

ALASKA LEGISLATURE COMMITTEE FILES | 1983-1984 | 86 / 2

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THE PROCESS

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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.

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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

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

CONCLUSIONS

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

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

MAINTAIN CURRENT CON PROCESS

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

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

REPEAL THE CON LAW

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

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

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

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

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

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

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

MODIFY THE CON PROCESS

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

RECOMMENDATIONS

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

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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- 2 Howell, Julianne. Regulating Hospital Investment: The Experience in Massachusetts. Hyattsville, Maryland. DHHS/Health Resources Administration, (HHS) 81-8298. March 1981.
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- 7 Roemer, M.I. and John E. Romer. The Social Consequences of Free Trade in Health Care: A Public Health Response to Orthodox Economics. *International Journal of Health Services*. 12(1):111-129. November 1982.
- 8 Needleman, Jack. Competition and State Health Planning Programs: Options for State Action. Alpha Center for Health Planning. Bethesda, Maryland. DHHS/BHP. HRA Contract #232-79-0035. June 1982.

APPENDIX

NATIONAL HEALTH PLANNING AND DEVELOPMENT ACT OF 1974

INTRODUCTION

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

HEALTH SYSTEMS AGENCIES

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

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

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

The Governor designated a State Health Planning and Development Agency (SHIPDA) as a unit of State government. The SHIPDA 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 SHIPDA also supports the function of the Statewide Health Coordinating Council and is responsible for administration of the Certificate of Need program. In Alaska, the SHIPDA 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 SHIPDA and SHCC are supported with a mix of Federal and State funds.



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

1135 West Eighth Avenue • Suite 1 • Anchorage, Alaska 99501

(907) 278-3631

October 6, 1983

Senator Joe Josephson
1016 West 6th Avenue
Anchorage, Alaska 99501

Dear Senator Josephson:

We appreciated the opportunity to discuss public health issues and our agency's activities with you. We agree with your suggestion that our agency can be a resource in upcoming needs assessments and program evaluation activities.

Please do contact us as soon as the date for your teleconference on public health issues is established. We will offer to notify our Board and other public health agencies in our region.

I have enclosed a copy of the paper^{on} certificate of need which you requested. Please contact our agency again if you would like further information on this subject.

Sincerely,

Barbara Berger
Program Manager

Enclosure

*Conference in Anch.
Info from other States.*

RECEIVED

*and notice on
community living
hearing.*

Josephson,

*Nov. 2
1-4pm.*

Give to Nancy

*Return to Postcard Paper/
Student Files*

CERTIFICATE OF NEED:

REVISION OR REPEAL

Prepared in
the
Public Interest
by
the

ALASKA HEALTH COALITION
February, 1983

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EXECUTIVE SUMMARY

Alaska's Certificate of Need (CON) Law was enacted by the State Legislature in 1976, following passage of Public Law 93-641, the National Health Planning and Resource Development Act of 1974. Provisions in the CON law require that non-federal health care institutions apply for and receive a Certificate of Need from the State of Alaska before proceeding with major capital investments which will result in new construction, alterations or renovations, and/or new services. The Thirteenth Alaska Legislature currently has before it companion bills, HB 19 and SB 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.

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

CONCLUSIONS

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

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

MAINTAIN CURRENT CON PROCESS

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

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

REPEAL THE CON LAW

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

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

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

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

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

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

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

MODIFY THE CON PROCESS

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

RECOMMENDATIONS

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

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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- 3 Headen, A. "The Impact of Certificate of Need Regulation on Hospital Investment: New Evidence." Presented at American Economic Association Health Economics Research Organization. Washington, D.C. December 1981.
- 4 Arthur D. Little, Inc. Development of an Evaluation Methodology for Use in Assessing Data Available to the Certificate of Need (CON) and Health Planning Programs. Final report prepared for DHHS/Office of Assistant Secretary for Health. Contract #233-79-4003. April 1982.
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- 6 Enthovan, A.C. Consumer Choice Health Plan (in two parts). New England Journal of Medicine. 298:650-658, 709-720. March 1978.
- 7 Romer, M.J. and John H. Romer. The Social Consequences of Free Trade in Health Care: A Public Health Response to Orthodox Economics. International Journal of Health Services. 12(1):111-129. November 1982.
- 8 Needlemen, Jack. Competition and State Health Planning Programs: Options for State Action. Alpha Center for Health Planning. Bethesda, Maryland. DHHS/BHP. HRA Contract #232-79-0035. June 1982.

APPENDIX

NATIONAL HEALTH PLANNING AND DEVELOPMENT ACT OF 1974

INTRODUCTION

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

HEALTH SYSTEMS AGENCIES

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

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

2-16-83

SB 85 - Certificate of Need

Dr. David Beale Anch - Ak State Med. Assoc.

supports repeal. CON increases costs
vic question - raising threshold; maintain review.

no level

Mass question -

Jan Fairs -

Ron Pavellas - Husnana

Michael Herring St. Peter's Home

Al Camasso - Providence

OMNIBUS MEASURE SUGGESTED BY JOE TO DEAL
WILL CRA ISSUES ETC. (P.R.P.) ONE
ISSUE MAY SUPPORT OTHERS, MUST
HAVE SOME

12
22,9
10
13 2
650
6,5
53,250

PROVIDENCE HOSPITAL

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



SERVING IN THE WEST SINCE 1856

December 27, 1982

DEC 28 1982

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

Rec _____
HEP DIR. OFC

Dear Mayor Knowles:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mayor Tony Knowles
Page Three
December 27, 1982

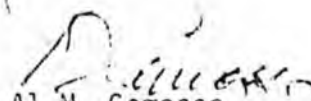
As the attached Policy Statement of the Alaska State Hospital Association (ASHA) notes, we are supportive of state and local planning for the health care needs. The process should be positive and proactive-- encouraging institutions to respond to needs in the community rather than reactive, cumbersome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

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

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

Best wishes for a prosperous 1983.

Sincerely,



Al M. Camosso
Administrator

Enclosure

Chairman of the Board
Ronald A. Pavellis
Kumana Hospital Alaska
Anchorage

Chairman-Elect
Mark Hawkins
Sikh Community Hospital
Sitka

Immediate Past Chairman
Tom Mingen
Fairbanks Memorial
Hospital
Fairbanks

Secretary/Treasurer
Edward Zeine
Tulovna Community
Hospital
Sitka

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

Alternate Delegate to the
American Hospital Assocn
Michael Lockwood
Central Peninsula Hospital
Sitka

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

Alternate Delegate to the
American Health Care
Association
Loren G. Ives
Kemper General Hospital
Fairbanks

Delegate to the Association
of Western Hospitals
M. Paul Fleming
Central Peninsula Hospital
Sitka

Alternate Delegate to the
Association of Western
Hospitals
Carol Ann Warringer
Ketchikan Island Hospital
Ketchikan

Trustee Delegate to the
American Hospital Assocn
Vig Hagen
Procter, Providence
Hospital
Anchorage

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

Physician Member of
the Board
Paul Brandesberger, M.D.
Anchorage

President
Dennis L. DeWitt
Juneau

POLICY STATEMENT

CERTIFICATE OF NEED

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

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

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

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

to the editor

Hospital bed shortage

Dear Editor:

As a physician in practice in Anchorage, I wish to call attention to a serious problem relating to health care in the community.

Both private hospitals in town at this time are experiencing an acute bed shortage, which has been an intermittent problem episodically over the past year. At this time, both hospitals are filled to capacity, and I have had several patients who have either not been admitted to the hospital when they should have been or have had admissions delayed as a result of this problem.

I wish to emphasize to the public that both hospitals have and have had for some time plans to expand and meet this need. These plans have been obstructed and delayed as a result of federal and/or state regulations which require all plans for hospital expansion to be approved by central health planners at various bureaucratic levels. This has come about in a mistaken belief that it would result in a lowering of health care cost by reducing hospital expenses.

Quite the opposite has occurred, with increased demand and increased medical costs related to delays in obtaining necessary medical care. Of greater concern is the serious threat to the public's health resulting from the current bed shortage.

The naive assumption that government bureaucrats can better determine the need for new or expanded health facilities than health care providers or consumers should now be laid to rest. No hospital bed shortage in this community would exist at present if free market forces had been allowed to prevail in the absence of artificial restriction. The need for more hospital beds in this community is painfully obvious to any sick person in one of our emergency rooms. Why has it been less obvious to our legislators and congressman? Perhaps they obtain their health care in Seattle or Washington, D.C.

Richard Farleigh, M.D.
Anchorage

CERTIFICATE OF NEED LAW REPEAL

The biggest impediment to orderly, timely, and intelligent expansion of health facilities in Alaska is the Certificate of Need Statute (AS 18.07) and regulations 7 AAC 07.010 - .120.

In an expanding economy the certificate of need process serves only to distort and stultify planning, delay construction, and raise costs.

The law should be repealed as early in the 1983 legislative session as possible.

Copy of a letter and attachments from a hospital administrator to the Mayor of Anchorage about this is attached.

Attachments
RW21/p/D4

INVOLUNTARY CONFINEMENT OF PERSONS
WITH ACTIVE TUBERCULOSIS

Alaska is one of two States not having an involuntary confinement law for quarantine of persons with dangerous infectious diseases like tuberculosis. Yet Alaska continues to have the highest rate of tuberculosis in the nation, and the rate has been rising in the past few years.

Attached is material supporting the need for an involuntary confinement act or regulation for persons with open tuberculosis.

Attachment
RW22/p/D4

FAIRBANKS HEALTH CENTER

800 AIRPORT WAY
FAIRBANKS, ALASKA 99701

2782001

November 5, 1979

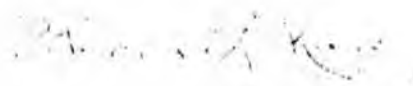
Robert I. Fraser, M.D.
Chief, Communicable Disease Control
Division of Public Health
Department of Health and Social Services
MacKay Building, Room 222
338 Denali Street
Anchorage, Alaska 99501

Dear Dr. Fraser,

I am writing to support the concept of involuntary confinement of patients with active tuberculosis who refuse to cooperate, or, because of their life styles, are incapable of cooperating, in the required treatment program. The need to invoke involuntary confinement would not occur often but without treatment these patients will infect other people.

For example, a Fairbanks resident, who is an alcoholic and has active tuberculosis, has not returned to her doctor for treatment and has successfully evaded all attempts to locate her. Meanwhile she has infected a five year old niece and a nine year old nephew who are now under treatment for primary active tuberculosis. If it had been legally possible to commit this adult for three to six months of intensive treatment, these children would not have been infected.

Sincerely,


Patricia L. Rogers
Public Health Nursing Supervisor

PLR/nlr



City of Galena

Antoski Hall • P.O. Box 149 • Galena, Alaska 99741 • Telephone (907) 656-1281

Resolution 82-22

A RESOLUTION ENCOURAGING LEGISLATION SUPPORTING ENFORCEMENT OF TREATMENT OF COMMUNICABLE DISEASES, PARTICULARLY TUBERCULOSIS, IN ALASKA.

WHEREAS, the City Council of Galena is the duly authorized governing body of the City of Galena, and;

WHEREAS, the City of Galena has experienced an ongoing problem with tuberculosis and a recent outbreak of the disease, and;

WHEREAS, the City is experiencing an incident where one individual who has active tuberculosis is refusing treatment, and;

WHEREAS, the nature of the tuberculosis disease is that it can be highly contagious and endanger a whole community, and;

WHEREAS, the disease can be prevented with adequate treatment, and;


WHEREAS, there is no legislation to enforce treatment, and;

WHEREAS, the City of Galena has a strong committment to protect the citizens, and;

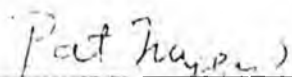
NOW, THEREFORE, Be It Resolved That the City Council of Galena requests the legislators to enact legislation to require individuals to obtain treatment for tuberculosis and other communicable disease.

PASSED AND APPROVE this 16th day of December ,1982

ATTEST:



Vernon White
Mayor



Pat Myers
City Manager

18.35.135 INVESTIGATION AND EXAMINATION OF SUSPECTED TUBERCULOSIS
CASES - ISOLATION - QUARANTINE.

(1) Whenever the Public Health Medical Officer shall determine on reasonable grounds that an examination of any person is necessary for the preservation and protection of the public health, he shall issue a written order directing said medical examination, setting forth the name of the person to be examined, the time and place of the examination, and such other terms and conditions as he may deem necessary. A copy of such an order shall be served upon the patient. Such an examination shall be made by a licensed physician of the examinee's own choice under such terms and conditions as the health officer may specify.

(2) Any person who depends exclusively on prayer for healing in accordance with the teachings of any well recognized religious sect or denomination, and claims exemption on such grounds shall nevertheless be subject to examination and provisions of this article concerning isolation and quarantine which apply when there is probable cause to suspect such a person is infected with tuberculosis in a communicable stage. Such person shall not be required to submit to any medical treatment or be confined in a hospital or other medical institution if he can safely be quarantined or isolated in his own home or other suitable place of his choice.

18.35.136 QUARANTINE OR ISOLATION ORDER

(1) Whenever a Medical Officer of the Division of Public Health shall determine that quarantine or isolation in a particular case is necessary for the preservation and protection of the public health, he shall make an isolation or quarantine order in writing, setting forth the name of the patient to be isolated and the initial period of time, not to exceed six months, during which the order shall remain effective; the place of isolation or quarantine; and such other terms and conditions as may be immediately necessary to protect the public health. A copy of such order shall be served upon the patient. The patient shall be re-examined at the time the initial order expires, or at any other time the patient so requests, to ascertain whether his tuberculosis continues to be infectious. Whenever it shall be medically determined that the patient is no longer infectious and communicable and that the patient has received sufficient treatment of his disease, the patient shall be relieved from all further liability or duty imposed by this article.

(2) Upon the receipt of information that any examination, quarantine, or isolation order, made and served as herein provided, has been violated, the Public Health Medical Officer shall advise the District Attorney of the pertinent facts relating to the violation.

18.35.137 VIOLATION AND PENALTY

(1) Any person who, after service upon him of an order of the Division of Public Health Medical Officer directing his isolation or examination as provided in 18.35.135 and 18.35.136, violates or fails to

comply with same or any provisions thereof is guilty of a misdemeanor and in addition to any penalties which may be imposed by law upon such convictions, the court may now make an appropriate order providing for isolation, quarantine or treatment.

November 1, 1979

REPEAL OF REQUIREMENT FOR
BLOOD TEST FOR SYPHILIS BEFORE MARRIAGE

There are fewer than 20 reported new cases of syphilis in Alaska annually, and most of these are among homosexual men.

It is unnecessary and very costly to test persons applying for marriage for syphilis because almost no one will have a positive test indicative of undiscovered untreated syphilis.

The proper time to test is provided otherwise in statute (AS 18.15.150) that is, at the time of pregnancy to be certain that syphilis does not occur in the baby.

The law (AS 25.05.101 and 105) allowing the Commissioner of Health and Social Services to test persons premaritally for infectious or heritable disease should not be repealed but language in Sec 25.05.105 should be clarified to make it discretionary on the part of the Commissioner as to whether any test is required. The present statute has been interpreted as requiring at least one test of some sort.

RW23/p/D4

WORKMEN'S COMPENSATION STATISTICAL INFORMATION

Present statute (AS 23.05.060(3)) empowers the Department of Labor to "make investigations, collect, and compile statistical information" relative to workmen's compensation matters.

Sec 23.20.110(a) speaks of sharing certain information with other state agencies or other States or the federal government but is silent about sharing information with a local government or with insurance carriers or other groups interested in on-the-job accidents and their costs.

Safety in the workplace is legitimate interest of local health departments. We request that the Department of Labor share statistical data including regional data with local governments and private organizations having valid interest in the matter.

RW24/p/D4

VITAL STATISTICS

Collection, collation, and analysis of vital statistics like births, deaths, marriages, divorces, and adoptions is ordinarily a state and federal function. In Alaska the Bureau of Vital Records within the Department of Health and Social Services does this. It prepares an annual report of Alaska Vital Statistics which is typically published over one year after the vital events.

Vital data is carefully protected by law and regulation (AS 18.50.300-320, 7 AAC 05.925, 7 AAC 05.200) in the interest of confidentiality and preventing misuse of statistics.

As principal health officer of the Municipality of Anchorage, I have need for more timely data particularly about deaths than the State can supply. I request help in obtaining copies of death certificates for statistical use.

Certain materials further explaining this are attached.

Attachments
RW25/p/D4

Municipality of Anchorage

MEMORANDUM

DATE: December 30, 1982

TO: Tom Klinkner, Assistant Municipal Attorney

FROM: Rodman Wilson, M.D., Director, Department of Health and
Environmental Protection

SUBJECT: Request for Death Certificates From State Coroner

Attached is a copy of a letter I wrote to the State Coroner in July about death certificates.

At that time Mr. Kelly Fisher, formerly of your department, advised me that if I did not get a response that the legal department might assist me in this matter. Despite a telephone call about a month ago to Mr. Wilks, I have still heard nothing.

Collection of vital statistics is a State function, but I see no reason why I should not have timely data too. The State publishes an annual report of vital statistics, but this is not available until long after the close of the statistical year. For example, the department received the annual report of Alaska Statistics for 1980 in the fall of 1982.

Other city health departments appear to have little trouble in gathering vital statistics. Attached is a copy of a page which regularly appears in a publication of the Center For Disease Control showing up-to-date death statistics from a number of cities.

I would appreciate whatever assistance you may give me in the matter.



Rodman Wilson, M.D.
Director

Attachment.

Municipality
of
Anchorage



POUCH 6-650
ANCHORAGE, ALASKA 99502-0650
(907) 264-4111

TONY KNOWLES,
MAYOR

DEPARTMENT OF HEALTH AND ENVIRONMENTAL PROTECTION

August 12, 1982

Ms. Delores Wilks
Coroner
State of Alaska
941 W. 4th Avenue, Room 137
Anchorage, Alaska 99501

Dear Ms. Wilks:

As Health Officer for the Municipality of Anchorage I am responsible under statutes and ordinances for protection of the health of the public.

In fulfilling this charge, I want to inspect, preferably on a daily basis, copies of all death certificates prepared in Anchorage.

I am aware that the State keeps vital statistics but their annual reports are not suitable for my purposes.

Sincerely yours,

A handwritten signature in cursive script, which appears to read "Rodman Wilson". The signature is written in dark ink and is positioned above a horizontal line.

Rodman Wilson, M.D.
Director, Department of Health
and Environmental Protection

D26/e

TABLE IV. Deaths in 121 U.S. cities,* week ending
December 11, 1982 (49th week)

Reporting Area	All Causes, By Age (Years)						P&I** Total	Reporting Area	All Causes, By Age (Years)						P&I** Total
	All Ages	≥65	45-64	25-44	1-24	<1			All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	661	441	156	31	20	13	56	S. ATLANTIC	1 179	693	328	78	35	45	43
Boston, Mass.	188	112	51	13	6	6	24	Atlanta, Ga.	130	74	40	8	4	4	4
Bridgeport, Conn.	38	25	10	2	-	1	6	Baltimore, Md.	156	110	53	19	7	7	4
Cambridge, Mass.	30	23	6	-	-	-	5	Charlotte, N.C.	80	41	25	4	3	4	3
Fall River, Mass.	26	19	5	1	1	-	-	Jacksonville, Fla.	92	51	30	6	4	1	7
Hartford, Conn.	40	26	11	1	2	-	5	Miami, Fla.	90	41	34	8	4	3	-
Lowell, Mass.	35	19	11	1	3	1	1	Norfolk, Va.	57	37	13	2	-	5	-
Lynn, Mass.	19	12	5	2	-	-	-	Richmond, Va.	81	47	28	4	-	2	4
New Bedford, Mass.	18	15	3	-	-	-	1	Savannah, Ga.	51	27	10	5	5	4	3
New Haven, Conn.	68	42	17	5	1	3	2	St. Petersburg, Fla.	93	69	20	2	1	1	6
Providence, R.I. †	56	52	-	2	-	-	5	Tampa, Fla.	75	52	13	4	2	4	3
Somerville, Mass.	11	8	3	-	-	-	-	Washington, D.C.	189	115	47	15	4	8	6
Springfield, Mass.	36	28	5	-	3	-	4	Wilmington, Del.	45	29	12	1	1	2	2
Waterbury, Conn.	43	28	12	2	1	-	1	ES CENTRAL	903	568	232	44	33	25	53
Worcester, Mass.	53	32	17	2	2	-	2	Birmingham, Ala.	135	92	28	10	4	1	5
MID ATLANTIC	2,530	1,691	554	150	68	69	95	Chattanooga, Tenn.	75	54	14	3	1	3	5
Albany, N.Y.	53	38	10	1	1	3	2	Knoxville, Tenn.	63	48	11	1	2	1	2
Allentown, Pa.	17	13	4	-	-	-	1	Louisville, Ky.	111	56	34	10	5	6	11
Buffalo, N.Y.	100	74	21	1	1	3	5	Memphis, Tenn.	228	138	65	8	5	11	12
Camden, N.J.	34	15	11	2	5	1	-	Mobile, Ala.	141	96	32	2	9	2	9
Elizabeth, N.J.	31	25	5	1	-	-	2	Montgomery, Ala.	41	27	11	2	1	-	3
Eng. Pa. †	43	22	17	4	-	-	2	Nashville, Tenn.	109	57	37	8	6	1	6
Jersey City, N.J.	45	29	10	1	-	-	5	WS CENTRAL	1,298	751	316	111	57	69	61
N.Y. City, N.Y.	1,415	947	296	108	36	28	48	Austin, Tex.	4*	32	8	3	3	1	3
Newark, N.J.	69	32	21	7	4	5	5	Baton Rouge, La.	43	26	13	-	1	1	1
Paterson, N.J.	24	13	2	3	2	4	2	Corpus Christi, Tex.	58	42	8	5	1	1	2
Philadelphia, Pa. †	263	163	89	13	9	9	13	Dallas, Tex.	179	100	44	16	14	5	4
Pittsburgh, Pa. †	60	40	13	3	-	4	-	El Paso, Tex.	82	46	16	7	5	8	14
Reading, Pa.	32	22	9	-	-	1	1	Fort Worth, Tex.	104	56	24	16	1	7	8
Rochester, N.Y.	94	65	17	3	3	6	6	Houston, Tex.	243	109	77	33	12	12	5
Schenectady, N.Y.	29	22	6	-	1	-	1	Little Rock, Ark.	84	52	24	3	1	4	4
Scranton, Pa. †	22	19	3	-	-	-	-	New Orleans, La.	122	63	32	7	9	11	-
Syracuse, N.Y.	108	83	20	1	4	-	-	San Antonio, Tex.	182	124	33	11	7	7	13
Trenton, N.J.	39	26	11	2	-	-	4	Shreveport, La.	55	36	7	7	3	2	-
Utica, N.Y.	26	24	2	-	-	-	-	Tulsa, Okla.	101	63	24	3	-	10	7
Yonkers, N.Y.	26	19	7	-	-	-	3	MOUNTAIN	678	434	143	40	27	34	27
EN CENTRAL	2,285	1,408	572	154	67	86	68	Albuquerque, N.Mex.	76	50	10	6	5	5	1
Akron, Ohio	65	37	20	3	2	3	3	Colorado Springs, Colo.	36	29	3	4	-	-	1
Canton, Ohio	42	29	9	2	1	1	1	Denver, Colo.	124	85	29	3	5	2	5
Chicago, Ill.	500	283	130	44	17	26	8	Las Vegas, Nev.	82	51	18	4	5	4	5
Cincinnati, Ohio	171	119	40	8	2	2	10	Ogden, Utah	19	11	2	1	-	4	1
Cleveland, Ohio	153	77	50	10	5	11	3	Phoenix, Ariz.	169	101	43	10	7	8	1
Columbus, Ohio	140	80	43	8	3	8	-	Pueblo, Colo.	14	11	2	-	1	1	1
Dayton, Ohio	109	74	24	3	5	3	1	Salt Lake City, Utah	62	28	20	4	3	7	1
Detroit, Mich.	266	146	82	36	10	12	7	Tucson, Ariz.	96	68	15	8	1	4	11
Evansville, Ind.	40	24	12	2	-	2	2	PACIFIC	1,795	1,210	406	77	43	57	102
Fort Wayne, Ind.	42	25	15	1	-	1	4	Berkeley, Calif.	20	14	4	-	1	-	-
Gary, Ind.	21	11	8	2	2	-	1	Fresno, Calif.	88	65	14	2	4	3	7
Grand Rapids, Mich.	55	37	14	2	1	1	1	Glendale, Calif.	39	28	7	1	-	1	1
Indianapolis, Ind.	187	112	44	13	7	11	1	Honolulu, Hawaii	56	35	17	2	1	1	6
Madison, Wis.	43	27	12	2	2	-	6	Long Beach, Calif.	105	60	37	1	1	6	5
Milwaukee, Wis.	132	100	24	6	1	1	3	Los Angeles, Calif.	455	298	110	25	12	9	15
Peoria, Ill.	49	29	14	1	2	3	4	Oakland, Calif.	59	43	9	4	2	1	3
Rockford, Ill.	33	26	4	3	-	-	2	Pasadena, Calif.	30	19	7	1	-	3	2
South Bend, Ind.	42	31	8	2	1	-	3	Portland, Oreg.	156	122	25	4	2	3	12
Toledo, Ohio	142	104	28	4	3	3	3	Sacramento, Calif.	77	49	15	4	3	6	3
Youngstown, Ohio	53	35	13	2	3	-	-	San Diego, Calif.	135	84	36	7	4	4	11
WN CENTRAL	739	499	151	43	21	25	33	San Francisco, Calif.	107	111	36	11	6	3	10
Des Moines, Iowa	57	34	17	3	3	-	2	San Jose, Calif.	154	103	32	7	2	10	16
Duluth, Minn.	40	30	4	5	1	-	-	Seattle, Wash.	153	105	35	4	3	6	2
Kansas City, Kans.	29	22	5	-	-	2	-	Spokane, Wash.	59	40	12	3	2	2	5
Kansas City, Mo.	101	61	25	8	3	4	3	Tacoma, Wash.	45	34	10	1	-	-	4
Lincoln, Neb.	34	28	2	3	-	1	1	TOTAL	12,066	7,693	2,852	728	369	423	538
Minneapolis, Minn.	88	68	9	4	3	4	4								
Omaha, Neb.	94	53	20	5	4	4	5								
St. Louis, Mo.	165	108	31	15	4	7	10								
St. Paul, Minn.	72	51	18	1	1	1	3								
Wichita, Kans.	59	42	12	1	2	2	5								

* Mortality data in this table are voluntarily reported from 121 cities in the United States, most of which have populations of 100,000 or more. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.

** Pneumonia and influenza

† Because of changes in reporting methods in these 4 Pennsylvania cities, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

†† Total includes unknown ages.

‡ Data not available. Figures are estimates based on average of past 4 weeks.

ABOLITION OF TELEVISION ADVERTISING
OF BEER AND WINE

Many young people drink beer all day long. Many drink enormous quantities of wine. Many people are confirmed alcoholics in their teens or twenties.

Much of the inducement to drink beer and wine comes from television advertising. The message is that social acceptance, relation, and enhanced sexuality come from drinking beer or wine.

Since this is patently false and clearly detrimental to many young people, it should be stopped, - just as television advertisement of smoking and drinking hard liquor was banned.

RW26/p/D4

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

Municipality
of
Anchorage



POUCH 6-650
ANCHORAGE, ALASKA 99502-0650
(907) 264-4111

TONY KNOWLES
MAYOR

DEPARTMENT OF PLANNING

January 14, 1983

The Plan Development Committee of the Anchorage Municipal Health Commission and South Central Health Planning and Development, Inc., are reviewing a variety of data to arrive at a position on projected community need for general acute care beds and inpatient rehabilitation beds. The results of the Committee's decisions will be used to guide the respective Project Review Committees as they review the Providence and Humana Hospital Alaska applications for certificates of need for major construction projects.

As part of the Plan Development Committee process of determining future need, members developed and reviewed position papers on both items (general acute and rehabilitation beds). These papers were sent to interested parties throughout the community, requesting pertinent comments and recommendations. To date we have received comments only from Providence and Humana Hospitals and the Alaska Treatment Center (ATC).

At the request of ATC, and with concurrence by the Plan Development Committee of the Commission, we strongly encourage members of the public to react to the contents of the inpatient rehabilitation position paper. While there appears to be some consensus on the question of the magnitude of the need for inpatient rehabilitation beds, the Committees are especially looking for guidance related to the issue of whether there should exist one or two (in one hospital or two) inpatient rehabilitation units. Evaluations of the impact of one or two units on (1) medical and support staffing, (2) optimum use of other existing community resources, (3) ability of units to complement an appropriate continuum of care, (4) other quality of care standards, etc., would be appreciated.

A POSITION PAPER
A REPORT ON ACUTE CARE
BED NEED PROJECTIONS
FOR ANCHORAGE

Acute care bed need projections for civilian, non-Native hospital services in Anchorage are included in the South Central Health Planning and Development (SCHPD) Health Systems Plan 1982-1986 and the Anchorage Health Systems Plan 1982-84 (herein referred to as the Plans). The methodology, assumptions, and analyses in both documents was developed jointly by SCHPD and Municipal Health Commission (MHC) staff.

Assumptions Underlying Community Bed Need Projections

The assumptions underlying the projections contained in the planning documents include:

1. Population distributions by age for the Municipality (excluding military) are assumed to be appropriate for the civilian non-Native (CNN) population in Anchorage.
2. The official Municipal 1985 projected total population is 231,000. The assumptions used to support this projected figure are viewed by experts to be optimistic. Therefore, this 1985 figure is likely to be high. Projections based upon a lower range of population growth are available in the SCHPD 1982 Health Systems Plan.
3. Age categories will remain approximately the same through 2000. Figures assume that the slowly increasing average age of the population will not significantly affect the use of Anchorage hospitals for the study period.
4. The availability of 80 to 100 skilled nursing beds in the Anchorage Pioneer Home will allow growing numbers with chronic conditions to have access to a skilled and/or intermediate level of care (Nakoyia's beds will likely come open as eligible patients transfer to the Pioneer Home).
5. There will be no major change in the array of services (beds) at Elmendorf Air Force Base Hospital and no substantial change in policy with respect to military use of private sector facilities.
6. Native use of private sector services may be effected by some changes in federal budgetary restraints, which effect other PHS facilities outside Anchorage (Bethel, Bristol Bay).
7. The population outside Anchorage will continue to increase at approximately the same annual rate which is lower (less than 3.0%) than the rate for the Anchorage area (greater than 3.0%). The same proportion of Alaskans will continue to use health services outside Alaska.

8. The non-Anchorage patient days may be effected by the new or expanded services of non-Anchorage facilities, such as in Palmer, Soldotna, Homer, Cordova.
9. It is possible that length-of-stay will increase in medical/surgical services or pediatrics. As more routine surgeries, typically requiring a shorter stay, are done on an outpatient basis, average acute length-of-stay might increase. Obstetric use rates will probably not increase, and may decline with increased use of alternative birthing opportunities. However, the addition of a neonatologist, more non-Anchorage high risk obstetric cases may be treated in Anchorage.
10. References to existing beds in projections refers to those acute care hospital beds in private facilities (Providence and Humana Hospital Alaska) that are officially licensed as such by the State of Alaska, as of the date of this paper (December 1982). (Providence 250 and Humana 199.) Note: Humana Hospital Alaska has 199 licensed acute beds and intends to request that the 21 beds currently used for the Chemical Dependency Unit (CDU) be used as general acute care when needed. Assuming that conversion, the community supply of licensed acute care beds would then be 250 plus 199 to equal 449 beds.

Table I: Comparison of Community Bed Need Projections 1985-1995

A summary of the analysis included in the plans is included in the first column of Table I. Figures are expressed as ranges due to the use of different population projections used in the SCHPD(HSA) and MHC planning process. Throughout this paper the lower figures in the left are from the SCHPD Plan and the higher figures on the right are from the MHC plan (see SCHPD plan for details).

The bed need projections in the plans were based on 1980 utilization data from Providence and Humana Hospitals. In order to determine how more recent information might affect the projections, staff obtained 1981 utilization and population data and re-calculated the bed projections. Utilization and patient origin data for 1981 were obtained from both hospitals. Results of the calculations are shown in the second column of Table I.

Table I also includes projections of community bed need contained in the most recent Certificate of Need applications submitted by Providence Hospital and Humana Hospital Alaska. Humana projected community bed need to 1985 and 1990. Providence estimated community bed need for 1995. Summaries of the projections contained in those applications are included in Table I.

There is discrepancy between projections for medical/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
<u>Medical/Surgical³</u>				
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	-
<u>ICU/CCU</u>				
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	-
<u>PCU</u>				
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
<u>Medical/Surgical Subtotal</u>				
1985	316/377	303/360	-	375
1990	359/402	344/385	-	401
1995	-/450	-/431	4555	-
<u>Obstetrics</u>				
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	51/50 ¹³	-	50
1995	-/56	-/66 ¹³	52-53 ¹⁷	-
<u>Pediatrics</u>				
Anchorage Use Rate - 1980/Proj.	134	132	140	172
Projected Anchorage Use	78.2%	78.3 ¹⁴	79.2% ⁶	78.2%
Population				
1985	39,758/47,455	Same as in Plans	-	47,455
1990	45,251/50,646	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	33/16	-	37
1995	-/41	-/41	41-44 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
<u>Thermal</u>				
Anchorage Use Rate - 1980/Proj.	10	11	49	-
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	-
<u>Psychiatry</u>				
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	-
<u>ACUTE CARE TOTAL¹²</u>				
1985	406/482	401/476 ¹³	-	464
1990	460/514	456/509 ¹³	-	496
1995	-/575	-/570 ¹³	503	-
<u>Neonatal Intensive Care</u>				
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 1 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		Humana		Optimum Occupancy ^c
	Patient Days ^a	%Occ	Patient Days ^b	%Occ	
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	3,536	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 CCU patient days.
 3. If assume proportion of I&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 HHC 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. OBs 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 application dated June 1982, (Anch. CNN patient days for 1995 divided by total patient days).
5. See p. 194 of Providence C/N application (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 482 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 173 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	
	Providence	Humana	Total	Plans		'01 Update		Providence C/N	Humana C/N	Providence C/N	Humana C/N
				ISA	MSK	ISA	MSK				
Medical/Surgical	138	152	290								
1985				247	294	236	281	--	293		
1990				281	314	266	300	--	314	88	31
1995				-	351	-	336	376	--		
ICU/CCU	20	18	38								
1985				39	46	39	45	--	47		
1990				44	49	41	48	--	48	8	10
1995				-	55	-	54	42	--		
PCU	22	--	22								
1985				30	37	29	34	--	35		
1990				34	39	31	37	--	39	6	10
1995				-	44	-	41	37	--		
Obstetrics	26	15	41								
1985				40	47	40	55	--	34		
1990				47	50	51	59	--	50	12	17
1995				-	56	-	66	52-53	--		
Pediatrics	18	14	32								
1985				29	35	29	34	--	34		
1990				31	37	31	36	--	37	10	5
1995				-	41	-	41	43-44	--		
Therapy	11	--	11								
1985				9	10	11	12	--	--		
1990				10	11	12	13	--	--	1	
1995				-	12	-	14	13	--		
Psychiatry	15	--	15								
1985				12	13	11	15	--	--		
1990				17	14	16	16	--	--	5	
1995				-	16	-	18	19	--		
TOTAL	250	199	449								
1985				401	482	401	476	--	461		
1990				461	514	450	509	--	496		73
1995				-	575	-	570	503	--	130	
Plus Proposed Inpatient Rehabilitation Beds										20	20
TOTAL PROPOSED ADDITIONS										150	93

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

	<u>Communitywide Need (Range)</u>	<u>Additional Beds Proposed</u>	<u>Community Bed Supply w/Additions of all Proposed Beds</u>
1985	403 to 482	Proposed beds not available yet	449
1990	456 to 514	<u>Prov</u> <u>HHA</u> <u>Total</u> 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:

	<u>Communitywide Need (Range)</u>	<u>Supply</u>	<u>Supply Status (Range)</u>
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:

<u>Community Need (Range)</u>	<u>Bed Supply</u>	<u>Supply Status</u>
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 1 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.

jg4/r:1

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Health, Education and
Social Services Committee



Official Business

Alaska State Legislature

Senate

Pouch V
State Capitol
Juneau, Alaska 99811
465-4907
465-4908

February 9, 1983

Al M. Camosso
Administrator
Providence Hospital
3200 Providence Drive
Pouch 6604
Anchorage, Alaska 99502

Dear Al:

Thank you for your letter concerning the certificate of need legislation.

I expect that the Senate Committee on Health, Education and Social Services will conduct hearings on the bill in the near future. I will be sure that your views are available to all member of the Senate committee.

I am also aware that the hospitals of Alaska are looking forward to an early decision by the legislature because some projects are in the mill now, which would be subject to certificate of need unless there is repeal or modification of the current program.

With best wishes, I am

Sincerely,


Joe P. Josephson

JPJ/rmc

PROVIDENCE
HOSPITAL

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



SERVING IN THE WEST SINCE 1856

January 26, 1983

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JAN 31 1983

The Honorable Joe Josephson
Alaska State Senate
State Capitol
Pouch V
Juneau, Alaska 99811

Josephson

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

Dear Senator Josephson:

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

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

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

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

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

Letter of intent to file certificate of need

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

Public Hearing on Certificate of Need Application (State)

Joint Project Review (HSA and Municipal Health Commission)

Concurrent Review (HSA and Municipal Health Commission)

Board Review (Municipal Health Commission)

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

Commissioner's Review (State)

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

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

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

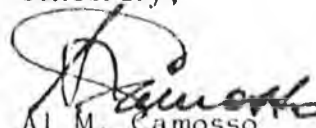
The Alaska State Hospital Association is unanimous in endorsing the repeal of the CON law. We have also received indications from several legislators and the Alaska Medical Association that repeal of the CON law would be best for a growing state such as Alaska.

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

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

Thank you for your consideration.

Sincerely,



Al M. Camosso
Administrator

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STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

STATEWIDE HEALTH COORDINATING COUNCIL

BILL SHEFFIELD, GOVERNOR

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

March 30, 1983

RECEIVED

APR 05 1983

The Honorable Joe Josephson
Chairman, Senate HESS Committee
Alaska State Senate
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Josephson,

Dear Senator Josephson:

The Alaska Statewide Health Coordinating Council, a 20-member citizen advisory board to the Department of Health and Social Services and sponsor of the State Health Plan for Alaska, has been on record for several years in support of cost-containment of rising health care costs through the certificate of need program.

During the March 23, 1983 meeting of the Alaska Statewide Health Coordinating Council, there was unanimous agreement to support the February 1983 position paper by the Alaska Health Coalition, entitled "Certificate of Need: Revision or Repeal" (enclosed), which concludes that the certificate of need program has been effective and can be modified to be more efficient. More specifically, the position paper recommends that negotiations take place among members of the Alaska State Hospital Association, the Legislature, and the Administration to work out revised certificate of need regulations.

Thank you for considering our recommendation.

Sincerely,



Joe Cladouhos, Chairman
Statewide Health Coordinating Council

Enclosure

cc: Robert London Smith
Vic Fischer
Rick Halford
Paul Fischer
Pappy Moss

CERTIFICATE OF NEED:
REVISION OR REPEAL

Prepared in
the
Public Interest
by
the

ALASKA HEALTH COALITION
February, 1983

RECEIVED

FEB 16 1983

Josephson,

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

RECEIVED

1983

Josephson.

Josephson,

FEB 16 1983

RECEIVED

Coalition Members

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

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EXECUTIVE SUMMARY

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

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

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

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

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

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

CERTIFICATE OF NEED PROGRAM

PURPOSE

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

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

WHO MUST APPLY

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

1. Capital expenditures in excess of \$150,000 toward building, improving, or purchasing a health care facility, including lease or purchase of equipment, costs of any study surveys, designs, and site acquisitions and preparations.
2. Any change within a two-year period in the licensed bed capacity of a health care facility amounting to 10 beds or 10 percent, whichever is the lesser, which increases or decreases the number of beds or redistributes beds among different categories of service.
3. Any addition or elimination of a major type of service offered in or through the health care facility.

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

THE PROCESS

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

EFFECTIVENESS

Nationwide

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

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

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

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

Alaska

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

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

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

Deterrent Effects

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

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

Improved Institutional Planning

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

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

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

Better Conformance with Identified Community Needs

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

Summary

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

PROBLEMS WITH THE CON PROCESS AND RECOMMENDATIONS FOR IMPROVEMENT

INTRODUCTION

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

COSTS

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

DELAYS

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

COMMUNITY CONTROL

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