BEFORE THE ALASKA OFFICE OF ADMINISTRATIVE HEARINGS ON REFERRAL BY THE COMMISSIONER OF HEALTH AND SOCIAL SERVICES

In the Matters of ALASKA REGIONAL HOSPITAL, and PROVIDENCE ALASKA MEDICAL CENTER	))))))))	OAH No. 15-1084-CTN Agency No. 3252

DECISION

I. Introduction

Two Anchorage hospitals, Providence Alaska Medical Center and Alaska Regional Hospital, applied for certificates of need to expand their emergency departments. Providence sought to expand its emergency department by adding 14 treatment rooms, 10 of which would be configured for treating children. Alaska Regional Hospital proposed building two freestanding emergency departments, one in South Anchorage and one in Eagle River. Each could have up to eight beds, but would open with fewer.

The Division of Health Care Services reviewed the two applications. It determined that up to 13 additional emergency department rooms could be approved for the Anchorage area. It recommended that the Commissioner of Health and Social Services deny Alaska Regional's application, and grant Providence 10 of the 14 requested rooms.

The Commissioner denied Alaska Regional's application, finding that its application did not meet the standards for an emergency-department certificate of need. The Commissioner approved a certificate for an eight-room expansion of Providence's emergency department.

Alaska Regional appealed only the denial of the Eagle River facility. Providence appealed the denial of the additional five rooms that could have been awarded under the methodology. A hearing was held on the two appeals.

The evidence at the hearing showed that Alaska Regional's proposal did not meet the Department's formula for determining the need for additional emergency department rooms in a service area. In addition, although the record did demonstrate that Alaska Regional's model for

providing emergency services was viable, the model would be an expensive and inefficient way to provide additional medical services to Eagle River. Alaska Regional's application is denied.

Providence's application meets the methodological requirements for adding 13 additional emergency department rooms in the Anchorage service area. In addition, its proposal would provide benefits to the community from its proposed specialization and low cost. Although this record suggests that reserving five additional rooms for future study or development could be justified, no party has come forward with a rationale for reserving rooms that is consistent with the evaluation standards and supported by evidence. Accordingly, Providence's application for a certificate of need to expand its emergency department by 13 additional rooms is granted.

II. Facts

A. The Municipality of Anchorage and its healthcare network

The Municipality of Anchorage has a modern and extensive healthcare network that serves its residents and other residents from across the State of Alaska. The network includes four different acute-care hospitals. Two of these hospitals serve only special populations: Alaska Native Medical Center (ANMC), which is both a primary care clinic and a hospital, serves the medical needs of Alaska Natives. JBER Hospital, located on the Joint Bases of Elmendorf Air Force Base and Ft. Richardson, serves only patients who are authorized to use military medical facilities.

The other two acute-care hospitals in Anchorage, Providence Alaska Medical Center and Alaska Regional Hospital, however, serve all residents. Providence is the largest hospital in the state, with 401 acute-care beds, 37 of which are emergency beds.[1] In 2014, Providence was designated a Level II trauma center, which meant that it had the ability to provide emergency care for patients with a significant level of injury.[2] Providence is owned by Providence Health & Services, a not-for-profit health system.

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[1] Admin. Rec. at 223.

[2] Admin Rec. at 1185. The American Trauma Society identified the elements of Level II Trauma Centers as follows:

- 24-hour immediate coverage by general surgeons, as well as coverage by the specialties of orthopedic surgery, neurosurgery, anesthesiology, emergency medicine, radiology and critical care.
- Tertiary care needs such as cardiac surgery, hemodialysis and microvascular surgery may be referred to a Level I Trauma Center.
- Provides trauma prevention and to continuing education programs for staff.
- Incorporates a comprehensive quality assessment program.

Available at http://www.amtrauma.org/?page=traumalevels.

Alaska Regional is a smaller hospital, with 250 acute care beds of which 18 are emergency beds. Hospital Corporation of America, the largest for-profit operator of healthcare facilities in the country, owns Alaska Regional.

Providence, Alaska Regional, and ANMC are all located within a two-mile radius in the core area of Anchorage, often called the "U-Med district" because of the proximity of the hospitals and the university. The geographical constraints of water and mountains limits the roads connecting the core area to the other parts of Anchorage metropolitan area. Two main roads lead out of town: one to the southeast, called the Seward Highway, and one to the northeast, called the Glenn Highway. Of particular concern in this case is that the communities to the northeast—Peters Creek, Eagle River, Eklutna, and Chugiak—have only one route to access the hospitals in the core area, the Glenn Highway. Significant bottlenecks and delays can occur during heavy commuting times to and from Anchorage. Like any single-access route, the highway could be cut off during a significant emergency.

B. The applications for certificates of need

Providence's 37 emergency department rooms operate over capacity. They are frequently busy, and patients can experience long wait times. To address overcrowding, and at the same time develop its emergency pediatric specialty practice area, Providence prepared a plan for expansion. Because it could not expand its emergency department without being granted a "certificate of need" from the state, on October 10, 2014, Providence applied to the Department of Health and Social Services, Health Care Services Division, for a certificate of need to expand its emergency department.[3] The application proposed the following:

- Repurposing existing clinical and non-clinical space to add 14 new emergency treatment rooms.
- Increasing the total number of emergency beds from 37 to 51.
- 10 of the rooms would be for a pediatric emergency treatment area. The area would be staffed with a full-time child-life specialist and, to the extent possible, by a physician certified in pediatric emergency care. The rooms could also serve adults when necessary.

[3] Admin. Rec. at 283-358.

- The existing psychiatric emergency department would be moved with a slight decrease in area but no decrease in number of beds.
- The square footage of the emergency department would increase by 2,728 square feet to 24,279 square feet.

Alaska Regional's emergency department has not been overcrowded—indeed, until very recently, its has been operating below capacity.[4] Nevertheless, on December 24, 2014, Alaska Regional, recognizing that Anchorage's emergency department need was underserved, applied to the Division for a certificate of need to expand its emergency department. Its application, however, did not propose to add more beds at its existing structure in the U-Med district of Anchorage. Instead, Alaska Regional proposed to build and equip two freestanding emergency departments (FSEDs) not attached to a hospital. One FSED would be in South Anchorage, and one in Eagle River.[5] The application proposed the following:

- Each FSED would be new construction containing 10,700 square feet. Each would be a single-story building with eight treatment rooms.
- The Eagle River FSED would open with five treatment rooms operational. The remaining three would open later when demand increased. The South Anchorage FSED would open with six rooms operational.
- A patient who needed to be admitted would be transported at no expense to Alaska Regional's hospital.
- The Eagle River FSED would cost $12,555,925. The South Anchorage FSED would cost $12,838.533.
- Both FSEDs would be operational in spring 2016.[6]

A procedural hiccup in this case has to do with the dates of the applications. When the Division receives an application for a certificate of need, it publishes notice of the application so that other potential providers can consider whether they would like to submit a competing application. If the Division subsequently receives a timely letter of intent to apply, followed by

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4 The statistics in the record all show Alaska Regional's emergency department with fewer than 1500 patients per bed per year, which is considered to be the normal capacity for an emergency department. Alaska Regional's Chief Executive Officer, Julie Taylor testified, however, that recently Alaska Regional's emergency department has reached the 1500-use threshold.

5 Admin. Rec. at 501-57.

6 Admin. Rec. at 507-09.

an application for identical or similar services, the Division processes the applications as concurrent applications. Under this process, the applications are compared, and the certificate of need is awarded based on the results of the comparison. Until all applications are complete and the application process closes, the contents of the applications are not made public, so that a competitor does not know the contents of the competing proposal.

Here, when the Division did not receive a timely letter of intent after it had given notice of Providence's application, it published Providence's application and sought public comment. When it received Alaska Regional's application in late December, it rejected the application as untimely. Alaska Regional, however, argued that the Division's notice was faulty, and went to court to force the Division to consider its application as a concurrent application. The Alaska Superior Court agreed that the notice was faulty, and on March 3, 2015, issued an injunction that prevented the Division from granting Providence's application until it had determined whether to do a concurrent review of both applications. The Division then determined to undertake a concurrent review.[7] Because the content of Providence's application had been disclosed before Alaska Regional had completed it application, the Division provided Providence with an opportunity to supplement its application. On April 29, 2015, Providence submitted an amended application. The amended application did not change Providence's proposal, but it did address the merits of Alaska Regional's proposal.[8]

A public hearing was held on May 18, 2015.[9] The staff of the certificate of need program issued its analysis of the applications in June 2015.[10] In the analysis, staff went through each of the applicable standards for evaluating the concurrent applications that the Department has adopted in its publication, *Alaska Certificate of Need Review Standards and Methodologies.*[11] The Division's analysis confirmed Providence's calculation that Anchorage would need 13 more emergency department treatment rooms over the next five years.

With regard to Alaska Regional's proposed FSEDs, staff found several shortcomings in the idea of having an emergency room separated from the main hospital. Some emergencies would require immediate admission to the hospital's operating room or catheter laboratory, so

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7 Admin. Rec. at 43.
8 Admin. Rec. at 454-500.
9 Admin. Rec. at 681-809.
10 Admin. Rec. at 221-51.
11 Alaska Dep't of Health and Soc. Servs., *Alaska Certificate of Need Review Standards and Methodologies* (December 9, 2005), *available at* dhss.alaska.gov/dhcs/Documents/CertificateOfNeed/Standards.pdf.

those patients would have to be transported to Anchorage anyway. Staff cited what appeared to be an admission in the application that the FSED would treat only the two-thirds of emergency patients who do not actually need *emergency* services. Many of these patients could be treated by an urgent care or primary care facility at a much lower cost. Moreover, an FSED is easily confused with an urgent-care facility, and staff was concerned that consumers would treat the FSED like an urgent-care facility. Although FSEDs are becoming common in other states, Alaska has no experience with them, and the report noted that Alaska's certificate of need regulations (and possibly other healthcare laws) were not tailored to FSEDs. Staff concluded that Alaska Regional's application failed many of its review standards, and recommended that the Commissioner reject both the proposed Eagle River and South Anchorage FSEDs.[12]

With regard to Providence's application, staff found fewer shortcomings. The analysis concluded that the application met the review standards, with the exception of General Review Standard #3, which related to stakeholder participation. Staff found this failure to be minor, and did not recommend rejection on this ground. The staff expressed concern, however, about "whether the community's access to hospital emergency department services is best accomplished by relying on a single hospital to fully meet the capacity for these service for at least the next five years."[13] Accordingly, the analysis recommended that the Commissioner approve a certificate of need for Providence to construct only 10 additional rooms, not the 14 for which it applied or the 13 for which staff found need under the formula.[14]

On July 14, 2015, Commissioner Valerie Davidson issued a decision on the two applications. She accepted staff's analysis that Alaska Regional's application for two free standing emergency departments did not satisfy two of the general review standards and one of the emergency room standards, and only partially satisfied a second emergency room standard. She expressed concerns that the FSED model of emergency services would be expensive and inefficient. She denied Alaska Regional's application in full.[15]

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[12] Admin. Rec. at 225-39. One issue that occupied considerable time at the hearing was the reference in staff's report that FSEDs cannot treat trauma patients. *Id.* at 227. At the hearing, however, the director of the certificate of need staff explained that this reference meant that FSEDs could not provide emergency surgery for the serious trauma patients. Kosin testimony.

[13] *Id.* at 252.

[14] *Id.*

[15] *Id.* at 137-39.

Commissioner Davidson also agreed with staff's analysis of Providence's application. She found that it aligned with Alaska's healthcare system, and that its proposal would "enhance emergency care by valuing the importance of serving the pediatric population."[16] Departing somewhat from staff's recommendation, however, Commissioner Davidson only approved a certificate of need for eight of the 13 needed emergency rooms. She determined that "PAMC's proposal on its own is not the best means of meeting that need."[17] Awarding a certificate for eight of the rooms would leave five additional rooms available for Alaska Regional, or another provider, to pursue in the future.

In support of her decision, Commissioner Davidson noted that she is required to consider the healthcare system as a whole. Under the regulations, she must consider special or extraordinary circumstances related to community access to care.[18] Based on this issue, she stated

> I am concerned [about] the reliance for access that would be created if I were to approve more than eight rooms for PAMC. Put another way, I do not believe that the community's access to hospital emergency department services is best accomplished by relying on a single hospital (i.e. PAMC) to fully meet the capacity for these services for at least the next five years.[19]

As further support for reserving five of the available rooms, the Commissioner noted that Medicaid and healthcare reform efforts have been encouraging patients to use primary-care services when appropriate, and to curb expensive overuse of emergency-care services. Based on this consideration, she concluded

> If these efforts are not enough to fully curb growth of hospital emergency department services, I find more benefit and certainty for community access to care by leaving the remaining capacity open so that there is opportunity over the next five years for another provider to diversify access to those services.[20]

Both Alaska Regional and Providence appealed the Commissioner's decision. Alaska Regional, however, later withdrew its appeal of the denial of the proposed FSED for South

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16 *Id.* at 137.
17 *Id.* at 138.
18 *Id.* (citing 7 AAC 07.070(b)(7)(A)).
19 *Id.*
20 *Id.*

Anchorage, leaving only its request for a certificate of need for the proposed five-bed FSED for Eagle River. Providence did not appeal the denial of the 14th room it had requested; it modified its request to the 13 rooms that were calculated as being needed under the methodology. A five-day hearing was held on November 19-25, 2015. Closing arguments were heard on December 15, 2015.

III. Discussion

A. What are the legal standards for evaluating an application for a certificate of need?

A certificate of need is required for most healthcare facility construction or expansion projects costing $1.5 million or more.[21] The department must grant an application for a certificate of need (other than a nursing home) when "the availability and quality of existing healthcare 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."[22] The department has adopted standards and methodologies for evaluating applications. For a case that involves two different applicants, the evaluation process has four components.

First, the Department must evaluate the need for the proposed medical service. To evaluate the current and projected need for emergency department services in a particular service area, the Department has adopted a formula, or "methodology."[23] The formula takes into

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[21] AS 18.07.031.

[22] AS 18.07.041.

[23] The methodology is as follows:

> The department will use the following formula to determine the need for emergency department treatment room services:
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> **EDTR = C5/1500**
> **C5= P5x SAS x UR**
>
> **EDTR** = emergency department treatment rooms needed
> **C5** = caseload (emergency department visits) projected for the fifth year after project completion
> **UR** = current utilization rate (average number of emergency department visits per year for the last three years, divided by population), to be determined on a service area basis
> **P5**= projected population for the fifth year after project completion
> **SAS** (service area share) = the proposed service area's current share of the population to be served, as of the most recent geographic population estimates. If there is public information about service area population changes expected over the planning horizon, such as a military base closing, or a major economic project such as a new mine, the service area share estimate may be modified with an explanation to reflect the expected change.

Alaska Certificate of Need Review Standards and Methodologies at 9.

account how many patients should be seen per emergency department bed, which is set in the methodology at 1500. The Department cannot waive the methodology for determining the need for the proposed service.[24]

Second, in performing its analysis of the merits of the application, the Division will first evaluate the proposal under a set of six general standards that apply to all medical facilities requiring a certificate of need.[25] These standards address need, planning, stakeholder participation, alternatives, impact on the target population, and accessibility.

Third, the Division will next apply an additional set of standards that address only the specific medical service governed by the application.[26] Four standards apply to review of applications for emergency-department rooms. They address stability and efficiency, whether each proposed room will operate at capacity, fast track services (not relevant here), and whether other service-specific standards apply.

Fourth, when the Division has more than one application for competing facilities addressing the same medical need, it must compare and contrast the applications based on its standards for concurrent review.[27] The Division's approach to concurrent review requires further explanation. Jared Kosin, who is the Executive Director of the Division's Office of Rate Review, and the supervisor of the certificate of need program, explained that Providence's application did not receive any special credit for including the pediatric specialty. The treatment rooms that would serve as pediatric specialty rooms were convertible to serve adults if necessary.

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[24] 7 AAC 07.205(c).

[25] *Id.* at 2.

[26] *Id.* at 8.

[27] The standards for evaluating concurrent applications are:

> **Additional Considerations for Concurrent Review of More than one Application**
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> In completing a concurrent review of two or more applications under 7 AAC 07.060, in addition to applying the standards set out above, the department will compare the extent to which each applicant, including any parent organization of the applicant,
>
> 1. demonstrates a commitment to quality that is consistent with, or better than, that of existing services, if any;
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> 2. demonstrates a pattern of licensure and accreditation surveys with few deficiencies and a consistent history of few verified complaints; and
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> 3. demonstrates that the applicant has consistently provided, or has a policy to provide, high levels of care to low-income and uninsured persons.

Id. at 3.

Therefore, the staff analyzed the proposal as it would any other proposal to provide quality emergency service.

Providence takes issue with this approach to the concurrent review. In its view, the whole point of doing a concurrent review is to compare two proposals, and to favor the one that will provide more health benefits to the community. If no such comparison is made, then when two competing proposals both generally comply with the review standards, by default you will be left with the first mover, even though the other proposal may be of much higher quality.

Providence is correct that Concurrent Review Standard No. 1 requires the Department to compare the applicants' commitments to quality. This standard allows the Department to consider the aspects that might make one proposal superior to another. Taking into account the innovative aspects of a proposal in doing this review for quality counteracts the tendency of the certificate of need process to be conservative and stifle innovation and change that comes from a competitive marketplace.

Both hospitals here have put forward innovative proposals for addressing unmet health-care needs of the citizens of Anchorage—Providence proposing a pediatric emergency specialty practice, and Alaska Regional proposing to address the lack of emergency services in Eagle River. Ironically, each hospital seizes on the inherently conservative nature of the certificate of need process to criticize the innovative nature of the other's proposal—each argues that the other's proposal should be rejected because it serves only a portion of the population. Were that a legitimate reason to reject a proposal, however, innovative approaches to serving select populations could never get a foot in the door. Therefore, in the analysis that follows, both hospitals will be given recognition for innovative ideas that have the potential to improve healthcare for residents.

The Division has a concern about evaluating proposed enhancements that appear to be outside the issues addressed by the certificate of need process because the Division may not be in a position to enforce the hospital's commitment to continue the innovative approach promised in its application. Yet, giving credit for innovative ideas does not imply that the Division is taking on an additional enforcement duty. The possible existence of a future concern should not deter the Department from evaluating the commitments made in an application, and how those commitments will affect the quality of the healthcare that will be provided by the applicant.

B. Does Anchorage need additional emergency rooms?

The first issue in an application for a certificate of need is whether the proposed medical service is necessary. Indeed, as the name implies, a core purpose of the certificate is to prevent unnecessary expensive medical infrastructure.[28] The theory behind government intervention in the marketplace is that because the health-care market is imperfect, if government did not regulate new construction, the consumer would pay the price for the overbuilding.

The department has adopted a formula for determining how many emergency rooms a community should have. The formula first requires identification of a service area. Then the rate at which the residents of the service area use emergency department services must be determined. The rate is expressed as the average number of emergency room visits per year for each resident, based on the average use rate for the prior three years. The use rate is then multiplied by the expected population in five years to determine the expected total usage per year for the service area, five years in the future. That number is then divided by 1500, which is the number of patients that each emergency room should serve each year. The resulting number is the number of emergency rooms a service area should have.[29]

The data in this record reveal the following:

- The three-year average use rate for the emergency departments at Providence and Alaska Regional is 0.309 visits per resident of Anchorage.[30]
- The predicted population for Anchorage for 2022 is 326,612.[31]
- Multiplying these two numbers together shows that five years from now, patients will visit these two emergency departments 100,940 times per year.[32]
- Dividing this number of visits by 1500 shows a need for 67.3 emergency department treatment rooms. Rounding up, this means a need for 68 rooms.[33]

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[28] *See, e.g., Beal v. McGuire*, 216 P.3d 1154, 1172 (Alaska 2009) ("The legislature adopted the CON program to avoid unnecessary duplication of health care resources in any one geographical area."); *South Cent. Health Planning & Dev., Inc. v. Comm'r of Dep't of Admin.,* 628 P.2d 551, 552-53 (Alaska 1981) (holding that "the reasons for the certificate of need program are implicated" because where "there is a surplus of similar facilities in the area there may be unnecessary duplication of health resources.").

[29] *Alaska Certificate of Need Review Standards and Methodologies* at 9.

[30] Admin. Rec. at 237.

[31] *Id.*

[32] *Id.* at 238.

[33] *Id.*

- Because the two hospitals have only 55 emergency rooms, the Department may issue a certificate of need for up to 13 more emergency rooms.[34]

Two issues need further explanation. First, the Division's calculation includes the entire population of Anchorage in the denominator of the fraction used to determine use rate, even though some of that population will use ANMC's or JBER's emergency rooms. The actual emergency room use at ANMC or JBER, however, was not included in the numerator: the numerator includes only emergency room use at Providence and Alaska Regional. The effect of this approach is that the formula includes the rate at which ANMC-eligible and JBER-eligible patients nevertheless choose to seek emergency services at Providence or Alaska Regional. The methodology assumes that this rate will stay constant going forward, which is an acceptable assumption. Although some witnesses suggested that this approach means we should ignore ANMC and JBER, the opposite is true. Because the entire population is included in the denominator (even though some of this population will use ANMC's or JBER's emergency departments), ANMC's and JBER's use rate is an implicit factor in the calculation, and therefore should be considered when addressing policy decisions.

Second, a key variable in this formula is correctly identifying the service area. Here, that issue looms large, because if the service area for Alaska Regional's proposal is Eagle River, instead of Anchorage as a whole, it would significantly affect the analysis. That issue is further discussed below in Section D.1 of this decision, which analyzes Alaska Regional's proposal.

C. Is the Department required to award all 13 rooms to a qualifying applicant?

Shortly after the appeals were filed, Providence moved for partial summary adjudication. It sought a ruling regarding the Commissioner's decision to withhold some of the 13 rooms that were determined to be available under the formula. Providence argued that the Commissioner's action was contrary to law.

Providence pointed out that under the regulations, the Commissioner had no discretion to waive the methodology for determining the needed rooms. It reasoned that once the Commissioner has determined that an applicant is qualified under the standards and the

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[34] *Id.* Although the parties made their initial calculations using slightly different estimates of population, by the time of the hearing the parties had agreed to the data used by the Division. Both 2021 and 2022 were used as the target year; the choice of target year did not affect the outcome. The parties agreed that the service area of Anchorage will need an additional 13 emergency department rooms in the next five years.

regulations, the Commissioner has no discretion to refuse to award those rooms to the qualified applicant.

In Providence's view, this result flows from the absolute requirement that the agency must not alter the methodology for calculating need. Providence pointed to the history of the ban on waiving the methodology, which was adopted after the agency had experienced having its methodology rejected in hearing and judicial proceedings. Providence asserts that if the agency is allowed to hold back on awarding needed rooms to a qualified applicant, it amounts to a *de facto* waiver of the methodology.

Providence's argument that the Commissioner's action was contrary to the regulations was rejected in an order issued on October 28, 2015.[35] The order found that the Commissioner's decision to withhold some of the available rooms could be supported in a number of ways consistent with the regulations. First, Emergency-Department Review Standard #1 instructs the department to scrutinize applications to ensure "a stable and efficient emergency medical system." Because holding back some rooms could increase efficiency (for example, by increasing competition), this standard could provide a rationale for the Commissioner's decision. Second, as noted by the Commissioner, 7 AAC 07.070(b)(7) requires consideration of special circumstances regarding community access to healthcare. Because distributing rooms among diverse providers could affect access through competition and choice, this rationale also could be used to support the decision to withhold some of the rooms. Another possible rationale for withholding some rooms (which was not discussed in the order, but is discussed later in this decision) could be to keep the project consistent with healthcare planning in the service area—an evaluation criterion found in both the regulations and the review standards. Any of these issues, or combination of issues, could provide grounds for awarding only some of the available rooms to an otherwise qualified applicant.

Therefore, Providence's argument that all available rooms must be awarded to a qualified applicant is not correct. If the evidence shows that withholding some rooms is a better fit with the standards and regulations than awarding all rooms (under any of these rationales), then, effectively, Providence would not be qualified for the full award. Because a hearing would be

[35] Order on Motions at 1-4 (Oct. 28, 2015).

necessary to determine whether the evidence supported the withholding of some rooms, summary adjudication was denied.[36]

Providence's argument was, however, accepted in one respect. The order recognized that the decision had to be firmly grounded in the evidence. Therefore, a decision to withhold an award of some rooms that otherwise would be granted would have to be based on a finding that a preponderance of the evidence proved that the withholding best met the requirements of a standard or a regulation.[37]

Here, both the Commissioner and staff were concerned that a failure to diversify the expansion of emergency room services would ultimately reduce the Anchorage health-care consumer's ability to make choices when seeking healthcare. This concern is a rational, commonsense approach to analyzing the facts, particularly with Providence being a dominant presence in the market. Whether a preponderance of the evidence shows that reserving some rooms for the future is more consistent with the legal standards than granting those rooms to a single provider is addressed in section F, below.

Another issue discussed by the order was the citation in the Commissioner's decision to Medicaid and healthcare reform. The Commissioner's decision noted that these reform efforts may be "reducing emergency room visits through appropriate, more efficient and cost-effective care at the primary-care level."[38] Again, this rationale is logical and, if proved, potentially persuasive. Reform could reduce demand, and therefore be used in a "trend" analysis to argue that the methodology may be overestimating the number of beds. Under 7 AAC 07.025(c), however, the agency is not permitted to use a trend analysis as a basis for awarding fewer beds than those computed as needed under the methodology. Because the methodology cannot be waived, as a matter of law, citation to a trend or expectation due to Medicaid and healthcare reform cannot be used to support a decision to award fewer than 13 beds. Therefore, the parties were instructed not to defend the withholding decision with a citation to any rationale that could be considered a trend analysis.[39]

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[36] *Id.*

[37] *Id.* at 3.

[38] Admin. Rec at 138.

[39] Order on Motions at 3-4. Also rejected in the order was Providence's argument that "access," as that term is used in 7 AAC 07.070(b)(7), is limited to whether clients are able to physically approach a facility. As Mr. Kosin explained in the hearing, access here includes how easily and effectively clients can use a healthcare service for their benefit.

D. Is Alaska Regional's application consistent with the standards?

With regard to Alaska Regional's application, staff found a failure to meet the following standards:

- General Review Standard #1 (need for the project).[40]
- General Review Standard #2 (consistent with planning).[41]
- Emergency-Department Review Standard # 1 (ensures stable and efficient emergency medical system).[42]

Staff found that Alaska Regional's application met all of the remaining review standards that were applicable to the Eagle River FSED application (including the concurrent review standards).[43]

The discussion of Alaska Regional's application in this decision will primarily address the three issues for which staff found the application deficient: need, planning, and efficiency of services. We begin with the issue of the need calculation. We then turn to a discussion of the quality and efficiency of the FSED model and how the proposal fits in with planning for delivery of medical services in the Anchorage area.

1. Does Alaska Regional's proposed Eagle River FSED pencil out under the methodology for determining need?

Three different review standards address the issue of need: the formula methodology (for calculating quantitative need), General Review Standard #1, and Emergency-Department Review Standard #2. As described above, staff determined that the quantitative need requirement determined under the methodology for Anchorage (13 emergency beds over the next five years) applied to Alaska Regional's application for two FSEDs to serve the Anchorage area. Staff therefore found that the application met the quantitative need requirements of the methodology and Emergency-Department Review Standard #2. Providence, however, challenges this finding, arguing that Alaska Regional's Eagle River FSED does not meet the quantitative formula.

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[40] Admin. Rec. at 227.
[41] Admin. Rec. at 229.
[42] Admin. Rec. at 236.
[43] Admin. Rec. at 230-40. For Emergency Review Standard #2, which asks whether the proposed emergency department was needed under the methodology, staff approved Alaska Regional's application up to the 13 beds allowed under the methodology. Admin. Rec. at 239. Because its original application arguably requested 16 beds (the two proposed buildings would each be capable of housing eight beds), staff considered this a partial denial. Given that Alaska Regional has withdrawn its application for the South Anchorage facility, this issue is moot.

Although staff concluded that Alaska Regional's combined application (for two FSEDs) met the quantitative need calculation, staff found that the application failed to meet the need requirement of General Review Standard #1 based on a qualitative analysis. It found that because the quality of the service to be provided by the proposed FSED was lower than the service provided by an attached emergency department, Alaska Regional had not demonstrated a need for these beds, even though a need existed for beds in general. This subsection of the discussion, however, will focus strictly on the quantitative issue prescribed by the methodology. We will take up the qualitative issues in the next subsection.

As explained above, the methodology requires calculation of a use rate (the average number of emergency department visits per year for the last three years). The use rate multiplied by the population will yield the number of patients that will be served in each room per year. In making the determination that Alaska Regional's proposal met the quantitative measure of need, staff viewed Alaska Regional's proposal for two FSEDs as meeting an area-wide need for emergency services. Therefore, the analysis applied the use rate for the Anchorage service area generally to the entire application, rather than applying a use rate for a South Anchorage service area and a use rate for an Eagle River service area.

Alaska Regional's application, however, identified Eagle River and South Anchorage as individual service areas, different from Anchorage as a whole.[44] A service area is "the geographic area to be served by the proposed activity, including the community where the proposed activity will be located."[45] For Alaska Regional's proposed Eagle River FSED, the proposed service area is the Peters Creek/Eagle River/Chugiak area.

Consistent with identifying Eagle River as a service area, Alaska Regional's application used Eagle River's population for the need calculation. It then multiplied the 2021 estimated Eagle River population (40,418) by the *greater Anchorage use rate* (0.309) to determine need for emergency rooms in Eagle River. It determined that the need would be eight rooms by 2021.[46]

Alaska Regional's approach, however, is not correct. Under the methodology, the use rate must be determined "based on the service area."[47] Alaska Regional did not do this—it

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[44] Admin. Rec. at 521; Taylor testimony.
[45] 7 AAC 07.900(36).
[46] Admin. Rec. at 521.
[47] *Alaska Certificate of Need Review Standards and Methodologies* at 8.

assumed that the use rate would be the same as Anchorage's use rate, 0.309.[48] Alaska Regional may rely on assumptions, but if it does so, it must prove that its assumptions are reasonable. Therefore, the question is whether the evidence proves that the Anchorage use rate is a reasonable proxy for the Eagle River use rate.

The first problem with Alaska Regional's calculation is that it did not reduce the use rate for the patients who, as Alaska Regional acknowledged, would bypass the FSED and use one of the attached public emergency departments in Anchorage. This issue was muddy in the application (it appeared there that the FSED would not serve the high-acuity patient). At hearing, however, Alaska Regional's Chief Executive Officer, Julie Taylor, explained that this was not an issue of not being able to treat emergencies, it was an issue of choice and protocols for the emergency medical services (under which ambulances will take to an attached emergency room any patient who is likely to be admitted to a hospital). Alaska Regional was acknowledging that some emergency patients—about one-third of Eagle River emergency patients—would either drive themselves or take an ambulance to an emergency department attached to an acute-care hospital. Based on this acknowledgment, the use rate for an Eagle River FSED should be reduced by one-third. Reducing the use rate by one-third, but still relying on the Anchorage rate, reduces the projected demand for 2021 from 8.33 to 5.55 rooms.

The second, and more serious, problem is that better data are available for Eagle River use rates. Alaska Regional's application argued that in the absence of "patient origin data" from Providence, it had to use the Anchorage use rate.[49] That, however, did not relieve it of its obligation to research the issue and show that it was using a reasonable proxy. For example, it still had its own patient-origin data, which it could have used to truth-test its assumption that the use rate for Anchorage was comparable to the use rate for Eagle River.[50] Its failure to do any analysis of its use-rate assumption makes its application unreliable.

Moreover, Providence submitted into the original record a May 26, 2015, report from economist Dr. Frank Fox that analyzed the emergency room use rate for patients at Providence and Alaska Regional based on zip codes. He obtained his data from the Alaska State Hospital and Nursing Home Association (ASHNA). At hearing, Dr. Fox's testimony confirmed his

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48 Admin. Rec. at 521.
49 Admin. Rec. at 520.
50 *See* Admin. Rec. at 520.

earlier analysis. He showed that when actual use rates are taken into consideration, based on the ASHNA data, the emergency-room use rate for Eagle River residents would be 14 visits per 100 residents. In a final, post-hearing report, Dr. Fox revised this estimate to 15.7 visits per 100 residents, based on additional data he obtained from a hospital located in Palmer, which some residents of Eagle River/Chugiak use.[51]

Dr. Fox based his conclusions on statistics for patients who reported their zip codes as 99567 or 99577, the same zip codes used by Alaska Regional in defining the service area. Converting Dr. Fox's revised estimate to rooms (multiplying 40,418 by 0.157 and then, using the formula's requirement that each room should service 1500 patients per year, dividing by 1500), the proposed Eagle River service area would support 4.23 rooms. This number then must be scaled back to reflect Ms. Taylor's testimony that one-third of the service area residents will still use an attached emergency room in Anchorage (or perhaps Palmer). The actual need for the service area would be 2.8, rounded to three, rooms.[52] Under this analysis, the Eagle River FSED application for five rooms (later expandable to eight) does not meet the methodological threshold for need.

Dr. Fox concluded that the proposed Eagle River FSED, if granted, would have "significant idle capacity"—that is, time that it is not being used or is being significantly under used. Given that a primary purpose of the certificate of need is to prevent overcapacity, this expert opinion, backed by a reasonable statistical analysis, is a sufficient reason to deny Alaska Regional's application.

Although Alaska Regional had Dr. Fox's report since May, it did not introduce any statistical analysis to refute Dr. Fox's conclusion. At the end of the hearing, Alaska Regional introduced, over Providence's objection, rebuttal testimony from Jody Corona, a health-facility and planning consultant who was the principal author of Alaska Regional's application. Ms. Corona testified that Dr. Fox's math was correct, but that the resulting statistic was not credible. Based on her experience with health planning and being involved in over 500 certificate-of-need applications, Ms. Corona explained that she had never seen a use rate anywhere near that low. If

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[51] Dr. Frank Fox, Rebuttal Opinion at 2 (Dec. 9, 2015). The original report and testimony were based on data provided by the Alaska State Hospital and Nursing Home Association (ASHNA). The rebuttal report included data provided by the Mat-Su Regional Medical Center for 2012, which apparently had not been reported to ASHNA.

[52] Dr. Fox did not make this calculation, but he did make the point that his number was too high because some Eagle River/Chugiak residents would still use the attached emergency rooms. Admin. Rec. at 1612.

Alaska Regional had calculated a rate in that vicinity, it would not have accepted it as correct, but would have done additional analysis.

In his post-hearing rebuttal report, Dr. Fox noted that Eagle River had a much higher percentage of residents who are eligible to use JBER than the rest of Anchorage. He testified that age is a factor in emergency room use rates, and his rebuttal report cited other factors such as alternatives, convenience, and insurance status.[53] In her reply report, Ms. Corona noted that Dr. Fox's statistics show that military residents, while of a higher percentage in Eagle River than in Anchorage as a whole, are still too small as a percent of the population to account for a use rate that is half that of Anchorage. Further, Eagle River has lower Native Alaskan population than Anchorage, so fewer residents would use ANMC's emergency department. She criticizes Dr. Fox's reliance on one year's (2012) data, noting that use rates are variable.[54]

Ms. Corona is correct that 15.7 emergency department visits per 100 residents is remarkably low, and that reliance on one year's data is suspect. The Center for Disease Control reports a nationwide use rate for 2011 of 44.5.[55] Dr. Fox, on the other hand, is persuasive that Eagle River's high military population, age demographics, and distance from an emergency room will all tend to lead to a lower use rate. We do not need, however, to resolve the dispute between Ms. Corona and Dr. Fox or determine whether Dr. Fox's calculation is accurate. The question here is whether Alaska Regional has met its burden of proving need.

Alaska Regional has applied for a certificate of need for an emergency department in a service area. The law requires that it calculate a use rate for that service area in order to prove need. The burden to prove the use rate for the service area is on Alaska Regional. To meet that burden requires evidence and statistics that tend to show that its calculations are reasonable. It has provided none. Providence has provided testimony and analysis from a qualified expert that tends to show that Alaska Regional's assumptions regarding use rate in the service are not reliable. Although some of Alaska Regional's criticisms of Providence's use-rate analysis may be valid, Providence does not have the burden of proving that its estimates are correct.

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[53] Fox testimony; Fox Rebuttal Opinion at 2-3.

[54] Jody Corona, *Reply to "Rebuttal Opinion" Issued by Frank Fox, PhD on December 9, 2015,* (Dec. 14, 2015).

[55] Center for Disease Control, *National Hosp. Ambulatory Medical Care Survey: 2011 Emergency Department Summary Tables* at 3; *available at* http://www.cdc.gov/nchs/data/ahcd/nhamcs_emergency/2011_ed_web_tables.pdf.

Moreover, Providence's analysis is the most reliable estimate of the use rate for Eagle River in this record.

In a previous case that discussed the need calculation, the Commissioner confirmed that the burden is on the applicant to identify the service area, the target population, and the number of procedures (or, in this case, visits), that are used to calculate the use rate.[56] In a lengthy discussion on the subject of substituting use rates, the Commissioner disallowed the use of the use rate for Anchorage for a service area that was either Fairbanks or northern Alaska (but was clearly not Anchorage).[57]

Here, Alaska Regional asserts that the use rate for the entire municipality is a good proxy for the use rate for the Eagle River service area. It has come forward with no data or expert opinion that shows that this is a reasonable assumption. Providence has come forward with data and an expert opinion that tends to show that the use rate for the Eagle River service area is very different from that of the municipality as a whole.

Alaska Regional's failure to establish a use rate for the service area for which it applied means that its application fails the test for need under the methodology, and it fails to comply with General Review Standard #1, and Emergency-Department Review Standard #2. Therefore, the Division's decision denying Alaska Regional's application is affirmed.

Although the issue of need is fatal to Alaska Regional's application, the remaining issues that were raised at the hearing will still need to be considered, for two reasons. First, if the conclusion regarding need were reversed, these issues will become pivotal. Second, as will be seen, the issue of the viability of the proposed FSED model will be a factor in weighing whether the decision to reserve up to five of the needed rooms for a future application can be affirmed.

2. Is an FSED a flawed model for providing quality emergency-room service?

The next issue is whether an FSED is a viable model for providing emergency care to residents of Eagle River. Providence was critical of the quality of emergency care that an FSED could provide. Alaska Regional, on the other hand, defended the FSED model, and argued that it was particularly apt for Eagle River. The viability of the model is important under General

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[56] *In re Kahtnu Ventures, LLC,* OAH No. 12-0123-DHS at 12-20 (Dep't of Health and Soc. Servs. 2013), *affirmed*, Case No. 3AN-13-04713CI (Alaska Superior Ct. 2014) (finding that although applicant showed staff had made error in double-counting some procedures (which were to be excluded from the numerator when determining use rate), applicant was unable to carry its burden of showing that its use rate data was correct).

[57] *In re Alaska Medical Development-Fairbanks, LLC,* OAH No. 06-0744-DHS at 41-43 (Dep't of Health and Soc. Servs. 2007) (Original Decision).

Review Standard #1, and Emergency-Department Review Standard #2, because, as staff found, if the model is not viable, then the facility would not be needed (even if it met the quantitative requirement for need).

Both sides defended their position on this dispute by bringing in experts in emergency care. Drs. Mark Kozlowski, Richard (Joe) Ybarra, and David Cadogan testified for Alaska Regional. Drs. Daniel Sfornek and Timothy Silbaugh testified for Providence. Each was very well-qualified. Each was knowledgeable and articulate. Each persuasively argued his point of view. And even though the two sides took contradictory views of FSEDs, none was wrong—whether FSEDs are a good or bad way to deliver emergency medical services depends on how you look at it.

a. Do FSEDs provide a substandard quality of emergency services?

We start the analysis with a discussion of the most important functions served by an emergency department. Emergency departments save lives. They quickly and efficiently detect serious conditions. They provide or obtain care that prevents serious impairment or dysfunction to bodily functions. Although emergency departments perform other functions, and non-emergency physicians also are capable of diagnosing life-threatening conditions, all parties to this case agree that emergency-department physicians stand out in their ability to save lives and prevent additional impairment.

On these all-important factors of saving lives and preserving bodily function, the Providence experts firmly believe that an FSED will fall short. They point out that FSEDs have no facilities other than an emergency room. A badly-injured trauma patient may need emergency surgery. A heart-attack victim may need an emergency catheter inserted to treat the obstruction that is causing the victim's heart to be starved for oxygen—a treatment that occurs at a "cath lab" and for which emergency departments are frequently evaluated based on their "door-to-balloon time." A stroke victim or a head injury may need emergency neurosurgery. Many types of emergencies (the example presented at the hearing was a tubal pregnancy that resulted in internal bleeding) can require immediate blood transfusions.

In the view of Providence's experts—particularly, Dr. Silbaugh—an emergency-department that is attached to a full-service hospital is far superior to an FSED. The emergency-department physician will detect the life-threatening condition (which often is not obvious—a serious life-threatening condition may present as similar to a minor injury or disturbance), and

then provide immediate life-saving measures or arrange for treatment to occur in the attached hospital. Providence's experts acknowledged that FSEDs were capable of diagnosis and initial stabilization. Not having comparable experts, facilities, or supplies at hand, however, leads to delay in treatment, and puts patients at risk.[58]

Alaska Regional's experts—particularly, Dr. Ybarra—contested Providence's arguments. Dr. Ybarra explained that an FSED would have a laboratory and diagnostic equipment, such as an EKG and a CT scan. An FSED stocks medical supplies, including two units of type-O blood. He acknowledged that the FSED will have to transport those patients who will need to be admitted to a hospital for further care. Yet those patients are only a small percentage—about seven percent—of an FSED's clientele. The Eagle River FSED would have an ambulance standing by, with a driver and a paramedic, so transportation to an Anchorage full-service hospital could occur shortly after the emergency physician determined that admission to a hospital would be needed.[59]

Even for the patients who will need immediate treatment to prevent tissue damage or loss of life—the group about whom Dr. Silbaugh was concerned—Dr. Ybarra was confident that an FSED could provide comparable emergency care to an attached emergency department. Dr. Ybarra explained that after an FSED emergency physician diagnosed a life-threatening condition, the physician would immediately contact the full-service hospital in Anchorage to alert it to the emergency. The hospital would then locate the appropriate physician and prepare the operating room, cath lab, or other appropriate facility. Almost no unnecessary delay in treatment would actually occur because even in a full-service hospital, some delay between emergency department and treatment is inevitable. Neurosurgeons, cardiologists, or other specialists are rarely immediately available. They may be in surgery with a different patient or at a different location. To Dr. Ybarra, the delay in transporting a patient to Anchorage was comparable to the delay in taking a patient down the hall from an emergency department to an operating room or cath lab. Indeed, Dr. Ybarra stressed that in an FSED, wait time and triage delays are typically less than in an attached emergency department, so the serious emergency patient might likely be treated sooner if first seen in an FSED.[60]

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58 Silbaugh testimony.
59 Ybarra testimony.
60 *Id.*

Alaska Regional's experts did not dispute that Anchorage's emergency medical services (EMS) ambulance staff could also provide the stabilize/transport function. Dr. Silbaugh cited having stabilization and transportation occur simultaneously in an ambulance as superior to the FSED approach of stabilize/then transport.[61] Dr. Ybarra, however, noted that the typical protocol for EMS is to take all patients with conditions assessed as life-threatening to an attached emergency department, so those very serious Eagle River patients who call an ambulance will receive the treatment protocol that Dr. Silbaugh favors. Those with life-threatening conditions who are walk-ins at the Eagle River FSED would receive the advantages of highly-qualified diagnosis, and of having the FSED team alert the appropriate hospital to prepare for providing services.[62]

Dr. Silbaugh pointed out that Alaska Regional's argument that an Eagle River FSED would provide the same quality of emergency care for serious conditions like heart attacks, intracranial bleeds, or strokes depended on the assumption that nothing would go wrong. In his experience, however, things do go wrong. He pointed to the tubular pregnancy episode, where he had missed the internal bleed upon his first examination of the patient (who did not know she was pregnant). When he returned to the patient and determined the serious, life-threatening nature of her condition, she needed four units of blood in the 15 minutes before the surgeon arrived, and 10 units before the surgery was finished. An FSED typically stocks only two units of blood. Although an FSED would respond to a situation as grave as this one by supplementing blood with other fluids, Dr. Silbaugh believes that the outcome would have been less favorable if she had not been seen in an attached emergency department. He testified that the FSED is comparable to an attached emergency department only in theory. In practice, where things go wrong, having the resources of the full hospital at one's disposal is much better.[63]

In its analysis and recommendation, the Division agreed with Providence that FSEDs would provide a lower-level of emergency care than attached emergency departments. Part of this conclusion was based on the Division's reasonable reading of Alaska Regional's application, which seemed to imply that the FSED's model of care was based on the assumption that the most challenging third of patients would bypass the FSED. In addition, the Division's conclusion was

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61 Silbaugh testimony.
62 Ybarra testimony.
63 Silbaugh testimony.

based to some extent on the commonsense conclusion that an FSED, with fewer supplies and personnel, would not be able to meet some emergencies with the same quality of care as an attached emergency department.[64] Mr. Kosin testified, however, that many of the Division's concerns had been addressed by Alaska Regional at the hearing, and he was less concerned about the quality issue than he had been at the time of the report.[65]

On this record, Alaska Regional has proven that an FSED can provide adequate and appropriate emergency care for the residents of Eagle River/Chugiak, and others who live northeast of the core Anchorage area. Yet, as Dr. Silbaugh explained, the proposed FSED would have limitations. When things go wrong, patients will be at greater risk of a worse outcome in an FSED. The better model would remain having patients with emergencies call an ambulance and be transported to a full-service hospital. Thus, if we could count on residents to call an ambulance when needed, I would find that the proposed FSED, while adequate, would not be an advantageous model for providing emergency care for Eagle River.

Yet, the fact is that most patients do not call an ambulance.[66] Most patients drive themselves or have a family member drive them to the emergency department. Some of these patients will have serious conditions that have not yet erupted into a crisis. This can occur, for example, with heart attacks, intracranial bleeds from a head injury, or stroke. Those driving themselves risk serious deterioration, and a serious automobile accident, should their condition suddenly take a turn for the worse. Those being driven by a family member are not much better off—if a crisis occurs, the family member/driver will be distracted and not have any good options for providing care or continuing to drive. And whether self-driving or having a family member drive (and even if a crisis does not occur enroute), the patient will not have the advantage of activating the Emergency Medical System, which would occur if an ambulance were called or the patient taken to a local FSED, and which would result in earlier stabilization/treatment and a better outcome. Because the risk of a bad outcome increases with the length of the drive, driving an emergency patient who lives in Eagle River/Chugiak to a local

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64 Admin. Rec. at 229.

65 Kosin testimony.

66 The nationwide statistics show that 15.7 percent of patients arrive at an emergency department by ambulance. Center for Disease Control, *National Hospital Ambulatory Medical Care Survey: 2011 Emergency Dep't Summary Tables* at Table 5, *available at* http://www.cdc.gov/nchs/data/hus/hus14.pdf#082.

Eagle River FSED would be a much better treatment modality than driving to a full-service hospital in Anchorage.

The advantages of having a local emergency department in Eagle River only increase as bad weather and traffic jams are taken into consideration. Those issues, and the situation of Eagle River generally, are discussed next.

b. Does Eagle River's geographical location, traffic patterns, and population make it an appropriate location for an FSED?

Above, we have considered the evidence of the medical advantages and disadvantages of an FSED in a suburb located approximately a 20-25 minutes' drive from a full-service hospital. We conclude that the FSED model has limitations, but it would provide a public-health advantage over having seriously-ill patients drive themselves, or have family members drive them, to the attached emergency department.

We turn now to whether the specific situation of Eagle River is a more or less compelling case for an FSED than a garden-variety suburb. This inquiry has several components. First, we look at issues like geography and traffic patterns. Second, we consider the population and the public comment. Third, we look at the issue of planning and how an FSED would fit into existing plans.

In identifying Eagle River as an appropriate location for an FSED, Alaska Regional noted the following:

- Depending on only one highway to transport patients to a hospital is always problematic. The Glenn Highway connecting Eagle River to Anchorage may be especially problematic at rush hour or in inclement weather.
- The traffic issue would be even worse if a natural disaster, such as an earthquake, struck the Anchorage area. If the bridges on the Glenn Highway were impassible, residents could not reach Anchorage by road.
- A community the size of Eagle River (almost 40,000) often will have a hospital. Indeed, many communities in Alaska that are smaller than Eagle River have a hospital. Eagle River has no hospital. At a minimum, in Alaska Regional's view, a community of this size should have an FSED.
- Residents of Eagle River are on average older than residents of the Municipality of Anchorage, and older people tend to require more medical care.

Although no statistics were provided regarding how often very sick patients transport themselves to emergency rooms in Anchorage, or how often ambulances carrying very ill patients from Eagle River to Anchorage are delayed by traffic or involved in accidents, these are all reasonable arguments, backed by commonsense. Furthermore, the public comment in the record helps flesh out these points. For example

- A parent described his daughter's allergic reaction to burn medication, causing her leg to swell dangerously during the 20-minute drive to Anchorage to get to an emergency room.[67]
- An elderly resident of Eagle River with heartburn-like symptoms refused to call an ambulance because he did not want to be embarrassed. His daughter started toward Anchorage but diverted to the fire station when he passed out. Fortunately, the paramedic was not out on a call and was able to restart his heart. The Eagle River resident giving this testimony believes an FSED would be a better and safer option for the community.[68]
- A resident gave examples of need for an emergency room in Eagle River, including a neighbor who had been mauled by a bear, his children needing stitches in the late evening, and his father-in-law waiting until morning (worst traffic time between Eagle River and Anchorage) to seek emergency medical care for his heart-attack symptoms.[69]
- The Chugiak Community Counsel commented that the Eagle River/Chugiak area is underserved and that a "stand-alone emergency room in Eagle River would complement the Chugiak-Eagle River emergency operations plan and would be an invaluable asset to the community in the event of a disaster."[70]
- A Chugiak resident believes that her complications from her emergency surgery due to delay in being seen in an Anchorage emergency room could have been avoided if she had received emergency treatment more quickly.[71]

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[67] Admin. Rec. at 890-91.
[68] Admin. Rec. at 892.
[69] Admin. Rec. at 908-909.
[70] Admin. Rec. at 1357.
[71] Admin. Rec. at 1369.

- An elderly Chugiak couple commented that they have accessed emergency services over their 47-years of living in Chugiak. They described the drive as "harrowing" and would be relieved to have emergency services closer to home.[72]
- A 35-year Eagle River resident has used emergency room services several times and considers it a "tough choice" about what to do when faced with an emergency that does not require an ambulance during winter driving conditions.[73]
- A retired firefighter favored the Eagle River FSED because under the current situation no transport (and potentially no emergency services) would be available for a critical patient when the Eagle River ambulance is already transporting a patient (who may not be a critical-condition patient). In addition, having fewer medical transports to Anchorage for the Eagle River ambulance keeps the EMS ambulance driver and paramedics in Eagle River to respond to other emergencies, such as fires.[74]

This is only a small sample of the public comment in support of the Eagle River FSED proposal. Of course, many members of the public also opposed the proposal. In addition, all public comment must be taken with some degree of caution, because members of the public may not have had full information, or may have had a narrow focus in their evaluation of the alternatives. The point is not that we are counting up the public comment, keeping score, or awarding the certificate on the basis of a popularity contest. The point made by the public comment is that public perception does indicate that people are worried about traffic and emergency preparedness in Eagle River, and many have a strong desire to see additional medical infrastructure and services in the Eagle River area.

Consideration of public comment is a factor in the review of an application.[75] Here, although much of the pro-FSED comment was the result of a "get-out-the-comment" campaign by Alaska Regional, it nevertheless has the appearance of genuine, heartfelt, individualized comment. Taking the public comment into consideration on the issue of whether emergency-treatment outcomes would improve or deteriorate for the most severe Eagle River emergency

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[72] Admin. Rec. at 1373

[73] Admin. Rec. at 1390.

[74] Admin. Rec. at 1399. Anchorage has one ambulance at Eagle River Fire Station. The Chugiak Volunteer Fire Department has three ambulances. Scheunemann testimony. Erich Scheunemann is an Assistant Chief of Operations for the Anchorage Emergency Medical System.

[75] 7 AAC 07.070(b)(3)-(4).

patients with an Eagle River FSED, I conclude that they would improve. In addition, the proposed Eagle River FSED would reduce traffic-related risks. Fewer seriously-ill patients would drive themselves to Anchorage. Fewer ambulances would drive round-trip to Anchorage.[76]

[76] *See, e.g.,* Goodrich testimony. Craig Goodrich is a retired Anchorage fire chief. He testified that he has seen ambulances have accidents during transports, and other drivers having accidents trying to get out of the way of the ambulance.

c. Is Eagle River an appropriate location for an FSED under existing plans for development of medical facilities in southcentral Alaska?

Another issue to consider in this inquiry is planning. As mentioned earlier, planning is also a factor in the review standards and the regulations.[77] Continuing with the inquiry discussed in the previous section regarding whether Eagle River is a particularly appropriate location for an FSED, we must ask how well this proposed development fits in with existing planning for medical services in the area.

On this factor, Alaska Regional's presentation was deficient. Although Alaska Regional presented the Municipality of Anchorage's Comprehensive Emergency Operations Plan (which was not admitted into evidence), the State of Alaska Emergency Operations Plan (Exhibit A3), and the Anchorage Fire Department Medical Operations Manual (Exhibit A1), none of these documents shed light on how the proposed FSED would integrate with other medical providers in Eagle River. As a result, the proposed FSED appears more like an ad-hoc addition to the Eagle River service area than a well-planned project. This may not be Alaska Regional's fault—planning is difficult in medical services, where some services are free market and other services are controlled by certificates of need—but it leaves Alaska Regional's proposal more vulnerable to attack as inefficient than a well-planned, integrated proposal would be. We turn next, then, to the issue of efficiency.

d. Is an FSED an inherently inefficient method of delivering emergency services?

One reason the Division disallowed Alaska Regional's application was a concern that many of the patients who would use the proposed FSEDs could be seen and treated at an urgent care facility at a fraction of the cost. Much of Alaska Regional's case involved refuting the allegation that an FSED was nothing more than a glorified urgent-care facility. Alaska Regional showed that an FSED has the following attributes that will usually not be available in an urgent-care facility:

- staffing with Board-certified emergency physicians, who are specially trained to recognize and address life-threatening or potentially-disabling conditions;
- open 24 hours;

[77] 7 AAC 07.070(b)(6) (requiring the commissioner to consider "relevant health planning documents on file with the department");General Review Standard #2, *Alaska Certificate of Need Review Standards and Methodologies* at2.

- nursing staff (not just medical assistants);
- computerized tomography (CT scans);
- more comprehensive laboratory analysis;
- stocks of medications used in emergency services, including intravenous narcotics and heart medications;
- must accept all patients, regardless of ability to pay.[78]

Thus, Alaska Regional has proved that its proposed FSED would offer services not provided by an urgent or primary care facility.

The issue raised by the Division and Providence, however, was somewhat different. Although an FSED *can* do more than an urgent-care facility, the question is whether it will be called upon to do so. If patients will use the new Eagle River FSED as if it were an urgent or primary care facility, and still take most of their true emergencies to the attached emergency departments in the core U-Med district of Anchorage, then the FSED would be inefficient. An emergency room is an expensive method of delivering medical services—not only does it charge for the physician's time, it also charges a facility fee. The cost will be several times as much as it would have been in a primary or urgent care facility.[79]

Alaska Regional points out that all emergency rooms have the same issue—many patients seen in emergency rooms could be seen in a less expensive facility. The only statistics on this issue in the record were those provided by Alaska Regional, published by the Center for Disease Control, that applied equally to all emergency departments, attached and free-standing, that showed 32.1 percent of emergency room visits are "non-urgent" or "semi-urgent;" 36.6 percent

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[78] Kozlowski testimony. The high standards for emergency departments, and the requirement to accept all patients regardless of ability to pay, were frequently mentioned as being required by "EMTALA"—the Emergency Medical Treatment and Active Labor Act (42 USC 1395dd *et seq*).

[79] Fox testimony; Kosin testimony. Cost was an issue explored in some depth at the hearing. All parties agree that cost per visit would be much higher at an emergency department than the cost would be if the same visit could be dealt with at an urgent or primary care facility.

A different cost issue—how the cost of the facilities would be reflected in a future Medicare/Medicaid billing rate—was hotly contested. It appears from the testimony of Amy Miller, the Senior Finance Director for Providence, that the Division's calculation showing a lower rate effect for Alaska Regional's proposal than Providence's proposal was in error. Mr. Kosin testified, however, that the future rate effect did not necessarily affect the certificate of need analysis. More important is the issue of efficiency.

On this record, the issues of the rate effect and capital costs of the two different projects will not be given much weight. Because Providence is remodeling rather than adding square footage, it has a low-cost proposal, which certainly is a point in its favor. The fact that it will cost money to build new infrastructure in Eagle River, however, is not necessarily a negative factor for the Alaska Regional proposal.

are “urgent;” and 15.0 percent are emergency or “immediate.”[80] Although Alaska Regional acknowledged that some patients may not initially understand that an FSED is for emergencies, and that nonemergencies should be seen at a primary or urgent care facility, its experts explained that education and counseling is part of an emergency-care facility’s duty.[81] An FSED, which is not as crowded as most attached emergency rooms, can counsel non-emergent patients to seek care in a less expensive facility. (If the counseling is unsuccessful, however, the emergency department must treat all patients.) Thus, in Alaska Regional’s view, an FSED is no more likely to be used as if it were urgent care than an attached emergency department.

Further, some doctors find the FSED model, with its dedicated staffing and equipment, and quicker “door to doc” time, more efficient than an attached emergency department.[82] In addition, patients often prefer an FSED, which usually has short wait times. Yet, to the extent that these benefits are because the FSED treats lower acuity patients, they are not gains in efficiency.

Again, however, the question is not whether patients *could* distinguish an FSED from urgent care, the question is whether patients *will* make that distinction. Professor Mouheine Guettabi, an economist with the University of Alaska’s Institute of Social and Economic Research, who researches and teaches health-care economics, looked into the question of FSED efficiency. He performed a literature review, reviewing all available scholarly literature on the subject. Both Dr. Guettabi and Dr. Fox testified that from an economic point of view, an FSED is an expensive and inefficient method of delivering emergency services.[83]

Dr. Guettabi’s testimony was credible. Although Dr. Guettabi’s study was commissioned by Providence, his institute maintains a requirement of strict independence. No expert in health-care economics refuted his testimony. Although we can acknowledge that Alaska Regional’s experts (Drs. Kozlowski and Ybarra) have had success in counseling patients to not overuse FSEDs, the weight of the evidence is that an FSED will generally serve lower acuity patients, many (but not all) of whom could be seen in an urgent or primary care facility.

Moreover, the testimony that the Eagle River FSED would be inefficient is particularly well-taken when considered in light of Dr. Fox’s testimony that the facility would have idle

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[80] Admin. Rec. at 517.
[81] Ybarra testimony.
[82] Kozlowski testimony; Ybarra testimony.
[83] Guettabi testimony.

capacity.[84] Dr. Fox further explained that adding an FSED to a community will increase use of emergency services that otherwise would not occur—a phenomenon that economists refer to as "Say's law."[85] Further, the 24-hour staffing model requiring at least a physician, nurse, patient care technician, administrative assistant (at least during the day and peak evening hours), paramedic, and ambulance driver, and the stand-alone building, all add to the picture of an inefficient and expensive method of providing emergency services.[86] In the absence of a carefully-planned project that would integrate the FSED with other medical facilities, the Division's conclusion that Alaska Regional's proposal does not fully comply with Emergency-Department Review Standard # 1 (ensures stable and efficient emergency medical system) is affirmed.

To summarize the analysis, we started by showing that Alaska Regional's proposal does not meet the quantitative need requirement. Moving on to the qualitative aspects of need, Alaska Regional did demonstrate that an FSED could offer quality emergency services. It also showed that, given the traffic patterns and population size, having emergency medical services in Eagle River would be a benefit to the community, although at a high cost. A further factor in the cost/efficiency equation is the likelihood that the FSED will be used by many patients as if it were an urgent care facility. Without a clearer sense of how the facility would avoid excess idle time, or other plans to keep the facility busy and efficient, the proposal does not meet the efficiency or planning requirement of the standards. Therefore, even if Alaska Regional's proposal met the quantitative need requirement, on this record, it would not be accepted.

E. Is Providence's application consistent with the standards?

With the exception of General Review Standard #3, which asks about stakeholder participation, the Division found that Providence's application met all the review standards.

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84 Fox testimony.

85 *Id.* Dr. Fox's testimony implied that in some states FSEDs may have been built in order to generate demand for emergency services.

86 Kozlowski testimony. Dr. Kozlowski testified about the staffing requirements. On the subject of efficiency, he explained that in all emergency departments, staff has idle time. He admitted, however, that a large emergency department would be more efficient than a small one. Alaska Regional argues that the faster turnaround and ability to keep ambulance services in Eagle River from having to run to Anchorage for many cases that could be treated and released at an FSED should be considered as aspects of efficiency. Alaska Regional Prehearing Brief at 14. This decision, however, has given Alaska Regional's proposal credit for these advantages on the "qualitative need" analysis. On a purely economic efficiency analysis, having an idle ambulance and idle staff at the FSED is inefficient.

Even taking this one failure into account, on balance, staff concluded that Providence's overall application warranted a grant of a certificate of need.[87]

Alaska Regional has appealed this finding. In Alaska Regional's view, Providence's application does not meet the review standards and should be rejected. The primary argument that Alaska Regional has raised regarding Providence's application is its argument that the proposed 10-bed pediatric specialty section will be off-limits to adults. In Alaska Regional's view, this proposal underserves a substantial portion of the population.

Alaska Regional, however, is wrong. Providence's experts, Drs. George (Tony) Woodward and Sandra Horning, testified that the pediatric specialty rooms will be fully available to serve adults when necessary. Having rooms be "kid-sized" does not make them inaccessible to adults. The rooms will actually be larger (so they can accommodate families), and equipment will be available to serve all children, including babies and hulking teenagers (who may be as large as adults), and adults. Making the rooms available to adults will simply be a matter of triage when the census requires it.[88]

Furthermore, Providence has made its case that pediatric-emergency care is a genuine subspecialty that requires its own set of skills and expertise. Children are different, and providing for sick or injured children, and their families, can be better accomplished in a facility specially designed for that purpose.[89] In addition, Providence was convincing when describing the educational component of its proposal. Providence participates in the training of doctors and nurses who are enrolled in programs offered through the University of Alaska. Many of these medical professional remain in Alaska, including in rural communities. Having graduates trained in a pediatric-emergency specialty unit, by professionals certified in this specialty, will be a benefit to the statewide communities served by those graduates.[90]

As the Division has pointed out, however, Providence has not proved that it needs the 13-bed expansion in order to provide the pediatric-emergency specialty service. It could hire staff and pursue specialization in existing rooms. Providence's experts did attempt to link the specialization to the expansion. They testified that it has been difficult to get the project off the ground, and that this expansion paved the way for the proposed specialty to receive the green

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[87] Admin. Rec. at 252-53.
[88] Woodward testimony; Horning testimony.
[89] Woodward testimony; Horning testimony; Sfronek testimony; Wellman testimony.
[90] Johnston testimony; Berner testimony.

light from administrators.[91] We must be careful in accepting this argument as a rationale for granting a certificate of need—we do not want to create an incentive for administrators to hold innovative physician-led projects hostage for a certificate of need. Yet, nothing here suggests that has occurred.[92] We can recognize that the doctors at Providence are being opportunistic, and using the expansion project to provide an innovation. All else being equal, that serendipitous circumstance is a good thing, and adds to the reasons for granting a certificate that otherwise generally meets the standards.

The question here is whether all else is equal. Here staff has raised an issue regarding access and market dominance by Providence. Given that the connection between the innovative pediatric specialty and the expansion is only opportunistic, not crucial, the advantages to Providence of having the pediatric build-out occur at the same time as the expansion would not be sufficient to overcome a detriment to the public's ability to access medical services, *if such a detriment is proved on this record.* Whether that detriment is real is the next, and final, inquiry in this decision.

F. Is the decision to withhold some of the needed rooms more consistent with the standards and regulations than awarding all available rooms to Providence?

As explained above, the Division recommended that three rooms be withheld from Providence's certificate of need, so that those rooms could be awarded to a future application. The Commissioner's initial decision actually withheld five. Even though all of Providence's application is consistent with the review standards, if withholding some of the rooms is more consistent with the standards, the decision to withhold those rooms will be affirmed. The reasons for withholding rooms, however, must be supported by actual evidence, not just supposition.

In testimony and at oral argument, the Division supported the withholding of rooms as an issue of public access. Detriment to public access is a standard that would be a reason to deny a certificate under 7 AAC 07.070(b)(7). Under this regulation, a commissioner may consider "special or extraordinary circumstances" that relate to community access to healthcare.[93] The Division explained that here, this was an issue of consumer choice. It sought to avoid having

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[91] Sfronek testimony; Horning testimony. Dr. Woodward did testify that adding eight rooms will not result in a center of excellence for pediatrics.

[92] Dr. Horning testified that upper-level management has been very supportive of the project.

[93] 7 AAC 07.070(b)(7).

one entity dominate the market, in order to preserve the freedom of consumers to choose a healthcare provider.

Healthcare economics, however, is a complicated subject. Indeed, one reason we have a certificate of need program is because we recognize that traditional market forces may be skewed in the healthcare marketplace. Therefore, without careful analysis from experts in healthcare economics, we may not be able to rely on our judgment about how an increase in market share for one provider will affect the end consumer. The health-care market for emergency room services in Anchorage is particularly difficult to assess, with four different providers, two of which would not admit a non-eligible patient to their in-patient facilities, but all of which must accept all patients who request emergency care. How this relates to the issue of consumer choice and access, and how the award of thirteen additional rooms to Providence would affect that choice, are not obvious.

On this record, no health-care economist or other expert presented an analysis of the Anchorage health-care market for emergency room services. None offered an opinion that consumer choice or access might be affected by awarding all 13 beds in this round of certificate of need applications to Providence. The only evidence on the issue of monopoly power is one letter received in public comment from a doctor who alleged that Providence had a "monopoly in specific children's services," and that it was using its market power to force consumers to use Providence's services.[94] In his view, consumers who were not "in-network" were harmed by Providence's actions. If true, this allegation could suggest some support for the Division's view that consumer access might be diminished by monopoly power. No testimony, however, was received to support or explain this allegation, and no party attempted to establish that Providence had market power with regard to emergency rooms. This minimal evidence is not sufficient to begin an analysis, much less draw conclusions, about how the award of the 13 rooms would affect consumer choice. Moreover, the issue of consumer choice is a particularly difficult rationale to offer as a reason for denying Providence its request, given that more consumers are choosing Providence's emergency services over Alaska Regional's.

Although the issues of consumer choice or monopoly power have not been established as valid rationales for finding that Providence's proposal could harm consumer access to healthcare,

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[94] Admin. Rec. at 1148 (letter from D. Bomalaski).

this record does suggest a different way of looking at the issue of access. This has to do with the inherently conservative nature of the certificate of need process, which can be a barrier to entry for a new approach. Once a medical provider has a foothold, that provider can continue to gobble up all subsequent need with small expansion projects, and never let the need reach the critical mass necessary to allow an alternative project to get off the ground. In this case, for example, if a provider wanted to build a small hospital with an attached emergency room in Eagle River (or a different approach to efficiently integrating emergency services with other medical services), that provider might have a difficult time in putting together a proposal of a sufficient size that makes economic sense and for which enough need could be established to warrant a certificate of need. Thus, in the right circumstances, if some need were left on the table in this round of applications, consumer access to medical care could be enhanced by enabling future innovative projects.

Here, this record provides some support for studying the issue of access to emergency care in the future for the residents of Eagle River. That support comes from the earlier analysis of the viability of an FSED in Eagle River, the public comment that shows a need for more services in Eagle River, the problems that Eagle River residents have on occasion with having clear access to services located in the core Anchorage area, and the potential for isolating a large sector of the community in an emergency. Nothing in this record is conclusive about how this would play out. The coin has two sides. It might be the case, for example, that overall healthcare in Anchorage would be best served by not carving out medical services. Having large, dominant hospitals in the core area, which may be able to offer care that approaches world-class healthcare, may be preferable. The point is that this record could support delaying the award of the full need in order to study how best to comprehensively address the issue of access to healthcare for the entire Anchorage area.

Were this approach adopted, reserving five (not three) of the available emergency treatment rooms for future development would make the most sense. Because the idea would be to spur innovation and planning, we would need to have sufficient reserve space in the hopper to make the planning for alternatives attractive.

Providence raises two arguments that apply in opposition to this approach. First, it likens the idea of reserving need for future planning to "Soviet-style" economics, fundamentally at odds with our market economy. Although this analogy is a formidable rhetorical flourish, it is not

persuasive. Because a certificate of need excludes other projects, a certificate of need program should integrate with planning. Ad-hoc first-come, first-served awards, with no thought to planning, could result in permanent structures that do not best serve the public but which cannot be challenged by competition. As the regulations and standards recognize, planning is part of a certificate of need program.[95] Moreover, Providence's own expert, Dr. Guettabi, testified that Alaska suffers from a lack of coordination of healthcare. In the appropriate case, the Department could reasonably reserve some award of need for future plans that respond to the need for coordinated care.

Second, Providence uses the formula in the Department's methodology to show that if it is only granted eight rooms, by the time the eight rooms are finished in 2017, the additional rooms will not be sufficient to meet Anchorage's need.[96] In Providence's view, withholding rooms prolongs the current plague of underservice (and long wait times) for Anchorage residents. This argument does not necessarily compel award all of the rooms to Providence because the formula in the methodology is not intended to be a precise prediction that must be fully met in all cases. As discussed earlier, however, the argument has some traction. Given that the methodology cannot be waived, the methodology should be fully implemented unless actual evidence in the record supports a different approach. Furthermore, as Providence has pointed out, overcrowding and underservice are real problems for real patients, who are stuck waiting for service on gurneys in hallways. Given that all of the overcrowding is at Providence, that means that 100 percent of the shortage is at Providence's facility. That is substantial justification for awarding all 13 rooms to Providence unless the evidence would strongly support withholding some of the rooms for future projects.

To sum up, I agree with the Division that reserving some of the available rooms would be justifiable on this record. I disagree, however, with the Division's rationale that the effect on

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[95] 7 AAC 07.070(b)(6); General Review Standard #2. Providence quotes from the Commissioner's decision in *In re Alaska Medical Development-Fairbanks, LLC* to argue that a certificate of need program is "'a planning tool' but it 'is not, fundamentally, economic planning.'" Memorandum in Support of PAMC's Motion that 13 ERs Must Be Awarded as a Matter of Law at 4 (quoting OAH No. 06-0744-DHS at 1-2 (Dep't of Health and Soc. Servs. 2007)). The point behind reserving some portion of need for the future, however, would not be to have the program itself perform the economic planning function. The point would be to allow planning to go forward and integrate the certificate with plans to address need. As the Commissioner stated in *Medical Development,* "the essence of certificate of need programs today remains the perception that a planning tool is needed to ensure that providers of health care services build adequate capacity, but not excess capacity, to supply the medical needs of a community." OAH No. 06-0744-DHS at 2 (Original Decision and Order).

[96] Fox testimony; Hale testimony.

public choice is a special circumstance affecting access. No evidence supports that rationale. A rationale could be found in support of withholding some rooms in order to address a comprehensive approach to meeting the need of the entire Anchorage area. This rationale would implicate both planning and public access as reasons to withhold some of the need.

Yet, this decision cannot, and does not, adopt that approach. No party has requested a delay in order to study the issue of consumer access to healthcare. (Although the Division suggested a delay in the hope that alternative proposals would surface, it has no funding to pursue a study.) No party has suggested that the need for services in Eagle River could be addressed efficiently by pairing emergency room services with other medical services. No party has identified a comprehensive plan. The only alternative to Providence's proposal in this record is Alaska Regional's Eagle River FSED, which does not pencil out under the quantitative methodology, is at most only slightly qualitatively advantageous, and is not an efficient approach to emergency services. Given the lack of alternatives to Providence's proposal, the situation is not a "special or extraordinary" circumstance, as that term is used in 7 AAC 07.070(b)(7). As the parties have presented this case, this case is an ordinary case of one provider having a proposal that meets the standards and another provider having a proposal that does not. Therefore, Providence is awarded a certificate of need for 13 additional emergency treatment rooms.

IV. Conclusion

Alaska Regional Hospital's application for a certificate of need to construct a freestanding emergency room in Eagle River is denied.

Providence Alaska Medical Center's application for a certificate of need to construct 13 additional emergency department treatment rooms, 10 of which will be designed to treat pediatric patients, while convertible to treat adults if necessary, is granted. Providence will submit a revised budget and timeline for this project no later than 60 days after the date of this decision. The revised project budget cannot exceed the original proposed project cost of $12,853,311, although a reasonable inflation factor to compensate for delay may be requested.

DATED this 15th day of January, 2016.

By: *Signed*
Stephen C. Slotnick
Administrative Law Judge

Adoption

I adopt this Decision under the authority of AS 44.64.060(e)(1), as the final administrative determination in this matter.

Judicial review of this decision may be obtained by filing an appeal in the Alaska Superior Court in accordance with Alaska R. App. P. 602(a)(2) within 30 days after the date of this decision.

DATED this 26th day of February, 2016.

By: *Signed*
Valerie Davidson
Commissioner, Health and Social Services

[This document has been modified to conform to the technical standards for publication.]