

ALASKA LEGISLATURE COMMITTEE FILES 1983-1984 86/2

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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.)

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

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

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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
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3. Expedite review of capital equipment replacement.
4. Specify a time limit for a decision by the Commissioner subsequent to a recommendation by the regional health planning agency.
5. Provide that each legislator be informed of all projects in his/her district, especially regarding the outcome of the review.
6. Consider a sunset provision of four or more years to review effectiveness of the CON process.

REFERENCES CITED

- 1 U.S. Congress, Congressional Budget Office. Health Planning Issues for Reauthorization. Washington, D.C. March 1982.
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- 8 Needleman, Jack. Competition and State Health Planning Programs: Options for State Action. Alpha Center for Health Planning. Bethesda, Maryland. DHHS/BHP. HRA Contract #232-79-0035. June 1982.

APPENDIX

NATIONAL HEALTH PLANNING AND DEVELOPMENT ACT OF 1974

INTRODUCTION

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

HEALTH SYSTEMS AGENCIES

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

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

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

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

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March 16, 1983

The Honorable Joe Josephson
Senator
Pouch V
Juneau, Alaska 99811

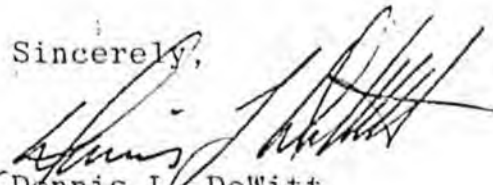
Dear Senator Josephson:

I have reviewed the attached Committee Substitute for SB85. I have reviewed the contents with the Executive Committee of the Alaska State Hospital Association and I inform you of our support for this Committee Substitute. This omnibus legislation addresses Certificate of Need, prospective payment for Medicaid and GRM, and revenue sharing in a manner acceptable to us on the whole.

While this bill does not repeal Certificate of Need, we are confident that the experience gained over the next 7 years will prove the point we have been making as to its uselessness. The prospective payment portion embodies an independent commission approach, basic principles of reimbursement, and a fair appeals mechanism. The suspension of Capital Revenue Sharing for 7 years is consistent with our commitment that CON and Capital Revenue Sharing should be dealt with on the same basis. Capping operational revenue sharing at \$250,000 per facility is in our judgement appropriate in the context of this bill.

I would like to extend to you my personal as well as the Association's appreciation for your willingness to work through the difficult issues with us. It has been both an intense and successful process leading to better understandings between the legislature and the industry I represent. While the negotiations were exhilarating I must confess my pleasure that they are concluded. We can now get about explaining this package to the Senate and House.

Sincerely,


Dennis L. DeWitt
President

DLD:hb

cc: Association Membership

DeWitt's Comments on CS SB 85

Section 1 - VERY Appropriate

Section 6 - OK - However This is Delt with in
CS SB 37 EXTRA

Section 7. a) We need basic principles - I believe
our ~~po~~ suggestion of yesterday is about as
NEUTRAL AS I CAN MOVE OUR BOARD

b) My people will scream - I will deliver - I Hope

Sec 8 UNIFORM ACT.

Thanks for (b)(3)

(d) I believe This is prudent AND my people will
buy it

~~Section 47.07~~

Appeal

I Think we can get agreement on this in
context of bill with inclusion of basic
principles in Section 7(a)

TELECOPY COVER SHEET
ANCHORAGE INFORMATION OFFICE

Senator
Joe
Josephson's office

TO: _____ FOR: _____ PHONE: _____

FROM: So. Cent. Health Planning & Dev. Inc. PHONE: 228-3631

ADDITIONAL INSTRUCTIONS: _____

DATE/TIME SENT: 2/14 PLEASE ACK. RECEIPT:

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_____ HOLD FOR PICK UP

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BY: hou

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Josephson,

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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

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.

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.

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

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

Alaska

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

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

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

Deterrent Effects

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

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 understanding¹ about the process and outcome of capital expenditure review programs. 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

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.

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.

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CERTIFICATE OF NEED:

REVISION OR REPEAL

Prepared in
the
Public Interest
by
the

ALASKA HEALTH COALITION
February, 1983

Health Issues Questionnaire
Attachment - Page One

Comment No. 1

- A formal mechanism should exist for citizen involvement in the expenditure of public funds for health program expenditures.
- Health outlays in recent years have been increasing at a greater rate than in other areas.
- The Federal and State outlays for health are increasing rapidly.
- Since substantial and increasing public monies provided by tax revenues are involved, citizen involvement in public program decision making is of increasing importance.
- The present formal mechanism for accomplishing citizen involvement could be open to changes and improvement based on careful analysis of past and present arrangements and potential new arrangements.

Comment No. 2

- Based on statutory and regulatory changes which are finally made, if any, in Federal and State laws related to State health planning efforts, including the health systems agencies, adequate financial support from the State and Federal level should be made available.
- An integral relation exists between a State Certificate of Need Program and outlays for health planning.
- Should the Certificate of Need Program on the Federal or State level, or both, be repealed, the financial outlays for the health systems agencies would be affected substantially as well, if not eliminated.
- A \$100,000 authorized support level for each health systems agency will not be sufficient to have an effective planning staff capacity. Should only \$100,000 be available for each agency, one of two developments would be indicated:
 1. Close the activity for three health systems agencies; or
 2. Combine the funds available into a single health systems agency with amended, limited functions and powers.

Summary of Private and Public Health Care Coverage In Alaska

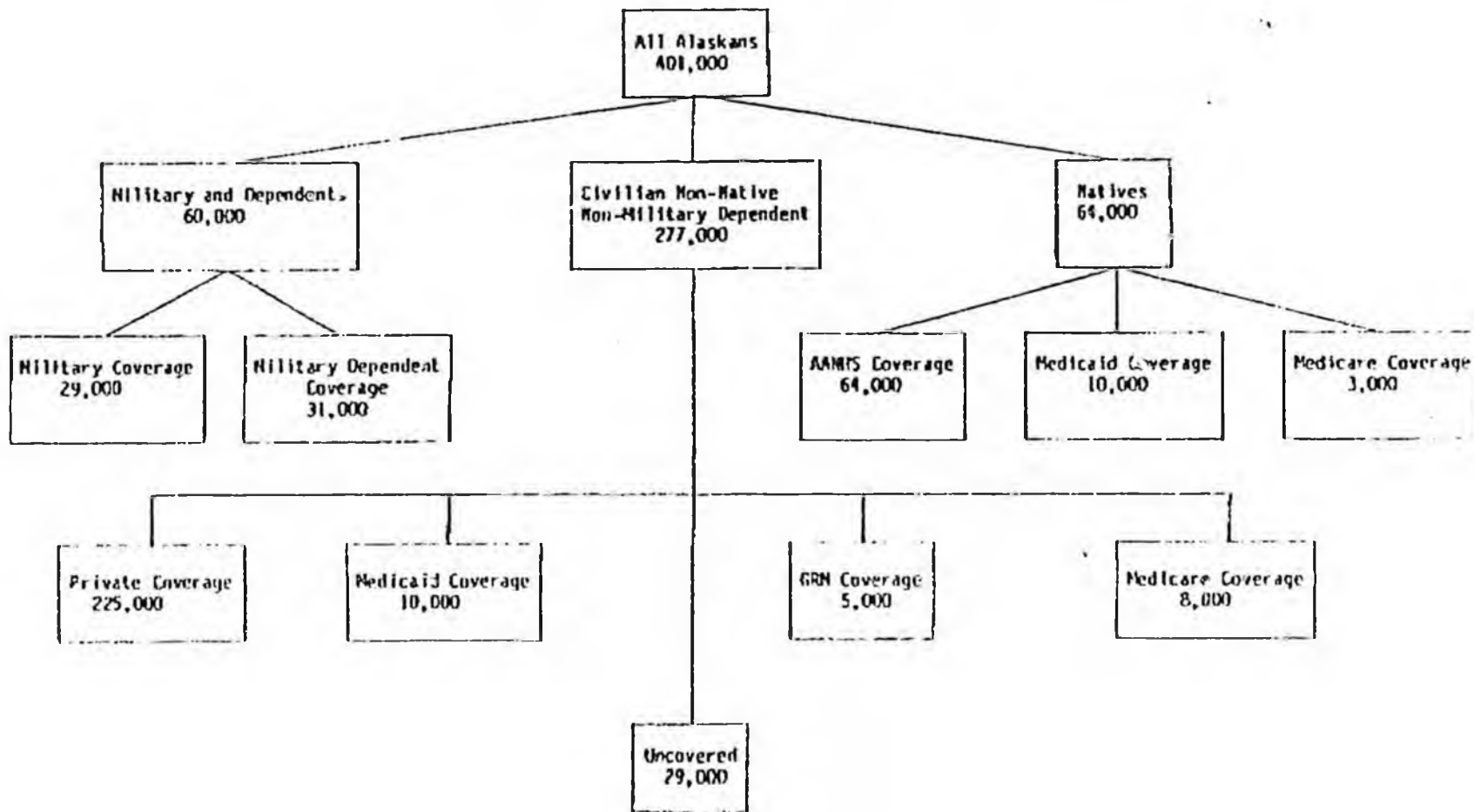


Figure 1.

Battelle Report -
Vol. I - March, 1982

- dental, vision, and hearing care;
- prescription drugs; and
- alcoholism treatment.

The elderly population covered only by Medicare faces the risk of high out-of-pocket medical expenses. Similarly, many persons covered by private plans must make significant out-of-pocket payments to receive their benefits. The supposedly comprehensive Native health care benefits are quite limited in certain instances due to the AAKHS budget constraints.

8.5. Expenditures and Expenditure Trends

The total health care bill in Alaska was \$480 million in 1979; approximately 14% of that amount was paid by state and local governments, 31% by the federal government, and 55% by the private sector. About 64% of the state and federal share was used to provide direct services, and the other 36% was used to pay for various public health programs. About 63% of the private sector share was paid directly by consumers for out-of-pocket expenses and health insurance premiums, and 37% was paid by employers for health insurance premiums (See Figure I-1 in Volume I).

The total cost of health care has been rising dramatically in Alaska. Population increases and decreases in the relative price of medical care account for some of this, but the largest part is due simply to general inflation. Health care expenditures could reach \$1 billion by 1990 if inflation continues at current rates.

C. OPTIONS FOR STATE ACTION

Weaknesses in the health care system determined during the survey of Alaska health care resources and financing were used to identify the types of options the state of Alaska could consider to improve the comprehensiveness and accessibility of health care. The principal barriers which reduce the accessibility of health care among the Alaska population, and specific actions that the state could consider for eliminating these barriers and improving

Comment No. 7 (cont'd)

in order to be equitable, must include all Alaskans. The implication of a State-sponsored comprehensive health insurance program must be considered only in relation to the Indian Health Service Program.

3. I strongly support the concept of cost sharing, co-payment, and deductible plans since such have been demonstrated to reduce over-utilization and abuse of both public and private and other health care insurance programs. If such arrangements are adopted, they should be fair, reasonable, and equitable and related to broad categories of ability to pay.
- With a population of approximately 450,000 in Alaska, a recent research study indicated that only 29,000 Alaskans (estimated) do not now have either private or public coverage. Any reasonable State program should probably focus on the uncovered populations. To do otherwise would be to displace program and financial responsibilities and result in shifting to the State financial responsibility not now assumed.
 - The best plan for improving health coverage and financing should focus on improvement to Medicaid, General Relief Medical, and Catastrophic Illness Programs, including the possibility of creation of a high risk pool for persons who are not low income but cannot afford coverage of any kind, because they are unemployed, part-time employed, or too ill.
 - While, for the above reasons, I oppose a comprehensive health insurance plan per se, any plan which would meet some of the more important objectives outlined above without creating counter-productive elements as indicated above would meet with my great interest and open mind.

* * *

WJS/jes

Comment No. 6

- It is understood that the private health sector may not under present arrangements be able to provide direct health services in all areas. This is especially the case in unusually remote locations and very small communities.
- The State should encourage wherever possible the providing of direct health services by the private sector, understanding that the Federal government has provided, and doubtless will continue to provide, a substantial level of direct health services in the rural regions.
- The State should not consider the automatic assumption of those direct health services which have been or may be terminated by the Federal government.
- The State should take all reasonable measures to work with the Federal government and insist that the Federal government continue an adequate level of direct health services which has been its historic responsibility and current responsibility under the applicable Federal statutes, programs, and policies.

Comment No. 7

- While I favor strongly the adequate and reasonable access to health services on behalf of every Alaskan, I am not convinced that a "comprehensive health insurance plan" with certain other provisions would be the best plan for the following reasons:

1. Health insurance for tens of thousands of Alaskans is a program based upon negotiated labor agreements between hundreds of employers, employees, and their respective unions.

The State should not take action to disrupt that part of the insurance arrangements which have worked exceedingly well, except for the growing costs.

2. The Federal government has certain levels of responsibility for approximately 60,000 Alaskan Natives with an annual outlay of more than \$100,000,000 for program services alone, excluding capital expenditures. Any program of comprehensive health insurance,

Comment No. 3

- It is my understanding that the Certificate of Need Programs on both Federal and State levels are faced with a measure of uncertainty.
- If the Certificate of Need Program is repealed by the State of Alaska, an appropriate program relating to planning of health services and facilities will be required based on the substantial public interest issues involved.
- While I oppose the continuation of the Certificate of Need Program "as presently designed", I could support an amended Certificate of Need Program within the State under two conditions:
 1. That no substantial multi-million dollar Federal penalty become applicable to Alaska due to the absence of a Certificate of Need Program; or
 2. The revised or amended Certificate of Need Program could remove some of the burdensome provisions related to the health facilities under a simplified and more efficient application and review process.

Comment No. 4

My views are expressed generally in line with the markings in the questionnaire under health education.

Comment No. 5

- Consideration should be given to a uniform "development of maturity" age for Alaskans which would take into account responsibilities related to voting age, military service age, and drinking age.
- To assume that a young person can exercise adequately some of the privileges and responsibilities of military service, voting for officials and using alcoholic beverages at different ages, I find problematical. However, substantial discussion and public input should be required before making changes in such important activities related to youth.

Strongly Support
Support
Oppose
Strongly Oppose

Alcohol abuse is widely recognized as a problem in Alaska. In addition to prevention and treatment programs, legislative changes have been proposed.

Indicate your feelings about the following legislative changes:

- SS S O SO Increase the sales tax on alcohol.
- SS S O SO Reduce the bar hours statewide (e.g., require closure for a minimum of 6 hours/day).
- SS S O SO Raise the drinking age to 21 years.
- SS S O SO Restrict alcohol advertising.
- SS S O SO Implement more stringent penalties for driving while intoxicated/operating a motor vehicle while intoxicated.
- SS S O SO Continue and/or increase State funding of treatment programs.
- SS S O SO Continue and/or increase State support for prevention programs.

Comment see Comment No. 5, attached

Traditionally the State has provided prevention and public health services in all parts of Alaska leaving the provision of direct health care services to the private sector and the Federal government. The Federal government is cutting back on direct services offered. Due to the isolation of many areas of the State, it has not been economically feasible for the private sector to provide direct health care services in all areas. Indicate your opinion about the idea that the State should financially support direct health care services in those areas that are medically underserved.

SS S O SO
*

Comment see Comment No. 6, attached

In the past legislative session, a bill was introduced proposing a comprehensive health insurance plan which would allow a choice of coverage for residents on a cost-sharing basis based on ability to pay. Indicate your feelings about some form of state-supported comprehensive health insurance.

SS S O SO
*

Comment see Comment No. 7, attached

Name Bill Sheffield

Sheffield Response to

HEALTH ISSUES QUESTIONNAIRE

Please circle the symbol that most closely corresponds to your opinion. If you wish, add any comments in the blank provided.

Strongly Support
Support
Oppose
Strongly Support

SS S O SO

A formal mechanism should exist for citizen involvement in State health program decision-making.

Comment see Comment No. 1; attached

Governed by volunteer boards made up of health care providers as well as a "consumer" majority, the three Health Systems Agencies (HSAs) in Alaska have provided a process for citizen involvement in health care decisions. The HSAs operate with both Federal and State financial support. Federal support, previously at up to \$300,000, and currently approximately \$125,000., constituted 75% of each HSA's funding in the past. State support was \$125,000. in FY 1976-77 and \$100,000. in FY 1978-81. The most recent allocation reduced the subsequent annual authorized amount by 50% to \$50,000. The Federal government has proposed eliminating support for Health Systems Agencies after the current fiscal year. Indicate your feelings about the following statements.

SS (S) O SO

The State should increase the current level of State support to each agency to at least \$300,000. to maintain citizen involvement in health decisions at the local level.

SS S (O) SO

The State should continue support at the authorized level of \$100,000. to maintain citizen involvement in health decisions at the local level.

SS S (O) SO

The State should provide no support.

Comment see Comment No. 2, attached

A program administered by the State requires that health care providers apply for a Certificate of Need prior to any capital expenditures in excess of \$150,000. and/or any change in licensed bed capacity of 10 beds or 10 percent. Indicate your feelings about the alternative suggestions below.

SS S (O) SO

The Certificate of Need program should continue as presently designed with review, public comment, and analysis at the regional level and the final decision at the Commissioner level.

SS (S) O SO

The Certificate of Need program should continue with an increase in levels to at least \$600,000.

SS S O (SO)

The role of regional Health Systems Agencies should be eliminated, leaving the review, analysis, and final decision with the Commissioner of Health and Social Services.

Comment see Comment No. 3, attached

A number of groups have indicated support for health education in the schools as a way to prevent some of the major health problems in Alaska. Indicate your feelings about the following proposals.

(SS) S O SO

Schools should have health education programs.

SS (S) O SO

Comprehensive health education should address the range of health problems in Alaska including sessions on alcohol and drug abuse, mental health, sex education, and values clarification.

SS S (O) SO

The Legislature should require comprehensive health education in all Alaskan schools.

SS (S) O SO

The Legislature, while not requiring health education, should provide financial assistance and other incentives to school districts to encourage development of school health education programs.

Comment see Comment No. 4, attached

Alaska Health Coalition

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

February 11, 1983

TO: Members of the Alaska Legislature

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

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

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

Best regards,



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

CMK:sem

Enclosure

Coalition Members

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

FISCAL SAVINGS FROM CS SB 85 (HESS)

SUSPENSION OF HOSPITAL CONSTRUCTION FUNDING AS 29.90

Providence Hospital expansion project of \$185.6 million projected costs will save the state \$46.4 million alone plus untold savings from any other hospital expansion plans during the period of suspension.

CAP ON HOSPITAL REVENUE SHARING

Providence Hospital expansion of 150 beds will save the state \$150,000 yearly by setting the cap in place.

PROSPECTIVE PAYMENT PROGRAM

Projected to save 1 - 3% of growth in the Medicaid and General Relief Medical Budgets. Projected FY 84 expenditures for these programs for hospital and long term care are \$43,726.2, so a 1 -3% savings would be between \$437,000 and \$1,311,700.

Two hospitals seek approval for expansion

By DON HUNTER
Daily News reporter

Two Anchorage hospitals are friendly antagonists in a struggle for a state certificate for expansion, but the success of either may hinge on the disposition of an existing certificate of need possessed by Dr. Michael Beirne.

Officials of Providence and Humana hospitals touted their multi-million dollar construction plans before a staff committee from the state Department of Health and Social Services on Wednesday. The committee will review the proposals and discuss them with hospital officials again Feb. 11 and 12, then send a recommendation to the municipal Health Commission and the Health Systems Agency, a Southcentral Alaska

planning organization.

The decision on which hospital — or perhaps both to a more limited degree — gets to expand will be made by the health department commissioner, Robert Smith.

The \$97 million Providence plan would add an additional 160 beds, bringing the hospital to a total of 400. It also would provide an in-patient rehabilitation center, and allow reallocations of space to make hospital care more efficient and effective, officials say.

The 93-bed Humana project would cost about \$21.5 million and bring that hospital to a total of 292 beds.

In an interview Wednesday, Providence planning director Kaaren Riehle said ex-

See Back Page, PROVIDENCE

Providence, Humana hospitals seek OK for expansion

Continued from Page A-1

pansion there "is necessary if we're going to provide the quality of care we have given up to this point.

"We're operating at 100 percent capacity" at times now, she said. "Bed turnover is constant . . . The beds don't get cold."

Finding beds for new patients is a frequent problem, and one that sometimes leads to pediatric patients being assigned to adult wards or vice-versa, she said.

Doctors, nurses and former patients who spoke at the committee hearing echoed those concerns and asked the

committee to allow the hospital to expand.

Ron Pavellas, the executive director of Humana, says the once-financially troubled hospital has recovered and currently reports annual occupancy rates of between 65 percent and 70 percent. "By 1985, both hospitals will be full," he predicted.

"We feel the community needs two strong acute care hospitals."

Neither Riehle nor Pavellas attempted Wednesday to critically undercut the construction bids of the opposing hospital, though both admit the institutions are in an adversarial position now.

Still clouding the expansion issue is the certificate of need held by Beirne, a former state representative who for more than a decade has been attempting to pull together financing for a new, 125-bed hospital on Lake Otis Parkway.

Beirne's proposed Lake Otis Clinic initially got a certificate of need because it was determined that construction was under way when the state law setting up the certification process was approved in the mid-1970s. However, only a few pilings have been driven at the Lake Otis site.

Beirne says extended lawsuits challenging the legitima-

cy of his certificate have prevented him from securing financing for his project.

Another decision on whether Beirne's certificate should be continued is now before state commissioner Smith.

Riehle acknowledged Wednesday that Beirne's certificate complicates the expansion applications of both Providence and Humana.

"It is a problem, because there are 125 beds that have a certificate of need," and the decision whether the two existing hospitals can expand is rooted in the number of hospital beds planners decide are needed in Anchorage, Riehle said.

Hein
3/14/83

Original sponsors: Faiks, P. Fischer
and Pettyjohn

1 IN THE SENATE

BY THE HEALTH, EDUCATION AND
SOCIAL SERVICES COMMITTEE

2 CS FOR SENATE BILL NO. 85 (HESS)

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 THIRTEENTH LEGISLATURE - FIRST SESSION

5 A BILL

6 For an Act entitled: "An Act suspending the certificate of need program;
7 amending provisions related to Medicaid and general
8 relief assistance; and providing for an effective
9 date."

10 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

11 * Section 1. FINDINGS AND DECLARATION OF POLICY. ^(a) The
 12 legislature finds and declares that health facilities are vital
 13 to the welfare of the people of the state. The legislature finds
 14 that the certificate of need program, as historically constituted
 15 and implemented in Alaska, has created delays in the construction
 16 of health care facilities, thus adding to the cost of such
 17 facilities both through the expenses of the administrative
 18 process itself and through the effects of delay-induced inflation.
 19 (b) Because the effects of the changes to be wrought by this Act
 20 will require monitoring, and because there is a degree of uncer-
 21 tainty concerning the federal statutory and regulatory environment,
 22 the legislature finds and declares that a suspension of the
 23 certificate of need process, with automatic review in future,
 24 is preferable to an outright repeal of the process at this time.
 25

-) -

(C) The legislature acknowledges the need to pay health facilities for services provided to beneficiaries of state programs at a level that will meet the proportionate share of the total financial requirements of the facilities that are attributable to those programs given prudent and cost-effective management and operation of such facilities.

~~Sec. 6. FINDINGS.~~ The legislature finds that, because Medicaid is a joint state and federal program and because federal Medicaid funds have been and are likely to continue to be reduced dramatically, a retrospective payment system no longer serves as an adequate management tool, nor does it respond with adequate flexibility to continued federal cutbacks. A prospective payment system is necessary to prudently address payments to health facilities under the Medicaid and general relief assistance programs.

* Section ~~1~~². AS 18.07.021 is amended to read:

Sec. 18.07.021. STATE HEALTH PLANNING AND DEVELOPMENT AGENCY. The office of planning and research in the department is the state health planning and development agency designated under 42 U.S.C. Sec. 300m(b)(3), (Sec. 3, P.L. 93-641) [SEC. 1521(b)(3), P.L. 93-641]. The office shall perform the functions enumerated under 42 U.S.C. Sec. 300m-2(a)(1)-(3), (a)(6)-(8), (b) and (c), (Sec. 3, P.L. 93-641) [SEC. 1523, P.L. 93-641, ADMINISTER THE CERTIFICATE OF NEED PROGRAM OUTLINED IN AS 18.07.041 - 18.07.111,] and other functions prescribed in this chapter.

1 * Sec. ~~32~~. AS 18.07.021 is amended to read:

2 Sec. 18.07.021. STATE HEALTH PLANNING AND DEVELOPMENT AGENCY.
3 The office of planning and research in the department is the state
4 health planning and development agency designated under 42 U.S.C. Sec.
5 300m(b)(3), (Sec. 3, P.L. 93-641). The office shall perform the
6 functions enumerated under 42 U.S.C. Sec. 300m-2 [300m-2(a)(1)-(3),
7 (a)(6)-(8), (b) AND (c)], (Sec. 3, P.L. 93-641), administer the
8 certificate of need program outlined in AS 18.07.041 - 18.07.111, and
9 other functions prescribed in this chapter.
10

1 * Sec. ~~43~~. AS 18.26.220 is repealed and reenacted to read:

2 Sec. 18.26.220. FACILITY COMPLIANCE WITH HEALTH AND SAFETY LAWS
3 AND LICENSING REQUIREMENTS. In order to receive financial assistance
4 under this chapter, a medical facility shall comply with AS 18.20 and
5 the licensing requirements of this chapter.

6 * Sec. ~~54~~. AS 18.26.220 is repealed and reenacted to read:

7 Sec. 18.26.220. FACILITY COMPLIANCE WITH HEALTH AND SAFETY LAWS
8 AND LICENSING REQUIREMENTS. A medical facility constructed, acquired,
9 improved, or financed under the this chapter and all actions of the
10 authority are subject to AS 18.07, AS 18.20, and any other state
11 licensing requirement for the facilities or services provided under
12 this chapter. A medical facility issued a certificate of need under
13 Sec. 4, ch. 275, SLA 1976 by virtue of being in existence or under
14 construction before July 1, 1976, must fully meet the requirements of
15 AS 18.07 in order to be eligible for funding under this chapter.
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* Sec. 68. AS 29.89.030(a)(1) is amended to read:

(1) to a municipality which has the power to provide hospital facilities and services and which exercises that power, \$1,000 per bed for each bed actually used for patient care in a hospital with not more than 50 acute care beds, limited to the number of beds provided for in the construction design of the hospital, or \$250,000 per [A] hospital for those hospitals with 10 to 50 acute care [OR MORE] beds, or \$50,000 per [A] hospital for those hospitals with less than 10 acute care beds, as the municipality may elect; money received under this paragraph may be used only for hospitals and shall be apportioned among qualifying hospitals as the municipality determines;

* Section 7. AS 47.07.070 is repealed and reenacted to read:

Sec. 47.07.070. PAYMENT TO HEALTH FACILITIES. (a) The payment rate to a health facility shall be determined by the ~~Medical Rate Commission~~ on the basis of a fair rate for reasonable costs that are incurred by the facility. The Commission shall ~~promulgate regulations setting forth the factors of which the Commission shall take cognizance in reaching its determinations~~ ^{by regulation list the factors it considers} under this section

(b) Prospective payments to hospitals shall be made at a rate in proportion to the rate of occupancy in ^{acute care} hospital beds. Maximum payment under this chapter may be made ~~only to~~

a hospital with
~~more than~~ more than 50 acute care beds only if the hospital
~~has an acute care bed occupancy rate of 90~~ percent or more.

1 * Sec. 8. AS 47.07 is amended by adding new sections to read:

2 Sec. 47.07.071. REPORTS BY HEALTH FACILITIES. Not later than
3 120 days after the end of each fiscal year of a health facility, the
4 facility shall submit to the ~~department~~ ^{Commission} a report on the facility's
5 financial performance during the fiscal year.

6 Sec. 47.07.072. REPORT BY THE ~~DEPARTMENT~~ ^{COMMISSION}. Not later than Sep-
7 tember 30 of each year, the ~~department~~ ^{Commission} shall submit to the governor a
8 report on the prospective payments made under this chapter during the
9 current fiscal year and an estimate of the prospective payments that
10 will be made during the remainder of the current fiscal year and the
11 next fiscal year. The report shall state the assumptions that are
12 used as a basis for the estimates.

13
14 Sec. 47.07.07³/₄. UNIFORM ACCOUNTING, BUDGETING, AND FINANCIAL
15 REPORTING. (a) The ~~department~~ ^{Commission} by regulation shall require a uniform
16 system of accounting, budgeting, and financial reporting for health
17 facilities receiving prospective payments under this chapter. The
18 regulations shall provide for the reporting of revenues, expenses,
19 assets, liabilities, and units of service. The ~~department~~ ^{Commission} shall
20 specify the date the system becomes effective for each health facil-
21 ity.

22 (b) In adopting regulations under this section, the ~~department~~ ^{Commission}
23 shall consider

24 (1) accounting, budgeting, and financial reporting proce-
25 dures used by health facilities;

26 (2) variations among health facilities in the following
27 areas. ~~S~~

~~the~~ types of health care services provided by health facilities;

³
(A) other factors the department considers relevant.

(c) The ~~department~~ ^{Commission} may waive or modify a requirement for accounting, budgeting, or financial reporting for a health facility if waiver or modification is

(1) necessary to avoid excessive costs to the facility; and

(2) consistent with the policies of this chapter.

Sec. 47.07.07⁴~~5~~. AUDITS AND INSPECTIONS. As a condition of obtaining payment under AS 47.07.070, a health facility shall allow

(1) the department ^{and the commission} reasonable access to the financial records of medical assistance beneficiaries; and

(2) inspection of financial records by ~~the department and~~ federal agencies to the extent required by federal law.

Sec. 47.07.07⁵~~6~~. APPLICATION OF ADMINISTRATIVE PROCEDURE ACT. Actions of the ~~department~~ ^{Commission} under AS 47.07 are subject to the provisions of the Administrative Procedure Act (AS 44.62).

* Sec. 9. AS 47.07.080 is amended by adding a new paragraph to read:

(b) "commission" means the Medical State Commission;

(7)(b) "health facility" includes a hospital, skilled nursing facility, intermediate care facility, rehabilitation facility, inpatient psychiatric facility, home health agency, rural health clinic, and outpatient surgical clinic.

with care facility for HR.

10.
* Section 6. AS 47.07 is amended by adding new sections to read:

ARTICLE 2. MEDICAL ^{RATE} ASSISTANCE ~~PROSPECTIVE PAYMENT~~ COMMISSION.

1 Sec. 47.07.110. MEDICAL RATE COMMISSION ESTABLISHED.

2 The Medical Rate Commission is established in the Department of ~~Health and Social Services~~

3
4 Sec. 47.07.120. COMPOSITION OF COMMISSION. The
5 commission consists of five members as follows:

6 (1) the chief executive officer of a health
7 facility that is licensed by the state but not owned or operated
8 by the state or federal government and that is subject to the
9 budget review process under this chapter;

10 (2) the commissioner of administration, ~~or the~~
11 commissioner of health and social services, or the appointed
12 ~~commissioner's~~ designee; ^{or other commissioner}

13 (3) a physician licensed to practice medicine in
14 the state who is actively engaged in the practice of medicine and
15 who is not employed by the state;

16 (4) a certified public accountant with relevant
17 experience;

18 (5) a person ~~who can~~ represent ^{the} consumers of health
19 services ~~and~~ who does not have ^a direct or indirect interest in an
20 entity that provides health care services.

21
22 Sec. 47.07.130. APPOINTMENT OF MEMBERS. Members of the
23 Commission are appointed by the governor and serve at the pleasure
24 of the governor.

25 Sec. 47.07.140. TERM OF MEMBERSHIP. A member of the
26 commission is appointed for a term of three years, and may not be
27 appointed to a successive term. The terms of the members shall be
28 staggered. A member appointed to fill a vacancy serves for the
29 unexpired term of the member he succeeds. A term shall be measured
from January 1 of the year in which the term of the vacant

1 position begins, regardless of when the vacancy is filled.

2 Sec. 47.07.150. COMPENSATION. A member of the
3 commission serves without compensation but is entitled to per
4 diem and travel expenses authorized by law for boards and commis-
5 sions under AS 39.20.180.

6 Sec. 47.07.160. OFFICERS. At the first meeting of each
7 year, the commission shall elect a chair from among its members.

8 Sec. 47.07.170. MEETINGS AND QUORUM. The commission
9 shall meet as often as is necessary to conduct its business.
10 Three members of the commission constitute a quorum.

11 Sec. 47.07.180. DUTIES ~~OF THE COMMISSION.~~ The
12 commission shall review proposed payment rates and budgets of
13 health facilities and establish payment rates for health facilities
14 under this chapter and AS 47.25.120 - 47.25.300.

15 Sec. 47.07.190. EMPLOYMENT OF PERSONNEL. The
16 commission may employ ^{and determine the salary of} an executive director, ~~at a salary that it~~
17 ~~shall determine.~~ With the approval of the commission, the
18 executive director may select and employ additional staff. The
19 commission shall be assisted by such officers or personnel of the
20 department of ~~health and social services~~ as the commissioner of
21 health and social services shall direct. The executive director,
22 ~~if any,~~ of the commission is in the exempt service under AS 39.25.
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1 * Sec. ~~10~~ AS 47.25 is amended by adding a new section to read:

2 Sec. 47.25.195. PAYMENT TO HEALTH FACILITIES FOR TREATMENT OF
3 NEE PERSONS. (a) The department may make prospective payments to a
4 health facility for the treatment of a needy person.

5
6 (b) A health facility receiving a payment under this chapter is
7 subject to the requirements of AS 47.07.070 - 47.07.076.

8 (c) For purposes of this section, "health facility" includes a
9 hospital, skilled nursing facility, intermediate care facility, reha-
10 bilitation facility, inpatient psychiatric facility, home health
11 agency, rural health clinic, and outpatient surgical clinic.

12 * Sec. ~~11~~¹². INTERIM PROSPECTIVE PAYMENT SYSTEM. The department shall
13 establish an interim system of prospective payments for health facilities
14 under this Act for the period July 1, 1983 to June 30, 1984.

15
16 * Sec. ~~13~~¹³. This Act does not affect funds to which the sponsor of a
17 hospital or health facility construction project is entitled under AS 29.90
18 on the effective date of this ^{ser. 17} Act.

19 * Sec. ~~12~~¹². The operation of AS 18.07.031 - 18.07.101, 18.07.111(1)-(4),
20 18.07.111(7)-(9), 18.07.111(11); and AS 47.80.140(b) is suspended for a
21 period of ~~two~~^{four} years after the effective date of sec. ~~15~~¹⁷ of this Act.

22 * Sec. ~~13~~¹³. ^{As 29.90 and} AS 47.07.080(1) ^{are} ~~is~~ repealed.

23
24 * Sec. ~~14~~¹⁴. Sections 2 and 4 of this Act take effect ~~two~~^{four} years after the
25 effective date of sec. ~~15~~¹⁷ of this Act.

26 * Sec. ~~15~~¹⁵. Sections 1, 3 and 5 - ~~13~~¹⁵ of this Act take effect immediately
27 in accordance with AS 01.10.070(c).

15 * Sec. 11. AS 47.25 is amended by adding a new section to read:

16 Sec. 47.25.195. PAYMENT TO HEALTH FACILITIES FOR TREATMENT OF
17 NEEDY PERSONS. (a) The department may make prospective payments to a
18 health facility for the treatment of a needy person.

19 (b) A health facility receiving a payment under this chapter is
20 subject to the requirements of AS 47.07.070 - 47.07.076.

21 (c) For purposes of this section, "health facility" includes a
22 hospital, skilled nursing facility, intermediate care facility, reha-
23 bilitation facility, inpatient psychiatric facility, home health
24 agency, rural health clinic, and outpatient surgical clinic ~~intermediate~~

*G.R.T
Medicaid*

IC-FMR

care facilities for the mentally retarded

25 * Sec. 12. INTERIM PROSPECTIVE PAYMENT SYSTEM. The department shall
26 establish an interim system of prospective payments for health facilities
27 under this Act for the period July 1, 1983 to June 30, 1984.

28 * Sec. 13. This Act does not affect funds to which the sponsor of a
29 hospital or health facility construction project is entitled under AS 29.90

1 because federal Medicaid funds have been and are likely to continue to be
2 reduced dramatically, a retrospective payment system no longer serves as an
3 adequate ~~management tool~~ ^{method of compensation}, nor does it respond with adequate flexibility to
4 continued federal cutbacks. A prospective payment system is necessary to
5 prudently address payments to health facilities under the Medicaid and
6 general relief assistance programs.

7 * Sec. 2. AS 18.07.021 is amended to read:

8 Sec. 18.07.021. STATE HEALTH PLANNING AND DEVELOPMENT AGENCY.
9 The office of planning and research in the department is the state
10 health planning and development agency designated under 42 U.S.C. Sec.
11 300m(b)(3), (Sec. 3, P.L. 93-641) [SEC. 1521(b)(3), P.L. 93-641]. The
12 office shall perform the functions enumerated under 42 U.S.C. Sec.
13 300m-2(a)(1)-(3), (a)(6)-(8), (b) and (c), (Sec. 3, P.L. 93-641)
14 [SEC. 1523, P.L. 93-641, ADMINISTER THE CERTIFICATE OF NEED PROGRAM
15 OUTLINED IN AS 18.07.041 - 18.07.111,] and other functions prescribed
16 in this chapter.

17 * Sec. 3. AS 18.07.021 is amended to read:

18 Sec. 18.07.021. STATE HEALTH PLANNING AND DEVELOPMENT AGENCY.
19 The office of planning and research in the department is the state
20 health planning and development agency designated under 42 U.S.C. Sec.
21 300m(b)(3), (Sec. 3, P.L. 93-641). The office shall perform the
22 functions enumerated under 42 U.S.C. Sec. 300m-2 [300m-2(a)(1)-(3),
23 (a)(6)-(8), (b) AND (c)], (Sec. 3, P.L. 93-641), administer the certi-
24 ficcate of need program outlined in AS 18.07.041 - 18.07.111, and other
25 functions prescribed in this chapter.

26 * Sec. 4. AS 18.26.220 is repealed and reenacted to read:

27 Sec. 18.26.220. FACILITY COMPLIANCE WITH HEALTH AND SAFETY LAWS
28 AND LICENSING REQUIREMENTS. In order to receive financial assistance
29 under this chapter, a medical facility shall comply with AS 18.20 and

1 the licensing requirements of this chapter.

2 * Sec. 5. AS 18.26.220 is repealed and reenacted to read:

3 Sec. 18.26.220. FACILITY COMPLIANCE WITH HEALTH AND SAFETY LAWS
4 AND LICENSING REQUIREMENTS. A medical facility constructed, acquired,
5 improved, or financed under the this chapter and all actions of the
6 authority are subject to AS 18.07, AS 18.20, and any other state
7 licensing requirement for the facilities or services provided under
8 this chapter. (A medical facility issued a certificate of need under
9 Sec. 4, ch. 275, SLA 1976 by virtue of being in existence or under
10 construction before July 1, 1976, must fully meet the requirements of
11 AS 18.07 in order to be eligible for funding under this chapter.

12 * Sec. 6. AS 29.89.030(a)(1) is amended to read)

13 (1) to a municipality which has the power to provide hospi-
14 tal facilities and services and which exercises that power, \$1,000 per
15 bed for each bed actually used for patient care in a hospital with
16 more than 250 acute care beds, limited to the number of beds provided
17 for in the construction design of the hospital, or \$250,000 per [A]
18 hospital for those hospitals with 10 ^{to 250} ~~to 50~~ acute care [OR MORE] beds,
19 or \$50,000 per [A] hospital for those hospitals with less than 10
20 acute care beds, as the municipality may elect; money received under
21 this paragraph may be used only for hospitals and shall be apportioned
22 among qualifying hospitals as the municipality determines;

23 * Sec. 7. AS 47.07.070 is repealed and reenacted to read:

24 Sec. 47.07.070. PAYMENT TO HEALTH FACILITIES. (a) The payment
25 rate to a health facility shall be determined by the commission on the
26 basis of a fair rate for reasonable costs incurred by the facility.
27 The commission shall by regulation list the factors it considers in
28 reaching its determinations under this section

29 (b) Prospective payments to hospitals shall be made at a rate in

1 proportion to the rate of occupancy in acute care hospital beds.
 2 Maximum payment under this chapter may be made to a hospital with more
 3 than 50 acute care beds only if the hospital has an acute care bed
 4 occupancy rate of 90 percent or more.

5 * Sec. 8. AS 47.07 is amended by adding new sections to read:

6 Sec. 47.07.071. REPORTS BY HEALTH FACILITIES. Not later than
 7 120 days after the end of each fiscal year of a health facility, the
 8 facility shall submit to the commission a report on the facility's
 9 financial performance during the fiscal year.

10 Sec. 47.07.072. REPORT BY THE COMMISSION. Not later than Sep-
 11 tember 30 of each year, the commission shall submit to the governor a
 12 report on the prospective payments made under this chapter during the
 13 current fiscal year and an estimate of the prospective payments that
 14 will be made during the remainder of the current fiscal year and the
 15 next fiscal year. The report shall state the assumptions that are
 16 used as a basis for the estimates.

17 Sec. 47.07.073. UNIFORM ACCOUNTING, BUDGETING, AND FINANCIAL
 18 REPORTING. (a) The commission by regulation shall require a uniform
 19 system of accounting, budgeting, and financial reporting for health
 20 facilities receiving prospective payments under this chapter. The
 21 regulations shall provide for the reporting of revenues, expenses,
 22 assets, liabilities, and units of service. The commission shall
 23 specify the date the system becomes effective for each health facil-
 24 ity.

25 (b) In adopting regulations under this section, the commission
 26 shall consider *size, organizational structure, + methods of obtaining payments*

27 (1) accounting, budgeting, and financial reporting proce-
 28 dures used by health facilities;

29 (2) variations among health facilities in the types of

1 health care services provided by health facilities;

2 (3) other factors the commission considers relevant, *including*

3 *size, organizational structure, and methods of obtaining payments.*

4 (c) The commission may waive or modify a requirement for ac-
5 counting, budgeting, or financial reporting for a health facility if
6 waiver or modification is

7 (1) necessary to avoid excessive costs to the facility; and

8 (2) consistent with the policies of this chapter.

9 Sec. 47.07.074. AUDITS AND INSPECTIONS. As a condition of
10 obtaining payment under AS 47.07.070, a health facility shall allow

11 (1) the department and the commission reasonable access to
12 the financial records of medical assistance beneficiaries; and

13 (2) inspection of financial records by federal agencies to
14 the extent required by federal law.

15 *De Novo*
Review Sec. 47.07.075. APPLICATION OF ADMINISTRATIVE PROCEDURE ACT.
16 Actions of the commission under AS 47.07 are subject to the provisions
17 of the Administrative Procedure Act (AS 44.62).

18 * Sec. 9. AS 47.07.080 is amended by adding new paragraphs to read:

19 (6) "commission" means the Medical Rate Commission;

20 (7) "health facility" includes a hospital, skilled nursing
21 facility, intermediate care facility, rehabilitation facility, inpa-
22 tient psychiatric facility, home health agency, rural health clinic,
23 and outpatient surgical clinic. *mentally*
retarded *and* *facilities for the intermediate*
care of the mentally retarded

24 * Sec. 10. AS 47.07 is amended by adding new sections to read:

25 ARTICLE 2. MEDICAL ¹⁰RATE COMMISSION.

26 Sec. 47.07.110. MEDICAL ¹⁰RATE COMMISSION ESTABLISHED. The Medi-
27 cal ¹⁰Rate Commission is established in the Department of Health and
28 Social Services.

29 Sec. 47.07.120. COMPOSITION OF COMMISSION. The commission
consists of five members as follows:

Hein
3/14/83

Original sponsors: Faiks, P. Fischer
and Pettyjohn

1 IN THE SENATE

BY THE HEALTH, EDUCATION AND
SOCIAL SERVICES COMMITTEE

2 CS FOR SENATE BILL NO. 85 (HESS)

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 THIRTEENTH LEGISLATURE - FIRST SESSION

5 A BILL

6 For an Act entitled: "An Act suspending the certificate of need program;
7 amending provisions related to Medicaid and general
8 relief assistance; and providing for an effective
9 date."

10 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

11 * Section 1. FINDINGS AND DECLARATION OF POLICY. (a) The legislature
12 finds and declares that health facilities are vital to the welfare of the
13 people of the state. The legislature finds that the certificate of need
14 program, as historically constituted and implemented in Alaska, has created
15 delays in the construction of health care facilities, thus adding to the
16 cost of such facilities both through the expenses of the administrative
17 process itself and through the effects of delay induced inflation.

18 (b) Because the effects of the changes to be wrought by this Act will
19 require monitoring, and because there is a degree of uncertainty concerning
20 the federal statutory and regulatory environment, the legislature finds and
21 declares that a suspension of the certificate of need process, with auto-
22 matic review in future, is preferable to an outright repeal of the process
23 at this time.

24 (c) The legislature acknowledges the need to pay health facilities
25 for services provided to beneficiaries of state programs at a level that
26 will meet the proportionate share of the total financial requirements of
27 the facilities that are attributable to those programs given prudent and
28 cost-effective management and operation of such facilities. The legisla-
29 ture finds that, because Medicaid is a joint state and federal program and

because federal Medicaid funds have been and are likely to continue to be reduced dramatically, a retrospective payment system no longer serves as an adequate method of compensation, nor does it respond with adequate flexibility to continued federal cutbacks. A prospective payment system is necessary to prudently address payments to health facilities under the Medicaid and general relief assistance programs.

* Sec. 2. AS 18.07.021 is amended to read:

Sec. 18.07.021. STATE HEALTH PLANNING AND DEVELOPMENT AGENCY. The office of planning and research in the department is the state health planning and development agency designated under 42 U.S.C. Sec. 300m(b)(3), (Sec. 3, P.L. 93-641) [SEC. 1521(b)(3), P.L. 93-641]. The office shall perform the functions enumerated under 42 U.S.C. Sec. 300m-2(a)(1)-(3), (a)(6)-(8), (b) and (c), (Sec. 3, P.L. 93-641) [SEC. 1523, P.L. 93-641, ADMINISTER THE CERTIFICATE OF NEED PROGRAM OUTLINED IN AS 18.07.041 - 18.07.111,] and other functions prescribed in this chapter.

Sec. 3. AS 18.07.021 is amended to read

Sec. 18.07.021. STATE HEALTH PLANNING AND DEVELOPMENT AGENCY. The office of planning and research in the department is the state health planning and development agency designated under 42 U.S.C. Sec. 300m(b)(3), (Sec. 3, P.L. 93-641). The office shall perform the functions enumerated under 42 U.S.C. Sec. 300m-2 [300m-2(a)(1)-(3), (a)(6)-(8), (b) AND (c)], (Sec. 3, P.L. 93-641), administer the certificate of need program outlined in AS 18.07.041 - 18.07.111, and other functions prescribed in this chapter.

* Sec. 4. AS 18.26.220 is repealed and reenacted to read:

Sec. 18.26.220. FACILITY COMPLIANCE WITH HEALTH AND SAFETY LAWS AND LICENSING REQUIREMENTS. In order to receive financial assistance under this chapter, a medical facility shall comply with AS 18.20 and

the licensing requirements of this chapter.

* Sec. 5. AS 18.26.220 is repealed and reenacted to read:

Sec. 18.26.220. FACILITY COMPLIANCE WITH HEALTH AND SAFETY LAWS AND LICENSING REQUIREMENTS. A medical facility constructed, acquired, improved, or financed under this chapter and all actions of the authority are subject to AS 18.07, AS 18.20, and any other state licensing requirement for the facilities or services provided under this chapter. A medical facility issued a certificate of need under Sec. 4, ch. 275, SLA 1976 by virtue of being in existence or under construction before July 1, 1976, must fully meet the requirements of AS 18.07 in order to be eligible for funding under this chapter.

* Sec. 6. AS 29.89.030(a)(1) is amended to read:

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

Sec. 7. AS 47.07.070 is repealed and reenacted to read:

Sec. 47.07.070. PAYMENT TO HEALTH FACILITIES. (a) The payment rate to a health facility shall be determined by the commission on the basis of a fair rate for reasonable costs incurred by the facility. The commission shall be regulation list the factors it considers in reaching its determinations under this section.

(b) The commission, in determining the payment rate to a health facility, may consider whether the rate of occupancy in acute care beds within the facility is lowered because of improvident or careless facility development by the facility during the period when the provisions of section 14 of this chapter are in effect.

Sec. 8. AS 47.07 is amended by adding new sections to read:

Sec. 47.07.071. REPORTS BY HEALTH FACILITIES. Not later than 120 days after the end of each fiscal year of a health facility, the facility shall submit to the commission a report on the facility's financial performance during the fiscal year.

Sec. 47.07.072. REPORT BY THE COMMISSION. Not later than September 30 of each year, the commission shall submit to the governor a report on the prospective payments made under this chapter during the current fiscal year and an estimate of the prospective payments that will be made during the remainder of the current fiscal year and the next fiscal year. The report shall state the assumptions that are used as a basis for the estimates.

Sec. 47.07.073. UNIFORM ACCOUNTING, BUDGETING, AND FINANCIAL REPORTING. (a) The commission by regulation shall require a uniform system of accounting, budgeting, and financial reporting for health facilities receiving prospective payments under this chapter. The regulations shall provide for the reporting of revenues, expenses, assets, liabilities, and units of service. The commission shall specify the date the system becomes effective for each health facility.

(b) In adopting regulations under this section, the commission shall consider

(1) accounting, budgeting, and financial reporting procedures used by health facilities;

(2) variations among health facilities in the types of health care services provided by health facilities;

(3) other factors the commission considers relevant, including but not limited to size, organizational structure, and methods of obtaining payments.

(c) The commission may waive or modify a requirement for accounting, budgeting, or financial reporting for a health facility if waiver or modification is

(1) necessary to avoid excessive costs to the facility; and

(2) consistent with the policies of this chapter.

(d) Any other provisions of this section notwithstanding, the commission may modify, by regulation generally applicable to facilities having fewer than 25 acute care beds, the system of accounting, budgeting, and financial reporting, for the purpose of reducing to such facilities the costs of their operations.

Sec. 47.07.074. AUDITS AND INSPECTIONS. As a condition of obtaining payment under AS 47.07.070, a health facility shall allow

(1) the department and the commission reasonable access to the financial records of medical assistance beneficiaries; and

(2) inspection of financial records by federal agencies to the extent required by federal law.

Sec. 47.07.075. APPLICATION OF ADMINISTRATIVE PROCEDURE ACT. Actions of the commission under AS 47.07 are subject to the provisions of the Administrative Procedure Act (AS 44.62).

* Sec. 9. AS 47.07.080 is amended by adding new paragraphs to read:

(6) "commission" means the Medicaid Rate Commission;

(7) "health facility" includes a hospital, skilled nursing facility, intermediate care facility, rehabilitation facility, inpatient psychiatric facility, home health agency, rural health clinic, outpatient surgical clinic, and facility for the domiciliary care of the mentally retarded.

* Sec. 10. AS 47.07 is amended by adding new sections to read:

ARTICLE 2. MEDICAID RATE COMMISSION.

Sec. 47.07.110. MEDICAID RATE COMMISSION ESTABLISHED. The Medicaid Rate Commission is established in the Department of Health and Social Services.

Sec. 47.07.120. COMPOSITION OF COMMISSION. The commission consists of five members as follows:

(1) the chief executive officer of a health facility that is licensed by the state but not owned or operated by the state or federal government and that is subject to the budget review process under this chapter;

(2) the commissioner of administration, the commissioner of health and social services, or the appointed designee of either commissioner;

(3) a physician licensed to practice medicine in the state who is actively engaged in the practice of medicine and who is not employed by the state;

(4) a certified public accountant with relevant experience;

(5) a person representing consumers of health services who does not have a direct or indirect interest in an entity that provides health care services.

Sec. 47.07.130. APPOINTMENT OF MEMBERS. Members of the commission are appointed by the governor and serve at the pleasure of the governor.

Sec. 47.07.140. TERM OF MEMBERSHIP. A member of the commission is appointed for a term of three years, and may not be appointed to a successive term. The terms of the members shall be staggered. A member appointed to fill a vacancy serves for the unexpired term of the member. A term shall be measured from January 1 of the year in which the term of the vacant position begins, regardless of when the vacancy is filled.

Sec. 47.07.150. COMPENSATION. A member of the commission serves without compensation but is entitled to per diem and travel expenses authorized by law for boards and commissions under AS 39.20.180.

Sec. 47.07.160. OFFICERS. At the first meeting of each year, the commission shall elect a chair from among its members.

Sec. 47.07.170. MEETINGS AND QUORUM. The commission shall meet as often as is necessary to conduct its business. Three members of the commission constitute a quorum.

Sec. 47.07.180. DUTIES. The commission shall review proposed payment rates and budgets of health facilities and establish payment rates for health facilities under this chapter and AS 47.25.120 - 47.25.300.

Sec. 47.07.190. EMPLOYMENT OF PERSONNEL. The commission may employ and determine the salary of an executive director. With the approval of the commission, the executive director may select and employ additional staff. The commission shall be assisted by the officers or personnel of the department the commissioner of health and social services shall direct. The executive director of the commission is in the exempt service under AS 39.25.

* Sec. 11. AS 47.25 is amended by adding a new section to read:

Sec. 47.25.195. PAYMENT TO HEALTH FACILITIES FOR TREATMENT OF NEEDY PERSONS. (a) The department may make prospective payments to a health facility for the treatment of a needy person.

(b) A health facility receiving a payment under this chapter is subject to the requirements of AS 47.07.070 - AS 47.07.076.

(c) For purposes of this section, "health facility" includes a hospital, skilled nursing facility, intermediate care facility, rehabilitation facility, inpatient psychiatric facility, home health agency, rural health clinic, outpatient surgical clinic, and facility for the domiciliary care of the mentally retarded.

* Sec. 12. INTERIM PROSPECTIVE PAYMENT SYSTEM. The department shall establish an interim system of prospective payments for health facilities under this Act for the period July 1, 1983 to June 30, 1984.

* Sec. 13. This Act does not affect funds to which the sponsor of a hospital or health facility construction project is entitled under AS 29.90 on the effective date of sec. 18 of this Act.

* Sec. 14. The operation of AS 18.07.031 - 18.07.101, 18.07.111(1)-(4), 18.07.111(7) - (9), 18.07.111(11); and AS 47.80.140(b) is suspended for a period of four years after the effective date of sec. 18 of this Act.

* Sec. 15. The operation of AS 29.90 is suspended for a period of four years after the effective date of sec. 18 of this Act.

* Sec. 16. AS 47.07.080(1) is repealed.

* Sec. 17. Sections 2 and 4 of this Act take effect four years after the effective date of section 18 of this Act.

A M E N D M E N T

Offered in the SENATE

By Josephson

TO: CSSB 85(Fin)

Page 1, line 6, after "to" insert "certificate of need,"

Page 1, after line 9, insert the following new section to read:

"* Section 1. AS 18.07.031 is amended to read:

Sec. 18.07.031. CERTIFICATE OF NEED REQUIRED. No person may make an expenditure of \$1,000,000 or more for any of [UNDERTAKE] the following unless authorized under the terms of a certificate of need issued by the office:

- (1) construction of a health care facility;
- (2) alteration of the bed capacity of a health care facility; or
- (3) addition or elimination of a category of health services provided by a health care facility."

Renumber remaining sections.

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- (2) alteration of the bed capacity of a health care facility; or
- (3) addition or elimination of a category of health services provided by a health care facility."

Renumber remaining sections.

SENATE AMENDMENT

By Josephson

To: Committee Substitute for SENATE BILL No. 85 (Finance)

To: _____ HOUSE BILL No. _____

PAGE: 6 LINE: 20

Add a new section to the bill to read:

Sec. ____ . The sponsor of a hospital or health facility construction project who is receiving or entitled to receive state aid under AS 29,90 on the day preceding the effective date of this act shall continue to receive state aid until the sponsor has received an amount which, combined with state matching money for construction of the hospital or health facility, equals 25 percent of the total project cost. Money received for construction may not be used for any other purpose.

SENATE AMENDMENT

By Josephson

To: Committee Substitute for SENATE BILL No. 85 (Finance)

To: _____ HOUSE BILL No. _____

PAGE: 6 LINE: 19

Add to Section 8:

Sec. 8. AS 47.07.080(1) and AS 29.90 are[is] repealed.

TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982 (TEFRA)

H.R. 4961 was passed by Congress, with the regulations promulgated by the Department of Health and Human Services becoming effective on October 1, 1982.

TEFRA is an attempt to control the rising costs of health care by implementing cost limitations for hospital and nursing home charges to the Medicaid program. Alaska's use of the Medicare principles of reimbursement have allowed a 14.5% (hospital) and a 19.5% (nursing home) annual percentage growth over the last four years.

The program increased from 19.5 million in FY 78 to 32.8 million in FY 82. The FY 84 budget of 43.8 million is a 125% increase in this six year period - a 20% average annual increase.

The Federal system has tightened up the budget for Medicare and Medicaid. The regulations implementing TEFRA are aimed primarily at nursing homes and result in a 25% decrease in reimbursement for FY 84, and an 8% decrease for hospital services.

The Routine Service Cost Limits have not been applied by the state of Alaska since 1981, mainly because Alaska's Medicaid reimbursement supports 95% of nursing home costs in the state, and the limitations are based on costs in the lower 48 with no higher living allowance for Alaska.

The effects of not applying the TEFRA law is that we owe the Federal government \$5 million since 1981, and an additional \$1.8 million for FY 83. This year, the state will be forced to implement TEFRA - and that will cause several of the nursing homes in Alaska to shut down operations for lack of funding.

The effects on hospitals are not so severe since there is a sole community provider exemption, and the limitations will therefore affect only Humana and Providence.

The only way to avoid TEFRA is to institute a Prospective Payment System for Medicaid payments, which would guarantee the Federal government that we are attempting to control costs. It will also allow Alaska to set their own rates according to reasonable costs in the state.

The Prospective Payment Program outlined in SB 85 and HB 19 was worked out carefully through a committee of providers and DH&SS personnel over a number of months, and refined through several meetings in Senate HESS. The costs of establishing the Commission to review and set rates is quite minimal when compared to the savings proposed by retention of facilities. The Federal Government will still alter its matching rate for nursing home and hospital reimbursement, but the state will be able to develop cost controls.

THE LEGISLATURE OF THE STATE OF ALASKA
THIRTEENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. CSSSHB 19 (Finance) Page 1 of 2

Title Relating to C.O.N. and state aid for health facility
Requested by House Finance Date 4/13/83

II. FISCAL DETAIL

Agency Affected Dept. Health & Social Services

Program Category Affected Health Facility Development

BRU, Program, Or Subprogram(s) Affected Health Planning & Development

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 83	FY 84	FY 85	FY 86	FY 87	FY 88
100 PERSONAL SERVICES	84,693	90,621	96,965	103,753	111,015	
200 TRAVEL	27,000	28,890	30,912	33,076	35,391	
300 CONTRACTUAL	70,000	20,000	20,000	20,000	20,000	
400 COMMODITIES	2,000	2,140	2,290	2,450	2,621	
500 EQUIPMENT	6,000	1,000	1,000	1,000	1,000	
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC						
TOTAL	189,693	142,651	151,167	160,279	170,027	

FUNDING (Thousands of Dollars)

GENERAL FUND	99,115	74,535	78,985	83,745	88,839
FEDERAL FUNDS	90,578	68,116	72,182	76,534	81,188
OTHER (Specify Source)					

POSITIONS

FULL TIME	2	2	2	2	2
PART TIME					
TEMPORARY					

III. ANALYSIS (See Fiscal Note Preparation Instruction, Section III)

See Attachment A

IV. DATE 4/13/83

PREPARED BY Al Adams, Chair *APA*
AGENCY House Finance Committee

Original: Legislative Finance PHONE 465-3706

cc: Budget & Management

Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/82)

100 Personal Services		
1) Executive Director	R24 \$4,251 X 12 =	51,012
2) Clerk Typist III	R8 1,487 X 12 =	<u>17,844</u>
		68,856
	Benefits .23%	<u>15,837</u>
		\$84,693
200 Travel and Per Diem		
5 Commission Members X 12 meetings		
X average cost of \$450	=	27,000
300 Contractual (Data Processing Assistance)		70,000
400 Commodities		2,000
500 Equipment		
1) Desks, Chairs and Files		6,000
Word Processor		
		<u>\$189,693</u>

Three existing Auditor III positions from the Division of Public Assistance will be transferred for Commission use as well as travel funds, etc.

Note that 47.7% of this budget will be supported with federal funds.

SECTION ANALYSIS FOR CS FOR SB 85)FINANCE)

SECTION 1 FINDINGS AND DECLARATION OF POLICY

THAT THE RETROSPECTIVE METHOD OF PAYMENT TO HEALTH FACILITIES IS INADEQUATE, AND THAT THE LEGISLATURE INTENDS TO CHANGE TO A PROSPECTIVE PAYMENT METHOD.

SECTION 2 GIVES THE COMMISSION THE MANDATE TO PROSPECTIVELY SET HEALTH FACILITY RATES BASED ON REASONABLE COSTS. AND LIST FACTORS BY REGULATION.

(b) IN SETTING RATES, THE COMMISSION SHALL DETERMINE THE PROPORTIONATE SHARE OF THE FACILITY'S FINANCIAL REQUIREMENTS, AND SETS ACCOUNTING PRINCIPLES TO BE FACTORED IN.

(c) PROVIDES AUTHORITY TO THE COMMISSION IN RATE SETTING FOR OVERBUILT OR OVERBEDDED FACILITIES.

SECTION 3 EACH HEALTH FACILITY IS REQUIRED TO SUBMIT A FINANCIAL REPORT TO THE COMMISSION BY 120 DAYS AFTER THE END OF THE FISCAL YEAR.

THE COMMISSION SHALL SUBMIT A REPORT TO THE GOVERNOR BY SEPTEMBER 30TH OF EACH YEAR ON PROSPECTIVE PAYMENTS MADE AND AN ESTIMATE OF CURRENT AND SUBSEQUENT YEAR.

A UNIFORM BUDGETING, ACCOUNTING AND FINANCIAL REPORTING SYSTEM WILL BE ESTABLISHED BY THE COMMISSION BY REGULATION WHICH TAKES INTO CONSIDERATION CURRENT SYSTEMS, DIFFERENCES IN FACILITIES AND THEIR SERVICES, AND OTHER FACTORS DETERMINED RELEVANT.

THE COMMISSION HAS THE POWER TO WAIVE OR MODIFY AN ACCOUNTING REQUIREMENT ON A CASE BY CASE BASIS.

THE COMMISSION MAY MODIFY REQUIREMENTS BY REGULATION FOR FACILITIES HAVING LESS THAN 25 ACUTE CARE BEDS.

AUDITS ARE REQUIRED, AND HEALTH FACILITIES SHALL ALLOW REASONABLE ACCESS TO FINANCIAL RECORDS BY THE COMMISSION, THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES AND ANY FEDERAL AGENCIES REQUIRED BY LAW.

ACTIONS OF THE COMMISSION ARE SUBJECT TO THE ADMINISTRATIVE PROCEDURES ACT.

SECTION 4 DEFINITIONS

SECTION 5 ESTABLISHES THE MEDICAL RATE COMMISSION WITHIN THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES.

LISTS THE FIVE MEMBERS TO BE APPOINTED BY THE GOVERNOR FOR THREE YEAR STAGGERED TERMS.

MEMBERS OF THE COMMISSION SERVE WITHOUT COMPENSATION BUT RECEIVE PER DIEM AND TRAVEL EXPENSES.

BOARD MEMBERS WILL SELECT A CHAIR AT THE FIRST MEETING OF EACH YEAR.

THE COMMISSION WILL MEET AS OFTEN AS NECESSARY WITH THREE MEMBERS CONSTITUTING A QUORUM.

THE DUTY OF THE COMMISSION IS TO ESTABLISH RATES PAID TO HEALTH FACILITIES FOR MEDICAID AND GENERAL RELIEF MEDICAL PROGRAMS.

THE COMMISSION MAY EMPLOY AN EXECUTIVE DIRECTOR WHO MAY HIRE ADDITIONAL STAFF AT THE APPROVAL OF THE COMMISSION. PERSONNEL OF THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES WILL PROVIDE ASSISTANCE TO THE COMMISSION.

SECTION 6 GIVES THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES THE AUTHORITY TO ESTABLISH A PROSPECTIVE PAYMENT PROGRAM FOR GENERAL RELIEF PAYMENTS TO HEALTH FACILITIES.

SECTION 7 THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES SHALL DEVELOP AN INTERIM PROSPECTIVE RATE SYSTEM FOR THE PERIOD JULY 1, 1983 TO JUNE 30, 1984.

SECTION 8 REPEALS THE RETROSPECTIVE METHOD OF PAYMENT CURRENTLY IN USE.

SECTION 9 IMMEDIATE EFFECTIVE DATE.

Vol. 6 May 1985 No. 5

CON REPEAL MOVES

June 5 - 8, 1985
AHCA Congressional Conference
Washington, D.C.

June 20, 1985
ASHA Executive Committee
Anchorage, Alaska

June 21, 1985
DRG Seminar
Sheraton Hotel
Anchorage, Alaska

August 1 - 3, 1985
AHA Convention
Houston, Texas

August 4 - 12, 1985
Western Network Institute
Berkeley, California

August 29 - 30, 1985
ACHA Seminar: Staff Evaluation
Anchorage, Alaska

September 18 - 21, 1985
ASHA Annual Meeting
Valdez, Alaska

On Thursday May 5th, the House of Representatives voted to repeal the Alaska certificate of need program. Then on Tuesday May 10th, on a motion to reconsider its May 5th action the body amended House Bill 19 to include a prospective payment program for Medicaid, place a \$250,000 cap on operation revenue sharing, and to repeal capital revenue sharing concurrent with the repeal of certificate of need. This action supported by the Alaska State Hospital Association rejected the Finance Committee recommendation to simply increase the thresholds for certificate of need.

Leading the fight for repeal of the certificate of need were Rep. Milo Fritz, (R) Anchorage, who rebutted claims that doctors admit patients to fill empty beds; Rep. Walt Furnace, (R) Anchorage, who questioned the necessity of an archaic system; Rep. Jack McBride, (D) Ketchikan, who assured the body that his experience as a labor negotiator demonstrated that there was no consumer indifference about health costs at the bargaining table; and Rep. Fred Zharoff, (D) Kodiak, who pointed out the excessive costs of the program and the inequities caused because many state and federal facilities are exempt.

Rep. Don Clocksin, (D) Anchorage, led the opposition to repeal continuing his allegation that supply creates demand for hospital beds and claiming that certificate of need is the only way we have of controlling the cost of health care. He was joined by Rep. Peter Goll, (D) Haines, who claimed that the public supports the program, and Rep. Terry Martin, (R) Anchorage, who suggested the legislature needed some other agency to make sure that grants the legislature makes to hospitals are appropriate.

The debate over the two days ran well over two hours. In the end, on a 25-13 vote the House adopted the sponsor substitute for House Bill 19 which would repeal certificate of need and rejected the Finance Committee substitute which would have raised some thresholds to \$1 million. Then on a 32-6 vote the House added the amendments on prospective payment and revenue sharing and sent the measure on the Senate. In the Senate it has been referred to the Health, Education and Social Services Committee and the Finance Committee.

According to Ron Pavellas, executive director of Humana Hospital Alaska and chairman of the Alaska State Hospital Association, "While it is only one of many battles we have had to win on this issue, the significance of winning such a battle on the floor of the House cannot be overstated. I was pleased that we were able to get our message to our elected representatives so effectively. It was a real team — grass roots — effort with people from Ketchikan to Nome involved. This is one more visible step toward becoming the effective advocacy force as outlined in our mission statement."

NOMINATING COMMITTEE APPOINTED

The 1985 Nominating Committee has been appointed by Association Chairman Ron Pavellas. The committee is chaired by Immediate Past Chairman Tom Mingen and includes Chairman Pavellas and Chairman-Elect Mark Hawkins. Offices to be filled are: chairman-elect; secretary/treasurer; delegate and alternate delegate to the American Health Care Association; trustee delegate and alternate delegate to the American Hospital Association; and physician member of the board. Nominations should be sent to the association office in Juneau before June 15.

DRG SEMINAR JUNE 21

Now is the time to make plans to attend the June 21st seminar on Diagnostic-Related Groups (DRG's) to be held at the Sheraton Hotel in Anchorage. The DRG seminar is sponsored by the Alaska State Hospital Association in cooperation with Providence Hospital.

Robert Barclay Fetter, D.B.A., director of the Health Systems Management Group, School of Organization and Management at Yale University will lead the seminar. He will discuss the effects on administrators and physicians as health care in the United States enters this new phase of reimbursement. The use of DRG's for measurement and control of both cost and quality of care will be the seminar's central focus.

A registration fee of \$85.00 per person is required. Pre-registration is encouraged, however participants may also register at the hotel at 8:30 A.M. the morning of the sessions. The seminar will begin at 9:00 A.M. and close at 5:00 P.M. Lunch is provided. Brochures and registration forms will be in the mail to health facilities by May 20. For further information, contact Bob Palanuk or Tedd Kessel at Providence Hospital, 562-2211.

BENNETT INTRODUCES CON STUDY

Senator Don Bennett, (R) Fairbanks, Co-Chairman of the Senate Finance Committee has introduced Senate Resolution 5 which would direct the Senate Finance Committee to conduct a comprehensive study of the state certificate of need program to determine the feasibility of maintaining the program in some form that is in compliance with federal law and if it is found ineffective, to recommend alternatives.

The resolution will be heard in the Senate Finance Committee on May 19. (The day after Northern Care goes to press.) The Association will testify that it feels the study is unnecessary but that we have no fears about such a study as it will demonstrate that certificate of need is an unnecessary appendage to health facility construction in Alaska. Further, if the Senate Finance Committee is unwilling to deal with repeal this year it is imperative that the certificate of need thresholds be increased and that the prospective payment portions of the bill (SB 85) be moved this year.

CORDOVA HOSTS NURSING WORKSHOP

More than 25 nurses and nurses aides met in Cordova in late April for a two-day workshop on rehabilitative nursing care. Fourteen of the participants came to Cordova from health facilities in Homer, Kodiak and Anchorage. The classes offered inservice education for the local nurses as well as allowing them to earn continuing education credits.

The workshop was organized and sponsored by Cordova Community Hospital and the Alaska State Hospital Association. Sharon Randall, L.P.T. who works at the Cordova hospital did most of the organizing legwork of the sessions. Kathleen Van Dyke, R.N., from the Good Samaritan Hospital and Rehabilitation Center Puyallup, Washington instructed the workshop.

SITKA COMMUNITY HOSPITAL NEW FACILITY

As a result of 3 years planning, design, and fundraising, the new physical plant for the Sitka Community Hospital opened its doors to accept patients on May 8. In terms of floorspace, the new facility is four times the size of the old structure with expanded ancillary sections and modern heating and ventilation systems. According to Mark Hawkins, hospital administrator, "the new facility allows us to serve as a 1983 hospital versus a 1950 hospital."

Although the number of patient beds has not changed, they are now organized in single patient rooms including a new birthing room and minimal security areas.

On permanent display in the foyer of the new hospital is a large plaque listing the names of individuals and groups who donated to the \$11.2 million project.

AT HUMANA — FAMILIES SHARE SURGERY

Relatives of patients at Humana Hospital Alaska in Anchorage now have an opportunity to view a family member's surgery — as it happens — on closed circuit T.V. The surgeon may explain procedures involving the ears, eyes, nose and throat as they progress and answer questions through a two-way phone system that links the surgery room with Humana's newly-opened video viewing room. One family videotaped a son's operation so he could show it to his science class afterwards.

Dr. David Williams, Humana physician who was instrumental in bringing video into the operating room, said "I wanted to bring surgeries live to the parents or spouse of those having surgery. I want them to see what's involved and understand it."

"It's not creepy or gory," a young wife reported after watching delicate ear surgery on her husband. "It was wonderful to be a part of the operation as opposed to sitting it out in a waiting room, twiddling my thumbs and wondering how things are progressing."

AMENDMENT TO SB 85

After line 27, insert:

"Section 3 AS 29.90.010-29.90.030 is repealed.

Section 4. Any hospital or health facility, ^{currently} receiving state aid for hospital and health facility construction shall receive such aid as it would have, had AS 29.90.010-29.90.030 not been repealed. However, no new applications for aid shall be received or processed after the effective date of this legislation."

Amendment

*1982 amendment
limited construction
funding prior to July 1, 1980*

*Alaska
State
Hospital
Association*

*Dennis L. DeWitt
PRESIDENT*

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

*Official copy
Return to:*

JUN 28 1962

DEPUTY COMMISSIONER
DEPT. OF HEALTH & SOCIAL SVCS
ANCHORAGE

BEFORE THE
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
STATE OF ALASKA

In the Matter of the Revocation)
of the Certificate of Need)
for LAKE OTIS HOSPITAL)
)
)
)
)
)

PROPOSED DECISION

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INTRODUCTION

Respondent, Lake Otis Clinic (hereinafter "LOC") was formally issued a grandfathered certificate of need (hereinafter "C/N") for construction of a 125-bed acute medical care hospital in Anchorage on July 27, 1977. The hospital has not yet been constructed. Petitioner, South Central Health Planning and Development, Inc. (hereinafter "South Central"), filed an accusation for revocation of respondent's C/N on August 8, 1980, alleging, in pertinent part, that LOC has neither "shown continuing progress toward commencement of the activities" contemplated by its C/N nor demonstrated "good cause" for its failure to complete construction of the hospital. AS 18.07.081(d)(1) and (2). Following substantial discovery, the case came on for hearing pursuant to the Administrative Procedure Act on January 25, 1982 and continued through February 2, 1982. Testimony from many witnesses, and numerous exhibits, were submitted by the parties. Post-hearing briefs were filed thereafter.

Having considered all the evidence and arguments presented, and after conducting independent research, it is the hearing officer's recommendation that respondent's certificate of need be revoked pursuant to AS 18.07.081(d)(2). Because the fact situations relevant to this determination cover many years and a variety of complex activities on the part of numerous individuals as well as private and governmental entities, and because an understanding of the sequence of events in this case is essential to the rendition of a reasoned opinion in this matter, and finally, because no transcript of these proceedings has been ordered, unusually extensive findings of fact have been prepared and are set forth below. A draft of these findings was submitted to counsel and their objections received and considered in finalizing this proposed decision. See, Pleadings, Tabs 40 - 42.

FINDINGS OF FACT

I. Background Information

1. In the mid-seventies, federal and state legislation was passed to provide for coordinated state-wide health planning. The lawmakers' intent was to facilitate access to health care at a reasonable cost. Hammett testimony.

2. Pursuant to these statutes, a hierarchy of quasi-public and public bodies within the State of Alaska was authorized to carry out the legislative mandate. As pertains to this case, the agencies include the Anchorage Municipal Health Commission at the municipal level (preceded by the Comprehensive Health Planning Council); South Central Health Planning and Development, Inc., the Health Services Agency ("HSA"), at the regional level; the Office of State Health Planning and Development ("SHPDA"); and, finally, the Commissioner of Health and Social Services.

3. South Central is organized as a nonprofit corporation. Policies are established by a board of directors from nine sub-areas. The majority of the board membership is comprised of consumers. Health care providers, presently including administrators from existing area hospitals, are also represented.

4. Under state law, no health care facility may be constructed, altered, or added to without issuance of a certificate of need from the state. AS 18.07.031. Applications for C/Ns in the Anchorage area must undergo a review process in which the municipal commission advises South Central which in turn makes a recommendation to SHPDA which presents its view to the Commissioner who ultimately issues or denies the C/N.

5. Central to the entire legislative plan and certificate of need process is the premise that traditional supply and

WRONG

demand economics do not apply to the area of hospital costs. According to Margaret Wilson, health planner with South Central, the cost of maintaining an empty hospital bed is 40 - 60 percent that of maintaining an occupied bed. Vacant beds can result in longer hospital stays. Hammett testimony. And patients generally do not "hospital shop," but rather use the facility in which their physician has staff privileges. Thus, the appropriateness of issuing a certificate of need for construction of a new hospital may hinge on a determination of whether development of the new facility would result in the community being "over-bedded," thus raising health care costs to the consumer. See, AS 18.07.041.

6. Certificates of need for hospital construction establish the number of beds a facility is entitled to have and can put into operation with reasonably little effort. A hospital's licensed capacity, on the other hand, is the number of beds actually approved after inspection for adequate lighting, heating, etc. Open beds are those licensed beds currently staffed. Hammett testimony.

7. Dr. Michael Beirne is a medical doctor, legislator, and businessman. He is the president of Lake Otis Clinic, Inc., the non-profit corporation formed to develop the Lake Otis Community Hospital ("LOCH"). The corporation is closely held, consisting of Beirne and family members on both the three-person board and in the officers' positions.

II. Chronology

1960's

8. 1962 - Three doctors, including Beirne, purchased a 10-acre tract of land for development of a professional building and hospital. In the mid-sixties, a plat was recorded for this tract, identified as "Medical Park Subdivision." The southern

five acres was depicted as a hospital site.

1970

9. January, 1970 - Beirne hired Don Emmal to assist him in the management of three operating clinics and to initiate development of the hospital project.

10. March, 1970 - LOC was organized and incorporated.

11. Spring, 1970 - Application for recommended approval of the hospital was made to the Comprehensive Health Planning Council.

1971 - 1972

a. LOCH activities

12. The Comprehensive Health Planning Council initially recommended approval of LOC's application, then denial, with affirmation of that denial recommendation some time later. According to Beirne, Providence and Alaska (then "Community") hospitals opposed LOC's request for approval. While there was no certificate of need law requiring agency approval at the time, Beirne testified that the action of the municipal commission effectively precluded FHA financing for the project. FHA financing was desired because FHA interest rates were then one to two percent lower than conventional financing.

13. January, 1972 - A feasibility study was performed by Hospital Associates at a cost of \$10,000. Exh. R-2.

14. January 17, 1972 - LOC applied for tax exempt status. No mention was made of the hospital project in this application. On Exhibit K to the application, Beirne indicated that he and Emmal spent approximately five and 15 percent of their time, respectively, working on corporation-related activities. Exh. P-39.

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15. Negotiations commenced with General Health Services, Inc. ("GHS") regarding private development and operation of the hospital. Exh. P-110 at 2.

b. Activities at other Anchorage hospitals

16. Providence Hospital was licensed for 150 beds. Community Hospital was licensed for 85 beds. Community Hospital requested 80 additional beds. LOC objected. The state authorized 40 additional beds on the condition that Community Hospital relocate. Beirne testimony.

1973-74

a. LOCH activities

17. An agreement was reached with GHS for financing and management of the project. Exh. R-3A. Beirne testified that GHS had obtained long-term financing under an agreement providing that it would not be obliged to close the transaction if the interest rate exceeded 10 percent.

18. Contracts were signed with Channen Construction Company (general contractors), Luckman & Associates (architects), KPFF (structural engineers) and others for construction of the hospital. Exh. P-110 at 3. Coopers & Lybrand performed a feasibility study.

19. Interim construction loans were obtained by GHS and LOC from Peoples Bank in the amount of \$900,000. Interest payments, if made timely would have amounted to \$61,617.19. Exh. P-95. Deeds of trust on various pieces of real estate owned by Beirne were taken as collateral.

20. Site work was commenced in mid-1973 with clearance of brush, excavation and removal of peat, refilling with gravel, and installation of pilings. Work was stopped in May or June, 1974 when the \$900,000 had been expended. Beirne waited for

a drop in interest rates. Beirne testimony.

21. Due to the escalation of the prime interest rate above the maximum acceptable to GHS, GHS terminated the financing and management agreements with LOC. LOC and Beirne proceeded to liquidate properties over a period of approximately three years to indemnify GHS which in turn was obliged to repay the loans from Peoples Bank., Beirne testimony.

b. Beirne's salary arrangements/representations

22. April 1, 1973 - Beirne entered into an employment contract with LOC which entitled him to a salary of \$70,000 per annum (adjustable upwards thereafter) plus benefits, for a term of 10 years. The contract provided, inter alia, that Beirne "shall devote substantial time to the performance of his duties as may from time to time be required." The agreement also recited that

It is understood that Employee is presently serving as an executive officer of other corporations including a corporation providing pathology and laboratory services and owning and operating real properties and that some of Employee's time may be devoted to such corporations.

Exh. P-37.

23. April 30, 1973 - Beirne signed a grant application which was filed with the Department of Health, Education and Welfare seeking funding for Fairview Health Care Center, to be operated by LOC with Beirne as project manager and Emmal as assistant project manager. The grant application budget provided that both those positions would be full time with salaries of \$41,650 and \$29,750, respectively. Exh. P-38A.

c. Status of LOCH site

24. Beirne testified that in 1973, he deeded the hospital site to LOC.

d. Activities re. other Anchorage hospitals

25. During this same period, the Teamsters acquired Community Hospital and began construction of that facility's new building, thereafter known as "Alaska Hospital." 101

26. Providence Hospital was operating 150 beds in its south tower, 58 of those beds not conforming to legal requirements. Hill-Burton funds in the amount of \$3.5 million were approved for construction of a north tower, with total bed capacity set at 219. Exh. R-74. (Exh. R-74 contains hearsay statements. The exhibit, however, is a 1979 letter from a disinterested party, Dr. McGinnis, to Al Camosso, Administrator at Providence. Dr. McGinnis was in a position to have access to records of past activities regarding Providence's bed status, and there is no reason to doubt the reliability of the historical information he presents. Most of the numbers and dates referenced in Exh. R-74 also appear in Exhs. R-51, R-51A, R-52, R-53, R-70, and/or R-71. R-74 is relied on in these Findings, thus, to delineate the approximate sequence of events leading to Providence's non-conforming bed waiver and increased licensure.)

27. May 14, 1974 - Providence applied to the Department for revenue sharing funds to modernize its south tower and eliminate the 58 non-conforming beds in that structure. Exh. R-74. 2

1975

a. LOCH activities

28. Beirne became more actively involved in the hospital project, meeting with GHS, and with Chalista, NANA and Aleut Native corporations. Emmal was transferred to the Aleut Corporation on July 1, 1975 to work on the project, but Beirne declined to extend the agreement with this party, because he believed the arrangement to be "too one-sided." Beirne testimony.

29. Local architect Richard Sears was hired to change the plans to meet new code provisions, and to make the project more cost-effective. Kingston Peters was hired to help liquidate the debt to GHS.

30. October, 1975 - GHS filed a foreclosure suit on LOC's debt to GHS.

31. LOC received \$312,000 in state revenue sharing funds. Exh. P-38.<

b. Status of LOCH site

32. Beirne transferred the hospital site to GHS by warranty deed. Beirne testimony. Beirne testified that [notwithstanding the legal significance of a warranty deed] this transaction was intended only to give GHS a security interest in the property.

c. Activities re. other Anchorage hospitals

33. Providence's May 14, 1974 application for revenue sharing funds to modernize its south tower was approved by the Department. Exh. R-74. - 1st time? / M

1976

a. LOCH activities

34. March 13, 1976 - A letter of agreement was entered into with Modern Construction, Inc.-Tri/Alaska Construction, Inc. for design and estimating work on the hospital project. The Modern-Tri/Alaska joint venture was to operate as architect and contractor for the project if construction became feasible. Exh. R-9.

35. A contract was entered into with Gilgan & Company to obtain economic feasibility studies, planning studies and mortgage financing. Exh. P-110 at 3. Beirne testified that Gilgan initiated the process of obtaining a FHA loan, which effort was not successful.