ALASKA LEGISLATURE COMMITTEE FILES 2001-2002 8672

10557 SENATE HEALTH EDUCATION & SOCIAL SERVICES

require a facility to establish the fair market value of the asset at the time of the purchase by means of an appraisal. After the appraisal is conducted, the depreciation base of the asset may not exceed its fair market value less accumulated depreciation. For long-term care facility acquisitions on or after October 1, 1985, the increase in the depreciable base is limited to one-half of the percentage increase since the date of the seller's acquisition, in the Dodge Construction Systems Cost for Nursing Homes, or, one-half of the percentage increase in the Consumer Price Index for All Urban Consumers (United States City Average), whichever is less. In addition:

(i) If depreciable assets are acquired from a related organization, the facility's depreciation base may not exceed the base the related organization had or would have had if the asset had been used for providing services to eligible state program recipients from the date of purchase.

(ii) The depreciation base of a donated asset is calculated as of the date of donation. The depreciation base of an asset received through testate or intestate distribution other than a donation is the fair market value at the date of death of the testate or intestate. However, if a donation or distribution is between related organizations, the depreciation base is the lesser of the fair market value, or the depreciation base the related organization had or would have had for the asset under a contract with the division of medical assistance.

(E) In preparing its annual budget, a facility shall account for depreciation by using useful lives for depreciable assets that are no shorter than useful lives for similar assets in the 1983 edition of "Estimated Useful Lives of Depreciable Hospital Assets," published by American Hospital Publishing, Inc.

(F) A facility shall measure the life of a depreciable asset from the date of the most recent arm's-length acquisition of the asset.

(G) A facility shall depreciate a building improvement over the remaining useful life of the building or building improvement, whichever is less, and must depreciate equipment over the remaining useful life of the equipment or over the remaining useful life of the building in which the equipment is located, whichever is less. If the remaining book value of the building is less than the equipment expenditure, the remaining life of the building must be evaluated for possible extension.

(H) A facility shall depreciate improvements to leased property for which it is responsible under the terms of the lease over the useful life of the improvement or the remaining term of the lease and available options to renew the lease, whichever is less.

(I) A facility may change the estimate of an asset's useful life to a longer life for the purpose of depreciation.

(J) In preparing its annual budget as required by 7 AAC 43.679, and in accordance with the provisions of the manual, a facility shall depreciate buildings, land improvements, and equipment, using the straight-line method.

(K) If depreciable assets are permanently abandoned or disposed of through sale, trade-in, scrapping, exchange, theft, wrecking, or fire or other casualty, a facility may no longer depreciate the assets, and the assets are considered retired assets.

(L) A gain or loss on the retirement of an asset is the difference between the remaining undepreciated base of the asset and any proceeds due from the retirement of the asset.

(M) If a retired asset is replaced, a facility shall deduct the gain from the depreciation base of the replacement asset in its annual budget or budget amendment. The loss to the depreciation base of the retired asset, if any, may be added to the depreciation base of the replacement asset if the facility has made reasonable effort to recover at least the undepreciated base of the retired asset.

(10) Costs authorized by a certificate of need.

(A) Interest, depreciation, and other capital costs will not be recognized on assets purchased after January 18, 1990 if a certificate of need was required and the facility did not secure one. Recognition of interest, depreciation, and other capital costs for which a certificate of need was required will be no greater than the amounts described within the certificate of need application and other information the applicant provided as a basis for approval of the certificate of need.

(B) Prospective payment rates for facilities which are calculated and paid on a per diem rate basis will be no greater than the per diem rates proposed within the certificate of need application and other information the applicant provided as a basis for approval of the certificate of need for a period of 24 months following:

(1) opening of the new or modified health care facility;

(2) alteration of the bed capacity; or

(3) the implementation date of a change in offered categories of health service or bed capacity.

(C) In determining whether interest, depreciation, and other capital costs exceed those amounts approved under a certificate of need, and for determining the maximum prospective per diem rate approved under a certificate of need, the department will consider

(1) the terms of issuance describing the nature and extent of the activities authorized by the certificate; and

(2) the facts and assertions presented by the facility within the application and certificate of need review record, including purchase or contract prices, the rate of interest identified or

assumed for any borrowed capital, lease costs, donations, development costs, staffing and administration costs, and other information the facility provided as a basis for approval of the certificate of need.

(D) If a certificate is issued, authorizing only part of the activities proposed within a certificate of need application, the limitation of rates will be based upon the factors noted under (C) of this paragraph.

(11) Limits on operating costs provided by related organizations. Costs of services, facilities, and supplies furnished to a facility by organizations related to the facility are allowable costs only to the extent that these costs do not exceed the lower of

(A) the documented costs of the services, facilities, or supplies to the related organization; or

(B) the reasonable price of comparable services, facilities, or supplies offered by a vendor not related to the facility.

(12) Related organization cost documentation. A facility shall document the cost to a related organization for services, facilities, or supplies furnished to the facility by the related organization. The commission will permit the cost to be included in the operating base of a prospective payment rate only if the cost to be included is fully documented as prescribed in the manual.

(13) Pharmaceutical supplies and materials. Pharmaceutical supplies and materials as defined in the manual for recipients who are residents of a long-term care facility, or an intermediate care facility for the mentally retarded, are reimbursed in accordance with 7 AAC 43.255(b) and 7 AAC 43.312(a). These costs, with the exception of the costs of nonprescription drugs dispensed as ordered by a physician, are excluded from facility prospective payment rates.

(e) OBRA '87-related nurse aide training and competency evaluation incremental costs as described in 7 AAC 43.695 are excluded from allowable operating costs. (Eff. 8/9/86, Register 99; am 7/20/88, Register 107; am 1/18/90, Register 113; am 4/12/90, Register 114; am 9/21/90, Register 116)

Authority: AS 47.07.070
AS 47.07.073
AS 47.07.180

7 AAC 43.709. DEFINITIONS. In 7 AAC 43.670 — 7 AAC 43.709

(1) "adjusted admission" means an adjustment to inpatient admissions that increases the number of admissions by outpatient revenue, at the rate of one additional admission for outpatient revenue equal to the inpatient rate;

(2) "ancillary costs" means, in the long-term care rate, patient-billed charges for additional services in long-term care facilities, such as pharmacy prescriptions, specific supplies, and physician-ordered laboratory tests; specifically excluded items a general physical therapy costs, general supplies, and other items not specifically ordered by a physician;

(3) "appraisal" means the process of establishing the fair market value of an asset by a professional designated by the American Institute of Real Estate Appraisers as a member appraisal institute

(MAI), or designated by the Society of Real Estate Appraisers as a senior real estate analyst (SREA) or a senior real property appraiser (SRPA); "appraisal" includes a systematic, analytic determination of the nature of property rights and investment in property and a determination of values based on a personal inspection and inventory of the property;

(4) "arm's-length transaction" means a transaction resulting from good-faith bargaining between a willing buyer and a willing seller who are not related organizations;

(5) "assets" means all economic resources of a health facility, recognized and measured in conformity with generally accepted accounting principles, including certain deferred charges that are not resources but that are recognized and measured in accordance with generally accepted accounting principles;

(6) "board-designated assets" means assets that have been designated or appropriated by the governing board of a facility for special uses and not for facility operations;

(7) "budget" and "budgeting" mean the financial data for, and the process of, developing a budget for annual submission to the department, by a facility receiving payment from the division of medical assistance, to support the projected prospective payment rates for the facility's fiscal year;

(8) "charges" means amounts that patients are billed for health care services provided by a facility;

(9) "commingled" funds means cash or cash equivalents, including restricted funds and board-designated assets which are accumulated in the same physical account as general operating cash or cash equivalents;

(10) "division of medical assistance" means the division within the Department of Health and Social Services responsible for administering the Medicaid and General Relief Medical assistance programs;

(11) "depreciation" means the systematic distribution of the cost or other base of a tangible asset over the estimated useful life of the asset;

(12) "donated asset" means an asset that the facility acquired nominally or with no payment in the form of cash, property, or services;

(13) "effective date" means the date on which a new or modified prospective payment rate is determined by the department to be effective;

(14) "employee benefits" means operating costs that include FICA; ESC; group health insurance; group life insurance; pension and retirement; worker's compensation insurance; and non-payroll-related employee benefits such as employee discounts, employee health centers, and child centers;

(15) "facility" means an acute care hospital, specialty hospital, skilled nursing facility, intermediate care facility, intermediate care facility for the mentally retarded, rehabilitation facility, inpatient psychiatric facility, home health agency, rural health clinic, or outpatient surgical clinic;

(16) "fair market value" means the lesser of the appraised value or the sales price of an asset in an arm's-length transaction;

(17) "findings and recommendations" means the analysis of a facility budget or budget amendment, the resulting findings, and commission staff recommendations relating to the acceptance or modification of a facility's proposed prospective payment rates or effective dates;

(18) "fiscal year" means the operating or business year of a facility, which includes 12 consecutive calendar months;

(19) "funded depreciation" means the investment of funds generated from an allowance for depreciation plus the accumulated interest earnings;

(20) "generally accepted accounting principles" means accounting principles approved by the Financial Accounting Standard Board (FASB);

(21) "general mailing list" means a mailing list maintained by the commission consisting of all persons who have requested in writing to be included on the list;

(22) "goodwill" means the advantage or benefit acquired by a facility beyond the mere value of the capital, stocks, funds, or property it holds, as a result of the general public patronage and encouragement it receives from constant or habitual customers because of its local position, common celebrity, reputation for skill or affluence or punctuality, or from other accidental circumstances or necessities;

(23) "historical cost" means the actual cost incurred in acquiring and preparing an asset for use;

(24) "intermediate care facility" means a licensed facility certified to deliver intermediate care services as defined in 7 AAC 43.185;

(25) "intermediate care facility for the mentally retarded" means a licensed facility as defined in 7 AAC 12.300;

(26) "long-term care facility" includes intermediate care facilities and skilled nursing care facilities;

(27) "manual" means the Medicaid Rate Commission Accounting and Reporting Manual, dated June 1987 and published by the commission, including all reporting forms and instructions;

(28) "notify" means to place written notice of an action in the United States mail, addressed to the last known address of a person, or to deliver written notice by hand to a person;

(29) "operating lease" means a lease under which rents or lease payments are included in current operating expenses;

(30) "patient day" means a calendar day of patient care;

(31) "person" means an individual, partnership, association, corporation, facility, municipal corporation, or the state;

(32) "prospective payment rate" means the rate authorized by the department to be paid by the division of medical assistance to a facility for services provided to Medicaid and General Relief Medical assistance recipients, as described in 7 AAC 43.676;

(33) "rate" means the average revenue per defined unit of service for each revenue center identified in the manual;

(34) "related organizations" means organizations having a relationship of the sort described in sec. 267(b) and 267(c) of the U.S. Internal Revenue Code as amended by P.L. 95-628, November 10, 1978;

(35) "restricted funds" means money that by agreement with or direction of the donor is restricted in the use of its principal or interest to a specific purpose;

(36) "skilled nursing facility" means a licensed facility certified to deliver skilled nursing care services to medical care recipients, as defined in 7 AAC 12.250 — 7 AAC 12.290;

(37) "state programs" means the Medicaid and General Relief Medical assistance programs of the state;

(38) "unrestricted funds" means money that is not restricted to a specific use by the donor;

(39) "occasion of service" means adjusted admission, as applied to acute care and specialty hospitals; patient day, as applied to long-term care facilities; surgery, as applied to outpatient surgery centers; and visit, as applied to rural health clinics;

(40) "rural health clinic visit" means a face-to-face encounter between a rural health clinic patient and any health care professional whose services are reimbursed by the division of medical assistance; encounters with more than one health care professional, and multiple encounters with the same health care professional, regarding the same illness or injury, which take place on the same day and at a single location, constitute a single visit;

(41) "rural health clinic" means a facility that has filed an agreement with the Department of Health and Social Services to provide rural health clinic services under Medicaid;

(42) "outpatient surgical clinic" means an ambulatory surgical center which operates as a distinct entity exclusively for the purpose of providing surgical services to patients not requiring hospitalization;

(43) "medicaid utilization rates" means the percentage of medicaid patient days within an acute care hospital's total patient days for a fiscal year;

(44) "the state" means the State of Alaska;

(45) "commission" means the Medicaid Rate Advisory Commission;

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

(47) "commissioner" means the commissioner of the Department of Health and Social Services or his or her designee;

(48) "deputy commissioner" means the deputy commissioner of the Department of Health and Social Services or his or her designee;

(49) "executive director" means the executive director of the Medicaid Rate Advisory Commission or his or her designee;

(50) "base year" means the facility's fiscal year ending 12 months before the prospective fiscal year;

(51) "certificate" means a certificate of need authorized by AS 18.07.031 — 18.07.111;

(52) "terms of issuance" means the terms specified by a certificate of need describing the nature and extent of the activities authorized by the certificate;

(53) "appropriate region" means the region described in the 1990 publication of *Alaska Wage Rates for Selected Occupations*, published by the Alaska Department of Labor, that is most applicable to a facility. (Eff. 8/9/86, Register 99; am 7/4/87, Register 102; am 5/8/88, Register 106; am 6/19/88, Register 106; am 7/20/88, Register 107: am 3/16/89, Register 109; am 3/13/89, Register 110; am 8/25/89, Register 111; am 10/11/89, Register 112; am 1/18/90, Register 113; am 9/21/90, Register 116)

Authority: AS 47.07.070
AS 47.07.073
AS 47.07.180

Editor's notes. — Copies of the publication *Alaska Wage Rates for Selected Occupations*, adopted by reference in 7 AAC 43.709(53), may be obtained from the Department of Labor, Division of Administrative Services, Research and Analysis, P.O. Box 21149, Juneau, AK 99802, telephone number 465-4500.

List of Certificate of Need Applications - 1996-2001: Amounts Requested and Approved and Actions

#	Facility	Project	Amount Requested	Amount Approved	Action
			2001		
1	Fairbanks - Renal Care	12-Station Dialysis	$ 1,900,000	$ -	Under Review
2	Providence (PAMC)	60 bed MH facility	$ 25,000,000	$ -	Under Review
3	Providence (PAMC)	North Tower Mod.	$ 8,550,000	$ -	Under Review
4	Valdez Community Hsp	Replacement Hosp.	$ 24,100,000	$ -	Under Review
5	Ketchikan Gen. Hosp	MRI/Remodel	$ 1,182,720	$ 1,182,720	Approved
6	Bartlett Regional (Jun)	8 New Beds/Expand	$ 40,000,000	$ 39,200,000	Garden Denied
7	Sitka Community	5 New NH Beds	$ 13,500	$ -	Under Review
8	Providence (PAMC)	PET Scanner	$ 3,200,000	$ 3,200,000	Approved
			2000		
9	Alaska Regional Hosp.	Expand/Remodel	$ 12,300,000	$ 12,300,000	Approved
			1999		
10	Tanana Vally Clinic	2 OP surg. suites	$ 4,200,000	0	Denied
11	Fairbanks ASC	2 OP surg. suites	$ 5,500,000	0	Denied
12	Fairbanks Mem Hosp.	2 OP surg. suites	$ 1,300,000	0	Denied
13	So. Peninsula Hosp.	10 New NH Beds	$ 2,967,000	$ 2,967,000	5 Beds Denied
14	Providence (PAMC)	N. Tower Mod.	$ 25,000,000	$ 25,000,000	Approved
15	Alaska Psych Inst.	CON Mod.	$ 50,868,000	0	Withdrawn
16	Fairbanks Mem Hosp.	20-Bed MH Unit	$ 3,388,000	$ 3,388,000	Approved
17	Valley Hospital	Expand/Remodel	$ 10,000,000	$ 10,000,000	Approved
20	Central Peninsula Hosp.	MRI	$ 1,410,000	$ 1,410,000	Approved
			1998		
21	So. Peninsula Hosp.	Remodel Acute	$ 6,333,756	$ 6,333,756	Approved
22	Alaska Regional Hosp.	Open Heart/Trauma	$ 1,313,000	$ 1,313,000	OH suite delayed
23	Alaska Regional Hosp.	Open Arc. MRI	$ 1,263,000	$ 1,263,000	Approved
24	Fairbanks ASC. Inc	2 OP Surg Suites	$ 2,894,606	0	Denied
25	St. Ann's Care Center	44-Bed Nurs Home	$ 14,948,573	$ 14,948,573	Asst Liv Req'd
			1997		
26	Providence (PAMC)	Heart Center	$ 1,600,000	$ 1,600,000	OH suite delayed
27	Bartlett Regional (Jun)	Expand/Remodel	$ 6,777,300	$ 6,777,300	Approved
28	Valley Hospital	60-Bed Nurs Home	$ 6,700,000	$ 6,700,000	Withdrawn
29	Providence (PAMC)	Pediatric Center	$ 7,000,000	$ 7,000,000	Approved
			1996		
30	Providence (PAMC)	Heart Center	$ 3,500,000	$ 3,500,000	Approved
31	Providence-Seward MC	Replacement Hosp.	$ 7,500,000	$ 7,500,000	Approved
	Total		$ 280,709,455	$ 155,583,349	

Source: State of Alaska/DHSS/DAS/Facilities & Planning

ALASKA STATE LEGISLATURE

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SENATOR LYDA GREEN
SENATE DISTRICT N

Sectional Analysis
CS Senate Bill 256

"An Act relating to the certificate of need program; establishing a working group on psychiatric care services; and providing an effective date."

Section 1:	Increases the threshold for certificate of need from $1,000,000 to $10,000,000 for facility construction, alteration or addition of a new category of health services at a health care facility.
Section 2:	Allows for the relocation of any health care facility within the same community without a certificate of need provided the facility does not increase number of beds or categories of services. Current statute allows only for ambulatory surgical facilities to relocate without a certificate of need.
Section 3:	Adds two new requirements to the standard of review for non-nursing home beds; the financial feasibility and long term viability of the project; and the forecast of the probable financial effect of the project on consumers and the state's fiscal condition
Section 4:	Provides for a temporary moratorium on certificates of need for psychiatric beds from the passage of the bill until July 1, 2003.
Section 5:	Establishes a six-member working group appointed by the Governor to analyze issues regarding psychiatric care services in Alaska. This group will report to the Legislature by the first day of the First Regular Session of the Twenty-Third Alaska Legislature.
Section 6:	Provides that the provisions of section 3 apply to applications of certificates of need that are initially filed on or before the effective date of this Act.
Section 7:	Provides for an immediate effective date

Prepared by Jerry Burnett
Legislative Staff to Senator Lyda Green
February 4, 2002

PIERCE TESTIMONY
FROM SHES 11/9/01

MR. DAVID PIERCE, Health Planner, said he is also known as the Certificate of Need Coordinator and that the office had been active since 1976. Most of the states established these offices in the 1970s; 74 percent of them still have Certificate of Need programs.

CHAIRWOMAN GREEN interrupted him to say the reason they are talking about it at all today is its tie-in to Medicaid.

MR. PIERCE explained that some of the big issues it deals with are rational development of health care, quality of care, access and to decrease unnecessary duplication and cost containment. It also has a public involvement component where people who are involved in the projects have input into the process. Most projects are approved, but over the past 20 years about 500 nursing home beds were proposed and not built. If all those beds had been built, it would save about $60 million per year.

Other states like Texas and California contract for certain numbers of beds rather than reviewing projects as they come in. Other states have also put moratoriums on construction to limit growth. Certificate of Need programs vary by state depending on the need. One of the key issues to think about in Alaska is that the small populations are served.

CHAIRWOMAN GREEN asked him to explain that further.

MR. PIERCE replied that some types of care will only be in the larger communities. Alaska doesn't have a CAT scanner, a type of radiology that detects cancer.

TAPE 02-52, SIDE B

There has to be a certain level of use to be able to support a piece of equipment financially. Also, certain types of services like open heart surgery, that if you don't have a high enough level of use of that service, the skill level of the physicians will not be maintained and there will be more complications with those surgeries.

MR. PIERCE said that approximately 86 percent of the nursing home bed care is Medicaid related. The average cost of a day in

a nursing home statewide is $306. So, basically, for every 10 nursing home beds is going to cost $1 million to Medicaid.

CHAIRWOMAN GREEN asked for an example of [indisc] versus long-term care.

MR. PIERCE replied the Mary Conrad Center with 90 beds and they are all full.

CHAIRWOMAN GREEN asked if anyone who walks through the door and qualifies for Medicaid can stay in that bed.

MR. PIERCE replied no. There are two kinds of payments. The other 14 percent of people are private pay or Veterans Administration.

CHAIRWOMAN GREEN asked if they are not in the Certificate of Need process and suppose Mary Conrad needed 10 more beds, does Medicaid have the ability to say they hadn't approved the beds and therefore, they wouldn't pay for the people.

MR. PIERCE said no, because once a place is licensed as a Medicaid provider, it is able to take patients.

CHAIRWOMAN GREEN asked why they would then need a Certificate of Need.

MS. JANET CLARKE, Department of Health and Social Services, said this was a good question. Mr. Pierce was talking about licensing, which comes after the Certificate of Need process, which comes prior to construction. Long-term care has been the concern of the Alaskan legislature for some time and declared a moratorium for a number of years. "When David says that once you're licensed, if someone comes in they are eligible for that is correct, but the Certificate of Need process is where the review happens."

Typically, someone will need skilled long-term nursing care, but is not eligible right away because they have to spend down some of their assets.

SENATOR TAYLOR commented that we have to bankrupt them first.

MS. CLARKE said that was right.

CHAIRWOMAN GREEN said she didn't want to be protected by the government all the time and she finds it strange that someone in

an office in Juneau can determine how many CAT scanners can be in the state of Alaska. If she wants one of the scanners at a hospital, she should be able to go out and buy one and go broke if that's what happens.

MS. CLARKE replied that a few years ago the legislature passed amendments to the Certificate of Need law and there care more stringent requirements for long-term care - because the legislature was concerned about the implications for Medicaid.

CHAIRWOMAN GREEN said there had been three major attempts to revise the process.

MS. CLARKE said she understands what the Senator is getting at, but:

> What I was trying to get at that - the Certificate of Need program as far as considering cost implications to Medicaid - based on the law - can only do that for long-term care. For the other parts, acute care or CAT scans, they can't consider the implications for Medicaid or cost. It's based on need and access, etc. The way the legislature has structured the law, there are two different review standards, and I think, because of the implications for Medicaid.

MR. PIERCE said one important thing to remember is that in most of the hospitals there's only one market in the state, Anchorage, where there's competition between hospitals. In most of the other communities there is one facility. In these cases, if someone goes bankrupt, you end up with people not having anything.

SENATOR TAYLOR said he wanted to get away from the Medicaid aspects of this.

> Why should anyone have to go through the process if economically they believe it's a good investment for them to put in an MRI or should they tell all patients in Ketchikan you can't have an MRI here. You need to buy a $350 - $400 airplane ticket and fly up to Juneau and use Juneau's machine, which, by the way, hasn't been approved yet, either.

CHAIRWOMAN GREEN asked if she knew of any case where people had been denied access to Providence.

MR. PIERCE replied that he didn't know of any circumstance like that.

MS. CLARKE reminded everyone that CON applies for capital construction of over $1 million; it's not for operating costs.

MR. PIERCE said a lot of health care is moving from the in-patient to the out-patient areas. He said, "Hospitals do a variety of things that some of them get more money than what they pay out in costs for the service."

CHAIRWOMAN GREEN asked for an example.

MR. PIERCE replied a critical care unit or an ICU or maybe in-patient services.

CHAIRWOMAN GREEN commented that this was more discouraging to her than encouraging.

MR. RICK JOHNSON, Valley Hospital Operating Board of Directors, said he thought Mr. Pierce was trying to say is that there is a concern about "cherry picking." He said:

> If you open up an out-patient surgery center and are in direct competition with Valley Hospital where we have to accept a reduced rate for Medicaid and Medicare, then all those services are going to go elsewhere where we make some money to be able to support our community hospital - that's going to be gone.

CHAIRWOMAN GREEN said everyone understands that. She was concerned that hospitals operate under a different set of rules when it comes time to make their reports to the federal government and when they pay taxes.

MR. JOHNSON said that was correct.

CHAIRWOMAN GREEN said she was perfectly willing to have his Board make decisions and not have an office telling them what they can and can't do.

MR. JOHNSON asked what happens when they don't have a Certificate of Need process and someone opens up a shop "out here" and takes everything away from Valley Hospital that makes money.

I'm not saying that we shouldn't be efficient and being able to compete, but we need to be able to do that - but they take everything else away from Valley Hospital and we don't have an opportunity, because we have to take everybody that walks through the door. We have to take Medicare and Medicaid patients at a lower reimbursement level and the only way that we can support ourselves is through profit centers. These other folks that open up a facility out here, they don't have to take Medicaid or Medicare.

CHAIRWOMAN GREEN asked:

Who's to say that they don't want to take low pay, co-pay private - just like the whole raft of assortment that you...Are you saying that because the law doesn't require them to do that?

MR. JOHNSON said that was correct.

CHAIRWOMAN GREEN said maybe that was the point they needed to address. She found it strange that he would turn over his decision-making ability to an agency in state government.

MR. JOHNSON agreed and said it was a strange paradox.

12:25

SENATOR TAYLOR said he was concerned about all the different rates that are charged for the same service and because they:

...Have a ticket to play, they are the only game in town and that Certificate of Need becomes how do we protect our monopoly to make certain that nobody else does come in a cherry pick. There's never been a level playing field; there's not going to be one..."

MR. JOHNSON responded:

But, we have requirements, but how do we correct those federal requirements, the state requirements that we have...We only get x amount of reimbursement on those particular things and we have to accept everybody who walks through the door and somebody can go down the street and open up a shop and they don't have to take them.

SENATOR TAYLOR said, "You have my complete sympathy; I understand. I was just trying the clarify the reality of where we're at today."

CHAIRWOMAN GREEN said she thought they could set aside the federal requirements. She doesn't have any delusion about making any substantive change in the Certificate of Need process. "I've got to tell you there is something massively wrong with the system right now and we either have to change the dollar amount, we have to change the requirement of people who come in and want to play; we have to do something where we don't say it's okay for Providence or Regional...

MR. JOHNSON said he is just looking for a level playing field.

CHAIRWOMAN GREEN said the problem is how do they get there.

MR. JOHNSON said their strategic plan is to build a new facility and they want to double their capacity and he doesn't want to have to go through the CON process. But he is also concerned that other people can build facility and not have the same requirements that his hospital does.

MR. PIERCE said that they are trying to educate the administrators so they can get up to speed and get the CONs in and not have the delays.

SENATOR DAVIS asked if it was correct that 74 percent of the states use the CON. Mr. Johnson said that was correct.

SENATOR DAVIS asked if he knew what the other states did who did not use that process and what kind of problems did they have.

MR. JOHNSON said he didn't, but he could get her some information.

SENATOR DAVIS said they had to have information on things that are working in other states because it might help the situation in Alaska.

MS. CLARKE said some of the other states might contract for a certain number of beds and that's all they'll pay for for Medicaid, for example.

Alaska State Hospital & Nursing Home Association

We're helping people care for people!

February 1, 2002

Senator Jerry Ward
Member, Health, Education and Social Services
State Capitol
Juneau, AK 99801-1182

Dear Senator Ward:

RE: Opposition to SB 256

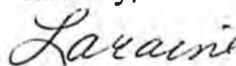
I am writing as the representative of the Alaska State Hospital and Nursing Home Association (ASHNHA). ASHNHA is an association of hospitals and nursing homes in the State of Alaska. With the exception of Nome and Barrow, all hospitals and nursing homes belong to the Association. At ASHNHA's fall Board meeting on November 8, 2001, the Board voted to oppose any certificate of need legislation in favor of having the law remain as it is currently written.

There are several reasons I am asking you to oppose the bill. Member hospitals, trustees and other concerned providers will be communicating their opposition to this legislation. Since they are directly involved in the delivery of health care to your constituents, I will let them iterate the details. The legislation will probably not affect the smaller, rural hospitals as there is not enough business in these communities for additional facilities. It will affect hospitals in medium to large population centers.

However, my concern is with all facilities in the State. Hospitals must deliver care to all who come to their doors, twenty-four hours a day, whether they can pay or not. Other types of providers, i.e., ambulatory surgery or imaging centers do not. As so frequently happens, we get unintended consequences with legislation. If SB256 passes from your committee, minimally, I would like to see it referred to the Finance Committee so that there might be a comprehensive analysis to determine what the financial effect on Medicaid would be.

If you would like to discuss ASHNHA's opposition to this legislation, please do not hesitate to contact me.

Sincerely,



Laraine L. Derr
President/CEO

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From: "Bill Patten" <billpattenjr@hotmail.com> Sun 11:34 AM
Subject: CON legislation
To: Senator_Lyda_Green@legis.state.ak.us
CC: Senator_Jerry_Ward@legis.state.ak.us, Senator_Bettye_Davis@legis.state.ak.us, Senator_Gary_Wilken@legis.state.ak.us, Senator_Loren_Leman@legis.state.ak.us

Dear Senator Green:
I understand that you have introduced SB 256 which will raise the limit on CON projects to $10,000,000.
I support such a change. However, I would suggest that other changes are also necessary.
As you may know, Sitka Community Hospital has been pursing the conversion of 5 acute care beds to 5 long-term care beds for sometime. In fact, we submitted our initial letter in November, 2000 and the completed application went to the Commissioner in July, 2001. Since that time, our CON has received no formal action.
Our project is estimated to cost us less then $35,000 to implement and yet it was subjected to the entire CON process. We have clearly identified the need for these additional long-term care beds. The issue now, as I understand it, is whether the State can afford these additional beds based upon our current rate of reimbursement.
While we do recieve a very attractive rate, two key points need to be mentioned. First, this rate is determined by state formulas, it is not something that results from our aggressive negoiations. Second, our current rate will expire in June of this year. We project a reduction of almost $200 per resident per day (a range of $400k - $600k in lost revenue).
We have clearly established the need for our additonal beds - from the presecpitive of the number of people in our area who have to leave their home town in order to receive long-term care. But there is also a financial side to this picture. The additional beds will help us replace revenue that we fully expect to lose at the end of June, 2002.
The CON process needs more then a higher limit. If small projects like ours are going to be subjected to this process, it should be renamed because need seems to have little to do with the current process.
I fully understand the financial pressure the State faces. Our organization has similiar challenges. It is discouraging when we are limited in our ability to perform our Mission to meet the needs of our local residents because of the State beuacracy.
At your convenience and as you may require, I am happy to discuss this matter with you further.
Thank you!

Bill Patten
CEO/Administrator
Sitka Community Hospital
Sitka, AK
907-747-1738

Send and receive Hotmail on your mobile device: http://mobile.msn.com

Alaska State Legislature
Public Opinion Messages

J Harold Michal,
Po Box 3549
Valdez, AK 99686
Phone: -
E-mail:

Constituency: N
Distribution: 27
Affiliation:
Reg Voter: Y

Subject/Bill SB 256 Opposes

Sec. 1a provided in (c) A person any amount of one million dollars or more of public state or taxpayers money should never be permitted as an expenditure without corroberation of a board of directors or legislative body.
Date Sent: 01/25/2002

Comparison of Draft and Final versions of MSRG Ambulatory Surgery Need Analysis

Executive Summary: The September 5, 1999 draft of the MSRG report was circulated to the CON applicants. To determine the need for ambulatory surgery services, the authors recommended "...looking at actual utilization and challenging hospital assumptions..." to understand the demand for ambulatory surgery services in Fairbanks. They performed a review of "...national benchmarking data and comparison studies of the three CON proposals." This approach is consistent with accepted research principals, and could accurately define the need for ambulatory surgical service in Fairbanks. After performing this rigorous analysis the report concluded that "TVC presented the most viable plan for a freestanding ASC". The report also noted that "...a cost advantage can be gained from an ambulatory surgery center..." However, after the preliminary release of the report, it was substantially edited, changed to such an extent that it often contradicts the first draft, even when drawing conclusions from the same data. The cost savings data was deleted. The "...looking at actual utilization...", and use of "...national benchmarking data and comparative analysis of the CON applications" were completely eliminated, presumably because both led to conclusions favorable to TVC's application. The Washington formula, required by law, was altered to favor the hospital and fully 25,000 minutes of FMH surgery scheduling capacity was created out of thin air. Comments critical of FMH data were eliminated, and a recommendation to limit additional FMH surgical suites was replaced with suggestions that FMH add a surgery suite. The change in the report, when taken together, present a disturbing picture. Either there was a very serious problem at the MSRG group that caused them to alter their report, or the Department bowed to pressure from FMH and gutted the MSRG report, exchanging well reason analysis for inconsistent, illogical conclusions. The Department then hired 3 professional peer reviewers to analyze the MSRG report, and 2 of the 3 were very critical of the lack of a population-based review of utilization (which had been at the heart of the original report) and concluded that the altered report was of limited or no value in determining need for ambulatory surgical services in Fairbanks. Nonetheless, the Department released the altered report and used its flawed analysis as the basis for denying a CON to TVC, thus protecting the status quo and guaranteeing a monopoly for FMH. The Department apparently sees no problem with this result.

A copy of the draft and altered final report are presented, along with a guide to the changes, to facilitate a side-by-side comparison of the 2 reports. In addition the 2 critical peer reviews are attached. Please contact Brian Slocum at 459 – 3509 with any questions. Thank you.

Comparison of Draft and Final versions of MSRG Ambulatory Surgery Need Analysis

Draft	Final
Dated September 5, 1999	Dated September 12, 1999
Executive Summary Conclusions page #4 states: "Access is only an issue sporadically. High season for trauma might create an access issue since elective (non-life threatening) surgery cases may be **bumped off the schedule** in favor of emergency cases."	No mention of access problems due to patients "...**bumped off the schedule**...";
Page #5 "Background Information" paragraph #2, last sentence states "To conduct a fair and impartial assessment of community needs, the interview process was supplemented with **national benchmarking data and comparison studies of the three CON proposals."**	Deleted **"...national benchmarking data and comparison studies of three CON proposals...";**
Page # 6, "Situation Analysis" first paragraph: **"94,248 (-) 68,850 (x) 2 = +50,796 minutes, TOTAL ADDITIONAL CAPACITY 145,044 minutes"**	Page # 6, "Situation Analysis" first paragraph: **"94,248 (-) 68,850 (x) 3 = +76,194 minutes, TOTAL ADDITIONAL CAPACITY 170,442 minutes"** Invented extra 25,398 minutes of surgery capacity for FMH;
Page #7, "Methodology" states "**Three main methods were employed** to determine 1) the level of unmet need that exists for ambulatory surgical capacity in the Fairbanks health service area; 2) the impact of each proposal on cost,	Page #7, "Methodology" states "**Two main methods were employed** to determine 1) the level of unmet need that exists for ambulatory surgical capacity in the Fairbanks health service area; 2) the impact of each proposal on

Comparison of Draft and Final versions of MSRG Ambulatory Surgery Need Analysis

Draft	**Final**
quality and access to services, especially to under- or uninsured residents; and 3) the overall effect of a realignment of providers within the community."	cost, quality and access to services, especially to under- or uninsured residents; ……"
"**The methods included…….a comparative analysis of the CON applications based on thoroughness of analysis, feasibility of facility staffing, design, and realistic financial expectations and assumptions**; and lastly, a quantitative analysis of capacity, **utilization** and projected demand using the Washington methodology, factoring in demographics changes and unique community factors."	Deleted reference to **"…a comparative analysis of the CON applications based on thoroughness of analysis, feasibility of facility staffing, design, and realistic financial expectations and assumptions;** Deleted any reference to "…**utilization…**" as a measure of unmet need;
Page #8, CON Competitive Analysis: Nearly a full page of information is listed covering how MSRG used "…intense scrutiny…" to perform a "…**comparative analysis**…." of all 3 CON applications. Page 22, Exhibit C**, the comparative analysis scoring page, listed TVC as the clear winner** with a score of 35 points, vs. FMH's 22.5 points and Dr. McGuire's 18 points ;	This **entire section was deleted** from the final version. **Exhibit C,** the comparative analysis scoring page, which listed TVC as the winner, **was also completely eliminated;**
Page #10 "Scheduled capacity (-) projected demand = excess operations capacity…" consistent with the required Washington State methodology formula;	Page #9 "Scheduled capacity (-) projected demand = excess operations capacity **using FMH surgery suite schedule…**" modifies the statutorily required Washington State methodology formula to artificially inflate

Comparison of Draft and Final versions of MSRG Ambulatory Surgery Need Analysis

Draft	Final
Page #12, "Population Trends", "Considering this shift in population, **projected demand** (as stated in each CON application) **was compared with national averages to determine if over- or under-utilization exists. The hospital projections are unreliable** when compared to an ambulatory surgery center since FMH does not maintain any dedicated, outpatient surgery suites. **The utilization projected by TVC seems to be on target…..**"	FMH surgery capacity; Page 11, "Population Trends", **deleted** entire paragraph discussing "…**projected demand …. Was compared to antional averages…..**" and "**The hospital projections are unreliable…..**" and "**The utilization projected by TVC seems to be on target….**";
Page #12 - 14, "Utilization Benchmarks", discusses how "…**utilization varies by geographic region…**", provides 3 tables of utilization rates and references the authoritative U.S. Dept of Health and Human Services study "**Ambulatory Surgery in the United States, 1996**" which lists national utilization rates for ambulatory surgery.	Pages #12 – 14, **deleted** "Utilization Benchmarks" in its entirety, including 3 charts and all references to U.S. Dept of Health and Human Services study "Ambulatory Surgery in the United States, 1996";
Page 15 - 16 "Cost, Quality and Access", "The table below presents a **comparison of costs for ambulatory surgical procedures performed in hospital outpatient centers and freestanding ambulatory surgery centers** provided by HCIA. ….**The table clearly demonstrates cost savings possible within all medical specialty areas…..**" Table lists 19 surgery procedures, with savings of 50% - 85% available in an ASC.	Page #12, "Cost, Quality and Access" **Paragraph describing savings and Table F demonstrating 50% - 85% cost savings eliminated** in final version;

Comparison of Draft and Final versions of MSRG Ambulatory Surg.ry Need Analysis

Draft	Final
Page #17, regarding ASC savings, states "In the typical case, however, **it is reasonable to assume cost savings of at least 20%...**"	Page #12, cost savings statement deleted;
Page 18, "Discussion of Issues" #4, speaks of using the Washington methodology to estimate need, and states "....**MSRG recommends looking at actual utilization and challenging hospital assumptions** to fully understand the capacity versus demand issue.";	Page 14, "Discussion of Issues" #4, states "....**MSRG recommends looking at actual scheduled capacity** to fully understand the capacity versus demand issue."; the recommendation to review actual utilization and challenge hospital assumptions deleted;
Page #20, " Final Comments, "**A cost advantage can be gained from an ambulatory surgery center, as well as providing the community with options of care settings and care providers, competitive pricing and enhanced access and quality.**" Page #20, "Final Comments" "When addressing FMH expansion plans the study says "**Given the current excess capacity at FMH, the addition of another surgery suite appears to be unnecessary at this time.**"	Page #16, Final Comments, "A cost advantage can be gained from an ambulatory surgery center, **in a highly competitive, well-managed environment.**" Change in working completely changes the meaning and eliminates all references to providing options in care settings and providers, competitive pricing and enhanced access; Page #16, "Final Comments, "**If FMH opened one additional surgery suite, it would satisfy demand for another five years**" precisely contradicting their draft recommendation that another FMH surgery suite was unnecessary;
Page #21, "Final Comments", "**TVC presented the most viable plan for a freestanding ASC**" Page #22, "CON Comparative Analysis" scores **TVC highest** at 35 out of 40 points (88%), vs FMH at 22.5 out of 40 points (56%).	Page #17, "Final Comments" statement eliminated.

Prices for Surgery in Fairbanks: Who's offers lower cost?

The discussion of who offers the lowest cost for surgery services in Fairbanks is confused, because the hospital does not bill for its services in the same way a freestanding Ambulatory Surgery Center (ASC) bills.

How a hospital bills: Fairbanks Memorial bills on a "menu" basis. If it was a restaurant, the hospital would advertise a steak for $15, but have to add a salad for $5, a baked potato for $4 and coffee for $2.00. Your steak dinner would then cost you $26.00, not the $15 that was advertised. Same with surgery. The hospital tells you their surgery costs, say $1,000 but they don't tell you that they add on charges that eventually might cost you, say $2,250 for the total package.

How a freestanding ambulatory surgery (ASC) center bills: Freestanding ambulatory surgery centers bill on a one-price-covers-all basis. If it was a restaurant, you would buy a steak for $18, which initially looks more expensive than the hospital's $15 steak. But, unlike the hospital, the $18 steak includes the salad, balked potato and coffee. Thus you get the steak diner for $18, not the $26.00 the hospital charges for the whole dinner. The same with surgery. A freestanding ASC charges perhaps $1,200 which looks higher than the hospitals advertised $1,000, but there are no add-ons that run up the bill. So your surgery at the ASC costs $1,200 vs the hospitals $2,250. You save $1,050 with the ASC.

Summary: When the discussion of ambulatory surgery arise, the hospital claims that their prices are lower than an ASC. But remember the steak diner story. **The hospitals quoted price is only part of the story – the total surgery charge when it's done in a hospital, is higher than the same surgery done in a freestanding ASC** - end of story.

[Code of Federal Regulations]
[Title 42, Volume 2, Parts 400 to 429]
[Revised as of October 1, 1998]
From the U.S. Government Printing Office via GPO Access
[CITE: 42CFR413.118]

[Page 436-437]

TITLE 42--PUBLIC HEALTH

CHAPTER IV--HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

PART 413--PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL D

Subpart F--Specific Categories of Costs

Sec. 413.118 Payment for facility services related to covered ASC surgical procedur

(a) Basis and scope. This section implements section 1833(a)(4) and (i)(3) of the Act and establishes the method for determining Medicare payments for services related to covered ambulatory surgical center (ASC) procedures performed in a hospital on an outpatient basis. It does not apply to services furnished by an ASC operated by a hospital that has an agreement with HCFA to be paid in accordance with Sec. 416.30 of this chapter. (For regulations governing ASCs see part 416 of this chapter.)

(b) Definitions. For purposes of this section--

Facility services are those items and services, as specified in Sec. 416.61 of this chapter, that are furnished by a hospital on an outpatient basis in connection with covered ASC surgical procedures, as described in Sec. 416.65 of this chapter.

[[Page 437]]

Standard overhead amount means an amount equal to the prospectively determined payment rate that would be paid for the procedure if it had been furnished by an ASC in the same geographic area.

(c) Payment principle. The aggregate amount of payments for facility services, furnished in a hospital on an outpatient basis, that are related to covered ASC surgical procedures (covered under Sec. 416.65 of this chapter) is equal to the lesser of --

(1) The hospital's reasonable cost or customary charges, as determined in accordance with Sec. 413.13, reduced by deductibles and coinsurance; or

(2) The blended payment amount as described in paragraph (d) of this section, which is based on hospital-specific cost and charge data and rates paid to free-standing ASCs.

(d) Blended payment amount. (1) For cost reporting periods beginning on or after October 1, 1987 but before October 1, 1988, the blended payment amount is equal to the sum of --

(i) 75 percent of the hospital-specific amount (the lesser of the hospital's reasonable cost or customary charges, reduced by deductibles and coinsurance); and

(ii) 25 percent of the ASC payment amount (that is, 80 percent of the result obtained by subtracting the deductibles from the sum of the standard overhead amounts.)

(2) For the period of time beginning with the first day of a

hospital's cost reporting period that beg ins on or after October 1, 1988 and ends on December 31, 1990, the blende d payment amount is equal to 50 percent of the hospital -specific amount and 50 percent of the ASC payment amount.

(3) For portions of cost reporting pe riods beginning on or after January 1, 1991, the blended payment amou nt is equal to 42 percent of the hospital -specific amount and 58 percent of the ASC payment amount.

(4) For cost reporting periods beginn ing on or after October 1, 1988 and before January 1, 1995, the blended p ayment amount is equal to the sum of 75 percent of the hospital -specific amount and 25 percent of the ASC payment amount for a hospital that ma kes an application to its fiscal intermediary and meets the followi ng requirements.

(i) More than 60 percent of the hospi tal's inpatient hospital discharges, as described in Sec. 412.60 o f this chapter, occurring during its cost reporting period beginnin g on or after October 1, 1986 and before October 1, 1987, are classifie d in diagnosis related groups 36 through 74.

(ii) During its cost reporting period beginning on or after October 1, 1986 and before October 1, 1987, more than 30 percent of the hospital's total revenues is derived from outpatient services.

(e) Aggregation of cost, charges, and the blended amount. For purposes of determining the correct payme nt amount under paragraphs (c) and (d) of this section, all reasonable c osts and customary charges attributable to facility services furnish ed during a cost reporting period are aggregated and treated separat ely from the reasonable costs and customary charges attributable to all other services furnished in the hospital.

[52 FR 36773, Oct. 1, 1987; 52 FR 37715, Oct. 8, 1987, as amended at 55 FR 33699, Aug. 17, 1990; 55 FR 34797, Aug . 24, 1990; 57 FR 36017, Aug. 12, 1992; 57 FR 45113, Sept. 30, 1992]

Compilation of Comments on the Failure of CON Laws

Excerpted from "*BEYOND HEALTH CARE REFORM: RECONSIDERING CERTIFICATE OF NEED LAWS IN A MANAGED COMPETITION SYSTEM*"
By PATRICK JOHN MCGINLEY
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CON laws evolved from the health care reforms of the 1940s and were heavily promoted well into the 1970s by health care providers, who found CON effective in sheltering their businesses from the costly effects of a competitive marketplace. Congress mandated CON in 1974, but quickly repealed the mandate when CON failed to lower the nation's health care costs.

"In one comparison of health care prices and expenses, it was shown that such prices and expenses are actually higher in areas with CON regulations than they are in areas without CON."[1] In fact, national hospital care expenditures increased from $52.4 billion when Congress enacted the 1974 National Health Act to an estimated $230.1 billion in 1989.[2] Today, Americans are spending nearly a trillion dollars annually on health care.[3] In searching the scholarly journals, one cannot find a single article that asserts that CON laws succeed in lowering health care costs.[4] CON "has elicited a remarkable evaluative consensus—that it does not work."[5]

CON, in addition to failing to decrease national health care expenses, was having detrimental effects on the provision of health care in local communities. The effect of CON on local communities was perhaps best related to Congress by the words of Representative Rowland of the Eighth District of Georgia. Representative Rowland recognized that CON appeared to be a good idea in theory, yet in reality failed to control health care costs and was often insensitive to community needs. ("At first glance, the idea [of certificate of need] may have looked pretty good. In practice, however, the effect of certificate-of-need on health care costs has been dubious, at best. And the program has certainly been insensitive in many instances to the true needs of our communities.") [6]

One may question the wisdom of continuing any form of state regulation that failed to produce its desired goal when implemented nationwide.[7] As the review of Congress's intent indicates, CON had one goal—to save money. However, in those states which retained their CON laws, the retention was often supported by new and creative justifications, many of which were unrelated to saving money. Commentators, in their traditional role of explaining the reason behind events, have set forth many justifications explaining why states have kept the same old CON laws.[8] All these justifications, however, are the crafty work of commentators, and not the motivation of state legislatures. No state legislature has codified any of these new justifications as legislative intent.[9] These justifications should therefore carry little weight in a proper analysis.[10]

Where certificate-of-need laws limit resources effectively, the owners of existing facilities are in a seller's market. They can charge inflated prices for their facilities,..... [C]ertificate-of-need laws will continue to raise health care costs by restricting the entry of cost-effective providers into the market.[11].

1. Mark E. Kaplan, Comment, *An Economic Analysis of Florida's Hospital Certificate of Need Program and Recommendations for Change*, 19 FLA. ST. U. L. REV. at 487 (1991).
2. *Id.* at 487 n.102.
3. Clark C. Havighurst, *Contract Failure in the Market for Health Services*, 29 WAKE FOREST L. REV. at 47. (1994).
4. One author contends that the proper evaluative analysis is not whether certificate of need succeeded in lowering the nation's health care costs, but whether it thwarted the rate of increase in the nation's health care costs. *See* Kaplan, *supra* note 1, at 487. That author concedes, however, that certificate of need is a failure even under his alternative analysis. *Id.*
5. *Id.* (quoting Lawrence D. Brown, *Common Sense Meets Implementation: Certificate-of-Need Regulation in the States*, 8 J. HEALTH POL., POL'Y & L. 480, 481 (1983)).
6. 134 CONG. REC. H9455-01 (1988)
7. For legislators, wisdom can sometimes fall prey to lobbyists. For example, the Texas Medical Association was instrumental in reinstating certificate of need laws after the Texas legislature repealed the regulations. *See Statelines—Texas: Certificate-of-Need Program Reinstituted*, 1 AMERICAN HEALTH LINE, June 16, 1992. In New Jersey, a coalition of twenty urban and teaching hospitals demanded that certificate of need laws not be repealed, warning that deregulation could force hospitals out of business, and stating that they were "concerned there is a push to a deregulated environment." *Statelines—New Jersey: Many Hospitals Fear Deregulation*, 1 AMERICAN HEALTH LINE, Nov. 19, 1992. Likewise in Georgia, the Atlanta Health Care Alliance says it has "supported the certificate-of-need law and health-planning regulations . . . . Duplicative, unnecessary health-care services have been very costly to our members." *Access, Quality, Cost—Cost Containment: Regulation "Back into Vogue,"* 1 AMERICAN HEALTH LINE, May 11, 1992. *See also* Clark C. Havighurst, *Regulation of Health Facilities and Services by "Certificate of Need"*, 59 VA. L. REV. 1143, 1148-51 (1973) [hereinafter Havighurst, *Regulation by CON*], at 1216 (noting that "avoidance of 'duplication' is of course consistent with a cartel's preference for minimizing competition"). Hospital lobbyists demand the protection of certificate of need, because "business coalitions . . . see planning as a way to control costs for their members." *Access, Quality, Cost — Cost Containment: Regulation "Back into Vogue"*, 1 AMERICAN HEALTH LINE, May 11, 1992 (quoting James Kimmey, Dean of the School of Public Health at St. Louis University).

Hospitals are aware that, instead of controlling costs (or "revenue" as seen from the hospital's perspective), certificate of need had the opposite effect. *See supra* part I.B.2. "Viewed in the light of possibilities for more fundamental changes in the market for insurance and health services, certificate-of-need laws may appear as conservative measures, designed to preserve the very institutions [that] create the problems to which they are addressed." *See* Havighurst, *Regulation by CON*], supra note 6, at 1156. Hospitals therefore fight to keep certificate of need alive.

8. *See generally* Kaplan, *supra* note 1; Maja Campbell-Eaton, Note, *Antitrust and Certificate of Need: A Doubtful Prognosis*, 69 IOWA L. REV. 1451, 1453 (1984).; Scott D. Makar, *Antitrust Immunity Under Florida's Certificate of Need Program*, 19 FLA. ST. U. L. REV. 149, 150 (1991); Bruce Babbitt & Jonathan Rose, *Building a Better Mousetrap: Health Care Reform and the Arizona Program*, 3 YALE J. ON REG. 243 (1986); Norman Daniels, *Technology and Resource Allocation: Old Problems in New Clothes*, 65 S. CAL. L. REV. 225 (1991); Mark A. Hall, *Managed Competition and Integrated Health Care Delivery Systems*, 29 WAKE FOREST L. REV. 1, 2 (1994); Carl J. Schramm & Steven C. Renn, *Hospital Mergers, Market Concentration and the Herfindahl-Hirschman Index*, 33 EMORY L.J. 869, 881 n.30 (1984) ("[H]istorically, demonstrating 'need' has often been an easy task, and less than one-quarter of all proposed projects fail to win planning agency approval."). The Supreme Court has held that "need" is not an unconstitutionally vague standard in regulatory statutes; John A. Robertson, *Asking the "Woman Question" About Health Care Reform*, 3 TEX. J. WOMEN & L. 1 (1994); David M. Frankford, *Privatizing Health Care: Economic Magic To Cure Legal Medicine*, 66 S. CAL. L. REV. 1 (1992). Examples of new justifications for old certificate of need laws include curbing "excessive competition," solving a "moral hazard," rectifying "inadequate information," and eliminating "inefficient incentives." *See, e.g.*, Kaplan, *supra* note 1, at 479-84. The true reasons for retaining CON are far more pragmatic. *See supra* note 6.
9. *E.g.*, CODE OF ALABAMA §§ 22-21-260 to 278 (1994); ALASKA STAT. §§ 18.07.021-.111 (1995); CAL. HEALTH & SAFETY CODE §§ 437.10, 439.7 (1995); CAL. GOV'T CODE § 15438.1 (1994); CONN. GEN. STAT. §§ 19a-154 to 155 (1994) (licensing and budget review law); 16 DEL. CODE ANN. §§ 9301-11 (1994); D.C. CODE ANN. §§ 32-326 (1981); FLA. STAT. ch. 408 (1993 and Supp. 1994); GA. CODE ANN. §§ 31-6-1 to 70 (1994); HAW. REV. STAT. §§ 323D-1 to 54 (1989); IND. CODE ANN. §§ 16-29-1 1 to 16 (Burns 1994) (expiring July 1, 1996 pursuant to IND. CODE ANN. § 16-29-1-16); IOWA CODE §§ 135.621-.73 (1994); KAN. STAT. ANN. §§ 65-4802 to 4822 (1992); KY. REV. STAT. ANN. §§ 216B.010-.310 (Baldwin 1994); ME. REV. STAT. ANN. tit. 22, 301-24 (1994); MD. CODE ANN., HEALTH-GEN., 19-101 to 222 (1994); MICH. COMP. LAWS §§ 333.22201-60 (1995); MISS. CODE §§ 41-7-171 to 209 (1995); MO. REV. STAT. §§ 197.30-.65 (1995); MONT. CODE ANN. §§ 50-5-301 to 316 (1994); NEB. REV. STAT. §§ 71-5801 to 70 (1994); N.H. REV. STAT.

ANN. §§ 151-C:1 to 15 (1994); N.J. REV. STAT. §§ 26:2H-1 to 2I-39 (1994); N.C. GEN. STAT. §§ 131E-175 to 190 (1994); N.D. CENT. CODE §§ 23-17.2-01 to 15 (1993); OHIO REV. CODE ANN. §§ 3702.51-.60 (Anderson 1995); OKLA. STAT. tit. 63, 1-850 to 858 (1995); OR. REV. STAT. §§ 442.58-.86 (1992); 35 PA. CONS. STAT. §§ 448.701-.712 (1995) (expiring 1996); S.C. CODE ANN. §§ 44-7-320 to 460 (Law. Co-op. 1976); TENN. CODE ANN. §§ 68-11-101 to 125 (1994); VT. STAT. ANN. tit. 18, 9431-44 (1994); VA. CODE ANN. §§ 32.1-102.1 to 102.11 (Michie 1994); V.I. CODE ANN. tit. 19, 223 (1994); WASH. REV. CODE §§ 70.38.015-.920 (1995); W. VA. CODE §§ 16-2D-1 to 15 (1995)..

10. A proper analysis of certificate of need should focus on the benefits of a regulated bed supply. After all, the purpose of certificate of need regulations is to control the size and growth of the bed supply. *See* discussion *supra* parts II.A., II.B. Therefore, to properly evaluate certificate of need laws, the effect of CON bed supply controls should be measured against the resulting increase or decrease in health care prices.

    Regulatory restraint on the growth of bed supply will result in somewhat higher prices than an unregulated marketplace would produce no matter how well the health care industry is regulated. Havighurst, *Regulation by CON, supra* note 4, at 1218. Certificate of need laws monitor only certain kinds of hospital costs, and therefore "may merely divert inflationary pressures and achieve no control." *Id.* In many instances, this diversion leads to a higher price for health care. For example, imagine two hospitals, one regulated by certificate of need, the other unregulated. Further imagine an unexpected increase in hospital wage costs. *Id.* (revealing that this type of event is rather common in the health care industry by stating that increases in hospital wages and "other types of cost increases . . . are equally likely to occur"). The unregulated hospital has the opportunity to add beds and thereby allocate the increase in wage costs over a greater number of patients, resulting in a smaller increase in health care cost per patient. *See id.* The regulated hospital, however, cannot add beds because of certificate of need regulations. *See id.* (implying that, when a hospital's bed supply is fixed, then its maximum revenue is fixed, even though maximum costs are not). The regulated hospital must allocate the increased cost to a smaller number of patients, resulting in a larger increase in health care costs per patient. In that case, a hospital would face increased costs because certificate of need laws do not regulate wages, yet the hospital would experience no increase in revenue because certificate of need has capped the hospital's maximum revenue. Certificate of need, therefore, can prove rather costly to individual patients.

11. Peter P. Budetti, *Public Policy Issues Surrounding Certificate of Need*, 1978 UTAH L. REV. at 44-45.

Additional Comments on the Failure of CON Legislation

"A recent study by Georgia State University of 37 papers on CON concluded with this statement "Our review of the research literature indicates that Certificate of Need programs have not only failed to achieve lower hospital costs, but they may have contributed to higher costs, greater inefficiency and lower quality of care. Although there have been no major studies of CON laws in the last five years, the evolution of the healthcare delivery system has removed much of the rational for these programs existence"".[1]

"Certificate of Need is based on the dubious economic theory that increased supply and competition will increase prices" [2]

"Today, thee is no evidence that CON reduces medical cots. In fact, thee is considerable evidence that CON increases the cost of health care. It dose so in three ways:

1) Administrative Costs – The CON program itself imposes substantial costs on both health care providers and the government. Since its inception, federal and state governments have spent more than $1 billion administering the program. For providers, preparing and defending a CON application can be time-consuming and expensive process. Needless to say, the added cost is late passed along to consumers.
2) Lack of competition – CON requirements erect barriers to market entry, thereby reducing competition among health care providers. In effect, existing providers are granted a monopoly. Providers frequently attempt to use the CON process to obstruct would be competitors. The impact of entry barriers is made even worse because the new provider seeking to enter the market is often more innovative and cost-effective than the established providers. Some health care economists estimate that CON barriers to market entry increase hospital costs by as much as 5 percent.
3) Shortages – Where CON requirements have produced a shortage of a particular health care service, prices for those services that are available are certain to rise. At the same time, consumers may be forced to shift to alternative services that are often more expensive.
   The Federal Trade Commission estimates that CON regulations increase the cost of hospital care nationwide by more than $1.3 billion annually.
   Certificate of Need programs also reduce access to health care for those who need it the most.
   It is time to realize that Soviet-style central planning is as big a failure in health care as in all other aspects of the economy. States should repeal their CON requirements".[3]

1. John Steen, Director of the State of Georgia Certificate of Need Program, "*Certificate of Need: A Review*", from the "AHPA Net" web site of the American He lth Planning Association, 2001.
2. Michael D. Turner, CATO Institute, Washington, D.C. "*Ending the CON Game*", pg 1, The Heartland Institute: Intellectual Ammunition, Jan – Feb 1996, from the web site, www.heartland.org, 2001.
3. Turner, supra note 2, page 1-2.

'The cost of applying for a CON can be considerable, exceeding $100,000 for major projects. If litigation is required, the cost may reach $300,000…".[4]

"If the (CON) process does not make a significant contribution toward cost containment and equitable distribution of health care resources, and it provides, as some critics suggest, an obstacle to improved health care, it may be that the CON requirements should be abandoned." [5]

"The enormous expenditure of time and money by both administrative agencies and health care provides in complying with the CON process substantially reduces any savings that might be attributable to it. For all its promise, CON review has resulted in the elimination of few projects. Of over 20,000 CON applications reviewed throughout the country between 1979 and 1981, only ten percent were ultimately disapproved." [6]

4. Roberta M. Ross, "*Certificate of Need for Health Care Facilities: A Time for Reexamination*", 7 Pace Law Review 491 (1987), from web site http://php.iupui.edu/~healthw/chapqo~1.htm
5. Ross, supra note 4, page 3.
6. Ross, supra note 4, page 3.

Additional comments on the Failure of CON and the value of Competition

"Health facilities exist to serve the public. How is the public served by a virtual monopoly over this most critical of all public needs"? *Former Mississippi Governor Kirk Fordice, in an address to the Mississippi Legislature, 1999, from the Mississippi state web page (wwwgovoff.state.ms.us/main/gc/gc020299.html);*

"CON laws, born out of an effort to control cost, may actually increase health care costs by suppressing competition, as noted by Department of Health Executive Director Dr. Ed Thompson in his 1995 response to PEER questions. A Daniel N. Mendelson and Judith Arnold study, based on extensive empirical analysis of hospital costs, concluded that CON programs have not held down hospital costs. These researchers also found no evidence of increased costs in the initial twelve states that repealed CON requirements." *Ibid.*

"According to the FTC complaint detailing the charges in this case, the [*ambulatory surgery center*] acquisition would violate antitrust laws by substantially reducing competition for outpatient surgery services in Anchorage. The market for these services is highly concentrated, having few competitors, and entry by new entities is difficult because of state certificate-of-need requirements, the complaint states. Thus, the FTC alleged, it is unlikely that, absent the divestiture required by the settlement, a new competitor could be established quickly enough to deter any anticompetitive behavior by Columbia/HCA. Moreover, the acquisition could increase the probability of collusion among remaining sources of outpatient surgery in the market and could, therefore, deny patients and others the benefits of competition based on price, quality and service for outpatient surgery services in Anchorage." *Press release from the Federal Trade Commission, September 15 1995, as listed on the FTC web site (www.ftc.gov/opa/predawn/F95/columbia-mca.htm);*

FEDERAL TRADE COMMISSION ECONOMICS STUDY FINDS CERTIFICATE-OF-NEED REQUIREMETNS INCREASE HOSPITAL PRICES AN COSTS

Consumers Benefit from Hospital Competition

"Certificate-of-need (CON) requirements, which were intended to control health-care costs, have actually increased hospital prices by four percent, according to a study issued today by the Federal Trade Commission's Bureau of Economics." *Press release from the Federal Trade Commission, May 5 1987, from the web site* (www.ftc.gov/opa/predawn/F87/hospitals.txt);

"In addition, the study found, hospital expenses are higher in states that have CON laws. According to the study, "There is no evidence that CON laws have resulted in the resource savings they were purportedly designed to promote." "*Ibid.*

"The study also found that in areas where there are more independent hospitals, consumers get higher quality at the same price because of the increased competition. However, CON laws may be used to reduce the number of hospitals, thereby injuring consumers, according to the Bureau of Economics. "Therefore recent plans and decisions to repeal CON laws in some states should increase consumer welfare," the study states." *Ibid.*

"According to Federal Trade Commission Chairman Daniel Oliver, "Their findings concerning CON laws provide further support for my belief that government restrictions on competition are a major source of consumer injury." " *Ibid.*

"Our regulatory treatment of ASCs recognizes the Department's historical policy of promoting greater utilization of ASCs because of the substantial cost savings to Federal health care programs when procedures are performed in ASCs rather than in more costly hospital inpatient or outpatient facilities." *U.S. Department of Health and Human Services, Federal Register, 11/19/99, (volume 64, number 223), page 38*;

"Many commenters noted that ASCs have saved Medicare hundreds of millions of dollars, forcing hospitals to become more competitive, because ASC payment rates are typically lower than hospital payment rates for the same procedures. Several commenters stated that ASCs foster patient access to care, particularly in medically underserved regions. Moreover, many commenters observed that patients generally prefer outpatient surgical care at an ASC to hospital care. .... We agree that ASCs can significantly reduce costs for Federal health care programs, while simultaneously benefiting patients." *Ibid, page 40;*

".......subsidies to promote the overall financial health of safety net hospitals are determined through often complex allocation mechanisms not directly related to the provision of services, and...... the demarcation of support for public health and specialty services versus care for the poor and uninsured is unclear. He suggests that in order to assure community access to vital public health and specialized services grants should be used to target, financial support for those services essential for community care." *Christine Grant, Chairperson, Commissioner of Health and Senior Services, quoting Darrell J. Gaskin, in Report of the Certificate of Need Study Commission, New Jersey, February 2000*;

"Mr. Havighurst was very critical of CON and supports a totally free market approach to the development of health care facilities and services. He believes CON is poorly conceived and has been responsible for serious policy mistakes that actually increased costs in the health care system;" *Ibid, citing Clark Havighurst, Wm. Neal Reynolds Professor of Law, Duke University School of Law*;

"Mr. Sweeney basically supported deregulation of CON because of the difficulty in balancing market forces and a strong CON program which might limit entry into the market." *Ibid, citing Raymond D. Sweeney, Executive Vice President, Healthcare Association of New York State (HANYS);*

"Ms. Dickson provided an historic overview and analytical analysis of CON. Her analysis indicated that CON does not reduce acute care costs…" *Ibid, citing Pamela Dickson, Senior Program Officer, Robert Wood Johnson Foundation.*

ALASKA STATE LEGISLATURE

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SENATOR LYDA GREEN
SENATE DISTRICT N

Sponsor Statement
Senate Bill 256

Certificate of Need (CON)

Senate Bill 256 increases the threshold for the certificate of need from $1 million to $10 million

"Certificate of need" laws were designed to keep health care costs low by requiring advance approval by a state agency for most hospital expansions and major equipment purchases. In 1974, the U.S. Congress required all states to enact CON laws but had repealed that requirement by 1986, as Congress found that the CON process was not effective in controlling healthcare costs. Over the past several years the trend nationwide has been to repeal or amend CON to make them less restrictive and to increase the threshold.

The current $1 million threshold for certificate of need in Alaska has been in effect since 1983. Over the past 19 years construction costs have increased. With the $1 million threshold the Department of Social and Health reviews applications for facility expansion and equipment that should be left to the providers and the marketplace.

Alaska is not facing an over supply of hospital beds, healthcare providers, doctors or healthcare workers in general. The more typical Alaskan experience is to find a shortage of healthcare options and to travel out of state for treatment. In fact, among in the United States, Alaska ranks 46th in the number of hospital beds per 1000 population, 51st in the number of healthcare workers as a percentage of our workforce, and 49th in the number of physicians per capita, according to the Kaiser Family Foundation, State Health Facts Online. Restricting the supply of health care resources in Alaska is not the answer to keeping health care costs down. Instead, easing restrictions on the expansion of current services is likely to bring consumers back to Alaska and provide lower healthcare costs through competition.

Bill History/Action Display

H

BILL: SB 256 SHORT TITLE:CERTIFICATE OF NEED PROGRAM
BILL VERSION:
SPONSOR(S): SENATOR(S) GREEN
CURRENT STATUS: (S) HES STATUS DATE: 01/23/02
THEN FIN
HEARING: (S) HES Feb 04 1:30 PM BUTROVICH 205 TELECONFERENCE

Committee Hearing History

TITLE: "An Act relating to the certificate of need program; and providing for an effective date."

Full Text No Fiscal Notes Available

Bill History

Jrn-Date	Jrn-Page		Action
01/23/02	2018	(S)	READ THE FIRST TIME - REFERRALS
01/23/02	2018	(S)	HES, FIN
01/23/02	2018	(S)	REFERRED TO HEALTH, ED & SOCIAL SVCS
02/04/02	Text	(S)	HES AT 1:30 PM BUTROVICH 205

Similar Subject Match or Exact Subject Match
CONSTRUCTION
HEALTH & SOCIAL SERVICES
HOSPITALS
MEDICAL CARE
NURSING HOMES
PIONEERS' HOMES

Bill Root: Display Bill Root

BOBBY APPROVED

TO REPORT PROBLEMS WITH BASIS INQUIRY

LIVE KTOO STREAMS

Return to Basis Main Menu (22 Legislature)
Return to Legislature Home Page

PREVIOUS ACTION

SB
264

COMMITTEE: SENATE HESS	SUBJECT: SB 264-MUNICIPAL BOND REIMBURSEMENT
DATE: MARCH 15, 2002	

PLEASE SIGN IN

NAME PLEASE PRINT	ADDRESS (MAILING & ZIP)	E-MAIL	REPRESENTING (No Acronyms)	TESTIFY Y/N
Kelly Jeans			Education	Y

ALASKA STATE LEGISLATURE

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SENATOR LYDA GREEN
SENATE DISTRICT N

Sponsor Statement
Senate Bill 264

Reimbursement program for municipal bonds, notes, or other indebtedness incurred for school construction

Senate Bill 264 would authorize 70% state reimbursement for $113 million dollars of school projects that are funded by voter authorized debt issued by local governments. The authorization would be distributed among school districts in the following manner; $50 million for projects in Anchorage, $15 million for project' in Fairbanks, $13 million for projects in Mat-Su, $10 million for projects in Kenai and $25 million for projects in smaller school districts in organized Alaska. The amounts are intended to equal $1000 in projects per student rounded to the nearest million dollars in each district.

Debt reimbursement is one of the methods that have been used to fund school construction in Alaska for a number of years. Debt reimbursement has a unique advantage over other financing methods in that it allows for maximum local involvement and input in the decision of which specific projects should be funded. Municipal debt reimbursement insures that the projects funded in a school district are the highest priority of the voters in that district. Projects need to meet state standards for approval but do not need to be funded in the state's priority order.

SB 264 is not intended to serve as a complete school funding package. School districts in unorganized Alaska cannot use debt reimbursement. Individual school projects are often larger than the authorization in SB 264 for any school district. Other funding methods, such as G.O. debt, must be used for most school construction and major maintenance in Alaska. Municipal debt reimbursement is, however, the best method for many school districts to build and maintain the facilities most important to the people in their community.

FISCAL NOTE

STATE OF ALASKA
2002 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: SB 264
(S) Publish Date: 3/1/02

Revision Date/Time (Note if correction):
Title "An Act relating to a reimbursement program for municipal bonds, notes, or other indebtedness..."
Sponsor Senator Green
Requester Community and Regional Affairs

Dept. Affected: EED
BRU School Debt Reimbursement
Component School Debt Reimbursement
Component No. 153

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims	0.0	7,910.0	7,712.3	7,514.5	7,316.8	7,119.0
Miscellaneous						
TOTAL OPERATING	0.0	7,910.0	7,712.3	7,514.5	7,316.8	7,119.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

FUND SOURCE	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008
1002 Federal Receipts						
1003 GF Match						
1004 GF		7,910.0	7,712.3	7,514.5	7,316.8	7,119.0
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	0.0	7,910.0	7,712.3	7,514.5	7,316.8	7,119.0

Estimate of any current year (FY2002) cost: 0.0
Check this box (X) if funding for this bill is included in the Governor's FY 2003 budget proposal: [ ]

POSITIONS

POSITIONS						
Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

This bill will add an additional $113 million in bonding capacity for reimbursable school construction projects. This bill allocates the authorization among 5 categories based on the number of students in a municipality. All projects would have to be approved by the Department of Education & Early Development before the bond proposition goes to the local voters. The bond propositions would have to comply with the voter information requirements of AS 14.11.100(j)(1). It is assumed that the authorization provided in this bill would be approved and sold in FY2003 with the first principal and interest payments coming due in FY2004. It is also assumed that the bonds will be 20 year bonds with equal principal payments to maturity.

Prepared by: Eddy Jeans, School Finance Manager — Phone 465-8679
Division: Education Support Services — Date/Time 2/26/02 8:45 AM
Approved by: Ed McLain, Deputy Commissioner of Education — Date 2/26/2002
Agency: Department of Education & Early Development

(Revised 9/2001 OMB)

COMMITTEE COP

ALASKA STATE LEGISLATURE

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SENATOR LYDA GREEN
SENATE DISTRICT N

Sectional Analysis SB 264

Section 1: Amends AS 14.11.100(a) by adding a new subsection (a)(11).
AS 14.11.100(a)(11) provides 70 percent reimbursement for retirement of principal and interest on outstanding, bonds, notes or other indebtedness authorized by municipal voters after June 30, 2002 to pay costs of school construction, additions and major rehabilitation projects that exceed $200,000.

Section 2: Amends AS 14.11.100(h) to provide a reference to new subsection (a)(11) added in Section 1

Section 3: Amends AS 14.11.100(i) to provide a reference to new subsection (a)(11) added in Section 1

Section 4: Amends AS 14.11.100(j) to provide a reference to new subsection (a)(11) added in Section 1

Section 5: Authorizes $113,000,000 for projects specified in Section 1, AS 14.11.100 (a)(11), and allocates the funding as follows:
$50,000,000 to projects in Anchorage
$15,000,000 to projects in Fairbanks
$13,000,000 to projects in Mat-Su
$10,000,000 to projects in Kenai
$25,000,000 to projects in municipalities with less than 9,000 students each (Juneau and smaller)

Section 6: Effective date July 1, 2002

Prepared by Jerry Burnett, Staff to Senator Lyda Green, 3-15-02

SB 264, Bonded Debt Reimbursement

- Provides 70% state reimbursement for $133 million in school construction projects funded by bonds approved by local voters

- Funding is allocated to school districts based on student population, the four largest districts have specific allocations of approximately $1,000 per student (rounded to the nearest million), $25 million is allocated in a block for use by any/all of the smaller districts, again approximately $1,000 per student

- Projects must meet state requirements and be approved by the Department of Education to qualify for reimbursement

- Projects do not have to be funded in rank order as determined by the Department of Education

- SB 264 provides reimbursement for bonds approved/issued after July 1, 2002 but does not provide a time limit for when the bonds must be approved

- SB 264 does not extend the time limit for authorizations currently in law. Fairbanks has reimbursement authorization that will expire in 2004 if not renewed

- SB 264 does not address the issue of reimbursement for projects paid for with investment earnings from bond proceeds, at least one school district has excess investment earnings from a bond issue and would benefit from a change to the statute that restricts the use of these earnings.

- REAA's cannot use this funding mechanism, the Department of Education and the members of the minority may argue that only by using the Department's

- Representative James' bill, HB 451, requires that school districts have in place an approved maintenance plan in order to qualify for debt reimbursement (this was a recommendation of the bond reimbursement committee) adding her language to SB 264 would possibly be politically useful

ALASKA STATE LEGISLATURE

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SENATOR LYDA GREEN
SENATE DISTRICT N

Sponsor Statement
Senate Bill 264

Reimbursement program for municipal bonds, notes, or other indebtedness incurred for school construction

Senate Bill 264 would authorize 70% state reimbursement for $113 million dollars of school projects that are funded by voter authorized debt issued by local governments. The authorization would be distributed among school districts in the following manner: $50 million for projects in Anchorage, $15 million for projects in Fairbanks, $13 million for projects in Mat-Su, $10 million for projects in Kenai and $25 million for projects in smaller school districts in organized Alaska. The amounts are intended to equal $1000 in projects per student rounded to the nearest million dollars in each district.

Debt reimbursement is one of the methods that have been used to fund school construction in Alaska for a number of years. Debt reimbursement has a unique advantage over other financing methods in that it allows for maximum local involvement and input in the decision of which specific projects should be funded. Municipal debt reimbursement insures that the projects funded in a school district are the highest priority of the voters in that district. Projects need to meet state standards for approval but do not need to be funded in the state's priority order.

SB 264 is not intended to serve as a complete school funding package. School districts in unorganized Alaska cannot use debt reimbursement. Individual school projects are often larger than the authorization in SB 264 for any school district. Other funding methods, such as G.O. debt, must be used for most school construction and major maintenance in Alaska. Municipal debt reimbursement is, however, the best method for many school districts to build and maintain the facilities most important to the people in their community.

Bill History/Action Display

H

BILL: SB 264 SHORT TITLE:MUNICIPAL BOND REIMBURSEMENT
BILL VERSION:
SPONSOR(S): SENATOR(S) GREEN
CURRENT STATUS: (S) HES STATUS DATE: 03/01/02
THEN FIN
HEARING: (S) HES Mar 15 1:30 PM BUTROVICH 205

Committee Hearing History

TITLE: "An Act relating to a reimbursement program for municipal bonds, notes, or other indebtedness incurred for school construction; and providing for an effective date."

Full Text Fiscal Notes

Bill History

Jrn-Date	Jrn-Page		Action
01/30/02	2068	(S)	READ THE FIRST TIME - REFERRALS
01/30/02	2068	(S)	CRA, HES, FIN
02/27/02	Text	(S)	CRA AT 1:30 PM FAHRENKAMP 203
02/27/02	Text	(S)	Moved Out of Committee
03/01/02	2337	(S)	CRA RPT 2DP 1DNP 1NR
03/01/02	2337	(S)	DP: TORGERSON, KELLY; DNP: LINCOLN;
03/01/02	2337	(S)	NR: PHILLIPS
03/01/02	2337	(S)	FN1: (EED)
03/01/02	2337	(S)	REFERRED TO HEALTH, ED & SOCIAL SVCS
03/15/02	Text	(S)	HES AT 1:30 PM BUTROVICH 205

Similar Subject Match or Exact Subject Match
BONDS & BONDING
CAPITAL PROJECTS
CONSTRUCTION
DEBT
EDUCATION
MUNICIPALITIES
SCHOOL DISTRICTS
SCHOOLS

Bill Root: Display Bill Root

BOBBY APPROVED

TO REPORT PROBLEMS WITH BASIS INQUIRY

PREVIOUS ACTION

SB

283

GARY WILKEN

SENATOR
West Fairbanks

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During Session:
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Fax: (907) 465-4714
Website: www.garywilken.com
E-Mail: Senator_Gary_Wilken@legis.state.ak.us

Senate Bill 283

Sponsor Statement

"An Act relating to temporary permits and licenses by endorsement issued by the Board of Nursing; and relating to the delegation of nursing duties,"

SB 283 is submitted at the request of the state Board of Nursing. It will reconcile current nursing industry standards with Alaska state law and maintain efficient management of licensed nurses in our state.

Specifically, it does the following:

1) codifies the authority of licensed nurses to delegate certain basic tasks to unlicensed assistive personnel;
2) extends the duration of a temporary nursing license from 4 to 6 months; and
3) updates the statutory language authorizing the issuance of licenses by endorsement.

These statutory adjustments are the result of diligent efforts by the state Board of Nursing. It would serve to tighten, clarify, and improve their ability to regulate and manage the delivery of safe and effective health care to the citizens of Alaska. There is no known opposition to or negative impact of these adjustments.

Please support the state Board of Nursing by enacting this beneficial legislation.

Gary Wilken

SB 283

An Act relating to temporary permits and licenses by endorsement issued by the Board of Nursing; and relating to the delegation of nursing duties.

SECTIONAL ANALYSIS

Prepared by Tim Lamkin, staff to Senator Gary Wilken

Section	Statute	Existing	Changes
1	AS 08.68.200 License by Endorsement	Applicants can receive a license by endorsement if they have trained to be a nurse and if they fulfill the requirements of subsections 1, 2, OR 3. Respectively, the subsections require(1) that the applicant was a nurse in another state; (2) passed the Canadian Nurses' Exam, if comparable to Alaska's exams, OR (3) not worked as a nurse in the past 5 years but has met the Board's Continuing Competency requirements.	Subsection 3 would be removed and added as (b) under AS 08.68.200 (see Section 2)
2	AS 08.68.200(b) License by Endorsement	(b) does not exist under current law	(b) is a new subsection and is the former subsection (3) of AS 08.68.200. Previously, applicants could acquire a license by endorsement if they met subsections (1), (2), or (3). The new law would require a combination of [(1) AND (3)] or [(2) AND (3)].
3	AS 08.68.210(a) Temporary Permits	Currently, the Board of Nursing may issue a temporary license by endorsement that is valid for 4 months.	This section would be amended to make temporary licenses by endorsement valid for up to 6 months.
4	AS 08.68.340(a)(2) Prohibited Conduct	Under this section, it is a class B misdemeanor to practice nursing without a license, unless the person is acting in an emergency situation.	Makes it okay to practice nursing without a license IF the person is executing tasks delegated by a registered or practical nurse, as set forth in AS 08.68.405 (see section 5)
5	AS 08.68.405 Delegation of Nursing Functions	This section does not exist under current law.	Establishes that registered or practical nurses may delegate nursing duties to other persons, including unlicensed personnel. Specific types of duties and eligibilities of assistive personnel are determined by regulations set by the Board of Nursing.

Alaska State Hospital & Nursing Home Association

We're helping people care for people!

February 25, 2002

Senator Gary Wilken
Alaska State Legislature
State Capitol, Room 514
Juneau AK 99801-1182

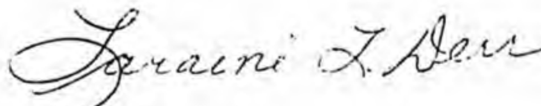
Dear Senator Wilken:

The Senate Health Education and Social Services Committee will be hearing SB 283 on February 27, 2002. As the president of the Alaska State Hospital and Nursing Home Association (ASHNHA), I am writing a letter of support for the Senate Bill No. 276, "An Act relating to temporary permits and licenses by endorsement issued by the Board of Nursing; and relating to the delegation of nursing duties."

This bill will put into law what has always been a part of nursing practice. The bill gives licensed nurses the authority to delegate nursing duties to other personnel and give the Board of Nursing authority to set out regulations to outline safe delegation of their duties. Because there is such a severe shortage in the nursing profession, extending the temporary nursing license from 4 to 6 months will allow extra time. Any help in this area will be greatly appreciated.

ASHNHA is an organization of 34 healthcare providers around the state of Alaska. We believe that passage of this legislation will allow for better health care delivery to our citizens.

Sincerely yours,



Laraine L. Derr
President/CEO

426 Main Street, Juneau, Alaska 99801
Phone: 907-586-1790 • Fax: 907-463-3573 • Web: ashnha.com

Alaska School Nurses Association
2207 E Tudor Road. Suite 34
Anchorage, AK 99507-1069

2/25/2002

To Senator Gary Wilken:

Thank you for introducing SB 283. Nursing is a complex and often poorly understood profession; in our efforts to meet the health needs of Alaska, we often encounter difficult and frustrating situations. This bill will help to clarify some of those issues, and give some authority in decision making to those who understand the ramifications of those decisions the best...

The Alaska School Nurses Association supports this bill.

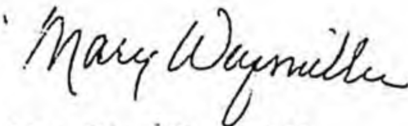
Elizabeth Engle, RN, BSN
President, ASNA

Senator Gary Wilken
State Capitol Building
Juneau, Alaska 99801-1182

Dear Senator Wilken,

I am writing in support of SB 283 "An Act relating to temporary permits and licenses by endorsement issued by the Board of Nursing; and relating to the delegation of nursing duties."
As you know the Board of Nursing is charged with protecting the public by developing reasonable and uniform standards for nursing practice.
SB 283 is a clean-up bill that clarifies several statutes by amendments and additions to AS 08.68.
Each of the statute clarifications listed in this bill will allow a more clear cut and precise description of the law and will allow the Board of Nursing to develop regulations needed to protect the public and offer clear guidelines for nurses and health care workers practicing in Alaska.
Thank you for considering this bill.

Sincerely,



Mary Weymiller, L.P.N.
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February 26, 2002

Honorable Gary Wilken
State Capitol
Juneau, Alaska 99801-1182

Dear Senator Wilken:

We are writing this letter is support of SB 283, "An Act relating to temporary permits and licenses by endorsement issued by the Board of Nursing; and relating to the delegation of nursing duties." This bill brings the nursing statutes up to date with current nursing practice in the areas of delegation of nursing duties and the issuance of temporary licenses and licenses by endorsement.

Over the last ten years there has been an increase in the number and type of ancillary unlicensed health care workers that RNs and LPNs are required to delegate nursing duties to and have oversight of the work they perform. The Attorney General's office recently ruled that the existing statues do not give the Board of Nursing the authority to promulgate regulations covering delegation of nursing duties to persons other than nursing assistants.

It is imperative that RNs and LPNs have regulations from the Board of Nursing covering delegation of nursing tasks. Nurses rarely hire or train the unlicensed personnel they are required to work with, yet their employers require nurses to make sure these persons perform the tasks delegated to them in a safe and accurate manner. Because these individuals are unlicensed, there is no regulatory body overseeing their training and competency. Nurses need the backing of the regulations promulgated by the Board of Nursing so that they can delegate in a manner that maintains the health and safety of their patients.

The sections of SB 283 which deal with temporary nursing licenses would extended the length of license from 4 to 6 months which would allow the Board of Nursing to complete necessary background checks. The section of the Bill dealing with license by endorsement would bring the statue into compliance with current practice of the Board concerning applicants who have not worked as a nurse in the past five years.

The Alaska Nurses Association is in full support of SB 283.

Sincerely,

Patricia Senner

Patricia Senner MS, RN, ANP

SITE: ANCHORAGE LIO

COMMITTEE: SHES

DATE: Feb 27, 2002

SUBJECT OF MEETING:

SB 283

UPDATE #: 1

PRINT YOUR NAME	ADDRESS (MAILING & ZIP)	REPRESENTING	DO YOU WANT TO TESTIFY? Y or N
✓ Lynn Hartz	family prac	Bd of Nursing	Y=SB283
Email address:			
✓ Patricia Senner	supports	AK Nurses Assoc Pres.	Y=SB283
Email address:			
✓ Nancy Sanders		Bd of Nursing member	Y=SB 283
Email address:			
✓ Dorothy Fulton		Bd of Nursing	Y=SB283
Email address:			
Email address:			
Email address:			
Email address:			

SITE: FAIRBANKS LIO

COMMITTEE: (S)HESS

DATE: 02/27/02

SUBJECT OF MEETING: SB 283

UPDATE #: 1

THE SEAL OF THE STATE OF ALASKA

PLEASE SIGN IN

PRINT YOUR NAME	ADDRESS (MAILING & ZIP)	REPRESENTING	DO YOU WANT TO TESTIFY? Y or N
Mary Weymiller		LPN -	Y SB 283
Email address:			
Email address:			
Email address:			
Email address:			
Email address:			
Email address:			
Email address:			

COMMITTEE: SENATE HESS	SUBJECT: SB 283-REGULATION OF NURSING
DATE: FEBRUARY 27, 2002	

PLEASE SIGN IN

NAME PLEASE PRINT	ADDRESS (MAILING & ZIP)	E-MAIL	REPRESENTING (No Acronyms)	TESTIFY Y/N
SANDY PERRY-PROVOST	327 W. 11th #4 JU		AK NURSES ASSOC.	NO
Nancy Davis	P.O. Box 110611 Juneau, AK DHSS		DHSS/ Public Health	Answer Questions if needed
Catherine Reardon	PO 110806 Juneau 99811		Division of occupational licensing	Yes
Loraine L Derr	426 Main St.		AK State Hosp. Assoc.	YES

SB

293

FISCAL NOTE

STATE OF ALASKA
2002 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: HB 402
(H) Publish Date: 2/15/02

Revision Date/Time (Note if correction):
Title: RELATING TO THE ALASKA TEMPORARY ASSISTANCE PROGRAM

Dept. Affected: Health & Social Services
BRU: Public Assistance
Component: ATAP

Sponsor: HOUSE (HES)
Requestor: HOUSE (HES)

Component Number: 220

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)

	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008
1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2002) cost:

Check this box (X) if funding for this bill is included in the Governor's FY 2003 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

Although this proposed legislation may allow more than 20% of the eligible ATAP caseload to receive benefits beyond 60 months, there are no projected financial impacts. The ATAP program is funded in part by the federal TANF block grant which does not vary regardless of the number of families served. Also, federal law requires the State to contribute a fixed amount of state funds toward the program, called maintenance of effort (MOE). Additionally, the provision that will allow the Department to offer transitional supportive services to clients no longer receiving a cash benefit will result is more families remaining off the program, thus reducing costs in the Temporary Assistance benefits component.

Prepared by: Jim Nordlund
Phone 465-5835
Division: Public Assistance
Date/Time 02/13/2002
Approved by: Elmer A. Lindstrom, Deputy Commissioner
Date 02/14/2002
Agency: Department of Health & Social Services

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SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

SENATOR LYDA GREEN, CHAIR

SB 293 "AN ACT RELATING TO WELFARE REFORM"
SPONSOR STATEMENT

While the Department of Public Assistance has made strides in the application of welfare reform, lessons have been learned, and insight has been gained, that led us to propose a tune-up of public assistance.

The intent of HB 293 is to align department program operations with the work-first philosophy that has been held up by all of us as the goal. One of the key premises of this philosophy is that the labor market is the best test of an individual's employability. Another is that all individuals are capable of moving themselves and their families toward self-sufficiency. A third is that "real job" experience is the best way to specifically identify training needs.

HB 293 has made changes that in general terms:

- Implement a broader and more responsive diversion process to assist families to avoid dependency on cash benefits;
- Strengthen the "up-front message" to clients that public assistance is as much about employment as it is about providing cash benefits;
- Provide more consistent guidance with regard to assessment, emphasizing the utilization of the labor market as the best test of employability and a family strength-based approach versus an approach that emphasizes pre-determining family barriers;
- Implement a more complete subsidized wage program and expanding community service for those unable to obtain unsubsidized employment.

SENATOR LOREN LEMAN, VICE-CHAIR
SENATOR JERRY WARD, SENATOR GARY WILKEN, SENATOR BETTYE DAVIS

Bill History/Action Display

BILL: SB 293

SHORT TITLE:ALASKA TEMPORARY ASSISTANCE PROGRAM

BILL VERSION:
SPONSOR(S): HEALTH, EDUCATION & SOCIAL SERVICES
CURRENT STATUS: (S) HES THEN FIN
STATUS DATE: 02/13/02
HEARING: (S) HES Feb 25 1:30 PM BUTROVICH 205

Committee Hearing History

TITLE: "An Act relating to diversion payments, wage subsidies, cash assistance, and self- sufficiency services provided under the Alaska temporary assistance program; relating to the food stamp program; relating to child support cases that include persons who receive cash assistance or self-sufficiency services under the Alaska temporary assistance program; and providing for an effective date."

Full Text

No Fiscal Notes Available

Bill History

Jrn-Date	Jrn-Page		Action
02/13/02	2182	(S)	READ THE FIRST TIME - REFERRALS
02/13/02	2182	(S)	HES, FIN
02/13/02	2182	(S)	REFERRED TO HEALTH, ED & SOCIAL SVCS
02/13/02	Text	(S)	MINUTE(HES)
02/22/02	Text	(S)	HES AT 1:30 PM BUTROVICH 205
02/22/02	Text	(S)	-- Meeting Canceled --
02/25/02	Text	(S)	HES AT 1:30 PM BUTROVICH 205

Similar Subject Match or Exact Subject Match
CHILD SUPPORT
PUBLIC ASSISTANCE
WAGES

Bill Root: ______ Display Bill Root

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Return to Basis Main Menu (22 Legislature)
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22-LS1449\C.1
Lauterbach
2/19/02

AMENDMENT

OFFERED IN THE SENATE BY SENATOR GREEN

TO: SB 293

1 Page 19, line 31, following "(1)":
2 Insert "beginning on the date the department makes a finding that the family is
3 not in compliance under this subsection."
4
5 Page 20, line 9, following "(2)":
6 Insert "beginning five months after the date the department made the finding that
7 the family was not in compliance under this subsection."
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9 Page 20, line 20, following "(3)":
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CHILD SUPPORT
PUBLIC ASSISTANCE
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SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE
SENATOR LYDA GREEN, CHAIR

SB 293 "AN ACT RELATING TO WELFARE REFORM"
SPONSOR STATEMENT

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HB 293 has made changes that in general terms:

- Implement a broader and more responsive diversion process to assist families to avoid dependency on cash benefits;
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- Provide more consistent guidance with regard to assessment, emphasizing the utilization of the labor market as the best test of employability and a family strength-based approach versus an approach that emphasizes pre-determining family barriers;
- Implement a more complete subsidized wage program and expanding community service for those unable to obtain unsubsidized employment.

SENATOR LOREN LEMAN, VICE-CHAIR
SENATOR JERRY WARD, SENATOR GARY WILKEN, SENATOR BETTYE DAVIS

SENATE BILL NO. 293

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SECOND LEGISLATURE - SECOND SESSION

BY THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Introduced: 2/13/02
Referred: Health, Education and Social Services, Finance

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to diversion payments, wage subsidies, cash assistance, and self-**
2 **sufficiency services provided under the Alaska temporary assistance program; relating**
3 **to the food stamp program; relating to child support cases that include persons who**
4 **receive cash assistance or self-sufficiency services under the Alaska temporary**
5 **assistance program; and providing for an effective date."**

6 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

7 *** Section 1.** AS 25.20.050(f) is amended to read:
8 (f) The child support enforcement agency may recover the costs of testing
9 ordered under (e) of this section from the alleged father unless the testing establishes
10 that the individual is not the father, except that costs may not be recovered from a
11 person who is a recipient of **cash** assistance **or self-sufficiency services** under
12 AS 47.27 (Alaska temporary assistance program). **For purposes of this subsection, a**
13 **person who receives a diversion payment and self-sufficiency services under**

1 **AS 47.27.026 is not considered to be a recipient of cash assistance or self-**
2 **sufficiency services under AS 47.27.**
3 * **Sec. 2.** AS 25.27.165(i) is amended to read:
4 (i) The agency may recover any costs it pays for genetic tests required by this
5 section from the putative father unless the testing establishes that the individual is not
6 the father, except that costs may not be recovered from a person who is a recipient of
7 **cash** assistance **or self-sufficiency services** under AS 47.27 (Alaska temporary
8 assistance program). **For purposes of this subsection, a person who receives a**
9 **diversion payment and self-sufficiency services under AS 47.27.026 is not**
10 **considered to be a recipient of cash assistance or self-sufficiency services under**
11 **AS 47.27.**
12 * **Sec. 3.** AS 25.27.900 is amended by adding a new paragraph to read:
13 (13) "assistance under AS 47.27," "assistance granted under
14 AS 47.27," or "assistance paid on behalf of the obligee under AS 47.27" means cash
15 assistance provided under AS 47.27 (Alaska temporary assistance program).
16 * **Sec. 4.** AS 29.45.650(f) is amended to read:
17 (f) A borough may not levy and collect a sales tax on a purchase made with
18 (1) food coupons, food stamps, or other type of **allotment** [CERTIFICATE] issued
19 under **7 U.S.C. 2011 - 2036 (Food Stamp Program)** [7 U.S.C. 2011 - 2025 (FOOD
20 STAMP ACT)]; or (2) food instruments, food vouchers, or other type of certificate
21 issued under 42 U.S.C. 1786 (Special Supplemental Food Program for Women,
22 Infants, and Children). **For purposes of this subsection, the value of a food stamp**
23 **allotment paid in the form of a wage subsidy as authorized under AS 47.25.975(b)**
24 **is not considered to be an allotment issued under 7 U.S.C. 2011 - 2036 (Food**
25 **Stamp Program).** This subsection applies to home rule and general law
26 municipalities.
27 * **Sec. 5.** AS 29.45.700(d) is amended to read:
28 (d) A city that levies and collects ales and use taxes under (a) of this section
29 may not levy and collect a sales tax on a purchase made with (1) food coupons, food
30 stamps, or other types of **allotments** [CERTIFICATES] issued under **7 U.S.C. 2011 -**
31 **2036 (Food Stamp Program)** [7 U.S.C. 2011 - 2025 (FOOD STAMP ACT)]; or (2)

1 food instruments, food vouchers, or other type of certificate issued under 42 U.S.C.
2 1786 (Special Supplemental Food Program for Women, Infants, and Children). **For**
3 **purposes of this subsection, the value of a food stamp allotment paid in the form**
4 **of a wage subsidy as authorized under AS 47.25.975(b) is not considered to be an**
5 **allotment issued under 7 U.S.C. 2011 - 2036 (Food Stamp Program).** This
6 subsection applies to home rule and general law municipalities.
7 * **Sec. 6.** AS 47.05.010 is amended to read:
8 **Sec. 47.05.010. Duties of department.** The Department of Health and Social
9 Services shall
10 (1) administer adult public assistance, the Alaska temporary assistance
11 program, and all other assistance programs, and receive and spend money made
12 available to it;
13 (2) adopt regulations necessary for the conduct of its business and for
14 carrying out federal and state laws granting adult public assistance, temporary **cash**
15 assistance**, diversion payments, or self-sufficiency services** for needy families under
16 the Alaska temporary assistance program, and other assistance;
17 (3) establish minimum standards for personnel employed by the
18 department and adopt necessary regulations to maintain those standards;
19 (4) require those bonds and undertakings from persons employed by it
20 which in its judgment are necessary, and pay the premiums on them;
21 (5) cooperate with the federal government in matters of mutual
22 concern pertaining to adult public assistance, the Alaska temporary assistance
23 program, and other forms of public assistance;
24 (6) make the reports, in the form and containing the information, that
25 the federal government from time to time requires;
26 (7) cooperate with the federal government, its agencies or
27 instrumentalities in establishing, extending**,** and strengthening services for the
28 protection and care of homeless, dependent**,** and neglected children in danger of
29 becoming delinquent, and receive and expend funds available to the department by the
30 federal government, the state or its political subdivisions for that purpose;
31 (8) cooperate with the federal government in adopting state plans to

1 make the state eligible for federal matching in appropriate categories of assistance, and
2 in all matters of mutual concern, including adoption of the methods of administration
3 that are found by the federal government to be necessary for the efficient operation of
4 welfare programs;
5 (9) adopt regulations, not inconsistent with law, defining need,
6 prescribing the conditions of eligibility for assistance, and establishing standards for
7 determining the amount of assistance that an eligible person is entitled to receive; the
8 amount of the assistance is sufficient when, added to all other income and resources
9 available to an individual, it provides the individual with a reasonable subsistence
10 compatible with health and well-being; an individual who meets the requirements for
11 eligibility for assistance shall be granted the assistance promptly upon application for
12 it;
13 (10) grant to a person claiming or receiving assistance and who is
14 aggrieved because of the department's action or failure to act, reasonable notice and an
15 opportunity for a fair hearing by the department, and the department shall adopt
16 regulations relative to this;
17 (11) enter into reciprocal agreements with other states relative to
18 public assistance, welfare services, and institutional care that are considered advisable;
19 (12) establish the requirements of residence for public assistance,
20 welfare services, and institutional care that are considered advisable, subject to the
21 limitations of other laws of the state, or law or regulation imposed as conditions for
22 federal financial participation;
23 (13) establish the divisions and local offices that are considered
24 necessary or expedient to carry out a duty or authority assigned to it and appoint and
25 employ the assistants and personnel that are necessary to carry on the work of the
26 divisions and offices, and fix the compensation of the assistants or employees except
27 that a person engaged in business as a retail vendor of general merchandise, or a
28 member of the immediate family of a person who is so engaged, may not serve as an
29 acting, temporary or permanent local agent of the department, unless the
30 commissioner of health and social services certifies in writing to the governor, with
31 relation to a particular community, that no other qualified person is available in the