ALASKA LEGISLATURE COMMITTEE FILES 1985-1986 8672

3932 SHES SB 158 - SB 163

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RECORDS CERTIFICATION

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James O. Smith
Signature of Camera Operator

10/31/89
Date

12-519 (REV 8/78)

SB
158

Senate Health, Education and Social Services Committee

Legislation Checklist

Bill number: SB 158

Sponsor: HESS committee

Date referred to committee: 2/14

Synopsis completed:

Fiscal note:

Further referrals: Judiciary + Finance

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.iE HALEY of the AHA Washington office called to advise:

Sanctions under health planning would be applied for failure of SHPDA to be fully designated..

1. State would lose SHPDA grant;

2. All public health service funds reduced
   25% - year 1
   50% - year 2
   75% - year 3
   zippo - year 4.

Shane's # (202) 638-1100.

bf

123.404 SCOPE OF CERTIFICATE OF NEED REVIEW PROGRAMS.

(a) Required coverage. The State certificate of need program must apply to the obligation of capital expenditures, the offering of new institutional health services, and the acquisition of major medical equipment. For the purposes of this subpart, "the obligation of capital expenditures, offering of new institutional health services, and acquisition of major medical equipment" means the following:

(a)(1) Capital expenditures that exceed the expenditure minimum. The obligation by or on behalf of a health care facility of any capital expenditure (other than to acquire an existing health care facility) that exceeds the expenditure minimum for capital expenditures (or any lesser amount the State may specify). The cost of any studies, surveys, designs, plans, working drawings, specifications, and other activities (including staff effort and consulting and other services) essential to the acquisition, improvement, expansion or replacement of any plant or equipment with respect to which an expenditure is made shall be included in determining if the expenditure exceeds the expenditure minimum. As to the obligation of a capital expenditure to acquire an existing health care facility, see paragraph (a)(5) of this section.

Explanatory note—Expenditures by a component of a larger institution, such as a university, which is distinct from a separate health care facility component, such as the university's hospital, need not be viewed as being "by a health care facility" for purposes of this section. Thus, a capital expenditure by a university medical school that is a distinct component of the university need not be considered to be "by" the hospital of the university. In finding that the medical school is distinct, the State Agency should find at least that the revenues derived from patient charges at the hospital of the university are not used for operating expenses of the medical school. If a capital expenditure exceeds the expenditure minimum, for it to be required to be subject to review, the State Agency must find that it is "on behalf of" a health care facility. Such an expenditure is also required to be subject to review if it is for the acquisition of major medical equipment and meets the conditions set forth in 123.404(a)(4) of this subpart. The same analysis would apply to a distinct research component of a legal entity, the primary activity of which is operating a hospital.

(a)(2) Bed capacity The obligation of any capital expenditure by or on behalf of any health care facility which—(i) increases or decreases the total number of beds, (ii) redistributes beds among various categories, or (iii) relocates beds from one physical facility or site to another—by ten beds or ten percent, whichever is less, in any two-year period.

(a)(3) Health services.

(i) The obligation of any capital expenditure by or on behalf of a health care facility which is associated with (A) the addition of a health service which was not offered by or on behalf of the facility within the previous twelve months, or (B) the termination of a health service which was offered in or through the facility; or

(ii) The addition of a health service which is offered by or on behalf of the health care facility which was not offered by or on behalf of the facility within the twelve-month period before the month in which the service would be offered, and which entails annual operating costs of at least the expenditure minimum for annual operating costs.

(a)(4) Major medical equipment.

(i) The acquisition by any person of major medical equipment that will be owned by or located in a health care facility; or

(ii) The acquisition by any person of major medical equipment not owned by or located in a health care facility, if (A) the notice of intent required by 123.406(a) is not filed in accordance with that paragraph, or (B) the State Agency finds, within 30

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123.404 SCOPE OF CERTIFICATE OF NEED REVIEW PROGRAMS, contd.

days after the date it receives a notice in accordance with 123.406(a), that the equipment will be used to provide services for inpatients of a hospital.

(iii) An acquisition of major medical equipment need not be reviewed if it will be used to provide services to inpatients of a hospital only on a temporary basis in the case of (A) a natural disaster, (B) a major accident, or (C) equipment failure.

(iv) A State program may cover major medical equipment not owned by or located in a health care facility beyond the minimum coverage required by this subparagraph; however, after September 20, 1982, the certificate of need program of a State may not be changed to include additional requirements for coverage of this equipment.

(a)(5) Acquisitions of health care facilities.

(i) Except as provided in 123.405(b) (HMOs), the obligation of a capital expenditure by any person to acquire an existing health care facility (A) if the notice of intent required at 123.406(b) is not filed in accordance with that paragraph, or (B) if the State Agency finds, within 30 days after the date it receives a notice in accordance with 123.406(b), that the services or bed capacity of the facility will be changed in being acquired.

(ii) Each State Agency shall specify, for purposes of the preceding sentence, what activities result in a change in the services or bed capacity of a health care facility; however, these activities must include at least (A) a change in bed capacity as described in paragraph (a)(2) of this section, (B) the addition of a health service which was not offered by or on behalf of the facility within the previous twelve months, and (C) the termination of a health service which was offered by or on behalf of the facility.

(b) Leases, donations, and transfers. An acquisition by donation, lease, transfer, or comparable arrangement must be reviewed if the acquisition would be subject to review under paragraph (a) of this section if made by purchase. An acquisition for less than fair market value must be reviewed if the acquisition at fair market value would be subject to review under paragraph (a) of this section.

(c) Incurring an obligation. No person may incur an obligation for a capital expenditure that is subject to review under paragraphs (a)(1), (a)(2), (a)(3)(i), or (a)(5) of this section without obtaining a certificate of need for the capital expenditure. An obligation for a capital expenditure is considered to be incurred by or on behalf of a health care facility: (1) When a contract, enforceable under State law, is entered into by or on behalf of the health care facility for the construction, acquisition, lease or financing of a capital asset; or (2) When the governing board of the health care facility takes formal action to commit its own funds for a construction project undertaken by the health care facility as its own contractor; or (3) In the case of donated property, on the date on which the gift is completed under applicable State law.

Note—A State may consider an obligation for a capital expenditure which is contingent upon issuance of a certificate of need not to be incurred until the certificate of need is issued.

(d) Subsequent reviews.

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123.404 SCOPE OF CERTIFICATE OF NEED REVIEW PROGRAMS, contd.

(d)(1) **Capital expenditures.** The State program must provide as follows: A proposed change in a project associated with a capital expenditure for which the State Agency has previously issued a certificate of need will require review if the change is proposed within one year (or any longer period established under the State program) after the date the activity for which the expenditure was approved is undertaken. (As an illustration, where a hospital receives approval to construct a new wing for its facility, the hospital will "undertake the activity" when it begins to provide services in the wing.) This subparagraph applies to changes associated with capital expenditures that were subject to review under paragraph (a)(1), (a)(2) or (a)(3)(i) of this section. A review is required under this subparagraph whether or not a capital expenditure is associated with the proposed change. A "change in a project" shall include, at a minimum, any change in the bed capacity of a facility as described in paragraph (a)(2) of this section, and the addition or termination of a health service.

Explanatory note—Examples that illustrate coverage required by this paragraph are as follows: (1) A certificate of need is obtained for the obligation of a capital expenditure which results in the addition of ten psychiatric beds. Within one year, those beds are proposed to be converted to pediatric beds. Certificate of need review is requi[illegible] the conversion, regardless of whether this later activity is associated with a capital expenditure. (2) A certificate of need is obtained for the obligation of a capital expenditure which results in the addition of a new psychiatric service. Within one year, this service is proposed to be converted to a new pediatric service. Certificate of need review is required, regardless of whether a capital expenditure associated with the new service will be incurred or annual operating costs of at least the expenditure minimum will result.

(d)(2) **Major medical equipment.** If a person acquires major medical equipment not located in a health care facility without a certificate of need and proposes at any time to use that equipment to serve inpatients of a hospital the proposed new use must be reviewed unless the use is one described in paragraph (a)(4)(iii) of this section.

(d)(3) **Existing facilities.** If a person acquires an existing health care facility without a certificate of need and proposes to change within one year after the acquisition (or any longer period of time established under the State program) the services or bed capacity of the facility, the proposed change must be reviewed if it would have required review under paragraph (a)(5) of this section originally.

(e) **Dissemination of scope of coverage** Before reviewing any project not previously within the scope of the State progam's coverage, each State Agency shall disseminate to all health systems agencies, health care facilities, and HMOs within the State, and shall publish in one or more newspapers of general circulation in the State, a description of the scope of coverage of its program. The description must include at least the coverage required by 123.404 and 123.405 of this subpart. Whenever the scope of coverage is revised, the State Agency shall disseminate and publish a revised description of it.

Source: Federal Register, Jan. 21, 1977; Apr. 2, 1979; Apr. 25, 1979; Oct. 21, 1980.

123.405 Health maintenance organizations (HMOs).

(a) **Required coverage.** With respect to an HMO or a health care facility controlled, directly or indirectly, by an HMO or combination of HMOs, the State Agency shall review any activity specified in 123.404 which is undertaken by or on behalf of an inpatient health care facility (unless these activities are exempt under paragraph (b)(1) of this section). In addition, the State Agency shall review the acquisition of major medical equipment by an ambulatory care facility of an HMO to the extent required by 123.404(a)(4) and 123.404(d)(2) (unless the acquisition is exempt under paragraph

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(b)(1) of this section). A State program may not exceed the coverage specified in this paragraph.

Explanatory note—A list of examples illustrating this coverage follows: (1) Major medical equipment acquired by HMOs which is not owned by or located in a health care facility and which is used primarily for inpatients of a hospital must be reviewed (unless the project is exempt); further, major medical equipment acquired by an HMO and located in a health care facility must be reviewed (unless the project is exempt). (2) A capital expenditure for an ambulatory clinic proposed by an HMO which expenditure is not proposed by or on behalf of an inpatient health care facility is not subject to review. (3) The establishment of an HMO is not subject to certificate of need review. (4) Any capital expenditure exceeding the expenditure minimum by or on behalf of an HMO's inpatient health care facility must be reviewed (unless the project is exempt). (5) A capital expenditure for the addition of ten beds to an HMO's hospital must be reviewed (unless the project is exempt).

(b) Exemptions.

(b)(1) Exemptions from review. The State Agency shall exempt from review any activity described in paragraph (a) of this section if the applicant meets the requirements of paragraph (b)(2) of this section and if the activity is proposed to be undertaken by:

(i) An HMO or a combination of HMOs if (A) the HMO or combination of HMOs has, in the service area of the HMO or the service areas of the HMOs in the combination, an enrollment of at least 50,000 individuals, (B) the facility in which the service will be provided is or will be geographically located so that the service will be reasonably accessible to the enrolled individuals, and (C) at least 57 percent of the patients who can reasonably be expected to receive the health service will be individuals enrolled with the HMO or HMOs in the combination; or

(ii) A health care facility if (A) the facility primarily provides or will provide inpatient health services, (B) the facility is or will be controlled, directly or indirectly, by an HMO or a combination of HMOs which has, in the service area of the HMO or service areas of the HMOs in the combination, an enrollment of at least 50,000 individuals, (C) the facility is or will be geographically located so that the service will be reasonably accessible to the enrolled individuals, and (D) at least 75 percent of the patients who can reasonably be expected to receive the health service will be individuals enrolled with the HMO or HMOs in the combination; or

(iii) A health care facility (or portion thereof) if (A) the facility is or will be leased by an HMO or combination of HMOs which has, in the service area of the HMO or the service areas of the HMOs in the combination, an enrollment of at least 50,000 individuals and, on the date the application is submitted under paragraph (b)(2) of this section, at least fifteen years remain in the term of the lease, (B) the facility is or will be geographically located so that the service will be reasonably accessible to the enrolled individuals, and (C) at least 75 percent of the patients who can reasonably be expected to receive the health service will be individuals enrolled with the HMO.

(b)(2) Application for exemption.

(i) An activity of an HMO, combination of HMOs, or health care facility shall not be exempt under paragraph (b)(1) of this section unless—

(A) The applicant has submitted, at the time and in the form and manner prescribed by the State Agency, an application for an exemption to the State Agency and the appropriate health systems agency,

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123.405 HMOs, contd.

(B) The application contains the information respecting the HMO, combination, or facility and the proposed offering, acquisition, or obligation that the State Agency may require to determine if the HMO or combination meets the requirements of paragraph (b)(1) of this section or the facility meets or will meet those requirements, and

(C) The State Agency approves the application.

(ii) The State Agency shall approve an application submitted under this paragraph if the applicable requirements of paragraph (b)(1) of this section have been met or will be met on the date the proposed activity for which an exemption was requested will be undertaken.

(b)(3) Sale, lease, acquisition, or use of exempt facilities or equipment. The State program must provide that a health care facility (or portion thereof) or medical equipment for which an exemption was granted under paragraph (b)(1) of this section may not be sold or leased, a controlling interest in the facility or equipment or in a lease of the facility or equipment may not be acquired, and a health care facility described in paragraph (b)(1)(iii) of this section which was exempted under paragraph (b)(1) of this section may not be used by any person other than the lessee described in paragraph (b)(1)(iii) unless,

(i) The State Agency issues a certificate of need for the sale, lease, acquisition, or use, or

(ii) The State Agency determines, upon application, that (A) the entity which intends to buy or lease the facility or equipment, or acquire the controlling interest in it, or which intends to use it, is an HMO or a combination of HMOs which meets the requirements of paragraph (b)(1)(i)(A) of this section; and (B) with respect to the facility or equipment, the entity meets the requirements of paragraph (b)(1)(i) (B) and (C) of this section or of paragraph (b)(1)(ii) (A) and (B) of this section.

(b)(4) Method of payment. The method of payment for services (i.e., prepaid or fee-for-service) is not relevant in determining whether an activity is subject to review under this subpart.

(c) Inclusion in health plans. If an HMO or a health care facility which is controlled, directly or indirectly, by an HMO applies for a certificate of need, a State Agency may not disapprove the application solely because the proposal is not discussed in the applicable health systems plan, annual implementation plan, or State health plan.

(d) Required approval. Notwithstanding general review criteria established in accordance with 123.412, if an HMO or a health care facility which is controlled, directly or indirectly, by an HMO applies for a certificate of need, the State Agency shall approve the application if it finds (in accordance with 123.412(a)(13)) that (1) approval of the application is required to meet the needs of the members of the HMO and of the new members which the HMO can reasonably be expected to enroll, and (2) the HMO is unable to provide, through services or facilities which can reasonably be expected to be available to the HMO, its health services in a reasonable and cost-effective manner which is consistent with the basic method of operations of the HMO and which makes these services available on a long-term basis through physicians and other health professionals associated with it.

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123.405 HMOs, contd.

(e) Sale, acquisition, or lease of approved facilities or equipment. The State program must provide that except as provided in paragraph (b)(2) of this section and notwithstanding 123.406, a health care facility (or portion thereof) or medical equipment for which a certificate of need was issued under this section may not be sold or leased, and a controlling interest in the facility or equipment or in a lease of the facility or equipment may not be acquired, unless the State Agency issues a certificate of need for the sale, acquisition, or lease.

Source: Federal Register, Jan. 21, 1977; Apr. 2, 1979; Oct. 21, 1980.

123.406 Notice of intent.

The State program must provide as follows:

(a) Major medical equipment. At least 30 days before any person enters into a contract to acquire major medical equipment which will not be owned by or located in a health care facility, the person shall notify the State Agency of the State in which the equipment will be located and the appropriate health systems agency of the person's intent to acquire the equipment and of the use that will be made of the equipment (see 123.404(a)(4)(ii)). The notice must be in writing and contain all information the State Agency requires in accordance with 123.410(a)(4).

(b) Acquisition of health care facilities. At least 30 days before any person acquires or enters into a contract to acquire an existing health care facility, the person shall notify the State Agency of the State in which the facility is located and the appropriate health systems agency of the person's intent to acquire the facility and of the services to be offered in the facility and its bed capacity (see 123.404(a)(5)). The notice must be made in writing and must contain all information the State Agency requires in accordance with 123.410(a)(4).

(c) Construction projects. The State Agency shall have procedures for persons proposing construction projects to submit to the State Agency and the appropriate health systems agency, as early as possible in the course of planning the project, a notice of intent in as much detail as may be necessary to inform the agencies of the scope and the nature of the project.

Source: Federal Register, Jan. 21, 1977; Apr. 2, 1979; Oct. 21, 1980.

123.407 Required approvals.

(a) Except as provided in paragraph (b) of this section, the State Agency shall issue a certificate of need for a proposed capital expenditure if (1) the capital expenditure is required (i) to eliminate or prevent imminent safety hazards as defined by Federal, State, or local fire, building, or life safety codes or regulations, or (ii) to comply with State licensure standards, or (iii) to comply with accreditation of certification standards which must be met to receive reimbursement under Title XVIII of the Social Security Act or payments under a State plan for medical assistance approved under Title XIX of that Act, and (2) the State Agency has determined that (i) the facility or service for which the capital expenditure is proposed is needed, and (ii) the obligation of the capital expenditure is consistent with the State health plan.

Explanatory note—For applications which meet the requirements of 123.407(a), the State Agency shall use procedures and apply criteria (to the extent they are appropriate to determine need) as required by this subpart. If the State Agency determines that the facility or service for which the expenditure is proposed is not needed (and thus that the expenditure to correct the deficiency is not needed), it must deny the certificate of need as required by 123.408(a). If the State Agency determines that the expenditure is not consistent with the

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123.407 REQUIRED APPROVALS, contd.

State health plan, it must deny the certificate of need unless there is an emergency that poses an imminent threat to public health (see 123.403(d)). Even in such a case, there is no requirement that the State Agency issue a certificate of need. The State Agency should consider alternative means of dealing with the threat to public health. State Agencies may wish to expedite the review of applications intended to correct deficiencies which pose a threat to the public health. In so doing, State Agencies may use any exceptions to the required review procedures which have been approved under 123.411.

(b) Those portions of a proposed project which are not required to eliminate or prevent safety hazards or to comply with certain licensure, certification, or accreditation standards are subject to review using the criteria developed under 123.412.

Source: Federal Register, Jan. 21, 1977; Apr. 2, 1979; Oct. 21, 1980.

123.408 Enforcement.

(a) The State certificate of need program must provide that (1) State Agencies may only issue a certificate of need for those obligations of capital expenditures, offerings of institutional health services, and acquisitions of major medical equipment which are found to be needed; and (2) persons may only obligate capital expenditures, offer institutional health services or acquire major medical equipment after a certificate of need is issued or an exemption under 123.405(b) is obtained; and (3) persons may not obligate capital expenditures, offer institutional health services, or acquire major medical equipment if a certificate of need authorizing that obligation, offering, or acquisition has been withdrawn by the State Agency.

(b) The State certificate of need program must provide sanctions, such as the denial or revocation of a license to operate, civil or criminal penalties, or injunctive relief, which the Secretary finds sufficient to ensure compliance with paragraph (a) of this section.

Source: Federal Register, Jan. 21, 1977; Oct. 21, 1980.

123.409 Adoption and public notice of review procedures and criteria.

(a) Each State Agency shall adopt, and review and revise as necessary, review procedures and criteria in accordance with the requirements of this subpart prior to conducting reviews.

(b) The State Agency, the Statewide Health Coordinating Council, and the health systems agencies within the State shall cooperate in the development of procedures and criteria under this subpart to the extent appropriate to achieve efficient reviews and consistent criteria for reviews.

(c) Before adopting the review procedures and criteria required by this subpart or any revisions of the procedures and criteria, the State Agency shall give interested persons an opportunity to offer written comments on the procedures and criteria, or any revisions thereof, which it proposes to adopt.

(c)(1) The State Agency shall distribute copies of its proposed review procedures and criteria, and proposed revisions thereof, to Statewide health agencies and organizations, the Statewide Health Coordinating Council, each health systems agency for a health service area located in the State, and any agency which establishes rates for health care facilities or HMOs in the State.

(c)(2) The State Agency shall publish, in one or more newspapers of general circulation in the State, a notice stating that review procedures and criteria, or revisions thereof, have been proposed for adoption and are available at specified addresses for inspection and copying.

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STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

JAY S. HAMMOND, GOVERNOR

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

May 10, 1982

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

Dear Rep. .sentative Beirne:

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

We appreciate the hearing you conducted on House Bill 19. . We believe this bill, with the amendments we offered, would bring our State Health Planning and Development Agency into full compliance with federal requirements. Your assistance in helping to move this legislation would be very much appreciated.

We appreciate your assistance and support in this matter.

Sincerely,

Helen D. Beirne
Commissioner

Enclosure

cc: Phoebe A. Lindsey

F38LH

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

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

June 22, 1982

Re: 10P 550016
Alaska SHPDA

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

Dear Mr. DeWitt:

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

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

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

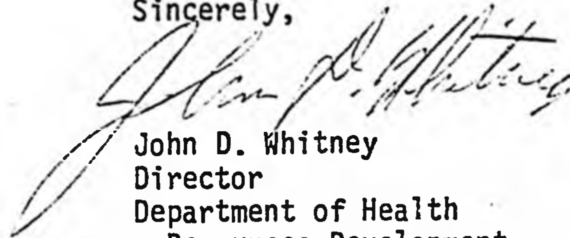
Fully designated SHPDAs (such as Alaska) which do not have complying CON programs but continue to meet other requirements, will be returned to conditional designation. As noted above, PL 97-35 prohibits the conditional designation of any SHPDA from extending beyond its penalty date. Any SHPDA which remains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

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

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

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

Sincerely,



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

Enclosures (2)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

JUN 21 1982

Re: IOP 550015
Alaska SHPDA

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

Dear Dr. Beirne:

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

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

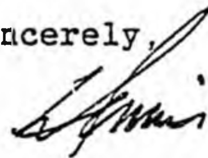
1. If the Agency is unable to retain full designation after September 30, 1982, it will be returned to conditional designation for the period October 1, 1982 to June 30, 1983.

2. The designation of the Agency will automatically terminate when the Agency reaches its penalty date, if the Agency still has not achieved full designation.

You may at any time prior to your penalty date (1-19-83, per PPM 82-12) submit documentation which you believe contains evidence that the State's CON program complies with the minimum Federal requirements, or a certification by the State's Attorney General, attesting to the program's complian

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

Sincerely,



Dennis L. DeWitt
President

DLD:lf
cc: Friday Mailing
Alaska State Medical Society
Governer Jay Hammond
Governer Elect Sheffield
Lt. Governer Terry Miller
Lt. Governer Elect McAlpine
American Hospital Association - Lynn Hart
Federation of American Hospitals

Red Petit 3355 Dave Williams 3015

under this chapter, is guilty of a misdemeanor and upon conviction is punishable by a fine of not more than $1,000. The sponsor or holder of a certificate of need injured by the violation of AS 18.07.081(e) may recover damages for loss incurred by reason of delay caused by a suspension. (§ 2 ch 275 SLA 1976)

Cross references. — As to sentences for misdemeanors, see AS 12.55.135.

Sec. 18.07.101. Regulations. The commissioner shall adopt, in accordance with the Administrative Procedure Act (AS 44.62), regulations which establish procedures under which sponsors may make application for certificates of need required by this chapter and which govern the review of those applications by the office, establish requirements for a uniform statewide system of reporting financial and other operating data, and otherwise carry out the purposes of this chapter. (§ 2 ch 275 SLA 1976)

Sec. 18.07.111. Definitions. In this chapter

(1) "commencement of activities" means the visible commencement of actual operations on the ground for the construction of a building, the alteration of the bed capacity of a health care facility, or the provision for or deletion of an existing category of health services to consumers, which operations are readily recognizable as such, and which operations are done with intent to continue the work until such activities are completed;

(2) "commissioner" means the commissioner of health and social services;

(3) "complete activities" means the substantial performance of the work required to comply with the terms of issuance of the certificate of need to which all parties participating in those activities have obligated themselves to perform;

(4) "construction" means the erection, building, alteration, reconstruction, improvement, extension or modification of a health care facility under this chapter, including lease or purchase of equipment, excavation or other necessary actions;

(5) "council" means the Statewide Health Coordinating Council organized and operated in accordance with § 1524, P.L. 93-641;

(6) "department" means the Department of Health and Social Services;

(7) "health care facility" means a private, municipal, state or federal hospital, psychiatric hospital, tuberculosis hospital, skilled nursing facility, kidney disease treatment center (including freestanding hemodialysis units), intermediate care facility, and ambulatory surgical facility; the term excludes

(A) an Alaska Pioneers' Home administered by the Department of Administration under AS 44.21.020 (10) and AS 47.25.010 — 47.25.100; and

(B) the offices of private physicians or dentists whether in individual or group practice;

(8) "category of health services" means a major type, program, unit, division, or department of care provided through a health care facility whether inpatient or outpatient, including an outpatient department, psychiatric wing, kidney dialysis program, radiotherapy, burn unit, or newborn intensive care unit, except that "service" does not include the lawful practice of a profession or vocation conducted independently of a health care facility and in accordance with applicable licensing laws of the state;

(9) "health systems agency" means an entity organized and operated in accordance with § 1521(b), P.L. 93-641, engaging in health planning and development functions in a specified health service area of the state;

(10) "office" means the office of planning and research in the Department of Health and Social Services;

(11) "secretary" means the secretary of the United States Department of Health, Education and Welfare. (§ 2 ch 275 SLA 1976; am § 2 ch 25 SLA 1981)

Effect of amendments. — The 1981 amendment, retroactive to June 29, 1976, in paragraph (7), added the subparagraph designation (B) preceding "the offices of private physicians" and added subparagraph (A).

Editor's notes. — Section 1 of ch. 25, SLA 1981, provides: "The purpose of this Act is solely to clarify and confirm that Alaska Pioneers' Homes are not, and never have been, subject to the provisions of AS 18.07."

Section 1524, P.L. 93-641, referred to in paragraph (5), and § 1521(b), P.L. 93-641, referred to in paragraph (9), may be found in 42 U.S.C. § 300m-3 and 42 U.S.C. § 300m(b), respectively.

The United States Department of Health, Education and Welfare, referred to in paragraph (11), has been redesignated as the Department of Health and Human Services.

Chapter 08. Emergency Medical Services.

Section
10. Administration
20. Advisory Council on Emergency Medical Services
30. Composition
40. Term of office
50. Compensation and per diem
60. Meetings

Section
70. Special committees
80. Regulations
82. Issuance of certificates
84. Certificate required
86. Immunity from liability
88. Penalty
90. Definitions

Collateral references. — 39 Am. Jur. 2d, Health, §§ 9-18.

39A C.J.S., Health and Environment, §§ 3-17.

Health Systems Agencies

alaska state hospital association

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

REPRESENTING ACUTE, LONG TERM AND OUTPATIENT FACILITIES

Chairman of the Board
Edward Zeine
Cordova Community Hospital
Cordova

Chairman-Elect
Michael Herring
South Peninsula Hospital
Homer

Immediate Past Chairman
Mark Hawkins
Sitka Community Hospital
Sitka

Secretary/Treasurer
Emma Ivy
Wrangell General Hospital
Wrangell

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

Alternate Delegate to the American Hospital Assoc.
Sister Barbara Haase
Ketchikan General Hospital
Ketchikan

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

Alternate Delegate to the American Health Care Association
Craig Slater
Petersburg General Hospital
Petersburg

Delegate to the Association of Western Hospitals
Keith Campbell
Seward General Hospital
Seward

Alternate Delegate to the Association of Western Hospitals
Jane Sabes
Norton Sound Regional Hospital
Nome

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

Alternate Trustee Delegate to the American Hospital Association
Maxine Robertson
Trustee, Ketchikan General Hospital

Physican Member of the Board
Morris Horning, M.D.
Anchorage

President
Dennis L. DeWitt
Juneau

POLICY STATEMENT

Certificate of Need

Position: Reduce coverage of Certificate of Need (AS 18.07) to cover only new beds and new facilities.

Rationale:

Many parts of the Certificate of Need program have proven costly, wasteful and unnecessary. It currently, as it has since its inception, treats similar projects and facilities providing identical services differently. Activities which are not specifically limited to the institutional setting ought not be regulated either in or out of the facility setting. Beyond that, remodeling and replacing worn out equipment ought not be a regulated activity.

Process: Amend AS 18.07.031 to limit application of the Certificate of Need process to net increase in licensed beds and new facilities requiring licensure or seeking to provide services to Medicaid beneficiaries.

December 6, 1984

alaska state hospital association

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

REPRESENTING ACUTE, LONG TERM AND OUTPATIENT FACILITIES

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

Chairman-Elect
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Sitka Community Hospital
Sitka

Immediate Past Chairman
Tom Mingen
Fairbanks Memorial Hospital
Fairbanks

Secretary/Treasurer
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Cordova Community Hospital
Cordova

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Al M. Camosso
Providence Hospital
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Alternate Delegate to the American Hospital Assoc.
Michael Lockwood
Central Peninsula Hospital
Soldotna

Delegate to the American Health Care Association
Jack Buck
St. Ann's Nursing Home
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Alternate Delegate to the American Health Care Association
Emma G. Ivy
Wrangell General Hospital
Wrangell

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

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

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

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

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

President
Dennis L. DeWitt
Juneau

POLICY STATEMENT

CERTIFICATE OF NEED

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

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

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

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

#1

bcc Dennis DeWitt

PROVIDENCE
HOSPITAL

SISTERS OF
PROVIDENCE

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

SERVING IN THE WEST SINCE 1856

December 27, 1982

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

Dear Mayor Knowles:

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

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

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

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

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

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

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

MEMBERS OF THE SISTERS OF PROVIDENCE CORPORATION—ALASKA: PROVIDENCE HOSPITAL, ANCHORAGE—WASHINGTON: PROVIDENCE MEDICAL CENTER, SEATTLE—THE DePAUL RETIREMENT RESIDENCE AND MOUNT ST. VINCENT NURSING CENTER, SEATTLE—PROVIDENCE HOSPITAL, EVERETT—ST. PETER HOSPITAL, OLYMPIA—ST. ELIZABETH HOSPITAL, YAKIMA—OREGON: PROVIDENCE HOSPITAL, MEDFORD—PROVIDENCE MEDICAL CENTER, PORTLAND—PROVIDENCE CHILD CENTER, PORTLAND—ST. VINCENT HOSPITAL AND MEDICAL CENTER, PORTLAND—CALIFORNIA: PROVIDENCE HOSPITAL, OAKLAND—PROVIDENCE HIGH SCHOOL, BURBANK—SAINT JOSEPH MEDICAL CENTER, BURBANK

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

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

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

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

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

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

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

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

Mayor Tony Knowles
Page Three
December 27, 1982

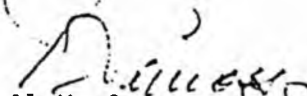
As the attached Policy Statement of the Alaska State Hospital Association (ASHA) notes, we are supportive of state and local planning for the health care needs. The process should be positive and proactive-- encouraging institutions to respond to needs in the community rather than reactive, cumbersome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

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

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

Best wishes for a prosperous 1983.

Sincerely,



Al M. Camosso
Administrator

Enclosure

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPARTMENT OF ADMINISTRATION

OFFICE OF THE COMMISSIONER

POUCH C
JUNEAU, ALASKA 99811

465-2200

May 29, 1981

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

Dear Representative Clocksin:

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

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

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

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

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

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

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

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

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

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

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

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

These conversations indicate that:

i. The federal government is not inclined to impose sanctions on a State for nonconformance with the certificate of need program;

ii. There are states which are nonconforming, and have been nonconforming for a number of years, on which federal sanctions have not been imposed; and

iii. The federal government is withdrawing total support for the certificate of need program by 1983. If the state wants to continue a planning process for health facility development it will have to provide for the process by using General Funds monies. Based on the aforementioned problems, now would be the appropriate time to revise this planning process to make it more meaningful.

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

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

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

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

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

In summary:

1. Administration believes the Legislature had always intended to exclude Pioneers' Homes from certificate of need;

2. The certificate of need process is not appropriate for Alaska;

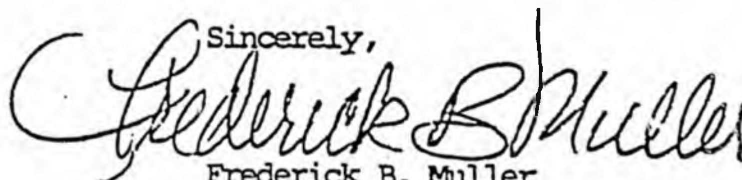
3. There needs to be planning for health care facilities and a more responsive process needs to be developed;

4. Grandfathering the nursing wing at Anchorage and the new Pioneers' Home at Ketchikan will not solve the complex problems existing at the Fairbanks, Palmer, and Sitka Pioneers' Home; and,

5. Passage of CSSB 225 will eliminate the potential for pain and suffering by allowing Pioneers' Homes residents to remain in their home.

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

Sincerely,



Frederick B. Muller
Deputy Commissioner for
Personnel Management

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

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

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

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

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

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

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

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

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

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

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

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

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

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

BILL SHEFFIELD, GOVERNOR

STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

December 22, 1982

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

Dear Mr. DeWitt:

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

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

Best regards.

Sincerely,

Bill Sheffield
Governor

LASKA STATE MEDICAL ASSOCIATION

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

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

RESOLUTION NO. 82-23

SUBJECT: Certificate of Need

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

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

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

DISTRIBUTION: Legislature
Alaska State Hospital Association
Press

#619

What happened....

1. Providence: Asked for 150 beds - got 37 acute/6 rehabilitation. Proposed $79,755,000 expenditures - got $79,750,000 expenditures. May construct and put in place the entire 150 beds but cannot use more than 53 (37 plus 16).

2. Humana: Asked for 93 beds - got 23 acute, 16 rehabilitation. Proposed $19,520,000 expenditures - got $19,520,000 expenditures. May construct and put in place the entire 93 beds but cannot use more than 39 (23 plus 16).

3. Lake Otis: Had CON for 125 beds - got CON revoked.

Problems in logic...

1. Providence: Proposed nursing stations with approximately 27 beds; with 37 total beds, has no relation to the design proposal.

Proposed 20 as an efficient rehabilitation unit but Department arbitrarily reduced this number to 16 beds for a less efficient unit.

2. Humana: Uses a floor plan with 42 beds per floor and 21 beds per nursing station. 23 beds fits neither, leaves one full nursing station and 2 beds down the hall creating necessity for added nursing station.

Proposed 20 beds as an efficient rehabilitation unit, also got 16 on an arbitrary basis.

Liability...

- What happens if Providence has 203 beds occupied (the maximum approved) and the balance of 97 sitting ready but not licensed?

1. Liability if a patient is denied admission and dies in an ambulance on the way to Humana.

2. Liability if patient is moved to a non-approved bed and dies for some reason.

3. How does the hospital's administration tell physicians and patients that the beds while there cannot be used?

Cost containment...

- These CON's permit Providence to construct the full 150 beds requested but can only operate 53 as revenue producers. Humana can construct 93 beds but only put 39 on line.

- If the expenditure is appropriate it can be factored into reimbursement but the full complement of beds cannot be used without additional expenditures for a new CON.

Sponsor Substitute for HB 19

Certificate of Need Repeal

Issue	Response
1. Are we the only state?	No. New Mexico's law terminates on 6/30/83. The legislature adjourned without extending the date. Arizona has exempted nursing homes.
2. What about recent federal law requiring review under Section 223?	That provision only becomes effective in October of 1986 if Congress fails to include the cost of capital expenditures in its new prospective payment program for Medicare. Work has already begun on developing legislation in this respect.
3. Is CON a cost containment tool?	It has not worked for that purpose. It has increased costs for facilities through delay, adding several percent to the cost of the projects as well as the costs of the process itself.
4. Every dollar of capital results in $1.85 in operating costs.	Of course. The study focuses on states which with CON laws, have been increasing the quantity of services. A hospital expansion is for the purpose of adding more services. This simply means that more people are getting care.
5. Supply causes demand.	1. When was the last time your doctor called the hospital to see if it needed a patient..then looked for a reason to send you to the hospital? 2. Look at Bartlett Memorial which has 64 beds and an average census of 30-32 patients. Seasonally that fluctuates, but if supply creates demand why isn't the average census much higher? 3. Alaska's length of stay is below the national average. The patient days per 1,000 population and beds per 1,000 population as well as the average occupancy rate in hospitals are all below the national average. If supply

Issue (continued)	Response
5. Supply causes demand. (cont.)	created demand, the industry could easily fill all its beds bringing occupancy up while remaining below the national average is the other areas. It has not been the case in Alaska, nor in most other western states.
6. Difference in cost per bed between Providence and Humana.	The total costs include different things: Providence includes extensive renovation of existing services and other items beyond bed space. Humana is primarily expanding its bed space.
7. What about public input in the expansion of health facilities?	1. Each hospital has a board comprised of citizens from the community. In the case of our many municipal hospitals, this board is a publicly constituted body. 2. Harborview Developmental Center in Valdez was awarded a CON on Feb. 11, 1983 without any HSA review of "public". input. The $3.5 million for repairs was included in the previous 2 years' budgets. The emergency CON was granted in February. The contract was awarded in mid-April. All this as a result of an emergency certified as an emergency by an employee of the Department with the CON granted by the commissioner. Where is the "public" input?
8. Consumer indifference.	Consumer indifference will change when we move away from first dollar insurance coverage and back to deductibles and co-payment features, or at least move to a "staywell" program as proposed in SCR 12 by Senator Josephson.
9. The approval of the Anchorage CON's will create a bed supply which exceeds the need.	The projected population numbers for Anchorage used by the HSA for judging the

Issue (continued)

9. The approval of the Anchorage CON's will create a bed supply which exceeds the need. (cont.)

Response

applications was 225,643.

Volume II of the 1983 State Health Plan for Alaska, page 38 calls for a goal of 3.5 beds per 1,000 population. The Humana and Providence projects would bring the bed supply to 693 ~~593~~ beds or a ratio of 2.90 ~~2.63~~ beds per 1,000 population. Including the Lake Otis project, the total would be 778 ~~727~~ beds or 3.46 ~~3.23~~ per 1,000 population ..both below the 3.5/1,000 figure found in the state plan.

These figures do not include any consideration of capacity needed for the referrals which come from outisde the Anchorage area.

Also excludes 40 rehabilitation beds as per state plan

Sponsor Substitute for HB 19

Harborview Developmental Center

- Recieved an emergency CON on February 11 for:

1. Life Safety Code corrections,

2. Re-roofing,

3. Mechanical energy conservation retrofit.

- This emergency allowed the Department to circumvent the substance of the CON process by:

1. Having a departmental employee certify that the project constituted an emergency,

2. Under the emergency CON procedure, eliminating all the public input process,

3. Then having the Department's commissioner grant the CON.

- It is important to note that the Department also operates Harborview.

- The Department recieved funding in the FY 82 and FY 83 budgets for these capital expenditures and notice from the fire marshall in July of 1982. One must wonder about the equity of this process.

- Seward General needed to replace its roof a few years ago. The same Life Safety issue yet it was forced through the full and laborous process.

- It seems that Seward General which has a publicly constituted board has more need for a public process than Harborview which is operated by the man who issued the CON.

LAW OFFICE
WILLIAM T. COUNCIL
A PROFESSIONAL CORPORATION
424 NORTH FRANKLIN STREET
JUNEAU, ALASKA 99801

WILLIAM T. COUNCIL
THOMAS E. WAGNER

(907) 586-1780

January 16, 1985

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

Re: Certificate of Need Legislation

Dear Dennis:

You have asked me to draft a bill for introduction in the legislature which would, if enacted into law, amend the current Certificate of Need (CON) legislation to accomplish the following objectives:

(1) Allow the addition or elimination of new categories of health services by a health care provider without the necessity of getting a CON, provided that offering or eliminating the service does not result in a net increase in bed capacity.

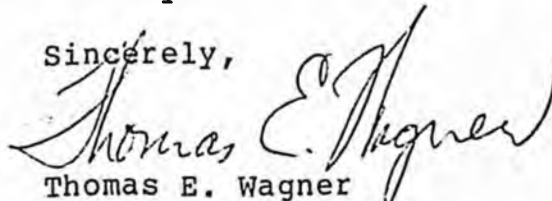
(2) Retain a CON requirement only for additions to, not simply any alteration of, bed capacity.

(3) Ensure that new health care facilities, including ambulatory surgical facilities, are required to obtain a CON, even if they spend less than $1,000,000. Especially, ensure that a CON is required of a facility which did not previously have a CON, when it becomes a facility for which a CON is required, even though no new building is constructed.

Enclosed is a draft of a bill which attempts to meet your requests. Objective 1 is achieved by deleting AS 18.07.031(3) and amending AS 18.07.061. Objective 2 is achieved by amending AS 18.07.031(2). Objective 3 is achieved by amending AS 18.07.031(1) to include construction <u>or operation</u> of a facility, and deleting the $1,000,000 triggering amount.

Please advise me whether this will meet your needs.

Sincerely,



Thomas E. Wagner

file SB 158

northern alaska health resources association, inc.

March 7, 1985

MAR 11 1986

The Honorable Bettye Fahrenkamp
Alaska State Senate
Pouch V
Juneau, Alaska 99811

Dear Senator Fahrenkamp:

In accordance with requests from your staff, I have reviewed SB 158, "An act relating to Certificate of Need," and offer the following comments for your consideration.

First, the bill should be expanded to cover major equipment purchases. This amendment would bring State law closer into compliance with federal law. More importantly, however, this add-back to the State law would help to close a major loophole in ungoverned health care expenditures. To be meaningful and cost-effective, of course, such an amendment should include a threshold amount to determine when an equipment purchase becomes "major." The $1 million threshold in the existing law is acceptable. However, a reduction to $750,000 would enable public review of the new generation of computed tomography equipment and certain other high-technology items which are now priced just below the $1 million mark. The costs for purchase and operation of this expensive equipment are passed on to the consumer and the taxpayer; we believe, therefore, that the public should have a voice in the types of services available in a given community.

In Section 18.07.031(2), lines 14-15, SB 158 would strike the words "alteration of" and substitute "an increase in." In our experience, elimination or conversion of existing beds can be as important to a community as the construction of new beds. We would recommend that the Certificate of Need law apply to any alterations in bed capacity involving elimination or conversion of beds in excess of a certain amount (perhaps twenty beds or twenty percent of the facility's capacity, whichever is fewer).

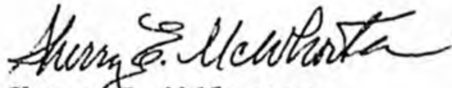
We would oppose the striking of Section 18.07.031(3), lines 16-17. Both additions and eliminations of whole categories of health services are important matters which impact upon the public welfare, as well as the taxpayers' pocketbooks. Deletion of lines 16-17 would open the door to a proliferation of specialized services, such as renal dialysis or radiation therapy, which may or may not be needed, financially feasible, or designed in the best interests of the consumer and the community. This requirement for review of categorical services should not be subject to the capital threshold figure. Again, we believe that the people and the State should have a voice in the way that community health services are configured, since they are the ultimate purchasers.

529 5th avenue, suite 8 fairbanks, alaska 99701 telephone (907) 456-2553

Finally, Sec.2.AS18.07.031(b), lines 19-21, should be tightened up so that the Act would grandfather only those projects covered by Certificates of Need in effect at the effective date of this Act. Currently proposed wording in the bill implies exemption for any health care facility which has ever been issued a Certificate of Need for construction of any sort.

I hope that these observations are helpful to you in your deliberations on SB 158. Please call if you wish further information or clarification. Thank you for this opportunity to comment.

Sincerely,



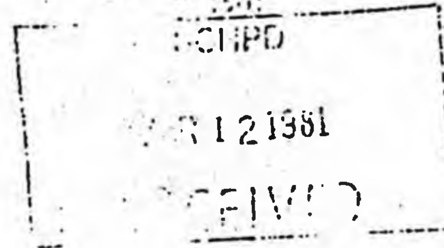
Sherry E. McWhorter
Executive Director

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Pioneer Home-S
Lynns Room

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



Re: TOP 550007-05

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

Dear Mr. Lawner:

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

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

2. We have reviewed the Alaska C/N statute and implementing regulations to determine whether Pioneer Homes would be included in the definition of a health care facility. We found that:

   a. The Alaska C/N statute defines a "health care facility" as:

      A private, municipal. . . hospital, psychiatric hospital, turberculosis hospital, skilled nursing facility. . . . (Sec. 18.07.111(7)).

   b. The Alaska C/N regulations, in turn, define "health care facility" as:

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

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

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

Please call us should you have further questions.

Sincerely yours,

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

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

alaska state hospital association

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

REPRESENTING ACUTE, LONG TERM AND OUTPATIENT FACILITIES

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Sitka Community Hospital
Sitka

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

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Jack Buck
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Anchorage

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

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

President
Dennis L. DeWitt
Juneau

Alaska State Hospital Association

Position Paper

Certificate of Need Repeal

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

Basic Issues

1. Equity

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

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

- Physician office construction and equipment purchase are also exempt.

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

2. Unnecessary

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

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

3. Conformity

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

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

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

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

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

4. Other States

- Louisiana does not have a certificate of need law.

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

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

5. Attachments

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

- Providence letter to Mayor Knowles explaining opposition to CON.

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

(Attachments cont.)

- Alaska Department of Administration letter to Representative Don Clocksin discussing Pioneers' Homes exemption, conformity problem, and potential for penalties.

- 42 USC 300m-(d)

- Alaska Department of Health and Social Services letter to Representative Mike Beirne indicating lack of compliance with federal program.

- Alaska State Medical Association Resolution calling for the repeal of certificate of need.

- Alaska State Hospital Association letter to Stevens on CON repeal.

- Governor Sheffield's response to the Association letter to Senator Stevens.

states can play in dealing with hospital cost containment. The discussion of these roles focuses on information useful to legislators and legislative staff as they explore the issues related to hospital costs and identify specific strategies. This guide is not intended to be prescriptive or to provide formulas or solutions.

The discussion within each chapter is presented in a question-and-answer format, which enables readers to quickly assess whether a particular topic area is of interest. Typically, the initial questions in each chapter provide background and explanatory information on a topic. These are followed by questions that develop the issues and important substantive considerations relating to each topic, indicate what strategies are available for dealing with it, illustrate how states have implemented those strategies and provide evidence to support or refute the use of the various strategies and cost containment options.

The guide provides information on how states are approaching a number of specific cost containment issues. These include paying for and assuring access to care for the medically indigent; financing or closing teaching institutions; assuring access to needed care for rural residents; finding alternative ways of financing care for the elderly and reducing the use of hospitals and nursing homes; making decisions about rationing care; promoting the idea that "wellness" programs and prevention at the front end of the health care system substantially reduce hospitalization.

Copies are available to non-legislators for $20.00 from NCSL, 1125 17th St., Suite 1500, Denver, CO 80202.

★ ★ ★ ★ ★ ★ ★ ★ ★ ★

According to a recent report from the National Governors' Association, Medi-Cal savings in **CALIFORNIA** in FY 1983-84 are estimated to reach $1.2 billion, of which $184 million is attributable to selective contracting. This report addresses the second full year of selective contracting for hospital services in the state, including the second round of Medi-Cal hospital negotiations. Savings in the first year are documented, and available information on recipient impact (access, quality) is summarized. Private sector preferred provider arrangements are reviewed in detail. The report assesses the impact of both initiatives on the practice of medicine, the hospital sector, the health insurance marketplace, employee health benefits, and the statewide health delivery system.

Single copies are available for $12.50 from: Publications Office, NGA, 444 N. Capitol St., N.W., Suite 250, Washington, D.C. 20001.

Highlights

SB 158
C.O.N.

• The **TEXAS** legislature refused to reauthorize the state's certificate of need program and its administering agent, the Health Facilities Commission. The state's program will expire September 1, 1985, bringing the total to eight states without a certificate of need program. (**CALIFORNIA'S** CON program is being phased out, with a final expiration date of January 1, 1987.)

• A **FLORIDA** bill (HB 391) would direct the Legislative Auditing Committee to appoint a health advocate to represent the general public concerning all matters relating to the provision of health services in the state.

• **CALIFORNIA** recently became the second state in the nation to earn concurrent accreditation of all of its state hospitals for the developmentally disabled. **TENNESSEE** is the first and only other state to have earned such a distinction. The accreditation comes from the Accreditation Council for Mentally Retarded and Other Developmentally Disabled Persons—a private, nonprofit organization whose criteria for accreditation are regarded as the most stringent in the field.

• The **NEW HAMPSHIRE** legislature is considering legislation (HB 240) which would prohibit corporations, associations, partnerships or individuals from owning more than 20 percent of the beds in health care facilities.

• **WEST VIRGINIA** amended (SB 616) its certificate of need (CON) legislation to require ambulatory health care facilities and community mental health and retardation facilities be subject to CON review. Also, the new law extends the CON requirement to include the acquisition, offering or development of major medical equipment (costing $400,000 or more) in private physician offices. In circumstances where specific criteria for evaluating the need for a new medical technology have not been developed, the state agency is authorized to impose a 90 day moratorium on the processing of applications for the acquisition of such equipment.

State Health Notes- May 85

of all live births will not be reached, nor will the 9 percent goal for black infants. Looking state by state, it reported that 38 states are expected to have low birth weights above the 5 percent goal; of the 28 states with more than 2,500 black births in 1978, only **KENTUCKY** is expected to have fewer than 9 percent low birth weight cases.

On the subject of prenatal care, the report said that during the decade spanning 1969-79, the number of women receiving prenatal care was steadily on the rise, with the gap between blacks and whites narrowing. "Recent natality data," it said, "reflect a departure from the upward trend" of the previous 10 years, for both black and white mothers. Given the trend, the 1990 objective of obtaining early prenatal care for 90 percent of mothers giving birth to live babies will not be reached for either white or black women, it concluded.

Although it is not on the HHS list, **ARIZONA's** Health Services Department, in a report assessing the state's record on low birth weight babies between the years 1969-83, also has noted reverse in a key trend line. For all but the last year of that period, it said, **ARIZONA** had experienced a 26 percent decline in the incidence of low birth weights. In 1983, the percentage of total births that produced low birth weight babies "abruptly rose, albeit slightly," the report found. Further, it said that two-thirds of those who die in infancy suffer low birth weight.

The report goes on to assess the risk factors that can lead to producing low birth weight babies. Among them: the educational level of the mother, the mother's ethnic background, her age and marital status and her access to prenatal care.

Of those, the two factors most commonly associated with low birth weight babies, it concluded, were the adequacy of prenatal care and the mother's marital status. Although the role of prenatal care may be more obvious, the state's analysis indicated "that the psychological and social problems associated with being a single mother greatly enhance the probability of giving birth to a low birth weight baby, independent of the level of prenatal care received. That is something that is often overlooked." it said.

All other things being equal, if all the mothers in the state had received prenatal care, 527 fewer low birth weight babies would have been born over the period assessed, according to the report. If single motherhood were not a factor, the number would have been reduced by 485. Moreover, it found that the incidence of infant mortality among single mothers was 1.7 times greater than for married mothers.

Copies of the report are available at no charge from the Office of Policy and Planning, Arizona Health Services Department, 1740 W. Adams Street, Phoenix, AZ 85007.

On a more hopeful note, **TENNESSEE's** Health and Environment Department has reported record lows in neonatal and infant deaths in the state in 1984 (as well as the lowest birth rates since 1933, when the data were first collected). The infant mortality rate for the first 9 months of last year stood at 13.2 deaths per 1,000 live births, the lowest ever recorded for **TENNESSEE**. In 1983, the rate was 13.4 The neonatal mortality rate in 1984 was 8.2 per 1,000 live births, compared to 8.3 in 1983. Recorded figures include births by women who may not be state residents.

Officials credit the "Healthy Children Initiative," which grew out of the Governor's Task Force on Healthy Children, with helping turn the tide. So far, the state has invested $3.5 million in the project, which concentrates on improving prenatal care for all women in the state.

Reports and Publications

IHPP has released its December, 1984, report entitled *Recent and Proposed Changes in State Medicaid Programs.* The report provides a comprehensive inventory of significant changes in Medicaid policy by state. The policy changes are divided into four broad areas: eligibility, benefits, reimbursement, and administration. The report provides a summary of significant Medicaid policy trends and developments during 1984. Also included are summaries of important indigent care legislation enacted during the year. Single copies are available without charge to state and federal officials. Others may obtain a copy by sending $9.00 to IHPP.

★ ★ ★ ★ ★ ★ ★ ★ ★ ★

Hospital Cost Containment: A Legislator's Guide is a recent product of the National Conference of State Legislatures. This guide, developed by a group of state legislators and legislative staff, concentrates on the primary roles that

RECORDS CERTIFICATION

I, the undersigned, an employee of the State of Alaska, do hereby certify that the microfilm images on this microform are accurate reproductions of the original records of the State of Alaska as accumulated during the regular course of business, and that it is the established policy and practice of this State to microfilm its records and to dispose of the original records after microfilm reproductions have been made.

Signature of Camera Operator

Date

SB
163

Senate Health, Education and Social Services Committee

Legislation Checklist

Bill number: SB 163

Sponsor: P. FISCHER

Date referred to committee: 2/19/85

Synopsis completed:

Fiscal note:

Further referrals: JUDICIARY

CONTACTS:

Bob Dawkins, Minority business task force, Chair
586-6429

Dirk Nelson, PO Box 81273 College 99708 479-5693
Jack Shockley, Jr, 1510 Kepner, Anch 99504 338-5500/561-0458

MAR 12 1986

STATE OF ALASKA 1985 LEGISLATIVE SESSION
FISCAL NOTE

Revision Date: ____________

REQUEST
Bill/Resolution No.: SB 163
Title: "An Act relating to marijuana......"
Sponsor: Sen. P. Fischer
Requestor: Sen. HESS
Date of Request: 3/7/85

FISCAL DETAIL
Agency Affected: Public Safety
Program Category Affected: Administration of Justice
BRU, Program or Subprogram(s) Affected: Alaska State Troopers

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 SUPPLIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS						
800 MISCELLANEOUS						
TOTAL OPERATING	-0-	-0-	-0-	-0-	-0-	-0-
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90
GENERAL FUND	-0-	-0-	-0-	-0-	-0-	-0-
FEDERAL FUNDS						
OTHER						
TOTAL	-0-	-0-	-0-	-0-	-0-	-0-

POSITIONS:

	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90
FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: Attach a separate page if necessary

Prepared By: Paul Conger
Phone: 465-4338
Division: Administrative Services
Date: 3-7-85

Approved by Commissioner: Michael J. Clarke
Date: 7-8-85
Agency: Public Safety

Distribution (by Agency preparing fiscal note):
- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

7/1/84

Introduced: 2/19/85
Referred: Health, Education & Social Services and Judiciary

1 IN THE SENATE — BY P.FISCHER, FERGUSON AND FAIKS

2 SENATE BILL NO. 163

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 FOURTEENTH LEGISLATURE - FIRST SESSION

5 A BILL

6 For an Act entitled: "An Act relating to marijuana; and providing for an
7 effective date."
8 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:
9 * Section 1. FINDINGS. (a) The legislature finds that
10 (1) THC, the mind altering ingredient in marijuana, is not
11 soluble in water, but goes into the fatty tissues of the brain, testicles,
12 ovaries, and other internal organs, and takes 30 days to be eliminated from
13 the body;
14 (2) the buildup of THC in the body causes the user to smoke more
15 marijuana to achieve the desired high and may result in loss of sleep,
16 appetite, and initiative, as well as moodiness and depression;
17 (3) it is possible for a human being to overdose from the use of
18 marijuana, especially if it is used in conjunction with alcohol, because it
19 increases the effects of alcohol;
20 (4) the THC content of a marijuana cigarette 10 years ago was
21 one percent, but is as high as 10 percent per cigarette today;
22 (5) marijuana causes schizophrenia, illusions, and hallucina-
23 tions, including a dulling of the senses, creating the possibility that the
24 user is unable to respond to body signals, such as pain;
25 (6) although it may take a heavy cigarette smoker as long as 20
26 years to develop lung cancer, one marijuana cigarette a day may cause lung
27 cancer in three years;
28 (7) THC affects eggs, sperm, sexual hormones, and the develop-
29 ment of a fetus, and marijuana use may result in deformed or undersized

1 offspring;

2 (8) other physical reactions to marijuana include irreversible
3 changes in the brain, sinusitis, pharyngitis, bronchitis, emphysema, in-
4 creased heart rate, and decreased blood circulation;

5 (9) other psychological reactions to marijuana include loss of
6 memory; impairment in thinking, reading comprehension, and verbal and
7 arithmetic problem solving; impairment of perception of distance and time;
8 and anxiety, panic, paranoia, psychosis, and psychological dependence; and

9 (10) the use of even small amounts of marijuana by adults in the
10 home subjects children present to a substantial health hazard.

11 (b) The legislature further finds there is a legitimate and com-
12 pelling governmental interest, based on testimonial evidence, that the
13 public health and welfare will suffer if personal use of marijuana even in
14 small amounts is allowed.

15 * Sec. 2. AS 11.71.060(a) is amended to read:

16 (a) Except as authorized in AS 17.30 or AS 17.35, a person
17 commits the crime of misconduct involving a controlled substance in
18 the sixth degree if the person

19 (1) uses or displays any amount of a schedule VIA con-
20 trolled substance or possesses one or more preparations, compounds,
21 mixtures, or substances of an aggregate weight of <u>less than one-half</u>
22 <u>pound</u> [ONE OUNCE OR MORE] containing a schedule VIA controlled sub-
23 stance [ON A PUBLIC STREET OR SIDEWALK OR ON THE PREMISES OF A PUBLIC
24 CARRIER OR BUSINESS ESTABLISHMENT OR IN ANY OTHER PUBLIC PLACE]; <u>or</u>

25 [(2) KNOWINGLY POSSESSES ANY AMOUNT OF A SCHEDULE VIA
26 CONTROLLED SUBSTANCE WITHIN THE IMMEDIATE CONTROL OF THAT PERSON WHILE
27 OPERATING A PROPELLED VEHICLE;

28 (3) BEING UNDER 19 YEARS OF AGE, POSSESSES ONE OR MORE
29 PREPARATIONS, COMPOUNDS, MIXTURES, OR SUBSTANCES OF AN AGGREGATE

1 WEIGHT OF LESS THAN FOUR OUNCES CONTAINING A SCHEDULE VIA CONTROLLED
2 SUBSTANCE;
3 (4) POSSESSES ONE OR MORE PREPARATIONS, COMPOUNDS, MIX-
4 TURES, OR SUBSTANCES OF AN AGGREGATE WEIGHT OF FOUR OUNCES OR MORE
5 CONTAINING A SCHEDULE VIA CONTROLLED SUBSTANCE; OR]
6 (2) [(5)] refuses entry into a premises for an inspection
7 authorized under AS 17.30.
8 * Sec. 3. AS 11.71.070 is repealed.
9 * Sec. 4. This Act takes effect immediately in accordance with AS 01.-
10 10.070(c).

keep in bill file

Alaska State Legislature

Senator Paul A. Fischer
Senate District D
Box 784
Soldotna, Alaska 99669
(907) 262-9420 W
262-9269 H

State Senate

While in Juneau
Pouch V
Juneau, Alaska 99811
(907) 465-3791

February 14, 1985

Dear Senator,

Tuesday, February 19th, I will be introducing two measures that relate to the control of dangerous drugs.

The first proposal is a Constitutional Amendment making clear that possession or use of cocaine, heroin, marijuana etc. is not to be interpreted as a protected right under the State Constitution. The effect of passage of this measure would be to reverse the State Supreme Court decision in Ravin v. State (1975) which construed the privacy section of our Constitution to "encompass the possession and ingestion of substances such as marijuana---in the home". It also restricts the court from expanding this opinion to protect the use of cocaine or other drugs.

The second measure is a bill which would declare possession of marijuana to be criminal misconduct. The enactment of this legislation would force the Judiciary to once again confront the question of marijuana in light of a decade of our experience with the existing status quo. In addition, passage of my measure would bring Alaska Law into conformance with the existing laws of both the federal government and all our sister states with regard to to marijuana.

I hope that you will join me as a cosponsor of the attached measures. If you have any questions or would care to have us add your name to either or both, please contact me or my staff at 465-3791.

Cordially,

Paul

Paul A. Fischer

fil

DEPARTMENT OF PUBLIC SAFETY

POSITION PAPER - SB 163

Support

March 5, 1985

SB 163 - An Act relating to Marijuana; and providing for an effective date."

The purpose of this legislation is to recriminalize the possession of any amount of Marijuana. The bill states that Marijuana is injurious to public health and welfare.

In addition to the public health and welfare issue from the standpoint of law enforcement, there are additional purely objective reasons why this bill should be passed.

(1) Existing state law, which provides for up to four ounces of Marijuana for personal use is in direct conflict with existing federal law. By having legalized small amounts, the state is in effect encouraging violations of federal law. Thus, only in Alaska can one sit at home and smoke Marijuana, secure in the knowledge that you are breaking federal law with the blessing of the State Supreme Court.

(2) The existing dichotomy of federal and state law is confusing in the mind of the public, which expects continuity, rather than conflict in the law. Such conflict tends to breed disrespect for the law in general, especially upon the impressionable minds of our youth.

(3) Alaska's lenient attitude toward Marijuana in effect creates a legal market for a substance grown illegally in other states, thereby worsening the problem of Marijuana cultivation in other states.

(4) Alaska's legalization of small amounts directly contravene the terms of the Single Narcotics Convention, the international treaty which outlaws Marijuana and other controlled substances. The United States is one of the numerous counrtries which are signators to the Convention.

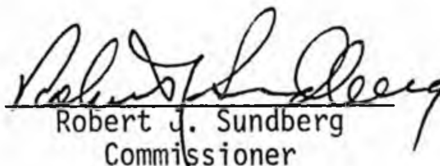
(Continued).

POSITION PAPER
SB 163 (Continued).

(5) Legalization of small amounts of Marijuana encourages most users to break the law. Absent personally growing the plants, users must buy Marijuana from sellers-an illegal act, and sellers must in turn buy from their sources which is equally illegal. In effect, the state's permissiveness encourages violations of the law, by stimulating illegal transactions involving the sale of Marijuana.

(6) Legalization of small amounts of Marijuana has had a chilling effect upon the investigation and prosecution of _any_ amounts of Marijuana, as witness the multi-pound transaction requirements of federal and state prosecutors, and the very few cases adjudicated involving Marijuana for the past few years.

(7) Recriminalizing Marijuana would not, as some fear, result in wholesale arrests of individuals possessing small amounts of marijuana, since the present drug enforcement philosophy of source interdiction recognizes the far greater cost-effectiveness of striking against high-level distributors, and sadly, there is no lack of high-level drug dealers in Alaska to occupy the enforcement efforts of narcotics officers.



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Commissioner