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establishing limited service clinics that can provide more convenient and lower cost care and bring more consumers into contact with the larger health care system.<sup>7</sup>

Although new strategies for lowering costs and enhancing quality are emerging, competition is not as effective as possible in most health care markets, because the prerequisites for competitive markets are not fully satisfied. Of particular concern for today's purpose is the extent to which state regulations can create barriers to entry in health care markets, without conferring countervailing benefits in quality of care or cost containment.<sup>8</sup>

At the same time, the empirical evidence generally does not indicate that CON laws control health care costs.<sup>9</sup> Recent broad studies analyzing both national and state

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<sup>7</sup> See, e.g., FTC Staff Comment Before the Massachusetts Department of Public Health Concerning Proposed Regulation of Limited Service Clinics, 12 (Oct. 2007).

<sup>8</sup> In discussing competition concerns raised by CON requirements, the Commission does not mean to suggest that state CON regulations are the only regulatory impediments to competitive forces in health care markets. For example, in testimony before the House Committee on Energy and Commerce on May 12, 2005, Mark McClellan, then Administrator of CMS, reported that CMS, following its own study of specialty hospitals pursuant to congressional direction, would analyze and reform its payment rates "to help reduce the possibility that specialty hospitals may take advantage of imprecise payment rates in the inpatient hospital prospective payment system" and "to diminish the divergences in payment levels [for ambulatory surgical centers] that create artificial incentives for the creation of small orthopedic or surgical hospitals." *Testimony of Mark B. McClellan, M.D., Ph.D., Administrator, Centers for Medicare & Medicaid Services, Before the H. Comm. on Energy and Commerce Hearing, "Specialty Hospitals: Assessing Their Role in the Delivery of Quality Health Care,"* (May 12, 2005), available at <http://www.hhs.gov/asl/testify/t050512.html>; see also *Testimony of Mark B. McClellan, M.D., Ph.D., Administrator, Centers for Medicare & Medicaid Services, on Physician-Owned Specialty Hospitals Before the S. Finance Comm.* (May 17, 2006), available at <http://www.hhs.gov/asl/testify/t060517b.html>.

<sup>9</sup> IMPROVING HEALTH CARE, *supra* note 2, at C. 8, at pp. 1-6. Although the larger body of CON literature – including anecdotal reports and small, uncontrolled studies – presents somewhat mixed conclusions on cost savings, the conclusions of the FTC/DOJ Report and staff research have substantially been borne out by more recent, sophisticated large-scale data analyses and literature reviews: "[O]n balance, the most methodologically sound studies have found that CON has no effect or actually increases both hospital spending per capita and total spending per capita." CHRISTOPHER J. CONOVER & FRANK A. SLOAN, EVALUATION OF CERTIFICATE OF NEED IN MICHIGAN, CENTER FOR HEALTH POLICY, LAW AND MANAGEMENT, TERRY SANFORD INSTITUTE OF PUBLIC POLICY, DUKE UNIVERSITY, A REPORT TO THE MICHIGAN DEPT. OF COMMUNITY HEALTH, 30 (May 2003) (reviewing literature and discussing national and Michigan-specific material regarding acute care [hospitals, MRI services, cardiac services] CON laws) (hereinafter "CONOVER & SLOAN, REPORT TO MICHIGAN"); WASHINGTON STATE JOINT LEGISLATIVE AUDIT AND REVIEW COMMITTEE (JLARC), EFFECTS OF CERTIFICATE OF NEED AND ITS POSSIBLE REPEAL, 1 (Jan. 8, 1999) ("The study found that CON has not controlled overall health care spending or hospital costs.

data reveal "little evidence that CON results in a reduction in costs and some evidence to suggest the opposite."<sup>10</sup> Studies also fail to show any consistent increase or surge in health care spending when states remove or modify their CON requirements.<sup>11</sup>

Barriers to entry can affect qualitative competition as well. As the Report noted, state CON laws can retard the entry of firms that could provide higher quality services than those offered by incumbents.<sup>12</sup> That may tend to depress consumer choice between qualitatively different treatment options or settings,<sup>13</sup> or it may reduce the pressure on incumbents to improve qualitative aspects of their own offerings.

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The study generally found either conflicting or limited evidence about the effects of CON on the cost of non-hospital services, and on the quality and availability of the various health care services.") DANIEL SHERMAN, FEDERAL TRADE COMMISSION, THE EFFECT OF STATE CERTIFICATE-OF-NEED LAWS ON HOSPITAL COSTS: AN ECONOMIC POLICY ANALYSIS, iv, 58-60 (1988) (concluding, after empirical study of CON programs' effects on hospital costs using 1983-84 data on 3,708 hospitals, that strong CON programs do not lead to lower costs but may actually increase costs); MONICA NOETHER, FEDERAL TRADE COMMISSION, COMPETITION AMONG HOSPITALS 82 (1987) (empirical study concluding that CON regulation led to higher prices and expenditures); KEITH B. ANDERSON & DAVID I. KASS, FEDERAL TRADE COMMISSION, CERTIFICATE OF NEED REGULATION OF ENTRY INTO HOME HEALTH CARE: A MULTI-PRODUCT COST FUNCTION ANALYSIS (1986) (economic study finding that CON regulation led to higher costs, and that CON regulation did little to further economies of scale). *But c.f.*, COMMONWEALTH OF VIRGINIA, REPORT OF THE JOINT COMMISSION ON HEALTH CARE, HOUSE DOC. NO. 82, STUDY OF VIRGINIA'S CERTIFICATE OF PUBLIC NEED (COPN) PROGRAM PURSUANT TO HB 1302 OF 1996 (1997), ("There is little evidence of significant COPN impact on aggregate health expenditures, but there is evidence of savings for specific services covered by COPN"). *Id.* at 1, available at [http://leg2.state.va.us/lls/h&sdocs.nsf/By+Year/HD821997/\\$file/HD82\\_1997.pdf?besi\\_scan\\_129F6A3CD B83467E=xLesgwML\\_73sPV18TFUnlHEOAAAD+O30W&besi\\_scan\\_filename=HD82\\_1997.pdf](http://leg2.state.va.us/lls/h&sdocs.nsf/By+Year/HD821997/$file/HD82_1997.pdf?besi_scan_129F6A3CD B83467E=xLesgwML_73sPV18TFUnlHEOAAAD+O30W&besi_scan_filename=HD82_1997.pdf) (last checked 1/31/08).

<sup>10</sup> CONOVER & SLOAN, REPORT TO MICHIGAN, *supra* note 9 at vii (discussing national and Michigan-specific material regarding acute care [hospitals, MRI services, cardiac services] CON laws); *id.* at 30-31.

<sup>11</sup> CONOVER AND SLOAN also report that, "[i]n most states that lifted CON, per capita spending on hospital and physician services (relative to the US) has remained below the U.S. average following removal of CON.") *Id.* at 50; see also Christopher J. Conover and Frank A. Sloan, *Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?*, 23 J. HEALTH POL'Y & LAW 455 (1998) ("no evidence of a surge in acquisition of facilities or in costs following removal of a CON.") 458.

<sup>12</sup> IMPROVING HEALTH CARE, *supra* note 2, at C. 8, p. 4 (citing Hosp. Corp. of Am., 106 F.T.C. 361, 495 (1985) (Opinion of the Commission) (stating that "CON laws pose a very substantial obstacle to both new entry and expansion of bed capacity in the Chattanooga market" and that "the very purpose of the CON laws is to restrict entry").

<sup>13</sup> With regard to hospital markets, see, e.g., HHS FINAL REPORT, *supra* note 6, at 10 (reporting "quality of care at least as good as, and in some cases better than, care provided at local competitor hospitals" for

**B. Incumbent Lobbying and Petitioning Protections:** When new firms threaten to enter a market, incumbent firms may seek to deter or prevent that new competition. Such conduct is by no means unique to health care markets; it is a typical reaction of incumbents to possible new competitors. In certain circumstances, such conduct may violate the antitrust laws.<sup>14</sup> Certain anticompetitive conduct may, however, be shielded from antitrust scrutiny. The *Noerr-Pennington* doctrine immunizes from antitrust liability conduct that represents petitioning the government, even when such petitioning is done “to restrain competition or gain advantage over competitors.”<sup>15</sup> Moreover, the state action doctrine shields from antitrust scrutiny many of a state’s own activities when a state government is acting in its sovereign, legislative capacity.<sup>16</sup>

In the context of health care competition, the combination of these two doctrines can offer antitrust immunity to providers that wish to lobby state officials to impede the entry of potential competitors, by denying or delaying the CONs required for operation. State CON programs generally prevent firms from entering certain areas of the health

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cardiac care, as well as “very high” patient satisfaction in cardiac hospitals and orthopedic specialty hospitals) (citations omitted). In addition, specialty hospitals appear to offer shorter lengths of stay, per procedure, than peer hospitals. See MEDICARE PAYMENT ADVISORY COMMISSION, REPORT TO THE CONGRESS: PHYSICIAN-OWNED SPECIALTY HOSPITALS, 15-17 (Mar. 2005) (hereinafter MEDPAC REPORT). MedPAC was directed to report to Congress on certain issues regarding specialty hospitals under the Medicare Prescription Drug, Improvement and Modernization Act of 2003. *Id.* at vii.

<sup>14</sup> See IMPROVING HEALTH CARE, *supra* note 2, at 15-16, ch. 1, at 31-33, ch. 3, at 22-27.

<sup>15</sup> *Andrx Pharm. v. Biovail*, 256 F.3d 799, 817 (D.C. Cir. 2001), *cert. denied*, 122 S. Ct. 1305 (2002). The doctrine is named for the seminal cases that treated it: *Eastern R.R. Presidents Conference v. Noerr*, 365 U.S. 127 (1961), and *United Mine Workers v. Pennington*, 381 U.S. 657 (1965).

<sup>16</sup> *Parker v. Brown*, 317 U.S. 341, 351 (1943). The state action doctrine also immunizes from antitrust scrutiny the actions of other entities and individuals if they are acting in furtherance of a clearly articulated state policy and are actively supervised by the state. See, e.g., *California Retail Liquor Dealers Assn. v. Midcal Aluminum*, 445 U.S. 97, 105 (1980).

care market unless they can demonstrate to state authorities an unmet need for their services. Because that demonstration can be time-consuming and costly, it may delay or, at the margin, prevent the introduction of certain needed facilities and services.<sup>17</sup> Indeed, limiting competitor entry and raising competitors' costs may both be incentives for incumbents to seek to abuse the regulatory process. The FTC/DOJ Report concluded that "incumbents can too easily use CON procedures to forestall competitors from entering an incumbent's market."<sup>18</sup> To the extent they are successful in doing so, incumbents may preserve their market shares and revenue streams without enhancing their own operating efficiency or providing health care savings to the state or its consumers.<sup>19</sup>

**C. The Scope of Alaska CON Law:** Alaska's current CON law is among the most stringent of such laws in the United States. Many CON programs trace their origin to a repealed federal mandate, the National Health Planning and Resources Development Act of 1974,<sup>20</sup> which offered states powerful incentives to enact laws implementing CON programs.<sup>21</sup> By 1980, all states except Louisiana had done so.<sup>22</sup>

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<sup>17</sup> See, e.g., IMPROVING HEALTH CARE, *supra* note 2, at C. 4, p. 25 (noting that approval of a CON "can take anywhere from 18 months to several years," and that regulatory delays from CON approval are in addition to those imposed by, for example, traditional licensing requirements).

<sup>18</sup> *Id.* at Exec. Summ., at 22.

<sup>19</sup> See, e.g., MEDPAC REPORT at 10-11 ("Some community hospital administrators admit that competition with specialty hospitals has had some positive effects on community hospitals' operations").

<sup>20</sup> Pub. L. 93-641, 88 Stat. 2225 (1975) (codified at 42 U.S.C. §§ 300k-300n-5), *repealed*, Pub. L. 99-660, § 701, 100 Stat. 3799 (1986).

<sup>21</sup> See JOHN MILES, 2 HEALTH CARE & ANTITRUST LAWS: PRINCIPLES & PRACTICE § 16:1, at 16-2 (2003) (noting that the federal Health Planning Act required providers to "obtain state approval – a 'certificate of need' – before spending set amounts on capital investments or adding new health care services.")

<sup>22</sup> See, e.g., *On Certificate of Need Regulation: Hearing on H.B. 332 Before the Senate Comm. On Health and Human Services* (Ohio 1989) (Statement of Mark D. Kindt, FTC Regional Director).

Congress repealed the federal law in 1986, however, and many states have repealed or revised their CON laws in the years since. Fourteen states have eliminated their CON requirements altogether<sup>23</sup> and although a substantial number of states continue to maintain CON programs,<sup>24</sup> they do so “often in a loosened form compared to their predecessors.”<sup>25</sup> Remaining CON laws may address only specific types of health care facilities – such as hospitals or nursing homes,<sup>26</sup> – exempt certain types of health care facilities,<sup>27</sup> or apply broadly to health care facilities improvements of a greater magnitude.<sup>28</sup> In addition, certain CON laws may be pending repeal according to a sunset provision.<sup>29</sup>

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<sup>23</sup> See, e.g., National Conference of State Legislatures, *Certificate of Need: State Health Laws and Programs* (updated Nov. 2007) (CON laws repealed or not in effect in CA, AZ, NM, TX, KS, CO, UT, WY, ID, SD, ND, MN, IN, and PA), available at <http://www.ncsl.org/programs/health/cert-need.htm> (last checked 01/25/08).

<sup>24</sup> MILES, *supra* note 21, § 16:2, at 16-9 (stating that “CON laws remain in many states and the District of Columbia”). Quite recently, Florida exempted from CON requirements new adult open-heart surgery and angioplasty programs at general hospitals and the addition of beds to existing hospital structures. Fla. Bill SJ 01740 (effective July 1, 2004), amending FLA STAT. ch. 408.036, .0361 (2003).

<sup>25</sup> MILES, *supra* note 21, § 16:1, at 16-2 to 16-3. See also Len M. Nichols et al., *Are Market Forces Strong Enough to Deliver Efficient Health Care Systems? Confidence is Waning*, 23 HEALTH AFFAIRS 1, 11 (Mar./Apr. 2004) (noting that CON programs “eroded through the 1990s”).

<sup>26</sup> See, e.g., OAC Ann. 3701-12-05 (2007) (regarding only certain activities by “long-term care” facilities in Ohio), R.R.S. Neb. § 71.5829.03 (2007) (CON covers only certain activities related to long-term care and rehab beds in Nebraska); ORS § 442.315(1) (2005) (regarding “any new hospital or new skilled nursing or intermediate care service or facility” in Oregon, subject to certain exclusions).

<sup>27</sup> For example, Connecticut law exempts critical access hospital beds and related equipment from the State’s CON laws. See Conn. Gen. Stat. § 19a-487a (2007); see also Fla. Stat. § 408.0361 (2007) (regarding cardiovascular services and burn unit licensing), Fla. Stat. § 408.036 (2007).

<sup>28</sup> For example, Connecticut health care facilities must obtain a CON prior to developing, expanding or closing certain services and expending more than \$3 million on a capital project. Conn. Gen. Stat. § 19a-638(a)(4) (2007); Delaware requires a CON for the establishment of a new facility, but only for capital expenditures by existing facilities in excess of \$5.8 million (or a higher amount based on inflation adjustments to the \$5.8 million baseline). See 16 Del. C. § 9304 (2007).

<sup>29</sup> See, e.g. 16 Del. C. § 9311 (2007) (sunset provision).

Alaska law requires a CON for any type of health care facility construction or improvement of \$1,000,000 or more, adjusted,<sup>30</sup> or the establishment of a nursing home facility independent of that cost threshold.<sup>31</sup> In so doing, it places significant regulatory burdens on the development or improvement of a very broad class of health care facilities – not just major hospital initiatives and expansions, which may be subject to long-term planning – but diverse outpatient clinic initiatives, which might otherwise develop dynamically in response to market needs. The scope of current Alaska law thus stands in contrast not only to the laws of those states that have eliminated their CON requirements altogether, but the laws of the many states that have more limited CON requirements. Alaska's low CON threshold itself may be a special burden to the State's health care spending, as low CON thresholds have been observed to increase costs – relative to higher thresholds – rather than decrease them.<sup>32</sup>

A degree of controversy may remain about particular issues addressed by certain CON laws. These include, for example, efficiency and possible conflicts of interest concerns about certain categories of physician-owned specialty hospitals and access issues for rural or other underserved areas.<sup>33</sup> However, the sweep of Alaska's CON law

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<sup>30</sup> Alaska Stat. § 18.07.031(a) (2007). The statute contains an adjustment provision, whereby the \$ 1 million dollar threshold may be increased by \$50,000 per annum, between 2005 and 2014. *Id.* at § 18.07.031(d).

<sup>31</sup> *Id.* at § 18.07.031(b).

<sup>32</sup> See SHERMAN, *supra* note 9, at 58-60 (1.4 percent decline in costs associated with doubling of all thresholds).

<sup>33</sup> See, e.g., Testimony of Mark B. McClellan, M.D., Ph.D. (2005), *supra* note 8; Testimony of Mark B. McClellan, M.D., Ph.D. (2006), *supra* note 8 (regarding CMS studies of physician-owned specialty hospitals, implementation and termination of limited moratorium on new specialty hospitals). The Commission does not here intend to analyze the details of ongoing regulatory reform at CMS designed to address special concerns about certain limited types of specialty hospitals (and related physician self-referral issues) or the various bodies of research on which those reforms are based. The FTC notes, simply,

is much broader than required to address any of those more narrow and complex issues and is likely to be detrimental to Alaska's health care consumers. The Commission recommends that Alaska carefully consider the evidentiary basis of these issues as they may relate to Alaska health care consumers. If the evidence and public policy considerations warrant some legislative action, the Commission recommends that Alaska consider regulation that is narrowly tailored to achieve focused health policy goals instead of broad regulation of entry into the market for health care facilities.

### III. Conclusion

CON laws were adopted throughout most states under particular market and regulatory conditions substantially different from those that predominate today and were intended to help contain health care spending. The best available research does not support the conclusion that CON laws actually reduce such expenditures. As the FTC and DOJ have said, "on balance, CON programs are not successful in containing health care costs, and ... they pose serious anticompetitive risks that usually outweigh their purported economic benefits."<sup>34</sup> CON laws tend to create barriers to entry for health care service providers who may contribute to qualitative competition and provide consumers with important choices in the market, but CON laws do not, on balance, tend to suppress health care costs or aggregate health care spending. Moreover, CON laws may be especially subject to abuse by incumbent providers, who can seek to exploit a state's CON process to forestall the entry of competitors in their markets.

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that most of the actual and potential health care entities subject to Alaska CON law are not such specialty hospitals and appear to fall outside the concerns driving those studies and reforms.

<sup>34</sup> IMPROVING HEALTH CARE, *supra* note 2, at Executive Summary, p. 22.

Alaska's current CON law – which House Bill 337 seeks to modify – is among the most stringent of such laws in the United States. As a consequence, Alaska CON law creates a barrier to entry for a very broad range of health care service providers, including small health care entities that may be ill-equipped to overcome it. The Commission believes that both the breadth of Alaska's CON law, and its low threshold, are of special concern, as they may work to the detriment of Alaska health care consumers. In the event that adequate evidence develops to support more narrow policy priorities, the Commission believes that Alaska should consider regulations narrowly tailored to meet those priorities, while minimizing the general costs to Alaska health care consumers.

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MAR 03 2008

ALASKA ORAL & FACIAL SURGERY CENTER  
Cosmetic Facial Surgery

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Member of American Society of Laser Medicine & Surgery*

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Representative Peggy Wilson  
House HESS Chair  
State Capitol, Room 108  
Juneau, AK 99801-1182

February 23, 2008

Re: Support House Bill 337 – Certificate of Need

Dear Madame Chair,

While listening to the hearing on HB 337 on February 23, 2008, you brought up a very interesting point with regard to physician shortage in Fairbanks. You stated there are other factors which may cause physician shortage other than the CON law; such as the cold weather, long dark hours and spouses unable to shop in larger shopping centers. I would like to add even one more deterrent for locating in Alaska, specifically, Fairbanks which may be a great distance from other family members.

You stated there was no proof the CON law was the cause of the physician shortage in Fairbanks. This may be a true statement. However, out of all these variables only the CON law is the variable that can be changed. So by changing this restrictive law, at least, we may have a chance to recruit physicians since there is really no substantial reason not to eliminate this law.

It is well documented; the CON law is ineffective in serving its original purpose. The change in government regulations eliminates the original justification for the CON law. There is equally important documented evidence the CON law stifles entrepreneurship, innovations, competition, free markets, eliminates consumer choices, protects incumbent hospitals by keeping prices and profits high, as well as, protecting their health care monopoly. The CON law also limits the ability to recruit physicians.

It is also well documented there is no empirical evidence the CON program has been effective in reducing hospital or health-care costs. Contrary to pro-con advocates there is no documented evidence that the elimination of the CON has caused hospital closures, nor any evidence of harm to incumbent hospitals.

Furthermore, the Medicare Payment Advisory Commission has determined that specialty hospitals do not undercut the financial stability of community hospitals. Neither will ambulatory surgery centers. This Advisory Commission stated the current CON law gives hospitals a monopoly. They also stated there is no evidence showing a community hospital being forced to close as a result of competition from an ambulatory surgery center.

Alaska citizens have the right to the lowest-cost, highest quality care they can receive along with ability to chose their provider and obtain second opinions. With the present CON law citizens have lost many of these rights. The CON law is an outdated and abusive restrictive law which serves no purpose except to provide restriction in a corrupt health care monopoly.

Since the CON law is the only variable that we have the capability of changing, I believe it would be appropriate to eliminate the CON law and, at least, give Alaska, and specifically Fairbanks a fighting chance to recruit quality physicians.

I would like to reference an article in the Fairbanks Daily New-Miner, dated January 13, 2008. "Shortage of Physicians is a Real Health Care Crisis"; by Mr. Van Allen, President of Timeline Recruiting, a physician recruiting firm based in Columbia, MO.

What the article stated was some of the major reasons for the shortage in physicians in the U.S. is that many physicians are leaving their practice due to an increasing difficult work environment, rising cost of liability insurance, the constant threat of being sued and increasing administrative burdens. Even though we do not have the capability to change all these variables we do have the opportunity to change the adversarial work environment in Alaska with the elimination of the CON law.

With the upcoming physician shortage this author has predicted. Does anyone realistically believe we can recruit and retain physicians in Alaska with all the adverse variables you mentioned along with the anti-competitive, health care monopoly which we presently have under the protection of the CON law? Under the present conditions we can't even retain the physicians we already have.

I am asking for your support in the elimination of the certificate of need law (CON) in the state of Alaska. Please support HB 337.

Sincerely,



Stephen H. Sutley DDS, MA

cc: Governor Palin  
Hess Committee HB 337

ALASKA ORAL & FACIAL SURGERY CENTER  
Cosmetic Facial Surgery



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Representative Bob Lynn  
State Capitol, Room 104  
Juneau, AK 99801-1182

February 20, 2008

Dear Rep Lynn:

**I am asking for your support in the elimination of the certificate of need law (CON) in the state of Alaska. Please support HB 337.** America and Alaska need to be on the forefront of medical health care with the ability to recruit quality physicians and not be stifled by an outdated CON law, government bureaucrats or multibillion dollar hospital institutions dictating our health care.

Health care in America is not perfect but is the envy of the entire world. Health care is a major issue in the 2008 national elections. It should also be a major issue in the state elections as well. The public needs to be aware where their elected officials stand on this important issue.

Health care has evolved and changed over the years through unimpeded entrepreneurship and innovative ideas. Without change there can be no improvement and growth. Unfortunately, everyone resists change to some degree. The reasons are many; they include fear of the unknown, tradition or personal loss. However, change will happen whether we like it or not. Government controlled national health care is neither the answer nor are bureaucrats in multibillion dollar hospital institutions.

As one considers making a change in anything, one should consider what it is going to cost and whether the change is needed for improvement and growth. It is important to measure the cost of change compared to the cost of the status quo.

**I believe our overall common goals include:**

- **Improve the quality of health care, and ensure patient access to medical care, quality and quantity physicians to provide options and second opinions, and to;**
- **Contain or reduce the costs of medical care for patients and the state of Alaska, and;**
- **Ensure protection of patients rights that include:**
  - **The right to know their treatment options, including alternative treatment and the ability to obtain a second opinion.**
  - **The right to know the quality and cost of their doctor, hospital bills, drugs, devices and procedures before they make a decision.**
  - **The right to the lowest-cost, highest quality care they can receive.**

**The cost of the status quo health care system to the public and Alaska is overwhelming.** The present CON law provides protection for big business and multibillion dollar hospitals. It stifles entrepreneurship and innovative ideas and keeps price and profits high. Under the CON law patients have lost many of their rights to options, second opinions, and low cost quality health care. As long as Alaska maintains status quo under the present CON law, health care in Alaska will never progress and our residents will be the losers.

As I listened to the hearings on SB 245 and HB 337, by far, the majority of what I heard was testimony from short sighted special interest individuals and hospital employees protecting their turf. I found the hearings a bit disingenuous in that I did not hear much about serving the public or the betterment of society or the improvement of health care. Little time was provided to national professionals that have studied the effects of CON nationally and have published numerous articles on the adverse effects of the CON law. In fact, during the HB 337 hearing individuals were rudely cut short by the chairperson, myself included.

As you are aware the push for National Health Care is going to be a major issue in the 2008 elections. In my opinion, the CON law is just one facet of the problems with health care today and very importantly demonstrates what happens when government, politicians, (national and state) bureaucrats and lawyers get involved in the private sector. The real evidence is overwhelmingly clear for the necessity to eliminate the CON law in Alaska. CON law is:

- Anti-competitive, eliminates consumer choice and creates a hospital-based monopoly. It prevents access to healthcare that would otherwise be available.
- It is a source of corruption, by guaranteeing very high fees and profits to those who benefit from the CON law.
- It prevents physician recruitment, entrepreneurship and health care innovation in Alaska.

I would like to briefly address each of these issues.

There is a segment of our patient population that would benefit by being treated in an out patient ambulatory surgery center since their medical condition and treatment does not warrant hospitalization but extensive enough to be risky in a clinic setting. Safety is always a concern with patient care.

We don't have this capability in Fairbanks due to the CON law. When attempts were made to develop an ambulatory surgery center in Fairbanks, it was aggressively and successfully block by Fairbanks Memorial Hospital, resulting in costly delays with one appeal after another and, of course, multiple lawsuits. This pattern is also evident in other areas of the state with different hospitals.

Fairbanks Memorial Hospital with the aid of the CON law has successfully restricted and eliminated progress of health care in Fairbanks. This restriction has also limited physicians in providing patients with options and treatment.

The patients I referred to are either forced to be treated in the hospital, or have elected to seek treatment out of state, which is expensive and inconvenient for the patient and family support. Many patients can not afford either of these options and end up not receiving treatment, delaying treatment or end up being treated in our clinic or the ER on an urgent or emergency basis.

The CON law is not only focused on keeping out new forms of health care delivery, it even limits existing providers to serve their own communities. Unfortunately, because of the restrictions of the CON law, we have lost several physicians in Fairbanks. In reality, the hospitals, with the aid of the CON law, play a significant role in the shortage of physicians in Alaska.

Yet, Fairbanks Memorial Hospital continues to portray the community hospital image with their "People First" ad which they state is the definition of a community hospital. They go on to say that "a community hospital means that regardless of ability to pay you always have access to the finest health care available." This may be true but very deceiving.

What they don't reveal is if you are unable pay your bill in a timely manner you will be referred to NorthRim Bank to obtain a loan with interest to pay your account. If you are unable to pay this account the hospital will turn you over to collections. I have witnessed patients and our staff members who have been threatened and turned over to collections for not being able to pay their debt in a timely manner.

They also deceive the public stating their goal is to recruit physicians in Fairbanks. Not only has Fairbanks Memorial Hospital and the CON law made recruitment of physicians almost impossible they have caused physicians to close their practices and leave Fairbanks. It is well known that Fairbanks Memorial Hospital has denied hospital privileges to highly respected qualified board certified physicians. This selective restrictions has forced these particular physicians to transfer their patients to Anchorage for treatment where they have been granted hospital privileges.

**Yet, Fairbanks Memorial Hospital continues to recruit and hire physicians with large bonuses. Along with the purchase of TVC and employment of their physicians they continue to grow like a cancer consuming and controlling the private sector and the community health care. This trend is alarming and should alarm everyone. This trend has the earmarks of an out of control corrupt monopoly.**

**I would like to reference a few publications by experts who have made a study of CON law and its effects on society.**

**The first is titled "CON Hinders Health Care Innovations" by Michael Morrissey (Professor of Health Economics at UAB School of Public Health; (morrisey@uab.edu) and Michael Ciamarra (Vice President of Alabama Policy Institute; (michaelc@alabamapolicy.org)).**

**What the article stated, and I feel it is extremely important; is entrepreneurs and innovators are developing new ways to deliver health care which is more convenient, high in quality and less costly than currently available health services.**

**The level of scientific knowledge that will be discovered over the next 25 years will be four to seven times greater than the past 25 years, and we can expect dramatic breakthroughs and discoveries in health care which will stagger the imagination.**

**However, the article followed up with this comment. "Unfortunately, bureaucratic relics of the past often stand in the way of developing a 21<sup>st</sup> century, intelligent healthcare systems."**

**The article went on to say; "The regulatory agencies that provide protection from market competition and thereby offer the potential for substantial profits are tempting targets for unscrupulous politicians, bureaucrats and businesses."**

**As we all know, power can cause corruption and absolute power corrupts absolutely.**

- **As referenced in the article "Corruption Trials are Painful, but Necessary to Restore Government" by Sen. Gene Therriault. Who stated: "as difficult as this is, it is necessary to begin restoring confidence in the Legislature".**

- I concur and also believe our CON law and its beneficiaries need to be equally scrutinized and changes made to restore integrity in the health care system. This will also be painful, but necessary.
- We need to have honest hearings and honest discussions with professional input on the floors of the Senate and House to look at the special interests and the present health care monopoly in our health care system under the protection of the CON law.

This article went on to say the CON provides less choice and less innovation and the CON program has never controlled costs and has become a mechanism to limit competition in health care, making all of us worse off.

- This was not the original intent of the CON law.
- The CON process stops growth and new providers find themselves tied up with costly CON hearings with appeals.
- This unfortunately, is certainly what we have experienced here in Fairbanks Alaska.

The article also stated; consumers don't save money with the CON program. Currently, hospitals and other protected providers argue that CON keeps new providers from coming in and taking the profitable patients. They agree this is a possibility.

- We often hear the term "Cherry Picking" by those individuals defending the CON law.

However, the article then stated; the existing providers and hospitals are collecting fees which are higher than their costs and probably higher than the new entrants would charge. So, by their own admission, these providers and hospitals are charging higher fees.

The article then stated; "What is amazing, there is virtually no empirical evidence that the CON program has been effective in reducing hospital or health-care costs and some evidence that it increases costs".

**Another extremely important point the article brought out was; “The evidence also shows that the elimination of the CON law HAS NOT caused any harm to incumbent hospitals”.**

- **The fact is hospitals responded to the competition by delivering better care.**
- **The elimination of the CON actually improved the health care with higher quality and lower cost in the marketplace.**

**In summary, the article stated: “The CON should be tossed into the dump heap and that it is time for the Legislature to dismantle CON completely”.**

**Contrary to the scare tactics used by pro-con advocates and claims the elimination of the CON caused closures of hospitals in Oklahoma, which is a fabrication of the truth. It is well documented these referenced hospital closures were mergers with other hospitals and had absolutely nothing to do with the elimination of the CON. There is no documented evidence that the elimination of the CON has caused any hospital closures. In fact, as previously noted there is no evidence the elimination of the CON as even caused any harm to incumbent hospitals.**

**Furthermore, the Medicare Payment Advisory Commission has determined that specialty hospitals do not undercut the financial stability of community hospitals. Neither will ambulatory surgery centers. This Advisory Commission stated the current CON law gives hospitals a monopoly. They also stated there is no evidence showing a community hospital being forced to close as a result of competition from an ambulatory surgery center.**

**My personal thoughts are: (and I believe this is very important).**

- **If the hospitals need protection to stay functioning they are not providing customer service or adequately serving the community.**
- **If these hospitals are truly user friendly, serving the community, and providing quality health care they have absolutely nothing to worry about, and should welcome growth and innovation in our community and in health care.**

- **If, in fact, certain hospitals are not providing these services they need to change their way of doing business and refocus their priorities and customer service.**
- **My question is - when is it the state governments' responsibility to protect and bail out big business?**

**In reality, the public, your constitutes, are the ones that need your protection and support, not big business or special interests.**

**The next article I would like to reference is on the antitrust perspective. On February 23, 2007 Mark Botti, (Chief Litigation Section, US Department of Justice, Antitrust Division) spoke on "Competition in Healthcare and Certificates of Need" before a Joint Session of the Health and Human Services Committee of the State House of Representatives in the State of Georgia**

**This entire presentation by the U.S. Department of Justice may be reviewed on web site: <http://www.usdoj.gov/atr/public/comments/223754.htm>**

**A summarization of this presentation is as follows:**

**The Antitrust Division's goal is to ensure a competitive marketplace in which the consumer will have the benefit of high quality, cost effective health care and a wide range of choices. Their overall mission is to preserve and promote competition, rather than to preserve any particular marketplace.**

**The Antitrust Division's experience and expertise has shown that Certificate of Need laws pose a substantial threat to the proper performance of healthcare markets. Indeed, by their very nature, CON laws create barriers to entry and expansion and thus are a ban to free markets.**

**The CON laws undercut consumer choice, weaken markets' ability to contain healthcare costs, and stifles innovation.**

- **Here again we are readdressing patients' rights, entrepreneurship and innovation.**

- My question, has it not always been the hallmark of America to protect citizens' rights, encourage entrepreneurship, and free enterprise?

**The article stated “Competition drives innovation and ultimately leads to the delivery of better healthcare systems and technology. Government intervention can undermine the ability of markets to deliver these benefits”.**

**Furthermore, the article stated the fact that; “CON laws have been ineffective in serving its original purpose”;**

- **Essentially, government regulations have changed which eliminates the original justification and the need for CON law.**
- **The federal government no longer reimburses on a cost-plus basis and in 1986, Congress repealed the CON law.**
  - **This, in itself, is reason enough to eliminate the CON law in Alaska.**
  - **The only purpose the CON law now provides is protection; protection of existing hospitals and big business. This, of course, was not the original intent of the CON law.**

**The conclusion of this presentation was that vigorous competition among healthcare providers promotes the delivery of high-quality, cost effective healthcare. Competition results in lower prices and broader access to health care and health insurance.**

**I would also like to reference an article in the Fairbanks Daily New-Miner, dated January 13, 2008. “Shortage of Physicians is a Real Health Care Crisis” by Mr. Van Allen, President of Timeline Recruiting, a physician recruiting firm based in Columbia, MO.**

**What the article stated was one of the major reasons for the shortage in physicians is the fact that many physicians are leaving their practice due to an increasing difficult work environment, rising cost of liability insurance, the constant threat of being sued and increasing administrative burdens.**

- **With the upcoming physician shortage this author has predicted, does anyone realistically believe we can recruit and retain physicians in Alaska with the adversarial environment and health care monopoly we presently have under the protection of the CON law when we can't even retain the physicians we already have?**

### **Summary:**

**As previously stated, CON laws have been ineffective in serving their original purpose. Government regulations have changed which eliminates the original justification for the CON program.**

- **CON law stifles entrepreneurship, innovations, competition, free markets, protects incumbent hospitals, eliminates consumer choices, and keeps prices and profits high.**
  - **Protects the present Health Care Monopoly.**
- **Competition breeds excellence, the lack of competition breeds mediocrity. Competition fosters entrepreneurship and innovation; it allows a wide range of choices, improves the quality of health care, access to health care and lowers the costs of healthcare services.**
- **Change is not easy: But without change there can be no improvement and growth. We must control our own destiny, not government, bureaucrats or big business. If we do not make appropriate changes to take care of our residents it is obvious other institutions will make changes for us.**

**If you truly want to help provide Alaskans with quality health care, and I trust you do, a more positive and productive approach would be:**


- **The elimination of the CON which would improve the work environment, and open the door for entrepreneurs and innovative ideas to improve health care, and;**
- **Assist in controlling health insurance, malpractice insurance and tort reform which would be a great start.**

**I am asking you, our elected legislators, to do the right thing and represent the citizens of Alaska that elected you into office and not the special interests organizations and their lobbyists.**

- **Americans and Alaskans in particular are by nature an independent and intelligent people. In general they are unwilling to accept the insidious growth and influence of government and big business impacting and controlling their private lives, including health care and the private enterprise.**
- **Let's quit beating this dead horse, and wasting our time and money. The CON law is an outdated, and abusive restrictive law which serves no viable function except protectionism and restriction of trade in a corrupt health care system. Let us get rid of it now.**
- **Progress is impossible without change. However, some things should never change, this being the values and integrity and belief in people to do what is right. In other words, live and lead by the golden rule. We are all here to serve, to serve the public in our own ways and professions.**
- **We need to get away from this scarcity mentality and protectionism and have more of abundance mentality, and a positive futuristic approach with our health care. We need to focus on what we can do, not on what we can't do.**

**Governor Palin has shown the foresight, courage and leadership in her quest to eliminate the CON law in Alaska. I am asking for your support and assistance to eliminate the CON law in Alaska.**

Sincerely,

  
Stephen H. Sutley, DDS, MA

cc: **Governor Palin**  
**Senators and Representatives**

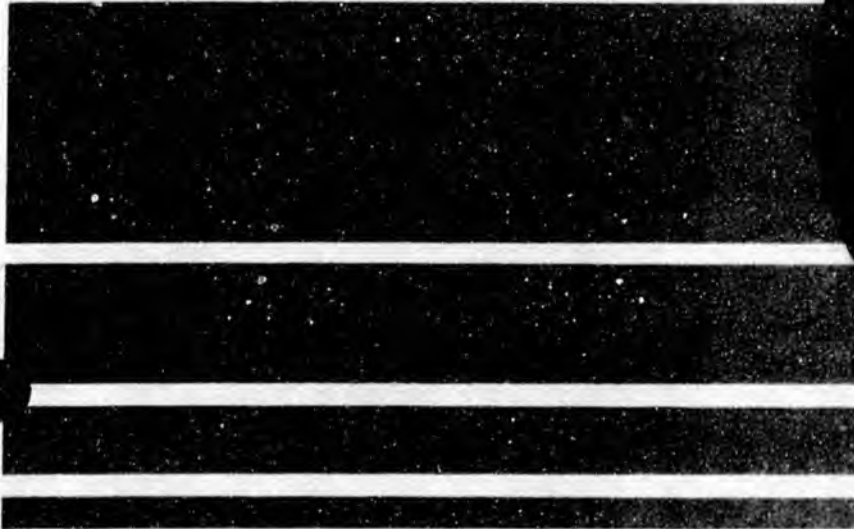


**ASHNHA**

Alaska State Hospital and  
Nursing Home Association

2008 ALASKA  
HOSPITAL  
COMMUNITY  
BENEFITS  
REPORT

ALASKA'S HOSPITALS  
CREATING  
HEALTHIER  
COMMUNITIES



# ALASKA'S HOSPITALS: IMPROVING HEALTH THROUGH COMMUNITY BENEFITS

## *About this Report*

The challenges to improving the health of Alaskans are as tall as our mountains and as unique as our topography, climates and communities. Each and every day, Alaska hospitals voluntarily offer programs and services in their communities that exceed traditional daily medical care. These programs and services — called Community Benefits — deliver health care assistance and solutions to specific populations with unique medical needs. The goal of Community Benefits is to improve the health of Alaska by improving the quality of life for Alaskans.

The Alaska State Hospital and Nursing Home Association (ASHNHA) is proud to present the *2008 Alaska Hospital Community Benefits Report*. While many people are familiar with hospitals' role as major employers, this is the first time ASHNHA has quantified and reported to Alaskans the Community Benefits provided by the state's acute care hospitals.

Community Benefits are programs and services that exceed the routine and emergency care provided around the clock daily by Alaska hospitals. Community Benefits are often provided free of charge or at substantially reduced fees. They are targeted programs and services that address the identified and often unique health care, social and welfare needs of the people who live in a particular community. These benefits provide measurable improvements in health status and access to health care for a community's residents. They also provide care to Alaskans regardless of ability to pay.

Sixteen Alaskan hospitals provided data to the *2008 Alaska Hospital Community Benefits Report*. Participating hospitals are Alaska Regional Hospital, Anchorage; Bartlett Regional Hospital, Juneau; Central Peninsula Hospital, Soldotna; Cordova Community Medical Center, Cordova; Fairbanks Memorial Hospital, Fairbanks; Ketchikan General Hospital, Ketchikan; Mat-Su Regional Medical Center, Palmer; North Star Behavioral Health, Anchorage; Petersburg Medical Center, Petersburg; Sitka Community Hospital, Sitka; South Peninsula Hospital, Homer; Wrangell Medical Center, Wrangell; Providence Alaska Medical Center, Anchorage; Providence Kodiak Island Medical Center, Kodiak; Providence Seward Medical & Care Center, Seward; and Providence Valdez Medical Center, Valdez.



## COMMUNITY BENEFITS: SAVING & CHANGING LIVES

### **Safe Kids Water Safety Program Saves Lives**

Dan Baeten credits his 14-year-old son for saving the lives of his family members after attending the Safe Kids Water Safety community benefit event in Soldotna. The young man's personal flotation device and his knowledge of how to handle a boating accident saved the family when their canoes overturned and were swept down river on a treacherous stretch of water.

### **WOW Ride Gives Back**

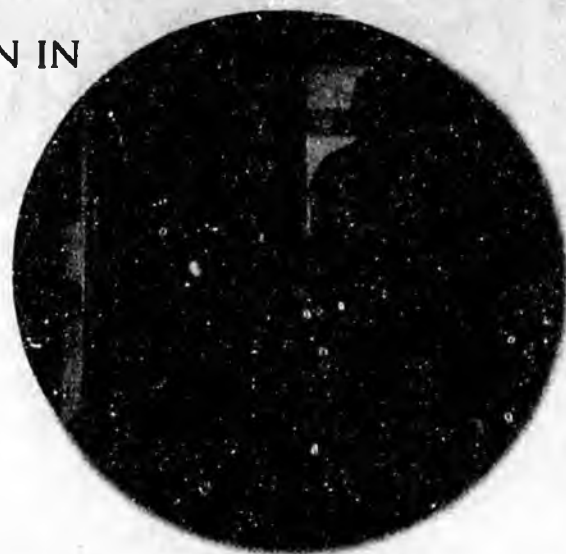
Oncology nurse Kathy Lopeman started a fun-filled winter snowmobile fundraiser. The event raised \$34,000 to distribute to community members as \$1,000 grants for those needing items not covered by insurance or assistance to travel for medical care.



# FINDINGS:

## ALASKA HOSPITALS PROVIDE \$151.6 MILLION IN COMMUNITY BENEFITS

Alaska hospitals provided \$151.6 million in Community Benefits to communities and citizens in 2006, the most recent year for which data are available. The hospitals also paid more than \$10.3 million in taxes and fees to state and local governments. The data come from surveys completed in January 2008 by 16 Alaska hospitals (see complete list on page 2 under "About this Report.") Community Benefits are programs and services offered by hospitals beyond required daily health care services. They target specific populations in a community with assistance and solutions to unique health care needs.



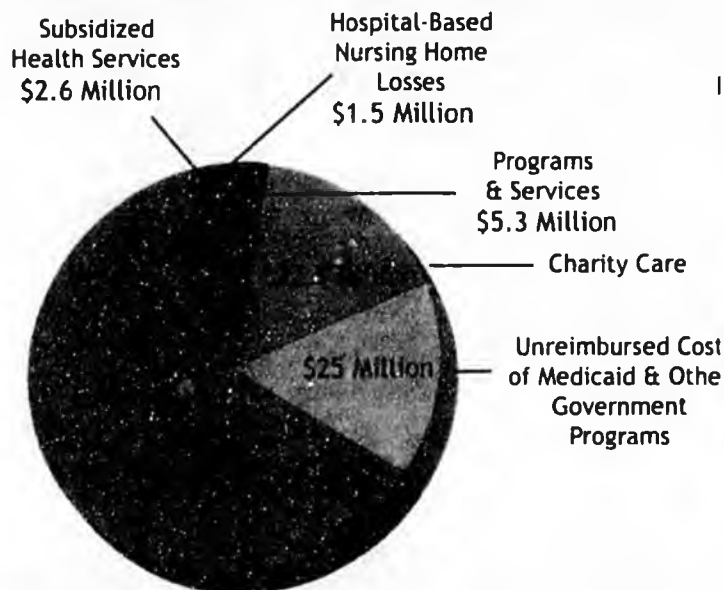
### ASHNHA Community Benefits Survey Report Summary

<i>Benefit Category</i>	<i>Participants Served</i>	<i>Loss/Cost</i>
<b>Community Health Improvement Services</b>		
Community Health Education	57,394	\$1,340,996
Support Groups	128	\$2,798
Self Help	242	\$1,900
Nonbilled/Reduced-Fee Clinics	7,016	\$142,434
Health Screening	989	\$49,494
Immunization	800	\$18,807
Counseling	424	\$76,755
Family Support Services	15	\$2,120
Free/Discounted Prescriptions/Supplies to Patients	473	\$75,512
In-Home Services	307	\$1,060
Meals/Nutrition Services	5,382	\$212,469
Transportation Services	628	\$38,314
All Other Health Care Support Services	75	\$500
<b>Community Health Improvement Services Total</b>	<b>73,873</b>	<b>\$1,963,159</b>
<b>Financial and In-Kind Contributions</b>	<b>15,730</b>	<b>\$1,214,786</b>
Health Professions Education Contribution	1,247	\$2,044,967
Health Research Contribution	0	0
Community Building Activities	16,046	\$79,375
Community Benefit Operations	0	\$3,700
<b>TOTAL PARTICIPANTS IN COMMUNITY BENEFITS PROGRAMS</b>		<b>106,896</b>
<b>Charity Care At Cost</b>		<b>\$22,967,322</b>
<b>Medicaid Underpayment</b>		<b>\$12,545,792</b>
<b>Losses on Other Public Programs</b> (Excludes Medicare and Medicaid)		<b>\$12,543,156</b>
<b>Bad Debt at Cost</b>		<b>\$37,198,890</b>
<b>Medicare Unreimbursed</b>		<b>\$56,830,190</b>
<b>Subsidized Health Services</b>		<b>\$2,664,408</b>
<b>Hospital-Based Nursing Home Losses</b>		<b>\$1,501,816</b>
<b>TOTAL COMMUNITY BENEFITS</b>		<b>\$151,557,561</b>

# COMMUNITY BENEFITS IMPROVE THE HEALTH OF THOUSANDS OF ALASKANS

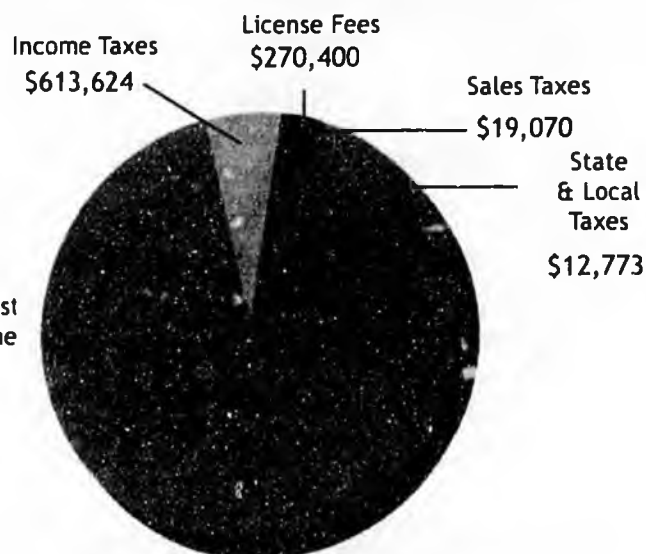
This report uses numbers to present the Community Benefits provided by Alaska hospitals. But Community Benefits are really about people. Community Benefits include care provided free of charge to Alaskans who are unable to pay. Programs and services can include prenatal care for expectant mothers and families, smoking cessation, preventing sports and other avoidable injuries, CPR and first aid classes, AIDS education and awareness, school-based health services, help for elderly citizens, work-site based health promotion, fitness and exercise seminars, blood pressure screenings, cholesterol testing, mental health and depression screenings, diabetes counseling, adult and child immunizations, blood drives, nutrition and weight loss management, substance abuse counseling, prescription drugs, transportation services, child car safety seat classes, and so much more. The goal of Community Benefits is to improve the health of Alaska by improving the quality of life for Alaskans.

## Alaska Hospitals Provide \$151.6 Million in Community Benefits



Total Value of Benefits Provided to Alaskan Communities: \$151.55 Million

## Alaska Hospitals Send \$10.3 Million in Taxes, Fees to State and Local Governments



Total Payments to State and Local Governments: \$10.31 Million



**ASHNHA**

Alaska State Hospital and Nursing Home Association

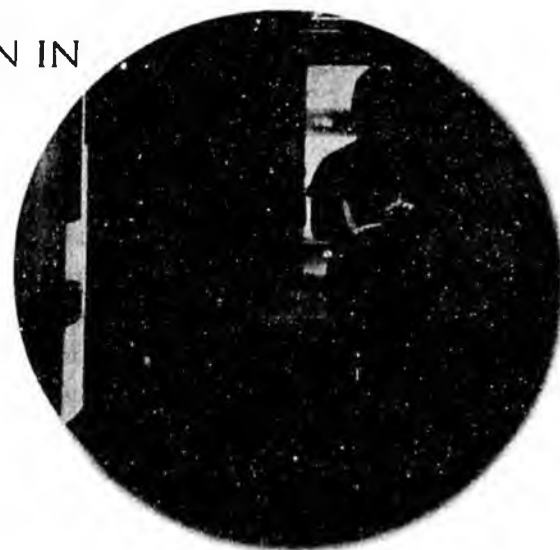
429 Main Street • Anchorage, ALASKA 99501

907-586-0790 • www.ashnha.org

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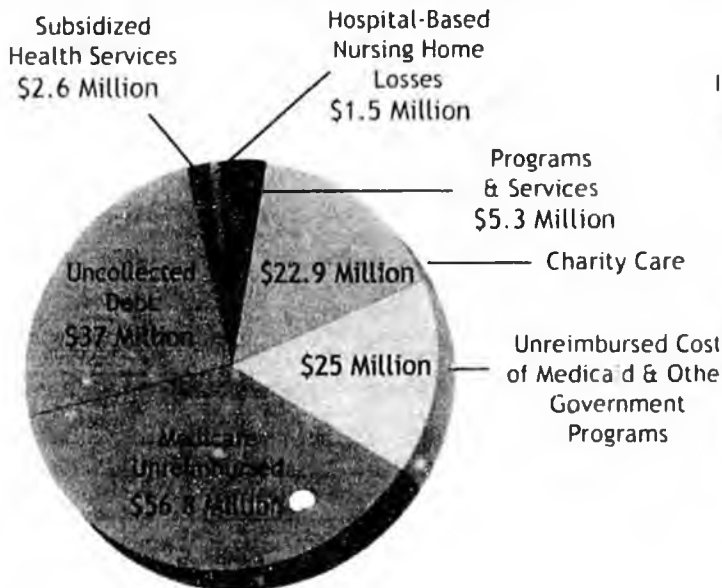
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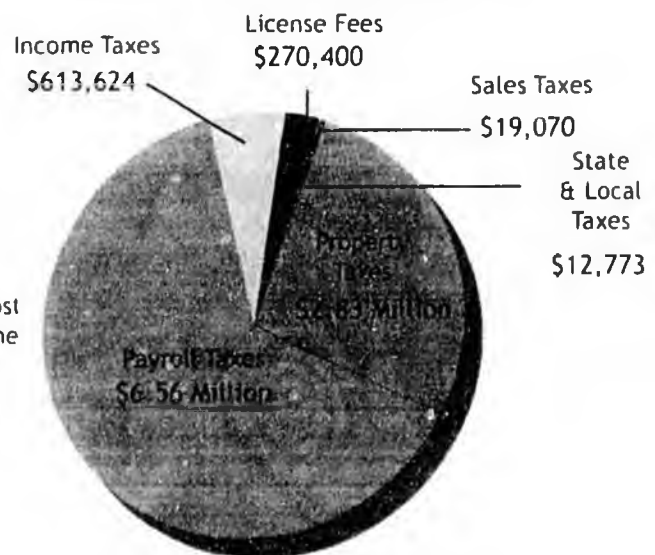
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## Alaska Hospitals Send \$10.3 Million in Taxes, Fees to State and Local Governments



Total Payments to State and Local Governments: \$10.31 Million

**HB**

**345**

# Alaska State Legislature

## Juneau

State Capitol Bldg., Rm. 513  
Juneau, AK 99801-1182  
Phone (907) 465-4976  
Fax (907) 465-3883  
Toll Free 866-465-4976



## Fairbanks

1292 Sadler Way, Ste 323  
Fairbanks, AK 99701  
Phone (907) 452-6084  
Fax (907) 452-6096

## Member

House Finance Committee  
Legislative Budget & Audit

## **Representative Mike Kelly**

*House District 7*

### Sponsor Statement – HB 345 (HES)

Since the passage of HB 511 four years ago Alaska's healthcare system has spawned a series of applications for new medical facilities and equipment. A rash of Administrative appeals and lawsuits regarding application of the rules of Alaska's Certificate of Need (CON) program has followed. The contentious and expensive litigation has been primarily caused by a lack of clear statutory definitions regarding medical facilities. Several of these lawsuits are still pending and their outcomes uncertain.

HB 345 offers a compromise for the hospitals that serve our communities and the physicians and others that desire to profit from owning and operating imaging equipment. The hospitals' concern is that doctors will open imaging centers that provide only the most profitable services, leaving the hospitals with everything else. It's easy to see what is motivating doctors to leave the system and set up shop separately. Our broken "big government" system forces doctors to take as little as fifty cents on the dollar for services to Medicare and Medicaid patients. Most doctors in Anchorage and Fairbanks are refusing to see new Medicare patients. Their solution – Leave the system and open up their own imaging center. Unfortunately, this leads the hospitals to provide all the red ink services that just don't pay. The HB 345 compromise attempts to protect the interests of hospitals while somewhat easing the restrictions in the CON process in larger communities for diagnostic imaging equipment.

HB 345 would exempt the purchase of imaging equipment from the Certificate of Need process as long as the equipment is used in a facility that meets three criteria:

- 1) The facility is located in a borough with a population of 60,000 or more
- 2) There is no critical access hospital supporting the community where the equipment will be used
- 3) The facility is at least 50% owned by one or more physicians who are licensed in the state and who actually interpret images in the facility

A facility would have to pass all three criteria for it to qualify for the CON exemption. The only communities that meet all three criteria are the Mat-Su region, Anchorage and Fairbanks. This bill protects smaller Alaskan communities, yet loosens restrictions on the market for imaging in larger communities that may be able to more easily handle an increase in competition.

# Alaska State Legislature

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Phone (907) 452-6084  
Fax (907) 452-6096

## Member

House Finance Committee  
Legislative Budget & Audit

Representative Mike Kelly  
House District 7

## MEMORANDUM

**DATE:** January 30, 2008  
**TO:** Representative Kelly  
**FROM:** Derek Miller  
**RE:** Sectional Analysis for HB 345 (HES)  
(Version No. 25-LS1402\E)

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The following sectional analysis of the bill should not be considered an authoritative interpretation of the bill. The bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

### Sectional analysis for HB 345 (HES) Version 25-LS1402\E

**Section 1.** Adds a cross-reference to an additional exemption added by section 3 of the act to the Certificate of Need process.

**Section 2.** Defines *critical access hospital* for purposes of section 3.

**Section 3.** Adds an exemption to allow a person to make an expenditure of \$1,000,000 or more for diagnostic imaging equipment without authorization under the terms of the Certificate of Need process if the equipment is used in a facility that is located in **1)** a borough with a population of 60,000 or more, **2)** a city that does not have a critical access hospital and **3)** is at least 50% owned by one or more licensed physicians who are qualified to and actually perform interpretations of the images produced at the facility.

**Section 4.** Provides applicability standards for health care facilities in existence or proposed after the effective date of the act.



426 Main St • Juneau, AK • 99801

Alaska State Hospital and Nursing Home Association

February 5, 2008

Representative Mike Kelly  
Alaska State Capitol  
Room 513  
Juneau, AK 99801

Dear Representative Kelly:

Thank you for introducing House Bill 345 which would amend Certificate of Need (CON) laws to clarify when new imaging equipment must go through CON review.

Your bill would do several things which ASHNHA's members support.

First, the bill would require that new imaging equipment which exceeds the specified dollar threshold must go through CON review if it is to be used in a borough of less than 60,000 population, or in a city with a Critical Access Hospital.

This would protect the most vulnerable of our small communities from overbuilding of expensive medical equipment. Given the vastness of our state and the different types of health care delivery we have, small hospitals in small communities must be protected. House Bill 345 does just that.

Second, the bill would establish criteria in boroughs of 60,000 population or more for determining whether or not new imaging equipment should be considered part of a physician's practice and therefore exempt from CON review. This clarification is vital to fill a definitional void in Alaska CON laws that have led to numerous administrative and judicial appeals of Department of Health decisions.

Alaska's CON laws are an important public health tool for matching expensive health care infrastructure to the needs of each community. HB 345 would improve existing CON laws by making needed clarifications rather than outright repealing CON laws as proposed in HB337 and SB245.

Sincerely,

A handwritten signature in cursive script that reads "Rod Betit".

Rod L. Betit  
President/CEO



central  
peninsula  
hospital

heritage  
place

February 8, 2008

Representative Mike Kelly  
Alaska State Capitol  
Room 513  
Juneau, Alaska 99801

Dear Representative Kelly:

I am writing to support your introduction of House Bill 345 and express my opposition to House Bill 337, specifically the repeal of the Certificate of Need program. Last September, I drafted a letter of support of the Certificate of Need program in preparation for the September 18, 2007 Joint Committee Hearing.

Since that time, I was invited by Commissioner Jackson to participate on the Certificate of Need negotiated regulation making committee convened under the authority of AS 44.62.710-44.62.800. I participated in working toward the goal of negotiated agreement on conceptual changes to regulations, statutes, and procedures to foster a cooperative regulatory environment that would further the Department of Health and Social Services to promote and protect the health and well-being of Alaskans.

Our Committee spent five days in Anchorage negotiating in good faith to reach a consensus on the issues identified by the Department related to the Certificate of Need Program. The Committee voted on 49 questions, most importantly, we voted 16-2 (90%) that the CON program not be fully eliminated.

On Saturday, January 19, 2008, I received an e-mail from Commissioner Jackson thanking me for my input to the process and announcing that SB 245 (HB 337) was introduced calling for the repeal of the CON program. In my mind, there was a vast disconnect between the efforts of the CON negotiated regulation making committee and these two bills.

Central Peninsula Hospital is a sole community provider that risks financial instability and irreparable harm to our community residents if the State does not insure that there is a need for more health care infrastructure before it is introduced to our community. Our community residents have voted to approve a \$49.9 million bond project for our Hospital expansion. Since 1974, community property taxpayers have contributed over \$43 million to our Hospital. They are vested in our future success. The repeal of CON threatens our hospital-community relationship.

As such, I would like to thank you for introducing House Bill 345 which would leave the program in tact and amend the laws to clarify when new imaging equipment must go through CON review.

Please contact me at 907-714-4718 if you have any questions.

Sincerely,

Ryan K. Smith  
Chief Executive Officer

CPH is a  
member of  
the Planetree  
Alliance.

Central Peninsula Hospital • 250 Hospital Place, Soldotna, AK 99669 • (907) 714-4404 • www.cpgh.org  
Heritage Place • 232 Rockwell Avenue, Soldotna, AK 99669 • (907) 262-2545 • fax (907) 260-4590

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**From:** Rush, Donald [mailto:Donald.Rush@providence.org]  
**Sent:** Thursday, February 07, 2008 2:14 PM  
**To:** Derek Miller  
**Subject:** HB 345

Dear Representative Kelly,

I am the administrator of a Critical Access Hospital on Kodiak Island and fully support HB 345.

Our small hospital relies heavily on our imaging revenue in order to fulfill our mission to the community of Kodiak. We provide care to everyone regardless of their ability to pay and this charity care continues to escalate as the population with no insurance or ability to pay continues to grow.

The imaging services we provide are vital to our overall financial well being. If imaging services were duplicated unnecessarily within our community, a risk we take without CON and HB 345, then our hospital becomes financially vulnerable, which ultimately will diminish the scope of services we provide to our community or worse, the quality of care will decline to our most isolated and vulnerable populations.

Small hospitals continue to operate precariously close to the margin, and your support and passage of HB 345 would certainly help in our continuing efforts to provide adequate and quality services to the many small communities of Alaska.

Please consider this HB 345 favorably.

Thank you.....

Don Rush, CEO  
Providence Kodiak Island Medical Center  
907-486-9596

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**From:** Branco, Patrick [mailto:P3branco@peacehealth.org]  
**Sent:** Thursday, February 07, 2008 3:02 PM  
**To:** Derek Miller  
**Cc:** Rod Betit  
**Subject:** support of HB 345

Dear Derek, please pass on to Representative Kelly my support for HB 345. Despite the fact that I am in a community that would be exempt, I still fully support the premise. In my opinion, eliminating the requirements for CON entirely would significantly compromise any hospital's ability to provide full service, comprehensive care to both paying and indigent populations. I also believe that even HB 345 may only buy a little time for The fallacious argument that the Governor and others seem to endorse that eliminating CON would increase competition and reduce expense to the consumer and payers is unsound. The fact that the current reimbursement structure only rewards surgery and imaging is a sad state of affairs and makes maintaining a positive bottom line challenging when coupled with huge amounts uncompensated care. Increasing competition in one small profitable area is akin to profiteering in time of war.

Thank you for the opportunity to express my opinion.

*Patrick J. Branco*

CEO  
Ketchikan General Hospital  
PeaceHealth  
3100 Tongass Avenue  
Ketchikan, AK 99901  
(907) 228-8300 ext. 7388

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## **Critical Access Hospital Statues and Regulations**

**FEDERAL:** Here is the federal definitions taken from 42 U.S.C. 1395i-4 (Medicare Rural Hospital Flexibility Program).

### **(c) Medicare rural hospital flexibility program described**

#### **(1) In general**

A State that has submitted an application in accordance with subsection (b) of this section, may establish a medicare rural hospital flexibility program that provides that—

(A) the State shall develop at least 1 rural health network (as defined in subsection (d) of this section) in the State; and

(B) at least 1 facility in the State shall be designated as a critical access hospital in accordance with paragraph (2).

#### **(2) State designation of facilities**

##### **(A) In general**

A State may designate 1 or more facilities as a critical access hospital in accordance with subparagraphs (B), (C), and (D).

##### **(B) Criteria for designation as critical access hospital**

A State may designate a facility as a critical access hospital if the facility—

(i) is a hospital that is located in a county (or equivalent unit of local government) in a rural area (as defined in section 1395ww (d)(2)(D) of this title) or is treated as being located in a rural area pursuant to section 1395ww (d)(8)(E) of this title, and that—

(I) is located more than a 35-mile drive (or, in the case of mountainous terrain or in areas with only secondary roads available, a 15-mile drive) from a hospital, or another facility described in this subsection; or

(II) is certified before January 1, 2006, by the State as being a necessary provider of health care services to residents in the area;

(ii) makes available 24-hour emergency care services that a State determines are necessary for ensuring access to emergency care services in each area served by a critical access hospital;

(iii) provides not more than 25 acute care inpatient beds (meeting such standards as the Secretary may establish) for providing inpatient care for a period that does not exceed, as determined on an annual, average basis, 96 hours per patient;

(iv) meets such staffing requirements as would apply under section 1395x (e) of this title to a hospital located in a rural area, except that—

(I) the facility need not meet hospital standards relating to the number of hours during a day, or days during a week, in which the facility must be open and fully staffed, except insofar as the facility is required to make available emergency care services as determined under clause (ii) and must have nursing services available on a 24-hour basis, but need not otherwise staff the facility except when an inpatient is present;

(II) the facility may provide any services otherwise required to be provided by a full-time, on site dietitian, pharmacist, laboratory technician, medical technologist, and radiological technologist on a part-time, off site basis under arrangements as defined in section 1395x (w)(1) of this title; and

(III) the inpatient care described in clause (iii) may be provided by a physician assistant, nurse practitioner, or clinical nurse specialist subject to the oversight of a physician who need not be present in the facility; and

(v) meets the requirements of section 1395x (aa)(2)(I) of this title.

#### **STATE REGULATIONS**

**(This is not all of the relevant regulations, just the two that specifically mention critical access hospitals)**

##### **7 AAC 12.104. Determination of critical access hospital**

(a) The department will consider a facility as a critical access hospital if the department finds that the facility

(1) provides inpatient short-term hospitalization for medical care of acute illness or injury;

(2) has no more than 25 inpatient beds;

(3) is located in a rural area of no more than 15,000 residents, based on the most recent calculations of the United States Bureau of Census; and

(4) meets the applicable requirements of 7 AAC 12.100 - 7 AAC 12.190 and 7 AAC 12.600 - 7 AAC 12.990.

(b) If a facility provides all of the services described in 7 AAC 12.105(a), the facility may elect to be licensed as either a general acute care hospital or a critical access hospital.

(c) If a facility qualifies both as a rural primary care hospital under 7 AAC 12.102 and as a critical access hospital under this section, the facility may elect to be licensed as either a rural primary care hospital or a critical access hospital.

**History: Eff. 9/1/2000, Register 155; am 6/23/2006, Register 178**

**Authority: AS 47.32.010**

AS 47.32.030

##### **AAC 12.190. Designation of critical access hospital under medicare**

(a) The department will designate a hospital that is licensed under this chapter as a critical access hospital under Medicare if the hospital meets the conditions of participation set out at 42 C.F.R. 485.601 - 42 C.F.R. 485.645, as amended through July 1, 1999 and adopted by reference, and the requirements of this section.

(b) To be eligible for designation as a critical access hospital under Medicare, a hospital must satisfy the criteria set out at 42 U.S.C. 1395i-4(c)(2)(B) and hold a license

under 7 AAC 12 as a hospital. An eligible hospital that wishes to be designated as a critical access hospital under Medicare must submit to the department

(1) an application on a form provided by the department;

(2) a description of the area served by the applicant;

(3) a community needs assessment analyzing the availability and utilization of health care services in the applicant's service area, including acute care, primary care, and emergency services, and a discussion of how operating as a critical access hospital under Medicare will better serve community needs;

(4) the applicant's plan for the delivery of health services within the applicant's service area;

(5) a financial feasibility study that analyzes the financial impact on the applicant of operating as a critical access hospital under Medicare, taking into account relevant operational factors, including changes in utilization, services, staffing, and Medicare reimbursement;

(6) a community education plan that describes the steps that have been or will be taken to educate and involve the residents of the service area in the decision to operate as a critical access hospital under Medicare;

(7) an emergency services plan that coordinates the provision of emergency medical services in the applicant's service area;

(8) a description of the volume capacity of the applicant and other related health care resources within the applicant's service area;

(9) the distance and travel time to other health care resources within the applicant's service area; and

(10) identification of barriers to accessing health care in the applicant's service area.

(c) Within 30 days after receipt of an application for designation as a critical access hospital under Medicare, the department will review the application for completeness. If the application is complete, the department will evaluate the application and designate the hospital as a critical access hospital under Medicare if the department determines that the applicant meets the requirements of this section.

(d) If the application submitted under (b) of this section is not complete or an applicant does not meet the requirements of this section, the department will

(1) return the application for additional information, as necessary; or

(2) decline to designate the applicant as a critical access hospital under Medicare.

(e) The department will, in its discretion, certify a hospital as a "necessary provider of health care services" for the purposes of 42 U.S.C. 1395i-4(c)(2)(B)(i)(II) if the hospital is less than a 35-mile drive from another hospital or, in the case of mountainous terrain or in areas with only secondary roads available, is less than a 15-mile drive from another hospital, and if the other hospital provides services only to a certain population group or subgroup and does not routinely provide services to all members of the community in which it is located.

(f) In this section, "critical access hospital under Medicare" means a critical access hospital under 42 U.S.C. 1395i-4 (Medicare Rural Hospital Flexibility Program).

**History: Eff. 9/1/2000, Register 155**

**Authority:** AS 18.05.030

AS 18.05.040

AS 18.20.010

AS 18.20.060

AS 47.05.010

AS 47.05.050

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

*Prepared by:*

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12/28/2007

## *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.

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? *8/27/11*
- Radiation therapy to be subject to CON? *11/27/11*
- Imaging services subject to CON? *11/23/11*

- 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 89.74% 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, 77.43% 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.

AUGUST 2006

REPORT TO THE CONGRESS

Physician-Owned  
Specialty Hospitals  
Revisited

**MEDPAC** Medicare  
Payment Advisory  
Commission

## Executive summary

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The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) required that MedPAC investigate several aspects of physician-owned specialty hospitals. We fulfilled this mandate with our March 2005 specialty hospital report. In that report we found that:

- Physician-owned specialty hospitals (specialty hospitals) did not have lower costs per severity-adjusted discharge than competitor community hospitals in their markets, although their patients had shorter lengths of stay.
- Specialty hospitals generally admitted less severe cases (which are expected to be more profitable) and concentrated on particular diagnosis-related groups (some of which were expected to be relatively more profitable than the average).
- Specialty hospitals tended to have lower shares of Medicaid patients than competitor community hospitals.
- Specialty hospitals drew patients from community hospitals, resulting in a small reduction in Medicare revenue growth. However, the financial impact on competitor community hospitals was limited because these hospitals took steps to compensate for lost revenue growth. Competitor community hospitals have had profit margins that are comparable to those of community hospitals located in markets without physician-owned specialty hospitals.
- From 1996 to 2002, cardiac surgeries per capita grew 4 percent faster in markets that gained a physician-owned heart hospital than in other markets. However, the 4 percentage point difference in growth rates was not statistically significant. The heart hospital markets also had a higher than expected rate of coronary artery bypass graft (CABG) surgery. The association between physician-owned cardiac hospitals and changes in the rate of CABG surgery per capita through 2002 was statistically significant.

However, the report also stressed that our findings could change as specialty hospitals evolve and capture a larger share of the market for hospital services. The 2005 report was based on the limited set of specialty hospitals that were operating for all of 2002. Our 2005 report and this report do not evaluate the quality of care in physician-owned specialty hospitals. Congress mandated that the Centers for Medicare & Medicaid Services (CMS) address that issue (CMS 2005).

After we presented the results from our March 2005 report, members of the congressional committees with jurisdiction over Medicare asked us to do some follow-up work when more data were available. The purpose of this paper is to update our analysis of physician-owned hospitals using two additional years of data (2003 and 2004) from an expanded set of specialty hospitals. We use the expanded data set to reexamine specialty hospitals' cost of inpatient care, Medicaid

share, impact on competitor community hospitals, and whether market entry of physician-owned heart hospitals is associated with an increase in cardiac surgeries.

In general, our findings are similar to our earlier work; however, the statistical significance of some findings has increased due to having a larger number of specialty hospitals to examine. Specifically we find:

- The number of physician-owned specialty hospitals roughly doubled from 2002 to 2004. Specialty hospitals continue to locate in areas that lack certificate-of-need laws and have above average population growth.
- The median heart hospital has 56 beds and a strong focus on Medicare inpatient services.
- The median orthopedic/surgical hospital has 14 beds, focuses on outpatient services, and receives a majority of its revenue from private payers.
- Both types of physician-owned hospitals tend to have lower shares of Medicaid patients than local competitors and nonlocal peer hospitals that specialize in cardiac or orthopedic care.
  - Medicaid patients represented 3 percent of discharges at the median physician-owned heart hospital and 2 percent at the median physician-owned orthopedic and surgical hospital. The median competitor community hospitals in those markets had a 13 percent Medicaid share. Competitor community hospitals may attract a larger share of Medicaid patients primarily because they offer a different set of services including obstetrics.
  - In an effort to control for service mix, we also compared physician-owned specialty hospitals to peer hospitals (hospitals with similar levels of specialization that are not physician owned). The median peer heart hospitals had a 7 percent Medicaid share, and the median peer orthopedic/surgical hospital had a 3 percent Medicaid share. The Government Accountability Office (GAO) found similar differences in their analysis of Medicaid shares.
- Specialty hospitals' inpatient services are not less costly than community hospitals' services, as might be expected from a "focused factory" hypothesis. But they do have some competitive advantages, such as shorter lengths of stay.
  - Heart hospitals have inpatient costs per discharge that are comparable to those of competitor community hospitals.
  - Orthopedic/surgical hospitals tend to have inpatient costs per discharge that are about 20 percent higher than those of competitor community hospitals. The difference in costs is statistically significant.

- Both groups of specialty hospitals have 20 percent to 25 percent shorter lengths of stay than competitor community hospitals, and the difference is statistically significant.
- However, the potential savings from shorter stays are not sufficient to offset the effects of other factors on orthopedic/surgical hospitals' costs.
  - Some of the higher costs per discharge at physician-owned orthopedic/surgical hospitals are due to low inpatient volume and higher unused capacity (medians of 14 beds and 28 percent occupancy).
  - Higher levels of depreciation and lease expenses per discharge may explain a small share of the higher costs at orthopedic/surgical hospitals.
- Physician-owned heart hospitals were associated with a statistically significant increase in the rate of cardiac surgeries in the market area.
  - For a typical market, we estimate that entrance of a physician-owned cardiac hospital was associated with a 6 percent increase in the number of cardiac surgeries per 1,000 Medicare beneficiaries (confidence interval 1 percent to 11 percent).
  - The typical heart hospital had 26 percent of the cardiac surgery market in 2004 and obtained most of its market share (roughly 20 of the 26 percentage points) by diverting patients from competitor community hospitals.
  - As was the case with our analysis of 2002 data, heart hospital markets had more CABG surgeries per 1,000 Medicare beneficiaries than would have been expected given the market's historical experience and national trends. Our model estimates that the entrance of a physician-owned hospital into a market is associated with a 9 percent increase in the number of CABG surgeries (confidence interval 1 percent to 18 percent) over the rate per 1,000 beneficiaries that would have been expected in the absence of the heart hospital.
  - We also categorized cardiac surgery patients into relatively high- and low-profit cases. Physician-owned hospitals did not have a significantly larger effect on the volume of relatively high-profit surgeries (low-severity patients) than they had on historically less profitable surgeries (high-severity patients) in the market.
  - Taken together these findings—an increase in overall surgeries, but no material shift in the ratio of high-severity to low-severity surgeries—are consistent with more than one hypothesis. One hypothesis is that physicians have a financial incentive to invest in cardiac hospitals, and these new specialty hospitals result in more surgical capacity and hence more surgeries per capita. Alternatively, individual physicians' clinical decision making is directly affected by financial incentives, but the change is a broad shift toward more surgeries rather than a precise shift toward the most profitable surgeries.

- While the specialty hospitals took profitable surgical patients from the competitor community hospitals (slowing Medicare revenue growth at some hospitals), most competitor community hospitals appeared to compensate for this lost revenue. From our site visits in 2004, we learned that in some cases competitor community hospitals cut expenses by cutting staff; in some cases they instituted “aggressive pricing strategies” to raise revenue from private payers; and in many cases they expanded profitable business lines such as imaging, rehabilitation, pain management, cardiology, and neurosurgery. These responses to the specialty hospital challenge coupled with population growth in many of the markets where specialty hospitals operate combined to allow competitor community hospitals to maintain profit margins that are in line with national averages.

As physician-owned entities capture more profitable service lines, the effect on community hospitals may increase. However, we found that community hospitals’ profit margins appeared stable through 2004, even in markets where physician-owned hospitals captured more than 10 percent of all admissions.

**HB**

**354**

# ALASKA STATE HOUSE OF REPRESENTATIVES

**Contact:**

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**Session**

(907)-465-3719  
FAX# (907)-465-3258  
**State Capitol**  
**Room 204**

## REPRESENTATIVE JOHN COGHILL

HB 354 OCS Revisions

### SPONSOR STATEMENT

This legislation was introduced at the request of Department of Law and the Office of Children's Services to address three issues of concern.

First the bill transfers to the department authority to adopt regulations to set the amount and length of time that a subsidy for a hard-to-place child may be granted. Currently that decision is made by the commissioner of HSS without clear guidelines to be consistent with eligibility. Also, with current statutory language the department could be determined to be required to give a subsidy for children from birth to three years old, even when the department determines there would not be a need for a subsidy.

Second, the bill clarifies that an employee can be charged with a misdemeanor for disclosing confidential or privileged information when that confidential information has been disclosed to them under AS 47.10.092(f), Disclosure to certain public officials and employees.

Third, Secs. 3 and 4 allow OCS could obtain child support orders for minors in state custody under CINA and delinquent minor statutes through administrative support orders by the Child Support Services Division.

The HESS Committee Substitute adds two provisions to the bill. First, it eliminates a contradiction in statutes dealing with the requirement of notification of parents when an eighteen-year-old wished to be adopted. Under current law, even if the biological had abandoned the 18-year-old eighteen years ago, the 18-year-old would have to attempt to locate the parent and give parental notice.

It also incorporates a provision from HIB 377 holding the state civilly liable for actions of employee's acting in an official capacity for the department that result in the injury or death of a child.

~~the amendments~~  
but the immunity  
has been

(b) Nothing in this section shall be construed to prohibit a civil action for common law negligence or an action under AS 29.55.580 on behalf of a child who is injured or dies while in the custody of the state.

Insert:

Delete all material

Page 4, lines 17 - 19

Amendment #1 to "c" Version

## James Feldman

---

**From:** Rep. Les Gara  
**Sent:** Wednesday, February 20, 2008 5:44 PM  
**To:** msimonian@friedmanrubinwhite.com  
**Cc:** James Feldman  
**Subject:** RE: Duty of care - Foster Care

-----Original Message-----

**From:** msimonian@friedmanrubinwhite.com [mailto:msimonian@friedmanrubinwhite.com]  
**Sent:** Wednesday, February 20, 2008 12:39 PM  
**To:** Rep. Les Gara  
**Subject:** Re: Duty of care - Foster Care

Hi Les. We could get the hearing transcribed. But, I'm not sure how you have a common law cause of action if AS 47 expressly precludes civil liability. A common law duty is derived from either statute, regulation, contract, undertaking, or the parties pre-existing special relationship. I suppose a plaintiff under the new statute could argue that the undertaking and pre-existing special relationship create a common law duty. But, that will be a tough argument in the face of the statutory language. The state will argue that the special relationship and undertaking are created by statute and those statutes preclude liability.

You should look at McGrew v. DFYS, as it illustrates the problem with arguing a duty in the face of statutory language precluding a duty. I've cut and pasted the relevant part of the decision below.

I don't think there is a supreme court decision that finds a common law duty in the face of statutory immunity, and that is essentially the position we are in now. The common law duty that was created by prior case law preceded these changes to the statutory language. As in McGrew, I think the court would find not common law duty with the sort of language that now exists.

In the McGrew decision, the supreme court stated that the bar relating to a standard and duty of care in the previous version of AS 47 meant that the statutes could not be relied upon to

In deciding whether a defendant owes a plaintiff a duty of reasonable care, we first determine whether a duty is imposed by statute, regulation, contract, undertaking, the parties' preexisting relationship, or existing case law.FN9 If these sources do not resolve the issue, we apply the multi-factor approach discussed in D.S.W. v. Fairbanks North Star Borough School DistrictFN10 to determine whether an actionable duty of care exists.FN11

FN9. In *Karen L. v. State, Department of Health & Social Services, Division of Family & Youth Services* we stated: "[T]ypical theoretical sources of actionable duties are statutes, regulations, certain contracts, express undertakings, or fiduciary relationships.... If one of those duty sources applied, it would not be necessary to consider the D.S.W. [v. Fairbanks North Star Borough School District] factors." 953 P.2d 871, 875 n. 9 (Alaska 1998) (internal citations omitted). See also *Wongittilin v. State*, 36 P.3d 678, 681 (Alaska 2001); *Waskey v. Municipality of Anchorage*, 909 P.2d 342, 343-44 (Alaska 1996) (finding it "unnecessary to resort to the D.S.W. approach" where we had decided other cases "more closely related" to the subject duty dispute); *Estate of Day v. Willis*, 897 P.2d 78, 81 n. 7 (Alaska 1995) (holding internal administrative and training manual did not impose duty of care toward fleeing suspects).

FN10. D.S.W. v. Fairbanks N. Star Borough Sch. Dist., 628 P.2d 554, 555 (Alaska 1981).

FN11. Wongittilin, 36 P.3d at 681. The D.S.W. factors include foreseeability of harm; degree of certainty plaintiff suffered injury; closeness of connection between defendant's conduct and injury; moral blame attached to defendant's conduct; policy of preventing future harm; extent of burden to defendant and availability; cost and prevalence of insurance for the risk involved. D.S.W., 628 P.2d at 555.

The McGrews argue that an actionable duty is imposed by AS 47.14.240, which specifies the responsibilities of the local review boards which review DFYS's placement decisions. It requires a review board to allow the child's relatives to participate. FN12 But another statute, AS 47.10.960, states that "[n]othing in this title creates a duty or standard of care for services to children and their families being served under AS 47.10." Lucy was a child being served under AS 47.10. Section .960 therefore precludes the McGrews from contending in a tort suit that AS 47.14.240 can be the basis of an actionable duty.

FN12. AS 47.14.240(d)(2).

The McGrews also assert that other statutes are sources of an actionable duty: \*323 AS 47.10.142(a), (e), and (h); FN13 AS 47.10.020(a); FN14 AS 47.10.080(1) and (1)(2)(B); FN15 and AS 47.05.060. FN16 Any claim based on these statutes is likewise barred by AS 47.10.960.

FN13. AS 47.10.142(a) allows the Department of Health and Social Services to take emergency custody of a child in certain circumstances. Subsection .142(e) provides that when a temporary custody hearing is held, a court shall then determine "whether probable cause exists for believing the child to be a child in need of aid." Subsection .142(h) provides that "[w]ithin 12 months after a child is committed to the department under this section, the court shall review the placement plan and actual placement of the child under AS 47.10.080(1)."

FN14. AS 47.10.020(a) provides in pertinent part:

Whenever circumstances subject a child to the jurisdiction of the court under AS 47.10.005-47.10.142, the court shall appoint a competent person or agency to make a preliminary inquiry and report for the information of the court to determine whether the best interests of the child require that further action be taken. If, under this subsection, the court appoints a person or agency to make a preliminary inquiry and to report to it, then, upon the receipt of the report, the court may ... (3) authorize the person or agency having knowledge of the facts of the case to file with the court a petition setting out the facts.

FN15. AS 47.10.080(1) provides in pertinent part:

Within 12 months after the date a child enters foster care as calculated under AS 47.10.088(f), the court shall hold a permanency hearing. The hearing and permanent plan developed in the hearing are governed by the following provisions ... (2) when establishing the permanent plan for the child, the court shall make appropriate written findings, including findings related to whether ... (B) the child should be placed for adoption or legal guardianship and whether a petition for termination of parental rights should be filed by the department....

FN16. AS 47.05.060 provides in pertinent part:

The purpose of this title as it relates to children is ... to preserve and strengthen the

child's family ties unless efforts to preserve and strengthen the ties are likely to result in physical or emotional damage to the child ... and ... to secure for the child adequate custody and care and adequate planning for permanent placement of the child.

In *Karen L. v. State, Department of Health & Social Services, Division of Family & Youth Services*, we considered whether a mother could assert tort claims arising from CINA proceedings addressing placement of a child in DFYS custody.FN17 The superior court there granted summary judgment to the state, DFYS, state social workers, and the child's guardians ad litem, dismissing all of the mother's claims, including her negligence claims. FN18 We held that the state and the social workers did not owe the mother an actionable duty of care.FN19 The mother therefore could not maintain negligence claims against the state or its agencies and employees.

FN17. *Karen L. v. State, Dep't of Health & Soc. Servs., Div. of Family & Youth Serv.*, 953 P.2d 871, 876 (Alaska 1998) (declining to impose duty of care on state and social workers because it was not reasonably foreseeable that their conduct would cause Karen L. ? actionable emotional harm?).

FN18. *Id.* at 873.

FN19. *Id.* at 876, 878.

We recognize here, as we did in *Karen L.*, that ?it is to be expected that any litigation, and certainly a CINA proceeding in which the child is taken from its [relatives] ... will cause the [relatives] some distress. That does not mean that the distress should be actionable.? FN20 *Karen L.* establishes that DFYS does not owe a parent an actionable duty of reasonable care in a CINA proceeding.FN21 *Karen L.* therefore precludes the grandparents' negligence claim in this case.

FN20. *Id.* at 876.

FN21. *Id.* at 878.

The McGrews attempt to distinguish *Karen L.* on the theory there was no claim in that case that the state had bad motives. They assert that DFYS here engaged in intentional deceit and ?affirmatively misled? them by making false statements about its placement plan for the child. That distinction is potentially pertinent only to the McGrews' claims alleging intentional misconduct. As to the McGrews' negligence claim, *Karen L.* controls.

The McGrews also argue that their case is distinguishable from *Karen L.* because DFYS failed to comply with the statutory requirements of AS 47.14.240, denying them their right to be ?meaningfully heard in a timely fashion.? They therefore argue that ?324 *Karen L.* does not apply to them because the court there held that there was no statute that imposed an actionable tort duty.

But as we saw above, AS 47.10.960 establishes that DFYS owes the McGrews no actionable duty arising out of any provision in Title 47. Therefore, *Karen L.* cannot be distinguished on a theory the McGrews were owed a statutory duty not addressed in *Karen L.*

Quoting "Rep. Les Gara" <Representative\_Les\_Gara@legis.state.ak.us>:

> Hi James and Meg - thanks for the briefing. It still doesn't provide  
> me what I'm looking for.  
>  
> The State brief is careful to say that AS 47 doesn't create a standard  
> or duty of care. I still need an express statement -either a  
> transcript from a hearing, or otherwise in writing, where the state  
> takes the express position that there is no common law negligence  
> liability by the state to foster kids. The brief doesn't expressly  
> state that there is no common law liability.  
>  
> Is there anything else you have in writing Meg? Or any transcript  
> position by the state?  
>  
> I think we can get an amendment adopted, but we have to show the  
> state's express position on the common law issue.  
>  
> Thanks. Les  
>  
>  
> Representative Les Gara  
>  
> Alaska State Legislature  
>  
> 716 W. 4th Avenue, Suite 310  
>  
> Anchorage, Alaska 99501  
>  
> Phone: 907-269-0106  
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> Fax: 907-269-0109  
>  
> www.akdemocrats.org  
>  
>

**HB**

**358**

# ALASKA STATE LEGISLATURE



REPRESENTATIVE LES GARA

## **HB 358: Increasing Opportunity for Alaska's Foster Children Sponsor Statement**

House Bill 358 (HB 358) is a multifaceted approach to improve the lives of children in the foster care. HB 358 assists children in the foster care system a few different ways.

First, it assists the education of children by ensuring in most cases they will be able stay in their original school, regardless of change of home placement. Many school districts already are doing this, but they do not receive any state general funds for it. In addition, it requires that the schools, in the event that a student must transfer, also transfer their records within ten days. A student's educational stability is a key determining factor in their success. A September 2007 report from the *National Working Group on Foster Care and Education* determined that each school change set a student back by four to six months.

Second, HB 358 gives the Commissioner of Health and Social Services the ability to increase the salaries of social workers if it is deemed necessary to attract and retain social workers who work with children in need of aid. This is a necessary step in providing support to those workers on the front line of preventing repeat child abuse, and caring for our most vulnerable population.

Finally, HB 358 requires the Department of Health and Social Services to re-adjust the foster family care reimbursement rates every year, based on the latest federal poverty guideline for Alaska. The fiscal year 2009 operating budget has an increase for this rate, but before this proposed increase, the rate had been changed one time in the last 16 years, and that was 9 years ago. The current rate is based on the 1993 federal poverty guideline. Alaska is facing critical shortages of qualified foster parents. Increasing the amount of money they are reimbursed for their services is just one way we can recruit and retain foster parents.

Please do not hesitate to contact me if you have any questions, concerns or require additional information.

# ALASKA STATE LEGISLATURE



REPRESENTATIVE LES GARA

## **HB 358: Increasing Opportunity for Alaska's Foster Children Sectional Analysis**

### **Section 1.**

Adds intent language relating to social workers.

### **Section 2.**

Requires school districts, to the extent possible, to provide transportation to those students who are in foster care placement or are considered homeless to their "school of origin." In addition, it requires that a student's records be transferred within 10 days of a transfer.

### **Section 3.**

Gives the commissioner of health and social services the latitude to raise social worker salaries if it is deemed necessary to recruit and retain social workers.

### **Section 4.**

Amends the guidelines for policy related to children to include support for their intellectual well being and includes the importance of an adequate education for children in the state's care.

### **Section 5.**

Adds that a child should remain in their school of origin to legislative findings relating to children.

### **Section 6.**

Requires the department to recalculate the foster family care reimbursement rates every year based on the current year's federal poverty guideline.

### **Section 7.**

Sets immediate effective dates for sections 1 and 3 of this act

# LEGISLATIVE RESEARCH REPORT

FEBRUARY 11, 2008



REPORT NUMBER 08.146

## FOSTER AND HOMELESS CHILDREN AND SCHOOL TRANSFERS

PREPARED FOR REPRESENTATIVE LES GARA

BY TIM SPENGLER, LEGISLATIVE ANALYST

You asked about how changing schools during the year affects the education of homeless or foster children. Additionally, you wished to know how the Anchorage and Fairbanks school districts address this issue and how it relates to the McKinney-Vento Act. Briefly, all the individuals we contacted, and all the literature we read, agree that children and youth who change schools during the year are less likely to be successful—both academically and socially.

Among the provisions of the federal McKinney-Vento Act, is a guarantee that youth who are homeless—including those lacking a "fixed, regular, and adequate nighttime residence" and those "awaiting foster care placements," have the right to remain in their original schools when they change living arrangements. It also assures transportation to their schools, and access to school-based liaisons to help them navigate the education system.<sup>1</sup> While the Act does not specifically include children and youth in foster care, many educational decision makers treat foster children as "homeless" for the purpose of attempting to avoid school moves. According to Melora Gaber, State of Alaska McKinney-Vento coordinator, opinions differ on the question of whether foster children fit into the McKinney-Vento definition of "homeless," but most Alaska districts attempt to keep foster children in their original schools.<sup>2</sup> Ms. Gaber notes that each district in the state currently has a homeless liaison and that this year Alaska received \$161,901 from the federal government toward the ongoing implementation of the McKinney-Vento Act. The funds are distributed statewide via a competitive bid process, and currently four districts are receiving these federal dollars.<sup>3</sup> Whether or not districts receive grant funding, they are expected to comply with the Act.<sup>4</sup>

<sup>1</sup> The McKinney-Vento Act was signed on July 22, 1987 as Public Law 100-77. It was reauthorized in 2001.

<sup>2</sup> Melora Gaber can be reached at (907) 465-8707.

<sup>3</sup> Districts receiving McKinney-Vento implementation funding are Anchorage, Mat-Su, Kenai, and Juneau.

<sup>4</sup> Ms. Gaber explains that other monies used by districts to assist homeless students include Title 1, Special Education and No Child Left Behind funds, as well as district general fund dollars. Nonetheless, she points out that it is very difficult for districts to be able to serve all their homeless youth, as a result of funding shortages.

Theresa Tanoury Lombardo, senior director, Alaska Strategic Consulting Office, Casey Family Programs, relates that there is a clear correlation between children who change schools mid year, and a lack of educational achievement.<sup>5</sup> Ms. Tanoury Lombardo notes that her professional experiences correspond with numerous studies on the question of school mobility—which emphasize the importance of educational stability. She pointed us to a white paper publication sponsored by Casey Family Programs entitled, *Educating Children in Foster Care, The McKinney Vento and No Child Left Behind Acts*.<sup>6</sup> The author notes that the high rate of mobility is one of the biggest educational challenges to children and youth in foster care. Citing a study of two northwestern states documenting that 65% of foster care alumni experienced seven or more school changes, the author points out the following in regard to the impact:

Since it takes the average child four to six months to recover academically after each school change, many children in foster care not only fail to recover, they actually lose ground.

In a 2006 Casey national study of 1,082 foster care alumni throughout the country, youth who had had one fewer placement change per year were almost twice as likely to graduate from high school before leaving care.<sup>7</sup> As it is universally acknowledged that a quality education is an important factor in future success, these statistics are especially noteworthy. According to statistics recently released by the U.S. Census Bureau, adults age 18 and over with a high school diploma earn an average of \$28,655. Those without a high school diploma earn an average of \$19,169. Additionally, individuals who graduate from high school live six to nine years longer than those who drop out.<sup>8</sup>

While much of the Casey Family Programs information pertains directly to children and youth in foster care, similar, or more difficult educational challenges, apply to homeless youth. The National Center for Homeless Education (NCHE) articulates some of the issues faced by homeless children in *Homeless Education: An Introduction to the Issues*.<sup>9</sup>

- At least 20% of homeless children will not attend school.
- Within a year, 41% of homeless children will attend two different schools; 28% of homeless children will attend three or more schools.
- With each change in schools, a student is set back academically by an average of four to six months.

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<sup>5</sup> Theresa Tanoury Lombardo can be reached at (907) 586-4014. Prior to working with the Casey Family Programs, Ms. Tanoury-Lombardo was the director of the State of Alaska's Division of Family and Youth Services (now titled the Office of Children's Services). The Casey Family Programs' mission is to provide and improve—and ultimately prevent the need for—foster care.

<sup>6</sup> Scott Jofus, EdD., *Educating Children in Foster Care, The McKinney-Vento Act and No Child Left Behind*, Casey Family Programs, 2007. We include this as Attachment A.

<sup>7</sup> *Educational Outcomes for Children and Youth in Foster Care and Out-of-Home Care*, National Working Group on Foster Care and Education, September 2007.

<sup>8</sup> *Educational Stability and Continuity for Children and Youth in Out-of-Home Care*, Legal Center for Foster Care and Education, 2007.

<sup>9</sup> *Homeless Education: An Introduction to the Issues*, can be found at <http://www.serve.org/nche/downloads/briefs/introduction.pdf>

- Children experiencing homelessness often feel like outsiders and have difficulty maintaining friendships due to frequent moves. Their lives feel out of control, and they often experience anxiety and depression as a result.

According to Carol Comeau, Superintendent of the Anchorage School District (ASD), changing schools is extremely disadvantageous for the academic and social progress of children and youth.<sup>10</sup> The district devotes a significant amount of resources in Anchorage to keep students from changing schools. Last year the Anchorage school district spent \$285,000 in transportation costs to keep homeless youth in the schools where they started the year, and to serve children in the foster care system—as much as possible—along with those who fall under the McKinney-Vento definition of homeless.<sup>11</sup> The bulk of these transportation expenses go to providing bus tokens, a scuttle service, and taxi cab fares. Spending such a large amount of funds on transporting these children puts a significant strain on the ASD's budget. Anecdotally, Ms. Comeau related that in her long career she has witnessed numerous situations where changing schools has adversely affected students.

According to Mike Fischer, Chief Financial Officer with the Fairbanks North Star Borough School District, the district spent approximately \$120,000 last year on transporting homeless children and youth to avoid educational disruption.<sup>12</sup> The district does not receive any state grant money for the McKinney-Vento Act but uses general funds to cover the expenses. We also spoke with Leona McDaniels, Fairbanks Homeless Education Liaison and Cheryl Mayo-Kriska, the district's Alaska Native Education Liaison.<sup>13</sup> Both spoke of how difficult it can be for children—many of whom may come from troubled backgrounds—when forced to change schools mid-stream. They note that such changes can cause youth to have difficulties building strong relationships—a situation that can lead to anti-social behavior.

The experts agree that when a child does need to change schools, it is very important that their transcripts follow them promptly and that they receive credit for what work they have done. When records are not transferred in a timely manner, this too can discourage students. This seems to be especially problematic when youth transfer between districts. The frustration and confusion may become one more barrier to academic success and, according to our sources, can be the final straw that leads students to drop out completely.<sup>14</sup>

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I hope you find this information to be useful. Please do not hesitate to contact us if you have questions or need additional information.

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<sup>10</sup> Carol Comeau can be reached at (907) 742-4312.

<sup>11</sup> The majority of the money used on transportation came from the ASD's general fund, according to Marie Laule, Budget Director. Ms. Laule can be reached at (907) 742-4330.

<sup>12</sup> Mike Fischer can be reached at (907) 452-2000.

<sup>13</sup> Both Leona McDaniels and Cheryl Mayo-Krista can be reached at (907) 452-2000.

<sup>14</sup> Carol Comeau voiced concern that Alaska's compulsory education cuts off at 16. She believes that if youth legally had to attend school until 18 it would affect at least a fraction of the drop out rate.

## **Attachment A**

White Paper, Educating Children in Foster Care, The McKinney-Vento and No Child Left Behind Acts, Scott Jofus, Ed.D., Casey Family Programs, 2007

White Paper



SCOTT JOFTUS, Ed.D., & ROSS & JOFTUS, LLC



**casey** family programs

fostering families. fostering change.

# Educating Children in Foster Care

Through McKinney-Vento and No Child Left Behind Acts

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Casey Family Programs' mission is to provide and improve—and ultimately to prevent the need for—foster care.

Established by United Parcel Service founder Jim Casey, the Seattle-based national operating foundation has served children, youth, and families in the child welfare system since 1966.

The foundation operates in two ways. It provides direct services, and it promotes advances in child welfare practice and policy.

Casey collaborates with foster, kinship, and adoptive parents to provide safe, loving homes for youth in its direct care. The foundation also collaborates with counties, states, and American Indian and Alaska Native tribes to improve services and outcomes for the more than 500,000 young people in out-of-home care across the United States.

Drawing on four decades of front-line work with families and alumni of foster care, Casey Family Programs develops tools, practices, and policies to nurture all youth in care and to help parents strengthen families at risk of needing foster care.

For more information, contact Casey Family Programs at [info@casey.org](mailto:info@casey.org) or 1300 Dexter Avenue North, Floor 3, Seattle, WA 98109. Visit our Web site at [www.casey.org](http://www.casey.org).

Bella Rosenberg and Debbie Staub contributed heavily to the research of this white paper.

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## Executive Summary

**Education begins at home.** Educators and policymakers often point out that parents are children's first and most enduring teachers. Indeed, no bond is more fundamental and life-defining than the one between parent and child. Children in foster care or out-of-home care, however, have had that crucial bond broken, frayed, or interrupted through no fault of their own. Traumatized first by the maltreatment, neglect, or abuse that brings them to the attention of the authorities, then by their removal from their family, and possibly yet again by their experiences in the foster care system, these children are among our most vulnerable.<sup>1</sup> For the 800,000 children and youth who are involved in the foster care system each year, a solid education is their best hope—in some cases, their only hope—of achieving independence and success in adulthood.

A quality education builds on a foundation of educational continuity and school stability. Unfortunately, too many children in foster care experience multiple placement changes, and each change in home placement frequently results in a change in school placement. Every school change has a significant impact on a student's education. Whenever students enter a new school, they must adapt to different curricula, different expectations, new friends, and new teachers. A stable school environment provides children with opportunities to develop positive relationships with supportive and caring teachers, school counselors, and classmates. These relationships and an established school routine often provide a measure of protection from

the disruption and uncertainty associated with foster care. Hence, both school stability and uninterrupted attendance are necessary.

**Education is vital for the future success of all children, but children and youth in foster care are particularly vulnerable to academic failure:**

According to a 2004 study of Chicago public school youth, fifteen-year-old students in foster care were only about half as likely as other students to have graduated from high school five years later, with significantly higher percentages of youth in care having dropped out (55%) or become incarcerated (10%).<sup>2</sup>

In a three-state Midwest study from 2004, youth in foster care on average read at only a seventh grade level after completing tenth or eleventh grade.<sup>3</sup>

**High rates of foster home placement changes are also documented, with direct consequences on academic outcomes:**

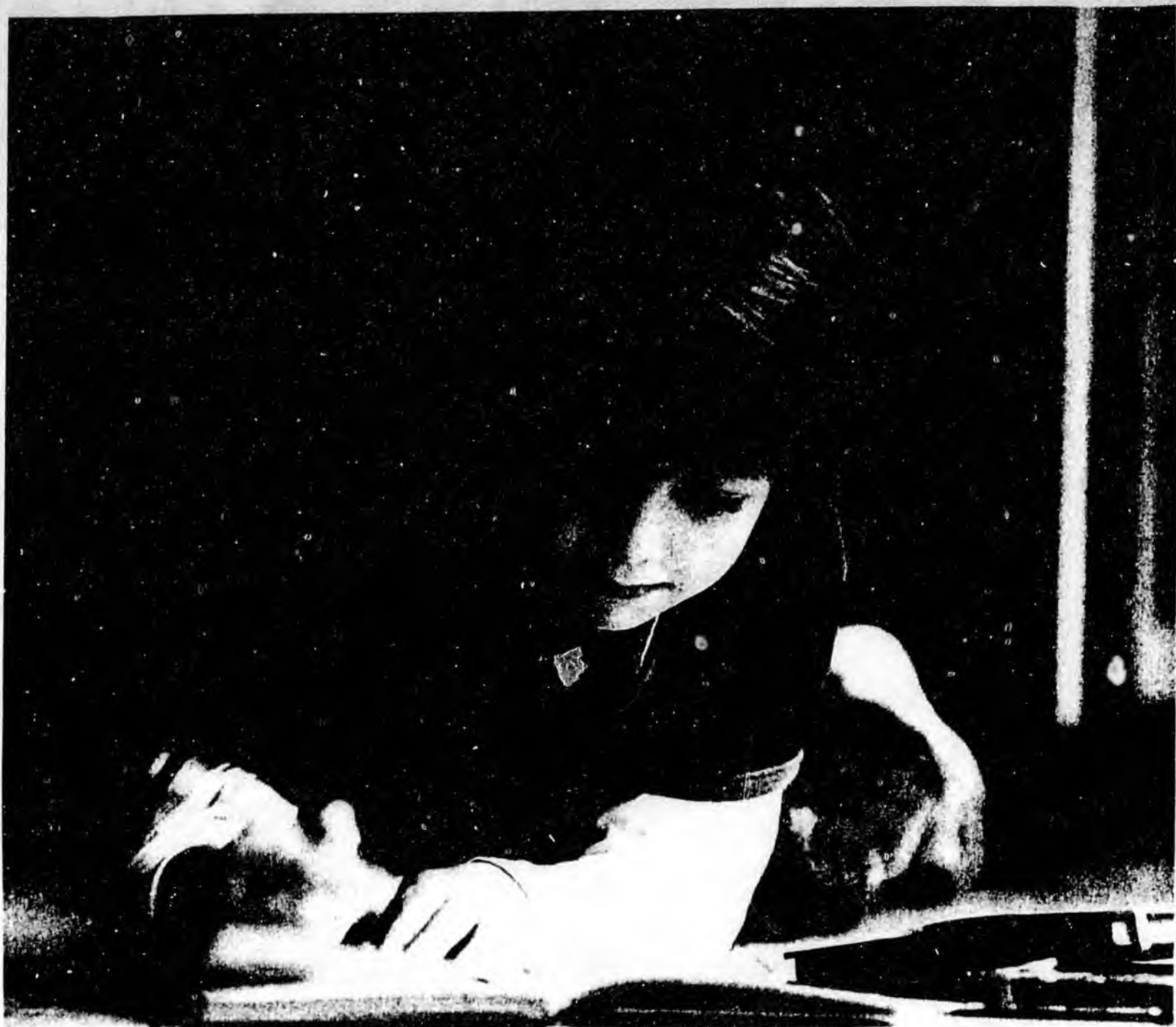
The same study of youth aging out of care revealed substantial levels of school mobility associated with placement in foster care. Over a third of young adults reported having had five or more school changes.<sup>4</sup>

<sup>1</sup> Christian, S. (2003). *Educating children in foster care*. Washington, DC: National Conference of State Legislatures. Retrieved March 27, 2006, from <http://www.ncsl.org/programs/cyf/CP/education.htm>; Gerber, J. & Dicker, S. (2005). Children adrift: Addressing the educational needs of New York's foster children. *Albany Law Review*, 69(1), 1-74. Casey Family Programs. (2006a). *Breakthrough Series Collaborative: Improving educational stability for children in out-of-home care*. Seattle, WA: Author. Retrieved March 18, 2007, from [http://www.abaret.org/child/edu/education/bsc\\_topic\\_selection\\_flow\\_chart.pdf](http://www.abaret.org/child/edu/education/bsc_topic_selection_flow_chart.pdf)

<sup>2</sup> Smithgall, C., Gladden, R.M., Howard, E., Goerge, R., & Courtney, M. (2004). *Educational experiences of children in out-of-home care*. Chicago, IL: Chapin Hall Center for Children at the University of Chicago. Abstract available online at [http://www.chapinhall.org/article\\_abstract.aspx?ar=1372](http://www.chapinhall.org/article_abstract.aspx?ar=1372). This report compared children in the Illinois Chicago Public Schools system. Data were pulled from the Integrated Database on Child and Family Services Child and Youth Center Information System and matched using probabilistic record matching with the Chicago Public Schools Student Information System to almost 16,000 students. Academic performance indicators used included elementary students' scores on the reading section of the Iowa Test of Basic Skills (ITBS), the percent of elementary students who were at least one grade level behind for their age, and high school dropout rates.

<sup>3</sup> Courtney, M.E., Terao, S. & Bost, N. (2004a). *Midwest evaluation of the adult functioning of former foster youth: Conditions of youth preparing to leave state care*. Chicago, IL: Chapin Hall Center for Children at the University of Chicago.

<sup>4</sup> Courtney et al., 2004a.



A 1999 study found that California high school students who changed schools even once were less than half as likely to graduate as those who did not change schools, even when controlling for other variables that affect high school completion.<sup>5</sup>

**On the other hand, when youth in foster care have stable home placements, with stable school attendance as a result, outcomes improve dramatically:**

In a national study of 1,087 youth who had been in foster care, those who had one fewer placement change per year were almost twice as likely to graduate from high school.<sup>6</sup>

The McKinney-Vento Homeless Assistance Act is the principal federal statute that addresses school stability, primarily for homeless youth.<sup>7</sup> McKinney-Vento was reauthorized and strengthened by amendments made in the No Child Left Behind Act of 2001.<sup>8</sup> The McKinney-Vento Act has proven an effective law and successful program for addressing the needs of homeless children and youth—those who lack a fixed, regular, and adequate nighttime residence. Currently, however, it covers only a fraction of the approximately 513,000 young people under the age of 18 who are in the U.S. foster care system on any given day.<sup>9</sup> All children in out-of-home care could

benefit greatly from inclusion in the scope of the McKinney-Vento Act.

While McKinney-Vento focuses on homeless children and youth, the No Child Left Behind Act (NCLB) identifies many other categories of at-risk students. Children in foster care often fall into one or more of the at-risk categories of students NCLB identifies. But while most disadvantaged children are explicitly singled out by NCLB for each of multiple academic risk factors, children in foster care are not specifically recognized. The result is to deprive many vulnerable students of the full benefit of the services provided under the law.

The reauthorization of the NCLB and McKinney-Vento Acts represents an opportunity to help ensure that children in foster care are no longer left behind. This opportunity for federal policymakers to take a leap forward in improving educational outcomes for these children also comes at a favorable time. The U.S. Department of Health and Human Services and state and local child-welfare agencies, the authorities that traditionally, and appropriately, hold chief responsibility for addressing the broad and acute needs of youth in out-of-home care, have identified improving educational outcomes as part of ongoing federal reviews.<sup>10</sup> But as the child-welfare community recognizes, advancing educational attainment requires the expertise of and collaboration with the education system.

A collaboration between schools and the child-welfare system would turn a sharpened focus on the problem. Although federal child-welfare policymakers seek to improve the foster care system by including educational outcomes in the federal reviews of each

<sup>5</sup> Rumberger, R., Larson, K., Ream, R., & Palardy, G. (1999). The educational consequences of mobility for California students and schools. *PACE Policy Brief* (University of California at Berkeley), 1(1), 1-12.

<sup>6</sup> Pecora, P.J., Williams, J., Kessler, R.C., Downs, A.C., O'Brien, K., Hiripi, E., & Morello, S. (2003). *Assessing the effects of foster care: Early results from the Casey National Alumni Study*. Seattle, WA: Casey Family Programs.

<sup>7</sup> 42 U.S.C. § 11431 et seq.

<sup>8</sup> Public Law 107-110. The Act reauthorized and substantially revised the Elementary and Secondary Education Act of 1965.

<sup>9</sup> U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. (2006). *The AFCARS report No. 13: Preliminary FY 2005 estimates as of September 2006*. Washington DC: U.S. Department of Health and Human Services. Retrieved November 7, 2006, from [http://www.acl.fhhs.gov/programs/cb/stats\\_research/afcars/tar/report13.htm](http://www.acl.fhhs.gov/programs/cb/stats_research/afcars/tar/report13.htm)

<sup>10</sup> U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau, 2006.

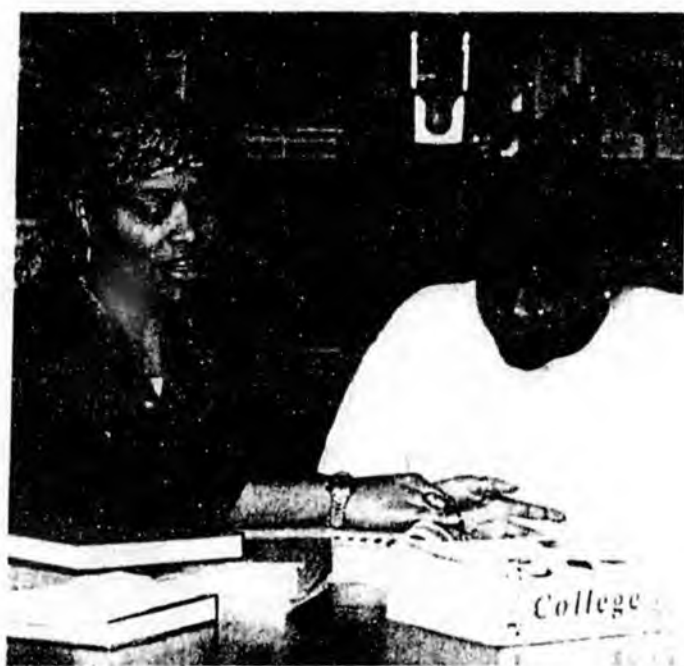
state's child-welfare system, this is only a first step in improving partnership. To realize this aim, federal lawmakers should make use of the largest significant program for the education of disadvantaged children, NCLB, and should align and address these issues in companion child-welfare legislation reform efforts.

The following recommendations are designed to bring students in foster care into the spotlight of NCLB and into the purview of educational systems that can address their needs and ensure their success. Because of the overriding importance of school stability for children in care and their need for educational advocates, the recommendations seek to expand the current coverage afforded children under the McKinney-Vento Homeless Assistance Act. In addition, reflecting research findings on improving educational outcomes, the recommendations also aim to strengthen NCLB provisions concerning supplemental educational services, school counselors, and mental health services.

**The recommendations are:**

- 1) Improve school stability by ensuring that the McKinney-Vento Homeless Assistance Act applies to all children in out-of-home care and increase funding for the McKinney-Vento Homeless Assistance Act under Title X, Part C, Subtitle B to a level that covers all eligible children.
- 2) Ensure that children and youth in foster care have access to education-related support services by making them automatically eligible for Title 1, Part A services and including them in the set-aside that exists for homeless children. Increase funding for school counselors (Elementary and Secondary School Counseling Programs), and mental health services (Grants to Improve the Mental Health of Children).

These recommendations are critical steps toward improving educational outcomes for children and youth in foster care. Accordingly, it is time for federal policymakers to address these concerns as the reauthorization of NCLB and McKinney-Vento looms.



## Introduction: Foster Care and Educational Outcomes

Education is a powerful determinant of quality of life in terms of economic, social, civic, and personal benefits.<sup>11</sup> For children in foster care, education is a route to life as an independent, responsible and contributing adult; virtually the only route available to some. Children in foster care depend heavily on schools, not only for education, but also for role models and social capital.

Educational attainment is a positive counterweight to the abuse, neglect, separation, and lack of permanence experienced by children in out-of-home care. Positive school experiences enhance well-being, help facilitate successful transitions to adulthood, and increase chances for personal fulfillment and economic self-sufficiency, as well as the ability to contribute to society. Unfortunately, children in care are particularly prone to academic failure:

In a 2004 study of Chicago Public School youth, fifteen-year-old students in out-of-home care were about half as likely as other students to have graduated from high school five years later, with significantly higher percentages of students in care having either dropped out (55%) or become incarcerated (10%).<sup>12</sup>

In a 2001 Washington State study, youth in out-of-home care attending public schools scored 16 to 20 percentile points below the general student population in statewide standardized tests.<sup>13</sup>

In a three-state Midwest study from 2004, youth in foster care read on average at only at a seventh grade level after completing tenth or eleventh grade.<sup>14</sup>

Children in out-of-home care are far more likely than other children to be classified as having emotional behavioral problems.<sup>15</sup> Their post-traumatic stress disorder rates exceed those in American Gulf War veterans.<sup>16</sup>

<sup>11</sup> Joffus, S. (2002). *Every child a graduate*. Washington, DC: Alliance for Excellent Education; Carnevale, A. & Desrochers, D. (2003). *Standards for what? The economic roots of K-16 reform*. Princeton, NJ: Educational Testing Service.

<sup>12</sup> Smithgall et al., 2004

<sup>13</sup> Burley, M. & Halpern, M. (2001). *Educational attainment of foster youth: Achievement and graduation outcomes for children in state care*. Olympia, WA: Washington State Institute for Public Policy. The sample of 4,559 children and youth in foster care in Washington State was generated by merging foster care data from the Division of Children and Family Services with Iowa Standardized Test Scores received from the Office of Superintendent of Public Instruction for grades 3, 6, and 9.

<sup>14</sup> Courtney et al., 2004a. Wave One of Longitudinal Study of Adolescent Health, as a comparison national sample.

<sup>15</sup> Smithgall et al., 2004

<sup>16</sup> McMillen, J. et al. (2005). Prevalence of psychiatric disorders among older youths in the foster care system. *Journal of the American Academy of Child & Adolescent Psychiatry*, 44(1), 88-95; Pecora, P., Kessler, R., Williams, J., O'Brien, K., Downs, A., English, D., et al. (2005). *Improving family foster care: Findings from the Northwest Foster Care Alumni Study*. Seattle, WA: Casey Family Programs. Retrieved March 19, 2007, from <http://www.casey.org/Resources/Publications/NorthwestAlumniStudy.htm>

Positive school  
experiences enhance  
well-being, help facilitate  
successful transitions to  
adulthood, and increase  
chances for personal  
fulfillment and economic  
self-sufficiency, as well  
as the ability to contribute  
to society.



A significant cause of the stress these children face is the lack of stability in their lives. According to the Children's Bureau of the U.S. Department of Health and Human Services, the average time spent in foster care is 29 months (the median time is 16 months), with 15 percent languishing in care for 5 years or more.<sup>17</sup> Youth in foster care average 3–4 placements before leaving care, with many youth experiencing one placement change approximately every 12 months. In fact, some youth in foster care have endured more than 20 placement changes by the time they age out of the foster care system.<sup>18</sup>

A change in home placement is often accompanied by a move to a new school. In Washington State, twice as many youth in foster care changed schools during the year, compared with the general student population.<sup>19</sup> Over a third of young adults in one study reported five or more school changes while in care.<sup>20</sup> School mobility rates are highest for those entering care for the first time—with over two-thirds changing schools in a Chicago study.<sup>21</sup>

It is also important to recognize that the foster care population consists disproportionately of children of color—58 percent compared to 42 percent of all U.S. children in 2005—with African American children comprising 32 percent of the foster care population.<sup>22</sup> These children are also disproportionately from low-income families, both in terms of their birth parents and their foster parents. Not surprisingly, then, like other low-income youth of color, children in foster care tend to be concentrated in high-poverty, underfunded, and low-achieving schools.<sup>23</sup> Attention to disparate outcomes must be considered in any solutions to be put forward.

<sup>17</sup> Based on those children still in care on September 30, 2005. U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau, 2006; Yu, E. et al. (2002). *Improving educational outcomes for youth in care*. A national collaboration. Washington, DC: Child Welfare League of America; Hochman, G. et al. (2004). *Foster care: Voices from the inside*. Washington, DC: Pew Commission on Children in Foster Care; Burrell, S. (2003). *Getting out of the red zone: Youth from the juvenile justice and child welfare system speak out about the obstacles to completing their education, and what could help*. San Francisco, CA: Youth Law Center. Available at <http://www.ylc.org/GettingOutoftheRedZone/October2003.pdf>

<sup>18</sup> Wolanin, T. (2005). *Higher education opportunities for foster youth: A primer for policymakers*. Washington, DC: The Institute for Higher Education Policy, Yu et al., 2002; Hochman et al., 2004; Burrell, 2003.

<sup>19</sup> Burley & Halpern, 2001.

<sup>20</sup> Courtney et al., 2004a.

<sup>21</sup> Smithgall et al., 2004.

<sup>22</sup> U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau, 2006; Annie E. Casey Foundation (2005). *KIDS COUNT State level Data Online*. Retrieved January 19, 2007, from [http://www.aecf.org/kidscount/state/profile\\_results.asp?l&d=13c-98p-58x-1a-5-5](http://www.aecf.org/kidscount/state/profile_results.asp?l&d=13c-98p-58x-1a-5-5).

<sup>23</sup> Smithgall et al., 2004.

## Left Behind: Educational Aspirations and Reality

Most youth hold high educational aspirations. Youth in foster care are no different.<sup>24</sup> But youth in care have traditionally received little or no help on the postsecondary education path. Although comprehensive national educational data on youth in out-of-home care are scarce, the best estimates place their high school completion rate at only about 74 percent, significantly lower than in the high school population rate in the general population (86 percent).<sup>25</sup> Moreover, youth in foster care complete their high school studies by getting a GED about five times as often as their peers. This is cause for concern because GED holders earn significantly less than holders of a traditional high school diploma.<sup>26</sup> Despite their college aspirations, only 37 percent of the youth in foster care who graduate from high school actually go on to attend college, in contrast with the approximately 60 percent of all high school graduates who attend college (based on a study from 1990–2001).<sup>27</sup>

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<sup>24</sup> Courtney, M. et al. (2004b). The educational status of foster children. Issue Brief 102. Chicago, IL: Chapin Hall Center for Children at the University of Chicago; Courtney, M. et al. (2001). Foster youth transitions to adulthood: A longitudinal view of youth leaving care. *Child Welfare* 80, 685–717; McMillen, C. et al. (2001). Education, experiences and aspirations of older youth in foster care. *Child Welfare* 82 475–495; Reilly, T. (2003). Transition from care: Status and outcomes of youth who age out of foster care. *Child Welfare* 82, 727–746.

<sup>25</sup> These figures are cited for comparability purposes. They include individuals taking more than four years to graduate from high school and individuals earning a GED. They are also likely inflated as they are based on self-reported census data. There is general agreement among researchers that the on-time graduation rate of the general population in the United States is closer to 71 percent, but there are not comparable figures for youth in foster care. Casey Family Programs. (2006b) Foster Care by the Numbers. WA. Author: Casey Family Programs, 2006a; National Foster Youth Advisory Council. *Promoting Educational Success for Young People in Foster Care*. Washington, D.C.: Author. Retrieved March 20, 2007, from <http://www.fy3.com/fy3/involved/yb/pdfs/educationStatement.pdf>; Pecora, 2003; Blome, W. (1997). What happens to foster kids: Educational experiences of a random sample of foster care youth and a match group of non-foster care youth. *Child and Adolescent Social Work Journal*, 14(1), 41–53; Burley & Halpern, 2001; McDonald, T. et al. (1996). *Assessing the Long-Term Effects of Foster Care: A Research Synthesis*. Washington, DC: Child Welfare League of America.

<sup>26</sup> Boesel, D., Alsalam, N. & Smith, T. M. (1998). *Educational and labor market performance of GED recipients*. Washington, D.C.: Department of Education, Office of Educational Research and Improvement; Cameron, S. V. & Heckman, J. J. (1993). The nonequivalence of high school equivalents. *Journal of Labor Economics* 11(1), 1–47.

<sup>27</sup> The foster care alumni college enrollment statistic was derived by averaging the results of a representative set of foster care alumni studies that interviewed older foster care alumni, who had more time to complete high school via a diploma or a GED, attend a postsecondary educational program, or complete a bachelor's degree than younger alumni. The studies were then weighted by study sample size so the larger studies carried more weight in the average. For more information contact Peter J. Pecora at [ppecora@casey.org](mailto:ppecora@casey.org). Examples of studies included in the analysis for the high school completion rate include:

Blome, 1997

Buehler, C., Orme, J. G., Post, J., & Patterson, D. A. (2000). The long-term correlates of family foster care. *Children and Youth Services Review*, 22(8), 595–625.

Casey Family Services. (1999). *The road to independence: Transitioning youth in foster care to independence*. Shelton, CT. Author. ([www.caseyfamilyservices.org](http://www.caseyfamilyservices.org))

Cook, R., Fleishman, E., & Grimes, V. (1989). *A National Evaluation of Title IV-E Foster Care Independent Living Programs for Youth* (Phase 2 Final Report, Volume 1). Rockville: Westat, Inc.

Courtney et al., 2001

Festinger, T. (1983). *No one ever asked us ... A postscript to foster care*. New York: Columbia University.

Pecora et al., 2005

Pecora et al., 2003

Reilly, 2003.



College statistics also tell a discouraging story: One regional study found that only 2.7 percent of foster-care alumni age 25–34, compared to 28 percent of those age 25–34 nationally, hold a bachelor's degree.<sup>28</sup>

### **School Stability Versus Mobility of Youth in Foster Care**

For children and youth in foster care, one of the biggest challenges to their educational achievement is their high rate of mobility. One study of two northwestern states showed that 65 percent of foster care alumni had experienced seven or more school changes.<sup>29</sup> This lack of stability is deeply significant. Youth in foster care who average one less placement in care per year are nearly twice as likely to finish high school.<sup>30</sup>

Since it takes the average child four to six months to recover academically after each school change, many children in foster care not only fail to recover, they actually lose ground.<sup>31</sup> The rate of placement change is associated not only with grade retention but also with the disproportionate likelihood of classifying children in foster care as emotionally disturbed.<sup>32</sup> One researcher observed that some children classified as emotionally challenged may instead be exhibiting transitory behavioral problems stemming from placement disruptions.<sup>33</sup>

Compounding the frequency of school moves for youth in care is their high rate of absenteeism and tardiness. In fact, they are absent at twice the rate of their peers, at least partly as a result of enrollment delays when they change placements, due to the length of time generally taken for records to be transferred. Frequent health and mental health needs and numerous appointments with child-welfare agencies also contribute to the higher levels of absenteeism.<sup>34</sup>

<sup>28</sup> Pecora et al., 2005.

<sup>29</sup> Pecora et al., 2005. For other placement change data see Courtney et al., 2004a, Gerber & Dicker, 2005.

<sup>30</sup> See, for example, Pecora et al., 2003. Although changes in foster care placements and changes in school placement are not synonymous, the two are closely correlated.

<sup>31</sup> Burley & Halpern, 2001; Yu et al., 2002.

<sup>32</sup> Courtney et al., 2004a, Gerber & Dicker, 2005; Smithgall et al., 2004.

<sup>33</sup> Smithgall et al., 2004. The research noted that schools do a good job of recognizing the special needs of children in foster care, however.

<sup>34</sup> Conger, D. & Rebeck, A. (2001). *How children's foster care experiences affect their education*. New York: Vera Institute for Justice. Retrieved March 20, 2007, from [http://www.vera.org/publication\\_pdf/117\\_183.pdf](http://www.vera.org/publication_pdf/117_183.pdf); Finkelstein, M. et al. (2002). *What keeps children in foster care from succeeding in school? Views of early adolescents and the adults in their lives*. New York: Vera Institute of Justice. Retrieved March 26, 2007, from [http://www.vera.org/publication\\_pdf/169\\_280.pdf](http://www.vera.org/publication_pdf/169_280.pdf); Smithgall et al., 2004, Gerber & Dicker, 2005.

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*— Courtney et al., 2004a*



It is obvious that school mobility ends the continuity of curriculum and instruction, relationships with teachers or guidance counselors and school friends, and participation in extracurricular activities. Not surprisingly, the greater the number of residential placements and school changes, the lower the odds that youth in foster care will complete high school, go on to postsecondary education, and achieve self-sufficiency.<sup>35</sup> Consequently, every major study of these youth—and every account of these young people's experiences in their own voices—has concluded that tackling the school mobility issue is a necessary and vital condition for improving outcomes for youth in foster care.

### **Counselors, Advocates, and School Supports**

Because of the lack of stability in their school and family lives, children in foster care need adults who can advocate for their educational supports and rights. Youth, caregivers, and child-welfare agencies all identify the lack of education advocacy as a major failure of the child-welfare system, and conversely, when advocacy is available, as one of its most important assets. The federal Child and Family Services Reviews cited a lack of "adequate educational advocacy" as a problem for 14 of 37 states on whom reports have been issued to date.<sup>36</sup>

Consistent education advocacy requires knowledge of a youth's needs and education history. Effective advocates can provide services in numerous areas, including increasing and improving access to school services and programs, facilitating school enrollment, working with schools on disciplinary actions resulting in expulsions or suspension, insuring that youth in out-of-home care attend school regularly, identifying and securing academic supports, and teaching youth how to be self-advocates.<sup>37</sup>

Frequent school changes also diminish a student's access to needed academic supports, school enrichment opportunities and participation in extracurricular activities. Children in foster care may also miss out on supportive relationships with adults and mentors. A recent study of alumni of foster care found that fewer than half reported having a positive

<sup>35</sup> Courtney et al., 2004a; Smithgall et al., 2004; Pecora et al., 2003.

<sup>36</sup> Christian, 2003, p. 4.

<sup>37</sup> Treehouse. (2007). *Educational Advocacy Program Annual Report 2006*. Seattle, WA: Author.

relationship with an adult while growing up. This finding is buttressed by the self-reports of youth in out-of-home care.<sup>38</sup>

As several studies have demonstrated, when youth in out-of-home care do receive such support, their educational, employment, and social outcomes are improved.<sup>39</sup> The child-welfare system must continue to assume the major role in meeting those needs, but the schools remain the best providers of academic supports. Reports on the education issues of youth in foster care consistently point out that increased collaboration among child welfare and education is critical. Effective collaboration means working together to maintain school placement stability, sharing a youth's pertinent information and records, and ensuring a youth's timely enrollment in school.<sup>40</sup> Advocates and counselors can also help ensure that student learning is effectively supported. They are the best source of expert help in navigating children in foster care through the academic route to high school graduation and entry into postsecondary education.

<sup>38</sup> Pecora et al., 2003. On self reports, see, for example, Hochman, G. et al., 2004.

<sup>39</sup> Ayasse, R. (1995). Addressing the needs of foster children: the foster youth services program. *Social Work in Education* 17(4), 207-216; Kerman, B. et al. (2002). Outcomes for young adults who experienced foster care. *Children and Youth Services Review*, 24(5) 319-344; Pecora, 2003.

<sup>40</sup> Yu et. al., 2002a.

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## Recommendations

Over 800,000 children and youth experience foster care every year. Our schools can improve the academic outcomes of these children with the support of the U.S. Department of Education and the harnessing of the power of the No Child Left Behind Act, the principal federal program for the education of disadvantaged children and youth. As noted, the U.S. Department of Health and Human Services and its state and local counterparts have recognized the importance of improving educational outcomes for youth in foster care; doing so is one of seven priorities to be assessed in the CFSTRs.<sup>41</sup>

Effective pursuit of this goal requires coordination with the public school system. To maintain school stability, the first recommendation seeks to expand the current coverage afforded children in foster care under McKinney-Vento Homeless Assistance Act. The intent is not to identify children in care as homeless, but rather to recognize the negative impact of school mobility on educational outcomes. Improving school stability is the catalyst for activating the improvements in the other NCLB recommendations.

Each recommendation, considered singly, can make a positive difference in the lives of these disadvantaged children and youth. But without greater school stability, none of these children can achieve their full potential. If children in foster care experience less upheaval in their schooling, all available evidence indicates that their academic achievement and attainment will improve—especially if they are provided supplemental education services such as tutoring, school counseling, and mental health services.

**The recommendations, then, are as follows:**

- A. Improve school stability by ensuring that the McKinney-Vento Homeless Assistance Act applies to all children in out-of-home care and increase funding for the McKinney-Vento Homeless Assistance Act under Title X, Part C, Subtitle B to a level that covers all eligible children.**

<sup>41</sup> Christian, 2003.



The McKinney-Vento Homeless Assistance Act, which was reauthorized by NCLB, is the primary federal statute that addresses the harmful effects of school mobility on children without fixed, regular, and adequate housing. Currently, McKinney-Vento provides that homeless children and children awaiting foster care placement are eligible for its protections and services. The act provides eligible students with numerous specific educational rights and benefits, including educational stability. It allows for children to remain in their school of origin, when feasible, and provides transportation to allow for that continuity.

The act also insures that eligible students have access to immediate school enrollment in a new school when remaining in the school of origin is not feasible, regardless of whether the students have required documentation such as school records, medical records, or proof of residency. Not only must eligible children be allowed to enroll in classes, they must also be permitted to participate fully in school activities.

A critical component of the act is the provision of liaisons for eligible students. Local education agencies (LEAs) must designate a staff person as liaison for these students to assist with identification, enrollment, and referrals for services and programs. States award competitive subgrants to LEAs to assist with implementation and provide direct services. McKinney-Vento also enables critical professional development for educators and pupil services personnel in meeting the needs of the students targeted by the act. Finally, students eligible under this act are also eligible for Title I benefits without needing to qualify based on their current academic performance.

A March 2006 U.S. Department of Education report on the McKinney-Vento program concluded that "states and LEAs have generally made significant progress in reducing the barriers that homeless children and youth face in enrolling, attending and succeeding in school."<sup>42</sup> There are, however, two challenges to making the services available to children in foster care. The first is the language of the act. McKinney-Vento provides services to homeless children, including those "awaiting foster care placement." This phrase is somewhat ambiguous. The

<sup>42</sup> U.S. Department of Education (2006). *Report to the President and Congress on the Implementation of the Education for Homeless Children and Youth Program under the McKinney-Vento Homeless Assistance Act*. Washington, D.C.: Author. Retrieved on March 26, 2007, from <http://www.ed.gov/programs/homeless/012006.doc>

states have taken a wide array of approaches in determining which children in out-of-home care are eligible under McKinney-Vento, from Delaware's approach of including all children in care, to only including children in short-term placements, and many variations in between. If McKinney-Vento were explicitly to extend services to all children in out-of-home care, these vulnerable children would be protected, and they would be treated more consistently across all fifty states.

Second, as the report notes, districts are stretched thin in providing all necessary services to the existing population of eligible students. Alarming, almost half of the 914,225 students identified under the McKinney-Vento Act in 2005–2006 were enrolled in school districts that do not have subgrants.<sup>43</sup> The current appropriation of \$61 million does not adequately cover all the children currently eligible. Including all children in foster care under the act would necessitate a significant increase in funding. Additional research is suggested to determine how much additional need exists.

The infrastructure for extending McKinney-Vento to children in foster care is generally already in place through the state coordinators and local education agency liaisons for children currently eligible under the act. These education contacts will be a tremendous benefit to child-welfare system professionals charged with responsibility for addressing all the needs of children in out-of-home care. While the overall responsibility for these children will remain with the child-welfare agencies (and will not be transferred to LEA liaisons), the child-welfare agencies' capacity to address the education needs of children will improve dramatically when they can work collaboratively with LEA liaisons and make use of them as points of contact for communications with the school system.<sup>44</sup>

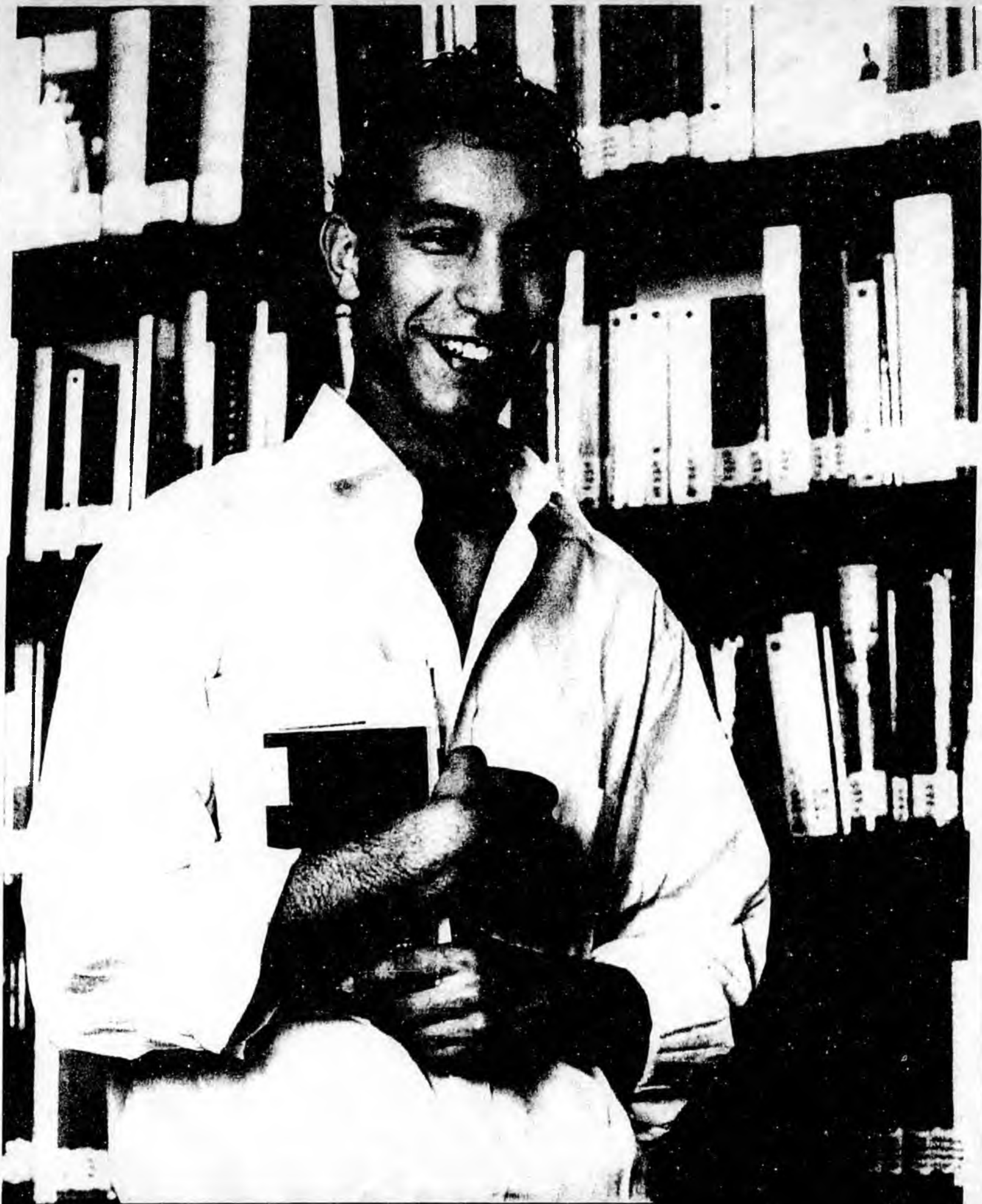
**B. Academic Support Services: Increase access to educationally related support services and increase funding for school counselors and mental health services.**

Currently, NCLB provides for a variety of support services that are critical to children in foster care and other students at the greatest

<sup>43</sup> U.S. Department of Education, 2006.

<sup>44</sup> U.S. Department of Education, 2006; Gerber and Dicker, 2005.

If McKinney-Vento were explicitly to extend services to all children in out-of-home care, these vulnerable children would be protected and they would be treated more consistently across all fifty states.



risk of failing to meet state standards. Children in foster care would benefit from eligibility for many of these services, but expansion of three services in particular would result in the most immediate and long-lasting impact:

- 1) Ensure that children and youth in foster care have access to education-related support services by making them automatically eligible for Title 1, Part A services and including them in the set-aside that exists for homeless children.**

The purpose of the Title I program is to serve disadvantaged children who are at risk of academic failure. Homeless children and youth are covered by Title I, Part A services. Title I resources must be accessible to serve a school district's homeless children and youth, and these children must be included in school district Title I accountability systems to ensure that their academic needs are addressed.

NCLB requires that both state and LEA Title I plans be coordinated within the McKinney-Vento Act. Homeless children are automatically eligible for Title I services. In addition, NCLB currently requires all LEAs reserve dollars to provide educationally related support services to homeless children. These Title I set-asides provide essential educational support, including tutoring, to help children achieve academically in schools throughout the district. In light of their similar needs, children in foster care would benefit from inclusion in these same provisions. Title I, Part A should include children in foster care in these provisions explicitly.

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