THE STATE
01 ALASKA
GOVERNOR BILL WALKER

Department of
Health and Social Services
OFFICE OF RATE REVTEW
Ce1tificate of Need Program
3601 C Street. Suite 978
Anchorage, Alaska 99503
Main: 907.334.2464
Fax: 907.334-2220

May 21, 2015

Via email & US Mail

Richard Davis, Chief Executive Officer
Central Peninsula General Hospital
250 Hospital Place
Soldotna, AK 99669

Re: Request for Dete1mination dated 4-30-2015, Central Peninsula Hospital

Dear Mr. Davis,

Thank you for your letter dated April 30, 2015 in which Central Peninsula Hospital (CPH) f01mally requests a dete1mination in accordance with 7 AAC 07.031 as to whether converting prior approved shelled-space in the Specialty Clinics Building to provide Computed Tomography (CT) services requires a Certificate of Need (CON). CPH's proposal includes acquisition of furniture, fixtures, and a SOMATOM Definition AS CT 128 Slice at a total cost of $854,630.

CPH received a CON on January 8, 2014 to construct its Specialty Clinics Building. However, that CON expressly denied the paii of the project that was dedicated to the addition of imaging services that included MRI services, PET/CT services, and CT services. This denial was reinforced by a condition attached to the CON. The condition reads as follows:

> *Appendix B: Approval of this certificate is conditioned on the premise that prior to using or converting any or all space that was dedicated to the components of the Certificate of Need application that were denied by the Commissioner- namely CT services . . . which is now estimated to be 7,400 square feet in 'shelled in' space, Central Peninsula Hospital must request a formal determination from the Department as to whether a Certificate of Need is required for the intended use or conversion of that space prior to expending any funds for conversion or operation.*

Since this condition clearly applies to CPH's request for determination, this analysis must first determine whether the condition is properly satisfied before it can evaluate project costs and other pe1tinent elements.

Analysis of Condition

Appendix B, which is the second condition to CPH's Specialty Clinics CON, requires CPH to request a formal determination prior to using or converting space that was dedicated to the originally requested CT services. CPH's act of submitting its request for determination dated April 30, 2015 satisfies the requirements of Appendix B. However, Appendix B still raises a key question that is the foundation to CPH' s request for determination: whether a CON is required for CPH's intended use or conversion of its shelled-in space?

CPH seeks to convert 791 square feet of shelled space for a new CT scanner. As described above, CPH's prior CON request for imaging services, including CT, was denied by the Department. The denial of the CT services was specifically premised on CPH' s failure to satisfy service-specific review standards #2 and #3 for CT services.

Since the Depaiiment previously concluded that CPH could not receive a CON for CT services in its Specialty Clinics Building because it failed to satisfy service-specific review standards, the only way to determine whether CPH' s new proposal for CT services requires a CON is to determine whether it still fails those service-specific review standards.

Service-specific review standard #2 and #3 for CT services read as follows:

> *2. An applicant who seeks to establish a new CT service in a rural area demonstrates the ability to provide a minimum of 1,000 CT scans per year by the end of the third operational year, dating from the initiation of the service.*
>
> *3. No new CT service will be approved in a service area or at a location that is less than 30 minutes travel time of an existing CT service performing fewer than 3,000 scans per year, or of a CON-approved but not yet operational, CT service.*

In the Staff Analysis to CPH' s original CON proposal, the Department asserted that CPH failed to meet service-specific review standard #2 because it failed to answer whether its proposed CT would provide the minimum CT scans by the end of the third operational year. CPH did not answer standard #2 or #3 because both of those review standards "relate to applicants seeking to establish a new service." See *Review of Central Peninsula Hospital October 23, 2013* at 13.

The CON Program disregarded CPH's position on grounds that CPH was seeking to establish a new CT machine, and the addition of the new CT would, in tum, expand CPH's existing CT service. Since the transaction included both establishing a new CT machine and expanding an existing line of service, the CON Program was firm that CPH's proposal was subject to standards for a new CT service (#2 and #3) and for expansion of an existing CT service (#4).

After further review, I conclude that the CON Program's position was logical and persuasive. However, I also conclude that CPH's position that it should only have been subject to review standard #4 since it sought (and now seeks) to expand an existing CT service is equally as logical

and persuasive. Despite conflicting interpretations, circumstances have changed since 2013, and CPH's position passes both interpretations on the merits and as a matter of public policy.

Approving CPH to acquire a new CT for its Specialty Clinics Building will not result in excess capacity for CT services in that area because the proposal easily satisfies service-specific review standards #2 and #4 for CT services.

Per its request for determination, CPH's lone hospital CT is projected to do over 8,000 scans in 2015. This is double the CON standard for expanding an existing service, meaning if CPH can acquire a second CT, it would be immediately operating both CTs at the CON maximum scan threshold (i.e. 4,000 CT scans annually). Clearly, excess capacity is not an issue. Moreover, CPH makes a strong case that there is demonstrated need.

Over the last two years, CPH reports that its only hospital CT was down for about two weeks. While CPH now owns a second CT in its outpatient imaging facility that is miles away, this is not a suitable environment for emergency patients or acute patients. Simply put, CPH has a massive annual scan volume in its hospital that surpasses the requirements in service-specific review standards #2 and #4. A second CT in the hospital will relieve that volume and be an effective backup for situations where emergency patients or acute patients cannot access the existing CT.

In 2013, the CON Program was quick to point out that CPH's proposal failed service-specific review standard #3 for CT services because Providence Health & Services owned an independent diagnostic testing facility less than thirty minutes away with a CT that was performing fewer than 3,000 scans per year. CPH now owns that imaging center, and thus owns its CT.

In its current request for determination, CPH indicates that if the CON Program determines a CON is necessary to add a CT machine in the Specialty Clinics Building, and if that CON is not granted, it has such a need for a second CT in its hospital, it will be forced to spend money to uninstall the CT from the imaging center, spend money to transport it to the hospital, spend money to install it, spend money to update it through a "routine replacement," spend money to store the old CT, wait a year to demonstrate adequate volume, spend money to transport the CT from storage back to the imaging center, and then spend money to install the very same machine in the imaging center that it removed the previous year.

CPH's alternative approach to acquiring a second CT for its hospital is a perfectly lawful way to avoid CON review while fully complying with the conditions placed on the Specialty Clinic's CON. Practically speaking, CPH can clearly achieve its objective of acquiring a new CT. However, this approach is costly, inefficient, and it is counter to public policy.

The CON Program exists to ensure that there is a demonstrated need for a new service. It is intended to analyze and monitor capacity for services. The theory behind CON is that too much capacity for services in an area comes at a cost to health care facilities in that area, and those

facilities make up for that cost by charging more for other services. Under this theory, excess capacity drives up prices for health care services, and those heightened prices come at cost to consumers.

As a matter of public policy, the CON Program does not want to see health care prices rise. Forcing CPH to execute its alternative plan will surely result in unnecessary costs, and those costs could be passed to consumers. If CPH were to now go through CON review, and if the CON Program were to apply the same standards as before, CPH could easily request a waiver under 7 AAC 07.025(b) to service-specific review standard #3 on grounds that meeting the standard would be counter to public policy as it will result in a reduction to the availability, quality, and accessibility of its CT services. The CON Program can say with certainty that it would agree with this position and recommend that the Commissioner grant a waiver and disregards standard #3.

In conclusion, the CON Program is satisfied that an additional CT does not create excess capacity for CT services because the hospital's scan volume satisfies service-specific review standards #2 and #4. Also, the CON Program believes that allowing the acquisition of a second CT is the most efficient and cost-effective approach for both the facility and its patients, and CPH's proposal would easily pass review standard #3 by way of a waiver that is consistent with public policy. Therefore, regardless of what service-specific review standards are applied to CPH's current proposal, it would easily pass CON review.

Based on the substance of its proposal, CPH satisfies Appendix B and does not require a CON for the acquisition of a new CT as long as the project costs do not exceed the CON monetary threshold.

Analysis of Project Costs

CPH's certified cost estimate for this project is $854,630. While this full amount is dedicated to furniture, fixtures, and equipment, there are several other cost descriptions listed, but the descriptions lack actual cost amounts. Rather, each description is accompanied by the following language: "approved Jan 8, 2014 Specialty Clinics Building CON." CPH is essentially saying that the cost of this project is only $854,630 because all of the other ordinary costs associated with this type of project have already been approved, and potentially expended, in the building of the shelled-in space where the proposed CT will be located.

Based on this logic, the activity of installing the CT is being financed with the activity of constructing the Specialty Clinics Building. On its face, one could contend that the proposed project is actually a "phased activity" under 7 AAC 07.025(d), and thus must be considered as paii of the Specialty Clinics Building project.

CPH's proposal does appear to meet the definition of a phased activity, so it is proper to analyze the other costs that affect the conve1ed space. However, that analysis was already completed by CPH because it is correct in its conclusion that the other costs were scrutinized by the

Department and approved in the Specialty Clinics Building CON. In fact, review and approval of those costs specifically recognized that they were being dedicated to shelled-in space, and that the shelled-in space would likely be conve1ted in the future (hence the addition and consideration of Appendices A and B). Accordingly, even after considering CPH's proposal in light of the Specialty Clinics Building project, the total project cost of $854,630 is coITect, and this amount is below the $1.5 million statutory threshold per AS 18.07.031.

Conclusion

CPH's proposed project fully satisfies Appendix B, which is a condition to its Specialty Clinics Building CON. CPH's proposed project is below the $1.5 million statutory threshold per AS 18.07.031. Since all conditions have been met, and since the project is below the CON statutory threshold, CPH's proposed project does not require a CON. Please be aware, this dete1mination has no effect on the conditions to CPH's Specialty Clinics Building CON, meaning the conditions are still in full effect and will continue to be enforced by the Depaitment in the future.

If you are dissatisfied with this determination, you may request reconsideration under 7 AAC 07.033. A request for reconsideration must be postmarked no later than 30 days after publication of the public notice. If you wish to revise your request for dete1mination, or apply for a CON, please notify the CON Program immediately.

Sincerely,

J C. Kosin
Executive Director, ORR, DHSS