ALASKA HOSPITAL & HEALTHCARE ASSOCIATION

October 28, 2025

Nicole Lebo
Executive Director, Office of Rate Review
Alaska Department of Health
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RE: Solicitation for Public Input – Certificate of Need

Dear Executive Director Lebo,

For over 70 years, the Alaska Hospital & Healthcare Association (AHHA) has served as a non-profit trade association representing Alaska's hospitals, nursing homes, and a growing number of healthcare partners across the continuum of care. AHHA members play an invaluable role, both as community providers and essential employers, in cities, towns, and villages across Alaska.

Per the public notice dated September 30, 2025, the Department of Health (DOH) is undertaking a solicitation process to ask the public for ideas, suggestions, and input concerning potential regulatory changes to Chapter 07. Certificate of Need (7 AAC 07.001 — 7 AAC 07.900).

DOH is particularly interested in specific ideas for regulatory change that may:

- clarify existing regulatory obligations;
- reduce costs for the public, industry, or government;
- improve or streamline procedures, application requirements, and review processes, for example, reducing the time required to apply for a license, permit, or benefit;
- reduce administrative burdens;
- streamline permitting procedures;
- improve communication procedures;
- provide greater transparency with respect to standards, decision-making, and rationales for application processing; or
- clarify interagency roles.

Certificate of Need (CON) laws are a healthcare planning and regulatory mechanism used by many states to balance healthcare access and cost. Because healthcare does not operate like a free market, regulatory constraints are deemed necessary to ensure expensive, unneeded services and facilities are not developed and that underserved populations have sufficient access to care. The goal of CON programs is to restrain healthcare costs and coordinate planning for healthcare infrastructure development.

AHHA supports regulatory changes and details potential ideas in this letter, but we also urge the State to be careful and judicious as it considers changes because significant rollbacks to the regulatory framework could harm Alaska's healthcare system.

AHHA Recommends Careful Analysis and Action for Revisions to Regulations

Among the 35 states with CON laws, there are substantial variations in services covered, enforcement, administrative policies, and threshold levels. DOH should be careful and considerate as it evaluates potential regulatory changes because there are documented instances from other states that eliminated CON requirements and saw increases in per capita health expenditure growth rates as a result.

Additionally, if one statistically compares Alaska to states that eliminated CON laws and regulations (i.e. "No-Con" states), Alaska's healthcare system outperforms for access and quality. For example, Alaska has 3 hospitals for every 100,000 residents, a rate that is 50% higher than the No-CON state median. Alaska provides 203 acute care hospital beds per 100,000 people, virtually the same as in No-CON states. Alaska has access to more Medicare-certified Ambulatory Surgery Centers (ASCs) than No-CON states. Alaska's quality scores outperform No-CON states, especially for nursing homes. Finally, the distribution of Alaska's hospitals is disproportionately higher in rural areas compared to the population, ensuring access to residents in more distant communities.

This is all relevant because we do not want to see all this progress undone in Alaska's healthcare system through poor policy changes and regulatory revisions.

Remember, community hospitals must provide 24-hour emergency services to all regardless of ability to pay. Because of the responsibility to provide 24-hour emergency medical services, hospitals have significant fixed and operating costs. Not all services in a facility are profitable. In fact, many operate at a loss and the facility relies on profitable services to maintain operations. Without reasonable CON standards, healthcare providers with purely economic motives can cherry-pick profitable service lines which threatens a hospital's ability to provide the full range of care to a community. Hospitals, unlike concierge, single-specialty, and niche providers, provide stabilizing treatment to anyone who comes to the door and maintain critical emergency preparedness infrastructure.

For example, Georgia repealed CON for single-specialty ambulatory surgery centers (ASCs) in 2008. The impact was immediate and significant—more than 180 single-specialty ASCs popped up in the first year of repeal, in addition to the 49 CON-approved ASCs that already existed. Within five years of repeal, the number of ASCs in Georgia grew by nearly 500%, while the volume of cases per facility declined. No Georgia

hospitals closed in the three-year period leading up to CON repeal (2005 to 2007). However, nine Georgia hospitals closed since repeal in 2008.

The story is similar for the state of Pennsylvania. After Pennsylvania CON laws were sunset, the number of ASCs increased by almost 200% over the next decade. Ohio repealed CON with a phased approach from 1995 to 1997. In the first three years following repeal, the number of ASCs increased by more than 500%. During the same three years, Ohio lost 14 of its 94 hospitals or 15% of the hospitals in the state.

While all these examples demonstrate the importance of proceeding with caution as DOH works on revising Chapter 07. Certificate of Need (7 AAC 07.001 — 7 AAC 07.900), it is important to acknowledge that the program standards and regulations are dated and often result in unintended consequences. Therefore, AHHA agrees with the need to evaluate and update the program with changes to regulations and review standards.

AHHA's Proposed Changes to Regulation

These comments are not exhaustive, and we think this type of reform requires an open sharing of ideas. To accomplish this, we encourage DOH to convene Alaska providers to work together on developing practical and necessary updates to CON regulations. A similar process consisting of a negotiated rule-making stakeholder group was used in 2007 to revamp the program, and we support recreating that effort.

If DOH convenes such a group, we recommend that the group take up the following changes to regulations.

Net Present Value of a Lease

7 AAC 07.010 details expenditures that must be included when determining whether a certificate of need is required by a facility. 7 AAC 07.010(a)(8) specifies that "leasing" of equipment or space must be included as an expenditure. 7 AAC 07.010(a)(8)(A) requires that the expenditure amount from a lease be calculated using a "net present value" formula.

However, the net present value formula is confusing, ineffective, and does not represent the true purpose of a net present value calculation, which is essentially to discount future cash flows to a present value. To eliminate confusion and stop entities from entering into abnormally short-term leases to avoid CON review, AHHA recommends that the Department adopt the following definition for "net present value:"

(A) the net present value of the lease; for purposes of this subparagraph, "net present value" is the sum of all lease payments made over the term of the lease discounted by a

specified rate. Net present value shall be calculated using the following algebraic expression:

$$Net\ Present\ Value = \sum_{y=1}^{N} \frac{Cy}{(1+d)^{y}}$$

(i) For purposes of this algebraic expression, "N" equals the term of the lease, "y" equals year, "C" is total lease payments made for the year, and "d" is the discount rate, which equals the annual average Consumer Price Index for All Urban Consumers in Anchorage, Alaska for the most recently completed calendar year, as published by the United States Department of Labor Bureau of Labor Statistics.

(ii) For purposes of this algebraic expression, if the lease is for space, the term of the lease shall equal five years or the actual length of the lease, whichever is greater. If there is no annual lease payment defined in the lease agreement for a given year, for that given year, "C" shall equal the average of the annual lease payments that are defined in the lease agreement.

Definition of "Independent Diagnostic Testing Facility"

There have been situations in which independent diagnostic testing facilities sought exemption from CON as an "office of private physicians." In fact, when the definition provided under 7 AAC 07.900(23) for independent diagnostic testing facilities is read in conjunction with the definition for office of private physicians under 7 AAC 07.001(b), it results in a confusing, circular reference. To alleviate the confusion and prevent independent diagnostic testing facilities from unjustly evading CON review, AHHA recommends adding the following subsection (or something to this effect) to 7 AAC 07.900(23):

(C) if an entity is enrolled with Medicare as an independent diagnostic testing facility or otherwise subject to 42 CFR 410.33 as those provisions relate to an independent diagnostic testing facility, then it meets the definition of independent diagnostic testing facility for purposes of this chapter, regardless of whether (A) or (B) are satisfied.

42 CFR 410.33(g) references Medicare enrollment of independent diagnostic testing facilities. More specifically, it is our understanding that the CMS 855b form is used by independent diagnostic testing facilities to enroll in Medicare. While it is also used by physician groups, attachment 2 in section 1 of the 855b form is for independent diagnostic testing facilities "only." Therefore, this would mean if an entity completes that section, then it is at least "otherwise subject to 42 CFR 410.33 as those provisions relate to an independent diagnostic testing facility." Accordingly, that entity meets the proposed definition of independent diagnostic testing facility for certificate of need purposes.

Definition of "Hospital"

With the rapid evolution of health care, there are models of care that do not currently exist in Alaska that may or may not be beneficial to its health care system and its overall cost of care.

A specialty hospital is an example of this type of model. It may be possible for these models to attempt to evade CON review by claiming they do not fall within the definition of "health care facility" in AS 18.07.111, or alternatively, if they do meet that definition, attempt to claim exemption as an "office of private physicians."

To ensure that the State is given the opportunity to weigh in on future models of care as they relate to capacity and cost, AHHA recommends amending the definition of "hospital" in 7 AAC 07.900(21) as follows:

(21) "hospital" has the meaning given in AS 47.32.900. For purposes of this chapter, hospital also includes specialty hospitals, such as but not limited to orthopedic hospitals, cardiovascular hospitals, surgical hospitals, women's health hospitals, and freestanding emergency departments, regardless if they satisfy 7 AAC 07.001(b)(1), 7 AAC 07.001(b)(3), or 7 AAC 07.001(b)(4).

Expenditures for Nonclinical Purposes; Routine Maintenance; Routine Replacement of Equipment

Understanding what the Department considers to be an expenditure for a nonclinical purpose can be confusing because it requires referencing multiple sections of the regulations. However, this appears to be reasonably clear so long as one confusing subsection is deleted. 7 AAC 07.010(e) excludes an expenditure for a nonclinical purpose if it satisfies a two-part test. Part two of the test—7 AAC 07.010(e)(2)—makes sense and should stay in place. However, part one of the test—7AAC 07.010(e)(1)—is confusing because it requires the facility to be an enrolled Medicaid provider and the expenditure at issue to be a non-reimbursable cost under the prospective payment system, which is a complicated rate methodology detailed in another area of the regulatory code.

Rather than continue this confusion and put the Department in the position of having to determine whether a reimbursement would be reimbursable under 7 AAC 150, AHHA recommends striking 7 AAC 07.010(e)(1) and simply relying on 7 AAC 07.010(e)(2) as the primary analysis for whether an expenditure should be excluded for relating to a nonclinical purpose.

AS 18.07.031(e) states that an "expenditure" does not include costs associated with routine maintenance and routine replacement of equipment at an existing health care facility. Both "routine maintenance" and "routine replacement of equipment" are defined in regulation at 7 AAC 07.900(33)-(34). While the definition of "routine maintenance" is reasonably clear, 7 AAC 07.900(33)(A)(i) has been interpreted to include service agreements for major pieces of equipment. For example, there have been independent diagnostic testing facilities that have acquired substantial pieces of imaging equipment, but have successfully evaded CON review by structuring the lease or purchase for an artificially low base price, and coupling it with an excessively high service agreement. Since the service agreement is interpreted to be exempt, only the artificially low base price is counted as an expenditure.

To close this loophole, the Department should add clarifying language that excludes service agreements from the definition of "routine maintenance" in 7 AAC 07.900(33)(A)(i), and list "service agreements for equipment" as an expenditure under 7 AAC 07.010.

"Routine replacement of equipment" should continue to be exempt from CON expenditures, but the definition in 7 AAC 07.900(34) needs revision. Subsection (B) states that routine replacement of equipment:

> does not include replacement of medical equipment that increases the technological capacity of the equipment or facility so long as the increase does not result in a change in the scope of services that are being provided; (emphasis added)

With the constant evolution of technology, especially in health care, AHHA believes that the CON program should encourage the replacement of equipment to offer patients in Alaska access to the most cutting edge, modern treatment options.

Consequently, the Department should strike "not" (specifically the "not" that is underlined above) in 7 AAC 07.900(34) so that technological advances can occur so long as they do not result in a change in the scope of services being provided by the facility.

Phased Activities

7 AAC 07.025(d) explains that multiple projects or project activities, and the expenditures thereof, will be considered a single activity with a single set of expenditures for CON purposes under certain circumstances. The circumstances exist as three scenarios in (d)(1)-(3) and can be summarized as follows: (1) two or more components of the activity are financed together plus constructed or acquired together; (2) one component of the activity is dependent upon completion of another component of the activity, and neither component alone would "meet the objectives of the certificate of need applications;" or, (3) constructed activities are built at the same time

or in a continuing manner with no more than 120 days between completion of one activity and commencement of the next activity.

These thresholds are both confusing and easily avoidable by providers who seek to keep activities below the $1.5 million expenditure limit. First, (d)(2) does not seem practical or applicable because it infers that there is a CON application to compare to a set of activities. Often, providers avoiding this phased activity classification have not submitted a CON application. (d)(1) is a good test in theory except it is simple to incorporate independent entities to finance activities separately. Finally, (d)(3) is extremely limited because waiting four months between construction activities can be accommodated by any project with little to no adverse effects.

At a minimum, the Department should consider replacing this three-part framework with a defined look-back period during which expenditures "directly related" to a project should be considered as a single set of expenditures for purposes of AS 18.07.031. Directly related expenditures should not include routine maintenance or operational expenses, and the look-back period should be two to three years.

This concept will only work if the Department enforces it, which means there should be some type of penalty for failure to provide the Department with applicable expense information upon notice and request. Perhaps a facility's license can be suspended if the facility fails to timely comply with a request.

Formulas from Review Standards and Methodologies

7 AAC 07.025(a)(3) essentially requires CON applications to meet the "certificate of need review standards and use[] the methodologies identified in the department's document entitled Alaska Certificate of Need Review Standards and Methodologies, dated December 9, 2005, and adopted by reference." This regulation presumably is for purposes of enforcing AS 18.07.041 and AS 18.07.043. AS 18.07.043 clearly provides the framework for the general review standards in the Alaska Certificate of Need Review Standards and Methodologies. Other than that, AS 18.07.041 is broad and essentially calls for a CON to be issued if "the availability and quality of existing health care resources or the accessibility to those resources is less than the current or projected requirement for health services required to maintain the good health of citizens of this state."

This is important to note because the *Alaska Certificate of Need Review Standards and Methodologies* include a variety of standards and methodologies that use rigid formulas based on historic usage rates to project future need. Again, both the Department and the health care industry have recognized that these rigid formulas are deeply flawed because they can only work if historic usage of a service was at a correct level. Simply stated, if historic usage does not represent appropriate access to care, then it is

problematic to be forced to use a methodology or formula that projects needed capacity based on a figure that does not represent actual care needs.

At initial glance, 7 AAC 07.025(b) creates the appearance of discretion and a workaround to these flawed formulas. Unfortunately, this is not the case because it only permits the CON program to recommend that the Commissioner waive a review standard. Most of the flawed formulas exist as methodologies, and 7 AAC 07.025(c) expressly prohibits the Department from waiving a methodology adopted by reference in the *Alaska Certificate of Need Review Standards and Methodologies.* Additionally, lack of consistency in applying (or not applying) these standards, methodologies, and regulations often creates a barrier to predictability.

Rather than focusing on what can or cannot be waived, the department should strike this altogether so that if something truly needs to be waived, it can be waived by the Commissioner for "special or extraordinary circumstances" under 7 AAC 07.070. In conjunction with this change, the Department should keep the General Review Standards, and then replace all the service-specific standards and methodologies in the 'Alaska Certificate of Need Review Standards' with service benchmarks that represent best practices and national standards.

Finding benchmarks for each service listed in the *Alaska Certificate of Need Review Standards and Methodologies* is an important undertaking that will require engagement with providers and outside consulting expertise.

Relocation of Ambulatory Surgery Centers; Disproportionate Treatment of Skilled Nursing Facilities

While these last issues can only be solved through a statutory change, they must be recognized by the Department. First, AS 18.07.031(c) effectively exempts a single class of providers—ambulatory surgery centers—from CON review in a way that allows them to relocate at an unlimited expense under very simple conditions. No other facility or provider type in Alaska is given this privileged status and it creates an enormous competitive advantage that has largely contributed to the explosion in ambulatory surgery centers over the last 10 years in our state.

This provision should be struck in full so that ambulatory surgery centers are treated the same as every other facility subject to CON.

Another example of disproportionate treatment is the excessive limitations placed on skilled nursing facilities. Unlike all other facilities subject to CON, skilled nursing facilities are required to apply for full CON review and approval in any instance in which they seek to add a single bed. This is despite the fact that adding a limited number of beds can appropriately be accomplished with an expenditure that is below the $1.5

million CON threshold. Alaska has the fewest skilled nursing facility beds per capita in the country, and it is well below states with the next lowest bed counts. Systems of care require access to all levels of care.

This limitation on skilled nursing facilities creates cumbersome barriers to establishing or expanding a level of care that is often desperately needed in communities. Again, this policy, and the adverse consequences thereof, needs to be openly discussed so Alaskans have an opportunity to remove unnecessary barriers to care.

Conclusion

These comments are not exhaustive, and we think this type of reform requires an open sharing of ideas. We encourage DOH to convene Alaska providers to work together on developing practical and necessary updates to CON regulations. We also encourage DOH to hire a consultant to assist in designing service benchmarks that represent best practices and national standards to replace current service-specific standards and methodologies used by DOH.

Thank you for your partnership and efforts in prioritizing access to quality, sustainable healthcare for all Alaskans. In addition to our comments in this letter, we are enclosing a copy of the December 2022 “CON Analysis and Impact Study” for your convenience, which is an analysis produced by Ascendient Healthcare Advisory, Inc, a national expert on CON laws.

Sincerely,

Jared C. Kosin, JD, MBA
President & CEO