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AMENDMENT

OFFERED IN THE HOUSE BY REPRESENTATIVE GARDNER

TO: CSHB 337(HES), Draft Version "E"

Page 1, lines 2 - 3:

Delete "**relating to the certificate of need program for certain health care facilities**"

Insert "**authorizing a study of the certificate of need program**"

Page 3, lines 1 - 10:

Delete all material.

Renumber the following bill sections accordingly.

Page 9, lines 6 - 13:

Delete all material and insert:

"* **Sec. 4.** The uncodified law of the State of Alaska is amended by adding a new section to read:

CERTIFICATE OF NEED STUDY. The Department of Health and Social Services may contract with an independent entity to conduct a study of the effectiveness of the certificate of need program in the state in fulfilling the purpose of the program. The department shall present a report to the legislature on the study when it is completed."

Page 9, lines 20 - 21:

Delete all material and insert:

*** Sec. 6.** Sections 4 and 5 of this Act take effect immediately under AS 01.10.070(c).

*** Sec. 7.** Except as provided in sec. 6 of this Act, this Act takes effect July 1, 2008."

STATE OF ALASKA
DEPARTMENT OF HEALTH & SOCIAL SERVICES
CERTIFICATE OF NEED
NEGOTIATED REGULATIONS COMMITTEE
REPORT

Prepared by:

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12/28/2007

Table of Contents

Executive Summary

The Negotiated Rulemaking Committee meetings for the Certificate of Need (CON) held in October and November this year produced several strong recommendations based on high consensus of the group. They included;

- That the CON process as it is currently, is broken
- It should not be eliminated
- Clear definition and specificity on the Physician office exemption (POE)
- What should be in for CON and what should be out
- CON covered entities should be required to serve all comers regardless of their ability to pay
- CON should be in alignment with Medicare guidelines

Several other areas of consensus of the committee included;

- The need for an ad-hoc advisory group to support the state in reviewing equipment thresholds, new procedures and remodels/renovations related to CON
- The state would benefit from having an ad-hoc advisory group for technical expertise in disputed CON situations
- Recommendation that the state collect data that shows whether the CON process actually accomplishes its stated purpose of cost containment and access.
- The State be empowered to a higher level of enforcement and monitoring that providers are staying within their CON
- That for definition purposes Anchorage, Mat-Su, and Fairbanks would be considered large communities and all other areas in Alaska would be considered small communities.

Efficacy of the CON was a major discussion topic. Where the CON is designed to contain costs and improve access, the committee noted a lack of data on whether the CON process actually accomplishes its intended purpose. The committee acknowledged that any movement towards collecting data will be time consuming and that all providers of services should be included in data collection in order to get a more comprehensive picture. Concurrently, the committee also noted the need to protect smaller community hospitals in select areas from being driven out of business and that the CON process accomplishes that end. Failure to do so will leave the CON vulnerable to attack and elimination.

The Physician office exemption (POE) definition was the most discussed and contentious topic at every session. The committee debated throughout the

sessions the definition of what a physician office is and is not for purposes of exemption from the CON. While the committee did reach consensus on specific language for the POE, it was based on the fear of the misuses of the POE process as perceived by many members versus a more positive outcome driven definition.

The negotiated rulemaking committee has the distinct merits of bringing together stakeholders to derive consensus on issues that are of importance to their communities and the state. In this first attempt to reduce the litigious atmosphere surrounding the CON, there were two distinct stakeholders not represented on the committee;

1. Patient / consumer representation was absent from the committee. The absence of patient viewpoint would be valuable in future committees to ensure that the committee stays focused more on what is best for the citizens of Alaska rather than healthcare business interests.
2. State of Alaska Healthcare point of view and plan. Several times the lack of state and or community healthcare plans/ goals, vision was notably absent as needed information for the committee to use in making decisions. If a plan was developed the CON decisions could be made in reference to the community and state plans as a guide.

Finally, as a matter of improving the committee process it is recommended that once a committee member is selected that substitutions not be allowed as it interferes with the group dynamic and the ability of the group to reach consensus.

I. Introduction

KMD Services & Consulting was contracted by the State of Alaska, Department of Health and Human Services (DHSS) to facilitate the Certificate of Need Negotiated Rulemaking Committee. Kevin Dee was lead facilitator. This was the first ever attempt to bring various vested parties together to attempt to reach consensus on the "Certificate of Need" (CON) process, rules and regulations.

The Committee members were selected through a voluntary process by DHSS and five days of meetings to review and make recommendations were held. The committee was asked to look at anything and everything related to the CON process including statutes, regulations and processes. The dates of the meetings were; October 29-30, 2007, November 13-14, 2007 & November 20, 2007. There were between 19 – 21 committee members present at all meetings. Committee members were comprised of Doctors and Hospital administrators and one representative from DHSS . The actual participants of the committee varied from session to session due to substitutions. The committee members and their attendance are listed below.

Certificate of Need Negotiated Regulation Committee Members

Present at meeting = X , Absent = A, Substitute = Sub

	Representing	Name						Substitute
1	Imaging	Ward Hinger, Administrator Diagnostic Health of Anchorage	X	X	X	Sub	X	Aaron Woolrich
2	Imaging	Jeff Kinion, CEO Alaska Open Imaging Center Wasilla	X	X	X	X	X	
3	Imaging	Robert Bridges, MD Aurora Diagnostic Imaging, LLC Fairbanks	X	X	X	X in am only pm = Sub	X	Kim Black sub in afternoon
4	Imaging	Chakri Inampudi, MD Alaska Radiology Associates Anchorage	X	X	X*	X	X	*Left prior to meeting end on 11/13
5	Imaging	Bradley K. Cruz, M.D. Alaska Imaging Associates, LLC Anchorage	X	X	X	X	Sub	Lester Lewis, MD

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1	Imaging	Ward Hinger, Administrator Diagnostic Health of Anchorage	X	X	X	Sub	X	Aaron Woolrich
2	Imaging	Jeff Kinion, CEO Alaska Open Imaging Center Wasilla	X	X	X	X	X	
3	Imaging	Robert Bridges, MD Aurora Diagnostic Imaging, LLC, Fairbanks	X	X	X	X in am only, pm = Sub	X	Kim Black sub in afternoon
4	Imaging	Chakri Inampudi, MD Alaska Radiology Associates Anchorage	X	X	X*	X	X	*Left prior to meeting end on 11/13
5	Imaging	Bradley K. Cruz, M.D. Alaska Imaging Associates, LLC, Anchorage	X	X	X	X	Sub	Lester Lewis, MD

	Represents	Name	10/29	10/30	[illegible]	11/15	[illegible]	Sub member
6	Hospital	Shawn Morrow, CEO Bartlett Regional Hospital Juneau	X	X	X	X	X	
7	Hospital	James Shill, CEO Northstar Behavioral Health Systems Anchorage	X	X	X	A	X	
8	Hospital	Edward Lamb, CEO Alaska Regional Hospital Anchorage	Sub	Sub	A	A	Sub	Jordan Herget = 10/29 & 10/30 Paul Morris = 11/20
9	Hospital	E Al Parish, CEO/VP Providence Health System Anchorage	X in am only pm = Sub	X in am only pm = Sub	Sub	Sub	Sub	Joel Gilbertson 4/5 of sessions
10	Hospital	Mike Powers, CEO/Administrator Fairbanks Memorial Hosp./Denali Center Fairbanks	X	X	X	X	X	
11	Hospital	Norman Stephens, CEO Mat-Su Regional Medical Center Palmer	X	X	Sub	Sub	X	Michael Zielasklewicz
12	Hospital	Ryan K. Smith, CEO Central Peninsula Hospital Soldotna	X	X	Sub	Sub	X	Jason Paret
13	Physician group	Cleeo Manikunlan, M.D. Anchorage	X	X	X	X (am only)	Sub	Vicki Crumptoula
14	Physician group	Baxter Burton, CEO Alaska Heart Institute, LLC Anchorage	X	X	X	A	X	
15	Physician group	Gerald L. Nicholson, Administrator Katmai Cardiology Group, LLC Anchorage	A	A	A	X	A	
16	Physician group	Jeremy Hayes Advanced Medical Centers of Alaska Anchorage	X	X	X	Sub in am / X pm	X	Cathy Giessel
17	Physician group	Bruce Jayne, MD Alaska Surgery Center	X	X	X	X	Sub	William Pethick

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18	Association (physician)	J. Ross Tanner, ASMA President	Sub	Sub	A	A	Sub	ASMA E.D. James Jordan served as designated substitute
19	Tanana Chiefs	Victor Joseph, Health Director, Tanana Chiefs Conference Health Svcs., Fairbanks	X	X	X	X	X	Left prior to meeting end
20	DHSS	Jay Butler, MD, FAAP, FACP Chief Medical Officer, DHSS Anchorage	X	X	X	X	X	
21	Association (hospital and nursing home)	Rod Betit, CEO, Alaska State Hospital & Nursing Home Association	X	X	X	X	X	
22	Physician group	Mark Wade, MD. Fairbanks	NA	NA	X	X	A	Late entry to committee. Resigned after 11/14 meeting

II. Committee Negotiation Processes

A set of ground rules for discussion was implemented throughout the committee meetings;

ESTABLISHED GROUND RULES:

- Seek first to understand then to be understood
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- All Voices count
- Follow facilitator instructions

The committee used open group discussion to determine topics and points of view on each subject and questions for voting were developed. Voting was conducted using an electronic anonymous (Consensor) polling system to determine the level of consensus of the group on specific topics.

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19	Tanana Chiefs	Victor Joseph, Health Director Tanana Chiefs Conference Health Svcs:, Fairbanks	X	X	X	X*	X	*Left prior to meeting end
20	DHSS	Jay Butler, MD, FAAP, FACP Chief Medical Officer, DHSS Anchorage	X	X	X	X	X	
21	Association (hospital and nursing home)	Rod Betit, CEO Alaska State Hospital & Nursing Home Association	X	X	X	A	X	
22	Physician group	Mark Wade, MD. Fairbanks	NA	NA	X	X	A	Late entry to committee, Resigned after 11/14 meeting

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A working definition for consensus was developed by the group. 66% or greater was the determinant number to say that consensus was reached and the higher the percentage the greater the level of group consensus. A show of hands established 70% or higher for high consensus

Discussion topics

The Committee generated a set of agenda topics for discussion framed around the purposes of;

- Clarifying the CON definitions and processes
- Reducing litigation
- Assisting in cost containment
- Assisting in access
- leveling the playing field

Primary topics for discussion included;

- ✓ Elimination or modification of CON
- ✓ Thresholds
- ✓ Definitions
- ✓ Timely processes – Application, review, determination , appeal
- ✓ Enforcement of CON
- ✓ Physician Office Exemption
- ✓ Radiology
- ✓ Ambulatory Surgery centers

The specific discussions and subtopics of discussion are listed in the notes (attached) and were initially global (example: Eliminate the CON?) and then became more specific as decisions and consensus were reached on each item (example: percentage of radiology reports interpreted locally to qualify for Physician office exemption (POE)).

The committee moved through the topics and strong consensus and recommendations were reached in many areas. Other votes when diametrically opposed parties were unable to reach a common ground reflect areas of compromise.

Recommendations for future rulemaking negotiations and process

Several committee members noted the absence of patient and community representation. This was most adamantly put forth by Dr. Wade in his comments and committee evaluation. Dr. Wade commented that the committee was highly self interested in the financial impacts of the CON to their worlds and "protecting their own turf" versus interest and investment in what is best for patients for communities. The absence of Patient advocacy or a State of

Alaska, Healthcare plan, meant the only voices heard were from the financially vested physicians and hospitals. Though several hospitals represented were community hospitals, there were few comments about what was best for patient, access or cost containment. Most comments were concerning what was best for those present. Diversity of representation must be present in order to ensure a balanced approach to this volatile topic.

Substitutions for committee members were allowed due to the short notice of the scheduling of the committee meetings and as a method to maintain representation. This had a negative effect on the building of consensus. Consensus building is best served when a group gets to know each other's interests and concerns over time. This allows for trust and common interest to be developed. The allowance of substitutions goes a long way in isolating positions and interests.

The absence of data for the efficacy of the CON was duly noted by committee members and the need for it was also highly recommended. The lack of overall reference points including data diminished the ability of the group to have a more substantive process and eliminate the personal interest factors from the room. The development of cohesive plans by communities and the State of Alaska regarding healthcare services will go a long way in guiding the CON process in ensuring the needs of a community are met. The ongoing collection and analysis of utilization and capacity data would go a long way in reducing disputes and making CON decisions more defensible.

III. Areas of High Consensus

HIGH CONSENSUS REACHED FOR THE FOLLOWING*:

- Eliminate CON fully? 88.89% NO.
- Radiation therapy to be subject to CON? 89.47% YES.
- Imaging services subject to CON? 83.33% YES.

- Should a new committee member be added? 70% YES.
  (The member was not added originally due to a communication issue).
- Should ambulatory surgery be included in CON? 85% YES.
- That statutorily defined Health Care Facilities, by definition, do not include physician offices. 100% agreed
- P.O.E. should be discussed separately from Radiology proposal.
  84.21%, YES
- Should CON programs require all entities to serve all patients?
  78.95%, YES
- Should CON processes and definitions be in alignment with Medicare
  80%, YES
- Should ad-hoc advisory groups be formed to assist DHSS in technical or contested decisions, what type? 73.68%, YES
- Recommend the state to seek out resources for clarification of issues in CON – tech advisory 94.74%, YES
- All facilities/equipment above the threshold must request P.O.E. letter of exemption - State issues letter of determination. 71.43%, YES
- The decisions reached are the best we can do, 71.43%, YES

**Please refer to "Consensor results" attachments for raw results*

IV. Areas of General Consensus

General Consensus was defined as either general agreement by show of hands, verbal support of the group to a concrete concept without opposition, or a vote that achieved between 66% and 71% (see attached meeting notes and "Consensor results" for raw voting results).

Different definitions for smaller communities needed for the CON process.

There are no hard deadlines in the CON process. Committee recommends the state establish process timeline deadline lengths, in days.

Committee asked who can file an appeal? *Reference: Current regulations; must prove you are truly adversely affected party in order to file an appeal. If you don't prove you're adversely affected there may be a consequence. Committee decided that the burden is on the appellant.

Who has the authority to enforce? The Commissioner should have the authority.

Committee requests that the state clarify: Appellants should have to prove they're providing "similar" services (make less vague). Recommendation to state: clarify what is "similar"

- Laws should be passed requiring physician's offices – or those practicing medicine have to serve all comers (all patients regardless of whether they have insurance or are able to pay).
- The CON Committee agreed by show of hands that "quality" was off the table for discussion as related to the CON. The Committee agreed that quality assurance is important, but better addressed in other forums.

- All committee members agreed that they wanted to protect smaller communities and let larger communities have competition.

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(FILE 2)

- Leave Financial thresholds as currently defined and request clarification on items below, as noted:

Equipment Thresholds:

Recommendation: state needs to clarify definition of equipment – differentiate between facility equipment and medical equipment (#2 on page 18) via an advisory group (see below):

Advisory group	Clearly define the differences between which items require CON • Refurbished equipment • Novel scope of services (possible CON) • Replacement equipment a. Same purpose b. New equipment

Facilities Thresholds:

Recommendation: state needs to clarify definition of facilities

Advisory group	Clearly define the differences between which items require CON • Refurbished, remodeling existing facilities, renovating and/or repairing existing facilities for same use, same scope of services– no added services • Novel scope of services • Replacement facilities a. Same purpose b. New facilities

- State needs to fund a data driven process in order to avoid a litigious CON environment.
- Ambulatory Surgery Centers need to be defined in State Statutes or Regulations.

- Increase Consistency in processes and timelines to eliminate loopholes.
- Level the playing field and create consistency in the POE application process. Everyone wants to level the playing field. Make the process crystal clear with rules for the Commissioner to follow.
- Ambulatory Surgery Centers require CON process
- Ultrasound Services are not included in CON
- All facilities and equipment above the threshold must request for POE letter of exemption

V. Areas of Non-Consensus

Definitions for the Physician Office Exemption (POE) were the most controversial topic throughout all the sessions. The POE was by far the biggest issue for the group and was repeatedly discussed in varying formats. The committee revisited this area in varying approaches with evolving dialog at each turn. This was reflected in the progression of numerous votes that did not reach consensus on the POE exemption definitions below. **However, the committee eventually reached consensus on the final vote for the POE during the last session (See IV. Physician Office Exemption below).**

The following represents the areas that were discussed in parsing the disputed topics of POE and radiology definition for POE. The lack of any consensus in these questions shows the diametrically opposed positions and interests that have led to the current spate of litigation.

Two additional areas of topical discussion included:

1) Expansion of imaging services in the state by entities other than hospitals

2) Development of free standing ambulatory surgery centers. (eventually reached high consensus that Ambulatory Surgery centers to be included in the CON)

While discussed separately, both issues had common points.

Some committee members did not want physician groups opening surgery centers "to treat their own patients" but were content to let any individual physician groups acquire any imaging equipment, to treat "their own patients".

Imaging specialists seemed very concerned about the unfettered expansion of imaging equipment by physicians who, until recently, never directly used or owned this equipment, were unfamiliar and untrained in the equipments appropriate and safe utilization.

The committee voted during the first session (October 29-30, 2007) on how to handle the physician office exemption issue and ranked them in the following order:

- Mitigate – 24.7%
- Accommodate – 20.8%
- Transfer – 19.5%

- Eliminate – 18.2%
- Avoid – 16.9%

No Consensus was reached in determining how to approach the POE issue.

Initially, No Consensus was reached initially in determining whether other partners besides hospitals be allowed for POE exemptions. Vote was split 50-50.

Initially, No Consensus was reached on whether other partners besides hospitals be allowed for P.O. exemptions. Vote was split 45% yes against 55% no. (this was re-voted on again later)

No Consensus was reached on whether physician ownership should be 100% for P.O. exemption from the CON process. 35% yes, 65% no (this was voted on again later with high consensus).

The group tried again to determine what percentage of ownership should physician's have for a P.O.E. (physician's office exemption). This time the committee was given 5 choices and results were split as listed below:

- At least 40% - 8 votes
- Greater than 50% - 4 votes
- 65% - 2 votes
- 75% - 4 votes
- 85% - 2 votes

No Consensus was reached on whether anyone can be a minority partner in a physician's office. Vote was split 52.63% vs. 47.37%.

No Consensus was reached when the committee tried to rank (in order from highest to lowest) the percentage for physician owned, when given the following choices, with results below:

- Physician owned 100% - 6 votes
- Physician owned with a hospital – 8 votes
- Physician with anyone – 6 votes

No Consensus was reached when the physician owned percentage question was changed to allow only 2 choices:

- Physician owned 100% - 13 votes
- Physician with anyone – 7 votes

No Consensus was reached for E&M Physician (non radiologist) 100% Physician owned. Vote was split 60% yes, 40% no.

No Consensus was reached for Radiologist – majority ownership with anyone. Split vote: 60% yes, 40% no.

No Consensus was reached when asked to: discuss small and large communities together. Split vote with 57.89% yes and 42.11% no.

No Consensus was reached: Discuss E&M and Radiology separately? Split vote: 52.63% yes and 47.37% no.

No Consensus was reached on the following question:

Physician ownership E&M and Radiologists – large communities:
75% - 8 votes (=38.10%)
100% - 13 votes (=61.90 %)

No Consensus was reached for:

POE – large communities: Split vote with 100% physician owned – 60% and partner with anyone 40%.

No Consensus was reached for non-radiologists – large communities: 100% owned received 57.89% of the votes and partner with anyone received 42.11% of votes.

VI. Physician Office Exemption: Final Consensus

Despite the opposing positions of many of the committee members in approaching the POE issue there was a general consensus that the exemption was a loophole as written and needed to be amended in order to protect interests. The committee wrestled the most with who could own a physician's office. The group also asked who shouldn't be a partner? They agreed that publicly traded companies cannot be a physician's office partner. A turning point on the last day was when one committee member described how the POE had worked against their hospital and that if it could happen to them it could also happen to anyone. After protracted discussion and reversing itself on ownership percentages the committee reached consensus that in order to qualify for the POE the physician office must be 100% owned by physicians (71.43%, YES). A higher degree of consensus would have been obtainable if those committee members with a vested financial interest in the vote were exempted from voting.

A high consensus was obtained for recommending the definitions for qualifying for the POE (derived from medicare guidelines) and amended by the committee, be as follows;

INDEPENDENT DIAGNOSTIC TESTING FACILITIES (IDTFs)
All suppliers that perform diagnostic tests, other than clinical laboratory or pathology tests, and are required to enroll as an IDTF. Not all suppliers that perform diagnostic tests are required to enroll as an IDTF. Generally, an entity can bill for the technical component of the diagnostic tests without an IDTF enrollment if it has the following characteristics:

- A physician practice that is owned 100%;
- A facility that primarily bills for physician services (e.g., evaluation and management (E&M codes) and not for diagnostic tests;
- A facility that furnished diagnostic tests primarily to patients who medical conditions are being treated or managed on an ongoing basis by one or more physicians in the practice;
- The diagnostic tests are performed and interpreted at the same location where the practice physicians also treat patients for their medical conditions.

However, if a substantial portion of the facility's business involves the performance of diagnostic tests, the diagnostic testing services may be sufficiently separate business to require enrollment as an IDTF. In that case, the physician or physician group practice can continue to be enrolled as a physician or physician group practice but are also required to enroll as an IDTF.

Diagnostic Radiology – Many diagnostic tests are radiological procedures that require the professional services of a radiologist. We recognize that a radiologist's practice is generally different from those of other physicians because radiologists usually do not bill E&M codes or treat a patient's medical condition on an ongoing basis. A radiologist or group practice of radiologists is not necessarily required to enroll as an IDTF. A radiologist or group of radiologists, are not required to enroll as an IDTF if all of the following conditions are met:

- The practice is owned 100% by radiologists, Physicians whose primary practice is Diagnostic Imaging and occasionally perform evaluation;

- The owning radiologist(s) and any employed or contracted radiologist(s) regularly perform physician services (e.g., test interpretations) at the location where the diagnostic tests are performed (>70% of tests);
- The facility does not usually purchase interpretations (generally interpreted <30% of tests);
- The billing patterns of the enrolled facility indicate that the facility is not primarily a testing facility and that it was organized to provide the professional services of radiologists (e.g., (1) the enrolled facility should not be billing for a significant number of purchased interpretations, (2) the facility should rarely bill for the technical component of a diagnostic test, (3) the facility should bill for substantial percentage (at least 70%) of all interpretations of the diagnostic tests performed by the practice), and
- The facility ordinarily bills globally

VII. Other Committee Recommendations

The following recommendations are a combination of general committee member comments and submitted recommendations by committee members

The Alaska State Medical Association (ASMA), in a letter dated November 6, 2007 to Karleen Jackson and Kevin Henderson, the House of Delegates (ASMA's policy making body) states that they support and advocate for the elimination of the entire CON program, except in small communities in Alaska. The reason they support the program only in small communities is because "Apparently, the State is not collecting nor analyzing sufficient data to show that the CON program has met its objectives."

The committee requests the state to define "excessive" and "need" more clearly in the regulations.

Community populations should be counted and need should be determined consistently (i.e.; count military/Native consistently the same). The population formula should be subject to revalidation if/when the population changes.

The committee would also like to see a state health plan/vision developed.

CON Process:

- Standards should be used as decision criteria
- Should be a data driven process
- A letter should be sent to CON P.O.E. grantees requiring them to submit data (# of patients served, etc.)
- Needs should be based on data, according to community (need community plans)
- Take market forces into consideration: can hospitals compete in the geographic area?
- Consider the capacity of each community
- CON grantees should be subject to revalidation based on data/numbers/need and changes
- The CON process should specify a window of response for other (competing) CON applications.

Administrative Hearing Process Recommendations:

- Needs to be more timely (90 days) *Note: Lawsuits start after the state decision or if it is taking too long.*

To curb lawsuits;

1. **Provide clear definitions** of the following:
    - Physician offices (see recommended language);
    - Define a small community? (Population) Population and capacity need to be looked at, in regard to the process.

2. **Get and Provide accurate data**, The State needs to provide better data and statistics according to geographical area (from discussion specific to definition of POE in CON process)

3. **Make administrative processes more timely**

4. **Create a consistent review process**

VIII. Attachments

Notes from sessions

Raw Consensor data in excel format

Session 1: October 29, 2007

ESTABLISHED GROUND RULES (which also apply to the rest of the committee meetings):

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- Focus on choices and consequences versus right and wrong
- All Voices count
- Follow facilitator instructions

Decision Considerations:

Quality & Safety
Cost
Access
Utilization
Purpose(s)
Public Duty
Level playing field

HOPES

Something we can all work with
Bring historical perspective current
From litigation to cooperation
Find common ground
Recognizing behavioral health needs
Balanced
Clarity/working agreements
Access
Unique markets:
geographic/demographic
Fairness: patients/providers
Alignment to demographic similar states
Reduce litigation
Level playing field
Quality, access, safety

CONCERNS

Certificate process not working
Current uncertainty/frequency of changes
Complexity
Diversity of interests
Anti-competitive
Competitive vs. non-competitive
Barriers

Preliminary Topics of Interest (that were brought up-for open space breakout groups)

Statutes
Scope
CON vs. No CON - Elimination of CON
What is competition in medical field?
What is CON accomplishing?

Purpose of CON?
Public duty of health care providers
Regulations
Quality: affected by what? Measured how? What is quality?
Cost: effective at controlling cost?
Definition of Cost: cost/charge (per unit? Global? By utilization?)
Applying for CON

OPEN SPACE BREAKOUT TOPICS (actual process):
~~Eliminate CON fully~~ (CONSENSUS not to eliminate CON fully)
~~Keep it as is~~ (CONSENSUS that CON cannot stay as is)
Modify CON substantially (more robust/add/clarify)
Eliminate CON mostly (change scope to regulate only a few fields)

RESULTS OF OPEN SPACE BREAKOUT GROUPS

ELIMINATE FULLY:
Revise first then decide if want to eliminate
Eliminating CON eliminates contributions to non contributing services
High margin vs. low margin
Mid size markets hurt even more (selective – high payor services)
Would aid in selective high payors recruitment / retention
Doesn't aid in recruitment / retention
A fair and transparent process
AK: Some of highest healthcare costs in nation (system broke)
Unfettered free market (does not exit, can be destructive)
Hospitals not free to compete
Population dependent
Strains on human resources
Creates open competition
Private sector serves public duty 2%-10%
Will bleed away from hospitals, could cause raised prices
Any willing provider
Payors can contaminate free market
Jeopardize public trust to provide emergency and charity care proportionate to the community
CON does not contain costs

MODIFY SUBSTANTIALLY
Adequate resource and staff to service appropriately
Accurate need assessments (utilization, tracking, capacity calculation)
Populations (Native, military)
Less onerous Process (application)
Define c ality
Credentic ls

Clarification (IDTF, physician office, dollar threshold, CHS definitions vs. state definition, service, affected vs. non-affected parties)
Modification procedure
Review of new services and community(s)

ELIMINATE MOSTLY:
What vs. Who (What is services, ie MRI. Who is physician office, hospital and is a location)
Why – hospital vs. independent?
Physician rep comment: eliminate all but small geographic
Eliminate all except for psychiatric
Who's here? (representing field)
To do so would negatively impact full-service hospital's ability to provide care such as Emergency and charity care, proportionate to community size, but not as much so as "fully" eliminating CON
Geographic
Maintain psych, nursing homes, outpatient diagnostic – further define, surgery center, beds
ASCs – shouldn't require CON
Based on population size?
Increase threshold for requiring CON

What's In (for future discussions)

Health Care Facilities (tab 4 page 9) - CONSENSUS

- Private, municipal, state or federal hospital
- Psychiatric hospital
- Independent diagnostic testing facility
- Residential Psychiatric Treatment Center
- Tuberculosis hospital
- Skilled nursing facility
- Kidney disease treatment center
- Ambulatory Surgery Center

Radiation Therapy

Imaging

- PET
- MRI
- CT
- Mammography
- Nuclear Medicine
- Cath Labs

New Services
IDTF vs. Physician's Office
Thresholds

Session 1: Day 2 : October 30, 2007

The CON Committee agreed that quality was off the table for discussion.

Recommendations to the state:
The committee would like to ask the state to define "excessive" and "need" more clearly.
The committee would also like to view a state health plan/vision.

"Intermediate Care Facility": The committee decided to revisit this issue when the group discusses PROCESS in future meeting(s).

"Who" Discussion:

- Physicians
- Anyone who wants to provide a what
- Whose money is it?
- Type of organization
- Owner structure (who are they? How are they integrated?

The following was agreed upon by the committee at the end of the October 30, 2007 meeting by a show of hands:

What physician offices would be exempt?

- Not a facility
- Independent from hospital (financially & managerially)
- Appropriately licensed and certified
- Works within scope of practice

Radiation Therapy Discussion:
What would radiation therapy (out of a hospital) in a physician's office look like? (e.g., radiotherapy seed business)

- Independent of hospitals
- Work within scope of practice
- Multiple equipment types
- Majority ownership by physician or physician hospital
- Licensed by NRC or state certified
- Local presence by owners

*note: hospital ownership of radiology equipment was tabled to the next meeting

A show of hands at the end of the second day of the meeting determined the start for radiology definition would be:

Paragraphs one and two of the CMS handout and then add the second paragraph of Chakri's definition.

(the following two paragraphs are excerpts from Attachment 2 on page 55 of CMS 855B (11/2001) and the last section was added by the CON Negotiated Regulation Committee on 10/30/07)

INDEPENDENT DIAGNOSTIC TESTING FACILITIES (IDTFs)
All suppliers that perform diagnostic tests, other than clinical laboratory or pathology tests, and are required to enroll as an IDTF must complete this attachment. CMS requires the information in this attachment to determine whether the enrolling supplier meets all IDTF standards. Not all suppliers that perform diagnostic tests are required to enroll as an IDTF. Generally, an entity can bill for the technical component of the diagnostic tests without an IDTF enrollment if it has the following characteristics:

- A physician practice that is owned, directly or indirectly, by one or more physicians or by a hospital;
- A facility that primarily bills for physician services (e.g., evaluation and management (E&M codes)) and not for diagnostic tests;
- A facility that furnished diagnostic tests primarily to patients who medical conditions are being treated or managed on an ongoing basis by one or more physicians in the practice;
- The diagnostic tests are performed and interpreted at the same location where the practice physicians also treat patients for their medical conditions.

Diagnostic Radiology – Many diagnostic tests are radiological procedures that require the professional services of a radiologist. We recognize that a radiologist's practice is generally different from those of other physicians because radiologists usually do not bill E&M codes or treat a patient's medical condition on an ongoing basis. A radiologist or group practice of radiologists is not necessarily required to enroll as an IDTF. A radiologist or group of radiologists, are not required to enroll as an IDTF it all of the following conditions are met:

- The practice is owned by radiologists, a hospital, or both;
- The owning radiologist(s) and any employed or contracted radiologist(s) regularly perform physician services (e.g., test interpretations) at the location where the diagnostic tests are performed;
- The billing patterns of the enrolled facility indicate that the facility is not primarily a testing facility and that it was organized to provide the professional services of radiologists (e.g., (1) the enrolled facility should not be billing for a significant number of purchased interpretations, (2) the facility should rarely bill for the technical component of a diagnostic test, (3) the facility

should bill for substantial percentage of all interpretations of the diagnostic tests performed by the practice), and

- A substantial majority of the radiological interpretations are performed at the practice location where the diagnostic tests are performed.

Paragraph to be added to CMS (recommended by CON Committee on 10/30/07):

Physicians whose primary practice is Diagnostic Imaging and occasionally perform evaluation

- The facility is owned by physicians, a hospital or both;
- Test interpretations are usually performed at the location where the diagnostic tests are performed (>70% of tests);
- The facility does not usually purchase interpretations (generally interpreted <30% of tests;
- The facility ordinarily bills globally

Sheraton Hotel, Josephine's Gallery
Session 2: November 13 & 14, 2007

Committee Members Present November 13, 2007:

1. Mark Wade
2. Robert Bridges
3. Ward Hinger
4. Jeremy Hayes
5. Victor Joseph
6. Shawn Morrow
7. Rod Betit
8. Michael Zielaskiewkz
9. Paul Morris (for Ed Lamb)
10. Mike Powers
11. Jeff Kinion
12. Brad Cruz
13. Joel Gilbertson
14. Bruce Jayne
15. James Shill
16. Creed Marnikunian
17. Jay Butler
18. Jason Paret
19. Baxter Burton

ESTABLISHED GROUND RULES (applies to all committee meetings):

- Seek first to understand then to be understood
- Speak directly to your point
- Respect everyone's choices as right for them
- Spend 10% of your time identifying concerns & issues, 90% of your time identifying options & solutions
- Focus on choices and consequences versus right and wrong
- All Voices count
- Follow facilitator instructions

Decision Considerations:
Will it reduce litigation?
Will it assist in cost containment?
Will it assist in access?
Does it level the playing field?

HOPES
Discuss Ambulatory Surgery Centers

CONCERNS
CON ends up in court and judges end up making decisions: to date committee has not discussed

NOTES FROM CON SESSION 2: *November 13, 2007*

Clarification requested regarding Tribal Clinics and how CON may affect them.

- State should be aligned with federal in regard to Tribal facilities
- Need clarity or specific language regarding Tribal Facilities included in CON for planning purposes

AGENDA ITEMS TO DISCUSS

(consensus prioritization – voted on with results of prioritization below)

1. P.O. Exemption (22%)
2. Thresholds (19%) -
3. Process tied with Enforcement of CON (16% each)
4. Ambulatory Surgery Centers (14%)
5. Tribal Clinics (13%)

RADIOLOGY / P.O. EXEMPTION

<u>P.O. Exemption</u>

- ✓ Financial Interest / Actively Participating
- ✓ Directed by Owner Physicians

- ➢ Should hospital ownership be allowed for P.O. Exemption?
- ➢ What does majority owned mean? (>70% - consensus)
- ➢ Other than hospital investors allowed?

What should a P.O. (non-physician) partner look like (for POEs)?

- Anyone
- No authority on day to day
- Non-medical, then expertise in area involved – skill of expertise
- Active in the field of practice
- Vested interest in healthcare of community

Who shouldn't be a partner?

- Publicly traded companies

<u>APPEND</u>

- As stated, CMS test (still to be decided on bullet one).

Bullet one: A physician practice that is owned, directly or indirectly, by one or more physicians or by a hospital; (still TBD)

From 10/29 and 10/30/07 notes on pages 6 & 7:

- Recommendation to clarify language on bullet 3 of diagnostic radiology office
- Recommendation to clarify bullet 4 of E&M
- Still TBD on bullet 1 (of IDTF) - ownership

Committee recommends adopting as stated in CMS test from notes pages 6 & 7 (as appended).

Committee noted that definitions don't match up with CMS.

Physician's Office Exemption (doctor involved must have):

- Financial interest
- Majority ownership
- Skin in the game ("actively practicing" physician
- Could be hospital or others

Why should hospitals be the only entity allowed to partner with physicians offices? At what point is it about community and what point is it about profit?

NOTES FROM CON SESSION 2: *November 14, 2007*

MORNING

Committee Members Present November 14, 2007:

1. Victor Joseph
2. Bruce Jayne
3. Aaron Wolirich (for Wade Hinger)
4. Robert Bridges (Kim Black in pm)
5. Cathy Giessel (Jeremy Hayes in pm)
6. Michael Zielaskiewicz
7. Gerald Nicholson
8. Shawn Morrow
9. Mike Powers
10. Jason Paret
11. Creed Marnikunian
12. Brad Cruz
13. Jeff Kinion
14. Chakri
15. Joel Gilbertson

*14 people voting during afternoon

CON Process

-Advisory Committee: Panel of impartial knowledgeable individuals (specific to issue at hand)

-Local knowledge to get true determination of need

RECOMMENDATIONS TO STATE:

Standards should be used as CON decision criteria, in a data driven process that takes community plans and market forces into account, with a letter requiring P.O.E. grantees to submit data to the state

CON Process:

Standards should be used as decision criteria

-Should be a data driven process

- A letter should be sent to CON P.O.E. grantees requiring them to submit data (# of patients served, etc.)

-Needs should be based on data, according to community (need community plans)

-Take market forces into consideration: can hospitals compete in the geographic area?

-Consider the capacity of each community

(grantees subject to revalidation based on data/numbers/need)

-Should the CON process specify a window of response for other (competing) CON applications?

Administrative Hearing Process Recommendations:

Needs to be more timely (90 days)

Who can contest decision? *Note: Lawsuits start after the state decision.*

To curb lawsuits

Recommend to state:

2) Provide clear definitions of the following:

- Physician offices,
- Define a small community? (Population) Population and capacity need to be looked at, in regard to the process.

3) Get and Provide accurate data
4) Make administrative process more timely
5) Create a consistent review process

Needed from the state prior to November 20, 2007 (the next CON committee meeting):

- Need data from state – go back 2 years and group appeals according to the nature of appeals. (need data by 11/20/07)

Enforcement Discussion took place and items were voted on regarding enforcement.

AFTERNOON DISCUSSION NOTES (11/14/07 PM):
(Discussion specific to definition of P.O.E. in CON process)

State needs to provide better data statistics according to geographical area.

Different definitions for smaller communities needed for the CON process.

Small	P.O.E.
100% physician owned	
Partner with local hospitals	
Partner with anyone in community (dividend)	

What is the definition of a small community? What about the Kenai Peninsula?

Would there be a different advisory committee for each specific situation? That would be too big of a burden on the state.

Large communities:
Anchorage, Mat-Su, Fairbanks: all others are small communities.

*Populations should be counted and need should be determined consistently (military/Native).

The population formula should be subject to revalidation if/when the population changes.

There are no hard deadlines in the CON process. Committee voted on deadline lengths, in days.

Committee asked, who can file an appeal? *Reference: Current regulations, pg. 17 at bottom of page (item #15). Must prove you are truly adversely affected party in order to file an appeal. If you don't prove you're adversely affected there may be a consequence. Committee decided that the burden is on the appellant.

Who has the authority to enforce? The Commissioner should have the authority.

Committee requests that the state clarify: Appellants should have to prove they're providing "similar" services (make less vague). Recommendation to state: clarify what is "similar"

*Small and large communities discussion was reintroduced.

Threshold Discussion

Comments from CON Committee members:

- -Facilities threshold should be increased (same for small and large communities).
- -Laws should be passed requiring physician's offices – or those practicing medicine have to serve all comers (all patients regardless of whether they have insurance or are able to pay).
- -Everyone seems to want to protect smaller communities and let larger communities have competition.
- -How does state determine need? Will the state count capacity of those outside CON when making CON capacity decisions? (this is recommended by the committee; as a way of collecting current data regarding the capacity of a community)
- -Smaller community hospitals don't have cath labs or oncology, etc. so need added protection from competition.

Facilities Threshold: Could make a recommendation to state to differentiate thresholds for large and small communities.

Equipment Thresholds:

Recommendation: state needs to clarify definition of equipment – differentiate between facility equipment and medical equipment (#2 on page 18) via an advisory group (see below):

Advisory group	Clearly define the differences between which items require CON • Refurbished equipment (no CON) • Novel scope of services (possible CON) • Replacement equipment a. Same purpose (no CON) b. New equipment (no CON)

Facilities Thresholds:

Recommendation: state needs to clarify definition of facilities

Advisory group	Clearly define the differences between which items require CON • Refurbished, remodeling existing facilities, renovating and/or repairing existing facilities for same use, same scope of services– no added services (no CON) • Novel scope of services (possible CON) • Replacement facilities a. Same purpose (no CON) b. New facilities (no CON)

Committee Members Present November 20, 2007:

1. Ward Hinger
2. Jeff Kinion
3. Robert Bridges
4. Chakri Inampudi
5. Lester Lewis (for Brad Cruz)
6. Shawn Morrow
7. James Shill
8. Paul Morris (for Ed Lamb)
9. Al Parrish
10. Mike Powers
11. Norman Stephens
12. Ryan Smith
13. Vicki Crumptoula (for Creed Markunian)
14. Baxter Burton
15. Gerald Nicholson
16. Jeremy Hayes
17. Bruce Jayne
18. Jim Jordan for (Ross Tanner)
19. Rod Betit
20. Victor Joseph
21. Jay Butler

Session 3 CON Committee Meeting Notes: November 20, 2007

HOPES

-Discuss 1 & 5: 1 is ASCs. 5 is POE recommendation to differentiate ownership requirements for large and small communities
-Would like hospitals to be able to partner with physicians
-Empower state to have some teeth in compliance

CONCERNS

-Discuss Enforcement
-Discuss Follow up
-Quality - measures

Decision Considerations:

Will it reduce litigation?
Will it assist in cost containment?
Will it assist in access?
Does it level the playing field?

MORNING DISCUSSION NOTES (11/20/07 am):

Victor Joseph asked to remove Tribal Exclusion language from the agenda.

Comments from Committee Members:

- Technical (knowledgeable and impartial) advisory group should be utilized regarding equipment.
- State needs to fund a data driven process in order to avoid a litigious CON environment. It takes resources to collect data.

Litigation Overview (Kevin Henderson, DHSS):

9 appeals last year; 3 related to POE and Imaging Services, 3 related to ASCs, 2 related to RPTCs(??).

ASCs (in CON process) Discussion - 8:00am

- ownership: active vs. passive investor
- scope of practice
- in practice together
- common EIN

Comments from Committee Members:

- Is it for own use or is it a pool of physician's who go to hospitals. Physicians differentiate by coding.
- Suggestion: 100% ownership

FOLLOW UP/ENFORCEMENT Discussion - 8:30am

Comments from Committee Members:

- Enforcement on bigger issues: keep it simple so as not to create more unfunded mandates.
- Penalty for gross misstatements or lack of compliance. State doesn't have resources to provide follow up for each CON grantee.
- No ASC definition in Statutes or Regulations.
- P.O.s should still have to submit a letter of determination to the state; the letters will provide data to the state which will help in determining need for CON applicants.
- There should be a mechanism that shows whether an MRI (etc.) is running at capacity.
- Count everything in a community when looking at need.
- capacity needs to be defined for this discussion. 600 CT scans for our office vs. 30,000 at Providence.
- Confidentiality of data submitted should be maintained.
- The group is not addressing purpose statement that was addressed on day one, so the group might as well throw out purpose statement.
- When we are talking about POE imaging modalities we will never come to a collective understanding.
- If there is a timely review and appeal process along with clear definitions, loopholes will be decreased.

POE Ownership for P.O. Exemption Discussion – 10am

Comments from Committee Members:

- Hospitals in large communities need to partner with imaging (for POE).
- If hospitals can partner with radiologists (radiology office exemption) there is a negative consequence that hospitals can play favorites.
- We voted before and decided that hospitals could partner and it was 83% yes, I'm surprised we're back discussing this issue again.
- Shows the need to split between large and small communities.
- How much competition can you put into a community without creating adverse affects?
- Concerned about a level playing field.
- I have shifted and have resigned to the fact that I'll have radiology centers.

- Physicians' don't have the ability to threaten hospitals as they are small entities. If we say yes to allow hospitals to practice in P.O.E. which was made for physicians. There shouldn't be a loophole for hospitals and/or large entities.
- From a legal standpoint, makes sense to make consistent ground rules. 100% for small communities then make it 100% for large communtieis. Make it the same across the board for ease of managing the process.
- Consistency to eliminate loopholes.
- Allowing abuse: number between 50% ownership. If forced to agree on a number, might find consensus. How easy is it to abuse? 50% is easy to abuse. Can we come up with a number to limit abuse?
- Process concerns: hope this is the last time the CON committee has to meet in the next 15 years. Drivers: Healthcare environment and an expectation of greater immigration between hospitals and primary care. Primary care is struggling and will probably go away eventually.
- See change in healthcare. In Maine 2/3 of new graduating medical students are employed by hospitals. Agree about the standards. There is a distinct difference between large and small communities. Small communities can be adversely affected. If there is going to be a CON process, should have to prove, through data, that you're (the state) doing what you set out to do (cost control, etc.). POE ownership: makes no difference in a large community.
- Every step we've said let's reduce competition. Hospitals need to embrace new competitors. CON reduced to competitive barriers to anything new in the state. Don't think there should be any restrictions. Don't see the difference between hospitals and any other businesses. Should be open to anyone.
- There is a need for some type of hospitals to work together. Geographic issue has come up.
- Either 100% physician owned or should be able to partner with anyone.
- 100% physician owned
- Level and consistent process
- Do see loopholes. All go through P.O.E. process.
- Level the playing field and create consistency in the P.O.E. application process. Everyone wants to level the playing field. Make the process crystal clear with rules for the Commissioner to follow. Have an issue with hospitals partnering with physicians. It's ok for physicians to partner with physicians.

Last vote on P.O.E. Exemption. Meeting adjourned at 3pm.

See attached excel spreadsheet

Position on House Bill 337 (Working Draft) - February 8, 2008
Prepared by: Rod Betit, President/CEO

ASHNHA Alaska State Hospital and Nursing Home Association

Madam Chairman, members of the Committee, I would like to speak to all three parts of the bill before you today, specifically the provisions repealing certain parts of CON law, creation of a Health Care Commission, and imposing mandatory information reporting requirements.

First, let me give a quick overview on ASHNHA's position on each section of HB337 followed by a sectional analysis.

ASHNHA's POSITION ON SECTIONS CONTAINED IN HB 337:

▪ Section 1 - Statewide Health Plan:	SUPPORT AS IS
▪ Section 2 - Repeal CON provisions	OPPOSE
▪ Section 3 - Repeal CON provisions	OPPOSE
▪ Section 4- Establish Alaska Health Care Commission	SUPPORT IF AMENDED
▪ Section 4- Establish Health Care Information Office & Establish Mandatory Reporting Requirement	SUPPORT IF AMENDED
▪ Section 5 - More Alaska Health Care Commission	SUPPORT AS IS
▪ Section 6 - More CON Repeal Provisions	OPPOSE
▪ Section 7 - More CON Repeal Provisions	OPPOSE
▪ Section 8 - CON Repeal Effective Dates	OPPOSE
▪ Section 9 - Statewide Health Plan Effective Date	SUPPORT AS IS
▪ Section 9 - Health Care Commission Effective Date	SUPPORT AS IS
▪ Section 9 - Health Care Information Office Effective Date	SUPPORT AS IS
▪ Section 9 - Mandatory Reporting Effective Date	OPPOSE

Section 1 - Statewide Health Plan:

ASHNHA supports the recommendation by the Governor's Health Care Strategies Planning Council to develop a statewide health plan. Development of a plan would serve several important purposes. One of those would be to plan for the appropriate development of health care infrastructure and equipment to meet Alaskan's health care needs both in the near and long term. Absence of such a plan has contributed to the ongoing disagreement as to both the quantity of unmet health needs in the State, and the most appropriate setting in which to meet those needs community by community. Initial development of a statewide health plan will likely take several years to complete but could be kept current and relevant with minimal effort and cost.

Amendments recommended in Statewide Health Plan Section 1:
(a) None. ASHNHA supports this section as written.

Sections 2, 3, 6, 7, and 8 - Repeal Certificate of Need:

ASHNHA's membership opposes these sections of HB337. We do not believe repealing CON is good public health policy.

Alaska CON statutes were updated in 2004 to align CON review with rapidly evolving changes in health care delivery practices. These statutory changes have only recently been fully implemented (2006) after a lengthy regulatory adoption effort by the Department of Health & Social Services to fully define the criteria to be used for review of any CON application.

Yes differences of opinion continued to exist within the stakeholder community on how these new laws should be applied. To address this Commissioner Jackson appointed a committee of 21 individuals to meet face-to-face to iron out their differences in September 2007. As you already know, by an 89% vote the participants voted **not to repeal CON.**

As a member of the Rulemaking Committee I can report that we took this charge very seriously. I and other participants believe we did what was asked of us and produced a series of recommendations for improving CON policy and process that the Department should consider or ask us to go back and work on further.

ASHNHA members believe the repeal proposed by HB337 would invite uncontrolled growth of health care services. This would have serious consequences to the financial viability of existing health care providers and undermine their ability to provide needed medical services to their community. In addition we believe it will cause health care costs to increase more rapidly rather than less rapidly.

Decisions around CON should be made in concert with other strategies the State should consider to make the health care market a more balanced economic environment for hospitals. You have heard these arguments before so I will not repeat them here. I have attached the key arguments ASHNHA has made over the years as to why CON is an important health policy tool.

Recently you heard testimony from the Department of Justice about their opinion on whether CON process is helpful or not to the consumer. I have attached a policy paper from the American Health Planning Association that gives a critique of the Department of Justice paper for your additional consideration.

Amendments recommended in CON sections of bill (3, 4, 6, 7, 8, 9, 10):
(a) ASHNHA's members recommend that all CON sections be deleted from HB337 and the Department asked to continue working with the Rulemaking Committee to refine CON regulations and processes to resolve any continuing concerns.

Section 4 - Establish Alaska Health Care Commission:

ASHNHA members support the creation of a Commission to develop incremental strategies to provide affordable, quality health care choices for all Alaskans, to oversee development of the State's health care data information base, and to promote individuals taking responsibility to improve their overall health status. While ASHNHA supports the establishment of a Commission, HB337 does not reflect the diverse membership needed to assure broad based support of Commission recommendations.

Amendments recommended in Health Care Commission Section 2:
(a) ASHNHA recommends the membership be modified to reduce the number of Administration representatives on the Commission, while increasing the number of consumers, business and health care industry representative on the Commission.
(b) Recommend balancing the member selection process in some way. Selection of the members should have support by the Governor and the Legislature.
There are several approaches to modifying the membership and appointment components of HB337 that would be acceptable to ASHNHA members, and we commit to meet immediately with the Administration, the Legislature and other interested parties to come up with a suitable solution to this important component of the bill.

Section 4 - Establish Information Office & Mandatory Reporting:

ASHNHA supports the goal of providing accurate and current health care information for consumers to assist them in making health care decisions. ASHNHA's members have been voluntarily expanding reporting of health care cost, quality and charity care information for many years. All of that information is already available to the Department.

Until now the State has shown no interest in creating a consumer friendly resource containing this type of health care information. Further there was no discussion with ASHNHA or other health care providers about how to best approach this goal prior to introduction of this legislation. This is a complicated and involved process that will take years to fully develop and implement. Some progress could be made by the State in the short term using the data already being provided by hospitals but certainly not by July 1, 2008.

While ASHNHA's members support the goal of expanding health care cost and quality information for consumers, there has been little thought given to how this will actually be accomplished. The bill is unclear on critical details with which to answer the following four questions:

1. **Who must report this data?** AS 47.32 (page 8, line 9) lists the following:
   - ambulatory surgical centers;
   - assisted living homes;
   - child care facilities;

- child placement agencies;
- foster homes;
- free-standing birth centers;
- home health agencies;
- hospices, or agencies providing hospice services
- hospitals;
- intermediate care facilities for the mentally retarded;
- maternity homes;
- nursing facilities;
- residential child care facilities;
- residential psychiatric treatment centers;
- rural health clinics;
- runaway shelters.
- Independent Diagnostic Testing Facilities come in on page 8, line 5

All of these entities would be expected to start reporting yet undefined data effective July 1, 2008. This is clearly not possible. Noticeably missing from the list is a key piece of the cost and quality equation for consumers, that of the physician. How can a consumer make a choice about their care without this information?

Also missing from this list is pharmacies yet the Department presented a State of Florida web site as an example of what the consumer would be able to access under their reporting program. How could that come about without statutory authority?

ASHNHA questions if all of these other 'facilities' understand whether they are to report under the provisions of HB337 effective July 1, 2008.

2. What data must be reported and how does that compare to what is reported now?
It is not clear what data the department is looking for. ASHNHA is the only entity in the list of impacted facilities that currently reports data and we do that voluntarily. The list of reports available to the Department right now is quite extensive including:

- ASHNHA members report all hospital inpatient data related to patient stays. This includes diagnosis, all treatment provided, charges, reimbursement received, third party insurers, length of stay, sex of patient, age of patient, patient residence, and a host of other information.
- ASHNHA members voluntary expanded beyond the inpatient data base to the department this year by reporting data for all outpatient services provided and all emergency department services. This includes all outpatient surgery, lab and imaging services
- ASHNHA members report financial data on the operations of their facilities on an annual basis.
- ASHNHA members report data on key quality measures to the federal Department of Health & Human Services and to the American Hospital

Association. These data are available to the public at these posted web sites for comparing Alaska hospitals to each other as well as comparing Alaska hospitals to those in other states.

- Many ASHNHA members also voluntarily report quality information on a number of quality and patient safety measures that go beyond that reported to the federal government. This data is also publicly available.
- ASHNHA members have supported the Legislature's desire to add health care facility acquired infections to the list of reportable items as proposed in SB 68 that passed out of this committee last year. We believe this is important information to report but recognize it is a difficult area to be statistically reliable in. SB 68 creates a process over several years to look at what other states have done, design a reporting program suitable for Alaska, and then implement reporting in Alaska. It is wise to go slow here as 14 states have passed similar legislation but only 2 or 3 have actually begun reporting due to the challenges this reporting presents.
- For the first time ASHNHA's members have again voluntarily launched and funded a new report that will give you and all Alaskans a look at the total 'community benefits' Alaska's hospitals provide. I have attached a copy of this inaugural report. Please note our first effort at collecting this information accumulated $150 million in benefits of one type or other. This number will grow in future years as we become more sophisticated at capturing this information.

3. How will the data be collected, validated and kept current?

There are several ways to develop and implement a reporting system. Three of those would be as follows for the hospital portion of this system. Which path is the State on?

- Hospitals could send the same raw data we send to these other expert data agencies and the department could edit, purge confidential information, format and post the data to their own data web site. This would be Herculean task essentially replicating efforts and costs already being invested; or
- The department could enter into an agreement with little or no cost to obtain the data from all the data agencies already producing reports and populate their own data site with that clean data. The department could then use that data to generate the online consumer inquiry system being envisioned; or
- The department site could provide links to these already existing data sites for ease of consumer movement through the system. This would be the simplest, least costly, and easiest to maintain approach because the cost, liability and administrative burden to keep the data current and accurate rest with other expert data parties.

4. When can reporting of new data elements realistically begin?

Clearly, answers to the above questions need to be obtained to evaluate when any new mandatory reporting requirement can be realistically implemented. In ASHNHA's

opinion the July 1, 2008 date is simply unrealistic. Further when you consider all the other providers who will be expected to report that do not have the jump start that hospitals have by voluntarily reporting for many years, there is serious question about how thoroughly the scope and complexity of this proposal has been fleshed out.

Amendments recommended in mandatory health care data reporting Section 2:
(a) Recommend these provisions be rewritten in a permissive rather than prescriptive tone and the development/implementation responsibility be placed with the Health Care Commission.
(b) Recommend all parties who will be expected to report be clearly listed in this section of the bill. The parties listed should include pharmacies and physicians which are not now included.
(c) Recommend the timelines for implementation of reporting be extended beyond July 1, 2008. There simply is no way this timeline can be met.
(d) Recommend the department initiate its reporting efforts as it pertains to hospitals with the data already being provided that is not now being made available to consumers after a dialog with ASHNHA on how to best proceed.

Thank you for the opportunity to testify and express ASHNHA's members' opinions about this legislation.

The Federal Trade Commission
&
Certificate of Need Regulation

An AHPA Critique

January 2005

American Health Planning Association

. . . putting it all together

I. Overview

In July 2004, the Federal Trade Commission (FTC) and the Department of Justice (DOJ) issued a joint report titled *Improving Health Care: A Dose of Competition.* Described as advisory in nature, ostensibly, it offers recommendations on how to "improve the balance between competition and regulation in health care."[1] The authors say they want "to inform consumers, businesses, *[and]* policy-makers on a range of issues affecting the cost, quality, and accessibility of health care."[2] Except for more effective enforcement of antitrust laws, which falls within the scope of the agencies' responsibilities, the report seeks to effect change by influencing the views and conduct of others, particularly national and State policymakers.

Eliminating certificate of need (CON) regulation is only one of several problematic arguments and recommendations presented. It is the only recommendation that has gained much public attention, but the issue is given only cursory, dismissive consideration in the report.[3] The overall thrust of the report is to encourage movement to a "consumer driven" health care system that relies on market forces to determine costs (prices), access, and quality. CON regulation and planning is seen as an obvious obstacle to this goal, but the report also cautions against:

- Over-reliance on health insurance;
- The system-distorting effects of Medicare and other "administered pricing" schemes;
- Economic cross-subsidies within the system;
- Government-imposed service mandates;
- Attempting to control prescription drug prices;
- Permitting collective bargains by physicians, and generally; and
- Any other action or process contemplated, in the pursuit of other (perhaps larger) social goals and interests that might limit competition or the full application of market forces.

Criticism of CON regulation in *Improving Health Care* is not surprising. Given the FTC *raison d'etre* of promoting free markets and unfettered competition, and its longstanding opposition to CON programs, little else could be expected. Nevertheless, the unsupported conclusion that CON programs "pose anticompetitive risks" and "risk entrenching oligopolists and eroding consumer welfare" is little more than doctrinaire posturing. Similarly, the recommendation that States with CON programs "reconsider whether these programs best serve their citizens' health care needs" is gratuitous. State legislatures do this regularly, often annually.

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[1] FTC-DOJ press release July 23, 2004, at <http://www.ftc.gov/opa/2004/07/heathcarerpt.htm>.

[2] *Ibid.*

[3] CON and related planning are treated briefly as "miscellaneous subjects" in Chapter 8, the last chapter of the report. Although there are occasional allusions to CON regulation elsewhere in the report, the question is discussed directly in fewer than 10 pages of the 350 plus page report. The cursory treatment of CON planning and regulation appears calculated: CON regulation is treated dismissively, almost as an afterthought, in the body of the report, but is elevated to prominence in the recommendations (number 2) offered "to improve competition in health care markets". ***Improving Health Care: A Dose of Competition.*** A Report by the Federal Trade Commission and the Department of Justice, July 2004. The full report is available at www.ftc.gov. See specifically Chapter 8 (pp. 1-6) and the Executive Summary (p.22), both of which discuss CON regulation directly.

opposed CON regulation in Georgia[7], Hawaii[8], Maryland[9], Michigan[10], Nebraska[11], New York[12], North Carolina[13], Ohio[14], Pennsylvania[15], and Virginia.[16]

FTC attacks have been multifaceted, with arguments ranging from the purported failure of CON regulation to meet legislative cost control objectives to assertions that it results in higher operating costs and charges, threatens quality, reduces innovation and system efficiency, and

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[7] In March 1988, FTC staff said "We believe the continued existence of CON regulation is contrary to the interests of health care consumers in Georgia. . . . More importantly, CON regulation tends to foster higher prices, lower quality and reduced innovation in health care markets". See FTC press release, March 7, 1988, at www.ftc.gov.

[8] In early1987, FTC staff told Hawaii legislators "we strongly encourage repeal of CON legislation. There is no evidence that the CON regulatory process has served its intended purpose of controlling health care costs. Indeed, CON regulation may well increase prices to consumers by restricting supply of hospital services below the level that would exist in a non regulated competitive environment." See FTC press release, March 17, 1987, at www.ftc.gov.

[9] In 1987, FTC staff advised Maryland policymakers to not control ambulatory surgery center development under the State's CON program. See FTC Annual Report, 1987, U. S. Federal Trade Commission, Washington, D.C. at www.ftc.gov.

[10] In March 1988, FTC staff advised Michigan health officials that the State's CON regulations were (are) "contrary to the interests of health care consumers in Michigan" because they "tend to decrease efficiency and impede competition." The staff also asserted "any potential benefits of CON regulation are likely to be outweighed by its adverse effects on competition in health care markets." See FTC press release, May 9, 1988, at www.ftc.gov.

[11] In February 1989, FTC staff informed the Nebraska Legislature "continuing CON regulation is likely to harm consumers by increasing the price and decreasing the quality of health services." See FTC press release, February 24, 1989, at www.ftc.gov

[12] In February 1987, FTC staff advised New York City Health Systems Agency officials that a contemplated reduction in excess hospital capacity "would substantially reduce the incentives for hospitals in New York City to improve the price and quality of their services." Consequently, officials should "rely on the hospitals themselves, rather than government regulation, to determine appropriate capacity levels." See FTC press release, February 10, 1987, at www.ftc.gov.

[13] In March 1989, FTC staff told the North Carolina policy-makers "CON regulation does not appear to be an efficient way to ensure the quality of health care services, to assure that health care is available to the indigent, or to control Medicaid expenditures for nursing home beds." Staff also argued "consumers would most likely be better served if CON regulations were removed." See FTC press release, March 14, 1989, at www.ftc.gov.

[14] In June 1989, FTC staff told the Ohio State Senate "'there is near universal agreement' among health care economists that Certificate of Need regulation 'has been unsuccessful in containing health care costs.'" See FTC press release June 22, 1989, at www.ftc.gov.

[15] In April 1988, FTC staff urged Pennsylvania to eliminate CON regulation, arguing "the benefits of CON regulation, if any, are likely to be outweighed by the adverse effects of such regulation on competition in health care markets. Consequently, continuing CON regulation is likely to harm consumers by increasing the price and decreasing the quality of health services in the state." See FTC press release, April 1, 1988, at www.ftc.gov

[16] In August 1987, FTC staff advised Virginia officials to eliminate its CON regulation of health care facilities because such regulation is "contrary to the interests of health care consumers" and "market forces generally allocate society's resources far better than decisions of government planners." FTC staff also asserted "any potential benefits of CON regulation are likely to be outweighed by the adverse effects of such regulation on competition in health care markets. Consequently, CON regulation is likely to harm consumers on balance by increasing the price, and decreasing the quality, of health services in Virginia." See FTC press release, August 10, 1987, at www.ftc.gov.

An underlying objective of the report is to change views on this question, especially among policymakers. The authors' recognize that mediating forces (insurance, public health and payer programs, lack of accurate and reliable cost and quality information, and the absence of a truly independent and sovereign consumer) make the current health care market an imperfect one. They insist that, given this circumstance, all efforts should be directed at perfecting the market, and paying directly any additional cost that a free unfettered market may entail.

FTC arguments presented in opposition to CON regulation, and in support of unrestrained market forces, are necessarily largely doctrinaire. There is little analytical or factual basis for the criticism of CON or for the recommendation to eliminate it. Similarly, other than recitation of orthodox economic doctrine, little is presented to demonstrate that market forces have had, or are likely to have, the positive effects in the health care system that the authors claim or assume.

The FTC opposes most barriers to market entry, whatever their nature, purpose or function, as an article of faith. The report makes clear that the FTC opposition is grounded in orthodox economic doctrine and the principles of the "American" market system. The Executive Summary of the report concludes with the report anthem:

> "The fundamental premise of the American free-market system is that consumer welfare is maximized by open competition and consumer sovereignty – even when complex products and services such as health care are involved. . . . The Agencies do not have a pre-existing preference for any particular model for the financing and delivery of health care. Such matters are best left to the impersonal workings of the marketplace." ***Improving Health Care: A Dose of Competition,*** *Executive Summary,* p. 11.

In other words, the FTC is not in favor of a particular model as long as the *de facto* model is the "American free market" model. Doctrine, or perhaps faith and hope, trump experience and reason. This is not surprising, given the FTC's mission of promoting competition. This inherent bias, though understandable, does not absolve the Commission of its responsibility to avoid substituting belief for fact, or to refrain from accepting uncorroborated allegations of interested parties as fact. The report, and the record compiled in producing it, shows the Commission relied on belief and uncorroborated allegations rather than demonstrated fact in its rebuke of CON.

Although packaged and presented as a major new report, the evidence and argument against CON regulation is either a rehash of FTC arguments from the 1980s,[19] or the uncorroborated self-serving allegations of interested parties.[20] There is a notable absence of documented fact or cogent analysis. No new evidence is offered to support the claim that, by raising market entry barriers for some services, CON raises costs, impedes access, or threatens quality. References to

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[19] See Keith B. Anderson and David I. Kass, ***Certificate of Need Regulation of Entry into Home Health Care***, FTC staff report, January 1986; Monica Noether, ***Competition Among Hospitals***, FTC staff report, May 1987; and Daniel Sherman, ***The Effect of State Certificate-of-Need Laws on Hospital Costs: An Economic Policy Analysis***, FTC staff report, January 1988.

[20] See unsupported and anecdotal testimony of John Hennessy, Executive Director, Kansas City Cancer Centers (a subsidiary of U. S. Oncology) and Megan Price, Director, Contracts and Communications, Professional Nurses Association. Both were (are) disappointed CON applicants who made bold, uncorroborated assertions that are problematic on their face.

effects of CON regulation. Statements to the contrary notwithstanding, these are doctrinaire assertions, not demonstrated fact.

IV. Allusive Arguments

The FTC assertion that, rather than helping control costs, "there is considerable evidence" that CON "can actually drive up prices by fostering anticompetitive barrier to entry" is not supported by credible evidence. This uncorroborated assertion is typical of the argument presented. No source for this conclusion is cited. The language, like the argument itself, is in the subjunctive, opaque and indirect. Considerable evidence is not otherwise defined or identified. So-called "anticompetitive barriers," such as CON, are not clearly distinguished from barriers such as licensure and insurance payment rules and regulations that, though they limit or otherwise affect market entry as forcefully as CON regulation, presumably do not rise to the level of being an "anticompetitive barrier".

The opaque assertion that CON "can actually drive up prices" permits the writers to project their views without having to meet the burden of proving them. Orthodox economic theory holds that market entry barriers "can," and often do result in higher prices in many markets, but there is no credible evidence that CON has, or necessarily does, lead to higher costs in health care. Recourse to theory is necessary if the argument is to appear plausible. In other words, if there is not evidence to document the practice or effect, simply assert repeatedly the belief or theory.

V. Related Opinions and Findings

The attack on CON, though sharp, is a small part of *Improving Health Care*. Perhaps more problematic are the related assumptions, beliefs and recommendations that, if implemented, would undermine community and regional planning, and subject those in need of health services to the vagaries of unfettered market forces. These views and assumptions include:

- *Opposition to Internal Subsidies (Cross-subsidies)*. The report recommends that governments (federal and state) re-examine their support of policies and practices that underlie cross-subsidies in health care markets. The rationale offered for this recommendation is that internal (service-to-service) subsidies are inefficient and have the "potential to distort competition."

  The report is indifferent to the implications of the loss of service to those who now benefit from these subsidies, noting that "competition cannot provide resources to those who lack them; it does not work well when certain facilities are expected to use higher profits in certain areas to cross-subsidize uncompensated care." If there is a genuine commitment to assist those benefiting from cross-subsidization, the necessity of such assistance should be weighed and, if found meritorious, be provided directly to recipients (presumably through direct payment or vouchers) because that approach would be "more efficient" and "transparent". There is no discussion of the practicality of this approach or of the likely affects on current beneficiaries of subsidies. The net social and health system gain (benefit) of eliminating cross-subsidization is assumed to be positive.

- *Health Insurance Distorts Markets and Competition*. The report does not recommend specific changes in the Medicare program or in other health insurer coverage or payment practices, but asserts repeatedly that insurance coverage and payment

theory, some level of surplus capacity—the level to be determined by market forces—is necessary for a competitive system. FTC staff assumes that the market will punish, and ultimately root out, surplus capacity, inappropriately low occupancy levels, and inefficiency (e.g., low throughput). In other words, there cannot be too many hospitals, hospital beds, or too much service capacity of any kind in a free market.[27]

VI. Supportable Report Findings and Recommendations

- *Information Asymmetry*. The report recognizes that a major imperfection in the current system is the lack of accurate and reliable cost and quality information consumers can use in seeking health services. The recommendation for a concerted, system-wide effort to make more of such information available is commendable. Unfortunately, the report does not recognize or acknowledge that knowledge and information asymmetry is inherent (unavoidable), nor does it suggest ways to deal with this question.

- *Enhance Incentives to Lower Costs and Improve Quality*. The recommendations offered in the report are generic in nature and unobjectionable. The need to improve incentives to reduce or control costs, and to improve quality is recognized and accepted by nearly everyone. Unfortunately, little guidance is offered about the specific questions to be addressed, the means to address them, or the problems likely to be encountered in dealing with them.

- *Implement Institute of Medicine Licensure Reforms.* The suggestion that the membership, and consumer representation on state health facility and service licensing boards be broadened is laudable. Both the scope and substance of licensing decisions, and the processes used in making them, need reform.

VII. Problematic Report Findings and Recommendations

- *Eliminate CON Regulation*. The recommendation that CON programs be eliminated is based largely on doctrine. The argument is a repackaged version of decades-old FTC arguments and positions. No new studies or analyses are offered. Empirical evidence and recent studies and experience showing the benefits of CON regulation are largely dismissed, not disproved.

- *Re-examine Subsidies in Health Care Services*. The value of all health care polices and practices should be examined periodically as a matter of course. In fact, most are. The underlying FTC argument against cross-subsidization is based on orthodox economic doctrine, not on an assessment of their intrinsic merit or the rationale for them. Most subsidies are in place for notably laudable purposes. Some, perhaps all, may need to be reconsidered, but not for theoretical or doctrinal reasons. The evolved connection between cross-subsidization, provision of charity care, and CON review contingencies and conditions is of considerable social value. Current practices should not be changed unless meaningful alternatives are in place.

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[27] Jeffrey Zuckerman, Director, Bureau of Competition, U. S. Federal Trade Commission, to Giri Vuppala, Assistant Director, Planning and Implementation, Health Systems Agency of New York City, February 9, 1987.

positive aspects of planning, CON regulation, facility licensure, and a number of other mediating social constraints are in place, in part, because market forces do not, and probably cannot, be used to discipline this market.

- *The studies critical of CON cited by the FTC are not reliable*. The argument that planning and CON regulation result in higher costs and prices, inferior quality, reduced access, less innovation, and lower operating efficiency, though asserted repeatedly, is not supported by demonstrated fact. This refrain is based largely on an unwavering adherence to orthodox economic doctrine.

  Most of the sources cited that purportedly show negative economic and quality effects of CON regulation, are FTC staff reports and FTC staff statements, which in turn, are often based on these studies. Thus, many of the citations are self-referential. The base studies themselves are suspect. The data used, the timeframes covered, and analytical processes relied upon are problematic. The conclusions drawn are debatable. Based on multivariate regression analysis and statistical correlation, none of these "studies" demonstrates cause and effect and, beyond theoretical conjecture, none explains the method or mechanism by which the changes observed were achieved.

  Analyses that try to examine the economic and quality effects of CON regulation yield mixed findings, not the uniformly negative results asserted in the FTC report. Contrary to the impression conveyed in the FTC report, there are no reliable studies showing the effects of CON regulation on access to care, system efficiency, innovation, or other specific system characteristics.

- *Empirical evidence and experience are ignored or treated dismissively*. The recently reported experience of U.S. automakers showing lower costs in States with CON programs, and published analyses showing significantly lower mortality rates among open-heart surgery patients in States with CON programs, are dismissed. This information, when acknowledged, is usually cited in the testimony of a commentator or hearing panel member and dismissed by pairing it with opposing anecdotal testimony of CON critics.

- *Health care as a privilege*. The FTC prides itself on working in the interest of the consumer, the average citizen. It argues that "consumer driven" health care system is desirable and possible if market forces are permitted free reign. The paean to consumer control, though superficially attractive, borders on the disingenuous when examined in the light of economic and health system realities. The report prescribes theoretical cures to real problems. The discussion is at the macroeconomic level. The assumption appears to be that, if you address, at least theoretically, overarching system questions and imperfections, maximum benefit will flow (trickle down) to the individual.

  Unfortunately, the individual is treated as a theoretical economic entity or construct. Market realities are such that, under FTC prescriptions access, to quality health care would become a privilege, not a right or reasonable social expectation, dependent upon the economic standing, the knowledge base, and the social status of the individual. The report appears to anticipate and endorse this outcome. It speaks approvingly of consumers needing incentives to "balance costs and benefits and search for lower cost health care with the

outcome is well known. It has been documented repeatedly for many of the services regulated under CON programs. CON regulation is the most reliable and practicable tool for implementing service, institutional and regional planning policies and practices that facilitate and ensure appropriately high program volumes.

X. Conclusions

Improving Health Care: A Dose of Competition appears to be largely a political treatise. It is not an analytical study. The underlying purpose appears to be an attempt to frame (shape) the debate over the nature and evolutionary direction of the U.S. health care system. It touts a "consumer driven" system as the ultimate goal. The report argues that this is possible if the nation has the courage to forgo internal subsidies, service mandates, over-reliance on insurance and government financing and purchasing, government regulation, and associated practices. Reliance on unrestrained market forces is prescribed as the best approach to determining health care capacity, cost, quality, and access. The negative effects of unfettered competition are not examined.

In terms of health planning and CON regulation, the report repackages and restates decades-old arguments against regulation. No new data, information or analysis is offered, and empirical evidence indicative of the efficacy of CON regulation and associated planning is dismissed. By almost any measure, the presentation is largely doctrinaire, based on an unwavering belief in the applicability of orthodox economic doctrine in health care rather than an objective analysis of market realities and experience.

The stated FTC goals of market efficiency, consumer control and informed stakeholders have been integral to community-based health planning for more than 40 years. The community has always been, and remains, an integral part of the planning, development and regulatory processes. The principal difference between FTC beliefs and assumptions, and those favoring planning and targeted regulation is how best to manage the tension between public and private interests, and between short-term and long-term perspectives and incentives. AHPA has always believed in the importance of community-oriented health care services and systems, and encourages ongoing reassessment of health planning and CON regulation to ensure they remain responsive to technological change, evolving health care practices, and community values and needs. The Association will continue to support these principles and practices.

ASHNHA
Alaska State Hospital and Nursing Home Association

REASONS FOR CONTINUING CERTIFICATE OF NEED IN ALASKA

- **Health care is not a conventional market; its economic forces are different.**
  - Health care has a finite need in each community. Introduction of additional medical providers redistributes finite revenue among more providers with 'winners and losers' in the community. Community hospitals will be the 'losers' as profitable services are aggressively sought by new imaging, surgery and specialty hospital providers. This will have profound adverse impact on their ability to fully meet community expectations.
  - Hospitals and nursing homes must offer a full range of outpatient, inpatient and emergency services 24 hours a day, 7 days a week, 365 days a year. A number of these essential services do not produce adequate revenue to offset their cost of operation yet they must be offered to fully meet the needs of the community.
  - Health care is heavily regulated by federal & state laws. These regulations do not afford the health care provider the same flexibility and efficiency found in other markets. For example, a reduction in profitable service lines cannot be recovered by increased pricing as nearly one-half of hospital revenue comes from sources that set their own pricing (Medicare and Medicaid).
  - There is no assurance that introducing additional health care providers in a community will reduce cost to the consumer. In fact there is recent research that continues to suggest otherwise.
- **Hospitals must serve all persons in the community that need care regardless of ability to pay and are the key responder in community disaster response.**
  - Without CON, specialty providers can enter the market and create unfair competition by offering only the most profitable medical services and limiting the number of non-paying and underinsured patients that they will see.
  - 18 of Alaska's 25 hospitals are 'sole community providers' which risk financial instability and irreparable harm to community residents if the State does not insure that there is need for more health care infrastructure before it is introduced into the community.
  - Hospitals invest preparedness funds and extensive training to serve the community in event of natural disasters, pandemic flu, biological, and chemical threats. These expenses are not recovered from health care purchasers and only partially offset by federal/state grants. CON helps assure these important services will not be threatened by loss of critical revenue to keep these protections in place.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM January 29, 2008

SUBJECT: Explanation of CSHB 337(HES) (Work Order No. 25-GH2050\C)

TO: Representative Peggy Wilson
Attn: Becky Rooney

FROM: Jean M. Mischel
Legislative Counsel

Enclosed is the draft CS you requested for HB 337. I wanted to alert you that the change requested to the definition of "health care facility" in the draft CS at page 8 is confusing. Paragraphs (C) and (D) were added to that definition but refer to a "provider" rather than a type of facility. In addition, those paragraphs contain substantive law requiring those providers to be "certified under regulations adopted by the department." Since that requirement appears nowhere else in statute, as a legal matter, those providers do not exist.

In addition, you asked two questions in your request for this CS.

1. Does removing the phrase "ex officio nonvoting" from the appointment of legislative members of the proposed Alaska Health Care Commission make the appointment illegal? Since the commission is established within an executive branch department, having legislative members vote on matters before the commission may violate the separation of powers doctrine. On the other hand, the commission's primary function appears to be advisory under new section 18.09.010(1) so that a decision making role does not appear to interfere with the independent functions of the executive and legislative branches of government. The only other function of the commission appears to be administrative in that the commission "approves" information for posting on the website and again does not appear to affect the separate providers of the legislative or executive branch.

2. Are health care regions already defined in statute? I have found only one reference to a "health care region" and that is in the context of regional public assistance programs under AS 47.27.300. That section does not define "region." On the other hand, local health units are defined as follows:

> **Sec. 18.10.010. Local health unit and health board.** Each community or settlement outside an incorporated city is a health unit. In each health unit there shall be a board of health composed of the president of the school board and two citizens of the unit selected by the school

> board. At least one of the members of the health board must, where practicable, be a licensed physician. In a health unit where there is no school board, the commissioner shall appoint three residents of the unit to the local board of health, at least one member of which must, where practicable, be a licensed physician.

In addition, health districts are described under AS 18.10.040 as:

> **Sec. 18.10.040. Health districts.** Two or more contiguous health units of two or more local boards of health for contiguous incorporated cities may be constituted a health district by the department. Members of the board of health for this type of health district shall be appointed by the department from residents of each health unit or incorporated city represented in the health district in the numbers and for the periods of time determined by the department.

If I may be of further assistance, please advise.

JMM:med
08-056.med

Enclosure

Amend CON

Wade Hoek

From: Governor Sarah Palin [governor@gov.state.ak.us]
Sent: Tuesday, February 20, 2007 2:30 PM
To: nkoumal@rcpcfairbanks.org
Subject: RE: Health_Care

Thank you for writing to Alaska Governor Sarah Palin. The concerns, opinions, and/or information you have sent are important and valuable to the Governor. Although she is unable to respond to each and every email herself, your message has been received and is being reviewed by the appropriate staff person in this office who can best address your need, suggestion, or comment.

-----Original Message-----
From: WebMail@gov.state.ak.us [mailto:WebMail@gov.state.ak.us]
Sent: Sunday, February 18, 2007 1:16 PM
To: governor@gov.state.ak.us
Subject: Health_Care

Web mail from: Ms. Nancy Koumal
address: PO Box 82779 FAIRBANKS AK 99708

MESSAGE:
Dear Governor Palin, I'm writing to express my thoughts on CON, and my interest in the health-care
system study task that you are setting-up. The current CON policy that shut down the Open Imaging Center in Fairbanks is wrong. They not only were a great business but I know from recent personal experience I saved more than $500 on a MRI using them instead of FMH. FMH has a monopoly and it isn't fair. Having said that, I have a great interest in the health-care system in Alaska and US,and would like to offer my service on the new task force being formed. As a 24 yr resident of Fairbanks,a RN for 25yrs,14 yrs at FMH, and most recently at the Resource Center for Parents and Children WIC Program for almost 6yrs, I feel somewhat qualified to have an opinion on many issues affecting our health-care policies and the well-being of our citizens, most notably our children. Please consider my opinion and my offer. Sincerly, Nancy Koumal RN

nkoumal@rcpcfairbanks.org

Michelle Fabrello

From: Linda Manns [linda_manns@gov.state.ak.us]
Sent: Wednesday, February 28, 2007 3:05 PM
To: Michelle Fabrello
Subject: Message to the Governor

Attachments: Linda_Manns.vcf

1857
AK

Linda_Manns.vcf
(348 B)

Fairbanks constituent call 2-28-07 3pm

To: Governor Palin
From: David & Ardena Morway
2120 Badger Rd.
North Pole, Ak. 99705
488-9089

Message:
We support SB65 and HB 4.
To amend the certificate of need. The people of Fairbanks and North Pole deserve to have more then one treatment option.

Thank you.

XRN CON File

Office of the Governor
550 West 7th Ave, Ste 1700
Anchorage, AK 99501
(907-269-7450)

2220
AK

PUBLIC OPINION MESSAGE

Date: *March 14, 2007*

From: *David Newton*
1045 Beech Lane #18
Anchorage, AK 99501-6015

To: *Governor Palin*

Subject: *Two bills*

Operator: *Tara Fradley*

I am supporting two bills, HB4 and SB65. If these get passed to you please sign them. HB4 is sponsored by Bob Lynn and SB65 is sponsored by Charlie Huggins.

Supports Repeal CON

Savland, Monica L (GOV)

From: Governor Sarah Palin (GOV sponsored)
Sent: Thursday, February 07, 2008 10:20 AM
To: westie@ptialaska.net
Subject: RE: Health_Care

Thank you for writing to Alaska Governor Sarah Palin. The concerns, opinions, and/or information you have sent are important and valuable to the Governor. Although she is unable to respond to each and every email herself, your message has been received and is being reviewed by the appropriate staff person in this office who can best address your need, suggestion, or comment.

-----Original Message-----
From: WebMail@gov.state.ak.us [mailto:WebMail@gov.state.ak.us]
Sent: Thursday, February 07, 2008 6:28 AM
To: Governor Sarah Palin (GOV sponsored)
Subject: Health_Care

Web mail from: Jan Ponder
address: PO Box 56992 North Pole AK 99705

MESSAGE:
Good Morning,
As a single parent, I attemp to "stretch" monthly income. I would like to see a new option in Fairbanks for health care. I am not a supporter of the certicate of need. In these times of high oil prices and struggling, it is difficult to make ends meet. The doctors seem to be getting back to the humanity reason of being a doctor. Lets allow better health care and hopefully the cost of care will come down.

westie@ptialaska.net

Support Repeal CON file

Savland, Monica L (GOV)

From: Governor Sarah Palin (GOV sponsored)
Sent: Wednesday, February 06, 2008 8:57 AM
To: loisk@starband.net
Subject: RE: Certificate of Need

Thank you for writing to Alaska Governor Sarah Palin. The concerns, opinions, and/or information you have sent are important and valuable to the Governor. Although she is unable to respond to each and every email herself, your message has been received and is being reviewed by the appropriate staff person in this office who can best address your need, suggestion, or comment.

-----Original Message-----
From: loisk@starband.net [mailto:loisk@starband.net]
Sent: Tuesday, February 05, 2008 3:04 PM
To: Governor Sarah Palin (GOV sponsored)
Cc: Bunde, Con (LAA); Cowdery, John (LAA); Davis, Bettye J (LAA); Dyson, Fred (LAA); Ellis, Johnny (LAA); Elton, Kim S (LAA); French, Hollis (LAA); Green, Lyda N (LAA); Hoffman, Lyman F (LAA); Huggins, Charlie (LAA); Kookesh, Albert (LAA); McGuire, Lesil L (LAA); Senator_Donald_Olson@legis.state.ak.us; Stedman, Bert K (LAA); Stevens, Gary L (LAA); Therriault, Gene (LAA); Thomas, Joe (LAA); Senator_Thomas_Wagoner@legis.state.ak.us; Wielechowski, Bill (LAA); Wilken, Gary R (LAA); Buch, Bob (LAA); Chenault, Mike (LAA); Cissna, Sharon (LAA); Coghill, John (LAA); Representative_Harry_Crawfod@legis.state.ak.us; Representative_Nancy-Dahlstrom@legis.state.ak.us; Doll, Andrea (LAA); Doogan, Mike (LAA); Edgmon, Bryce E (LAA); Fairclough, Anna (LAA); Foster, Neal (LAA); Gara, Les (LAA); Gardner, Berta (LAA); Gatto, Carl (LAA); Gruenberg, Max F (LAA); Representative_David_Gruenberg%legis.state.ak.us.Representative_John_Harris@legis.state.ak.us; Hawker, Mike (LAA); Holmes, Lindsey (LAA); Representative_Lyle_Johansen@legis.state.ak.us; Johnson, Craig W (LAA); Joule, Reggie (LAA); Kawasaki, Scott Jw (LAA); Keller, Wes (LAA); Representative_Michael_Kelly@legis.state.ak.us; Kerttula, Beth (LAA); Ledoux, Gabrielle R (LAA); Lynn, Bob (LAA); Meyer, Kevin G (LAA); Nelson, Mary (LAA); Neuman, Mark A (LAA); Olson, Kurt E (LAA); Ramras, Jay B (LAA); Roses, Bob (LAA); Salmon, Woodie W (LAA); Samuels, Ralph (LAA); Seaton, Paul (LAA); Stoltze, Bill (LAA); Representative_William_Thomas@starband.net; "Jr."@legis.state.ak.us; Wilson, Peggy A (LAA)
Subject: RE: Certificate of Need

PLEASE - PLEASE - GET RID OF THE MONOPOLY IN FAIRBANKS/NORTHPOLE/SALCHA AREAS! RE: Fairbanks Memorial Hospital/Banner Health Care

We have had our own experiences regarding 'treatment' in the ER - from either not looking close enough at circumstances/symptoms and 'diagnosis,'
more so in the last year, specifically 6 mos.

People are not getting what is needed or misdiagnosed or not checked thoroughly enough, and given wrong RX's, etc., for condition.

If you want 'specifics' contact me, glad to fill you in.

It is bad enough to at last resort have to go to the ER, they do not like to see you back in there with same symptoms on your next visit, let alone again, within 'hours,' and speaking from experience, and after nearly 4 hrs. in ER, placed in ICU for 3 days, second visit in less than 5 hrs.

Ed and Lois Kincaid
7921 Steese Hwy.
Fairbanks, AK 99712-1744
[redacted]-389-2324
[redacted]sk@starband.net

Supports repeal of CON

Savland, Monica L (GOV)

From: Governor Sarah Palin (GOV sponsored)
Sent: Wednesday, January 30, 2008 7:46 AM
To: cpurdy@northstar.k12.ak.us
Subject: RE: Health_Care

Thank you for writing to Alaska Governor Sarah Palin. The concerns, opinions, and/or information you have sent are important and valuable to the Governor. Although she is unable to respond to each and every email herself, your message has been received and is being reviewed by the appropriate staff person in this office who can best address your need, suggestion, or comment.

-----Original Message-----
From: WebMail@gov.state.ak.us [mailto:WebMail@gov.state.ak.us]
Sent: Tuesday, January 29, 2008 2:37 PM
To: Governor Sarah Palin (GOV sponsored)
Subject: Health_Care

Web mail from: Ms. Carolyn Purdy
address: P.O. Box 16255 Two Rivers AK 99716

MESSAGE:
Thank for trying to get rid of the certificate of need!

I read the notes from the commission. Most of the people involved seemed to be those who would lose money if they lose their stranglehold on the system. I've been a nurse in Alaska since 1971. I have seen the "good old boy club" with the hospital in Fairbanks chase away lots of medical providers. Then they put the same service in place with what appears to me to inferior service. Since they won't allow the competition we will never know for sure. There is a cancer center in Seattle donated by a Fairbanks man because he couldn't put it here or get the treatment he needed. The new Providence cancer center was rumored to be here. The imaging center that accepted 300 lb people is gone and now those people have to go to somewhere else. There was a cardiac clinic, and eye clinic that I know of that have gone elsewhere.

Why does Kelly (part of the hospital) have a say so on this bill? Its a conflict of interest for him.

I tried to contact LIO and website comes back to error message so thought I would try sending this through you.

cpurdy@northstar.k12.ak.us

Supports Repeal

Office of the Governor
PO Box 110001
Juneau, AK 99811-0001
3rd Floor Capitol Building
(907-465-3500)

PUBLIC OPINION MESSAGE

Date: 2/14/2008

From: Ms. Tess N. Bonney
1824 Kennedy Street
Fairbanks, AK 99709
907.590.9976

To: Governor Palin

Subject: Please repeal certificate of need.

Operator: Donna Collins

cc:

Supports Repeal CON

Office of the Governor
PO Box 110001
Juneau, AK 99811-0001
3rd Floor Capitol Building
(907-465-3500)

PUBLIC OPINION MESSAGE

Date: 12-12-07

From: Ruth Vzey 451-3299

To: Governor Palin

Subject: Certificate of Need and Fluride in water

Message: Against the Certificate of Need, also pls take the Fluride out

Operator: sb

Supports Repeal

Governor Palin
House Bill - 337
Senate Bill - 245
Fax: 907-465-3532

Date: 2/14/08

RE: Elimination of the Certificate of Need (CON)

Yes, I support your initiative to eliminate the Certificated of Need (CON) in Alaska.

As a concerned citizen of Alaska I have the right to the best health care I can receive.

I have the right to know my treatment options, including alternative treatment and to obtain a second opinion.

I have the right to know the quality and cost of my doctor, hospital, medical devices, drugs or procedures before I make the decision for treatment.

I have the right to be part of the lowest-cost, highest quality care I can receive.

I feel I have lost these rights due to the restriction of trade the Certificate of Need has imposed on the health care in Alaska.

I support your initiative to eliminate the Certificate of Need (CON) in our state of Alaska.

Print Name: Carol Nordin
Signature: Carol Nordin
Address: 1243 Grenac Rd Fairbanks, AK 99709
Telephone: 907 479-3476

Fax Received
FEB 14 2008
Office of the Governor

repeal CON

NRN
Con File

2196
AK

Fax Received
MAR 14 2007

Jayne Hempstead DVM
P.O. Box 175
Cantwell, AK 99729
907-768-2228
March 14, 2007

Dear Senator Charlie Huggins, Representative Bob Lynn and Governor Sarah Palin;

This letter is regarding the Certificate of Need mandate and the closure of Alaska Open Imaging Center in Fairbanks. Last year I was referred to Alaska Open Imaging Center in Fairbanks for an MRI. The service was excellent and because I live 150 miles out of town, they were able to perform the procedure the same day I was referred by my physician. I would consider it a huge loss should Alaska Open Imaging Center be forced to permanently close their doors. Even though the CON mandate seemed like a good idea at the time in 1974, it certainly is forcing out any competition. When we inquired about a surgical procedure at Fairbanks Memorial Hospital, we were treated, frankly rather rudely and decided to drive to Anchorage for the procedure. The decision was made not only because of the "curt" interactions over the phone but it was also less expensive in Anchorage. My husband and I would like to support the Fairbanks community but if Fairbanks Memorial Hospital is the only provider of surgical and imaging services we will be forced to take our business to Anchorage.

We need new legislation to eliminate CON in Alaska. Thank you for your attention to this matter.

Jayne Hempstead

OFFICE OF
HA
JUN 7

950 Windflower Lane
Fairbanks, Alaska 99712
June 8, 2007

NIR

Sarah H. Palin, Governor
State of Alaska
P. O. Box 110001
Juneau, Alaska 99811

3505
AK

SUBJECT: Certificate of Need (CON) Controversy

Dear Governor Palin,

First off, please accept my apologies for the weather Fairbanks provided for your recent picnic. It was unfortunate for you and your husband to host those of us who had the desire to share with you and provide our appreciation for your courage and strong State support. Thank You.

I am writing with a specific request. The populace of interior Alaska would benefit if you would appoint a member of your staff to look into the CON events of the last eighteen (18) months. During this period, members of the Department of Health and Social Services, the Judicial Department, members of the Legislature and local Fairbanks entities have been intimately involved. I have no personal fiscal interest or benefit in any outcomes surrounding the present controversy. However, I am a 32-year Alaska resident, a PERS and TRS retiree, have a family background of providing enhanced medical service, and truly believe in the right of free enterprise.

Fairbanks Memorial Hospital (FMH), now an affiliate of Banner Health Systems, has long been a fiscal and political entity preventing individual physicians from developing outpatient surgical facilities in the Fairbanks area. Alaska State Representative Kelly, a member of the FMH Board of Directors, has, I believe unethically, written a most demeaning letter to many Fairbanks residents criticizing those physicians who might wish to build private facilities. The CON issue is not isolated to the present, but has been a problem for as long as I can recall. Currently there is CON legislation bottled in committee as the chairperson will not bring it up for discussion, for reasons I believe are politically motivated. Regardless of my personal beliefs, the concept needs discussion, honest review, and resolution in a manner which is determined only with the people needing service in mind.

I am aware there are many broader concerns on your desk, many which directly relate to all the people of Alaska. However, the CON issue has been with us for many years and requires resolution based on facts and not on biased information.

Respectfully,

Boy N. Collier, PhD

repeal CON

Savland, Monica L (GOV)

From: Governor Sarah Palin (GOV sponsored)
Sent: Tuesday, August 07, 2007 2:06 PM
To: eval@mosquitonet.com
Subject: RE: Legal_and_lawsuits

Thank you for writing to Alaska Governor Sarah Palin. The concerns, opinions, and/or information you have sent are important and valuable to the Governor. Although she is unable to respond to each and every email herself, your message has been received and is being reviewed by the appropriate staff person in this office who can best address your need, suggestion, or comment.

-----Original Message-----
From: WebMail@gov.state.ak.us [mailto:WebMail@gov.state.ak.us]
Sent: Tuesday, August 07, 2007 12:29 PM
To: Governor Sarah Palin (GOV sponsored)
Subject: Legal_and_lawsuits

Web mail from: Ms. Eva Anderson
address: P.O. Box 60014 Fairbanks AK 99706
907-479-6428

MESSAGE:
this is a copy of letter sent to Kurt West, Office of the Commissioner, regarding the review of the CON laws.rnrncc: Governor Sarah Palin;rnrnDear Mr. West,rnrnWe greatly urge you to consider the needs of the people of Fairbanks as your committee reviews and hopefully listens to our wishes concerning the repeal of the CON laws.rnrnOur family (40+ members) has been in Fairbanks since 1941 aand on many occasions have found it necessary to travel to the lower 48 or to Anchorage for our medical needs with no other available choice.rnrnAs you are aware Fairbanks has one hospital and no outpatient surgical facilities, while Anchorage has three hospitals and five outpatient surgical facilities.rnrnOnce again we urge you to consider the needs of the people and to repeal the CON laws and allow a free market system in Fairbanks and all of Alaska.rnrnSincerely,rnrnTury G. and Eva L. Anderson

eval@mosquitonet.com

Supports File N/R

Savland, Monica L (GOV)

From: Governor Sarah Palin (GOV sponsored)
Sent: Wednesday, January 16, 2008 8:13 AM
To: ersausdahl@hotmail.com
Subject: RE: Health_Care

Thank you for writing to Alaska Governor Sarah Palin. The concerns, opinions, and/or information you have sent are important and valuable to the Governor. Although she is unable to respond to each and every email herself, your message has been received and is being reviewed by the appropriate staff person in this office who can best address your need, suggestion, or comment.

-----Original Message-----
From: WebMail@gov.state.ak.us [mailto:WebMail@gov.state.ak.us]
Sent: Tuesday, January 15, 2008 9:53 PM
To: Governor Sarah Palin (GOV sponsored)
Subject: Health_Care

Web mail from: Ms. Elizabeth Stinson
address: 14830 Goldenview Drive Anchorage AK 99516
907 227 5919

MESSAGE:
Dear Governor Palin,

I want to thank you for your stand on the CON issue. Your State of the State of address was wonderful with a theme of taking Alaska back for Alaskans. Repeal of the CON law will be a major step in that regard. We need to expand health care options, reduce costs, and attract new quality physcians to the state. Repeal of the CON will go along way towards making that happen. Your care and concern for the state was evident throughout the whole speech. I like the way you inspired all of us toward unity and common goals. It left me feeling excited, full of hope for the future of our great state, and proud to be an Alaskan.

Sincerely,
Elizabeth Stinson

ersausdahl@hotmail.com

Supports File N/R

Savland, Monica L (GOV)

From: Governor Sarah Palin (GOV sponsored)
Sent: Wednesday, January 16, 2008 8:20 AM
To: alaskatrail@mtaonline.net
Subject: RE: Health_Care

Thank you for writing to Alaska Governor Sarah Palin. The concerns, opinions, and/or information you have sent are important and valuable to the Governor. Although she is unable to respond to each and every email herself, your message has been received and is being reviewed by the appropriate staff person in this office who can best address your need, suggestion, or comment.

-----Original Message-----
From: WebMail@gov.state.ak.us [mailto:WebMail@gov.state.ak.us]
Sent: Tuesday, January 15, 2008 6:49 PM
To: Governor Sarah Palin (GOV sponsored)
Subject: Health_Care

Web mail from: Cheryl Ward
address: PO Box 13 Willow AK 99688

MESSAGE:
/EEEES ! Delete the monopoly of the corrupt certificate of need for healthcare providers to open up competition to BRING DOWN COST ! I have worked in the health care field for almost 40 years and do not have any health insurance due to unavailable thru my employer. Try SHOPPING for private pay healthcare ! Nobody does it, but it will open your eyes to UNBELIEVABLE STICKER SHOCK when pricing proceedures when paying out of pocket!!! PLEASE help ! ! Open up competition! Eliminate bribes & lobbying by Mega Healthcare owners who DO on our Alaska hospitals and healthcare!!! Thank you!

alaskatrail@mtaonline.net

File
CON

Savland, Monica L (GOV)

From: Governor Sarah Palin (GOV sponsored)
Sent: Wednesday, January 16, 2008 1:46 PM
To: Savland, Monica L (GOV)
Subject: FW: State of the State Address
Attachments: CON PUBLIC INFORMATION.doc; Health Care in Alaska.doc

From: Dr. Stephen Sutley [mailto:ssutley@aksurgerycenter.com]
Sent: Wednesday, January 16, 2008 1:18 PM
To: Palin, Sarah H (GOV)
Cc: drsutley@aksurgerycenter.com
Subject: State of the State Address

Dear Governor Palin,

Thank you!!!

First, I would like to thank your for attending our open house at the Steese Medical Center.

Next I would like to compliment you on your "state of the state" address yesterday. The address was great and I appreciate your vision and leadership for Alaska.

I especially want to thank for your stand on the elimination of the CON. This, I believe, took real courage, leadership and vision for the future Alaska's medical care.

I will do what ever I can to get public support and comments of support to our legislators.

For your information I am enclosing two separate white papers we have been working on to educate the public and gain support for the elimination of the CON. We will be distributing these in our respective patient waiting areas.

Thanks again for your vision, courage, support and leadership.

Dr. Stephen H. Sutley

Certificate of Need (CON):

What is a Certificate of Need? **January 1, 2008**

- **The Certificate of Need (CON) concept was introduced by congress in 1974 under the National Health Act to control the cost of health care.**

Why was a Certificate of Need legislation originally passed?

- **The primary goal of CON was to control health care costs.**
- **Congress mandated that each state pass their CON laws.**

Why was the Certificate of Need repealed by the US Congress?

- **In 1986 Congress repealed the 1974 Health Care Act and its requirement for state CON laws because the CON process failed miserably to control the cost of health care.**
- **In essence, the CON protects the preexisting facilities from competition by restricting new facilities from the marketplace.**
- **In other words, the CON creates monopolies for large hospital organizations much like the Standard oil monopoly that the Supreme Court broke up in 1911.**

The majority of the States have repealed or modified the CON laws.

- **Fourteen states have repealed all their CON regulations, while most of the other states have significantly downsized theirs.**

What has the State of Alaska done with its CON regulations?

- **The state of Alaska has gone the opposite direction.**
- **Under the lobbying powers of the major hospitals (FMH / Banner Health, Providence), and self-serving politicians the CON laws have become more restrictive and controlling.**

Why was the Certificate of Need not repealed in Alaska?

- **Protection for the hospitals.**

Why do Banner Health / Fairbanks Memorial Hospital spend thousands of dollars in advertising?

- **To maintain their monopoly by keeping competition out.**
- **If indeed FMH was public oriented and as cost effective as they profess, they would not need to advertise.**

Results:

- **The free market system has been eliminated from the health care industry in Alaska.**

The Hospitals Flawed Argument:

The hospitals arguments for maintaining Certificate of Need (CON) and corresponding rebuttals:

Eliminating the Certificate of Need requirements would increase health care costs.

Rebuttal: Since the 1980's when states were set free from the federal requirements to have CON laws, numerous studies have examined the change in health care costs as states eliminated their laws. If CON laws were "working" as advertised, then one would expect to see a rise in health care costs in states where laws were eliminated. But in fact this is not the case.

One of the most widely referenced studies was written by Duke University Professors Christopher Conover and Frank Sloan and published in the *Journal of Health Politics, Policy, and Law: June 1998.*.

- They found that output restrictions which resulted from CON laws led to higher not lower costs and higher profits for existing providers (hospitals).
- The authors point out that CON laws resulted in higher costs per day and per admission in states with CON regulations, along with higher hospital profits.
- So, in states where CON laws remained, patients were charged more money, more often than in states that repealed the law.
- Simply put, the result of repealing CON regulations is lower health care costs for the people of that state.
- It's just as wrong-headed to think that limiting the supply of health care facilities can reduce health care costs, as it would be to think that oil prices could be brought down with further reductions in oil production.

In 1972, the United States Congress passed a law requiring all states to implement a Certificated of Need program in an attempt to control health care costs and prevent duplicating of services throughout the country. In 1986, the Congress repealed the CON requirements after it became clear this law was unsuccessful in controlling health care costs.

In June 2004, the Federal Trade Commission and the Department of Justice jointly released a study stating the CON program was not successful in containing healthcare spending or hospital costs and can actually increase prices by fostering anticompetitive barriers. Their recommendation was for the states with CON programs to reconsider whether these programs best serve their citizens' healthcare needs.

If Alaska's CON regulations are repealed, the hospitals will no longer be able to provide care to the indigent or poor.

Rebuttal: The argument here is that entry restrictions, and the higher prices and profits that go along with them, are necessary to induce providers to provide free indigent care.

- So let me get this straight…the cost of health care and the profits to hospitals are purposely kept high by granting monopoly privileges.
- It is then expected that these excess profits will be used to provide free health care to the indigent.
- So health care customers are forced to pay a premium created by CON laws and the proceeds from this premium are used to pay for indigent care.
- This directly contradicts any "cost-savings" argument made by supporters of CON.
- If patients are paying a higher price in order encourage indigent care, then CON regulations are driving prices up, not down.
- Additionally, the State's use of non-medical criteria in deciding whether to approve a Certificate of Need (like an applicant's record of providing charity care) is evidence that the process has become arcane and politicized.
- Finally, the "free" indigent care the hospitals are providing is actually being paid for by the government in the form of huge subsides granted to them for such care.
- If the care is paid for by the state, why are we really charging patients a premium?
- Not only is Fairbanks Memorial Hospital provided with government subsides for indigent care the doctors who actually provide the care for these indigent patients are not provided any subsides or compensation for their services.

Repealing the Certificate of Need laws in Alaska would lead to the development of Ambulatory Surgery Centers which are cited as a major cause of Hospital closures across the country.

Rebuttal: From 1987 – 1994, a period that saw more than a doubling of the number of Ambulatory Surgery Centers in this country, the number of Hospital closures declined. Numerous other factors however, have been cited for hospital closures including:

- Hospital mergers and acquisitions leading to large scale market consolidation during the 1990's
- Failure to adjust to managed care and large reductions in average length of stay
- The excess bed capacity of hospitals during the shift from inpatient to outpatient care.

State Commission on the Efficacy of the Certificate of Need Program and its Effect on Cost, Quality, and Access in Georgia; 08/08/2005

Free Market competition can't work as a means of cost-control in the health care industry.

Rebuttal: The idea that in the area of health care services free market competition can't work as a means of cost control is not grounded in either economic theory or empirical evidence. Competition is widely considered by economists as *the* most effective tool for driving down costs, something Alaska desperately needs. In areas where competition is allowed to flourish, the customer is well served with plenty of options and competitive pricing. Further, it is competition that provides the incentives to discover new technologies and new efficiencies for delivering those technologies to patients. Lastly, believing that CON laws and the bureaucrats that administer them can do a better job at containing costs than the competitive market process is not only wishful thinking, it's the economic equivalent to believing the earth is flat. Everyday experience shows that when the market is free to operate under minimal government oversight, the result is abundant, quality service and low price.

Repealing CON regulations would lead to duplication of facilities and services.

Rebuttal: Facility duplication is at the heart of competition. Indeed, the definition of a monopoly market is one where there is no duplication. And this is why customers in monopoly markets lose; they are denied the option of turning to others who are providing "duplicated" services when monopoly providers act like monopolists.

The Alaska State Legislature
W3.legis.state.ak.us/

This web site offers you the ability to locate and contact your legislator(s), track the progress of bills, access committee information and stay up-to-date on legislative activities.

We encourage you to contact your legislator(s) and support legislation to eliminate the Alaska Certificate of Need (CON) law.

Please share this information to friends, family and associates.

Health Care in Alaska

Patient Rights: **January 1, 2008**

- You have the right to know your treatment options, including alternative treatment and to obtain a second opinion.
- You have the right to know the quality and cost of your doctor, hospital, medical device, drug or procedure before you make a decision.
- You have the right to be part of the lowest-cost, highest quality care you can receive.
- **Did you know you are rapidly losing these rights?**

Information:

Alaska is the most restrictive and controlling state in the nation when it comes to health care. Such restriction and control is even more evident right here in Fairbanks. Fairbanks Memorial Hospital is the only hospital and is protected from competition by an archaic state regulation called the certificate of need (CON) law. With the recent purchase of Tanana Valley Clinic (TVC), the largest privately owned clinic in Fairbanks, Fairbanks Memorial Hospital will have a total monopoly on health care in Fairbanks.

City Comparison:	Population	Hospitals	Ambulatory Out Patient Surgery Centers
Fairbanks North Star Borough:	86,754	1	0
North Pole City	1,828	0	0
Anchorage Municipality:	278,700	3	5
Wasilla:	9,236	1	2

Fairbanks Memorial Community Hospital:
Hospital Foundation:

- Net worth 330 million includes real estate, holdings and investments.
- Tax exempt

Banner Health Corporation: (based in Arizona).

- Net worth: multibillion dollars
- Hospital Foundation contracted Banner Health to manage Fairbanks Memorial Hospital.
- Where does this money go?
    - Arizona, not Alaska

Health Care in Alaska

Mr. Van Allen, president of Timeline Recruiting, a physician recruitment firm based in Columbia, MO. states "Shortage of physicians is a real health care crisis." Printed on Sunday, January 13, 2008, Fairbanks Daily News-Miner, Opinion section. Mr. Allen states "The U.S. health care industry is already seriously understaffed, and the lack of physicians is felt most acutely in rural and poor urban areas where a dearth of money and state-of-the-art equipment serve as a disincentive for attracting new talent."

Mr. Allen states the real problem of the ailing health care system is physician supply and patient demand. This predicament facing American health care system will only be exacerbated with universal health care. Here in America, one only needs to look at the Veterans Administration for a glimpse of what the health care system might be like. The deplorable conditions at Walter Reed Army Medical Center made headlines in February 2007, in the Washington Post where Dana Priest and Anne Hull wrote of the deterioration of a facility that stands just five miles from the White House and Congress.

The imbalanced supply and demand in the universal health care industry in Canada has resulted in a robust semi-underground market for quality health care for the wealthy Canadians who are increasingly turning to "cash-and-carry" services with doctors who have removed themselves from the compulsory insurance system. This has resulted in poorer Canadians being left out in the cold. It is well documented that many Canadians wait an inordinate amount of time for their much needed medical and surgical care. Many Canadians end up coming to the United States for their treatment.

To compound the shortage of physicians in America is the fact that more and more doctors are leaving the profession because of increasing difficulty work environment, rising cost of liability insurance, the constant threat of being sued and increasing administrative burdens. **Alaska, specifically Fairbanks has another reason for the alarming rate of losing physicians. The reason being the state sponsored restriction of trade. This restriction of trade is the Certificate of Need (CON) law.**

With all of this in mind what are the odds that Alaska can recruit physicians in rural areas if we can not even retain the physician we have. With the current loss of physicians, the aging population of our physicians and the inability to recruit physicians Alaska (specifically, Fairbanks) is already in a health care crisis.

Health Care reform is one of the biggest political issues in America and will be a major issue in the upcoming 2008 elections. Over the last few decades we have seen many examples of political and corporate corruption throughout our nation and in Alaska. Many of our political and corporate leaders are disdainful of our national values and the interests of the people they claim to serve. These lofty political and corporate elites have abandoned American values and its people. These elitists have, unfortunately, been elevated to positions of tremendous social, economic and political powers. This elitist attitude and abuse of power along with the apathy and tolerance of the American citizens have allowed this assault on the welfare of our citizens and the future of this country.

The political elites talk of reforming our national health care system which, in many cases, is nothing more than socialized medicine controlled by the medical corporations and third-party payers (medical insurance). Government controlled universal health care is **not** the answer. What good is universal health care if there are not enough physicians to satisfy patient demands? These political elites seem to put no emphasizes on training more physicians or retaining the physicians already in practice. These politicians do not talk about preventive medicine, early detection, and wellness, individual responsibilities, nor do they address the biggest reasons for the our out of control health care costs: third-party payers (medical insurance) and the medical insurance system (malpractice insurance), or tort reform to protect good doctors from predatory lawsuits.

The Certificate of Need was the governments attempt to control the cost of health care. It failed, it had the opposite effect. The United States Congress repealed the CON requirements and encouraged the states to do the same. Some states saw the wisdom in removing the CON requirements others did not. Fourteen states have repealed all their CON regulations; most of the other states have significantly downsized their CON regulations. Alaska, however, was one of the only states that decided to maintain the entire CON requirements even though it was shown in multiple studies that it failed to control or reduce the cost of medical care.

The CON is nothing more than a restriction of trade, in other words a monopoly. This restriction of trade will ultimately dictate to you how, where and when you will receive health care. The certificate of need is but one example of the political and corporate elite's attitude in determining what is best for Alaska citizens.

What is a monopoly?
Monopoly: exclusive control or ownership, as of a commodity or service.
(Webster Dictionary)

The Unites States Government has a history of breaking up monopolies dating back to Theodore Roosevelt's administration when the Supreme Court recognized the anticompetitive activity of the Standard Oil business activity and broke this company monopoly up in 1911. Yet, even after the United States Congress repealed the CON requirements because of its failure to control health care costs; Alaskan politicians continue to support this big business monopoly and restriction of trade.

It is extremely important to understand that the health care system in America is second to none. Regardless of your political persuasion, government or multi-billion dollar corporations in control of our health care is not the answer. This as already been demonstrated with the Veterans Administration system, Walter Reed Army Center and the Certificate of Need program. Four hundred years of entrepreneurial, technology, and science-based free market capitalism in America has proven citizens get more choices, higher quality, and reduced prices.

Supports Repeal

Savland, Monica L (GOV)

From: Governor Sarah Palin (GOV sponsored)
Sent: Monday, August 27, 2007 9:55 AM
To: ckwenzel@ak.net
Subject: RE: Health_Care

Thank you for writing to Alaska Governor Sarah Palin. The concerns, opinions, and/or information you have sent are important and valuable to the Governor. Although she is unable to respond to each and every email herself, your message has been received and is being reviewed by the appropriate staff person in this office who can best address your need, suggestion, or comment.

-----Original Message-----
From: WebMail@gov.state.ak.us [mailto:WebMail@gov.state.ak.us]
Sent: Saturday, August 25, 2007 9:12 AM
To: Governor Sarah Palin (GOV sponsored)
Subject: Health_Care

Web mail from: Mr. Christopher Wenzel
address: 125 Wire St. #A Juneau AK 99801
(907)523-0424

MESSAGE:
Gov Palin, rnrnWant to start by letting you know you are doing a good job. rnI would like to touch on the subject of health care in this state and the rest of the country. rnrnFirst of all, I would like to see an end to the Certificates of Need. We all lose in the end due to the loss of competition. I understand that a small town with a small hospital cannot have another hospital come in to compete with the local folks but that is not going to happen anyway. A CON is not needed these days. Competition will not come in unless it is needed period. Case in point, in Fairbanks, we lost an MRI/CT because the hospital did not want competition. The people lost.... not the company. In Anchorage, a dialysis unit is needed due to a waiting list. No one other than the existing will come in there due to the CON. That part of health care needs competition badly due to large companies eating up smaller ones..... the largest being from Germany. rnrnNext, the nursing short!
age. The big health care companies, including our dialysis company, are starting to open schools in other countries to train nurses and then signing contracts with them to work in the US. What is going on here. Why aren't they doing that here. (Labor is cheaper there and the bet is that people won't raise a stink when their nurse can't speak English because they have the only dialysis unit in town.rnI have an idea. Let's make Alaska the nursing education magnet and oasis of the country. We can ask for money from healthcare in the lower 48 to train nurses and we will reap the benefits of the nurses coming up here to get their degrees. This includes the schools, staff, and students spending money throughout the state. Many will stay put upon graduation. This could be a private/public venture. (I'll help start it). Being a nurse I am appalled at our sending money overseas to train nurses. So many of my co-workers would like to go to nursing school but they are eit!
her full or they cannot afford it. "Alaska, Nursing Ed!
ucation Capital of the US". Why not. rnrnThanks for listening, rnrnChris Wenzel RNrnDialysis Nurse

ckwenzel@ak.net

Kim, Anna C (GOV)

From: Kim, Anna C (GOV)
Sent: Monday, August 27, 2007 3:17 PM
To: 'ckwenzel@ak.net'
Subject: Certificate of Need

Dear Mr. Wenzel,

Thank you for writing Governor Palin with your thoughts on the Certificate of Need (CON) issue. She has asked that I respond on her behalf.

The CON issue has many complicating factors, and at one point, I shared your view. However, many other factors contribute to policy surrounding the CON program and the administration is actively working on a solution. The solution will take the cooperation of the administration as well as the legislature and stakeholders.

In addition to the many experts and public comment on this subject, the Governor's Health Care Planning Strategies Council will be taking a look at this issue as well.

Thanks again for taking the time to write.

Anna

Anna Kim
Special Staff Assistant
Office of the Governor