REVIEW OF PROVIDENCE ALASKA MEDICAL CENTER EMERGENCY DEPARTMENT EXPANSION
&
ALASKA REGIONAL HOSPITAL ESTABLISHMENT OF FREESTANDING EMERGENCY DEPTS

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BACKGROUND

This is a "comparative review" (aka "concurrent review") of two certificate of need (CON) applications. See *7 AAC 07.060*. The originating application for this CON review is Providence Alaska Medical Center's (PAMC) proposed expansion of its emergency department because it was submitted prior to Alaska Regional Hospital's (ARH) proposed establishment of two freestanding emergency departments.

PAMC is an acute care hospital with 401 acute care beds, 34 psychiatric beds, and 10 rehabilitation beds in Anchorage, Alaska. PAMC is operated by Providence Health & Services Alaska, and it is the largest acute care hospital in the state. See *PAMC CON Application* at 13. ARH is an Acute Care Hospital with 250 acute care beds. It is operated by Hospital Corporation of America, and it is the second largest acute care hospital in the state. See *ARH CON Application* at 5.

PAMC submitted its application for CON review in October 2014, and ARH submitted its application for CON review in December 2014. The CON program initially started evaluating the applications through separate, standalone reviews, but per an order from the Alaska superior court in February 2015, the CON program combined the processes into a single, concurrent review under 7 AAC 07.060.

PROJECT DESCRIPTION

PAMC Emergency Department Expansion

The proposed project will create 14 additional treatment rooms, 10 of which will be dedicated to pediatric emergency services for a total of 51 rooms within PAMC's Emergency Department. The 10 pediatric treatment rooms will be housed in a pediatric treatment area designed to provide specific pediatric trauma services, including staffing of expert pediatric caregivers. The proposed pediatric-only treatment area will service pediatric patients nine hours a day initially, and expand availability as volume dictates. Support from the pediatric subspecialists at The Children's Hospital at Providence will be provided in addition to the hiring of a full-time child life specialist as part of the project.

The total square footage of PAMC's ED will increase by 2,728 square feet, for a total of 24,279 square feet. The proposed expansion maximizes the use of the existing infrastructure and does not require building new space outside PAMC's existing footprint. Instead, PAMC will be repurposing existing clinical and non-clinical space to make room for the expanded ED.

The total cost of the proposed project is $12,853,311, and it is expected to be operational in December 2016. See *CON Application* at 8.

ARH Freestanding Emergency Departments

The proposed project will create 16 additional emergency department treatment rooms by building two freestanding emergency departments (FSEDs), one in Eagle River and one in South Anchorage.

Each FSED will have eight treatment rooms and be completely self-contained: "In addition to general ED capabilities, the rooms will include capability for pediatrics, OB/GYN, isolation, bariatric, secure holding and trauma. To facilitate diagnosis and treatment, each FSED will include lab, general radiology, ultrasound, and CT scanning. They will both have the capability to observe patients until decisions can be made regarding the appropriate course of action." *ARH CON Application* at 7. The FSEDs will operate as an extension of the ARH main emergency room department located in Anchorage. The same policies, procedures, oversight and governance will apply. The FSEDs will be operational 7 days a week, 24 hours a day and staffed with board certified and trained emergency physicians and nurses. *Id*. at 6.

Each FSED will be 10,700 SF of new construction and consist of a single story building. The total cost of the project is $25,394,478—$12,838,553 for the South Anchorage FSED and $12,555,925 for the Eagle River FSED. ARH expects them both to be operational by Spring 2016. *Id.* at 8.

PROJECT COSTS

PAMC Emergency Department Expansion
Total cost of the project is estimated at **$12,853,311**

$9,366,362 Construction Costs
$1,583,249 Movable Equipment
$1,903,700 Other Costs

ARH Freestanding Emergency Departments
Total cost of the project is estimated at **$25,394,478**

- South Anchorage FSED: $12,838,553

  $10,299,701 Construction Costs
  $1,863,738 Movable Equipment
  $675,114 Other Costs

- Eagle River FSED: $12,555,925

  $9,999,071 Construction Costs
  $1,863,738 Movable Equipment
  $693,116 Other Costs

REVIEW

PAMC and ARH are both licensed health care facilities under AS 18.07.111(8), and each proposed project consists of an "expenditure" that is over the $1.5 million threshold for "construction" of a health care facility or "alteration" of a health care facility's capacity. Therefore, each project will receive general review and service-specific review for Hospital

Emergency Department Services. Service-specific review for Computed Tomography (CT) Services will also be considered for ARH's proposal since it seeks to add a CT scanner in each FSED.

To perform this review, each project will first be subject to the General Review Standards. Then, "[a]fter determining whether an applicant has met the general review standards in Section I of this document, the department will apply the . . . service-specific review standards, as applicable, in its evaluation of an application for a certificate of need." *Alaska Certificate of Need Review Standards and Methodologies* at 23-24. Since this is a concurrent review of two competing proposals, additional considerations specified in regulation for concurrent review will also be applied in this analysis. *Id.* at 3.

General Review Standards

General Review Standard #1- Documented Need:

The applicant documents need for the project by the population served, or to be served, including, but not limited to, the needs of rural populations in areas having distinct or unique geographic, socioeconomic, cultural, transportation, and other barriers to care.

PAMC Emergency Department Expansion

PAMC states that its proposed emergency department (ED) expansion project will address three overarching, existing problems with its delivery of emergency services: the increasing demand for emergency services; overcrowding of the PAMC ED; and, the need for improved pediatric emergency care. PAMC currently has 37 ED treatment rooms and averages approximately 67,000 visits per year. See *PAMC CON Application Addendum* at 2.

Given the high number of ED visits that both ARH and PAMC have averaged annually, PAMC states that it is well over the threshold utilization of 1,500 visits per room used by the CON Review Standards and Methodologies. Therefore, more treatment rooms are necessary to meet the needs of both the pediatric and overall community. "ED visits are increasing at an average rate of 60% faster than the population growth, contributing to overcrowding, increased wait times and higher rates of medical errors. The projected expansion of the PAMC's ED will help alleviate the problem of ED crowding, it will increase patient satisfaction, improve PAMC's ED throughput and streamline ED workflows." *PAMC CON Application* at 14.

Per PAMC's application, there is also an increased need for emergency services within the pediatric population. "There has been considerable growth in the number of emergency department visits in the United States over the past two decades, and children have (*sic*) accounted for nearly a quarter of these visits." *Id.* PAMC specifically contends that in order to meet the unique needs of pediatric emergency patients, dedicated space and expertise is necessary in their treatment. "Creating a dedicated pediatric treatment area within PAMC's ED will allow for development of a higher standard of care for children in emergencies." *Id.* at 11. Additionally, having the dedicated pediatric emergency trauma services will provide "initiation of pediatric care in continuity with the in-patient trauma care at The Children's Hospital at Providence (TCHAP)." *Id.* at 10.

Currently, PAMC relies on one of its two trauma rooms to provide general emergency services to meet its high ED volume and demand for services. This is problematic because PAMC received its Level II Trauma Center designation earlier this year, and it needs to maintain both trauma rooms for their intended purpose. *Id* at 11.

Lastly, in addition to the aforementioned need, the applicant states that additional space is necessary to support its on-going teaching role through the University of Alaska Anchorage (UAA). PAMC anticipates its role in providing ED practice care and supervision to grow in relation to the expanding UAA medical program in the future. *Id*.

ARH Freestanding Emergency Departments

ARH states that there is a municipality-wide need for additional ED treatment room capacity, so it is problematic to continue adding and locating 100% of the ED capacity in a two-mile radius of downtown Anchorage. ARH currently has 18 ED treatment rooms and averages approximately 26,000 visits per year. ARH believes that improving ED access with FSEDs in two of the fastest growing segments of the Municipality, South Anchorage and Eagle River, is the best solution for an efficient, decentralized service delivery system. See *ARH CON Application* at 15.

ARH proposes introducing the concept of FSEDs to Alaska, stating "According to a July 2009 Issue Brief of the California HealthCare Foundation, the concept of a freestanding emergency department emerged in the early 1970s as a result of the need for emergency care in rural or other underserved regions of the US." *Id.* at 16. ARH adopts the FSED model as a means of providing "higher patient satisfaction, improved quality and system-wide efficiency[.]" *Id*. at 17.

Based on ARH's estimates, Eagle River is growing faster than the rest of the Municipality and currently has a population of 36,817. "By 2021 it will have a population of more than 40,000, or 12% of all Municipality residents. The 65+ population in Eagle River is projected to grow by 86.0% in the next 7 years, such that in 2021, it will have more than more than 5,200 elderly residents, and they will comprise 13.1% of the total population." *Id*. at 23.

Based on the same estimates, ARH concludes that South Anchorage is also growing faster than the rest of the Municipality and currently has a population of 80,187. South Anchorage "will have more than 86,000 residents in 2021—or more than one of every four residents of the Municipality. The 65+ population in South Anchorage is projected to grow by 69.6% in the next 7 years, such that in 2021, it will have nearly 13,000 elderly residents, and they will comprise 15% of the total population." *Id.* at 24.

Given these growth projections, ARH tailors its proposal to Eagle River and South Anchorage as standalone service areas that require instant access to ED services. "[T]his innovative means of addressing unmet need will provide easier access, reduce the number of patients leaving without being seen, and provide faster throughput and shorter average door to doctor times, thereby enhancing access and availability in the fastest growing and rapidly aging communities to the north and south of downtown." *Id*. at 25.

Lastly, ARH asserts that FSEDs can easily accommodate need. "As noted in the Brief . . . the

Centers for Disease Control and Prevention have reported that 32.1% of ED visits are non-urgent or semi-urgent, 36.6% are urgent and 15.9% are emergency or immediate." *Id*. at 16.

Recommendation General Review Std #1: PAMC satisfies #1; ARH does not satisfy #1.

PAMC adequately demonstrates an immediate need for additional ED capacity. Simply stated, the CON service-specific review standard for hospital emergency department services uses a threshold of at least 1,500 cases per room per year. PAMC points out that it currently has 37 rooms with an average annual patient volume of 66,896. This is equal to 1,808 visits per room. The CON threshold that must be satisfied for adding capacity is 1,500 visits per room. This means, putting all other elements of the service area aside, PAMC could satisfy the CON threshold based on its existing capacity alone by adding 8 rooms (66,896 / 1,500 = 44.5 rooms = 45 rooms).

Accordingly, based on immediate capacity and future capacity, PAMC cannot provide adequate ED services without additional ED treatment rooms. Based on the numbers and PAMC's position, it clearly satisfies General Review Standard #1.

ARH adequately identifies the need for additional ED services based on population, but it fails to demonstrate how its proposal will satisfy that need. First, the CON program fully agrees that there is a need for better access to services in Eagle River and South Anchorage. However, simply peeling off ED services and locating them with FSEDs in those areas does not address comprehensive access needs that represent a true service area. Moreover, this approach appears to be costly and inefficient.

ARH notes "the Centers for Disease Control and Prevention have reported that 32.1% of ED visits are non-urgent or semi-urgent, 36.6% are urgent and 15.9% are emergency or immediate." *ARH CON Application* at 16. This statistic means that 68.7% (32.1% non-urgent + 36.6% urgent) of ED visits can be appropriately cared for in an urgent care clinic or a physician's primary care office.

ARH cites the brief containing this statistic several times in its application. Even if 15.9% of visits are true emergencies that can only be cared for in an emergency-room setting, ARH's proposed FSEDs would not be capable of treating all of these individuals because FSEDs cannot offer trauma services (i.e. surgery and other treatment). "FSEDs are not equipped to handle all trauma cases, do not have in-house specialty care, do not have cardiac catheterization capacity and do not have intensive care or advanced surgery capabilities." *PAMC CON Application Addendum* at 9.

ARH's existing ED appears to operate below the CON threshold for adding treatment rooms. The average patient volume for 2011-2013 is 25,601 for 18 treatment rooms. This equals 1,423 visits per room per year. This means, putting all other elements of the service area aside, ARH fails to satisfy the CON threshold to add any additional rooms based on its existing capacity. While the actual capacity analysis accounts for future growth, PAMC's argument for need is more compelling than ARH's position because ARH is currently below capacity for providing ED services.

Finally, hospital emergency department care, regardless of whether it is provided in a hospital building or FSED, is expensive because under Medicaid and Medicare, both the physicians / professional staff providing the care and the hospital entity receive reimbursement. Only physicians / professional staff are reimbursed for care rendered in an urgent care clinic or physician's primary care office, meaning there is no additional facility fee that is reimbursed (i.e. fee to the hospital entity). Given that ARH's statistics support that 68.7% ED visits can be appropriately cared for in an urgent care clinic or a physician's primary care office, introducing FSEDs in Eagle River and South Anchorage will create greater access to a more costly setting, despite there being no need for such care or cost.

While it is agreeable that having a majority of hospital services located in a 2-mile radius is not ideal, FSEDs are not an adequate means of meeting need and decentralizing services in an efficient way. Even in cases of disaster, FSEDs are limited because they are not equipped for or capable of providing surgery services and trauma care.

General Review Standard #2 – Relationship to Applicable Plans:

The applicant demonstrates that the project, including the applicant's long-range development plans, augments and integrates with relevant community, regional, state, and federal health planning, and incorporates or reflects evidence-based planning and service delivery. A demonstration under this standard should show that the applicant has checked with the department regarding any relevant state plan, with appropriate federal agencies for relevant federal plans, and with appropriate communities regarding community or regional plans.

PAMC Emergency Department Expansion

Per its application, PAMC demonstrates that it considered local, regional and state governmental plans, in addition to its own internal strategic plan. External plans include "Healthy Alaskans 2020," "Transforming Health Care in Alaska," "The Alaska Health Care Strategies Planning Council's 2007 Report," and "Healthy People 2010." PAMC also references the alignment of its proposal with the goals of the Alaska Emergency Medical Services for Children (EMSC) program and the Alaska Pediatric Partnership. See *PAMC CON Application* at 16.

PAMC states that its project is consistent with national trends and guidelines to improve emergency care for all patients, especially children. Specifically, by designating pediatric ED treatment areas, PAMC believes that it is incorporating a national standard of care for large pediatric settings.

Finally, PAMC's proposal is aligned with its internal strategic plan. This is demonstrated by the fact that the proposal is consistent with other projects from Providence Health & Services Alaska, which include expansion of prenatal emergency services available at PAMC's Maternity Center. *Id.*

ARH Freestanding Emergency Departments

Per its application, ARH demonstrates that it considered local, regional and state governmental plans, in addition to its own internal strategic plan. External plans include "Healthy Alaskans 2020," "The Alaska's Health Care Action Plan," and "Transforming Health Care in Alaska."

ARH states that its "long-range plan calls for it to continue to be responsive to community health care needs. For nearly three years we evaluated ED trends, volumes and needs within the Municipality." See *ARH CON Application* at 14.

ARH expresses confidence its proposal directly addresses the issues identified in the aforementioned planning documents by placing capacity and supply "closer to where residents live[.]" *Id*. at 15.

Per its application, ARH also asserts that current ED capacity is insufficient and any attempts to expand capacity must include EMS and disaster preparedness plans. "Our proposal directly addresses these Plans by placing capacity (supply) closer to where residents live and providing additional Essential Facilities to support emergency response and preparedness within the Municipality." *Id*. at 15.

Recommendation General Review Std #2: PAMC satisfies #2; ARH does not satisfy #2.

Both PAMC and ARH did an adequate job outlining the incorporation of several relevant plans in their project planning. Both plans cite relevant health policy and planning documents, and both seem grounded in evidence-based planning. It should be noted that the CON program does not necessarily agree with the evidence-based planning. For example, the CON program appreciates ARH's consideration of EMS and disaster preparedness planning. However, as stated in the recommendation for General Review Standard #1, in the ordinary course of care and in disasters, the value of FSEDs appears to be overstated because the facilities are not equipped for or capable of providing surgery services and trauma care.

Regardless, only PAMC's proposal augments and integrates with relevant community, regional, state, and federal health planning. ARH contends that it will be enhancing access by creating more access points for emergency department services that are closer to where residents live. From a planning perspective, the Department of Health and Social Services supports improving care and the efficient delivery of services. However, merely increasing access points to ED services may improve convenience, but it does not necessarily improve care or efficient delivery of services.

This point is supported by one of the department's highest priorities for Medicaid services. Specifically, in order to better assure appropriate use of Medicaid services, improved outcomes, and better control of increasing Medicaid costs, the department's Division of Health Care Services was selected by the National Governor's Association in 2013 to implement a 24-month project that seeks to manage and coordinate care for "super utilizers" ED services. Key goals of the program are to reduce emergency room visits and improve use of preventative services.

Establishing multiple convenient access points for ED services contradicts the department's priority and long term planning to contain costs by curbing unnecessary use of emergency rooms.

General Review Standard #3 – Stakeholder Participation:

The applicant demonstrates evidence of stakeholder participation in planning for the project and in the design and execution of services.

PAMC Emergency Department Expansion

There is very little evidence in PAMC's application of outside stakeholder participation in the specific planning of the design and execution of services for this project.

PAMC states that there was extensive participation by internal stakeholders (i.e. PAMC medical staff). "Members of the PAMC Medical Staff have been extensively involved in the planning of the proposed project. Their opinions and evaluation of this project have been frequently solicited, and they receive regular updates through Medical Staff meetings. Many additional meetings have been held with emergency medicine specialists, pediatric subspecialists and the Medical Executive Committee, beginning with the earliest planning efforts and continuing through the present." See *PAMC CON Application* at 48.

Aside from a reference to the availability of support letters, some of which were attached to PAMC's application, there is little else that demonstrates outside participation in the planning of this project. It is worth noting, the letters that were submitted as part of the application were from providers who either are employed by Providence or who work with Providence.

ARH Freestanding Emergency Departments

There is evidence in ARH's application of stakeholder participation in the latter end of project planning. ARH clearly engaged key business and policy entities to support the project concept. The Chugiak-Eagle River Senior Center, which is representative of the growing elderly population in the Eagle River area, shows support for both the concept and location of the project. Additionally, the Chugiak-Eagle River Chamber of Commerce's Executive Board offers strong support from a community standpoint. Representative Hawker, who represents South Anchorage and the Turnagain Arm area, indicated support on behalf of his constituents. Lastly, an ambulatory surgery center and the Anchorage Community Land Trust offer support from a service standpoint and policy standpoint. See *ARH CON Application* at 68.

Recommendation General Review Std #3: PAMC does not satisfy #3; ARH satisfies #3.

Again, there is very little evidence of outside stakeholder participation in the planning of the design and execution of services for PAMC's project.

In contrast, ARH's application provides key letters of support because they are from entities that represent community businesses (i.e. chamber of commerce), constituents' interests (i.e. State Representative), and a key population (i.e. senior center), among other things. These letters are not mere endorsements, but rather, represent consideration of ARH's proposal and a decision that it makes sense from a planning and service delivery perspective.

General Review Standard #4 – Alternatives Considered:

The applicant demonstrates that they have assessed alternative methods of providing the proposed services and demonstrates that the proposed services are the most suitable approach.

PAMC Emergency Department Expansion

Per its CON application, PAMC demonstrates that it considered alternative methods for providing the proposed services, and that it is pursuing the most suitable approach.

PAMC states that it considered doing nothing, building a separate pediatric emergency department, converting existing nonclinical space to general use ED treatment rooms, adding fewer than 14 ED treatment rooms, and converting an ambulatory surgery unit to a pediatric emergency treatment area. PAMC ultimately chose the option proposed in its application because "it will address the problem of increasing demand for emergency department services without building new space outside PAMC's existing footprint. And, at the same time, it will allow children and their families to be cared for in a comforting child-friendly environment, minimizing the adverse effects of children's experiences in a hospital setting." *PAMC CON Application* at 36.

PAMC rejected the idea of an FSED "because not only is it a more expensive option in terms of (sic) capital requirements but also construction of freestanding emergency department (FSED) facilities in our community will be detrimental to the state's health care delivery system and will work against the state's efforts to decrease health care expenditures." *PAMC CON Application Addendum* at 4.

ARH Freestanding Emergency Departments

Per its CON application, ARH demonstrates that it considered alternative methods for providing the proposed services, and based on those alternatives, it is pursuing the most suitable approach from its perspective.

ARH states that it considered three alternatives when looking at expansion of ED services in the Municipality. These options include doing nothing, expanding the existing hospital ED, or establishing one or more FSEDs.

ARH chose establishing two FSEDs. "The option of establishing two FSEDs was selected after discussions with stakeholders and our analysis of the promise of FSEDs to increase access, enhance patient satisfaction and in the case of the Anchorage Municipality, reduce the community's reliance on downtown-centric capacity by creating new Essential Facilities that can participate and support the region in times of emergency." *ARH CON Application* at 43.

Recommendation General Review Std #4: PAMC satisfies #4; ARH satisfies #4.

Both PAMC's and ARH's consideration of alternatives were adequately thorough. Since both applicants' fully considered alternatives, general review standard #4 is satisfied by the applications. It should be noted that each proposal believes the chosen approach is "the most suitable." The CON program understands that each approach is the most suitable for each

hospital. However, in terms of being most suitable for the State, based on the CON Program's concerns about FSEDs (see recommendation for general review standard #1 and #2), it believes that ARH's plan is less suitable than PAMC's plan.

General Review Standard #5 – Impact on the Existing System:

The applicant briefly describes the anticipated impact on existing health care systems within the project's service area that serve the target population in the service area, and the anticipated impact on the statewide health care system.

PAMC Emergency Department Expansion

Per its CON application, PAMC describes the anticipated impact of its proposed project on the community. PAMC recognizes that it is one of four hospital emergency service providers in the Municipality of Anchorage. However, since Joint Base Elmendorf-Richardson hospital and the Alaska Native Medical Center have population-specific beneficiaries, only PAMC and Alaska Regional are considered when calculating the Municipality's ED utilization and capacity for purposes of CON. See *PAMC CON Application* at 37.

"PAMC and ARH emergency departments serve both adult and pediatric patients, and in the last three years, on average, these two hospitals provided over 92,000 emergency visits, based on the utilization data received from DHSS." *Id.*

PAMC does an adequate job detailing impact on specific emergency services and delivery in the Municipality. PAMC references existing collaborative relationships and transfer agreements with other health care providers at the community, state and national level. PAMC also describes a need for pediatric emergency care and how such care will complete the Municipality's health care system. *Id*.

ARH Freestanding Emergency Departments

Per its CON application, ARH describes a positive impact of FSEDs on Anchorage's existing health care system. More specifically, ARH asserts that FSEDs will complement existing services because they will relieve ED pressure in the Municipality by "freeing up" or "decanting" ED service volumes in the downtown corridor. See *ARH CON Application* at 30

ARH expresses concern about current service delivery by noting that patients leave PAMC's ED without being seen. ARH anticipates shifting some volume with its proposed FSEDs in a way that concentrates higher acuity patients at its hospital emergency department. "This shifting (from downtown EDs to the FSEDs) should improve throughput, patient care and patient satisfaction at both hospitals." *Id.* at 26.

Further, ARH intends on coordinating with both EMS and the Municipality's Emergency Management Department. *Id.* ARH states that it has a long standing working history with other health care providers, agencies and organizations community wide. *Id*. at 31.

Recommendation General Review Std #5: PAMC satisfies #5; ARH satisfies #5.

Both applications describe anticipated impact on existing health care systems within the service area. They also include statewide considerations.

It must be noted that based on the conclusion in General Review Standard #1, the CON program does not believe that FSEDs will have a desirable impact on the existing health care systems. One particularly concerning issue is the fact that there is no statutory or regulatory framework in place concerning FSEDs in Alaska. Based on articles cited in comments submitted by the public, other states and the federal government have been working to contain the rapid growth of FSEDs. The CON program questions whether a statutory change will be necessary in the event that ARH's application receives a CON.

General Review Standard #6 – Access:

The applicant demonstrates that the project's location is accessible to patients and clients, their immediate and extended families and community members, and to ancillary services. This includes the relocation of existing services or facilities.

PAMC Emergency Department Expansion

Per its CON Application, PAMC demonstrates that the project's location is accessible. PAMC is located in Anchorage, Alaska and is accessible by private, public, medical and other community transportation. "Located in the geographic center of Anchorage, PAMC is easily accessible within no more than 30 minutes for most residents and from the international airport." *PAMC CON Application* at 42.

PAMC complies with all standards and regulations of the Americans with Disabilities Act, the Joint Commission and Alaska Department of Health and Social Services, and the Federal Register for Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities. PAMC has an open door policy and does not discriminate on a patient's ability to pay, nationality, race, or creed.

ARH Freestanding Emergency Departments

Per its CON Application, ARH proposes two FSEDs in the Anchorage municipality: one in Eagle River and one in south Anchorage. "Throughout this application, we have demonstrated the real and measurable impact on access . . . . The fastest growing regions of the Municipality are to the North and South of downtown." *ARH CON Application* at 29.

ARH states that residents of Eagle River and south Anchorage account for approximately one-third of all residents in the Municipality. Therefore, locating facilities in each area will make ED services more accessible by patients, immediate and extended families, and community members. Moreover, the FSEDs will be open 24 hours per day, 7 days a week.

Recommendation General Review Std #6: PAMC satisfies #6; ARH satisfies #6.

Both PAMC and ARH sufficiently demonstrate that their proposals satisfy access needs or concerns.

Additional Considerations for Concurrent Review of More than one Application

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;

PAMC Emergency Department Expansion

PAMC is the largest acute care hospital in Alaska. It is a highly integrated health care system that is designated as a Level II trauma center. PAMC has been committed to meeting needs through expansion of its services. As of late, this includes the addition of pregnancy emergency services. Finally, PAMC does a thorough job of explaining the need for this project and how it fits with PAMC's long-range planning for service delivery and quality care.

ARH Freestanding Emergency Departments

ARH is the second largest acute care hospital in Alaska. Like PAMC, ARH clearly is committed to quality. It is in the process of renovating its emergency department and other areas of its hospital. This includes updates to the intensive care, inpatient surgical, cardiovascular care, and pediatric units. ARH is capable of meeting the demand for additional emergency room treatment services, and it appears genuinely committed to delivering efficient and quality services. However, ARH's proposal (i.e. FSEDs) is not the best avenue for meeting demand for emergency services. Regardless, the conclusion about FSEDs does not reflect on ARH's commitment to quality and performance.

Recommendation Std #1: PAMC satisfies #1; ARH satisfies #1.

2. Demonstrates a pattern of licensure and accreditation surveys with few deficiencies and a consistent history of few verified complaints; and

Both applicants sufficiently demonstrate a pattern of licensure and accreditation with few deficiencies and a consistent history of few verified complaints.

Recommendation Std #2: PAMC satisfies #2; ARH satisfies #2.

3. Demonstrates that the applicant has consistently provided, or has a policy to provide, high levels of care to low-income and uninsured persons.

Both applicants sufficiently demonstrate that they consistently provide high levels of care to low-income and uninsured persons. The State of Alaska is thankful for both hospitals and considers them to be vital partners in meeting the needs of low-income and uninsured persons.

Recommendation Std #3: PAMC satisfies #3; ARH satisfies #3.

Service-Specific Review Standards

After determining whether a project meets the general review standards, the department must apply service-specific review standards for services designated in the *Alaska Certificate of Need Review Standards and Methodologies*. For purposes of this application, Hospital Emergency Department Services require this additional review.

Hospital Emergency Department Review Standards

1. The applicant demonstrates that the project promotes, or otherwise helps ensure, the maintenance of a stable and efficient emergency medical system.

PAMC Emergency Department Expansion

A thorough and extensive analysis was undertaken by PAMC to identify areas of growth that are critical to the ongoing provision of quality health care. The analysis substantiated the need for expanded capacity in ED services, especially as it relates to pediatric care. "Providence is committed to growing to meet community need, and this project is the result of an extensive analysis assessing the existing and future needs and capacity in the community." See *PAMC CON Application* at 7.

ARH Freestanding Emergency Departments

ARH adequately identifies the need for additional ED services based on population, but it fails to demonstrate that its proposal will promote and ensure the maintenance of a stable and efficient emergency medical system. Based on a study cited by ARH, 68.7% (32.1% non-urgent + 36.6% urgent) of ED visits can be appropriately cared for in an urgent care clinic or a physician's primary care office. Moreover, even if 15.9% of visits are true emergencies that can only be cared for in an emergency room setting, ARH's proposed FSEDs would not be able to treat all of these individuals because FSEDs cannot offer trauma services (i.e. surgery and other treatment). Even in cases of disaster, FSEDs are limited because they are not equipped for or capable of providing surgery services and trauma care.

Recommendation Std #1: PAMC satisfies #1; ARH does not satisfy #1.

2. For the addition or expansion of general emergency services, a proposal will not be approved unless each emergency department treatment room will provide a minimum of 1,500 visits annually. . . . The department may approve additional space if the applicant documents use patterns, and submits data and analysis that show seasonal high peak use rates warranting additional treatment rooms.

The department uses the following formula to determine the need for emergency department treatment room services:

EDTR=C5 / 1500

C5=P5 x SAS x UR

EDTR emergency department treatment rooms needed
C5 caseload: ED visits projected for the fifth year after project completion
UR current utilization rate: average of number of ED visits per year for last three years divided by population, based on the service area
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

In its application, PAMC uses the Alaska Department of Labor (AKDOL) Population Estimates (2008 – 2013) and Projections (2017, 2022).

PAMC uses the AKDOL Population Projection for 2022 for the Municipality of Anchorage to determine the value of P5. Note, the project's fifth year is actually 2021, but AKDOL's projection is based on five-year intervals, so PAMC elects to use the nearest available data point (i.e. 2022) for the P5 value. This approach appears reasonable.

P5 = 326,612.

PAMC uses the entire Anchorage population for its service area share in its calculation. This is based on the premise that while certain Anchorage residents (i.e. American Indian / Alaska Native and military beneficiaries) can seek emergency care at the Alaska Native Medical Center (ANMC) and Joint Base Elmendorf-Richardson (JBER) hospitals, they may also choose to obtain services from PAMC's emergency department.

SAS = 100%.

PAMC only analyzed emergency department visits at PAMC and ARH. This is important because it specifically excludes emergency visits at ANMC and JBER. While the CON Program acknowledges that this is not the most accurate method for determining the actual usage rate, it is the most reasonable approach, and it is the approach used by the department, because ANMC and JBER only serve certain populations. Therefore, it is correct not to consider ANMC and JBER in utilization because ANMC and JBER cannot serve the general population. Similarly, it is still correct to consider the full anchorage population in the SAS calculation because while certain populations can only go to ANMC and JBER, those same populations can also choose to go to PAMC or ARH.

Based on emergency visits to PAMC and ARH over the past three years, and based on the AKDOL Population Estimates for 2011-2013, UR = (ED visits / population averaged 2011 – 2013) = [(93,742/296,167 + 94,549/298,576 + 88,524 / 301,134)/3] = 0.309.

UR=0.309

C5=P5 X SAS X UR

C5=326,612 x 100 x .309

C5=100,940

EDTR= C5 / 1500

EDTR=100,940 / 1,500

EDTR = 67.3. Since there is no such thing as a thirtieth of a treatment room, the decimal must be rounded up to the nearest whole number, which is 68 emergency department treatment rooms.

EDTR=68

PAMC and ARH currently have a combined 55 emergency department treatment rooms. Based on the EDTR calculation, there is a demonstrated need for a total of 68 emergency department treatment rooms. Therefore, there is room for 13 additional emergency department treatment rooms (68-55=13) in the service area (Municipality of Anchorage).

In its application, ARH uses a variety of data sources to determine capacity for emergency department treatment room services. Sources include the Healthcare Cost and Utilization Project ("H-cup" data), Nielsen Claritas, and the Alaska Department of Labor. ARH ultimately concludes that application of the CON methodology for emergency department treatment room services shows a capacity for 12 additional treatment rooms in the Municipality of Anchorage.

The CON Program appreciates both approaches and the desire to cite accurate data. Ultimately, it agrees with PAMC's use and application of Department of Labor statistics. Therefore, for purposes of this analysis, after applying the rounding adjustment, the CON Program concludes there is capacity for 13 additional emergency department treatment rooms in the service area of the Municipality of Anchorage.

Both proposals exceed the available capacity. PAMC proposes adding 14 emergency department treatment rooms: 10 pediatric emergency treatment rooms and 4 general emergency treatment rooms. This proposal exceeds capacity requirements by 1 emergency department treatment room. ARH proposes adding 16 emergency department treatment rooms: 8 in Eagle River; 8 in South Anchorage. Its proposal exceeds capacity by 3.

PAMC seeks the department's approval in full on the premise that "The department may approve additional space if the applicant documents use patterns, and submits data and analysis that show seasonal high peak use rates warranting additional treatment rooms." *PAMC CON Application* at 19.

PAMC does not show seasonal peak use rates that support broad capacity. Rather, it only shows peak use rates during the day at PAMC. This usage data is reflective of PAMC's ability to service the population, not the health care system's ability to service the population. If PAMC is too busy to serve the population, the population can go to Alaska Regional (or ANMC and JBER, depending on the population type). Since the EDTR methodology concludes that there is

room for 13 EDTRs, there is no need to add a 14th room just because PAMC experiences congestion on a daily basis. Again, PAMC is not alone in serving the population. Since it did not submit data that shows seasonal high peak use rates that affect the entire ED health care system for the service area, its analysis does not warrant an additional treatment room beyond the EDTR calculation.

ARH seeks the department's approval in full on the premise that each "treatment room is projected to provide a minimum of 1,500 visits annually by the 5th year of operation." *ARH CON Application* at 45. This conclusion is misleading because it is based on an analysis that treats Eagle River as a standalone service area and South Anchorage as a standalone service area. This is not an acceptable approach because simply peeling off ED services and locating them with freestanding facilities in those areas does not address comprehensive access needs that represent an actual service area. For example, it is inconsistent to consider Eagle River and South Anchorage as standalone service areas when their residents have to leave these areas to access nearly all other health care services (i.e. hospital services, trauma services, surgery services, etc, are mainly located in downtown or midtown Anchorage). This approach is not persuasive and ARH fails to demonstrate that it meets an exception that would warrant waiving the available capacity for its project.

Recommendation Std #2: PAMC satisfies in part (13 of 14 rooms) #2; ARH satisfies in part (13 of 16 rooms) #2.

3. For the addition or expansion of fast-track emergency services within a facility. . . .

This review standard is not applicable to either application as there are no fast-track services proposed**.**

Recommendation: Specific Review Standard #3 is not applicable.

4. For a proposal for additional space in the hospital emergency department, the applicant must perform a size-by-functional-need survey and analysis for additional space that demonstrates efficient use of the space.

A size-by-function-need survey is enclosed in Appendix C of PAMC's CON application. Based on the survey, this standard is met. This standard does not apply to ARH's CON application because its proposal does not seek to add space to an existing structure.

Recommendation Std #4: PAMC satisfies #4; #4 is not applicable to ARH.

Computed Tomography Review Standards

For purposes of this application, ARH's request for additional CT scanners in each proposed FSED requires a service-specific review using the computed tomography review standards. Since PAMC's proposal does not include addition of a CT scanner, this analysis only needs to consider ARH.

ARH's proposal is unique because it seeks to essentially establish two new emergency departments. Its new emergency departments will need diagnostic equipment to provide emergency treatment services. This includes CT scanners that "will not be open to the general community and will not support other services." *ARH CON Application* at 46. Rather, the CT scanners will solely be dedicated to emergency department services to patients using the FSEDs. See *Id*.

Again, this component is unique in that unlike other hospital or imaging projects, ARH is seeking to establish purely emergency-based CT scanners. Doing so will not create an outpatient service that is available by referral. It will not establish an independent diagnostic testing facility. Finally, it also will not free up capacity on an existing scanner that will allow ARH to compete for general outpatient CT needs.

Given that these CT scanners are truly limited to emergency department services, they are deeply engrained in ARH's proposal as a whole. Therefore, for these particular circumstances, the true service-specific review standard for the CT scanner component are those that were applied to the project as a whole for hospital emergency department services. Accordingly, the CON Program agrees with ARH and concludes that the service-specific review using the computed tomography review standards does not apply to ARH's proposal.

Recommendation: Computed Tomography Review Standards are not applicable to ARH.

FINANCIAL FEASIBILITY

PAMC Emergency Department Expansion

The total cost of the project is $12,853,311. This includes of $9,366,362 in construction costs and $1,583,249 in equipment costs. The construction, equipment, and start-up costs will be financed with Providence Alaska's cash reserves. See *CON Application* at page 39.

1. Construction Method (Please check)

a. ☐ Conventional bid ☐ Contract management ☐ Design and build
b. ☐ Phased ☐ Single project ☐ Fast Track
X Design-Assist[55]

2. Construction Cost (New Activity)	(Omit cents)
a. Site acquisition (Section VIIIA.2.f)	$ -
b. Estimated general construction**	$ 9,366,362
c. Fixed equipment, not included in a**	$ 1,583,249
d. Total construction costs (sum of items a, b, and c)**	$ 10,949,611
e. Major movable equipment**	$ -
f. Other cost:**	
(1) Administration expense[56]	$ 813,600
(2) Site survey, soils investigation, and materials testing	$ -
(3) Architects and engineering fees	$ 970,100
(4) Other consultation fees	$ -
(5) Legal fees	$ -
(6) Land development and landscaping	$ -
(7) Building permits and utility assessments	$ -
(8) Additional inspection fees (clerk of the works)	$ 120,000
(9) Insurance (required during construction period)	Included in (b)[57]
g. Total project cost (sum of items d, e, f)	$ 12,853,311
h. Amount to be financed	$ -
i. Difference between 2.g and 2.h	$ 12,853,311
j. Anticipated long-term interest rate	NA%
k. Anticipated interim (construction) interest rate	NA%
l. Anticipated long-term interest amount	$ -
m. Anticipated interim interest amount	$ -
n. Total items g, l, and m	$ 12,853,311
o. Estimated annual debt service requirement	NA
p. Construction cost per sq. ft.[58]	$ 683
q. Construction cost per bed[59]	$ 669,026
r. Project cost per sq. ft.[60]	$ 937
s. Project cost per bed[61]	$ 918,094

** Items must be certified estimates from an architect or other professional.

Schedule I.A. Facility income statement for the last five years.					
in thousands					
	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Gross Patient Revenue:					
Inpatient Routine	777,319	864,583	949,760	1,027,152	1,138,056
Inpatient Ancillary	-	-	-	-	-
Outpatient	372,763	439,798	451,198	504,291	556,976
Long-Term Care	N/A	N/A	N/A	N/A	N/A
Swing Beds	N/A	N/A	N/A	N/A	N/A
Other	17,091	9,215	14,761	15,819	16,182
Total Patient Revenue	**1,167,173**	**1,313,596**	**1,415,719**	**1,547,262**	**1,711,214**
Less Deductions:					
Charity Care	55,863	65,756	52,326	96,062	119,085
Contractual Allowances	564,770	671,724	768,607	858,146	957,780
Bad Debts	43,824	44,639	54,103	32,561	37,223
Total Deductions	664,457	782,119	875,036	986,769	1,114,088
Net Operating Revenues	**502,716**	**531,477**	**540,683**	**560,493**	**597,126**
All Other Revenues	29,315	28,689	32,565	37,400	38,265
EXPENSES:					
Salaries	166,624	173,012	185,290	182,685	185,833
Benefits	51,961	50,760	52,455	55,595	54,462
Supplies	87,959	94,496	92,756	93,196	99,812
Utilities	7,005	7,524	8,559	7,344	7,717
Property Tax	1,192	1,968	1,229	1,576	1,441
Rent	1,502	3,620	3,902	3,873	3,908
Lease	2,888	2,496	2,419	2,408	2,603
Other Expenses	117,534	103,773	116,977	118,044	139,855
Depreciation	37,630	41,462	39,216	39,189	40,071
Interest	8,053	7,370	7,294	8,022	10,990
Total Expenses	**482,348**	**486,481**	**510,098**	**511,932**	**546,692**
Excess (Shortage) of Revenue over Expenditures	**49,683**	**73,685**	**63,150**	**85,961**	**88,699**

Note: Use one copy of this form for the previous five years, another for the construction or development period, and five years after the project opens.

Schedule I.C. Facility income statement for the five years after the project completion.					
in thousands					
	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Gross Patient Revenue:					
Inpatient Routine	1,320,837	1,388,927	1,471,939	1,538,171	1,623,197
Inpatient Ancillary					
Outpatient	645,862	695,453	739,079	784,512	832,232
Long-Term Care					
Swing Beds					
Other	18,375	19,081	19,426	20,173	20,540
Total Patient Revenue	**1,985,074**	**2,103,461**	**2,230,444**	**2,342,856**	**2,475,969**
Less Deductions:					
Charity Care	120,731	127,071	134,597	141,297	149,276
Contractual Allowances	1,193,928	1,292,984	1,399,172	1,489,352	1,594,509
Bad Debts	50,786	53,462	56,657	59,485	62,873
Total Deductions	1,365,445	1,473,517	1,590,426	1,690,134	1,806,658
Net Operating Revenues	**619,629**	**629,944**	**640,018**	**652,722**	**669,311**
All Other Revenues	24,395	25,086	25,798	26,530	27,284
EXPENSES:					
Salaries	204,698	210,922	217,337	223,949	230,764
Benefits	61,409	63,277	65,201	67,185	69,229
Supplies	101,845	103,308	105,374	107,482	109,631
Utilities	6,897	7,104	7,317	7,537	7,763
Property Tax	35	36	37	38	39
Rent	2,957	3,045	3,137	3,231	3,328
Lease	1,768	1,821	1,876	1,932	1,990
Other Expenses	132,197	136,668	140,235	143,410	146,876
Depreciation	31,215	31,243	30,642	28,859	29,157
Interest	10,570	9,745	9,636	9,518	8,198
Total Expenses	**553,590**	**567,170**	**580,792**	**593,140**	**606,975**
Excess (Shortage) of Revenue over Expenditures	**90,434**	**87,860**	**85,024**	**86,111**	**89,620**
Note: Use one copy of this form for the previous five years, another for the construction or development period, and five years after the project opens.					

ARH Freestanding Emergency Departments

The total cost of the project is $25,394,478—$12,838,553 for the South Anchorage FSED and $12,555,925 for the Eagle River FSED. The construction, equipment, and start-up costs will be funded from existing HCA reserves (i.e. the corporate parent of ARH). See *ARH CON Application* at 8.

3. Construction Method (Please check)

a. ☐ Conventional bid □ Contract management **x** Design and build

b. ☐ Phased □ Single project **x** Fast Track

☐

4. Construction Cost (New Activity)	(Omit cents)
Site acquisition (Section VIIIA.2.f)	$ 2,411,960
a. Estimated general construction**	$ 7,887,741
b. Fixed equipment, not included in a**	$ N/A
c. Total construction costs (sum of items a, b, and c)**	$ 10,299,701
Major movable equipment**	$ 1,863,738
d. Other cost:**	
(1) Administration expense	$ 127,114
site survey, soils investigation, and materials testing	$ 19,400
(2) Architects and engineering fees	$ 350,600
Other consultation fees	$ 75,000
(3) Legal fees	$ 20,000
(4) Land development and landscaping	Included in (b)
Building permits and utility assessments	$ 51,000
Additional inspection fees (clerk of the works)	$ 10,000
(5) Insurance (required during construction period)	$ 22,000
Total project cost (sum of items d, e, f)	$ 12,838,553
e. Amount to be financed	$ -
f. Difference between 2.g and 2.h	$ 12,838,553
g. Anticipated long-term interest rate	NA%
h. Anticipated interim (construction) interest rate	NA%
i. Anticipated long-term interest amount	$ -
j. Anticipated interim interest amount	$ -
k. Total items g, l, and m	$ 12,838,553
l. Estimated annual debt service requirement	NA
m. Construction cost per sq. ft.[58]	$ 963
n. Construction cost per bed[59]	$ 1,604,819
o. Project cost per sq. ft.[60]	$ 1,199
p. Project cost per bed[61]	$ 1,604,819

** Items must be certified estimates from an architect or other professional.

5. Construction Method (Please check)

a.	☐ Conventional bid	□ Contract management	**x** Design and build
b.	☐ Phased	□ Single project	**x** Fast Track
			☐

6. Construction Cost (New Activity)	(Omit cents)
Site acquisition (Section VIIIA.2.f)	$ 1,373,200
a. Estimated general construction**	$ 8,625,871
b. Fixed equipment, not included in a**	$ N/A
c. Total construction costs (sum of items a, b, and c)**	$ 9,999,071
d. Major movable equipment**	$ 1,863,738
e. Other cost:**	
i. Administration expense	$ 127,316
ii. site survey, soils investigation, and materials testing	$ 33,200
iii. Architects and engineering fees	$ 336,600
iv. Other consultation fees	$ 75,000
v. Legal fees	$ 20,000
vi. Land development and landscaping	Included in (b)

vii.	Building permits and utility assessments	$ 68,000
viii.	Additional inspection fees (clerk of the works)	$ 14,000
ix.	Insurance (required during construction period)	$ 22,000
f.	Total project cost (sum of items d, e, f)	$ 12,555,925
g.	Amount to be financed	$ -
h.	Difference between 2.g and 2.h	$ 12,555,925
i.	Anticipated long-term interest rate	NA%
j.	Anticipated interim (construction) interest rate	NA%
k.	Anticipated long-term interest amount	$ -
l.	Anticipated interim interest amount	$ -
m.	Total items g, l, and m	$ 12,555,925
n.	Estimated annual debt service requirement	NA
o.	Construction cost per sq. ft.[58]	$ 934
p.	Construction cost per bed[59]	$ 1,569,491
q.	Project cost per sq. ft.[60]	$ 1,173
Project cost per bed[61]		$ 1,569,491

** Items must be certified estimates from an architect or other professional.

Alaska Regional Hospital					
Schedule 1. Facility Income Statement					
Last Five Years Actual					
Gross Patient Revenue:	2010	2011	2012	2013	2014
Inpatient Routine	$ 68,217,000	$ 76,018,000	$ 87,422,000	$ 90,680,000	$ 94,364,400
Inpatient Ancillary	$ 288,623,000	$ 300,187,000	$ 338,498,000	$ 324,297,000	$ 340,132,800
Outpatient	$ 204,406,000	$ 224,566,000	$ 220,843,000	$ 212,246,000	$ 213,715,200
Long-Term Care	$ -	$ -	$ -	$ -	$ -
Swing Beds	$ -	$ -	$ -	$ -	$ -
Other	$ 4,785,000	$ 6,145,000	$ 4,671,000	$ 4,741,000	$ 3,812,400
Total Patient Revenue	$ 566,031,000	$ 606,916,000	$ 651,434,000	$ 631,964,000	$ 652,024,800
Less Deductions					
Charity Care	$ 6,143,000	$ 4,726,000	$ 7,858,000	$ 14,263,000	$ 8,136,000
Contractual Allowances	$ 349,202,000	$ 369,707,000	$ 390,919,000	$ 397,313,000	$ 418,245,600
Bad Debts	$ 10,769,000	$ 13,699,000	$ 21,269,000	$ 7,756,000	$ 13,476,000
Total Deductions	$ 366,114,000	$ 388,132,000	$ 420,046,000	$ 419,332,000	$ 439,857,600
Net Operating Revenues	$ 199,917,000	$ 218,784,000	$ 231,388,000	$ 212,632,000	$ 212,167,200
All Other Revenues	$ -	$ -	$ -	$ -	$ 2
EXPENSES:					
Salaries	$ 51,934,000	$ 53,406,000	$ 57,980,000	$ 57,427,000	$ 57,687,600
Benefits	$ 13,413,000	$ 13,236,000	$ 14,068,000	$ 13,588,000	$ 13,869,600
Supplies	$ 38,514,000	$ 40,725,000	$ 40,825,000	$ 39,079,000	$ 37,579,200
Utilities	$ 2,393,000	$ 2,692,000	$ 2,531,000	$ 2,891,000	$ 3,162,000
Property Tax	$ 2,180,000	$ 1,627,000	$ 1,742,000	$ 1,994,000	$ 1,764,000
Rent	$ 966,000	$ 858,000	$ 1,155,000	$ 1,814,000	$ 1,430,400
Lease	$ -	$ -	$ -	$ -	$ -
Other Expenses	$ 49,338,377	$ 55,101,509	$ 58,950,448	$ 55,118,177	$ 54,725,088
Depreciation	$ 9,604,000	$ 9,423,000	$ 9,379,000	$ 9,405,000	$ 9,889,200
Interest	$ 3,798,000	$ 7,433,000	$ 4,752,000	$ 4,205,000	$ 2,774,400
Total Expenses	$ 172,140,377	$ 184,501,509	$ 191,382,448	$ 185,521,177	$ 182,881,488
Excess (Shortage) of Revenue	$ 27,776,623	$ 34,282,491	$ 40,005,552	$ 27,110,823	$ 29,285,712
Over Expenditures					

Alaska Regional Hospital

Schedule I. Facility Income Statement

Five Years Following Project Completion

Gross Patient Revenue:	2017	2018	2019	2020	2021
Inpatient Routine	$ 118,871,967	$ 128,381,724	$ 138,652,262	$ 149,744,443	$ 161,723,999
Inpatient Ancillary	$ 428,469,370	$ 462,746,919	$ 499,766,673	$ 539,748,007	$ 582,927,847
Outpatient	$ 269,219,602	$ 290,757,170	$ 314,017,744	$ 339,139,163	$ 366,270,296
Long-Term Care	$ -	$ -	$ -	$ -	$ -
Swing Beds	$ -	$ -	$ -	$ -	$ -
Other	$ 4,802,526	$ 5,186,728	$ 5,601,666	$ 5,713,700	$ 5,827,974
Total Patient Revenue	$ 821,363,465	$ 887,072,542	$ 958,038,345	$ 1,034,345,313	$ 1,116,750,116
Less Deductions					
Charity Care	$ 11,095,237	$ 12,303,966	$ 13,644,375	$ 15,130,810	$ 16,779,180
Contractual Allowances	$ 570,370,434	$ 632,507,306	$ 701,413,447	$ 777,826,310	$ 862,563,686
Bad Debts	$ 18,377,508	$ 20,379,577	$ 22,599,754	$ 25,061,799	$ 27,792,063
Total Deductions	$ 599,843,179	$ 665,190,849	$ 737,657,576	$ 818,018,920	$ 907,134,930
Net Operating Revenues	$ 221,520,286	$ 221,881,693	$ 220,380,769	$ 216,326,393	$ 209,615,187
All Other Revenues	$ 5	$ 6	$ 7	$ 8	$ 9
EXPENSES:					
Salaries	$ 61,218,543	$ 62,442,913	$ 63,691,772	$ 64,965,607	$ 66,264,919
Benefits	$ 14,718,530	$ 15,012,901	$ 15,313,159	$ 15,619,422	$ 15,931,811
Supplies	$ 39,879,348	$ 40,676,935	$ 41,490,473	$ 42,320,283	$ 43,166,688
Utilities	$ 3,355,540	$ 3,422,650	$ 3,491,103	$ 3,560,926	$ 3,632,144
Property Tax	$ 1,871,971	$ 1,909,410	$ 1,947,599	$ 1,986,551	$ 2,026,282
Rent	$ 1,517,952	$ 1,548,311	$ 1,579,277	$ 1,610,863	$ 1,643,080
Lease	$ -	$ -	$ -	$ -	$ -
Other Expenses	$ 54,442,209	$ 51,462,054	$ 46,551,956	$ 39,021,003	$ 28,763,689
Depreciation	$ 10,494,498	$ 10,704,388	$ 10,918,476	$ 11,136,845	$ 11,359,582
Interest	$ 2,944,215	$ 3,003,100	$ 3,063,162	$ 3,124,425	$ 3,186,914
Total Expenses	$ 190,442,806	$ 190,182,663	$ 188,046,977	$ 183,345,925	$ 175,975,109
Excess (Shortage) of Revenue	$ 31,077,481	$ 31,699,030	$ 32,333,792	$ 32,980,468	$ 33,640,078
Over Expenditures					

Eagle River

Schedule I. Facility Income Statement

Five Years Following Project Completion

Gross Patient Revenue:	2017	2018	2019	2020	2021
Inpatient Routine	$ 16,447,130	$ 18,118,159	$ 19,958,964	$ 21,986,794	$ 23,745,738
Inpatient Ancillary	$ -	$ -	$ -	$ -	$ -
Outpatient	$ 16,280,429	$ 20,220,293	$ 25,113,604	$ 31,191,097	$ 33,686,384
Long-Term Care	$ -	$ -	$ -	$ -	$ -
Swing Beds	$ -	$ -	$ -	$ -	$ -
Other	$ -	$ -	$ -	$ -	$ -
Total Patient Revenue	$ 32,727,560	$ 38,338,452	$ 45,072,568	$ 53,177,891	$ 57,432,122
Less Deductions					
Charity Care	$ 4,126,691	$ 5,100,160	$ 6,306,648	$ 7,798,542	$ 9,643,357
Contractual Allowances	$ 18,474,085	$ 21,899,303	$ 26,021,173	$ 31,000,560	$ 32,920,383
Bad Debts	$ 716,734	$ 839,612	$ 987,089	$ 1,164,596	$ 1,257,763
Total Deductions	$ 23,317,510	$ 27,839,075	$ 33,314,911	$ 39,963,698	$ 43,821,504
Net Operating Revenues	$ 9,410,050	$ 10,499,377	$ 11,757,657	$ 13,214,193	$ 13,610,619
All Other Revenues					
EXPENSES:					
Salaries	$ 2,486,962	$ 2,533,997	$ 2,581,973	$ 2,630,908	$ 2,683,527
Benefits	$ 593,820	$ 611,753	$ 630,228	$ 649,261	$ 662,246
Supplies	$ 1,412,514	$ 1,440,765	$ 1,469,580	$ 1,498,972	$ 1,528,951
Utilities	$ 179,220	$ 184,597	$ 190,134	$ 195,839	$ 199,755
Property Tax	$ 252,434	$ 287,289	$ 328,154	$ 376,181	$ 383,705
Rent	$ 24,480	$ 24,970	$ 25,469	$ 25,978	$ 26,498
Lease	$ -	$ -	$ -	$ -	$ -
Other Expenses	$ 2,097,394	$ 2,512,820	$ 2,997,376	$ 3,558,352	$ 3,682,488
Depreciation	$ 445,750	$ 445,750	$ 445,750	$ 457,554	$ 470,000
Interest	$ -	$ -	$ -	$ -	$ -
Total Expenses	$ 7,492,574	$ 8,041,941	$ 8,668,665	$ 9,393,045	$ 9,637,170
Excess (Shortage) of Revenue Over Expenditures	$ 1,917,476	$ 2,457,436	$ 3,088,992	$ 3,821,147	$ 3,973,448

South Anchorage

Schedule I. Facility Income Statement

Five Years Following Project Completion

Gross Patient Revenue:	2017	2018	2019	2020	2021
Inpatient Routine	$ 14,433,361	$ 15,899,791	$ 17,515,210	$ 19,294,755	$ 20,838,336
Inpatient Ancillary	$ -	$ -	$ -	$ -	$ -
Outpatient	$ 15,794,174	$ 19,616,364	$ 24,363,524	$ 30,259,496	$ 32,680,256
Long-Term Care	$ -	$ -	$ -	$ -	$ -
Swing Beds	$ -	$ -	$ -	$ -	$ -
Other	$ -	$ -	$ -	$ -	$ -
Total Patient Revenue	$ 30,227,535	$ 35,516,155	$ 41,878,734	$ 49,554,252	$ 53,518,592
Less Deductions					
Charity Care	$ 2,906,433	$ 3,592,573	$ 4,443,009	$ 5,494,762	$ 6,795,485
Contractual Allowances	$ 16,782,101	$ 20,025,667	$ 23,952,178	$ 28,721,279	$ 30,870,487
Bad Debts	$ 661,983	$ 777,804	$ 917,144	$ 1,085,238	$ 1,172,057
Total Deductions	$ 20,350,517	$ 24,396,044	$ 29,312,332	$ 35,301,279	$ 38,838,030
Net Operating Revenues	$ 9,877,018	$ 11,120,111	$ 12,566,401	$ 14,252,973	$ 14,680,562
All Other Revenues					
EXPENSES:					
Salaries	$ 2,486,962	$ 2,533,997	$ 2,581,973	$ 2,630,908	$ 2,683,527
Benefits	$ 593,820	$ 611,753	$ 630,228	$ 649,261	$ 662,246
Supplies	$ 1,412,514	$ 1,440,765	$ 1,469,580	$ 1,498,972	$ 1,528,951
Utilities	$ 179,220	$ 184,597	$ 190,134	$ 195,839	$ 199,755
Property Tax	$ 289,140	$ 332,041	$ 382,731	$ 442,780	$ 451,636
Rent	$ 24,480	$ 24,970	$ 25,469	$ 25,978	$ 26,498
Lease	$ -	$ -	$ -	$ -	$ -
Other Expenses	$ 2,298,193	$ 2,777,223	$ 3,339,588	$ 3,995,854	$ 4,133,256
Depreciation	$ 426,822	$ 426,822	$ 426,822	$ 438,530	$ 450,000
Interest	$ -	$ -	$ -	$ -	$ -
Total Expenses	$ 7,711,151	$ 8,332,167	$ 9,046,525	$ 9,878,122	$ 10,135,868
Excess (Shortage) of Revenue Over Expenditures	$ 2,165,867	$ 2,787,944	$ 3,519,876	$ 4,374,850	$ 4,544,694

PUBLIC COMMENTS

A public meeting was held in Anchorage, Alaska on May 18, 2015. Approximately 136 individuals attended the meeting in person, and about 41 individuals provided verbal comment. Of those in attendance, there were a combination of private citizens, Providence Health System employees, Alaska Regional Hospital employees, and community health care providers.

PAMC Medical Director, Dr. Richard Mandsager, gave a PowerPoint presentation on PAMC's proposed emergency department expansion project. The presentation outlined the project plan, its alignment with PAMC's strategic goals, and the support for additional and expanded hospital emergency department services in the Municipality of Anchorage.

ARH Chief Executive Officer, Julie Taylor, gave a PowerPoint presentation on ARH's proposed construction of two FSEDS: one in Eagle River and one in South Anchorage. The presentation outlined ARH's corporate structure and holdings, gave an overview of the proposed Eagle River and South Anchorage facilities, and explained the need for FSEDs versus urgent care clinics and traditional hospital-based emergency department services in the Municipality of Anchorage.

Of the approximately 41 comments made at the public meeting, 15 were in favor of the PAMC project, 18 were in favor of the ARH project, 4 were opposed to the ARH project with no mention of the PAMC project, and 4 comments favored both projects. Approximately half of the comments came from employees of either PAMC or ARH.

Many of the public comments articulated a need for additional emergency or urgent care services in Eagle River. However, the need for FSEDs to provide those services was not universally agreed upon as many comments spoke to the need for non-emergency care versus emergency department services. The need for pediatric emergency treatment was also supported.

A written public comment period was open from May 1, 2015 – June 1, 2015. A total of 302 written comments were received.

Of the written comments received:

	PAMC	**ARH**
In favor	37	148
Opposing	3	114

PAMC submitted an independent comparative evaluation and summary of the PAMC and ARH CON applications by Frank Fox, an economist with expertise in quantitative health care planning. PAMC also submitted a statement from the Institute of Social and Economic Research (ISER), UAA regarding the policy implications of freestanding emergency departments. Dr. Guettabi and Dr. Frazier of ISER state that their assessment is based solely on a review of publicly available information on FSEDs. They discuss what FSEDs are, how they are regulated, how FSEDs affect the costs of health care and the potential benefits and disadvantages of FSEDs. They do not state an opinion on either the PAMC or the ARH proposed projects.

ARH submitted the bulk of the comments in favor of its project in a single packet (ARH sponsored a website dedicated to receiving public comment). The website and participation was promoted by ARH through a mass mailing to the residents of the Municipality of Anchorage.

Finally, there were several other materials submitted through written comment. These materials included comprehensive letters from health care providers (i.e. Physicians Opposed to Freestanding Emergency Departments) and studies.

RECOMMENDATION

The CON Program recommends that the Commissioner approve, in part, PAMC's application for a CON concerning its Emergency Department Expansion Project. The CON Program also recommends that the Commissioner deny, in full, ARH's application for a CON concerning its project to establish two FSEDS. This recommendation is based on the demonstration of capacity for thirteen more emergency department treatment rooms in the Municipality of Anchorage service area.

The CON Program recommends full denial of ARH's application because it fails General Review Standards #1 and #2. It also fails service-specific review standards #1 and #2 (in part) for Hospital Emergency Department Services. As stated throughout the analysis, ARH's proposed FSEDs are expensive settings for care that are inefficient due to their inability to provide trauma care and other critical emergency services. Finally, most cases that would present at the FSEDs could be handled in less expensive, more appropriate settings for care like urgent care clinics and physicians' primary care offices.

The CON Program recommends approval of PAMC's application because it satisfies all review standards except General Review Standard #3 and service-specific review standard #2 (in part) for Hospital Emergency Department Services. As stated throughout the analysis, PAMC's proposed emergency department expansion better aligns with Alaska's health care system, will provide a more cost and service efficient setting for care than FSEDs, and it should enhance emergency care by valuing the importance of serving the pediatric population.

Although PAMC demonstrated capacity for 13 additional emergency department treatment rooms to meet the need of the population in the Municipality in Anchorage, the CON Program questions whether PAMC's proposal on its own is the best means of meeting the need of the service area.

Per 7 AAC 07.070(b)(7)(A), in granting or denying a CON, the Commissioner must consider "any other special or extraordinary circumstances related to . . . community access to health care[.]" There is no doubt that over the next 5 years, there is capacity for at least 13 additional emergency department treatment rooms. Also, there is no doubt that PAMC's proposal met nearly all of the CON review standards. However, and understandably, PAMC's proposal only considers how the review standards, and the issues therein, affect its facility. In contrast, in issuing her final decision, the Commissioner of the Department of Health & Social Services must consider how PAMC's proposal will affect the entire health care system and the community's access to that health care system.

While PAMC's proposal would meet the need of the service area, given the Commissioner's need to consider the impact on the health care system, and the community's access to that health care system, the issue is 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 services for at least the next five years. This especially warrants closer consideration when there is a desire and plan by the other largest hospital in the service area to use some or all of the hospital emergency department services capacity to meet the very same need.

Given the demonstrated capacity and need for hospital emergency department services, and given the benefit of saving capacity so that there is opportunity over the next five years for another provider to diversify access to those services, the CON Program recommends approving 10 of PAMC's requested 14 emergency department treatment rooms. This is reasonable because based on PAMC's existing rooms and service volume, it could immediately add 8 additional rooms according to the CON threshold of 1,500 visits per room. Therefore, 10 additional rooms will relieve immediate pressure from volume and provide an ability to absorb modest growth over the next 5 years. It also leaves at least 3 rooms for ARH to consider filling in the immediate future.

Accordingly, the CON Program recommends that the Commissioner approve PAMC for the construction of 10 emergency department treatment rooms. This approval should be contingent on Commissioner review and approval of a revised budget and timeline from PAMC for a modified project that meets the limitations set forth above.

APPENDIX A

Estimated Impact to Medicaid

THE STATE of ALASKA
GOVERNOR BILL WALKER

Department of Health and Social Services
OFFICE OF RATE REVIEW

3601 C Street, Suite 978
Anchorage, Alaska 99503
Main: 907.334.2464
Fax: 907.334-2220

MEMORANDUM

To: Alexandria Hicks, CON Coordinator

From: Christine Goetz, Audit Supervisor
Office of Rate Review

Date: February 17, 2015

Subject: Certificate of Need Review for Providence Alaska Medical Center Emergency Department Expansion

Providence Alaska Medical Center (PAMC) proposes to repurpose existing clinical and non-clinical space within PAMC to build 14 additional emergency department treatment rooms, including a 10-room pediatric emergency treatment area. The total number of treatment rooms within PAMC's emergency department (ED) will increase from 37 to 51. It will not be a new service as PAMC's ED currently serves both adults and pediatric patients. The proposed expansion includes adding two nurse stations and other support areas within the ED, as needed. The facility also plans to add a full-time child life specialist as well as a number of staff registered nurses. The estimated total cost of the project is $12,853,311, including $9,366,362 cost of construction and the $1,583,249 cost of equipment to be purchased. The proposed project will be financed with the cash reserves of Providence Health and Services Alaska. The estimated operational date is December 2016 and the project completion date will be December 2017.

The chart below estimates the added cost to Medicaid over the three years following the completion of the operational date of the project for the Medicaid rate for reimbursement to the facility associated with the increase in outpatient services from the project.

Estimated Medicaid Cost (*using information available in CON*)

	2017	2018	2019
Gross Revenue of Additional Emergency Dept. Treatment Rooms	$28,146,000	$31,903,000	$34,785,000
Medicaid Utilization	20.28%	20.28%	20.28%
Gross Medicaid Revenue (i.e. Total Medicaid Charges)	5,708,009	6,469,928	7,054,398
Medicaid Payment Rate *	28.38%	28.38%	28.38%
Increased Cost to Medicaid Program	$1,619,933	$1,836,166	$2,002,038

*Payment rates for FY2017-2019 are estimated based on current Medicaid rate.

Please note, all calculations in this memorandum are estimates only and are based on the assumptions set forth in the CON application. The Department is not bound by these estimates or assumptions. Also, please note 7 AAC 07.070(i):

> ***Approval of a certificate of need does not imply any guarantee of federal, state, or private money, including Medicaid payments or grant awards, and does not imply any guarantee of profitability.***

Should you have any questions please contact Christine Goetz at 334-2476.

THE STATE of ALASKA
GOVERNOR BILL WALKER

Department of Health and Social Services

OFFICE OF RATE REVIEW

3601 C Street, Suite 978
Anchorage, Alaska 99503
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MEMORANDUM

To: Alexandria Hicks
CON Coordinator

From: Christine Goetz, Audit Supervisor
Office of Rate Review

Date: May 22, 2015

Subject: Certificate of Need (CON) Review for Alaska Regional Hospital

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Alaska Regional Hospital is proposing to establish two Freestanding Emergency Departments (FSED), one in Eagle River and one in South Anchorage. Each facility will be built with eight (8) treatment rooms, though the facility in Eagle River will initially only operationalize five (5) of the rooms and South Anchorage will operationalize six (6). Each FSED will included a lab, general radiology, ultrasound and CT scanning and will have the ability to hold patients in observation status until decisions can be made regarding the appropriate course of actions (i.e.: transfer to another facility). Additionally, both FSEDs will include the diagnostic equipment, infrastructure, staffing and other resources to care for about two-thirds of all emergency room type visits. The FSEDs will operate with the same policies, procedures, oversight and governance as does Alaska Regional's main hospital ED. They will operate 24 hours per day, 7 days per week and will be staffed by experienced and trained Board Certified emergency physicians and nurses.

The main drivers for the project are to meet the growing population and geographic needs for emergency services in the Anchorage Municipality.

The total project is estimated to cost $25,394,478 – the Eagle River component portion $12,555,925 and the South Anchorage component portion $12,838,553 and will be funded from existing HCA reserves.

The information below estimates the added cost to Medicaid over the next four years following the operational date of the project for the Medicaid rate reimbursement to the facility associated with the increase in outpatient services from the project.

Estimated Medicaid Cost (*using information available in the CON*)

Note: FSED's do not currently exist in the State of Alaska, the estimated Medicaid costs were calculated assuming the current outpatient rate methodology.

Eagle River Freestanding Emergency Department

	2016	2017	2018	2019
Outpatient Revenues	$ 12,210,322	$ 16,280,429	$ 20,220,293	$ 25,113,604
Medicaid Utilization	14.01%	14.01%	14.01%	14.01%
Medicaid Revenues	$ 1,710,666	$ 2,280,888	$ 2,832,863	$ 3,515,905
Medicaid Payment Rate*	24.03%	24.03%	24.03%	24.03%
Increased Cost to Medicaid	**$ 411,073**	**$ 548,097**	**$ 680,737**	**$ 844,872**

South Anchorage Freestanding Emergency Department

	2016	2017	2018	2019
Outpatient Revenues	$ 11,845,631	$ 15,794,174	$ 19,616,364	$ 24,363,524
Medicaid Utilization	14.63%	14.64%	14.63%	14.63%
Medicaid Revenues	$ 1,733,016	$ 2,312,267	$ 2,869,874	$ 3,564,384
Medicaid Payment Rate*	24.03%	24.03%	24.03%	24.03%
Increased Cost to Medicaid	**$ 416,444**	**$ 555,638**	**$ 689,631**	**$ 856,521**

*Payment rates for FY2016-2019 are estimated based on current Medicaid rate.

Please note, all calculations in this memorandum are estimates only and are based on the assumptions set forth in the CON application. The Department is not bound by these estimates or assumptions. Also, please note 7 AAC 07.070(i):

> ***Approval of a certificate of need does not imply any guarantee of federal, state, or private money, including Medicaid payments or grant awards, and does not imply any guarantee of profitably.***

If you have any questions please contact Christine Goetz at 334-2476 or me at 334-2447.

APPENDIX B

I. General Review Standards Applicable to all Certificate of Need Applications

Review Standards

The department will apply the following general review standards, the applicable service-specific review standards set out in this document, the standards set out in AS 18.07.043, and the requirements of 7 AAC 07 in its evaluation of each certificate of need application:

1. The applicant documents need for the project by the population served, or to be served, including, but not limited to, the needs of rural populations in areas having distinct or unique geographic, socioeconomic, cultural, transportation, and other barriers to care.

2. The applicant demonstrates that the project, including the applicant's long-range development plans, augments and integrates with relevant community, regional, state, and federal health planning, and incorporates or reflects evidence-based planning and service delivery. A demonstration under this standard should show that the applicant has checked with the department regarding any relevant state plan, with appropriate federal agencies for relevant federal plans, and with appropriate communities regarding community or regional plans.

3. The applicant demonstrates evidence of stakeholder participation in planning for the project and in the design and execution of services.

4. The applicant demonstrates that PAMC has assessed alternative methods of providing the proposed services and demonstrates that the proposed services are the most suitable approach.

5. The applicant briefly describes the anticipated impact on existing health care systems within the project's service area that serve the target population in the service area, and the anticipated impact on the statewide health care system.

6. The applicant demonstrates that the project's location is accessible to patients and clients, their immediate and extended families and community members, and to ancillary services. This includes the relocation of existing services or facilities.

Additional Considerations for Concurrent Review of More than one Application

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;

2. Demonstrates a pattern of licensure and accreditation surveys with few deficiencies and a consistent history of few verified complaints; and

3. Demonstrates that the applicant has consistently provided, or has a policy to provide, high levels of care to low-income and uninsured persons.

APPENDIX C

B. Hospital Emergency Department Services Review Standards

After determining whether an applicant has met the general review standards in Section I of this document, the department will apply the following service-specific review standards, as applicable, in its evaluation of an application for a certificate of need that involves the expansion of an emergency department:

1. The applicant demonstrates that the project promotes, or otherwise helps ensure, the maintenance of a stable and efficient emergency medical system.

2. For the addition or expansion of general emergency services, a proposal will not be approved unless each emergency department treatment room will provide a minimum of 1,500 visits annually. The total number of emergency department treatment rooms (excluding specialized rooms such as cast/x-ray rooms, observation rooms, secure rooms and space for visiting physician clinics) approved will not exceed one room per 1,500 visits annually, based on utilization projections in the fifth year of operation. The department may approve additional space if the applicant documents use patterns, and submits data and analysis that show seasonal high peak use rates warranting additional treatment rooms.

3. For the addition or expansion of fast track emergency services within a facility, a proposal will not be approved unless the applicant demonstrates that:

    a. the fast track space will have at least one physician, advanced nurse practitioner, or physicians' assistant assigned full-time to the service; and

    b. a minimum of two fast track rooms are needed, each anticipated to accommodate at least 1,500 visits per room per year by the fifth year of operation; and

    c. remaining general emergency service rooms will continue to handle a minimum of 1500 visits annually.

4. For a proposal for additional space in the hospital emergency department, the applicant must perform a size-by-functional-need survey and analysis for additional space that demonstrates efficient use of the space.

Review Methodology

The department will use the following formula to determine the need for emergency department treatment room services:

$$\mathbf{EDTR = C_5/1500}$$
$$\mathbf{C_5 = P_5 \times SAS \times UR}$$

EDTR = emergency department treatment rooms needed
C_5 = 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
P_5 = 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.