FY84 and later years. The State is facing an estimated 4 to 5 million dollar cutback in federal funding for FY84. Absent additional funding to replace these lost federal revenues, critical decisions need to be made prospectively to bring program spending in line with available resources.

- Prospective Payment System cause decisions relating to unit price to be made before a fiscal year starts. A consensus is now developing that prospective rate setting is effective in lowering the rate of increase in hospital spending by several percentage points a year--at least in mature rate-setting programs, after an initial start-up periodof ___ years, after which the State can expect to see some minor savings. However, prospective payment will not eliminate the shortfall in medical spending for FY84 as the size of the projected shortfall is far larger than a 1 or 2% savings can offset. Rather, prospective reimbursement will force critical decisions governing eligible populations, service coverages and unit price to be resolved in the Legislative process in advance of each fiscal year. It will also cause the State to more precisely define its health care policy for all areas of Alaska, particularly in rural areas where the delivery of health care cannot be as competitive or cost-efficient as that possible in urban areas such as Anchorage and Fairbanks.

- The Legislature must specifically approve adoption of prospective payments in Alaska. The Alaska Attorney General has ruled that present Alaska Statutes preclude adoption of a prospective payment system. This leaves the Department in the position of needing either, 1) specific legislative approval to replace diminishing federal resources, or 2) specific approval to adopt a prospective payment system and specific guidance as to the resources available for medical care in FY84, or 3) Governor's guidance in how to impose a $4-5 million reduction in medical coverage and rates of payment in FY84. The Department may not adopt prospective payments until the Legislature specifically endorses this change in hospital and nursing home payment system.

Alaska State Legislature

Senate

Committee on Finance

September 12,1983

Senator Joe Josephson
921 West Sixth Ave, Rm 230
Anchorage, Alaska 99501

Health Care Facility
CERTIFICATE OF NEED PROGRAM

Dear Joe,

The health care facilities Certificate of Need Program study, as authorized by Senate Resolve 2, is now in the process of announcing public hearings on the subject.

Your name has been obtained from an assortment of materials which have been collected from the various legislators who have taken an active role in the State's Certificate of Need Program. Because of your past involvement with the CON process you may wish to continue your efforts and may be interested in participating in any of the following hearings:

September 22, 1983 - 2pm in Juneau - State Capitol Building - Butrovich Room

October 18, 1983 - 2pm in Fairbanks - Fairbanks Memorial Hospital - Eva McGown Room

November 3, 1983 - 2pm in Anchorage - Legislative Information Office - 1016 Sixth Avenue

If you are unable to attend any of the hearings but would still like to contribute input to the CON study, please do not hesitate to contact my office by phone (452-7624) or by writing (315 Barnette Street, Suite 103, Fairbanks, Alaska 99701).

Best Regards,

Senator Don Bennett

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

A. CERTIFICATE OF NEED REVIEWS COMPLETED

1. Lake Otis Clinic, Anchorage -- "Grandfathered CON" for 125 general acute care hospital; (issued 7/27/77)

2. Sitka Community Hospital, Sitka -- Review status of "Grandfathered CON" for new facilty; (six-month extension issued 12/31/78)

3. Lake Otis Clinic, Anchorage -- Review of status of "Grandfathered CON" for new facility; (six-month extension issued 12/31/78)

4. Fairbanks Memorial Hospital, Fairbanks -- Purchase and installation of laboratory information system; (information in archives)

5. Fairbanks Memorial Hospital, Fairbanks -- Application to Medical Facility Authority for bond sale; (information in archives)

6. Alaska Hospital and Medical Center, Anchorage -- Provide 21 bed chemcial dependency unit; (information in archives)

7. Juneau Regional Rehabilitation Facility, Juneau -- Construction of a 16 bed drug abuse/detoxification and rehabilitation facility; $654,000. (issued 6/7/79)

8. Providence Hospital, Anchorage -- Purchase and instalation of a simulator for radiation therapy; $195,365. (issued 9/4/79)

9. Providence Hospital, Anchorage -- Purchase and installation of a G.E. flouricon system; $285,000. (issued 2/14/80)

10. Lake Otis Clinic, Anchorage -- Review to determine status of "Grandfathered C/N"; (Bonified certificate status continued 3/10/80)

11. Fairbanks Memorial Hospital, Fairbanks -- Remodel of labor, delivery, and nursery areas; $540,000. (issued 2/26/80)

12. Central Peninsula Hospital, Soldotna -- expansion and improvement of facility (phase one); $6,762,646. (issued 4/2/80)

13. Providence Hospital , Anchorage -- Purchase and installation of a linear accelerator; $1,785,000. (issued 5/15/80)

14. Valdez Community Hospital, Valdez -- Purchase and installation of replacement radiology room; $150,000. (issued 5/15/80)

15. Seward General Hospital, Seward -- several energy saving construction projects; $286,113. (issued 10/6/80)

16. Valley Hospital, Palmer -- Minimal expansion and remodeling of facility; $2,000,000. (issued 6/9/80)

17. South Peninsula Hospital, Homer -- expansion and improvement of facility; $6,472,300. (issued 10/28/80)

18. Faith Hospital, Glennallen -- Expansion of outpatient areas of facility; $700,000. (issued 11/3/80)

19. Providence Hospital, Anchorage -- "Grandfathered C/N" for 250 bed acute care facility; (issued 5/1/81)

20. Alaska Hospital and Medical Center, Anchorage -- "Grandfathered C/N" for 199 bed acute care facility; (issued 12/4/81)

21. Sitka Community Hospital, Sitka -- 1122 review of diagnostic ultrasound services; $79,320. (five year lease with option to purchase) (issued 11/5/80)

22. Providence Hospital, Anchorage -- Replacement of radiology room; $236,000. (issued 12/26/80)

23. Juneau Regional Rehabilitation Facility, Juneau -- Remodel facility to meet hospital standards; $250,000. (issued 2/21/81)

24. Central Peninsula Hospital, Soldotna -- Purchase and installation of radiographic and fluorscopic imaging system; $305,899. (issued 5/21/81)

25. Wrangell General Hospital, Wrangell -- Renovation and Expansion of facility; $6,870,000. (issued 7/13/81)

26. Providence Hospital, Anchorage -- Purchase of replacement radiology room; $230,000. (issued 7/20/81)

27. Providence Hospital, Anchorage -- Construction of hostel for outpatients and family of inpatients; $900,000. (issued 7/29/81)

28. Petersburg General Hospital, Petersburg -- Renovation and expansion of facility; $7,150,000. (issued 8/11/81)

29. Alaska Hospital and Medical Center, Anchorage -- Purchase adjacent professional office building for expansion of chemical dependancy unit and other hospital areas; $15,236,000. (issued 9/24/81)

30. Central Peninsula Hospital, Soldotna -- Expansion of surgery and other areas of facility (phase two); $5,849,000. (issued 11/10/81)

31. Family Centered Birth, Juneau -- Construction of a birthing center; Review terminated following a Department of Law Opinion regardng applicability of C/N statute to birthing centers; (review terminated 12/22/81)

32. Alaska Treatment Center, Anchorage -- Construction of a new free-standing inpatient rehabilitation facility; $11,400,000. (denied, 1/22/82)

33. Valley Hospital, Palmer -- Construction of a new hospital adjacent to existing facility; $10,570,000. (issued 2/19/82)

34. Cordova Hospital, Cordova -- Construction of a new hospital at a new site; $15,075,000. (issued 4/13/82)

35. Providence Hospital, Anchorage -- Purchase and installation of a laboratory computer; $440,000. (issued 4/23/82)

36. Petersburg General Hospital, Petersburg -- Modification of previously issued CON, increase in space and expenditure; $2,005,000. (issued 5/18/82)

37. Fairbanks Memorial Hospital, Fairbanks -- Construction of new 5 floor patient tower, increase in acute care beds; $26,200,000. (issued 6/2/82)

38. Humana Hospital, Anchorage - Application for temporary certificate for expansion of chemical dependency unit; $1,000,000. (denied 6/28/82)

39. Providence Hospital, Anchorage -- Purchase and install replacement hospital incinerator; $200,000. (issued 7/20/82)

40. Humana Hospital Alaska, Anchorage -- Purchase and install CT full body scanner to replace CT head scanner; $848,000. (issued 10/1/82)

41. Advanced Health Systems, Anchorage -- Construct new free-standing Raleigh Hills alcoholism treatment hospital; $3,700,000. (issued 11/16/82)

42. Charter Medical Corporation -- Construct new free-standing psychiatric and substance abuse hospital; $12,248,000. (issued 11/16/82)

43. Providence Hospital, Anchorage -- Purchase and install replacement CT full body scanner; $832,000. (issued 11/16/82)

44. Providence Hospital, Anchorage -- Purchase and install new digital fluorography system; $256,000. (issued 11/30/82)

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

1. Providence Hospital, Anchorage -- Purchase and install new hospital information system; $2,698,000.

2. Providence Hospital, Anchorage -- Construct new 160 bed patient tower, increase acute care beds, add inpatient rehabilitation program, expand ancillary departments; $79,754,000.

3. Surgery Center, Inc., Anchorage -- Construct new free-standing ambulatory surgery center to replace current facility; $2,698,000.

4. Humana Hospital Alaska, Anchorage -- Renovation and expansion of emergency department; $1,012,200.

5. Humana Hospital Alaska, Anchorage -- Construction of new patient tower adjacent to existing hospital, 73 bed increase in acute care beds, addition of 20 bed inpatient rehabilitation program; $20,000,000.

6. Lake Otis Hospital, Anchorage -- Hearing to determine whether CON should be revoked; cost of project not identified. Decision - pending.

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

1. Valley Hospital, Palmer -- Termination of skilled nursing services. No further action by VH. (LOI dated 12/13/79)

2. Metlakatla Indian Community, Metlakatla -- construction of long term care facility. $200,000. No further action by MIC. (LOI dated 12/26/79)

3. Lake Otis Clinic, Anchorage -- Construction of 265 bed acute care/chemical deependancy hospital. $7,000,000.+ No further action by LOC. (LOI dated 2/14/80)

4. Providence Hospital, Anchorage -- Construction of 132 bed addition and expansion of services. $25,400,000. No further action by Providence. (LOI dated 3/31/80)

5. Health Care Services - Alaska, Anchorage -- Sale of Nakoyia Health Care Center. $14,200,000. No further action by HCS. (LOI dated 6/6/80)

6. Alaska Kidney Foundation, Anchorage -- Construction of a new facility for Alaska Kidney Center. Capitalized five year lease = $200,000. No further action by AKC. (LOI dated 6/23/80)

7. Norton Sound Regional Hospital, Nome -- Provision of family services unit. No further action by NSRH. (LOI dated 9/25/80)

8. Kodiak Island Hospital, Kodiak -- Offering of diagnostic ultrasound services. Decision - diagnostic radiology is a part of radiology department and not a new service; therefore, is not subject to CON review. (LOI dated 10/14/80)

9. Alaska Hospital and Medical Center, Anchorage -- Addition of 21 beds to chemical dependancy unit. No further action by AHMC. (LOI dated 10/21/80)

10. Alaska Hospital and Medical Center, Anchorage -- Purchase of professional office building for facility expansion; $10,000,000. (LOI dated 12/28/80)

11. Ketchikan Genceral Hospital, Ketchikan -- Replacement of computer system. $103,000. Decision - not subject to CON review. (LOI datded 2/11/81)

12. Ketchikan General Hospital, Ketchikan -- provision of recompression chamber. $55,000. Decision - not subject to CON review. (LOI dated 7/21/81)

13. Akeela House, Anchorage -- new building for residential drug abuse therapy program. $460,000. Decision - not subject to CON review. (LOI dated 8/4/81)

14. Ketchikan General Hospital, Ketchikan -- Offering of diagnostic ultrasound services. $70,000. Decision - not subject to CON review. (LOI dated 8/19/81)

15. Providence Hospital, Anchorage -- Predevelopment application for large construction project; $4,000,000. (withdrawn 10/8/81)

16. Humana, Anchorage -- Purchase of Alaska Hospital and Medical Center by Humana. $65,000,000. Decision - not subject to CON review. (LOI dated 11/13/81)

17. Comprehensive Care Corporation, Anchorage - Establishment of a 50 bed alcoholism and chemical dependency hospital in Anchorage. Letter of intent still valid through 2/16/83, however letter received from applicant // indicates that application was not expected to be submitted. (LOI dated 2/17/82)

18. Providence Hospital, Anchorage -- Offering of home health services; cost uncertain. Decision - subject to CON review. (LOI dated 1/19/82)

19. Kodiak Island Hospital, Kodiak - Purchase of gamma camera, $90,000. Decision - not subject to CON review. (LOI dated 2/10/82)

20. Humana Hospital, Anchorage - Relocation and expansion of chemical dependency unit, increase CDU from 21 beds to 36 beds; $1,000,000. Letter of intent withdrawn. (LOI dated 5/10/82)

21. Anchorage Community Mental Health, Anchorage - Establishment of residential transitional facility. Decision - not subject to CON review. (LOI dated 6/14/82)

22. Humana Hospital, Anchorage, Purchase of hospital data processing services; Decision - not subject to CON review. (LOI dated 10/11/82)

23. Penninsula Addiction Center, Inc., Soldotna - Establishment of new freestanding 12 to 24 bed substance abuse treatment facility; cost undetermined. Application anticipated. (LOI dated 5/14/82)

24. Bartlett Hospital, Juneau -- Construction of new patient tower, increase in acute care beds; $20,000,000. Application anticipated. (LOI dated 7/21/82)

25. Providence Hospital, Anchorage -- Purchase of new cardio-vascular imaging system; $820,000. Application anticipated. (LOI dated 10/1/82)

26. Providence Hospital, Anchorage - construction of employee child care center; $1,400,000. Decision - not subject to CON review. (LOI dated 10/14/82)

27. Sisters of Providence, Inc. Seattle - Purchase of Nakoyia Health. Care Center Applicability of certificiate of need requirement under review by Department of Law. (LOI dated 12/10/82)

ALPHA CENTERPIECE NOVEMBER-DECEMBER 1982
A report on health policy issues

SETTING AFFORDABLE LIMITS ON CAPITAL EXPENDITURES

A fundamental issue in any discussion of health care costs is the increasing demand for capital investment in the hospital industry. Projections of the need for hospital capital in the decade of the 1980s range from $80 billion to close to $200 billion. For the hospitals a major concern is how to gain access to the capital needed to finance future construction projects. But for the states the critical question is: how much of this capital investment can they afford?

Some states are exploring ways to limit capital spending in the health care industry through regulation. Others believe that under a competitive approach, market forces would inevitably control expenditures. Regardless of which strategy a state chooses, many observers predict that the supply of capital will be insufficient to meet all the competing demands. Thus, only a certain number of facilities will be able to get financing for their proposed projects. The concern about relying on the capital market as the "new regulator" is that the investor-owned and the well-established nonprofit hospitals will be favored in the marketplace. Inner-city and rural hospitals, especially public facilities, will be particularly disadvantaged, yet they may actually have a greater need for financing for capital projects.

In this issue of ALPHA CENTERPIECE, we look at how states can limit total capital spending by incorporating the concept of affordability into their regulatory programs. If states step in to regulate the level of capital investment, they may also be able to help direct the limited supply of dollars to those projects that are needed most.

Growth in Capital Demands

The capital demands of the hospital industry have increased significantly over the last 30 to 40 years, beginning with enactment of the Hill-Burton program in 1946. That federal program provided grants and loans to health care facilities for construction projects. Before World War II, hospitals depended mainly on philanthropy as the source for investment capital.

In the 1960s, passage of Medicare and Medicaid, as well as the expansion of private insurance, spurred further capital growth. Hospitals sought to invest in capital projects to meet the increased demand for services generated by the third-party payment programs. In providing reimbursement for depreciation and interest, the public and private insurance programs improved the financial stability of many hospitals, enabling them to finance construction and renovation through borrowing.

The incentives for debt financing increased, resulting in more demand for capital investment. Hospitals' access to borrowed funds was enhanced with the availability of tax-exempt revenue bonds in the 1960s. While direct funding and philanthropy declined as sources of capital financing in the hospital industry, debt financing rose from 38.7 percent in 1968 to 61.2 percent in 1979, according to a November 1981 article by R. Mullner in *Hospital Financial Management*.

Projected Increase in Capital Investment

Investment in hospital capital construction totalled $5.8 billion in 1980 and almost $50 billion in the years 1971-1980, according to the U.S. Bureau of the Census. For a variety of reasons the trend toward capital growth—financed mainly through debt—is expected to continue in the decade of the 1980s. Projections on the total capital investment vary widely. Michael Hernandez of Kidder, Peabody & Co., Inc., has estimated that total capital demands of community hospitals in this decade will reach $158 billion, assuming a bed capacity reduction of 15 percent; without a reduction, the total may exceed $190 billion, he predicted. Estimates of other analysts are lower. Donald Cohodes and Brian Kinkead, authors of a Johns Hopkins study on hospital capital formation, concluded that capital requirements in the 1980s will be no more than $100 billion, still about twice the level in the preceding decade.

One major factor for the expected increase in capital investment is the so-called "Hill-Burton bulge." Many facilities built in the 1950s and 1960s with Hill-Burton money will seek replacement or renovations in the coming years. Second, the current cost-based reimbursement system encourages additional capital investment and debt financing.

Another reason for continued growth in capital demand in this decade is the increase in population, particularly those 65 and over. Population increases mean greater hospital utilization, and the rate of utilization is much higher among the elderly. The expected continuing shift in the population to growth states will also create demand for additional capital investment. In

addition, some predict that the growing supply of physicians in the 1980s may generate increased demand for new facilities and services.

Finally, more capital will be demanded to finance the latest medical and technological innovations in equipment and services. A hospital's survival may depend on its ability to acquire the most up-to-date technological advances, as pointed out in the Johns Hopkins study.

Regardless of the estimate used, these pressures mean that the capital demand in the hospital industry will be substantial in the years ahead. But the amount of capital sought by the health facilities may outstrip the amount of capital available to them, and may far exceed what we can afford. Not only will the facilities have to compete among themselves for capital, they will have to compete with the demands for capital replacements and improvements from other public systems, such as transportation and sewers.

Impact on Health Care Costs

The cost of capital investment goes far beyond the money needed to finance specific projects. Because the current reimbursement system covers interest and depreciation expenses, capital financing has a profound impact on overall health care costs. The more demand there is for capital investment financed through debt, the higher the interest rates and therefore the level of costs reimbursable under the current payment system.

A hospital's capital expenditures can also add to its operating expenses. While capital investment in other industries is undertaken to reduce production costs, in the hospital industry "it is typically undertaken because the new technology promises to improve the quality of care, not reduce the cost," according to a paper entitled "State Limitation on Capital Expenditures by Hospitals Can Help to Contain Rising Hospital Costs," prepared by the Michigan Office of Health and Medical Affairs. "In fact, this improvement in quality usually adds to the costs of care; the new technology normally requires more intensive use of labor and other associated resources than the technologies it replaced," the Michigan document said.

A similar conclusion was reached in a study by Arthur D. Little, Inc. (ADL), conducted for the U.S. Department of Health and Human Services. "Hospital capital investment is contributing to the seemingly inexorable rise in the cost of health care as a percentage of GNP [Gross National Product]," concluded the ADL report titled "Development of an Evaluation Methodology for Use in Assessing Data Available to the Certificate of Need (CON) and Health Planning Programs."

Up to now the only tool states have had to control capital expenditures has been certificate of need. State CON laws are designed to curb health care costs by allowing approval of only those projects for which there is a demonstrated need. Some studies have found that CON can be effective in controlling health care costs, particularly institutional costs and especially when combined with other regulatory methods. But CON programs generally have little effect on the total statewide level of hospital capital spending. Even where CON laws have been shown to be effective in limiting specific capital expenditures, the total amount of investment approved is believed by many to be beyond what we can afford.

One reason for the failure of many CON programs to control health care costs is their focus on capital expenditures rather than on operating expenses, explained a paper entitled "New Approaches to Using the Determination of Need Processes to Contain Hospital Costs," prepared for the Massachusetts Department of Public Health. While operating costs and capital costs are linked directly through the reimbursement system's payment of depreciation and interest expenses, the Massachuesetts paper said, "no look at capital expenditures alone can measure the cost of a proposed project to the payment system."

Relative Need

Even with strong CON programs, most states are unable to keep total capital spending within affordable bounds because CON procedures apply "a test of absolute need," the Michigan paper said. Federal criteria for CON review require consideration of the direct and indirect costs of proposed projects, as well as their need, financial feasibility and other factors. For the most part, however, CON programs have concentrated on the criterion of need, resulting in approval of almost any project for which need can be demonstrated. Such an approach, said the Michigan document in describing the state's CON statute, "ignores the fact that all needs are relative. Resources are scarce, which means that no society can afford to devote resources to every use that promises some positive benefit."

To some extent many states have applied the idea of relative need to their CON process by reviewing applications for similar proposed projects in batches, evaluating them in relation to one another, as now required by federal regulation. Although such batching results in comparison of the relative needs of competing proposals, it does not compare those needs with the needs for other types of projects and other ways of delivering health care; it does not look at a proposal in the context of its effect on systemwide health care costs.

Because resources are limited, because there are limitations to what society can afford, "there must be priorities—even among 'needs'," according to the Massachusetts paper. If states are going to attempt to limit capital spending to an affordable level, they must evaluate the need for one proposed capital project in relation to the need for others, setting priorities and making tradeoffs.

Defining Affordability

Applying the concept of affordability means developing a capital expenditures budget, setting a limit on capital spending, and determining just how much the state is willing to allow for capital investment in the health care industry in rela-

tion to other public demands for capital. The decision to define that level "is basically a value judgment rather than a technical question," according to the Michigan publication. "The correct amount is the amount the people of the state believe balances the need for high quality medical care with the need to meet other socially desirable objectives." Once established, the level should be reviewed periodically to make sure the amount is not too high or too low, the document added.

There are a number of different approaches states can take in placing a cap on health facility capital expenditures. For instance, after establishing the amount of the cap, the state could rank all applications submitted, evaluating every proposed project in relation to all others. Such a process would involve comparing dissimilar projects and establishing priorities among them.

Another method is to determine a statewide budget and then to allocate that cap to specific regions. Under this system, proposals could be considered relative to similar applications in the region, or they could be ranked with all proposed projects in the region. This approach might include a provision to apportion over several years the cost of a very expensive project.

A problem with a regional cap is the design of an allocation formula that is equitable to all in the state. A number of characteristics of each region would have to be weighed against those in other areas. Among the factors that could be considered are: population size; population characteristics, especially relative age; patient admission patterns; age of physical plants; and relative construction costs.

Analysis of Effect on Operating Costs

Besides setting caps on capital expenditures, states can apply the affordability concept by analyzing proposed projects in terms of their effect on operating costs. For example, instead of limiting the total level of capital spending on a statewide or regional basis, states could establish limits on the operating costs generated by proposed projects. Such an approach is being considered in Massachusetts. Or states could establish maximum operating cost increases for specific types of projects, so that projects with operating costs above the established level would be disapproved or would be reimbursed only to the allowable limit.

Another option is to set facility-specific capital limits, a method now being tried in New Jersey. This approach could limit the total capital expenditures of a specific facility to a certain maximum percentage of its operating budget.

At the very least states can increase affordability analysis in the CON review process by focusing more on a project's impact on overall costs and by requiring applications to include, for example, an assessment of less costly alternatives and the effect on operating costs.

In the following examples we look at the approaches underway or being considered in three states to control health care costs by setting affordable limits on capital expenditures.

Moratorium, 5-Year Plan for Capital Allocation Proposed in New York

New York State's Blue Ribbon Panel on Capital Affordability has called for a one-year moratorium on all CON applications involving capital expenditures so as to allow the state to institute major revisions in the CON program. The proposed changes in the CON process, part of a package of recommendations submitted to Governor Hugh Carey in December, are aimed at applying the principles of relative need and affordability to help control rapidly accelerating capital expenditures in the state. Unless the state takes action, requests by hospitals for capital spending for replacement projects are expected to exceed $5 billion through 1984, the panel reported.

The committee, appointed by the Governor, included representatives of the business community, insurers, investment bankers and state policy councils. After reviewing the group's report, Governor Carey will offer his own recommendations to the new governor.

During the first six months of the moratorium proposed by the panel, acute and long-term care facilities would prepare five-year capital plans and budgets to be submitted to the HSAs and the Department of Health (DOH). At the same time, the state would develop a plan for resource allocation and a five-year projection on the availability of resources. DOH would analyze the institutions' and state's budgets and then, with the aid of the HSAs, complete a comprehensive, statewide five-year plan for capital resources allocation. The plan would set priorities among the capital projects expected to be needed over the period.

The panel also recommended that the existing CON review criteria —need, character, competence, and financial feasibility—be amended to include explicitly the concepts of relative need and affordability. Further, the committee suggested additions to the content of CON applications to increase affordability analysis.

To control the frequent rise in costs between preliminary approval and final permission to proceed with construction, the panel recommended that once a project clears both stages, the Rate-Setting Commission would establish the reimbursement rate for a three-year period. Any costs above the established rate would have to be absorbed by the applicant. The panel also recommended that if the cost of a proposed project exceeded the preliminary estimate by a specified percentage, the application would be returned to the first stage for further review.

The panel made a number of other recommendations, including a proposal for a guaranteed loan program to help financially distressed hospitals gain access to capital for critically needed projects.

New Jersey Applying Facility-Specific Capital Cap

Concerned over high interest rates and the impact of capital financing costs on overall health care costs,

New Jersey adopted a cap on interest rates in 1979 in the hope of stemming capital expenditures in the 1980s. Because of the "Hill-Burton bulge," almost 85 percent of hospitals in the state are expected to seek replacement between 1984 and 1987. But this approach—which "shut down everything, whether of value or not," said Gar Reed in the Department of Health's Health Economics Services—was abandoned after a year and replaced in 1981 with a cap on the ratio of capital reimbursement to total reimbursement. The limit on capital expenditures is applied on a hospital-by-hospital basis, rather than statewide. The advantage of this type of cap, Reed explained, is that it takes into account "the historical use of capital and it allows a hospital to adjust project size in relation to the price of capital, or interest rate."

The cap, adjusted annually, was set at 12.9 percent for 1982. To get that figure, department health economists took the ratio of capital reimbursement to total reimbursement for all hospitals in the state, distributed the ratios along a scale of low to high, and then used a point at the 97.5 percentile of distribution as the cap. Excluded from the calculations were hospitals with special arrangements to exceed the previous year's cap because of demonstrated efficiencies.

The cap is implemented through the CON review process. The state estimates a hospital's total reimbursement (including both operation and capital costs) for the first year in which a proposed project is expected to be in operation. If the ratio of capital reimbursement to total reimbursement exceeds the cap, the hospital has three options. First, it can demonstrate that the proposed project will result in cost efficiencies, thus reducing future operating costs. Or, the hospital can reduce the scope of the project, thus decreasing its cost. The third option is for the applicant to give reasons unrelated to cost why the project should be approved, such as it provides a much needed, albeit expensive, regional service.

The problem with the facility-specific approach, Reed said, is that it makes no direct effort to control overall capital spending in the state, to limit capital growth. What is needed, he said, is a way to set a growth target for the industry so as to smooth out over a ten-year period the rebuilding sought as a result of the "Hill-Burton bulge."

Capital Limit Based on Operating Costs Proposed in Massachusetts

A proposal under consideration in Massachusetts would incorporate the measure of affordability into the CON review process by setting a statewide limit on the total incremental costs associated with proposed new projects or services. Such a constraint on capital approvals would be the most effective way to limit "aggregate cost impacts on the hospital system," concluded the Work Group on Capital and Operating Cost Limits in its November 1982 report to the Governor's Health Care Cost Containment Coalition. In 1981, the state approved $217 million in hospital capital expenditures, 26 percent above the previous year. Pending requests currently total $750 million, most of which is for hospital plant replacement.

Although the work group did not suggest a specific budget figure, the coalition is expected to recommend to Governor King in its final report, due December 20, a limit of up to 2 percent of total operating costs associated with capital expenditures, according to William Decker, the coalition's staff director. A 2 percent cap would mean that about $240 million would be available. This figure was derived from the estimate by Blue Cross of Massachusetts that each $1.00 of capital cost approved annually means $.30 in new operating costs—$.19 of additional depreciation and interest and $.11 of additional operating expenses.

The advantage of linking capital costs to total incremental costs, the work group said in its report, is that "allowable capital cost increases will be a function of the rate of growth of operating costs in the hospital system." Such an approach will also encourage hospitals to contain their costs, thus promoting construction of the least expensive health care delivery modes and contributing to reduced interest expenses.

Under the plan proposed by the panel, the state cap would be allocated on a regional basis "to insure that quality and accessibility of care is maximized within that economic constraint." The proposal emphasized the role of proposed regional health care cost coalitions (RHCCCs) in helping the state to define local capital needs and to allocate the budget to hospitals in the region.

Another work group looked at interest expense and concluded that these costs could be reduced by requiring a certain percentage of equity contribution, based on the dollar size or type of proposed project.

Alpha Center, 7316 Wisconsin Avenue, Suite 400, Bethesda, Maryland 20814. 301-656-4260. Editor: Sarah Williams.

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northern alaska health resources association, inc.

February 03, 198.

The Honorable Joe Josephson
Alaska State Legislature
Pouch V (MS 3100)
Juneau, Alaska 99811

Dear Senator Josephson:

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

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

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

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

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

3. Expedite review of capital equipment replacement.

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

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

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

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

Sincerely,

J. B. Carnahan
President

JBC:flr

cc: William Sheffield
Governor

Robert London Smith, Ph.D.
Commissioner, DHSS

Alaska Health Coalition

Southeast Alaska HSA

South Central Health Planning
and Development, Inc.

SENATE HESS COMMITTEE OBSERVER/WITNESS SIGN-UP SHEET

DATE: 3/14/83 SPONSOR:

SUBJECT(S): SB 85 (HESS CS)

NAME	REPRESENTING	ADDRESS	PHONE	Observer	Witness		
Rodman Wilson MD	Municipality ANCH	Box 6-650 Anch 99502	264-4621		✓		
Ronald A. Pavellas	Alaska State Hospital Assoc.	JUNEAU	586-1790		✓		
Jim Burns	Bartlett Hospital	3260 Hospital Drive Juneau, AK 99801	586-2611		✓		
M. Treadwell	Blue Cross	605 Dimond Hill	344-2112				
Mason Anderson	DHSS	Room 309 AOB Juneau	364-3247	✓			
John Pugh	DHSS	Pouch H-01	465-3030		✓		
Rod Betit	DHSS/DPA	Pouch H-07	465-3355	✓			
~~Dennis~~ Elliott	Hospital Association	315 Seward St	586-1750		✓		
Sandy Stone	Sen. Sam Cole	Pouch V	465-4523	✓			

Give to Nancy ✓

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

September 13, 1983

Senator Joe Josephson, Chairman
Senate HESS Committee
1526 "F" Street
Anchorage, Alaska 99501

Dear Senator Josephson:

The attached paper is a review and summary of the current literature on swing bed/long term care services.

Since we are answering requests for copies of this paper from projects throughout the state, we thought you might be interested in receiving a copy. I hope you will find it helpful in your decision making.

Please don't hesitate to call this office if we can be of further assistance.

Sincerely,

Barbara Berger

Barbara Berger
Program Manager

BB/ab

Attachment

Need to check out

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

September 16, 1983

To: Senate and House HESS Members

From: Arlene Brovald for Barbara Berger

Enclosed is the paper on swingbed/long term care services which was inadvertently left out of Barbara Berger's letter of September 13, 1983. I apologize and hope this oversight has not inconvenienced you.

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

OVERVIEW OF
SWING BED CONCEPT

Introduction

The term "swing bed" refers to the use of hospital beds to provide both acute care and long term care depending on the need at any given time. The federal government has recently published regulations which allow for appropriate Medicare and Medicaid reimbursement to small rural hospitals who implement the swing bed concept.

This paper looks at the swing bed concept and nationwide program, how it has developed, what it offers, and advantages and/or disadvantages for hospitals in Alaska.

History

Prior to the advent of Medicare in the mid-1960s, most general hospitals offered comprehensive care that did not divide acute from extended care. Title XVIII of the Medicare legislation encouraged the development of freestanding extended care facilities that were designed primarily to shorten the hospital stays of patients over 65 who no longer required the intensity of hospital services. But the high cost of construction along with small populations precluded the practical development of long term care facilities in most rural areas. An irony, therefore, existed especially for small rural hospitals - while they typically had occupancy rates of less than 50%, there was a shortage of long term care beds.

In Utah in 1973 and later in South Dakota, Iowa and Texas, an experimental program was initiated whereby 25 rural hospitals with 10 to 95 beds and an occupancy of under 60% were permitted to use beds that were consistently empty for long term patients on a continuing or an intermittent basis, depending on need. Extensive evaluation of these experiments by HCFA showed that hospitals with swing bed programs could offer long term care services to patients in a cost-effective manner without sacrificing quality of care.

In the Omnibus Reconciliation Act of 1980, Congress amended Titles XVIII and XIX of the Social Security Act to provide that hospitals may enter into an agreement with the Secretary "under which its inpatient hospital facilities may be used for the furnishing of services of the type which, if furnished by a skilled nursing facility, would constitute extended care services". Regulations implementing this swing bed program were published in the July 20, 1982 Federal Register. The program is now receiving a great deal of national attention and support. While the guidelines for participation are set, there is no question that with increasing feedback on its effectiveness, the program will expand and be modified through future regulations.

Eligibility and Requirements

In order for a hospital to be eligible to receive Medicare and Medicaid reimbursement for the provision of long term care services, several conditions must exist:

- .The hospital must be located in a rural area.
- .The institution must have fewer than 50 acute care beds (excluding bassinets and intensive-care unit beds).
- .A swing bed hospital may not have in effect a 24-hour nursing waiver; a registered nurse must be present in the hospital at all times.
- .If the hospital does not already offer long term care, it is considered a "new service" and would require a Certificate of Need.

The federal regulations state that eligible hospitals are required to meet six standards (in addition to those required for acute care) to qualify for Medicare reimbursement under the swing bed program. These standards are:

- .Patients' rights. For example, "a patient must be fully informed of available services, and a patient may be transferred or discharged when medically necessary or when such action is in the best interest of that or other patients".
- .Specialized rehabililative services. Services such as occupational therapy and physical therapy must be available (within the hospital or by consulting contract) as needed by the patients.
- .Social Services. The social and emotional needs of the long term care patient are especially important and must be provided for either in-house or on referral arrangements by a qualified social worker.
- .Patient activities. A qualified patient activities coordinator (e.g. a Physical therapist or Occupational therapist) must be designated to promote the physical, social, and mental well-being of patients.
- .Dental Services. A hospital must establish an agreement with a dentist to consult in staff education for nursing and other appropriate personnel and to recommend oral hygiene policies and practices in the care of patients.
- .Discharge Planning. An organized discharge planning program must exist and be evaluated by the hospital's utilization review committee.

Reimbursement

Swing bed programs offer opportunities for hospitals to improve their cash-flow problems by offering a reliable source of operating revenues for previously empty beds or during times of census fluctuations. Once a hospital meets the eligibility and service requirements, it will be able to bill federal (Medicare) and state (Medicaid) insurers for swing bed services. In general swing bed services are subject to the same coverage requirements and coinsurance provisions that apply to skilled nursing facilities.

The method of reimbursement outlined in the regulations is called a

"carve-out" method. The rate is established based on the previous year's Medicaid rate for SNF and ICF, and Medicare will be computed based on the hospital's routine service costs (revenues from ancillary services are handled and reimbursed separately as they are for acute care). Swing bed costs not covered by Medicaid SNF and ICF rates will be included in the hospital routine cost base and potentially be recovered through inpatient acute care rates. At present only minimal alterations of a hospital's financial system are required to implement a swing bed program.

Advantages and Disadvantages

The swing bed program provides a unique opportunity for small hospitals in rural areas to offer expanded services in their communities. The elderly (over 65) population is projected to grow at twice the rate of the total population during the 1980's. Since this is the population group most likely to utilize a swing bed program, the availability of this kind of program could be a valuable community resource as well as an additional source of revenue to a hospital. In addition to the fact that patients would not have to be transferred away from familiar surroundings it would also be a cost savings to family and friends who support the long term care patient.

The cost savings of not building a separate facility are significant to the community. For the rural hospitals that lack the economy of scale and shared services available to their urban counterparts, the advantages of the swing bed concept include increased efficiency of staff and greater economy from such departments as pharmacy.

Implementation of a swing bed program can be an incentive to small hospitals to diversify even more into such services as home health care, adult day care, and hospice to name a few.

With all the apparent advantages, there are also some potential problems with a swing bed program. Most of these were realized during the development years in the experimental projects. Summarized, these areas of possible concern are:

- .Additional professional staff required for the program may not be readily available.
- .Orientation of care for long term care patients is very different from short term care and may be a difficult transition for regular staff to do well.
- .Visiting patterns differ for acute care patients (frequent) and long term care patients (less frequent) and some long term patients can become a drain on staff.
- .Long term patients often have multiple problems that are frequently accompanied by antisocial behavior.
- .Remaining in the same bed (wing, or institution) while transiting from acute to long term care can confuse the patient's (and family's) expectations for care.
- .Even with the carve-out method for calculating expenses, long term care in a swing bed program is more expensive per bed than care in an existing SNF, based on the calculation of total costs as they are spread over the whole operation.

.Though quality of care is difficult to formally "regulate", reports from the experiments indicate that the facility, patient, and problem measures of the quality of care were significantly higher for comparison nursing homes than the experimental swing bed programs.

There may be, of course, many more potential problems, but despite all of those encountered in the experimental programs, the program is still recommended by national program observers.

Conclusion

Taking into account all of the above information, the decision to implement a swing bed program should obviously be done only after a careful examination of a hospital's situation (a feasibility study) and comprehensive in depth planning throughout the process. The following are ten major areas for consideration in the feasibility study and planning process (not necessarily in sequence or order of importance).

1. Hospital occupancy If the annual utilization rate is relatively high (60-70%), it is not likely that participation in a swing bed program would be substantial. Also there may be more need for flexibility for acute care use if use fluctuations are high or in case of an emergency.
2. Nursing home occupancy If nursing homes in a hospital's community are underutilized and provide adequate care, then a swing bed program may not be needed.
3. Physician acceptance If, after becoming familiar with the swing bed concept, physicians are neither neutral nor positive about attempting a swing bed program, it will probably prove impossible to implement successfully.
4. Reimbursement An understanding and acceptance of the carve-out method of reimbursement is necessary to implement a comprehensive approach to swing bed care. Those who are against this approach to reimbursement should perhaps not become involved in swing bed care.
5. Nursing staff acceptance The evaluation studies on the experimental programs have shown that, with experience, nurses have become increasingly impressed with the value of providing long term care in acute care beds. However, just as with physicians, if the nurses believe that the program should not be undertaken, it probably shouldn't.
6. Community acceptance and understanding Discussions regarding the potential for swing bed care should start with the hospital board, then other community health providers, and other interested community organizations and individuals. Aim for full understanding.
7. Utilization projections A reasonable number of beds to be designated and patient days utilization can be made by talking to nursing homes, physicians, interested public and home health nurses. Designating more beds than can reasonably be expected to be used may create unnecessary anxiety on the hospital staff and allow for possible over use before all details of the transition are tested and evaluated. Once a shospital has a swing bed program more beds can easily be added as needed.

8. Appropriateness of long term care Especially, the question of whether the hospital wants to offer long term care services along with acute care. This is true for hospitals that have no experience in long term care or keep staff's separate awareness of how the services differ is important. The hospital must foster a new , different environment of learning, adaptiveness, program development, a concept because any swing bed program will take at least two to three years to mature.
9. Regulatory requirements A hospital must be willing and able to follow all of the requirements of the program (see references).
10. Use of resources for planning When all of the above have been thoroughly considered there will undoubtedly be many questions that this short overview cannot answer. Below is a listing of sources of additional information.

.John Supplitt, Project Director
American Hospital Association Center for Small and Rural Hospitals
Telephone (312) 280-6400

.Dan Meddleton, Director
State Health Planning and Development Agency
DHSS
Telephone (907) 465-3082

.Portia Kaufman, Manager
Division of Health Facilities Certification and Licensing
Telephone (207) 561-4350

.Your respective Health Systems Agency:

South Central Health Planning and Development, Inc.
Telephone (907) 278-3631

Northern Alaska Health Resources Association
Telephone (907) 456-2553

South East Alaska Health Systems Agency
Telephone (907) 225-9631

References

1. Omnibus Reconciliation Act of 1980 (Public Law 96-499)-Amendments to Titles XVIII and XIX of the Social Security Act.

2. Federal Register, Vol. 47 # 139, Tuesday, July 20, 1983, PP. 31518-31528.

3. "Program Information Letter", Bureau of Health Planning, U.S. Department of Health and Human Services, # 82-24, September 20, 1982.

4. Technical Assistance Memo #71, "Rural Hospital Diversification Strategies: by E. Anthony Golda MPH, Western Center for Health Planning. January 15, 1981

5. Volunteer Memo # 1, "Planning for Health Facilities: A Conceptual Overview" by Joseph P. Peters. Western Center for Health Planning. February 25, 1981.

6. An Evaluation of Swing Bed Experiments to Provide Long Term Care in Rural Hospitals. Volumes 1 and 11, Center for Health Services Research, University of Colorado Health Sciences Center, March 1980.

7. A Position Paper on Swing-Bed Care in Hospitals by Ann Trickler, Center for Health Services Research, Univeristy of Colorado Medical Center, June 15, 1979.

8. Small or Rural Hospital Report, Vol 6 #4, American Hospital Association. 1982.

9. Small or Rural Hospital Report, American Hospital Association, January February, 1983.

10. Small or Rural Hospital Report, American Hospital Association, March-April, 1983.

11. "Small Hospitals find Swing Beds Profitable", by Dr. Bruce A. Walter, J.Donald West, and Mark D. Elggren, HCFA Forum, June 1980.

12. "Swing Beds Can Work - With Good Planning", by Dulcey B. Miller, Hospitals, May 16, 1980.

13. "Swing Beds meet Patient's Needs and Improve Hospitals Cash-Flow. Hospitals, July 1, 1982

14. Swing Bed Series:
    .Swing Beds: New Diversification Opportunity for Small and Rural Hospitals, by John T. Supplitt
    .Quality Assurance: Evaluating Services of Small Swing Bed Hospitals, by William F. Jessee, MD.
    .Reimbursement: Carve-out Method Benefits Swing Bed Hospitals, by Fran Pennell.
    .Planning: Implementing New Swing Bed Programs, by Peter W. Shaughnessy and Robert E. Schlenker.
    Hospitals, pp. 67-90, November 16, 1982

Give to Nancy

Alaska State Legislature

Senate

Committee on Finance

Official Business

September 12,1983

Pouch V
State Capitol
Juneau, Alaska 99811

Senator Joe Josephson
921 West Sixth Ave, Rm 230
Anchorage, Alaska 99501

Health Care Facility
CERTIFICATE OF NEED PROGRAM

Dear Joe,

The health care facilities Certificate of Need Program study, as authorized by Senate Resolve 2, is now in the process of announcing public hearings on the subject.

Your name has been obtained from an assortment of materials which have been collected from the various legislators who have taken an active role in the State's Certificate of Need Program. Because of your past involvement with the CON process you may wish to continue your efforts and may be interested in participating in any of the following hearings:

September 22, 1983 - 2pm in Juneau - State Capitol Building - Butrovich Room

October 18, 1983 - 2pm in Fairbanks - Fairbanks Memorial Hospital - Eva McGown Room

November 3, 1983 - 2pm in Anchorage - Legislative Information Office - 1016 Sixth Avenue

If you are unable to attend any of the hearings but would still like to contribute input to the CON study, please do not hesitate to contact my office by phone (452-7624) or by writing (315 Barnette Street, Suite 103, Fairbanks, Alaska 99701).

Best Regards,

Senator Don Bennett

DB/kf

RECEIVED
SEP 1 - 1983

Josephson.

Give to Nancy ✓

ANCHORAGE INFANT LEARNING PROGRAM

Alaska Treatment Center
3710 East 20th Avenue
Anchorage, AK 99504
(907) 272-0586 Ext. 42 & 43

SEptember 16, 1983

Senator Joe Josephson
1526 F St.
Anchorage, AK 99501

Dear SEnator Josephson:

Anchorage area legislators have been valuable allies to Infant Learning Programs throughout the state. Your assistance in funding our programs has had a tremendous impact on our ability to serve families with disabled children.

The Anchorage Infant Learning Program was started in 1976 to provide expert training for parents in early intervention techniques. The home-based nature of the program allows parents and siblings the opportunity to improve the skills and potentials of a disabled child in a healthy and normal setting.

Each year since 1976 the number of clients needing appropriate training has increased, yet the budget has not kept pace. This past year the Anchorage program has tripled its projected case load. More than 350 families are expected to be served in FY 84.

One of the reasons for this increase is due to significant developments in prenatal and postnatal care. The number of premature infants surviving in Anchorage has grown at an enormous rate. The services provided by the Anchorage Infant Learning Program are exciting and we would like to share that excitement with you and your staff. During the week of October 3 - 7 we hope to schedule a time for you or a key staff member to share in a home visit with a member of our staff. We will be in touch next week to schedule a time if you are interested. Again, thank you for your continued support.

Sincerely,

Mary Carr

Mary Carr
Director of Infant Learning

/bp

cc: Josef Reum, Handicapped Services Coordinator

PLEASE NOTE: THE FOLLOWING PAGES WERE TREATED AS A UNIT IN THE ORIGINAL DOCUMENT

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

To: Persons interested in the new Swing Bed concept

From: Susan Callan, Project Review Staff Susan Callan

Subject: Introduction to Swing Bed Concept Paper

Date: August 15, 1983

You may be involved (now in the near future) in making decisions about swing bed/long term care services.

The attached paper is a review and summary of the current literature. I hope you will find it helpful in your decision making.

Please don't hesitate to call this office if we can be of further assistance.

SMC/ab

Attachment

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

OVERVIEW OF SWING BED CONCEPT

Introduction

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This paper looks at the swing bed concept and nationwide program, how it has developed, what it offers, and advantages and/or disadvantages for hospitals in Alaska.

History

Prior to the advent of Medicare in the mid-1960s, most general hospitals offered comprehensive care that did not divide acute from extended care. Title XVIII of the Medicare legislation encouraged the development of freestanding extended care facilities that were designed primarily to shorten the hospital stays of patients over 65 who no longer required the intensity of hospital services. But the high cost of construction along with small populations precluded the practical development of long term care facilities in most rural areas. An irony, therefore, existed especially for small rural hospitals - while they typically had occupancy rates of less than 50%, there was a shortage of long term care beds.

In Utah in 1973 and later in South Dakota, Iowa and Texas, an experimental program was initiated whereby 25 rural hospitals with 10 to 95 beds and an occupancy of under 60% were permitted to use beds that were consistently empty for long term patients on a continuing or an intermittent basis, depending on need. Extensive evaluation of these experiments by HCFA showed that hospitals with swing bed programs could offer long term care services to patients in a cost-effective manner without sacrificing quality of care.

In the Omnibus Reconciliation Act of 1980, Congress amended Titles XVIII and XIX of the Social Security Act to provide that hospitals may enter into an agreement with the Secretary "under which its inpatient hospital facilities may be used for the furnishing of services of the type which, if furnished by a skilled nursing facility, would constitute extended care services". Regulations implementing this swing bed program were published in the July 20, 1982 Federal Register. The program is now receiving a great deal of national attention and support. While the guidelines for participation are set, there is no question that with increasing feedback on its effectiveness, the program will expand and be modified through future regulations.

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The method of reimbursement outlined in the regulations is called a

Alaska State Legislature

Senate

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

September 15, 1983

Senator Don Bennett
315 Barnette Street, Suite 103
Fairbanks, Alaska 99707

Dear Senator Bennett:

Thank you for your letter concerning Certificate of Need hearings, as I've maintained a considerable interest in the topic having closely followed this issue in my three years with the HESS Committee. I hope the materials lent to your research were valuable, and I am sorry that I turned the many national reports collected since 1981 over to the state library. Both NCSL and the Health Care Financing Administration are excellent resources on CON studies.

Because of other commitments, I will not be able to attend the hearings in Juneau and Anchorage but I would be very interested in the directions of the testimony if you put together any final data.

I have recently received a research paper, attached, on the "swing bed" concept of Medicare and Medicaid payments and their requirements through regulation, which include a Certificate of Need process. Swing beds would allow rural hospitals to use beds as acute or long term care, depending on the current need, increasing both occupancy rate and revenues. Since this option has been discussed for Alaska in the past, I thought it may be of interest to the committee.

Sincerely yours,

Nancy Deirrick
Senate HESS Committee Aide

Official Business

Alaska State Legislature

Senate

Committee on Finance

Pouch V
State Capitol
Juneau, Alaska 99811

September 12, 1983

Nancy Dietrick
c/o SENATOR JOE JOSEPHSON
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Health Care Facilities
CERTIFICATE OF NEED PROGRAM

Dear Nancy:

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If you are unable to attend any of the hearings but would still like to contribute input to the CON study, please do not hesitate to contact my office by phone (452-7624) or by writing (315 Barnette St., Suite 103, Fbks, AK. 99701).

Best regards,

Senator Don Bennett

DB/jan

PLEASE NOTE: THE PRECEDING PAGES WERE TREATED AS A UNIT IN THE ORIGINAL DOCUMENT.

NOTICE OF ADOPTION OF EMERGENCY REGULATIONS
BY THE DEPARTMENT OF HEALTH & SOCIAL SERVICES

As required by AS 44.62.250, notice is given that, under authority vested by AS 47.05.010, 47.07.050, and section 8, ch. 95, SLA 1983, the Department of Health and Social Services adopted on this date, as emergency regulations, new regulations, amendments of regulations, and repeals of various sections of 7 AAC 43 relating to the establishment of an interim prospective payment system for the Medicaid and General Relief Medical programs.

This action is not expected to require an increased appropriation.

Copies of these regulations may be obtained by writing or calling Kimberly Busch, Medical Assistance Program Officer, Division of Public Assistance, Pouch H-07, Juneau, Alaska 99811, (907) 465-3347.

The Department expects that permanent regulations will be adopted in the future to establish a prospective payment system under the Medicaid Rate Commission. However, if it does not appear that the Commission is ready to adopt those regulations before the end of the 120-day limit of effectiveness of these emergency regulations, the Department will provide public notice of a hearing and comment period necessary to make these emergency regulations permanent, until such time that the Commission adopts regulations.

DATE: 10/18/83

Juneau, Alaska

Robert London Smith

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

7 AAC 43.040(b) is amended to read:

(b) Repealed / / .

7 AAC 43.090 is amended by adding new paragraphs to read:

(23) "facility" means a hospital, SNF, ICF, ICF/MR, rehabilitation facility, inpatient psychiatric facility, home health agency, rural health clinic, and outpatient surgical clinic;

(24) "commission" means the medicaid rate commission authorized by AS 47.07.110 -- 47.07.190. (Eff. 8/18/79, Reg. 71; am / / , Reg.)

Authority: AS 47.05.010
AS 47.07.050
AS 47.07.080
AS 47.07.195

7 AAC 43.170 is amended to read:

7 AAC 43.170. CONDITIONS FOR PAYMENT. (a) Requirements for payment under medicaid as a SNF or ICF are that

(1) the facility has been certified by the division as in compliance with federal certification requirements

(A) SNF certified for medicaid -- certification is by the division for the federal Department of Health and Human Services,

(B) ICF -- certification is by the division;

(2) a level-of-care decision has been made by the division or fiscal agent indicating that the beneficiary requires the level of care that the facility is certified to provide;

(3) there be a current provider agreement on file with the division

(b) Payment will be made by the division in accordance with 7 AAC 43.675 -- 7 AAC 43.707. (Eff. 8/18/79, Reg. 71; am / / , Reg.)

Authority: AS 47.05.010
AS 47.07.050
AS 47.07.070

7 AAC 43.215(a) is amended to read:

(a) Payment will be made by the division in accordance with 7 AAC 43.675 -- 7 AAC 43.707. (Eff. 8/18/79, Reg. 71: am / / , Reg.)

Authority: AS 47.05.010
AS 47.07.050
AS 47.07.070

7 AAC 43.235(a) is amended to read:

(a) Payment by the division is payment in full for those services authorized under medicaid. If the facility obtains from another source any additional payment for the care provided to a beneficiary for services that have been paid for by medicaid, it is the obligation of the facility to refund or credit the additional payments to the division. (Eff. 8/18/79, Reg. 71; am / / , Reg.)

Authority: AS 47.05.010
AS 47.07.070

7 AAC 43.240 is amended to read:

(a) Payment will be made by the division in accordance with 7 AAC 43.675 -- 7 AAC 43.705.

(b) Rates will not be issued to out-of-state facilities. Payment for care in out-of-state facilities will be made under the general provisions of the rules established by the medicaid state agency in the state where the facility is located. (Eff. 8/18/79, Reg. 71; am / / , Reg.)

Authority: AS 47.05.010
AS 47.07.070

7 AAC 43.310(3) is amended to read:

(3) comply with the requirements of 7 AAC 43.675 -- 7 AAC 43.705. (Eff. 8/18/79, Reg. 71; am / / , Reg.)

Authority: AS 47.05.010
AS 47.07.070

7 AAC 43.360 is amended to read:

7 AAC 43.360. PAYMENT. (a) Payment will be made by the division in accordance with 7 AAC 43.675 -- 7 AAC 43.705.

(b) Payment will be made for the day of admission but not for the day of discharge, transfer, or death.

Authority: AS 47.05.010
AS 47.07.050
AS 47.07.070

7 AAC 43.365 is amended to read:

7 AAC 43.365. CONDITIONS FOR PAYMENT. To receive payment under medicaid, a hospital must

(1) must be licensed under state law;

(2) comply with the requirements of 7 AAC Chapter 43;

(3) have a division-approved plan of utilization review. (Eff. 8/18/79, Reg. 71; am / / , Reg.)

(4) have a current provider agreement on file with the Division

Authority: AS 47.05.010
AS 47.07.050

7 AAC 43.400(a) is amended to read:

(a) Repealed / / .

7 AAC 43.400(b) is amended to read:

(b) Repealed / / .

7 AAC 43.560(2) is amended to read:

(2) comply with the requirements of 7 AAC 43.675 -- 7 AAC 43.705. (Eff. 8/18/79, Reg. 71; am / / , Reg.)

Authority: AS 47.05.010
AS 47.07.050

7 AAC 43.675 is amended to read:

7 AAC 43.675. ALLOWABLE REIMBURSEMENT COSTS. (a) Until June 30, 1983, payment to a facility will be governed by the medicare cost reporting principles contained in 42 CFR 405.401 -- 405.488 (which are further clarified through the Medicare Provider Reimbursement Manual, HIM-15 published by the Health Care Financing Administration), medicaid cost reporting principles contained in 42 CFR 447.250 -- 447.371, and 7 AAC 43.675 -- 7 AAC 43.705.

(b) Payment to a facility whose fiscal year begins on or after July 1, 1983, will be governed by AS 47.07.070 and Section 2 of Chapter 95, SLA 1983.

Authority: AS 47.05.010
AS 47.07.050
AS 47.07.070

7 AAC 43.680 is amended to read:

7 AAC 43.680. COST REPORTING. (a) A facility must file an annual cost report, as follows:

(1) A reporting period of less than one year may be allowed for a facility entering the program after the beginning of its established fiscal year, or for a facility terminating its participation in the medicaid program before the end of its fiscal year;

(2) If a facility is enrolled for participation in both medicare medicaid, the annual reporting period under this section must conform to that required by the medicare program;

(3) A facility must submit its cost report, including a copy of its annual financial statement and a copy of its medicare cost report, to the division within 90 days after the close of the facility's fiscal year. An extension of 30 days may be granted by the division upon timely application;

(4) Upon change of ownership at a time other than the end of a facility's fiscal year, a facility must file a cost report within 120 days.

(b) The cost report is to be completed on forms prescribed by the division. (Eff. 8/18/79, Reg. 71; am / / , Reg.)

Authority: AS 47.05.010
AS 47.07.050
AS 47.07.070
AS 47.07.071

7 AAC 43.685 is amended to read:

7 AAC 43.685. MEDICAID AUDIT SECTION. All reports are to be submitted to the medicaid audit section of the division. The medicaid audit section is responsible for

(1) reviewing cost reports;

(2) making recommendations concerning the division's annual cost settlement with each facility; and

(3) providing information upon which the division establishes the rate to be paid a health facility under 7 AAC 43.675 -- 7 AAC 43.705. (Eff. 8/18/79, Reg. 71; am / / , Reg.)

Authority: AS 47.05.010
AS 47.07.050
AS 47.07.070
AS 47.07.071

7 AAC 43.690(a) is amended to read:

7 AAC 43.690. ANNUAL COST SETTLEMENT. (a) Cost settlement for a facility for services before July 1, 1983, will be made when desk review of its cost report is completed by the medicaid audit section. At the discretion of the division, the full amount necessary to accomplish the settlement will be paid by the division or the facility within 30 days of submittal of a completed cost report. (Eff. 8/18/79, Reg. 71; am / / , Reg.)

Authority: AS 47.05.010
AS 47.07.050
AS 47.07.070

7 AAC 43.700 is amended to read:

7 AAC 43.700. AUDIT AND INSTITUTIONAL REVIEW. (a) As a condition of participation in the medicaid program, a facility under 7 AAC 43.675 -- 7 AAC 43.705 must provide reasonable access to fiscal and patient care records for all medicaid beneficiaries.

(b) A facility must allow inspection of its records by authorized representatives of state and federal agencies which administer the medicaid program.

(c) Repealed / / .
(Eff. 8/18/79, Reg. 71; am / / , Reg.

Authority: AS 47.05.010
AS 47.07.050
AS 47.07.070

7 AAC 43 is amended by adding new sections to article 12 to read:

7 AAC 43.701. INTERIM PROSPECTIVE PAYMENT SYSTEM. (a) The provisions of 7 AAC 43.685 -- 7 AAC 43.705 implement the interim prospective payment system for facilities for state fiscal year 1984 as required by section 8, ch. 95, SLA 1983.

(b) The interim prospective payment system will apply to a facility beginning July 1, 1983. (Eff. / / , Reg.)

Authority: AS 47.05.010
AS 47.07.050
Sec. 8, ch. 95, SLA 1983

7 AAC 43.702. INTERIM PROSPECTIVE PAYMENT RATE. (a) The division will set an interim prospective payment rate for a facility participating in the interim prospective payment system.

(b) For a facility with a fiscal year ending June 30th that receives payment on a per-diem basis, the facility's rate in use on June 30, 1983 will become the rate which, when increased by an annual inflation factor of 8 percent, will be the interim rate until the Commission establishes a rate or the rate is adjusted pursuant to 7 AAC 43.703.

(c) For a facility with a fiscal year ending June 30th that receives payment on a percentage-of-charges basis, the division will continue to use the percent in use as of June 30, 1983 until revised by the Commission or by the Division pursuant to 7 AAC 43.703.

(d) For a facility with a fiscal year that ends after July 1, 1983, payment will be made to the facility at the present per diem or percent-of-charges rate until revised by the Commission or by the Division pursuant to 7 AAC 43.703.

7 AAC 43.703. ADJUSTMENT OF INTERIM PROSPECTIVE PAYMENT RATE.
(a) The division may adjust an interim prospective payment rate upon the request of a facility if

(1) the facility is sold;

(2) an extraordinary circumstance occurs such as damage from fire, natural disaster, or breakdown of major equipment necessitating repair or replacement;

(3) the facility will experience a substantial change in costs that reasonably will not be met by the previously established rate.

(4) a significant mathematical, mechanical, or clerical error exists in financial data submitted by the facility.

(b) The division will review the documented requests and consult with the representative of the facility and approve, deny, or propose modifications to the adjustment within 30 days after receipt of all information required. Adjustments shall be effective July 1, 1983 and retroactive payment will be made as soon as possible. (Eff. / / , Reg.).

(c) Interim prospective rates established pursuant to 7 AAC 42.702 or this section shall be subject to review and further revision by the Medicaid Rate Commission, when it is formed, if a facility applies for a revision.

Authority: AS 47.05.010
AS 47.07.050
Sec. 8, ch. 95, SLA 1983

7 AAC 43.704. DEFINITIONS. In 7 AAC 43.675 -- 7 AAC 43.707

(1) "interim prospective payment rate" means the payment rate established by the division to implement the interim prospective payment system;

(2) "percentage of charges" means a payment that is a percent of the usual and customary charges of a facility for services provided to the general public;

(3) "per-diem rate" means the rate approveded by the Division for each day of services provided by the facility.
(Eff. / / , Reg.)

Authority: AS 47.05.010
AS 47.07.050
Sec. 8, ch. 95, SLA 1983

7 AAC 43.705. APPEAL. A facility that disagrees with the interim prospective payment rate established under 7 AAC 43.675 -- 7 AAC 43.705 may appeal the rate determination under 7 AAC 43.085. (Eff. / / , Reg.)

Authority: AS 47.05.010
AS 47.07.050
Sec. 8, ch. 95, SLA 1983

7 AAC 43.805 is amended by adding a new subsection to read:

(d) Payment will be made by the division in accordance with 7 AAC 43.675 -- 7 AAC 43.705. (Eff. 8/18/79, Reg. 71; am / / , Reg.)

Authority: AS 47.05.010
AS 47.07.050

7 AAC 43.810. BILLING RATE. Repealed / / .

7 AAC 43.850(3) is amended to read:

(3) comply with the requirements of 7 AAC 43.675 -- 7 AAC 43.705. (Eff. 8/18/79, Reg. 71; am / / , Reg.)

Authority: AS 47.05.010
AS 47.07.050

7 AAC 43.880 is amended to read:

7 AAC 43.880. CONDITIONS FOR PAYMENT. For payment under medicaid, an outpatient surgical clinic must:

(1) have a system to transfer patients requiring emergency admittance or overnight care to a fully-licensed, medicaid enrolled facility following any surgical procedure performed at the outpatient surgical clinic;

(2) comply with the requirements of 7 AAC 43.675 -- 7 AAC 43.705;

(3) have a division-approved plan of utilization review. (Eff. 8/18/79, Reg. 71; am / / , Reg.)

(4) have a current provider agreement on file with the Division.

Authority: AS 47.05.010
AS 47.07.050

7 AAC 43.885 is amended to read:

7 AAC 43.885. PAYMENT. Payment for services rendered by an outpatient surgical clinic to beneficiaries will be paid in accordance with 7 AAC 43.675 -- 7 AAC 43.705. This payment fee covers all operative functions attendant to medically-necessary surgery performed at the center by a private physician or dentist, including admitting and laboratory tests, patient history and examination, operating room staffing and attendants, recovery room care, and discharge. It includes all supplies related to the surgical care of the beneficiary while in the center. The payment excludes the physician, radiologist, or anesthesiologist fee. (Eff. 8/18/79, Reg. 71; am / / , Reg.)

Authority: AS 47.05.010
AS 47.07.050

7 AAC 43.890 is amended to read:

7 AAC 43.890. BILLING RATE. Repealed / / .

PLEASE NOTE: THE FOLLOWING PAGES WERE TREATED AS A UNIT IN THE ORIGINAL DOCUMENT

Alaska Health Coalition

520 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,

Chas M. Kaltenbach

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

CMK:sem

Enclosure

Coalition Members

J. B. Carnahan, Fairbanks; Joseph Chadombos, Juneau;
Charles Kaltenbach, Dr. P.H., Fairbanks; Steve Lesko, Anchorage;

CERTIFICATE OF NEED:

REVISION OR REPEAL

Prepared in
the
Public Interest
by
the

ALASKA HEALTH COALITION
February, 1983

TABLE OF CONTENTS

EXECUTIVE SUMMARY

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

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

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

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

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

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

CERTIFICATE OF NEED PROGRAM

PURPOSE

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

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

WHO MUST APPLY

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

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

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

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

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

THE PROCESS

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

EFFECTIVENESS

Nationwide

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

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

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

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

Alaska

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

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

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

Deterrent Effects

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

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

Improved Institutional Planning

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

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

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

Better Conformance with Identified Community Needs

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

Summary

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

PROBLEMS WITH THE CON PROCESS AND RECOMMENDATIONS FOR IMPROVEMENT

INTRODUCTION

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

COSTS

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

DELAYS

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

COMMUNITY CONTROL

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

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

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

MARKETPLACE ECONOMICS: COMPETITION vs. "REGULATION"

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

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

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

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

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

THRESHOLD LIMITS

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

CONCLUSIONS

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

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

MAINTAIN CURRENT CON PROCESS

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

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

REPEAL THE CON LAW

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

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

A competitive pricing market does not exist within the health care services industry of any community in Alaska. In addition, the State of Alaska did not renew its Section 1122 agreement with the federal government in 1981 because the Certificate of Need law was in place.[9] (Section 1122 of PL 92-603 required that health care facilities, which received federal monies under Titles XVIII and XIX, be subject to review to ensure consistency with state health plans.) Repeal of the CON law would leave the State entirely without a capital expenditure review process for health care facilities; therefore, the State would have to rely principally on either the competitive market or incentives established under some kind of a prospective reimbursement system to control costs and allocate resources. (Hospitals are currently reimbursed by the federal government under Medicare and Medicaid on a retrospective basis; that is, after the costs have already occurred. Under this

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

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

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

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

MODIFY THE CON PROCESS

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

RECOMMENDATIONS

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

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

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

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

3. Expedite review of capital equipment replacement.

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

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

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

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APPENDIX

NATIONAL HEALTH PLANNING AND DEVELOPMENT ACT OF 1974

INTRODUCTION

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

HEALTH SYSTEMS AGENCIES

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

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

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

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

STATEWIDE HEALTH COORDINATING COUNCIL

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

PLEASE NOTE: THE PRECEDING PAGES WERE TREATED AS A UNIT IN THE ORIGINAL DOCUMENT.

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 paper concludes that there is merit in the Certificate of Need program though modifications should be made.

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

Sincerely,

Margaret McClure Wilson

Margaret M. Wilson
Executive Director

MMW/ab

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

February 11, 1983

TO: Members of the Alaska Legislature

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

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

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

Best regards,

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

CMK:sem

Enclosure

CERTIFICATE OF NEED:

REVISION OR REPEAL

Prepared in
the
Public Interest
by
the

ALASKA HEALTH COALITION
February, 1983

TABLE OF CONTENTS

EXECUTIVE SUMMARY

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

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

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

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

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

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

CERTIFICATE OF NEED PROGRAM

PURPOSE

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

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

WHO MUST APPLY

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

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

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

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

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