ALASKA LEGISLATURE COMMITTEE FILES 2007-2008 SHES 12

Providence operates three municipally owned hospitals outside Anchorage—operating facilities at Seward and Valdez under management agreements and a facility at Kodiak under a lease.

Providence Seward Medical Center (PSMC)
Providence has operated a 6-bed hospital and a 43-bed long term care facility in Seward since 1996. In 2005, PSMC lost $402,000 for a -3.7% total margin.

Providence Valdez Medical Center (PVMC)
The City of Valdez pays PH&S to manage this 11-bed hospital and a 10-bed long term care facility. In 2005, PVMC lost $146,000 for a -1.9% total margin.

Providence Kodiak Island Medical Center (PKIMC)
Providence began managing this 25-bed hospital and a 19-bed long-term care facility in 1996 under a 10-year renewable lease from the Kodiak Island Borough (KIB). PH&S collects no management fee and actually pays the borough $720,000 annually for the right to operate the facility. In 2005, PKIMC posted a $769,000 profit for a 3.6% total margin.

Growth

PH&S is cementing its dominance in Alaska with a plan to spend $321 million to build a host of new facilities by 2008, including:

- new medical office buildings
- a heart institute
- another cancer center
- administrative offices
- visitor housing and
- a 40-acre commercial development that 'surrounds' the competing Mat-Su Regional Medical Center.

Expanding its strength in the long-term care market, PH&S opened the for-profit St. Elias Specialty Hospital in Anchorage on December 18, 2006. This $24 million facility, a partnership between PH&S and Bridgecare Hospitals from Alabama, is the only one of its kind in the state. St. Elias Specialty Hospital focuses on non-critical patients requiring long-term acute care, and will receive patients from hospitals throughout the state. Once St. Elias Specialty Hospital demonstrates that patients stay at the hospital an average of more than 25 days, administrators say that they will seek certification by Medicare as a long-term acute care hospital.

The State of Alaska is currently considering applications for certificates of need for seven PH&S Alaska projects totaling $48 million. The most controversial project seems to be the proposed imaging center in the Matanuska-Susitna (Mat-Su) Valley.

Providence Projects in Certificate of Need Process – May 9, 2007		
Project	Status	Value
Anchorage – Cardiovascular Observation Area Expansion	Application Complete	$ 1,312,575
Anchorage - Catheterization Labs	Application Complete	$5,001,614
Anchorage - Outpatient Therapy Services	Application Received	$3,643,586
Anchorage Ambulatory Surgery Center	Hearing Scheduled	$9,600,000
Seward - Providence Wesley Care Center	CON Approved	$28,100,000
Anchorage Abbott Road Imaging Facility	Appealed	
Mat-Su Imaging Services	Appealed	
Total		$47,657,775

Matanuska-Susitna Valley Controversy

After losing a bid to partner with the Valley Hospital Association, PH&S Alaska is aggressively undermining the new community hospital in Mat-Su Valley, first by purchasing land surrounding it, and now by seeking to open a competing imaging center without Certificate of Need approval.

In 2002, the Valley Hospital Association decided to build a new community hospital in the Matanuska-Susitna Valley that could treat more patients locally. Lacking the cash to undertake the project, the association's board entertained several proposals, and ultimately entered into a joint venture with for-profit Triad Hospitals, Inc. Under the agreement, Triad agreed to spend up to $75 million on the new facility, maintain a local presence on the board of directors with 50%

of the board's vote, and proportionately share the hospital's profits with the community. The association rejected a bid from Providence out of concern that the company would push to stabilize patients and then transfer them to Providence Anchorage Medical Center rather than keeping them at "our own full-fledged hospital" said Elizabeth Ripley, spokeswoman for the Mat-Su Valley hospital. "We wanted to deliver care locally," she said.

The community broke ground on the new 74-bed Mat-Su Regional Medical Center on May 17, 2004 and opened its doors on January 27, 2006.

Shortly before the deal with Triad was approved, Providence had announced it had purchased an option to buy 99 acres of land just south of the new Mat-Su hospital. In June 2005, Providence announced that it would relocate two of its physician clinics to a new medical office building it was developing on the land. In December 2005, Providence announced a joint venture with the Imaging Associates of Providence (IAP) radiology group. The joint venture, Mat-Su Imaging Services, would locate in the new office building.

Providence did not file an application for a certificate of need for the imaging facility; but in March 2006 Norman Stephens, CEO of the new Mat-Su hospital, wrote to Health Commissioner Karleen Jackson asking the state to investigate whether or not a certificate of need was required. In doing so, Stephens said, "Mat-Su Regional Medical Center may be adversely and substantially affected by the violation of the Certificate of Need statute..."

Commissioner Jackson agreed with PH&S Alaska that the imaging facility was actually a physician's office, not a "heath care facility," and was therefore exempt from the certificate of need requirements. Mat-Su appealed, arguing that "IAP does not meet the exemption for physician offices as its majority investor is a hospital, Providence Health System. Every day that IAP is allowed to continue operating its MRI is a violation of the law and financially penalizes Mat-Su Regional. " (Imaging is a widely known as a lucrative health care business that acute care hospitals often resent because independent imaging operations can "cream" revenue away from a hospital's fragile service mix.)

Jackson rejected that appeal. She reversed herself, however, after a court ruled that an independent diagnostic testing facility in Fairbanks, Alaska, required a Certificate of Need. She informed IAP on August 17, 2006 that a certificate of need would be required for Mat-Su Imaging Services.

At the request of Ed Lamb, CEO of Alaska Regional Medical Center, Jackson informed Providence that IAP's Anchorage Abbott Road Imaging Facility would also require a certificate of need.

Providence appealed both decisions. Administrative Law Judge Terry L. Thurbon consolidated the cases in November 2006, and is now considering the matter.

PH&S Alaska currently owns at least 40-acres of land that surrounds the Mat Su Regional Medical Center. The former Providence employee who secured the land purchase while he worked for the hospital now holds a 10-year development agreement that gives him exclusive rights to develop the property, where he hopes to build a hotel, retail and office space, and several "destination restaurants. " Asked about the property "in the vicinity of the new Valley Hospital," Providence Alaska Region CEO Parrish stated, "It's not only in the vicinity, it completely surrounds it. "

Executives

Al Parrish became CEO of the Providence Alaska Region in 2002 after working in the Alaska tourism industry for the previous 20 years. In a recent interview, Parrish acknowledged PH&S Alaska's ambitious plans, saying, "It probably does give the appearance, which is an accurate appearance, that we really have a lot of irons in the fire. But the need was there and we said we will address that need. " Providence reports Parrish's 2005 salary as $417,641.

Robert Dvorak earned a $338,162 salary in 2005 for his work as Providence Alaska's chief financial officer.

Susan Humphrey-Barnett is the area operations administrator for PH&S Alaska, where she is in charge of operations outside of PAMC. Her 2005 salary was $191,844.

Joel Gilbertson, former Alaska Commissioner of Health and Social Services, is now regional

Alaska Health, Education & Social Services Committee

Testimony on Certificate of Need

by

Robert James Cimasi

MHA, ASA, CBA, AVA, CM&AA, CMP

January 25, 2008

Testimony Related to Alaska Senate Bill 245: ***An Act establishing the Alaska Health Care Commission and the Alaska Health Care Information Office; relating to healthcare planning and information; repealing the certificate of need program for certain healthcare facilities; and providing for an effective date"***

January 25, 2008

By Robert James Cimasi, MHA, ASA, CBA, AVA, CM&AA, CMP

Good afternoon Senators and Ms. Chairman. Thank you for the opportunity to speak before members of the Alaska Senate Health Education & Social Services Committee regarding the proposed Senate Bill 245: "*An act establishing the Alaska Health Care Commission and the Alaska Health Care Information Office; relating to healthcare planning and information; repealing the certificate of need program for certain healthcare facilities; and providing for and effective date.*[1]"

My name is Robert James Cimasi. I am President of Health Capital Consultants, a national healthcare economic and financial consulting firm located in St. Louis, MO. On August 16, 2001, I was appointed to serve on the Acute Care Focus Group of the Missouri Certificate of Need Technical Advisory Committee (CONTAC) for the Missouri Health Facilities Review Committee (MHFRC). Over the past years my firm has conducted dedicated, focused research resulting in a comprehensive reference manual & sourcebook encompassing the statutory, regulatory, administrative, and legal aspects of Certificate of Need (CON) regulation from its inception in the late 1960's to the present. Elements of this research on CON have been published in December 2005 as "*The U.S. Healthcare Certificate Of Need Sourcebook*" which summarizes numerous studies, monographs, and research reports regarding CON regulations, as well as, law review, and bar journal articles, and in excess of 700 published legal cases related to CON. Attached to your handouts is a brief description of my professional qualifications.

Over the years, the scope of my professional activities, including testimony in court, and before legislative and agency hearings, has required and permitted me and my firm to conduct extensive research and analysis in the areas of healthcare delivery; public health planning; healthcare economics and market competition; as well as, other Certificate of Need (CON) related topics. Based on these activities, and experience, it is my informed view that this committee should vote to advance Senate Bill 245 (hereinafter referred to as the PROPOSED BILLS).

CON is a failed public health policy which is bad for Alaska citizens and patients for several key reasons. The following topics should be addressed:

1. **CON's History as Failed Health Planning Policy;**
2. **The Effects of CON Repeal in Several States;**
3. **The Federal Trade Commission's Repeated Denunciation of CON;**
4. **CON Has Failed to Lower Healthcare Costs;**
5. **CON is Anti-competitive;**
6. **CON is a Barrier to Healthcare Innovation;**

[1] Health Care Plan/Commission/Facilities by Alaska Senate, Alaska Senate, January 2008, www.legis.state.ak.us/basis/get_complete_bill.asp?session=25&bill SB245(2008)

7. **CON Reduces Access and Patient Choice; and,**
8. **CON Hasn't Improved Healthcare Quality.**

1. CON's History as Failed Health Planning Policy

CON legislation was put in place nationally as a result of a Federal mandate in 1974. Based on over three (3) decades of experience, it is now clear that the CON process does not offer the better, more efficient solution to reducing healthcare cost that its proponents have proudly proclaimed. As Duke Professor of Law Clark Havighurst concludes "*Protectionist regulation, long discredited in other areas, is particularly misguided in healthcare, where health insurance greatly increases the profitability of monopoly and imposes the resulting higher costs on unwilling premium payers. To use cross-subsidies to finance even worthy (let alone unworthy) health care projects is to put public burdens unfairly (regressively) on the backs of working Americans.*"[2]

By 1986, the federal government had shifted its attitude toward CON regulation. The federal CON legislation that was passed in 1974 had, within over a decade, became apparent that the effort had failed. The National Health Planning Act was repealed due to "mounting empirical evidence that certificate of need cost containment objectives were not being realized."[3]

Instead, the application of CON regulation has only encouraged erroneous outcomes, to the detriment of Alaska's public interest, on the basis of insufficient valid data; flawed methodology; arbitrary and capricious standards; and, the ambiguity of unrestricted agency discretion in an atmosphere of political influence. The Alaskan CON process' almost total lack of applicable, valid empirical data; the absence of generally accepted methodological standards of economic and financial analysis; and, the lack of consideration of all required pertinent variables, are based on statutes and rules that are so fatally flawed and so clearly based on arbitrary and capricious standards as to be unreasonably burdensome on the citizens and patients of Alaska. Your passage of Senate Bill 245 would relieve this onerous situation.

2. Effects of CON Repeal

The Joint Legislative and Audit Review Committee and the Health Policy Analysis Program of the University of Washington's School of Public Health and Community Medicine published a study of the certificate-of-need program in the state of Washington on January 8, 1999. The results of this study are published as the "*Effects of Certificate of Need and Its Possible Repeal*". This meta-study, one of the most comprehensive efforts recently conducted in the area of CON, "*examined the effects of CON and its possible repeal on the cost, quality, and availability of five health services – hospitals, ambulatory surgery, kidney treatment, home health, and hospice – as*

[2] "Monopoly Is Not The Answer," By Clark C. Havighurst, Health Affairs, August 9, 2005.

[3] *See* Aaron S. King, *Medical Market Failure in Maine: Is the Dirigo Reform Act's Certificate of Need a Market Correction?*, 22 Me. B.J. 156 (2007).

well as on charity care and health services in rural areas."[4] Results of this study were based on literature review, interviews and information from healthcare providers and healthcare economic experts in the State, as well as an analysis of eight (8) states which completely or partially repealed their CON laws (i.e. Arizona, Indiana, Ohio, Pennsylvania, Tennessee, Texas, Utah, and Wisconsin).[5] The study found that CON *"has not controlled overall healthcare spending or hospital costs."* It also found *"conflicting or limited evidence about the effects of CON on the quality and availability of other healthcare services or about the effects of repealing CON."*[6]

The study does not predict the effects of CON repeal; however, the study reflected that CON has been shown to restrict the supply of some specific health services in some areas, and inferred that, perhaps as a result, supply surges occurred in some specific health services of some areas.[7] Some supply surges were experienced in psychiatric hospitals and nursing homes (Utah); nursing homes and open heart surgery (Arizona); home health (Tennessee); hospitals, ambulatory surgery centers, dialysis, and pediatric services (Ohio); hospitals and psychiatric hospitals (Wisconsin) and nursing homes and psychiatric hospitals (Texas) after the repeal of CON.[8] These finding were not consistent in every state that completely or partially repealed their CON laws that was included in the Washington study.

> *"Not all states experience surges after repeal. When surges do occur, they tend to moderate over time"...In addition, initial surges are sometimes followed by periods of shakeout and stabilization. Therefore, while short term supply increases do appear at times after CON repeal, such surges have been insufficiently studied to determine if there are any persistent effects on cost (or on other goals such as quality and access).*[9]

A 1998 empirical study, which examined health spending between the late 1970's and 1993 looked at spending prior to and directly after state CON laws were repealed, stated:

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[4] "Effects of Certificate of Need and Its Possible Repeal", Joint Legislative and Audit Review Committee and the Health Policy Analysis Program of the University of Washington's School of Public Health and Community Medicine, Jan. 8, 1999, p. i.

[5] "Effects of Certificate of Need and Its Possible Repeal", Joint Legislative and Audit Review Committee and the Health Policy Analysis Program of the University of Washington's School of Public Health and Community Medicine, Jan. 8, 1999, p. ii, 6.

[6] "Effects of Certificate of Need and Its Possible Repeal", Joint Legislative and Audit Review Committee and the Health Policy Analysis Program of the University of Washington's School of Public Health and Community Medicine, Jan. 8, 1999, p. iii.

[7] "Effects of Certificate of Need and Its Possible Repeal", Joint Legislative and Audit Review Committee and the Health Policy Analysis Program of the University of Washington's School of Public Health and Community Medicine, Jan. 8, 1999, p. 10.

[8] "Effects of Certificate of Need and Its Possible Repeal", Joint Legislative and Audit Review Committee and the Health Policy Analysis Program of the University of Washington's School of Public Health and Community Medicine, Jan. 8, 1999, p. 13.

[9] "Effects of Certificate of Need and Its Possible Repeal", Joint Legislative and Audit Review Committee and the Health Policy Analysis Program of the University of Washington's School of Public Health and Community Medicine, Jan. 8, 1999, pp. 11, 13.

> *"The major findings about CON can be summarized as follows: first, we found no surge in expenditures after CON was lifted; second, despite a statistically significant reduction by mature programs on acute spending per capita, there was no corresponding reduction in total per capita spending (apparently due to offsetting expenditures on non-hospital services)...We found that mature CON reduced hospital bed supply per capita population, but could detect no increase in bed supply following the removal of CON.*[10]

Further, the study authors found that established CON programs increased cost per adjusted patient day and also cost per admission.

According to a Conover and Sloan 1998 study, there was no empirical support that CON saved any money. Further, researchers concluded "There is no evidence of a surge in acquisition of facilities or in costs following removal of CON regulations . . . CON regulations generally have no detectable effect on diffusion of various hospital-based technologies. It is doubtful that CON regulations have had much of an effect on quality of care, position of negative."[11] Experts have surmised that CON may increase the cost of health care. Administrative costs associated with state-level oversight and litigation expenses increase to the costs.[12] This is compounded by the problem that the CON approval process is highly technical in nature.

3. The Federal Trade Commission's Repeated Denunciation of CON;

3.1 FTC and DOJ Joint Hearings and Report on Healthcare Competition and CON

In November, 2002, FTC Chairman, Timothy J. Muris, announced that the FTC would hold joint hearings with the DOJ on competition in healthcare in 2003.[13] On July 23, 2004, following the conclusion of the hearings lasting over six (6) months, the FTC and DOJ (agencies) issued a joint report on July 23, 2004, entitled "*Improving Health Care: A Dose of Competition*" in which the agencies recommended that states decrease barriers to entry into provider markets. The agencies encouraged states to reconsider whether CON programs "*best serve their citizens' health care needs*".[14]

Following testimony at numerous hearings from industry representatives and legal, economic,

[10] "Does Removing Certification-of-Need and Regulations Lead to a Surge in Health Care Spending?" Conover, Christopher J., Sloan, Frank A., Journal of Health Politics, Policy and Law, vol. 23, no. 3, June 1998, p. 455

[11] Christopher J. Conover, Frank A. Sloan, *Does Removing Certificate of Need Regulations Lead to a Surge in Health Care Spending?*, 23 J. HEALTH POL. POL'YY & L. 455 (1998).

[12] *See* Aaron S. King, *Medical Market Failure in Maine: Is the Dirigo Reform Act's Certificate of Need a Market Correction?*, 22 Me. B.J. 156 (2007).

[13] "FTC Chairman Announces Public Hearings on Health Care and Competition Law and Policy to Begin in February 2003" Federal Trade Commission, www.ftc.gov/opa/2002/11/murishealthcare.htm. (Accessed Aug. 5, 2004).

[14] "Improving Health Care: A Dose of Competition" A Report by the Federal Trade Commission and the Department of Justice, July 2004, Executive Summary, p. 22.

and academic experts on the healthcare industry and health policy, the agencies concluded that the burdens placed on competition by CON programs "*generally outweigh*" its "*purported economic benefits*". **The agencies suggested that instead of reducing costs, there is evidence that CON programs actually drive up costs by "*fostering anticompetitive barriers to entry*".**[15]

The agencies expressed concern that CON programs raise healthcare costs because they appear to be used to shield healthcare providers from competition. The agencies expressed further concern that CON programs tend to prevent entry into the market by enterprises that may be able to provide higher quality care, and the report contended that CON programs may delay the introduction of new technology. In support of their conclusions, the agencies relied upon empirical studies that showed CON programs generally failed to control costs and actually appear to result in higher healthcare costs.[16]

Subsequent to the FTC's July 23, 2004 report, in a May 24, 2005 "*Prepared Statement of the Federal Trade Commission Before the SubCommittee on Federal Financial Management, Government Information, and International Security of the Committee on Homeland Security and Governmental Affairs, U.S. Senate on New Entry Into Hospital Competition*," the agency stated that, " *vigorous competition can have important benefits in the hospital arena, just as in the multitude of markets in the U.S. economy that rely on competition to maximize the welfare of consumers. Competitive pressures can lead hospitals to lower costs, improve quality and compete more efficiently. Competitive pressures also may spur new types of competition. In hospital markets, some new entrants specialize and prove only a limited portion of the in-patient and out-patient services that general hospital tend to provide.*"[17] Specifically, the FTC testimony emphasized that, "Overall, testimony at the FTC/DOJ Hearings identified a number of benefits that SSHs [single specialty hospitals] may offer to consumers, with no significant controversy about the potential for SSHs to provide those benefits. Rather, as discussed in more detail below, debate about SSHs generally centered on how they may affect the functioning of general hospitals."[18] Ultimately, the FTC testimony related to the efficacy of CON concluded that,

> "*The Commission believes that CON programs generally are not successful in containing health care costs, and that they can pose anticompetitive risk. As noted above, CON*

[15] "Improving Health Care: A Dose of Competition" A Report by the Federal Trade Commission and the Department of Justice, July 2004, ch. 8, pp. 1-2.
[16] "Improving Health Care: A Dose of Competition" A Report by the Federal Trade Commission and the Department of Justice, July 2004, ch. 8, p. 4.
[17] Prepared Statement of the Federal Trade Commission Before the SubCommittee on Federal Financial Management, Government Information, and International Security of the Committee on Homeland Security and Governmental Affairs, U.S. Senate on New Entry Into Hospital Competition, May 24, 2005, p. 3.
[18] Prepared Statement of the Federal Trade Commission Before the SubCommittee on Federal Financial Management, Government Information, and International Security of the Committee on Homeland Security and Governmental Affairs, U.S. Senate on New Entry Into Hospital Competition, May 24, 2005, p. 8.

> *programs risk entrenching oligopolists and eroding consumer welfare. The aim of controlling costs is laudable, but there appear to be other, more effective means of achieving this goal that do not pose anticompetitive risks. Indeed, competition itself is often the most effective method of controlling costs. A similar analysis applies to the use of CON programs to enhance health care quality and access.*"[19]

These Federal findings, by the FTC and DOJ, are only one of the significant pronouncements in the last several years that support the rational justification to eliminate CON and support a level playing field for providers in fostering *"a dose of"* market competition in healthcare.

3.2 Previous FTC Studies of CON

The FTC's unfavorable review of CON as a failed health policy planning mechanism is not a new event. Beginning in the late 1980s, the FTC issued several studies on CON and stated that, "*Market forces generally allocate society's resources far better than decisions of government planners.*"[20]

3.3 The FTC's Recommendations That States Repeal CON

The FTC has consistently recommended that the states remove their CON regulations. In a 1987 letter to Virginia officials they stated, *"Any potential benefits of CON regulation are likely to be outweighed by the adverse effects of such regulation on competition in health care markets. Consequently, CON regulation is likely to harm consumers on balance by increasing the price, and decreasing the quality, of health services in Virginia."*[21] The FTC has issued similar statements before numerous states considering the repeal of CON laws.

4. CON Has Failed To Lower Healthcare Costs

After nearly thirty (30) years of study, the preponderance of healthcare economic analysis has clearly indicated that CON laws have failed to achieve their stated objectives. In an article reviewing CON laws and their application to modern markets, Patrick J. McGinley, Esq. wrote, "*In searching the scholarly journals, one cannot find a single article that asserts that CON laws succeed in lowering healthcare costs.*"[22]

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[19] Prepared Statement of the Federal Trade Commission Before the Subcommittee on Federal Financial Management, Government Information, and International Security of the Committee on Homeland Security and Governmental Affairs, U.S. Senate on New Entry Into Hospital Competition, May 24, 2005, p. 18.

[20] Press Release from the Federal Trade Commission, Aug. 10, 1987

[21] Press Release from the Federal Trade Commission, Aug. 10, 1987

[22] "Beyond Health Care Reform: Reconsidering Certificate of Need Laws In a Managed Care Competition System", McGinley, PJ., Florida State University Law Review, 1995.

Thomas Obermeyer

From: Tom Piper [macquest@mac.com]
Sent: Friday, February 15, 2008 8:41 AM
Subject: Missouri CON story

I have attached below the text of a lead editorial in today's St. Louis Post-Dispatch newspaper.

Tom

Pros and CON

02/15/2008

Long before the movie "Field of Dreams" and its iconic theme of "if you build it they will come," Dr. Milton I. Roemer reached the same conclusion. But instead of baseball fields, he was thinking about hospital beds.

Dr. Roemer's simple observation: The more that hospitals expand and the more hospital beds that are made available, the more beds that will be filled with patients and the more money that will be spent on health care. In other words, supply — not price or need — drives much of the demand for health care.

The idea stands traditional market economics on its head. Yet it's so widely accepted by health care economists that it's known today as Roemer's law.

It explains why many states require hospitals that want to build expensive new facilities to get an approval called a Certificate of Need, or CON. Missouri is one of those states. But a group of legislators with a shaky grasp of health care economics wants to change that.

House Bill 1806 would eliminate the CON process for hospitals and free-standing surgical centers. It was voted out of committee last week.

HB 1806 is being pitched as a way to increase competition and decrease costs, but it would have the exact opposite effect. That's counter-intuitive, especially to people who aren't professionals in health care economics. But it's been demonstrated time and again, and not just for hospital beds.

Wisconsin and Ohio both did away with their CON requirements. But the promised savings failed to materialize. What came instead is exactly what Dr. Roemer would have predicted.

— 26 new hospitals were built when Ohio's CON law was repealed.

— 82 new multi-million dollar MRI and CT scan centers were opened.

— The number of open heart surgeries performed in the state jumped by 38 percent. Many were judgment calls, done at the discretion of doctors who otherwise would opt for a more conservative approach than surgery.

When Pennsylvania's CON law was repealed, the number of MRI machines jumped from 78 to 187, and capacity at cardiac catheterization labs jumped by 90 percent.

All that new equipment and expertise has to be paid for somehow. A 2001 study by Chrysler, Ford and General Motors shows the effect. The study examined health costs over several years in eight states, including Missouri. It found that costs were 11 to 39 percent lower in states with CON requirements than in those without it.

In a landmark study, Dartmouth University researchers found that Medicare pays twice as much per patient in Miami as it does in Minneapolis. The difference largely is because Florida patients are more likely to be referred to medical specialists, where they often are given expensive tests and admitted to hospitals.

But the patients in Miami don't live longer or have a better quality of life than those in Minneapolis. A more recent Dartmouth study found that patients in cities where health spending was highest actually died sooner than those where it was lower.

National health spending grew by 55 percent between 2000 and 2006, from $1.3 trillion to $2.1 trillion. That trickles down in the form of higher spending on Medicaid and bigger premiums for state employees' insurance. It's understandable that Missouri lawmakers would be looking for a way to slow that staggering rate of growth.

But repealing CON requirements on hospitals and surgical centers would be like trying to douse a fire with gasoline. The St. Louis Area Business Health Coalition, made up of big companies that provide insurance to their workers, testified against HB 1806 last week. The coalition analyzes health costs and hospital performance in the region. It often publishes information that hospitals would prefer go unnoticed.

Lawmakers on the House Special Committee on Healthcare Transformation, which approved the CON repeal, obviously didn't hear what the professionals had to say. Legislative leaders should sidetrack this ill-considered bill or we'll all end up paying higher prices.
spacer

Senate Bill - 245
Senator Bettye Davis
Fax: 907-465-3756

Date: 2-25-2008

RE: Elimination of the Certificate of Need (CON)

Yes, I support Governor Palin's initiative to eliminate the Certificated of Need (CON) in Alaska.

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

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

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

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

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

I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Kyle R. Fulford
Signature: Kyle R. Fulford
Address: P.O. Box 3071 Anderson AK
Telephone: 1-907-582-2941

Senate Bill - 245
Senator Bettye Davis
Fax: 907-465-3756

Date: ___________

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

I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: David B Henry
Signature: [signature]
Address: P.O. Box 60527 Fairbanks, AK 99
Telephone: 907 455 4673

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

SARAH PALIN, GOVERNOR

P.O. BOX 110601
JUNEAU, ALASKA 99811-0601
PHONE: (907) 465-3030
FAX: (907) 465-3068

February 13, 2008

Honorable Bettye Davis, Chair
Senate HES Committee
State Capitol, Room 30
Juneau, AK 99801-1182

Dear Senator Davis:

Referring to **Senate Bill 245, Version K**, the department responses to questions received concerning the definition of health care facility, which includes on p.3, lines 6-8, Sec. 2, (8)(A)(ii), "a facility that is in a community in which a hospital is designated by the department as a critical access hospital," are provided below:

1) ***clarification and a list of which health care facilities in Alaska are designated by the department as "critical access hospitals;"***

Critical Access Hospitals in Alaska: (Medicare certified)

Cordova Community Medical Center
Kanakanak General (Dillingham)
Ketchikan General
Maniilaq Health Center (Kotzebue)
Norton Sound Regional Hospital (Nome)
Petersburg Medical Center
Providence Kodiak Island Medical Center
Providence Seward Medical & Care Center
Providence Valdez Medical Center
Samuel Simmonds Memorial (Barrow)
Sitka Community
South Peninsula (Homer) *
Wrangell Medical Center

*Applying to be designated as a CAH

Critical Access Hospitals are small, rural hospitals that are financially challenged given the limited population size they serve. These are hospitals that are located in a county (borough) considered rural, is located more than a 35 mile drive from another facility or is a necessary provider of health care services to residents in the area, and has no more than 25 in patient beds.

2) ***how long they are designated as "critical access hospitals;" – because CON protection expires with repeal per page 12, Sec. 13, July 1, 2010;***

Designation as a "critical access hospital" is ongoing, unless the hospital requests another type of designation as a hospital from CMS (Centers for Medicare and Medicaid Services), or they no longer meet the criteria for designation as a "critical access hospital", such as having over 25 beds.

3) ***whether the definition of "critical access hospital" on page 3, lines 21-24, Sec. 3, (11) is what the state uses under federal definitions – because Jean Mischel, in a cursory look at over 100 pages of federal statutes and regulations cited in the bill, found that the section seemed only to apply to rural areas; yet, she noted, for many purposes, all of Alaska is considered "rural" under federal law;***

That definition is correct.

The definition in federal regulation for Medicare indicates that "rural areas" refer to places outside of Metropolitan Statistical Areas and "large urban areas" which are defined as having more than 1,000,000 people. Thus all of our designated "critical access hospitals" are in rural areas.

4) ***Based on state designation of "critical access hospitals," are Providence, Fairbanks Memorial, and Bartlett hospitals considered "critical access hospitals?***

Providence, Fairbanks and Bartlett hospitals are not "critical access hospitals" as noted in the first question and response above. Each of these hospitals has over 25 beds and therefore do not meet the criteria for being designated as "critical access hospitals." In addition, Providence hospital is located within 35 miles of another hospital which would also disqualify them for designation. However, Providence has facilities in locations outside of Anchorage that are "critical access hospitals."

Sincerely,

Sherry Hill
Assistant Commissioner for Public Affairs

cc: Senator John Cowdery, Capitol Building, Room 101
Senator Kim Elton, Capitol Building, Room 506
Senator Joe Thomas, Capitol Building, Room 510
Senator Fred Dyson, Capitol Building, Room 121
Karleen Jackson, Commissioner
Jay Butler, Chief Medical Officer
Wilda Laughlin, Special Assistant
Russell Kelly, Governor's Office, Legislative Director
Mindy Rowland, Governor's Office, Deputy Legislative Director
Anna Kim, Special Assistant
Stacie Kralie, Chief Assistant Attorney General
Deborah Behr, Chief Assistant Attorney General

Don Burrell

From: Deborah Sward [deborah.sward@ncsl.org]
Sent: Tuesday, February 12, 2008 8:54 AM
To: Don Burrell
Subject: NCSL Emerging Health Leaders Conference Call for Legislative Staff

Dear Mr. Burrell:

You have been selected as a knowledgeable legislative staffer with previous interaction with NCSL's Emerging Health Leaders Project (also known as CHAP or Critical Health Areas Project). As we begin the third year of the CHAP project, we are seeking your help. We would like your ideas on how to involve legislative staff in this project in a more central way.

Over the past two years, CHAP has provided training, research support and technical assistance to legislators who are likely to be future state health policy leaders and have been appointed by their state's legislative leadership. CHAP focuses on four health issues: chronic care and quality, healthcare access, addiction prevention and treatment, and the health care workforce. Currently, staff designated by CHAP legislators receive listserv notices and publications and, at times, attend meetings with or instead of their states' CHAP members. As we plan CHAP activities for the year, we would like to consider new strategies to better meet the needs of legislative staff working on state health policy.

We invite you to participate in a conference call to share your thoughts on strengthening the project's involvement with legislative staff. Please let us know whether you can participate and indicate which of the three times listed below (or others) works best for you for a phone conversation. Please return the form at the bottom of this page by fax or email to Deborah Sward at (202)737-1069 or deborah.sward@ncsl.org. Prior to the call, we will send you discussion questions and dial-in instructions.

Thank you for considering this request. We look forward to talking with you. For more information on CHAP, please contact Tara Lubin at (202)6?4-3558 or at tara.lubin@ncsl.org.

Regards,

Deborah Sward
On behalf of
Donna Folkemer, Group Director
Forum for State Health Policy Leadership, National Conference of State Legislatures RSVP Information - CHAP Staff Conference Call Please fax or email to Deborah Sward at (202)737-1069 or deborah.sward@ncsl.org

Name Don Burrell Jr
State Alaska Title H.E.S.S. Committee Aide
Email Address don_burrell@legis.state.ak.us Phone # 907-465-[illegible]/907-269-[illegible]

X I would like to participate in the CHAP staff conference call.
Availability (please check all that apply):
___Friday, February 29, 2008; 3:00-4:00 p.m. ___ Other: ______

___Monday, March 3, 2008; 3:00-4:00 p.m.
X Tuesday, March 4, 2008; 3:00-4:00 p.m.
___ Wednesday, March 5, 2008; 3:00-4:00 p.m.
___I will not be participating.

Please list any previous or current involvement with CHAP if applicable (e.g. receiving CHAP newsletter): CHAP Meeting October 3-5, 2007 - St. Louis, Mo

Alaska State
Legislature
State Capitol
Junaau, AK 99801
907 465-3822 office
907 465-3756 fax
From the Office of Senator Bettye Davis

To:	Legal Services	**Fax:**	**465-2029; phone: 465-2450**
From:	Thomas S. Obermeyer	**Date:**	2/19/2008
Re:	Request for typed amendments drafted to revise CSSB 245( ), Work Draft 25-GS2050\L (dated 2/11/08) - see attached	**Pages:**	12 pages including cover
CC:			

X **Urgent** **For Review** ☐ **Please Comment** **Please Reply** ☐ **Please Recycle**

Please rush typed amendments, if possible, before HESS meeting Wednesday, 2/20/08 at 1:30 p.m.

To Whom It May Concern:

Senator Davis asks if you could type and fax or hand-deliver amendments for the changes marked up on the attached copy of work draft 25-GS2050 L by the time of the meeting Wednesday, February 20, 2008 at 1:30 p.m. Senator Davis prefers to discuss these changes with the HESS Committee in a form easier to read if possible. She does not want a CS at this time.

Please call me in the morning if you are unable to draft amendments by time of hearing.

Thank you for your consideration.

Tom Obermeyer
465-3762

P. 01

TRANSACTION REPORT

FEB-19-2008 TUE 06:40 PM

FOR: Senator Bettye Davis 9074653756

SEND

DATE	START	RECEIVER	TX TIME	PAGES	TYPE	NOTE	M#	DP
FEB-19	06:39 PM	94652029	1'28"	12	FAX TX	OK	975	

TOTAL : 1M 28S PAGES: 12

Alaska State Legislature
State Capitol
Juneau, AK 99801
907 465-3822 office
907 465-3756 fax
From the Office of Senator Bettye Davis

To: Legal Services **Fax:** 465-2029; phone: 465-2450

From: Thomas S. Obermeyer **Date:** 2/19/2008

Re: Request for typed amendments drafted to revise CSSB 245( ), Work Draft 25-GS2050\L (dated 2/11/08) -see attached **Pages:** _12_ pages including cover

CC:

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Please call me in the morning if you are unable to draft amendments by time of hearing.

Thank you for your consideration.

TOM

Tom Obermeyer
465-3762

25-GS2056\I
Mischel
2/11/08

CS FOR SENATE BILL NO. 245( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIFTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): SENATE RULES COMMITTEE BY REQUEST OF THE GOVERNOR

A BILL

FOR AN ACT ENTITLED

1 **"An Act establishing the Alaska Health Care Commission and the Alaska health care**
2 **information office; relating to health care planning and information; amending the**
3 **certificate of need requirements to exclude expenditures for diagnostic imaging**
4 **equipment in certain circumstances; and providing for an effective date."**

Suggested title changes coming

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

6 *** Section 1.** AS 18.05.010(b) is amended to read:
7 (b) In performing its duties under this chapter**, AS 18.09,** and AS 18.15.355 -
8 18.15.395, the department may
9 (1) flexibly use the broad range of powers set out in this title assigned
10 to the department to protect and promote the public health;
11 (2) provide public health information programs or messages to the
12 public that promote healthy behaviors or lifestyles or educate individuals about health
13 issues;
14 (3) promote efforts among public and private sector partners to

Pg 2

1 develop and finance programs or initiatives that identify and ameliorate health
2 problems;
3 (4) establish, finance, provide, or endorse performance management
4 standards for the public health system;
5 (5) develop, adopt, and implement
6 **(A) a statewide health plan under AS 18.09 based on**
7 **recommendations of the Alaska Health Care Commission established in**
8 **AS 18.09.010; and**
9 **(B)** public health plans and formal policies through regulations
10 adopted under AS 44.62 or collaborative recommendations that guide or
11 support individual and community public health efforts;
12 (6) establish formal or informal relationships with public or private
13 sector partners within the public health system;
14 (7) identify, assess, prevent, and ameliorate conditions of public health
15 importance through surveillance; epidemiological tracking, program evaluation, and
16 monitoring; testing and screening programs; treatment; administrative inspections; or
17 other techniques;
18 (8) promote the availability and accessibility of quality health care
19 services through health care facilities or providers;
20 (9) promote availability of and access to preventive and primary health
21 care when not otherwise available through the private sector, including acute and
22 episodic care, prenatal and postpartum care, child health, family planning, school
23 health, chronic disease prevention, child and adult immunization, testing and screening
24 services, dental health, nutrition, and health education and promotion services;
25 (10) systematically and regularly review the public health system and
26 recommend modifications in its structure or other features to improve public health
27 outcomes; and
28 (11) collaborate with public and private sector partners, including
29 municipalities, Alaska Native organizations, health care providers, and health insurers,
30 within the public health system to achieve the mission of public health.
31 * **Sec. 2.** AS 18.07.031(a) is amended to read:

1 (a) Except as provided in **(c), (d), and (f)** [(c) AND (d)] of this section, a
2 person may not make an expenditure of $1,000,000 or more for any of the following
3 unless authorized under the terms of a certificate of need issued by the department:
4 (1) construction of a health care facility;
5 (2) alteration of the bed capacity of a health care facility; or
6 (3) addition of a category of health services provided by a health care
7 facility.
8 *** Sec. 3.** AS 18.07.031(e) is amended to read:
9 (e) In
10 **(1)** (a) of this section, "expenditure" includes the purchase of property
11 occupied by or the equipment required for the health care facility and the net present
12 value of a lease for space occupied by or the equipment required for the health care
13 facility; "expenditure" does not include costs associated with routine maintenance and
14 replacement of equipment at an existing health care facility**;**
15 **(2) (f) of this section, "critical access hospital" refers to a facility**
16 **designated as a critical access hospital by the department by regulatory authority**
17 **exercised under AS 18.05 or AS 18.20**.
18 *** Sec. 4.** AS 18.07.031 is amended by adding a new subsection to read:
19 (f) Notwithstanding the limitations in (a) of this section, a person may make
20 an expenditure of $1,000,000 or more for diagnostic imaging equipment without
21 authorization under the terms of a certificate of need issued by the department if the
22 equipment is used in a health care facility that
23 (1) is located in a
24 (A) borough with a population of 60,000 or more; and
25 (B) a city that does not have a facility designated by the
26 department as a critical access hospital; and
27 (2) has at least a 50 percent ownership by one or more physicians
28 licensed in the state who are qualified to interpret, and actually interpret, diagnostic
29 images produced by the equipment in the facility.
30 *** Sec. 5.** AS 18 is amended by adding a new chapter to read:
31 **Chapter 09. Statewide Health Care Planning and Information.**

1 **Article 1. Alaska Health Care Commission; State Health Plan.**

2 **Sec. 18.09.010. Alaska Health Care Commission.** The Alaska Health Care
3 Commission is established in the Department of Health and Social Services. The
4 purposes of the commission are
5 (1) to provide recommendations for and foster the development of a
6 statewide plan to address the quality, accessibility, and availability of health care for
7 all citizens of the state; and
(2) to review and approve the department's plan for who shall report data, what data will be required, with each facility type will be required to begin reporting, and the reporting system to be imposed
8 (3) to review and approve facility health care information for
9 placement on the department's Internet database established under AS 18.09.110.

10 **Sec. 18.09.020. Composition; chair.** (a) The commission consists of 13
11 members as follows:
12 ~~(1) the state officer assigned the duties of medical director for the~~
13 ~~department;~~
14 (1) one member representing the ~~Department of Administration~~ Governor,
15 appointed by the ~~commissioner of administration~~ Governor;
16 ~~(3) one member representing the Department of Commerce,~~
17 ~~Community, and Economic Development, appointed by the commissioner of~~
18 ~~commerce, community, and economic development;~~
19 ~~(4) one member representing the Department of Labor and Workforce~~
20 ~~Development, appointed by the commissioner of labor and workforce development;~~
21 (2) ~~(5)~~ three ~~six~~ public members, appointed by the governor; one of the
22 members appointed under this paragraph must be a small business owner in the state;
(3) three health care providers representing hospitals, physicians and mental health
23 (4) ~~one~~ two member from the house of representatives, appointed by the
24 speaker of the house;
25 (5) ~~(7)~~ ~~one~~ two member from the senate, appointed by the president of the
26 senate; and (6) one member representing Alaska tribal health care system.
27 ~~(8) one member representing the Office of the Governor.~~
(7) one member representing health care insurance
28 (b) The ~~department's~~ Governor's representative appointed under (a)(1) of this section shall
29 serve as chair of the commission.

30 **Sec. 18.09.030. Term of office.** (a) Public members of the commission
31 appointed under AS 18.09.020(a)(5) serve for staggered terms of ~~three~~ Five years.

1 (b) If a vacancy occurs in a public member's seat on the commission, the
2 governor shall make an appointment for the unexpired portion of that member's term.
3 (c) The governor may remove a public member of the commission from office
4 only for cause.
5 **Sec. 18.09.040. Executive director.** The commission shall employ an
6 executive director, with appropriate health care policy experience, who may not be a member of the commission. The executive
7 director serves at the pleasure of the commission. The commission shall establish the
8 duties of the executive director. The executive director is in the partially exempt
9 service under AS 39.25 (State Personnel Act).
10 **Sec. 18.09.050. Staff.** The department may assign employees of the
11 department to serve as staff to the commission. The commission shall prescribe the
12 duties of the commission staff.
13 **Sec. 18.09.060. Bylaws.** The commission, on approval of a majority of its
14 membership and consistent with state law, shall adopt and amend bylaws governing
15 proceedings and other activities, including provisions concerning a quorum to transact
16 commission business and other aspects of procedure; frequency and location of
17 meetings; and establishment, functions, and membership of committees.
18 **Sec. 18.09.070. Duties of the commission.** (a) The commission shall serve as
19 the state health planning and coordinating body. Consistent with state and federal law,
20 the commission shall provide recommendations for and foster the development of a
21 statewide health plan containing the following:
22 (1) a comprehensive statewide health care policy;
23 (2) a strategy for
24 (A) encouraging personal responsibility in prevention and
25 healthy living for all residents of the state;
26 (B) reducing rate of growth in health care costs for all residents of the state to
27 ~~below the national average;~~ make it more affordable.
28 (C) improving ~~ensuring~~ access in communities to safe water and
29 wastewater systems;
30 (D) developing a sustainable health care workforce in the state;
31 (E) improving ~~ensuring~~ access to quality health care for all residents of the

New Text Underlined [DELETED TEXT BRACKETED]

1 state; and
2 (4) increasing the number of residents of the state who are
3 covered by insurance for health care services.
4 (b) The commission shall review and approve health care information for
5 placement on the department's database developed under AS 18.09.110 and establish a
6 schedule for implementation of the database and reporting requirements under
7 AS 18.09.120.
8 (c) The commission shall submit to the governor and the legislature by
9 January 15 of each year an annual report regarding the commission's
10 recommendations and activities.
11 **Sec. 18.09.080. Compensation, per diem, and expenses.** A public member
12 appointed to the commission under AS 18.09.020(a)(5) is not entitled to a salary, but
13 is entitled to per diem, reimbursement for travel, and other expenses authorized by law
14 for boards and commissions under AS 39.20.180.
15 **Article 2. Alaska Health Care Information Office.**
16 **Sec. 18.09.100. Office.** The Alaska health care information office is
17 established in the department. The purpose of the office is to improve access by
18 residents of the state to consistently updated
19 (1) information about health care ~~facilities~~ services price & quality to aid consumers ~~of health~~
20 ~~care services of health care facilities in the state; and~~ in making health care decisions;
21 (2) information to encourage personal responsibility in prevention and
22 healthy living.
23 **Sec. 18.09.110. Dissemination of information.** (a) The department shall
24 establish and maintain an information database on the Internet of information about [all] delete
25 health care facilities in the state to provide objective, unbiased, and factually based
26 information on health care [facilities] services in the state. The department may require those
27 health care facilities to provide information in a standard form or format to the
28 department for placement in the database. Before information is placed on the
29 database, the commission shall review the information for accuracy with the health care facility.
30 (b) The database developed under (a) of this section ~~must~~ may include the
31 following

do you want to make this change?

1 (1) a list of preferred drugs approved by the department for
2 reimbursement by the department;
3 (2) a complete list, organized by region and address, of
4 (A) health care facilities located in the state;
5 (B) licensed pharmacists and pharmacies located in the state;
6 (C) emergency and urgent care facilities located in the state;
7 (D) health insurance companies offering coverage in the state;
8 (E) health care providers licensed in the state, including the
9 provider license number, type, and expiration date along with disciplinary
10 actions, if any;
11 (F) long-term, in-home, and hospice care providers located in
12 the state;
13 (G) public assistance offices of the department;
14 [(3) a list of the 100 most commonly prescribed medications in the state
15 and the source and price, updated monthly, of the medications;] -- ? means what ?
16 (3) [(4)] a list of the 100 most commonly conducted medical procedures in
17 the state, organized by the cash and negotiated price of the procedure at available
18 providers and insurers, updated annually; the list must include medical procedures
19 covered by workers' compensation under AS 23.30;
20 (4) [(5)] available hospital ratings, such as Hospital Compare, including the rates of hospital acquired
21 infections and mortality occurring at each hospital located in the state;
22 (5) [(6)] consumer education information on topics that include body mass
23 index, diet and nutrition, exercise, smoking cessation, and alcohol and drug addictions,
24 that includes the location of available sites that provide care and treatment related to
25 those issues;
26 (6) [(7)] a list of procedures approved by state agencies for emergency
27 response and treatment;
28 (7) [(8)] disease management support information;
29 (8) [(9)] insurance information that includes
30 (A) a navigator to determine insurance eligibility using a
31 matrix of available insurers;

Do you want to make these changes?

very difficult to define -- do.

What is this.

1 (B) links to Internet websites for purchasing insurance policies;

2 (C) an explanation of mandatory and optional insurance

3 coverage; (9)

4 ~~(10)~~ a list of primary care clinics that cater to uninsured and self-pay

5 patients; and (10) a list of physicians that accept new Medicare clients

6 (11) information on the quality of health care facilities, including any

7 actions taken by state or federal agencies related to

8 (A) licensure and accreditation of a health care facility; or

9 (B) a licensed professional practicing in a health care facility.

10 (c) The department may contract with a private entity to provide services and

11 information required under (a) of this section.

12 (d) The department shall develop and consistently update an Internet website

13 to provide residents of the state timely and accurate information regarding prevention

14 and healthy living.

15 (e) The department shall post and make available information related to the

16 commission, including the commission's annual reports under AS 18.09.070(c).

17 **Sec. 18.09.120. Mandatory reporting.** (a) A health care facility shall provide

18 to the department, based on a schedule set by the commission under AS 18.09.070(b),

19 the following information related to the facility's health care services for placement in

20 the database developed under AS 18.09.110:

21 (1) information on costs to the consumer for health care services; which includes both facility and physician components of care

22 (2) types of insurance and payment accepted by the health care facility

23 for health care services;

24 (3) each location where the health care facility operates, and the hours

25 of operation;

26 (4) the types and scope of health care services offered at the health

27 care facility;

28 (5) the Internet address of any Internet website of the health care

29 facility the purpose of which is to provide factual information to aid the consumer;

30 (6) any other readily accessible information that the department

31 determines would help the consumer to make informed decisions about the health care

facility's services.

(b) The department shall develop a standard form or format for reporting the information required in (a) of this section. The department shall adopt regulations specifying the timing and frequency of the reporting of the information required by (a) of this section.

(c) The department shall notify the health care facility of a failure to report under (a) of this section and give the health care facility an opportunity to contest or cure the failure. If the health care facility does not promptly cure the failure, the department shall post the notice of failure on the database developed under AS 18.09.110.

Sec. 18.09.130. Coordination of departments. The Department of Administration, the Department of Commerce, Community, and Economic Development, the Department of Labor and Workforce Development, and the Department of Law shall

(1) provide to the commission for placement on the database developed under AS 18.09.110 information regarding an adverse action taken against a health care facility in the state or against a licensed professional practicing in a health care facility in the state; and

(2) cooperate with the commission in the performance of its duties.

Article 3. General Provisions.

Sec. 18.09.900. Regulations. The department may adopt regulations under AS 44.62 (Administrative Procedure Act) to carry out the purposes of this chapter.

Sec. 18.09.990. Definitions. In this chapter,

(1) "commission" means the Alaska Health Care Commission established in AS 18.09.010;

(2) "costs to the consumer" means actual price paid by the consumer for health care services;

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

(4) "health care facility" means

(A) a facility licensed under AS 47.32;

(B) an independent diagnostic testing facility providing

1 services in the state;

2 (C) a provider of a home and community based waiver service
3 that is certified under regulations adopted by the department;

4 (D) a provider of personal care services that is certified under
5 regulations adopted by the department.

6 * **Sec. 6.** AS 39.25.120(c)(7) is amended to read:

7 (7) the principal executive officer of the following boards, councils, or
8 commissions:

9 (A) Alaska Public Broadcasting Commission;
10 (B) Professional Teaching Practices Commission;
11 (C) Parole Board;
12 (D) Board of Nursing;
13 (E) Real Estate Commission;
14 (F) Alaska Royalty Oil and Gas Development Advisory Board;
15 (G) Alaska State Council on the Arts;
16 (H) Alaska Police Standards Council;
17 (I) Alaska Commission on Aging;
18 (J) Alaska Mental Health Board;
19 (K) State Medical Board;
20 (L) Governor's Council on Disabilities and Special Education;
21 (M) Advisory Board on Alcoholism and Drug Abuse;
22 (N) Statewide Suicide Prevention Council;
23 (O) the State Board of Registration for Architect, Engineers,
24 and Land Surveyors;
25 **<u>(P) Alaska Health Care Commission;</u>**

26 * **Sec. 7.** The uncodified law of the State of Alaska is amended by adding a new section to
27 read:

28 APPLICABILITY. Sections 2 - 4 of this Act apply to health care facilities in existence
29 or proposed on or after the effective date of this Act. A decision of the Department of Health
30 and Social Services made before the effective date of this Act denying or granting a certificate
31 of need that was applied for or issued for a health care facility described in AS 18.07.031(f).

word being researched by Rep Kelly's office

1 added by sec. 4 of this Act, shall be void and unnecessary. A pending application for a
2 certificate of need for a health care facility described in AS 18.07.031(f), added by sec. 4 of
3 this Act, shall be returned to the applicant.

4 * **Sec. 8.** The uncodified law of the State of Alaska is amended by adding a new section to
5 read:

6 TRANSITION: REGULATIONS. The Department of Health and Social Services may
7 proceed to adopt regulations necessary to implement the changes made by this Act. The
8 regulations take effect under AS 44.62 (Administrative Procedure Act), but not before the
9 effective date of the statutory change.

10 *** Sec. 9.** **Section 8 of this Act takes effect immediately under AS 01.10.070(c).**

11 *** Sec. 10.** **Except as provided in sec. 9 of this Act, this Act takes effect July 1, 2008.**

~~Sec. 11.~~

Notes:

1) Need sunset date after five years for Commission.

2) Mandatory reporting on page 8, beginning with line 17 should have effective date of July 1, 2009 to allow Commission time to define reporting requirements for each health facility type, and to allow the department to adopt regulations

3) Need authority for department to require reporting by pharmacists and physicians. How do I add this?

4) Section 4 of this Act takes effect immediately.

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

SARAH PALIN, GOVERNOR

P.O. BOX 110601
JUNEAU, ALASKA 99811-0601
PHONE: (907) 465-3030
FAX: (907) 465-3068

February 28, 2008

Honorable Bettye Davis, Chair
Senate HES Committee
State Capitol, Room 30
Juneau, AK 99801-1182

Senator Davis:

Referring to **Senate Bill 245, Version L and Amendments dated 2/20/08**, the department provides the following responses to questions received during the hearing of February 20, 2008.

RE: composition of the Health Care Commission
DHSS comment on the Amendment to change the membership of the Commission to:
2 members representing the Governor and appointed by the Governor
3 public members
3 health care providers representing hospitals, physicians, and mental health
2 members from the House of Representatives
2 members from the Senate
1 member AK Tribal Health Care System
1 member representing Health Care Insurance

Page 4, line 12, delete (1): The Department feels that the department needs to be represented on the Commission, and the Chief Medical Officer should be that person OR a DHSS representative to be designated by the Commissioner of Health and Social Services. An amendment is attached which proposes the following composition of the Commission,
with 9 voting members, one of which will serve as chair appointed by the Governor:
2 state agency representatives, of state agencies providing, paying for or monitoring health care services or addressing employment issues in the state (appointed by the Governor)
1 member from the House of Representatives appointed by the speaker of the house
1 member from the Senate appointed by the president of the senate
5 public members (appointed by the Governor):
    1 hospital representative
    1 licensed physician
    1 health care consumer
    1 small business owner in AK
And 4 non-voting members:
added back 1 DHSS commissioner or commissioner's designee
already on 1 Mental Health Trust Authority representative (appointed by the Governor)
New 1 Alaska State Medical Association member (appointed by the Governor)

Questions on information collected by the Information office and disseminated on the state Web Site:

Page 7, line 14 (Amendment): eliminates collection of information regarding prescription drug costs.

The Department objects to this change. Consumers should be able to compare Prescription drug costs of the most common prescription drugs.

Page 6, line 30 (Amendment) Replaces "must" with "may"

The Department prefers retaining "must," as it needs to be clear that the information and data collected from health care providers is all posted on the web site.

Questions regarding Certificate of Need:

Does the Department/Administration have a comment on Sections 2, 3 and 4 of the SB245, version L, which changes Governor's proposal regarding the Certificate of Need program?

Governor Palin continues to support repeal of the Certificate of Need program, with some exceptions. The exceptions to a complete repeal of CON that are acceptable to Governor Palin includes a two year delayed repeal of Certificate of Need for Nursing Homes, Residential Psychiatric Treatment Centers, and Communities with Critical Access Hospitals.

An amendment to SB245, Version, which accomplishes this intent, is attached.

In addition, the Department respectfully requests consideration of the **following amendments** to SB245, Version L, attached.

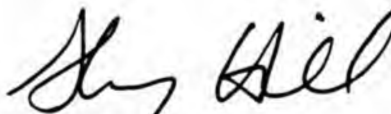
- Page 7, Sec. 18.09.110 paragraph (4) (Page 7, lines 16-19): modify information collected from health care providers
- Sec. 18.09.990 (page 9): need to add a definition of pharmacies and other providers.

Also, to ensure that the appropriate facility definitions are included in this legislation, **the attached amendment defines** the various health care facilities, and it also exempts Tribal Health entities owned or operated by the federal government, Indian Tribe or tribal organization from any Certificate of Need requirements.

Version L of SB245, Sections 2-4, resolves some, but NOT all, of the pending litigation. To eliminate all pending litigation, the following would need to be changed in HB345:

- include Ambulatory Surgery Centers to be exempt for CON in communities larger than populations of 60,000
- define Physician offices in statute

Sincerely,



Sherry Hill
Assistant Commissioner for Public Affairs

cc: Senator John Cowdery, Capitol Building, Room 101
Senator Kim Elton, Capitol Building, Room 506
Senator Joe Thomas, Capitol Building, Room 510

Senator Fred Dyson, Capitol Building, Room 121
Karleen Jackson, Commissioner
Jay Butler, Chief Medical Officer
Wilda Laughlin, Special Assistant
Russell Kelly, Governor's Office, Legislative Director
Mindy Rowland, Governor's Office, Deputy Legislative Director
Anna Kim, Special Assistant
Stacie Kralie, Chief Assistant Attorney General
Deborah Behr, Chief Assistant Attorney General

25G-2
2/28/2008
(8:22 am)

AMENDMENT

OFFERED IN THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE BY ____________________

TO: CSSB 245 (25-GS2050\L)

1 Page 1, line 4, following "**circumstances;**":
2 Insert "**repealing the certificate of need program for certain health care facilities and**
3 **relating to the repeal;**"
4
5 Page 3, line 1 - 7:
6 Delete all material and insert:
7 "(a) Except as provided in **(c), (d), and (f)** [(c) AND (d)] of this section, a person
8 may not make an expenditure of $1,000,000 or more for any of the following unless
9 authorized under the terms of a certificate of need issued by the department:
10 (1) **except as provided in (4) and (5) of this subsection,** construction of
11 a health care facility **in a community with a critical access hospital**;
12 (2) **except as provided in (4) and (5) of this subsection,** alteration of the
13 bed capacity of a health care facility **in a community with a critical access hospital**;
14 [OR]
15 (3) **except as provided in (4) and (5) of this subsection,** addition of a
16 category of health services provided by a health care facility **in a community with a**
17 **critical access hospital;**
18 **(4) construction of, alteration of the bed capacity of, or addition of a**
19 **category of health services provided by a nursing home; or**
20 **(5) construction of, alteration of the bed capacity of, or addition of a**
21 **category of health services provided by a residential psychiatric treatment center**."

1
2 Page 3, lines 8 - 17:
3 Delete all material.
4
5 Renumber the following bill sections accordingly.
6
7 Page 3, following line 29:
8 Insert new bill sections to read:
9 "* **Sec. 4.** AS 18.07.111(8) is repealed and reenacted to read:
10 (8) "health care facility"
11 (A) means, if located or providing services in this state,
12 (i) an acute care hospital;
13 (ii) an ambulatory surgical center;
14 (iii) a critical access hospital;
15 (iv) an independent diagnostic testing facility;
16 (v) an intermediate care facility;
17 (vi) a kidney dialysis center;
18 (vii) a nursing home;
19 (viii) a psychiatric hospital;
20 (ix) a residential psychiatric treatment center;
21 (B) includes a facility owned or operated by a private person, the
22 state, or a local government of the state;
23 (C) excludes a facility that is
24 (i) exempt from state licensure or certification under
25 applicable law and owned or operated by the United States, an Indian
26 tribe, or a tribal organization;
27 (ii) an office of private physicians or dentists whether in
28 individual or group practice;
29 * **Sec. 5.** AS 18.07.111 is amended by adding new paragraphs to read:
30 (11) "acute care hospital" has the meaning given to "hospital" in
31 AS 47.32.900;

1 (12) "ambulatory surgical center" has the meaning given in AS 47.32.900;
2 (13) "critical access hospital" means a facility that is a hospital licensed in
3 the state that satisfies the criteria set out in 42 U.S.C. 1395i-4(c)(2)(B) and meets the
4 conditions of participation set out in 42 C.F.R. 485.601 - 485.647;
5 (14) "independent diagnostic testing facility"
6 (A) means a fixed-location or mobile outpatient facility that is
7 designed and equipped solely to perform diagnostic testing using major diagnostic
8 testing equipment for an independent diagnostic purpose; in this subparagraph,
9 "independent diagnostic purpose" means to perform a diagnostic test for a patient
10 who has been referred by a physician or medical professional who
11 (i) is not associated with the facility;
12 (ii) is treating the patient's specific medical problem; and
13 (iii) uses the diagnostic test result in the treatment of the
14 patient's specific medical problem;
15 (B) does not include a practice 100 percent owned by one or more
16 radiologists or physicians whose primary practice is diagnostic imaging and
17 occasionally evaluation;
18 (15) "intermediate care facility" means a nursing home that is not a
19 skilled nursing facility;
20 (16) "kidney dialysis center" means a treatment center, including a
21 free-standing hemodialysis unit, that is devoted to the treatment of kidney disease;
22 (17) "nursing home" means a nursing facility as defined in 42 U.S.C
23 1396r(a);
24 (18) "office of private physicians or dentists" means an office that
25 (A) is 100 percent owned by physicians licensed under AS 08.64
26 or dentists licensed under AS 08.36; and
27 (B) provides medical services, whether in individual or group
28 practice, to patients on an ongoing basis;
29 (19) "psychiatric hospital" means a hospital or part of a hospital that is
30 primarily for the diagnosis and treatment of mental, emotional, or behavioral disorders."
31

1 Renumber the following bill sections accordingly.
2
3 Page 4, lines 10 - 29:
4 Delete all material and insert:
5 "**Sec. 18.09.020. Composition; chair.** (a) The commission consists of nine voting
6 members as follows:
7 (1) two members, appointed by the governor, representing state agencies
8 providing, paying for, or monitoring health care services or addressing employment
9 issues in health care in this state;
10 (2) one member from the house of representatives, appointed by the
11 speaker of the house;
12 (3) one member from the senate, appointed by the president of the senate;
13 and
14 (4) five public members, appointed by the governor; the appointments
15 made under this paragraph must include the following:
16 (A) a representative of a hospital in this state;
17 (B) a physician licensed under AS 08.64;
18 (C) a consumer of health care services;
19 (D) a small business owner in the state.
20 (b) In addition to the members of the commission specified under (a) of this
21 section, the following persons shall serve as non-voting members of the commission:
22 (1) the commissioner of health and social services or the commissioner's
23 designee;
24 (2) a member, appointed by the governor, of the Alaska Mental Health
25 Trust Authority established under AS 37.14.001 - 37.14.099;
26 (3) a representative, appointed by the governor, of the health care
27 insurance industry;
28 (4) a representative, appointed by the governor, of the Alaska State
29 Medical Association.
30 (c) The governor shall appoint the chair of the commission from the public voting
31 members appointed under (a)(4) of this section."

1
2 Page 4, line 31:
3 Delete "AS 18.09.020(a)(5)"
4 Insert "AS 18.09.020(a)(4)"
5
6 Page 6, line 12:
7 Delete "AS 18.09.020(a)(5)"
8 Insert "AS 18.09.020(a)(4)"
9
10 Page 6, line 30 through page 8, line 9:
11 Delete all material and insert:
12 "(b) The database developed under (a) of this section must include the following:
13 (1) a list of preferred drugs approved by the department for
14 reimbursement by the department;
15 (2) a complete list, organized by region and address, of
16 (A) health care facilities located in the state;
17 (B) licensed pharmacists and pharmacies located in the state;
18 (C) emergency and urgent care facilities located in the state;
19 (D) health insurance companies offering coverage in the state;
20 (E) health care providers licensed in the state, including the
21 provider license number, type, and expiration date along with disciplinary actions,
22 if any;
23 (F) long-term, in-home, and hospice care providers located in the
24 state; and
25 (G) public assistance offices of the department;
26 (3) a list, updated monthly, of not more than 25 most commonly
27 prescribed medications in the state and the source and price of the medications;
28 (4) a list, updated monthly, of not more than 25 most commonly
29 conducted medical procedures in the state, organized by the cash and negotiated price of
30 the procedure at available providers and insurers; the list must include medical
31 procedures covered by workers' compensation under AS 23.30;

1 (5) available hospital ratings, including the rates of hospital-acquired
2 infections and mortality occurring at each hospital located in the state;
3 (6) consumer education information on topics that include body mass
4 index, diet and nutrition, exercise, smoking cessation, and alcohol and drug addictions,
5 that includes the location of available sites that provide care and treatment related to
6 those issues;
7 (7) a list of procedures approved by state agencies for emergency
8 response and treatment;
9 (8) disease management support information;
10 (9) insurance informatioı ıt includes
11 (A) a navigator to determine insurance eligibility using a matrix of
12 available insurers;
13 (B) links to Internet websites for purchasing insurance policies;
14 and
15 (C) an explanation of mandatory and optional insurance coverage;
16 (10) a list of primary care clinics that cater to uninsured and self-pay
17 patients;
18 (11) information on the quality of health care facilities, including any
19 actions taken by state or federal agencies related to
20 (A) licensure and accreditation of a health care facility; or
21 (B) a licensed professional practicing in a health care facility."
22
23 Page 9, line 29 through page 10, line 5:
24 Delete all material and insert:
25 "(4) "health care facility"
26 (A) has the meaning given in AS 18.07.111; and
27 (B) also includes
28 (i) an assisted living home;
29 (ii) a free-standing birth center;
30 (iii) a home health agency;
31 (iv) a hospice or agency providing hospice services or

1 operating hospice programs;

2 (v) an intermediate care facility for the mentally retarded;

3 (vi) a pharmacy;

4 (vii) a provider of a home and community-based waiver

5 service that is certified under regulations adopted by the department;

6 (viii) a provider of personal care services that is certified

7 under regulations adopted by the department;

8 (ix) a rural health clinic; and

9 (x) an urgent care facility."

10

11 Page 10, following line 5:

12 Insert new bill sections to read:

13 "* **Sec. 7.** AS 18.26.220 is amended to read:

14 **Sec. 18.26.220. Facility compliance with health and safety laws and licensing**

15 **requirements.** A medical facility constructed, acquired, improved, financed, or otherwise

16 under the provisions of this chapter and all actions of the authority are subject to

17 [AS 18.07,] AS 47.32[,] and any other present or future state licensing requirements for

18 the facilities or services provided under this chapter. [A MEDICAL FACILITY ISSUED

19 A CERTIFICATE OF NEED UNDER SEC. 4, CH. 275, SLA 1976, BY VIRTUE OF

20 BEING IN EXISTENCE OR UNDER CONSTRUCTION BEFORE JULY 1, 1976,

21 MUST FULLY MEET THE REQUIREMENTS OF AS 18.07 IN ORDER TO BE

22 ELIGIBLE FOR FUNDING UNDER THIS CHAPTER.]

23 * **Sec. 8.** AS 21.86.030(c) is amended to read:

24 (c) Nothing in this section relieves a health maintenance organization that wishes

25 to exercise the power described in (a)(1) of this section from the requirements of

26 (1) [AS 18.07, REGARDING OBTAINING A CERTIFICATE OF

27 NEED;

28 (2)] AS 47.32, regarding regulation of hospitals; and

29 **(2)** [(3)] other statutes applicable to hospitals or other health care

30 facilities."

31

1 Renumber the following bill sections accordingly.
2
3 Page 10, following line 25:
4 Insert a new bill section to read:
5 "* **Sec. 10.** AS 18.07.021, 18.07.031, 18.07.035, 18.07.041, 18.07.043, 18.07.045, 18.07.051,
6 18.07.061, 18.07.071, 18.07.081, 18.07.091, 18.07.101, 18.07.111; and AS 47.80.140(b) are
7 repealed."
8
9 Renumber the following bill sections accordingly.
10
11 Page 10, line 28:
12 Delete "Sections 2 - 4"
13 Insert " Sections 2 - 5"
14
15 Page 10, line 1:
16 Delete "sec. 4"
17 Insert "sec. 3"
18
19 Page 10, line 2:
20 Delete "sec. 4"
21 Insert "sec. 3"
22
23 Page 11, following line 3:
24 Insert new bill sections to read:
25 "* **Sec. 12.** The uncodified law of the state of Alaska is amended by adding new sections to
26 read:
27 TRANSITION: PENDING APPLICATIONS, ADMINISTRATIVE APPEALS, AND
28 COURT ACTIONS FOR THE CERTIFICATE OF NEED PROGRAM. The commissioner of
29 health and social services through the Department of Law shall immediately take steps to seek
30 dismissal of pending administrative appeals and court actions concerning the issuance of
31 certificates of need, as appropriate, under AS 18.07, as amended by secs. 2 - 5 of this Act or

1 implementation of AS 18.07.

2 *** Sec. 13.** The uncodified law of the State of Alaska, enacted in sec. 12 of this Act, is amended

3 to read:

4 TRANSITION: PENDING APPLICATIONS, ADMINISTRATIVE APPEALS, AND

5 COURT ACTIONS FOR THE CERTIFICATE OF NEED PROGRAM. The commissioner of

6 health and social services through the Department of Law shall immediately take steps to seek

7 dismissal of pending administrative appeals and court actions concerning the issuance of

8 certificates of need, as appropriate, under AS 18.07, as **repealed by sec. 10 of this Act**

9 [AMENDED BY SECS. 2 - 5 OF THIS ACT] or implementation of AS 18.07."

10

11 Renumber the following bill sections accordingly.

12

13 Page 11, line 10:

14 Delete "Section 8"

15 Insert "Section 14"

16

17 Page 11, following line 10:

18 Insert a new bill section to read:

19 "*** Sec. 16.** Sections 7, 8, 10, and 13 of this Act take effect July 1, 2010."

20

21 Renumber the remaining bill sections accordingly.

22

23 Page 11, line 11:

24 Delete "sec. 9"

25 Insert "secs. 15 and 16"

Senate Bill - 245
Senator Bettye Davis
Fax: 907-465-3756

Date: 3-18-2008

RE: Elimination of the Certificate of Need (CON)

Yes. I support Governor Palin's initiative to eliminate the Certificated of Need (CON) in Alaska.

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

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

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

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

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

I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Andrew M. Boyle
Signature: [signature]
Address: 7602 Roland rd.
Telephone: 907-452-7778 cell 907 347-9592

Senate Bill - 245 Date: 3/3/08

Senator Bettye Davis
Fax: 907-465-3756

RE: Elimination of the Certificate of Need (CON)

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

I am asking for your support to eliminate the Certificate of Need (CON) in our state of Alaska.
Thank you for your support.

Print Name: Charles E. Walmsley Jr
Signature: [signature]
Address: 984 Senate Loop, Fairbanks AK 99712
Telephone: 907-374-9915

CONFIDENTIAL MEMORANDUM
(Not to be distributed without prior authorization)

DATE: February 21, 2008
TO: Senator Bettye Davis
FROM: Thomas S. Obermeyer
RE: SB 245 – 25-GS2050\L – Explanation of revised draft amendment, 25-GS2050\L.3 (attached) by Jean Mischel, Legislative Legal Counsel, and draft amendment by Don Burrell, Aide to Senator Davis, both dated February 20, 2008 and distributed to Senate HESS Committee 2\20\08

" An Act establishing the Alaska Health Care Commission and the Alaska Health Care Information Office; relating to health care planning and information; amending the certificate of need requirements to exclude expenditures for diagnostic imaging equipment in certain circumstances; and providing for an effective date."

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1. 25-GS2050\L.3 should be adopted by the Senate HESS Committee as the official working document for the amendment of the "L" version of CS for SB 245( ), 25-GS2050\L (2\11\08).
2. Don Burrell only drafted on short notice and distributed to the Senate HESS Committee 2\20\08 an amendment to the "L" version of SB 245 in the absence of a draft amendment from Legislative Legal Services which was forthcoming. The Mischel draft amendment, 25-GS2050\L.1, arrived in the middle of the hearing and was also distributed on short notice with one minor typographical error in the title, indicating "Offered in the House" instead of "Senate".
3. I will distribute the revised amendment, 25-GS2050\L.3, to Committee members with a brief explanation prior to receiving and distributing Ms. Mischel's more complete forth-coming analysis.
4. 25-GS2050\L.3 (attached) comports with legislative drafting requirements and recognizes necessary changes in statutes due to the sunset provisions of the proposed amendment. As a result, it also deletes "commission" or substitutes "department" for "commission" in cross-references to the "commission."

5. 25-GS2050\L.3, p.2, lines 16-18, proposes a new section 2, AS 18.05.010(b), following Sec. 1, line 30, page 2 of the "L" version in order to conform to drafting requirements in the deletion of the language in the first page of the amendment: [BASED ON RECOMMENDATIONS OF THE ALASKA HEALTH CARE COMMISSION ESTABLISHED IN AS 18.09.010].
6. 25-GS2050\L.3 added a new Section 8 as a "repealer" of the commission by July 1, 2013 (see 25-GS2050\L.3, p. 6, lines 21-23) in order to implement the sunset provision requirement.
7. 25-GS2050\L.3 left intact the "list of procedures approved by state agencies for emergency response and treatment" ("(7)", page 7, line 26), while the Burrell version deleted this item due to vagueness, which was questioned by the Committee.
8. 25-GS2050\L.3, page 5, lines 7-9, inserted "may" for "must" concerning mandatory reporting in the database, in line 6, page 30 of "L" version.
9. 25-GS2050\L.3, page 5, lines 29-31, inserted the words, "Beginning July 1, 2009," in line 17, page 8 of the "L" version to give a year to implement changes: "Beginning July 1, 2009, a health care facility shall provide to the department... the following information: . . . ."
10. 25-GS2050\L.3, page 6, lines 13-16, inserted in the "L" version, page 10, after line 5 and following "department" two additional health care facilities described as "(E) a licensed pharmacy" and "(F) a physician's office."
11. 25-GS2050\L.3, page 5, lines 22-24, inserted in the "L" version, page 8 following line 5, a new paragraph to include in information disseminated "(10) a list of physicians who accept patients with Medicare coverage." Other sections are to be appropriately renumbered.

Fresenius Medical Care

FACSIMILE TRANSMITTAL SHEET

TO: Senator Bettye Davis	FROM: Jean Stevens, RVP & Mitch Long, Area Manager
COMPANY:	DATE: 3/12/2008
FAX NUMBER: 907.465.3756	TOTAL NO. OF PAGES INCLUDING COVER: 1
PHONE NUMBER:	SENDER'S REFERENCE NUMBER: 503.944.2608
RE: 6pm Phone Call	YOUR REFERENCE NUMBER:

☐ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

Dear Senator Davis,

Jean Stevens, Regional Vice President and Mitch Long, Area Manager for Fresenius Medical Care will be on this evenings call at 6pm. They may want to testify tonight.

Thank you,

Jean Stevens, Regional Vice President
Mitch Long, Area Manager

RECEIVED
MAR 12 2008

Fresenius Medical Care North America • Dialysis Services
Pacific Northwest Region Office, 2121 SW Broadway, Suite 111, Portland, OR 97201 503-944-2800 Fax: 503-944-5800

March 11th, 2008

AK State Capitol
Senate Health, Education and Social Services (HESS)
Juneau AK 99801-1182

Dear Senator Davis, Senator Thomas, and other Senators of the Senate HESS Committee

As an AK resident and healthcare administrator I implore you not to consider the portion of SB 245 which recommends removal of AK's Certificate of Need (CON) program. Thorough and unbiased research needs to be accomplished prior to any such action given the potential negative impact such legislation would have on the safety and quality of AK's healthcare.

I currently serve as the AK Area Administrator for Diagnostic Health and directly oversee a full modality outpatient imaging center located in midtown Anchorage[1]. As a healthcare administrator with over 15 years of experience I have grave concerns regarding current legislation in the Senate and House to eliminate or modify AK's CON program. I strongly urge unbiased research/study to determine the full short-term and long-term impact before any such action is taken. Some particulars which need to be contemplated are as follows:

- Thirty-six states still maintain some form of a Certificate of Need program. Many of the states that repealed their laws in the 80s and 90s experienced a proliferation of facility development and major medical equipment acquisition. This is particularly disturbing given that "supply" for outpatient imaging services (in the Anchorage area) is currently greater than "demand."
- Removing/modifying AK's CON program could have an extremely negative outcome with regard to quality of care as many freestanding imaging centers would not bother to hire registered technologists or ensure their facility is accredited. The American College of Radiology is conscious of this fact and thus tends to favor tighter CON restrictions for imaging services.
- Removing/modifying AK's CON program would certainly have an immediate and possibly long-term impact on the availability of skilled labor (registered technologists) causing shortages in many fields/modalities with the strong probability of negatively impacting the safety and quality of AK's healthcare.
- Market and business-driven healthcare in AK is idealistic but not a reality. It's a contradiction for some to say that "health care must be market-and business-driven, rather than restricted by government" when reality illustrates that healthcare is the most heavily regulated industry and that government dictates a significant portion of most healthcare entities reimbursements.

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[1] Diagnostic Health Anchorage LP (formerly HealthSouth Diagnostic Center of Anchorage LP) has been providing full modality outpatient imaging services in a timely, quality, and cost-effective services to AK residents for over 10 years.

ASHNHA Comments on Senate Bill 245 Version "O"
Prepared by: Rod Betit, President/CEO
March 12, 2008

Madam Chairman, members of the Committee, I appreciate the opportunity to update ASHNHA's position relative to this version of SB 245.

As you will note, ASHNHA's membership supports this rewrite of SB 245. This is a much improved version of SB 245 that not only solves current CON appeals/disputes before the State, but also creates a Health Care Commission to develop solutions to Alaska's health care costs, access and quality challenges. The bill would also begins the process of creating a consumer friendly information resource to aid Alaskans in making health care decisions.

ASHNHA's POSITION ON SECTIONS CONTAINED IN SB 245(Version O):

Section	Position
▪ **Section 1 - Statewide Health Plan**	**SUPPORT**
▪ **Section 2 - Section 1 Amended for Commission Sunset**	**SUPPORT**
▪ **Section 3- Technical - renumbers to reflect new sections**	**SUPPORT**
▪ **Section 4 - Adds definition for Critical Access Hospital**	**SUPPORT**
▪ **Section 5 - New language clarifying imaging offices**	**SUPPORT**
▪ **Section 6/Article 1 - Creates Health Care Commission**	**SUPPORT**
▪ **Section 6/Article 2 - Creates Information Office & Reporting**	**SUPPORT**
▪ **Section 6/Article 3 - General Provisions**	**SUPPORT**
▪ **Section 7- Technical - Adds Health Commission to List**	**SUPPORT**
▪ **Section 8- Sunsets Health Care Commission in 2013**	**SUPPORT**
▪ **Section 9 - CON Transition Regulations**	**SUPPORT**
▪ **Section 10 - CON Transition Regulations**	**SUPPORT**
▪ **Section 11 - Effective Date for Section 2**	**SUPPORT**
▪ **Section 12 - More 'Effective Dates'**	**SUPPORT**
▪ **Section 13 - Commission & Reporting Effective Date**	**SUPPORT**

Sections 1 & 2 - Statewide Health Plan:

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

Section 4 - Add Definition of Critical Access Hospital (CAH)

This definition would clarify which hospitals have Critical Access Hospital status. Currently there are CAH hospitals in Cordova, Dillingham, Ketchikan, Kotzebue, Nome, Petersburg, Kodiak, Seward, Valdez, Barrow, Sitka and soon in Homer.

ASHNHA Alaska State Hospital and Nursing Home Association

Section 5 - Clarification of Imaging Offices Exempt from CON
Alaska statutes have always exempted physician's offices from CON and it is clear that a radiologist is a licensed physician. Most disputes under CON law have been around what types of health care settings are physician offices versus imaging centers that would be subject to CON review.

This Committee Substitute defines an imaging physician's office as an office that is at least 50% owned by radiologist physicians who are actively providing the medical procedures of interpretation and diagnosis. In other words to be granted the physician office CON exemption, the physicians in question must actually work in the practice, must own at least 50% of the practice including the equipment, and must actually interpret the images that their imaging equipment produces. If these criteria are met the office/facility would not be subject to CON review.

The Committee Substitute also limits the CON exemption for these physician practices to boroughs over 60,000 in population as a protection to smaller hospitals in smaller markets.

There is wide-spread agreement on this language within the imaging and hospital community as a fair resolution of this long standing area of disagreement. ASHNHA's members overwhelmingly support this language. Two ASHNHA members would like to see more restrictive requirements but all others support this more reasonable approach to resolving up to 80% of the appeals/lawsuits currently before the Department.

Section 6/Article 1 - Create Alaska Health Care Commission:
ASHNHA members support the creation of a Commission to develop incremental strategies to provide affordable, quality health care choices for all Alaskans, to oversee development of the State's health care data information base, and to promote individuals taking responsibility to improve their overall health status. ASHNHA supports the establishment of a Commission and the diverse membership contained in this rewrite.

CSSB 245 would give the Commission broad discretion to define reporting expectations and to determine what would be useful information for the public to have. This 'permissive' authority for the Commission to develop these requirements is a strong aspect of this bill. There are many unanswered questions, missing definitions and other challenges too many to list that warrant giving the Commission this degree of latitude in developing Alaska's consumer information data base.

Section 6/Article 2 - Establish Health Care Information Office & Reporting:
ASHNHA supports the goal of providing accurate and current health care information for consumers to assist them in making health care decisions. As detailed in an earlier position paper on Version A of SB 245, ASHNHA's members have been voluntarily reporting of health

care cost, quality and charity care information for many years. All of that information is currently available to the Department could be posted to a consumer web site once actually operational.

Section 6/Article 3 - General Provisions:
Adds definitions including what entities must report under the requirements of Section 6/Article 2. This version of SB 245 makes it clear that pharmacies and physicians are subject to reporting as defined by the Commission.

Section 8 - Sunsets Health Care Commission:
Requires reauthorization of Commission in 2013 at which time the effectiveness of the Commission would be reviewed by the Legislature before its life is extended.

Section 9 & 10 - CON Transition Regulations:
Legislative Legal believes these sections are necessary even though CON repeal provisions have been removed from this version of SB 245. ASHNHA has no position on that and defers to the experts on the need for this language.

Section 11 - Effective Date for Section 2:
This section brings back the language found in Section 1 after the Commission expires in 2013 without reference to the Commission in the Department's duties from that point forward.

Section 12 - More Effective Dates:
ASHNHA has no comment on this section.

Section 13 - Commission and Reporting Effective Dates:
Information gathering and reporting is a complicated and involved process that will take years to fully develop and implement. Some progress could be made by the State in the short term using the data already being provided by hospitals but certainly not by July 1, 2008. Clearly the July 1, 2008 effective date is simply a starting point to begin this long journey.

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

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

SARAH PALIN, GOVERNOR

P.O. BOX 110601
JUNEAU, ALASKA 99811-0601
PHONE: (907) 465-3030
FAX: (907) 465-3068

March 13, 2008

Honorable Bettye Davis, Chair
Senate HES Committee
State Capitol, Room 30
Juneau, AK 99801-1182

RECEIVED
MAR 13 2008

Senator Davis:

During the hearing of March 12, 2008, the Senate HES committee discussed an amendment to add a study of the effects of the Certificate of Need Program to **Senate Bill 300**, and questions were posed about the cost of such a study and who should manage the study.

Cost of a Certificate of Need Study:
In Fiscal Year 2005, the Legislature, through Senate Finance, contracted for an analysis of the state Medicaid program. This study cost $247,000. The Department has issued two recent Requests for Proposals for studies, with the range of $320,000 to $325,000 (the first was a comprehensive Rate setting study and the second was a long term care plan).

Management of the Study:
The amendment discussed yesterday had the Health Care Commission manage the study. The Department strongly recommends against that approach. The Commission would not start functioning until members were selected, an Executive Director was hired, etc., which would delay the RFP process. We propose two options: that the Legislature or Department contract for the study.

We recommend that the Legislature contract for the study to ensure full confidence that the study is unbiased, and meets the Legislature's expectations. The Senate HES and Finance Committees could jointly sponsor the study; which would not require a fiscal note, ensuring proposals are not targeted to a specific amount of funding.

Should the HES committee want the Department to contract for the study, we will submit a fiscal note.

Sincerely,

Sherry Hill
Assistant Commissioner for Public Affairs

cc: Senator John Cowdery, Capitol Building, Room 101
Senator Kim Elton, Capitol Building, Room 506

Senator Joe Thomas, Capitol Building, Room 510
Senator Fred Dyson, Capitol Building, Room 121
Karleen Jackson, Commissioner
Jay Butler, Chief Medical Officer
Wilda Laughlin, Special Assistant
Russell Kelly, Governor's Office, Legislative Director
Mindy Rowland, Governor's Office, Deputy Legislative Director
Anna Kim, Special Assistant
Stacie Kralie, Chief Assistant Attorney General
Deborah Behr, Chief Assistant Attorney General

Don Burrell

From: Yocom, Lauren J (GOV) [lauren.yocom@alaska.gov]
Sent: Saturday, March 29, 2008 12:02 PM
To: Don Burrell
Cc: Hill, Sherry (HSS); Laughlin, Wilda J (HSS)
Subject: SB245 Fiscal Notes
Attachments: SB245CS(HES)-DHSS-MS-03-28-08.pdf; SB245CS(HES)-DHSS-HPI-03-28-08.pdf; SB245CS(HES)-DHSS-CO-03-28-08.pdf

sponsor: Governor
requesting committee: Senate HES
date & time: no hearing scheduled in Finance yet, submitting these at the request of Senate HES

Only one (Health Planning & Infrastructure) had substantive changes. These are the changes from the LL 0050 fiscal notes (listed by component):

- Medicaid Services: deleted the graph on the last page
- Health Planning & Infrastructure: changed to indeterminate; deleted the graph on the last page

In addition, I made one correction to the Commissioner's Office FN we submitted 3-21, so I re-dated to 3-28

- Commissioner's Office: corrected Division from "Chief Medical Officer" to "Public Health"

- Laughlin

Thanks,
Lauren

Lauren Yocom
Legislative Office Assistant
Office of Governor Sarah Palin
465-4021

FISCAL NOTE

STATE OF ALASKA
2008 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: CS SB 245 (HES)
() Publish Date:

ID(File name) SB245CS(HES)-DHSS-MS-03-28-08
Title HEALTH CARE: PLAN/COMMISSION/FACILITIES
Sponsor RULES BY REQUEST OF THE GOVERNOR
Requester SENATE HES

Dept. Affected: Health & Social Services
RDU Health Care Services
Component Medicaid Services
Component No. 2077

Expenditures/Revenues (Thousands of Dollars)

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

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2009**	**FY 2009**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims	*		*	*	*	*	*
Miscellaneous							
TOTAL OPERATING	*	0.0	*	*	*	*	*
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (0)							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	*		*	*	*	*	*
1003 GF Match	*		*	*	*	*	*
1004 GF							
1037 GF/Mental Health							
Other(Specify Type-do not abbreviate)							
Other(Specify Type-do not abbreviate)							
TOTAL	*	0.0	*	*	*	*	*

Estimate of any current year (FY2008) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

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

This bill eliminates the Certificate of Need program. This fiscal note is indeterminate. Eliminating the CON program would likely increase costs to Medicaid, however the costs are unknown at this time.

This fiscal note is based on projects denied, withdrawn, or reduced as the result of the CON program which is estimated to have saved the Alaska Medicaid program approx. $3 million per year in payments for avoided capital costs (50% federal/50% GF/M). This represents 1.2% of the total project costs for these facilities.

Prepared by: William Streur, Deputy Commissioner Phone 465-5830
Division Health Care Services Date/Time 03/28/2008
Approved by: Karleen Jackson, Commissioner Date 03/28/2008
Agency Department of Health and Social Services

(Revised 11/19/2007 OMB)