AK LEGISLATURE FINANCE COMMITTEES FILES 2007-2008 3314

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ES HSS A

Potential Savings: No estimate made by PHPG. Saving would be dependent upon the amount of general funds currently being spent that could be refinanced with Federal Medicaid dollars. If waivers were approved, some portion of the current general fund expenditure of $2.6 million could be anticipated to be saved.

Substance Abuse/Mental Health Waiver .
Medicaid services are generally not provided to adults between the ages of 22 and 64. However, this is the segment of the population which has significant incidence of substance abuse and mental health issues. It has long been recognized that substance abuse costs Alaska hundreds of millions of dollars in lost work, increased health care, education and criminal justice costs. One option available to the state is to address this issue is to expand its Medicaid program to provide Medicaid services to a targeted group of adults needing behavioral health services. This could be done through a Medicaid waiver. However, before this were proposed additional work is necessary to define the population and services and to determine if any cost benefit would result.

This work would also relate to the Bring the Kids Home Initiative. Even though a child is Medicaid eligible and receiving behavioral health services it may be that his or her parents are not Medicaid eligible. Situations arise in which the child successfully completes treatment but then returns to a family situation which has not improved and which may have been a contributing factor to the child's behavioral problems. It makes sense to treat both the child and the parents to assure that negative behavior patterns will not repeat. Parents of children receiving mental health services through Medicaid would be one of the target groups evaluated in the waiver analysis.

How: Work to be done by a contractor familiar with Medicaid waiver law and policy. Work to be completed in SFY 08/09.

Resources needed: $35.0 Total Funds ($17.5 GF, $17.5 Federal).

Potential Savings: No estimate made by PHPG. Potential savings are not limited to Medicaid, but could occur in other programs whose expenditures would be decreased through lower instances of substance abuse.

The following projects will be started in SFY 08. They are, however, projects with long time horizons. The implementation plans resulting for these activities will be ongoing for several years.

Increase Federal Funds. A separate document (attached) describes the strategy for addressing the issues raised by the PHPG report with regard to Medicaid and rural health programs.

ES HSS A

Long Term Care Planning;
The PHPG notes the huge potential increase to Alaska Medicaid that may occur over the next ten years as a result of the aging of the population. The report urges the State to address this issue and to continue building the long term care systems that will be needed to address this demographic shift. In the absence of a plan, Alaska could simply be overwhelmed by the future need for services.

Alaska has a variety of long term care services in place, however, the current array and quantity of services will be inadequate to meet future growth. Alaska needs to develop a long term care plan which provides a detailed strategy for addressing the future needs in the most cost effective way.

How: Work to be done by a contractor familiar with long term care planning. Work to be completed by the end of SFY 09.

Resources needed: $300.0 Total Funds. ($100.0 GF, $150.0 Federal). DHSS has $50.0 GF for current planning that can be used on this project.

Potential Savings: No estimate made by PHPG. However, the report notes that if the current long term care system were to try to accommodate the state's projected increase in long term care recipients, Medicaid expenditures for LTC services would increase from $273 million in 2005 to $877 million in 2015. The report suggests that a significant portion of this increase can be mitigated through development of more cost effective services.

Other Resources Needed:
A project this complicated requires significant coordination from the department to manage all grants and contracts and coordinate with partners and the federal government. In recognition of that effort, DHSS is request funds for one coordinator position.

How: Internal position in DHSS and all support costs and travel.
Resources needed: $136.0 Total Funds ($68.0 GF, $68.0 Federal).

ES HSS A

DRAFT 3-23

RURAL PROVIDERS RESPONSE TO MEDICAID REPORT
(Dollars in thousands)

The PHPG report identifies approximately $220 million that is currently paid by Medicaid to providers on behalf of American Indians and Alaska Natives. If these services were to be provided by appropriate providers, the services would be paid with all federal funds, thereby saving the current general fund portion of the payment.

Capturing these federal dollars will require the participation of Alaska Medicaid, the Alaska Native Tribal Health Consortium and other health providers, especially the Yukon Kuskokwim Health Corporation (the largest rural health provider) and will be an ongoing process for several years. There are significant issues to address if the capture of these federal funds is to be successful. These can generally be categorized as (1) strategic planning, (2) specific service planning and service definition, (3) reimbursement methodology.

Managed Care Assessment. The PHPG report suggested that, eventually, managed care may be a way for the state and the rural providers to maximize Federal Financial Participation (FFP). However, there are significant challenges to achieving full managed care. Any managed care arrangement would have to conform to both Federal Medicaid and Indian Health Service law and regulation. Additionally, history has shown that traditional managed care plans have the potential to put participating organizations at both financial and legal risk. Further study is necessary to broadly define the parameters for a managed care arrangement and to identify the significant legal and financial considerations. This study to be undertaken by ANTHC should be done in conjunction with State Medicaid.

Estimated Cost: ANTHC: $50.0 Total Funds ($25.0 GF/ $25.0 Federal

Specific Service Planning and Service Definitions. Generally, patients go to other providers simply because the service is not provided by a rural health provider. There are a variety of barriers that may preclude the tribal health program from offering a particular service, including, reimbursement, nature of the service, legal requirements and staffing. Some of these barriers can be addressed in the short term while other will take longer to resolve.

ES HSS A

Further study is needed to identify services the health programs could provide, identify the barriers to providing the service and develop work plans to eliminate these barriers. Implied in this process is a prioritization which first identifies and addresses those services which will have the largest impact in the short term (within one year) on the Medicaid budget. This will be the first phase of this effort.

A few rural health providers have been working on a similar process over the past few years and these efforts should continue. Therefore, the effort described above should have a dual focus. A rural, regional provider should be identified and, as part of this process, expand its current efforts while the Alaska Native Tribal Health Consortium should undertake this planning with the balance of the tribal health program in the State. The rural, regional provider should be selected based on their Medicaid eligible population and the progress they have already made in their planning. The experience of the regional provider will be shared with the other providers by ANTHC, thus accelerating the progress of the other tribal providers. Both the regional provider and ANTHC will work with State Medicaid throughout the process.

As noted, it is anticipated that some barriers identified above can be addressed in the short term but that others will take a longer time to resolve. Therefore, there needs to be a second phase to this project that identifies longer term barriers that need to be addressed.

For example, some Medicaid services as defined by Federal law are simply not workable in rural Alaska. However, it may be that changing the service definition or combining the service with another similar service would make them more relevant. It may be that the State will have to seek waivers from Federal Medicaid to do this. Services such as long term care and behavioral health will likely need this level of attention. Other longer term "fixes" may require staff training or capital construction such as the building of nursing homes or other long term care facilities.

The long term planning will be undertaken by both ANTHC and the regional provider with the cooperation and involvement of State Medicaid.

Estimated Cost: ANTHC $700.0 Total funds ($350.0 GF/ $350.0 Federal
Regional Provider: $214.0 Total funds ($107.0 GF/ $107.0 Federal)

Reimbursement methodology. In many cases existing reimbursement methodologies do not work for rural health programs because the health care delivery system is so different. However, it may be possible to develop more relevant reimbursement systems. Before this can be done, however, the State and the rural providers must first undergo a process of determining the true cost of care for the services provided. This cost determination is necessary before Federal Medicaid will approve alternate reimbursement methodologies and it is also necessary to ensure that the tribal health programs are earning sufficient revenue to pay for and sustain services.

ES HSS A

As with most planning, the larger regional providers are further ahead on cost analysis than are other, smaller providers. Therefore, the cost identification effort will include a component to enhance the effort of a large rural, regional provider that has made significant progress in cost analysis. This provider will then be able to share its experience and knowledge with others. ANTHC will assist the other providers in undertaking their cost analysis.

The State's will use the cost information that is determined by the providers, and in conjunction with these providers, determine an alternate way to reimburse them for various services. The State will also prepare any required documentation and submittals for Federal Medicaid and work to secure Federal approvals of the alternate reimbursement.

ANTHC will also establish a statewide effort to provide technical assistance to all rural health providers in billing for Medicaid services. Most of the rural health providers are relatively inexperienced in billing for services, particularly Medicaid. However, these providers will have to become proficient billers if they are to pay for and sustain new services that they undertake.

Estimated Costs: ANTHC: $250.0 Total Funds ($125.0 GF/ $125.0 Fed.)
Regional Provider: $138.0 Total Funds ($69.0 GF/ $69.0 Fed)
State: $372.0 Total Funds ($186.0 GF / $186.0 Fed.)

Preliminary Work Plan
Medicaid Review Report

Project #	Projects in Medicaid Report	Who/How	Fiscal Year	Total Cost	Comment
1	Tiered Phamacy Pricing	DHSS-Internal	FY07/08/09	0.0	No new resources needed
2	Pharmacy Prior Authorization	DHSS-Internal	FY07/08/09	0.0	No new resources needed
3	Level of Care contols in Personal Care Assistant program	DHSS-Internal	FY07/08/09	0.0	No new resources needed
4	Alternate Reimbursement Methodogy for DD services	DHSS-Internal	FY07/08/09	0.0	No new resources needed
5	Implement Disease Management Program	DHSS-Internal	FY07/08	80.0	
6	Personal Care Assistant Waivers	DHSS-Internal	FY07/08/09	0.0	No new resources needed
7	Federal Financial Participaton in Pioneer Homes	DHSS-Contractor	FY07/08	50.0	
8	Address Wait List for DD Services	DHSS-Contractor	FY07/08	20.0	
9	Federal Funds Participaton for CAMA	DHSS-Contractor	FY07/08	20.0	
10	Substance Abuse/Mental Health Waiver	DHSS-Contractor	FY07/08	35.0	
11	Long Term Care Planning	DHSS-Contractor	FY07/08	250.0	$50.0 GF already exists in DHSS
12	Other Resources	DHSS-Internal	FY07/08	136.0	State coordination of project
13	Increase Rural Providers Federal Funds participation				Estimates of costs provided by rural providers
	13-a Managed Care	Grant to ANTHC	FY07/08	50.0	
	13-b Specific Service Plan/Definitions	Grant to ANTHC	FY07/08	700.0	
		Additional Grant	FY07/08	214.0	Grant to Regional Provider
	13-c Reimbursement methodology	Grant to ANTHC	FY07/08/09	250.0	
		Additional Grant	FY07/08/09	138.0	Grant to Regional Provider
		DHSS-Internal State	FY07/08/09	372.0	
	TOTAL COSTS			2,315.0	Costs to DHSS can be funded at 50% federal thru medicaid
	State General Fund costs			1,132.5	

E5 #55 A

STATE OF ALASKA

SARAH PALIN, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

P.O. Box 110650
Juneau, AK 99811-0650
Phone: (907) 465-3082
Fax: (907) 465-2499

OFFICE OF THE COMMISSIONER
FINANCE AND MANAGEMENT SERVICES

April 11, 2007

The Honorable Lyman Hoffman, Co-Chair
The Honorable Bert Stedman, Co-Chair
The Honorable Charlie Huggins, Vice-Chair
Senate Finance Committee
State Capitol, Room 518, 516 and 119
Juneau, AK 99801-1182

Dear Senators Hoffman, Stedman and Huggins:

The Department is requesting $6.5 million in SB 83 and HB 139 for Fairbanks Virology Laboratory Completion. It has come to the Department's attention that this project not be considered in the Supplemental Bill. We would like to let you know the extent of the consequences this would have on the project.

Currently, Department of Transportation and Public Facilities (DOT/PF) is expecting the funding to be in place by April 30th so that they can issue the Notice to Proceed to the contractor on May 2. The contractor, GHEMM Company, Inc. is expecting to be on site on May 5 to start clearing the site and begin excavation work. Every day the project is delayed will cost the State approximately $10,000 (see attached – Delay Impact Analysis). If the contract is delayed until the 15th of May, the State can expect to pay an additional $150,000 ($10,000 x 15). DOT/PF cannot legally issue a contract until all the funding for the project is in place.

In order for the Department to keep within the existing budget, the contractor must break ground now. It is imperative that the building be completely closed in by September so that the contractor can work through the winter.

If you have additional questions regarding this issue, please contact me at 465-1630.

Sincerely,

Janet Clarke

Janet Clarke
Assistant Commissioner

cc: Senator Kim Elton. Capitol Building, Room 506
Senator Donny Ol n, Capitol Building, Room 514
Senator Joe Thomas, Capitol Building, Room 510
Senator Fred Dyson, Capitol Building, Room 121
Karleen Jackson, Commissioner
Anthony Lombardo, Deputy Commissioner
Bill Hogan, Deputy Commissioner
Sherry Hill, Special Assistant
Laura Baker, Budget Chief, Finance and Management Services
Karen Rehfield, Director, Office of Management and Budget
Mary Sutton, Budget Analyst, Office of Management and Budget
Gary Zepp, Fiscal Analyst, Legislative Finance
Deven Mitchell, Debt Manager, Department of Revenue

VIROLOGY LABORATORY
PROJECT 58900

DELAY IMPACT ANALYSIS

ITEM	ESTIMATE	COMMENTS
APPROPRIATION DELAYED TO MAY 15, 2007		
15 day delay	**$150,000**	$10,000 per calendar day, pushes work more into winter, more OT
APPROPRIATION DELAYED 1 YEAR TO MAY 15, 2008		
Escalation	$1,800,000	Only if funding appropriated no later than May 15, 2009
Contractor Delay Impact	$500,000	Redirection of labor, bonding costs, etc.
Redesign, Rebidding	$250,000	
Preconstruction Services	$100,000	
Total	**$2,650,000**	

file: Constr Delay Analysis.xls

SB

62

SFIN

FILE

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: SB 62
(S) Publish Date: 3/14/07

Revision Date/Time (Note if correction):
Dept. Affected: Health & Social Services

Title: TASK FORCE ON HEALTH CARE INFECTIONS
RDU: Public Health
Component: Epidemiology

Sponsor: STEVENS
Requester: SENATE (HES)
Component No. 296

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Personal Services	140.8	176.3	176.3	176.3	176.3	176.3
Travel	20.0	20.0	20.0	20.0	20.0	20.0
Contractual	10.0	10.0	10.0	10.0	10.0	10.0
Supplies	15.0	5.0	5.0	5.0	5.0	5.0
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	185.8	211.3	211.3	211.3	211.3	211.3
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)

Fund Source	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
1002 Federal Receipts						
1003 GF Match						
1004 GF	185.8	211.3	211.3	211.3	211.3	211.3
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
TOTAL	185.8	211.3	211.3	211.3	211.3	211.3

Estimate of any current year (FY2007) cost:
Mark this box (X) if funding for this bill is included in the Governor's FY 2008 budget proposal:

POSITIONS

Positions	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Full-time	1	1	1	1	1	1
Part-time	1	2	2	2	2	2
Temporary						

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

SB 62 establishes the Advisory Committee on Public Reporting of Health Care Associated Infections to develop specific recommendations for the type of data to be collected, the mechanisms for data collection, and the optimal system for synthesizing and disseminating data in a manner useful to all Alaska healthcare consumers. Since 2002, 15 states have enacted legislation that requires hospitals to report hospital acquired infections to state health officials or other state agencies. Advocates of mandatory reporting, including the Consumers Union, believe that making such information publicly available will enable patients to make more informed choices about their healthcare and will improve overall healthcare quality.

Prepared by: Jay Butler, M.D. Phone 465-3090
Division: Public Health Date/Time 02/08/2007
Approved by: Karleen Jackson, Commissioner Date 02/13/2007
Agency: Department of Health and Social Services

(Revised 9/7/2005 OMB)

COMMITTEE COPY

FISCAL NOTE
FN # 1

STATE OF ALASKA
2007 LEGISLATIVE SESSION

BILL NO # SB 62

ANALYSIS CONTINUATION

ANALYSIS (Continued)

The bill requires the Advisory Committee to disband by June 30, 2012. However, 1.5 FTEs will be needed to develop the initial program beginning in FY08. In FY09, a Microcomputer/Network Specialist II (Range 20, 0.5 FTE) will be added. (Continued on Page 2)

Details of FY08 costs:

PERSONAL SERVICES for staff to administer and run the program ($140.8): Public Health Specialist II (Range 20D, 1.0 FTE), Administrative Clerk III (Range 10, .5 FTE).

TRAVEL ($20.0): Quarterly 1-day meetings; 1 in Juneau, 3 in Anchorage.

CONTRACTUAL ($10.0): Printing of committee reports.

SUPPLIES ($15.0): Initial setup for two positions - office furniture, computers, printer and general office supplies. After FY08, supply costs would be approximately $5.0 annually.

SESSION ADDRESS
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Fax: (907) 465-3517
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Senator Gary Stevens
Alaska State Legislature

INTERIM ADDRESS:
112 Mill Bay Road
Kodiak, Alaska 99615
(907) 486-4925
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Sponsor Statement for SB 62

"An Act establishing the Advisory Committee on Public Reporting of Health Care Associated Infections"

SB 62 is legislation recommended by the Task Force to Assess Public Reporting of Health Care Associated Infections, which met during the 2006 Legislative Interim to study the unique challenges facing Alaska with regard to tracking and reporting health care acquired infections. This bill creates the Advisory Committee on Public Reporting of Health Care Associated Infections under the Department of Health and Social Services.

The Advisory Committee will consist of one member of the Senate, appointed by the Senate President, one member of the House of Representatives, appointed by the Speaker of the House, the state official in charge of epidemiology, and nine members appointed by the Governor as follows:

1. two physicians with significant experience in the area of infectious diseases;
2. a representative of the Alaska Native Tribal Health Consortium;
3. a representative of the Alaska Chapter of the Association of Professionals in Infection Control and Epidemiology;
4. a representative of the Alaska State Hospital and Nursing Home Association;
5. a health care consumer from urban Alaska;
6. a health care consumer from rural Alaska;
7. and a statistician.

In the coming years, the Advisory Committee's role will be to develop recommendations for collecting, analyzing and distributing information related to health care associated infections. By January, 2009, the Advisory Committee will provide recommendations to the Department for establishing a pilot program for public reporting of health care associated infections. By January, 2011, the Advisory Committee will provide to the Legislature a report addressing the unique challenges in the state, as well as recommendations for ongoing reporting.

Some 2 million infections a year are acquired in hospitals and an estimated 90,000 people die as a result of these infections, making it the sixth-leading cause of death in the country. The cost to the consumers is between $4.5 and $11 billion a year. Given these

Senate District R
Senator_Gary_Stevens@legis.state.ak.us

alarming statistics, it is vital for consumers to have full knowledge of how medical facilities fare with infection rates. Passage of SB 62 can help accomplish this goal by providing lawmakers, state health officials and medical professions the opportunity to craft workable legislative recommendations for the collection of data on hospital-acquired infection rates.

I urge your support of this important legislation.

// LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

<u>MEMORANDUM</u> January 23, 2007

SUBJECT: SB 62; Sectional Summary (Work Order No. 25-LS0332\C)

TO: Senator Gary Stevens
Attn: Doug Letch

FROM: Alpheus Bullard
Legislative Counsel

You have requested a sectional summary of the above referenced bill draft. As a preliminary matter, please note that a sectional summary should not be considered an authoritative interpretation of the bill, and the bill itself is the best statement of its contents.

<u>Section 1.</u> Authorizes the Department of Health and Social Services to collect, analyze, and maintain databases of information related to health care associated infections.

<u>Section 2.</u> Requires health care facilities to report health care associated infections to the department. Requires the department to disseminate health information obtained under this section to the public. Requires the department to consider the recommendations of the Advisory Committee on Public Reporting of Health Care Associated Infections. This section takes effect in 2009 after the committee established in sec. 3 issues recommendations to the department.

<u>Section 3.</u> Establishes the Advisory Committee on Public Reporting of Health Care Associated Infections in the Department of Health and Social Services. Sets out the composition and duties of the committee.

<u>Section 4.</u> Requires the governor to consider appointing persons to the new committee who served on the previously established Task Force to Assess Public Reporting of Health Care Associated Infections.

<u>Section 5.</u> Requires the committee to provide certain reports in 2009 to the department and in 2011 to the legislature.

<u>Section 6.</u> Repeals all sections having to do with the committee in June of 2012.

<u>Section 7.</u> Provides that sections 1 and 2 of the Act take effect January 1, 2009.

Section 8. Provides that sections 3, 4, and 5 of the Act take effect immediately.

TLAB:med
07-038.med

SB 62

APR 02 2007

April 2, 2007

The Honorable Lyman Hoffman, Co-Chair
Senate Finance Committee
Alaska State Capitol, Room 518
Juneau, AK 99801-1182

The Honorable Bert Stedman, Co-Chair
Senate Finance Committee
Alaska State Capitol, Room 516
Juneau, AK 99801-1182

RE: SB 62 (Stevens)--Support

Dear Co-Chairs Hoffman and Stedman:

On behalf of the members of AARP in Alaska, we encourage you and your colleagues on the Senate Finance Committee to support SB 62, authored by Senator Gary Stevens.

Nosocomial infections are infections that are acquired in a hospital. Depending on the facility, 6 to 17 % of hospitalized patients will acquire a new infection after hospitalization. Older patients are particularly at risk for contracting these infections due to the declines in their physiologic reserves and declining immunity, and because they commonly have longer hospital stays and multiple treatments.

SB 62, authored by Senate Majority Leader Gary Stevens, will create a task force to assess public reporting of health care associated infections. Consumers should have access to information about infection rates in health care facilities. The goal of SB 62 is not just to be able to provide helpful consumer information but to reduce infections. Some of these infections are systemic problems and, if known, our health professionals can address them and find ways to prevent them.

Reporting of and eventual reduction of medical infections is in the best interest of all Alaskans. SB 62 is good public health and good common sense.

3601 C Street, Suite 1420 | Anchorage, AK 99503 | toll-free 866-227-7447 | 907-341-2270 fax | toll-free 877-434-7598 TTY
Marie F. Smith, President | William D. Novelli, Chief Executive Officer | www.aarp.org/ak

AARP recommends an "AYE" vote on SB 62.

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,

Marie Darlin

Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Vice-Chair Charlie Huggins
Senator Kim Elton
Senator Donald Olson
Senator Joe Thomas
Senator Fred Dyson
Majority Leader Gary Stevens

April 2, 2007

Senators Bert Stedman and Lyman Hoffman, Co-Chairs
Senate Finance Committee
And Senate Finance Committee Members

Re: SB 62

Dear Senators,

SB 62, under normal circumstances would not have come under my radar, so to speak, however, a recent event highlighted to me how important it is for the State of Alaska to join others in the reporting of serious infections.

During the past week I've hosted a young lady from out of town, because her father developed a serious staph infection that landed him in the local hospital. They were both visiting homer from elsewhere in the state. And, it was a health care associated infection.

Because of the information I have since received, it is very clear to me, that it would be very helpful, especially to our medical community, to know where these infections occur and if there is a pattern to them. At this time, such reporting does not occur, and that is clearly to the detriment of the public, which the medical community serves.

Therefore, I urge your support of SB 62.

Thank you,

Sincerely,

Milli Martin
P/O. Box 2652
Homer, AK 99603
907-235-6652

March 5, 2007

The Honorable Bettye Davis, Chair
Senate Health, Education and Social Services Committee
Alaska State Capitol, Room 30
Juneau, AK 99801-1182

RE: SB 62 (Stevens)--Support

Dear Chair Davis:

On behalf of the members of AARP in Alaska, we encourage you and your colleagues on the Senate Health, Education and Social Services Committee to support SB 62, authored by Senator Gary Stevens.

Nosocomial infections are infections that are acquired in a hospital. Depending on the facility, 6 to 17 % of hospitalized patients will acquire a new infection after hospitalization. Older patients are particularly at risk for contracting these infections due to the declines in their physiologic reserves and declining immunity, and because they commonly have longer hospital stays and multiple treatments.

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Reporting of and eventual reduction of medical infections is in the best interest of all Alaskans. SB 62 is good public health and good common sense.

AARP recommends an "AYE" vote on SB 62.

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Marie F. Smith, President | William D. Novelli, Chief Executive Officer | www.aarp.org/ak

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,

Marie Darlin

Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Senator Joe Thomas
Senator John Cowdery
Senator Kim Elton
Senator Fred Dyson
Majority Leader Gary Stevens

Last update 2/20/07

2007 Legislative Session
Hospital-acquired infection public reporting bills
Click on bill numbers to access bill text

Georgia - HB 61; SB 78; SB 150
Bill Status: HB 61 in House Committee on Health and Human Services; SB 78 and SB 150 in Senate Health and Human Services
Bill Sponsor(s): HB 61: Rep. Powell; SB 78: Sen. Hamrick and Hill (Judson); SB 150: Sen. Hill (Judson)
Other Information: HB 61 is based on the Consumers Union model act and is the best bill so far.

Hawaii – HB 1438; SB 1239
Bill Status: HB 1438: Introduced on 1/22; SB 1239: Introduced on 1/24.
Bill Sponsor(s): HB 1438: Rep. Belatti; SB 1239: Sen. Fukunaga.
Other Information: Both bills require public reporting of hospital infection rates.

Indiana – HB 1592; SB 513; SB 531
Bill Status: HB 1592: Introduced and referred to House Committee on Public Health on 1/12; SB 513: Introduced and referred to Senate Committee on Health and Provider Services on 1/23; SB 531: Introduced and referred to Senate Committee o Health and Human Services 1/23.
Bill Sponsor(s): HB 1592: Sen. Dvorak; SB 513: Sen. Alting; SB 531: Sen. Dillon
Other Information: HB1592 and SB513 require public reporting of hospital infection rates. SB 531 allows for a committee and agency to determine what infection information should be reported.

Kansas – HB 2342, HB 2271
Bill Status: HB 2342 and HB 2271: Introduced 1/29; referred to House Committee on Health and Human Services 2/2.
Bill Sponsor(s): Both bills sponsored by the House Committee on Health and Human Services

Minnesota – SF 755, HF 1076
Bill Status: SF 755: introduced 2/12; sent to committee on Health Housing and Family Security; HF 1076 introduced and referred to House Health and Human Services (2/19)
Bill Sponsor(s): SF 755: Sen. Berglin; HF 1076: Kahn; Huntley; Ruud; Fritz; Abeler; Murphy, E.

New Mexico – HB 165; HB 944
Bill Status: HB 165: Introduced 1/17; assigned to House Committee on Judiciary; then House Committee on Health and Governmental Affairs; HB 944: Introduced 2/6 and referred to House Health and Governmental Affairs..
Bill Sponsor(s): HB 165: Rep. Anderson; HB 944: Rep. Rodella

Oregon – HB 2524
Bill Status: Introduced 1/30; referred to Health Care Committee 2/6; assigned to subcommittee on Health Policy 2/8; public hearing held 2/15.
Bill Sponsor(s): Rep. Tomei, Greenlick, Barker, Barnhart, Boone, Buckley, Cannon, Clem, Cowan, Dingfelder, Galizio, Gelser, Gilliam, Holvey, Lim Nelson, Riley, Rosenbaum, Shields, Witt

Texas – HB 1398; HB 678; SB 288
Bill Status: HB 1398 introduced 2/13, referred to the House Public Health Committee 2/19, HB 678 introdu ed 1/22, referred to House Public Health Committee (2/6); SB 288: introduced 1/24.
Bill Sponsor(s): HB 1398: Rep. Delisi; HB 678 Rep. Davis; SB 288: Sen. Nelson
Other Information: HB 1398 reflects recommendation of a state advisory committee on hospital infections.

Washington – HB 1106
Bill Status: Substitute passed by Health Care and Wellness Cmte (11-2) on 2/8; referred to Appropriations Committee 2/12, scheduled for public hearing in the House Committee on Appropriations at 3:30 PM (Subject to change) on 2/22.

Bill Sponsor(s): Rep. Campbell

West Virginia – HB 2234; SB 85
Bill Status: HB 2234 in House Cmte on Health and Human Resources 1/16; SB 85 in Senate Cmte on Health and Human Resources 1/15.
Bill Sponsor(s): HB 2234: Rep. Hamilton; Hrutkay, Hatfield; SB 85: Sen. Hunter and Foster.

Hospital-acquired infections take toll on bottom lines

Posted 11/21/2006 12:18 AM ET
By Julie Appleby, USA TODAY

Reducing the number of infections patients contract while in hospitals would not only benefit patients but also hospitals' profits.

Researchers say the finding in a study out Monday counters an assumption that hospitals make money on patients who fall ill with a hospital-acquired infection because they often receive higher payments from insurers for dealing with complicated cases. But the higher payments do not cover the additional costs.

"This adds economic strength to the notion that we ought to be doing away with infections," says Richard Shannon, co-author of the study and vice chair of clinical affairs in the department of medicine at the University of Pennsylvania.

"Not only is it the right thing to do from the patient perspective," he says, "but infections are in fact costing payers and hospitals lots of money."

His study showed an average $26,830 loss to the hospital for each patient who came down with one type of infection called a central-line-associated bloodstream infection. A central line is a catheter placed into a vein to provide fluids or medication. Of 54 patients who got that type of infection during a three-year period at the one hospital studied, only four resulted in a break-even or profit for the hospital.

That's because the costs of caring for a patient who gets an infection usually far exceed the amount the facility is paid by insurers, says the study, one of three studies on the effects of hospital-acquired infections published in the *American Journal of Medical Quality*.

The journal articles come as hospitals nationwide are being asked to provide more information on cost and quality, but many have balked at providing information on hospital-acquired infections. Debate is ongoing about what types of infections should be reported and how to tell whether patients got the infections while in the hospital, came to the facility with them or developed them after being discharged.

Hospital-acquired infections are estimated to affect about 2 million patients annually and cause an estimated 100,000 deaths, according to one of the studies.

About 16 states have laws covering a variety of infection-reporting requirements for hospitals, but only Pennsylvania has issued a public report that gives infection rates at individual hospitals. Last week, Pennsylvania reported that more than 19,000 patients got an infection while in a hospital last year, raising costs.

The two other reports in the same issue of the journal take issue with another assumption about hospital infections: that patients who get them may have higher risks that cause them to come down with infections.

"Hospital-acquired infection is not an anticipated byproduct of taking care of the very ill," says David Nash, editor of the journal and chairman of the Department of Health Policy at Jefferson Medical College in Philadelphia. "It's a failure in the process of how medical care is delivered."

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State eyes hospital infection reports

By Jessica Fargen
Boston Herald Health & Medical Reporter
Wednesday, February 21, 2007 - Updated: 04:01 AM EST

Jessica Fargen
Boston Herald Health & Medical Reporter
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Patients may soon be able to shop for the safest hospitals thanks to a new $1 million public health plan that will make rates of deadly infections at Bay State medical centers readily available to the public for the first time.

The Department of Public Health team, which has enlisted 50 experts and surveyed 73 hospitals so far, expects to make recommendations ir ne on how to reduce life-threatening in-hospital infections and put in a place a plan to make the rates public, officials said yesterday.

Hospital-acquired infections kill 90,000 Americans each year, including about 2,000 Bay Staters, and some experts say those deaths are largely preventable. Patients contract the infections at the hospital in many ways, including surgery, bacteria-ridden catheter tubesand unwashed hands.

Paul Levy, president of Beth Israel Deaconess Medical Center, created a big stir recently when he posted the hospital's infection rates on his blog and encouraged other hospitals to follow suit without a complicated state mandate.

"Wouldn't it be easier to try it out voluntarily - see how it goes?" he told the Herald. "My point is these numbers are available in real time. We all keep track of it. All the state has to do is set up a Web site and let us enter our data."

Sen. Richard T. Moore, (D-Uxbridge), chairman of the Legislature's Health Care Financing Committee, has filed a bill that would add Massachusetts to the list of 16 states that have passed mandatory reporting of hospital infections.

But public health officials are taking a more measured approach, hiring experts, doing research and surveying hospitals.

"Just the nature of the patients, the case mix of patients means that there is not a one-size-fits-all solution to the problem," said Nancy Ridley, director of the Betsy Lehman Center, which is leading the project with the DPH.

Massachusetts General Hospital spokeswoman Valerie Wencis echoed that concern, saying the hospital won't post its rates until it's mandated.

"You have to have a standard across all the hospitals," she said. "That's something that needs to be taken into consideration before rates would be put online or made public."

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East News

R.I. Lawmaker Targets Hospital Errors

February 27, 2007

Between 44,000 and 98,000 patients die each year in U.S. hospitals because of mistakes, infections and other adverse situations. That's more deaths than those caused by breast cancer, AIDS or car accidents.

Most of those deaths are avoidable, according to Rhode Island Sen. Charles J. Levesque (D-Dist. 11, Portsmouth, Bristol), who has introduced legislation aimed at reducing their occurrences in hospitals in his state.

Senator Levesque's "Patient Safety and Medical Error Reduction Act" (2007-S 0650) would require all hospitals in Rhode Island to participate in a program to increase patient safety by reducing medical errors.

Most of the hospitals in Rhode Island are among the 3,000 hospitals nationwide already participating voluntarily in a campaign run by the Institute for Healthcare Improvement to reduce medical errors, infections and other mishaps.

Their voluntary participation is excellent, said Senator Levesque, but he would like to see them all taking part.

"Everybody involved in the health care system wants patients to be safe and to receive proper care when they're in the hospital. I'm sure we can all agree that all hospitals in Rhode Island should be doing everything they can to reduce mistakes, hospital-acquired infections and medication errors so every patient can leave the hospital healthier than when he or she arrived," said Levesque.

The act specifically lists two national organizations the National Quality Forum and the Institute for Healthcare Improvement that have developed programs to help reduce medical errors, but hospitals would be allowed to use other programs as long as they are approved by the Department of Health. Each hospital would be required to report their progress in improving patient safety.

The act would also link hospitals' performance in terms of patient safety to funding by allowing the Department of Human Services to use it to determine their reimbursement rates.

Common ways hospitals can increase patient safety include standardizing safety, communication and sterilization procedures. Computerizing patient information to the greatest extent possible is also a way to reduce the possibility of human error.

According to a 1999 Institute of Medicine report, To Err is Human, costs of preventable "adverse events" in hospitals are estimated to be between $17 billion and $29 billion every year.

"Mistakes in hospitals hurt everyone. They tarnish the health care industry, they cost everyone money in the form of higher health care and insurance costs, and worst of all, they cost lives. I commend the hospitals in Rhode Island that are already taking the initiative to reduce errors and infections, and I hope this legislation formalizes this process and ensures every hospital's full compliance," said Senator Levesque.

Source: R.I. Legislative Press Bureau

Find this article at:
http://www.insurancejournal.com/news/east/2007/02/27/77190.htm

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ASHNHA Position on SB 62
Prepared by: Jennifer Grogg, RN on behalf of ASHNHA
March 1, 2007

WHO DOES ASHNHA REPRESENT?

The *Alaska State Hospital and Nursing Home Association* membership includes 24 acute care hospitals, 2 behavioral health facilities, 6 assisted living facilities (Alaska Pioneer Homes), and 5 free-standing nursing facilities. Nine of our 24 acute care hospitals also provide nursing home services. We believe ASHNHA's rich composition of private, federal, state, and tribal health care facilities provides a balanced viewpoint on important health care policy matters. (Full membership is listed on page 2)

ASHNHA's POSITION ON SB 62:

ASHNHA's membership urges a cautious approach on SB 62 and supports the establishment of an Advisory Committee on Public Reporting of Healthcare Associated Infections; relating to reporting and dissemination of data concerning healthcare associated infections.

SUPPORTING TESTIMONY:

➲ This Advisory Committee will be able to review the status and success of States with similar legislation on the issue of mandatory reporting of Healthcare Associated Infections. Many States have yet to implement these regulations because of the difficulty in creating equitable guidelines for all the reporting agencies. This important issue should be designed with the nuances of Alaska in mind, there is no room for 'cookie cutter' legislation.

➲ Alaskans do not have a wide variety of choices in their selection of Healthcare Facilities, we need to be certain that Alaskans understand that the goal is to create the safest healthcare environment possible for all Alaskans.

➲ With more procedures and surgeries being performed in ambulatory or same day surgical facilities, these organizations should be included in the reporting process to give a broad base of information.

➲ The members of the Advisory Committee will require background knowledge and information to establish a foundation of mutually agreed upon definitions of infections that all Healthcare facilities in the State of Alaska will adhere to when reporting on Healthcare Associated Infections.

➲ This common base of definitions and terms will allow for the equitable formulation of reporting and maintain the confidentiality of the patients who are being served at these facilities.

➲ THIS LEGISLATION MUST BEGIN THIS PROCESS. SB 62 is a complicated issue. Alaskans would be best served with deliberate and quick actions.

➲ ➲

ASHNHA Position on SB 62
Prepared by: Jennifer Grogg, RN on behalf of ASHNHA
March 1, 2007

➲ ASHNHA urges your support of SB 62.

➲ Others either on the phone or in the room who could speak to the need of an Advisory Committee:

- Alaska Chapter of the Association of Professionals in Infection Control
- Alaska Department of Health & Social Services, Dr. Jay Butler

➲ Thank you for this opportunity to comment.

This Testimony is on Behalf of the Following Alaska Health Care Facilities

Alaska Regional Hospital, Alaska Native Medical Center, Alaska Pioneer Home System, Bartlett Regional Hospital, Bassett Army Community Hospital, Central Peninsula General Hospital, Cordova Community Medical Center, Denali Center Nursing Home, Fairbanks Memorial Hospital, Heritage Place Nursing Home, Kanakanak General Hospital, Ketchikan General Hospital, Maniilaq Health Center, Mary Conrad Center, Mat-Su Regional Hospital, Mt. Edgecumbe Hospital SEARHC, Norton Sound Regional Hospital, Petersburg Medical Center, Providence Alaska Medical Center, Providence Extended Care Center, Providence Kodiak Island Medical Center, Providence Seward Medical & Care Center, Providence Valdez Medical Center, Sitka Community Hospital, South Peninsula Hospital, St. Elias Specialty Hospital, USAF 3rd Medical Group- Elmendorf, Wrangell Medical Center, Yukon Kuskokwim Delta Regional Hospital, Alaska Psychiatric Institute, North Star Behavioral Health System, Wildflower Court Nursing Home.

An APIC Briefing

February 2007

Dispelling the Myths:

The True Cost of Healthcare-Associated Infections

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To obtain a copy of the HAI Cost Calculator, visit www.apic.org

APIC's mission is to improve health and patient safety by reducing risks of infection and other adverse outcomes. The Association's more than 11,000 members have primary responsibility for infection prevention, control and hospital epidemiology in health care settings around the globe, and include nurses, epidemiologists, physicians, microbiologists, clinical pathologists, laboratory technologists and public health practitioners. APIC advances its mission through education, research, collaboration, practice guidance and credentialing.

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Executive Summary

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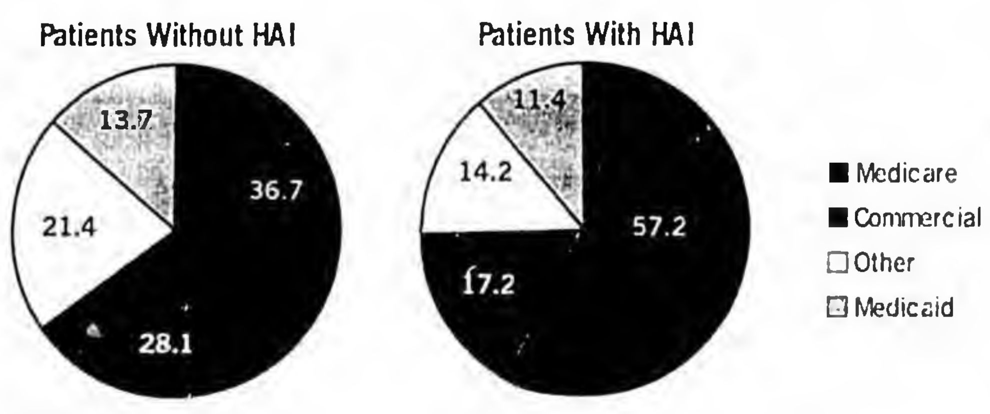
Hospital leaders are aware that healthcare-associated infections (HAIs) impact patients but many have no idea of the extent of the situation and the degree to which HAIs impact cost and operating margin. For example, some hospital executives believe the number of inpatients that acquire an HAI is far smaller than the actual rate. The purpose of this paper is to present the business case for reducing healthcare-associated infections from the perspective of the healthcare executive. Case studies of significant cost savings are presented along with a methodology for determining the cost of various categories of HAIs.

The large impact these cases have on costs and operating margins is even more significant. A recent study of 1.69 million admissions from 77 hospitals found that patients with a healthcare-acquired infection reduced overall net inpatient margins by $286 million or $5,018 **per infected patient**. The study found that the average additional incremental direct cost for patients with an HAI was $8,832[1].

HAIs erode the bottom line. Therefore in classes where reimbursement is lower, the loss impact is even greater. Figures 1 and 2 demonstrate that the average payer mix for patients without infections is 37% Medicare, 28% commercial payers, 21% other and 14% Medicaid. For patients with healthcare-associated infections, the mix changes to 57% Medicare, 17% commercial 14% other and 11% Medicaid[2]. Closer examination of payer type for patients with HAIs brings the potential for net loss into greater focus.



Figures 1 and 2.
SOURCE: MedMined, Inc 1.69 million admission study September 2006

APIC's mission is to improve health and patient safety by reducing risks of infection and other adverse outcomes.

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Visit APIC online at www.apic.org.

Healthcare-associated infections have long been considered a byproduct of healthcare, an outcome of treating an increasingly older, sicker patient

population with an increasingly invasive arsenal of interventions. The costs associated with these infections were thought to be largely offset by reimbursement. But as the methodology of accounting for the costs of HAIs has become more sophisticated, institutions are finding that HAIs are not revenue neutral or positive, that HAIs substantively erode the profit margin of the average hospital. Leading institutions are also finding that significant reductions in many categories of HAIs cannot only be reached but sustained, providing a substantive opportunity for improving patient outcomes and the bottom line as well.

There is emerging evidence that reimbursement for infection does not cover the cost of the required additional care. In fact, HAIs result in considerable operating losses in almost all cases.

This paper seeks to dispel three widely held myths where HAIs are concerned:

1. That HAIs are an expected byproduct of treating an older, sicker patient population with an increasing array of invasive techniques;
2. That the additional cost of an HAI is largely offset by reimbursement, making the infection revenue neutral or positive;
3. That the number of HAIs in most institutions is not significant, making the cost savings associated with reduction of HAIs not worth the investment.

Our goal is to aid healthcare executives in better understanding the true cost of HAIs and engage them in an evaluation of the costs in their particular institution. By clarifying the business case and providing a practical methodology to estimate the value of reducing healthcare-associated infections we are confident that hospital leaders will take a more aggressive approach to infection prevention.

Current Situation

The current system of reimbursement obscures the true cost of HAIs to health care institutions. There is emerging evidence that reimbursement for infection does not cover the cost of the required additional care. In fact, HAIs result in considerable operating losses to hospitals in almost all cases.

It is our position that pursuing perfection[3], setting HAI reduction strategies at the theoretical ideal (zero preventable infections), represents a substantial opportunity for hospital leaders to improve safety, quality and significantly reduce cost.

In 2005, the Top Issues Confronting Hospital CEO's survey conducted by the American College of Healthcare Executives ranked financial challenges as the number one concern of hospital CEOs[4]. Financial challenges had also been ranked number one in the 2003 and 2004 surveys. In addition to traditional financial challenges, the "C-suite" executives must respond to external pressures from regulatory and standard-setting agencies, consumer advocacy groups, and their own community boards to reduce adverse outcomes of hospitalization.

The pressure to keep patients safe and deliver high quality clinical outcomes will further impact reimbursement as pay for performance initiatives become a reality nation-wide. All this said, most executives would agree that keeping patients safe is the right thing to do regardless of financial implications. We hope to provide evidence to demonstrate that infection prevention is not only the right thing to do for patients, but is good business as well.

Healthcare-associated infections cost between five and six billion annually and result in almost one hundred thousand deaths in the United States.

Evidence

In the past decade there has been increasing activity in the measurement of the specific impact infection prevention has had on operating margins and excess costs associated with HAIs. Healthcare-associated infections cost between $5–6 billion annually and result in almost 100,000 deaths in the US[5]. This paper presents two notable examples of healthcare organizations that documented the economic value of eliminating HAIs and did it using validated economic analysis[6].

Allegheny General Hospital

Bloodstream infections are a risk for patients needing vascular access lines, especially if lines are placed in large central veins leading to the heart.

In 2004, the Jewish Health Foundation and Pittsburgh Regional Health Initiative launched an all-out assault on central line associated bloodstream infections (CLABs) through implementation of evidence-based prevention measures. With 40 hospitals working in concert, they set their theoretical goal at zero, meaning their target was no central line infections. With results audited by the Centers for Disease Control and Prevention, they were able to achieve an overall 63% reduction in these serious adverse outcomes of hospitalization.

One participant, Allegheny General Hospital, was able to achieve a 90% reduction in CLABs from fiscal year 2003 to 2004 (from 49 to 3 with an average savings of $14,572 per CLAB[7]. A summary of the Allegheny General's CLAB-related study, as reported in the Nov-Dec 2006 American Journal of Medical Quality Supplement on Hospital-Acquired Infection: Meeting the Challenge (Richard P. Shannon, MD), yielded the following information:

- Average reimbursement per case: $64,894
- Average cost per case with CLAB: $91,733
- Average Loss per case: **$(26,839)**
- Total Loss from operations associated with CLABs: **$(1,449,306)**
- Percent of total cost of care associated with CLABs: **43%**
-

What price tag can be placed on the lives saved from successful prevention measures deployed by this organization?

Allegheny General Hospital

Central Line Associated Bloodstream Infections

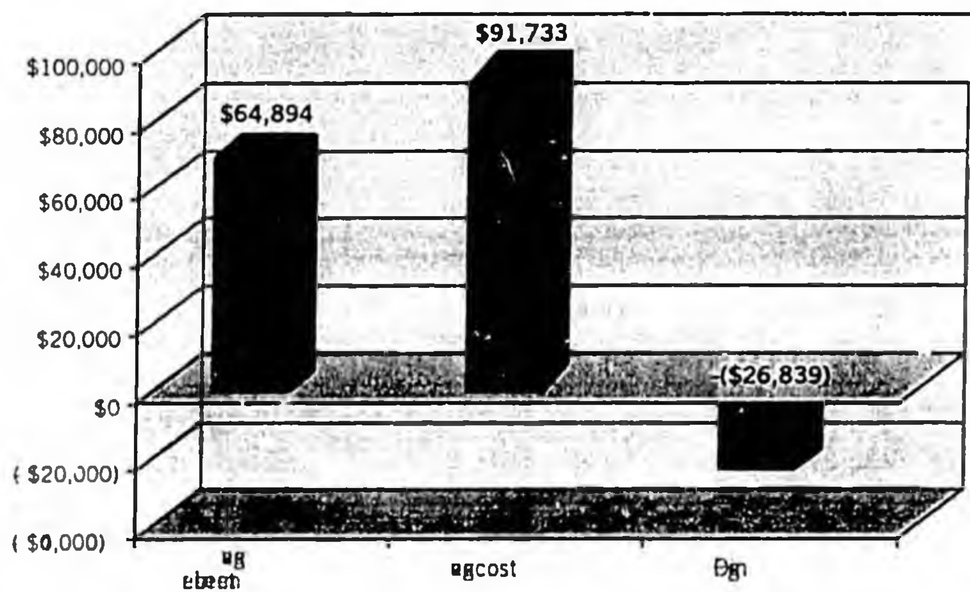


Figure 3.
SOURCE: Shannon, R.P. (unpublished data)

In addition to their work on CLABs, AGH also demonstrated significant improvement in reducing ventilator-associated pneumonias (VAPs). Their results showed a reduction from 46 VAPs in FY 2003 and 45 in 2004 to 8 in FY 2005 (82% reduction). Their economic analysis for fiscal years 2003–2005 indicated that cases with a VAP resulted in lost revenue. VAP cases averaged a loss of $(24,435). The average reimbursement for VAP cases totaled $62,883 while the average cost was $87,318; therefore, the average loss for each case was $(24,435).

During the two year effort to eliminate CLAB's and the one year effort targeting VAPs, the total cost savings was $2.2 million. The cost to obtain this level of savings was just under $35,000. The cost per ventilated patient to achieve the targeted improvement was just $17. Note that the mortality associated with ventilator-associated pneumonia and central line associated bloodstream infections is 20–60%. What price tag can be placed on the lives saved from successful prevention measures deployed by this organization?

BJC HealthCare

In 1996, infection control leaders at BJC HealthCare, a 13-hospital, non-profit health care system based in St. Louis, Missouri, presented to their senior management and board of directors a formal business case for increasing

resources to eliminate HAIs. In 2000, they estimated the excess cost generated by just four categories of healthcare-associated infections (CABG surgical site infections (SSI), spinal SSI, bloodstream and ventilator-associated pneumonia infections) at **$8.2 million** across all BJC hospitals. Based on this information, leadership approved an investment of $350,000 to enhance system-wide efforts to eliminate HAIs. Individual hospitals also invested an additional $50,000–$150,000 to increase full time equivalents (FTEs) dedicated to infection prevention and/or medical direction during that same time period. By year end 2001, the same four categories of HAI were associated with excess costs of $6.4 million, an almost $1.8 million dollar reduction in excess costs.

Table 1 contains a summary of the impact of targeted interventions at Barnes Jewish Hospital, BJC's 1300 bed academic medical center, between 2000 and 2004. In a four year period, infection prevention efforts yielded a reduction of excess cost in just four HAI categories of almost $2.5 million. Studies

Table 1

Barnes Jewish Hospital—Impact of Interventions To Decrease Healthcare-Associated Infections

	2000	2004	Intervention Impact
CABG Surgical Site Infections (SSI)			
#SSI	43	18	-25
%SSI	6.8%	5.6%	-18%
Excess Cost	$825,000	$322,610	-$502,390
Spinal Surgical Site Infections (SSI)			
#SSI	20	5	-15
%SSI	2.07%	0.8%	-61%
Excess Cost	$301,327	$44,823	-$256,504
Bloodstream Infections (BSI)			
#BSI	309	87	-222
BSI/1,000 patient days	8.4/1000	1.5/1000	-82%
Excess Cost	$1,446,120	$459,690	-$986,430
Ventilator Associated Pneumonia (VAP)			
#VAP	166	73	-93
VAP/1,000 ventilator days	10.1/1,000	4.8/1,000	-52%
Excess Cost	$1,382,780	$632,180	-$750,600
Total Cost of all HAI tracked	**$3,955,225**	**$1,459,303**	**-$2,495,924**

SOURCE: Denise Murphy, Marilyn Jones, BJC Infection Control and Healthcare Epidemiology Consortium, St. Louis, MO.

evaluating "routine" processes such as changing of ventilator circuits every 24-48 hours also resulted in annual savings of $1 million in supply and equipment reductions associated with fewer ventilator circuit changes (with no adverse impact on patients).

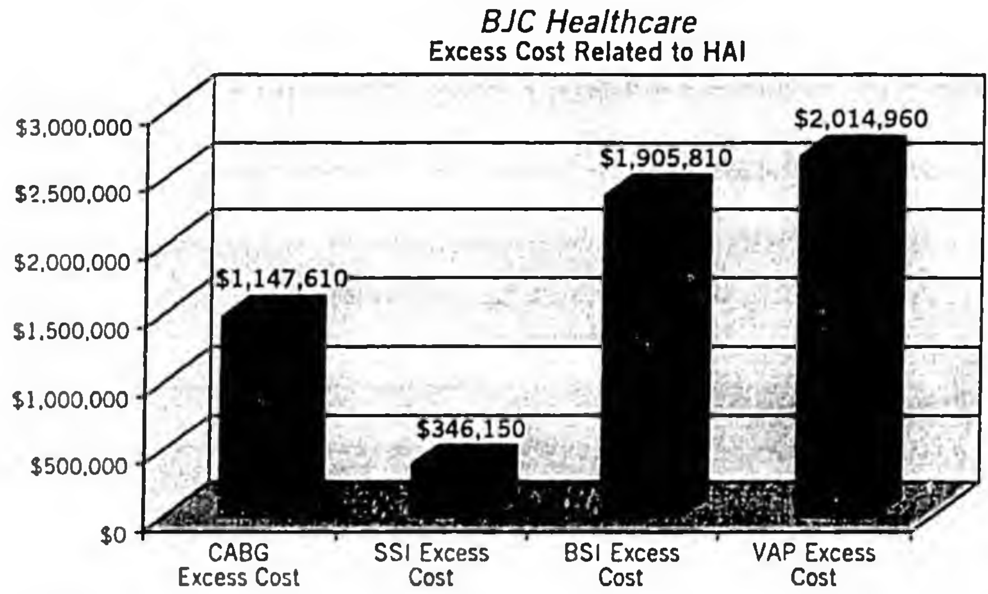


Figure 4.
SOURCE: Denise Murphy, Marilyn Jones, BJC Infection Control and Healthcare Epidemiology Consortium, St. Louis, MO.

In addition to the cost of infections, Infection Prevention Specialists also began sharing excess length of hospitalization with executives. In 2000, surgical site infections after coronary artery bypass graft surgeries alone resulted in 1,350 excess days (average of 27 days/SSI) over the expected stay for patients who did not acquire an infection. With volumes being the main driver of revenue, this information supported the need for enhanced prevention efforts.

Opportunity Cost

Based on the data submitted for the first nine months of 2005, it is estimated that HAIs added 227,000 extra hospital days in Pennsylvania alone.

As noted above, a largely hidden cost of HAIs is the additional patient days they consume. While many hospitals routinely run near or at capacity, the elimination of HAIs can provide the hospital with additional patient care capacity at little or no cost. A 1985 article estimated that HAIs add a total of 7.5 million excess patient days nation wide[9]. According to the Pennsylvania Healthcare Cost Containment Council (PHC4), the 1.9 million admissions in their state in 2005 without an HAI had an average length of stay less than 5 days[10]. For the 24,000 admissions that were reported with an HAI, the average length of stay

was **23 days**. Based on the data submitted for the first nine months of 2005, it is estimated that HAIs added **227,000 extra hospital days** in Pennsylvania alone. Pursuing zero tolerance for HAIs can free up a significant number of bed days that can be used for patients potentially bringing in a higher level of reimbursement.

The evidence is compelling that taking action to invest in prevention can have a profound positive impact on the organization's bottom line, patients' safety and satisfaction, and reputation.

The Business Case

The business case for pursuing perfection and eliminating HAIs is designed to identify the reasons for action and the expected benefits. The business case for quality can be defined as "an analysis aimed at determining the economic liabilities of preventable errors to ensure that an investment in quality will bring the greatest value"[11]. The evidence is compelling that taking action to invest in prevention can have a profound positive impact on the organization's bottom line, patients' safety and satisfaction, and reputation. Whenever possible, meaningful measurements should be expressed in operational terms. The importance of forming a partnership with the Finance Department at the outset in the development of the business case, in which the infection prevention and control specialist and a finance partner work together to quantify the economic impact of HAIs to the organization, is key. In this case, the focus is on demonstrating that operating margins can be improved as a result of targeted actions to reduce HAIs to zero.

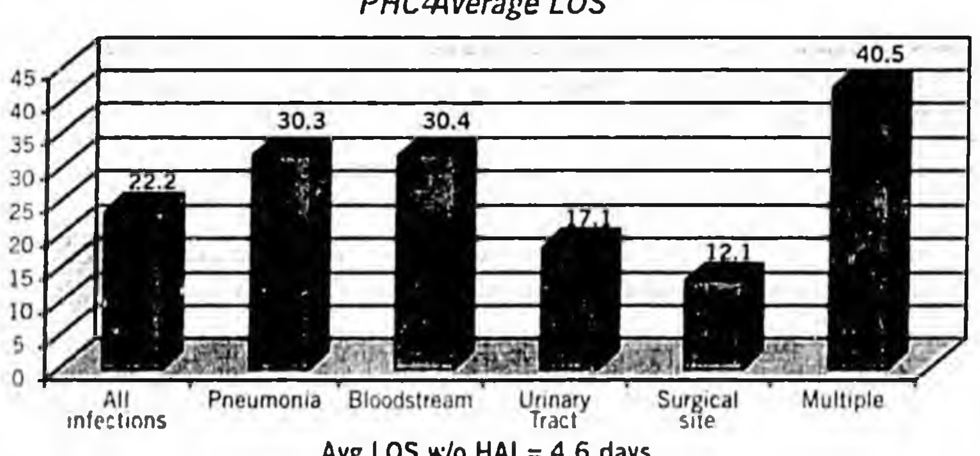


Figure 5.

Methodology

While it may be interesting to read the validated financial results from other organizations, our primary purpose is to provide the reader with practical guidelines to analyze how HAIs are impacting their bottom line. What follows is a simple and practical methodology that can be used to calculate the economic

value of reducing HAIs in your organization. Based on the cases outlined above, we believe that most if not all hospitals have a significant opportunity to improve the bottom line by eliminating HAIs. The following methodology will enable you to identify and quantify that opportunity by using your own organization's data.

To calculate the estimated value (excess cost or impact on margin) of eliminating HAIs in your organization, the following methodologies are suggested:

1. Select one of the following options for the population to be analyzed.
   a. Option 1 – select a number such as 10 patients who acquired a CLAB
   b. Option 2 – select a class of HAIs for the last year. (Include any case where a payer was billed for any service related to a healthcare-associated infection. DO NOT include a case if the primary cause of admission was for an infection; DO INCLUDE readmissions for HAI.)
2. Identify the actual or estimated reimbursement for each case
3. Identify the total costs associated with the case, based upon activity-based cost accounting, if available
4. Identify the costs attributable to the HAI
   a. This step requires clinical and financial expertise to identify which services provided were attributable to the infection AND the cost of these services

Table 2
The Impact of CLAB's on Gross Margin*[12]

	DRG 204/2721** (n=3)	DRG 191 (n=3)	DRG 483 (n=2)	[illegible]
	Acute Pancreatitis [illegible]	[illegible]	Pancreatitis w [illegible] tracheotomy	[illegible] with CLAB
Revenue ($)	5,907	99,214	125,576	200,031
Expense	5,788	58,905	98,094	241,844
Gross Margin	119	40,309	27,482	(41,813)
Costs attributable to HAI				170,565
LOS	4	38	41	86

**CLAB – central line-associated bloodstream infection*
*** Complication/comorbidity*

SOURCE: Shannon, R.P., et al. ASMQ Supplement, Vol 21, No. 6, 2006

5. Calculate the Gross Margin for the case by subtracting the expenses (3) from the reimbursement (2)
6. Compare the gross margin for the case to the gross margin of similar cases without a healthcare-associated infection, matched for age, principal diagnosis, and admission severity
   a. See Table 2

When you have completed the analysis of the HAIs in your organization, use this information to target an area that has significant opportunity for improvement, and then "pursue perfection". Set the target for elimination of this HAI. This approach drives innovation, removes complacency, centers on patients' needs and spurs deep system change.

Continued research and performance improvement efforts must be dedicated to eliminating HAIs and providing a safer environment for patients and providers. These efforts must be supported, if not led, by executive leadership.

Call to Action

In an effort to enhance the attention and resources dedicated to the culture of zero tolerance toward HAIs, it is critical that organizations commit to the following actions:

1. Identify a financial partner to work with Infection Prevention and Control Specialists in your organization.
2. Quantify the economic impact of HAIs in your organization by using the methodology described above.
3. Based on the results of this economic analysis, target a high risk, high volume procedure or patient population and lead efforts to eliminate HAIs using a zero tolerance (or "pursue perfection" mentality).
4. Ensure that Specialists are educating healthcare workers about infection prevention and driving applicable evidence-based best practice recommendations.
5. Identify process defects and institute necessary systems or practice changes where indicated.
6. Measure the results of the efforts and repeat the process.

Conclusion

There is a finite supply of health care dollars in the United States. Regardless of whether health care coverage is managed by employers, insurance companies or the government, consumers fund the system. It is the responsibility of executives and clinicians to protect this investment. To accomplish this task requires an understanding of the risks and liabilities associated with entering the health care system and what it takes to improve health care delivery. Continued research and performance improvement efforts must be dedicated to

eliminating HAIs and providing a safer environment for patients and providers. These efforts must be supported, if not led, by executive leadership.

Because many deserving issues don't get attention unless executives understand their economic implications, APIC is committed to continuing to communicate and clarify the business case for infection prevention. We hope that the practical examples presented in this executive briefing will encourage hospital executives, especially financial executives, to develop a deeper understanding of the economic impact of healthcare-associated infections and, with that understanding, undertake the steps that will lead to healthier bottom lines and improved patient outcomes.

The dollars and infection rates are about people—our family, our friends and our neighbors, who are needlessly harmed every day, and the significant human and economic costs associated with these events.

An Actual Patient Account:

In February 2002, a 37-year old father of four was admitted to the hospital with acute Pancreatitis. Three days into his stay he developed abnormally low blood pressure and respiratory failure. On Day 6, his blood culture tested positive for MRSA (methicillin-resistant *Staphylococcus aureus*) after a femoral vein catheter had been in place for 4 [illegible] The patient had multiple complications related to the infection which required an exploratory laparotomy (a surgical procedure to gain access to the abdominal cavity) and eventually a tracheostomy (a surgical procedure on the neck to provide a direct open airway). On the 86th day of his stay, the patient was discharged to a nursing home. He never returned to work.

The total cost of this patient's care was $241,844, 70% of which ($170,565) was attributable to the central line-associated bloodstream infection (CLAB) he acquired while in the hospital. This patient had commercial insurance which reimbursed the hospital $200,031. Despite this high level of reimbursement, **the hospital lost $41,818 on this case alone.** While this case represents a severe impact of a healthcare associated infection, it is an all too common occurrence.

This story and millions like it occur every year in American hospitals. While our primary objective is to increase hospital leadership attention to the economics of healthcare-associated infections, the dollars and infection rates are about people—our family, our friends and our neighbors, who are needlessly harmed every day, and the significant human and economic costs associated with these events.

***SOURCE:** Shannon, R.P., et al. ASMQ Supplement, Vol 21, No. 6, 2006*

APPENDIX

Definitions

Activity-Based Cost Accounting: A powerful tool for measuring performance, Activity-Based Costing (ABC) is used to identify, describe, assign costs to, and report on operations. A more accurate cost management system than traditional cost accounting, ABC identifies opportunity to improve business process effectiveness and efficiency by determining the "true" cost of a product or service.

There is a finite supply of health care dollars in the United States. Regardless of whether health care coverage is managed by employers, insurance companies or the government, consumers fund the system.

Attributable Cost: The services provided and billed to a patient that were caused by a healthcare-associated infection.

Business Case: A business case addresses at a high level the business need that the project seeks to resolve. It may include the reasons for the project, the expected business benefits, the options considered (with reasons for rejecting or carrying forward each option), and the expected costs of the project, a gap analysis and the expected risks. The option of doing nothing should be included with the costs and risks of inactivity included along with the differences (costs, risks, outcomes etc) between doing nothing and the proposed project.

Excess Cost/Length of Hospital Stay: The cost/LOS the patient incurred as a result of a healthcare-associated infection over and above usual costs and LOS. The cost/LOS that would be avoided if an HAI did not occur.

Healthcare-associated Infection: A localized or systemic condition resulting from an adverse reaction to the presence of an infectious agent(s) or its toxin(s) that:

1. occurs in a patient in a hospital, and
2. was not found to be present or incubating at the time of admission unless the infection was related to a previous admission to the same setting.

Operating Income: The amount by which total operating revenue exceeds total operating expenses.

Operating Margin: The ratio of operating income to total operating revenue. This measure places operating income in perspective with the volume of business realized by the hospital.

Best-practice Examples

During the Futures Summit on "The Economics of Infection Prevention" sponsored by APIC in April 2006, several best-practices for the elimination of HAIs were shared. These practices significantly contributed to an organization's pursuit of a zero tolerance approach to HAIs. These practices are not absolute guarantees of success, and not all practices may work at every organization. They are, however, worthy of consideration as part of a comprehensive strategy to enhance infection prevention and patient safety.

Executives, especially financial leaders, can have more of an effect on elimination of HAIs simply by talking about zero tolerance, and making small incremental investments in prevention, than all the policies and procedures in the world.

Champions

A common denominator in achieving a zero tolerance strategy is the commitment of champions to this effort. Often champions become engaged in the fight to eliminate HAIs as a result of their involvement in an incident where a patient was severely injured by an HAI, or when a relative or friend had suffered the effects of an HAI. Successful transformation toward a prevention vs. a reactive culture is generally a result of the extraordinary efforts of a few dedicated people. Organizations should identify, invest in, and empower those people.

Leadership

Organizational leaders set the culture and language shapes it. Executives, especially financial leaders, can have more of an effect on elimination of HAIs simply by talking about zero tolerance, and making small incremental investments in prevention, than all the policies and procedures in the world.

Data and Human Focus

Several of the organizations who have been most successful in the fight to eliminate HAIs have found a way to present data to governing boards, quality committees and other groups that promote a bias toward action. For example, HAIs are often reported using rates. If an organization's rate is 5.1/1000 patient days and our competitor's rate is 5.4/1000 patient days, this may appear acceptable. Also, communicating rates does not define how many people are being injured and possibly killed by HAIs. No infection is acceptable despite the fact that, in hospitals, all infections are not preventable. Key decision makers must know numbers of people affected, rates, action plans and the resources it will take to get to zero.

Language Barrier

HAI-related information is often communicated using terms that are unfamiliar to many non-clinical leaders. To enhance the success of HAI elimination efforts, it is important to create an environment where non-clinical leaders

receive data and information they can understand. It is equally as important for Infection Prevention and Control Specialists to work with financial leaders and learn the language and terms of business and finance, such as payer mix, ROI and operating margin. The sooner we can remove language barriers, the sooner we can create better results together.

CFOs can help clinicians in Infection Prevention and Control to never assume that adding resources is the only way to improve care.

Results First

While resources are critical to support the fight, demonstrating success and return on investment makes a great case for enhancing resources. Succeeding first, THEN asking for more resources, is a good strategy. CFOs can help clinicians in Infection Prevention and Control to never assume that adding resources is the only way to improve care. Collaborate to find ways to enhance prevention program efforts even if additional FTEs are not possible. The Specialists, once successful in eliminating infections, may begin bargaining for a percentage of the organizational cost savings to further enhance prevention efforts.

---

[1] 1.6 Million Admission Analysis, MedMined, Inc. September 2006

[2] 1.6 Million Admission Analysis, MedMined, Inc. September 2006

[3] Reinertsen, James and Schellekens, Wm. 10 Powerful Ideas for Improving Patient Care. Chicago: Health Administration Press. 2005

[4] Top Issues Confronting Hospitals: 2005, American College of Healthcare Executives

[5] Public Health Focus: surveillance, prevention and control of nosocomial infections. MMWR Morb Mort Rep 41:738-787, Oct. 23, 1992.

[6] Reference Carnegie-Mellon validation of AGH and Hollenbeak validation of BJC.

[7] Shannon, Richard, MD, Hospital-Acquired Infections: Meeting the challenge. American Journal of Medical Quality, Supplement to Vol. 21, No. 6, Nov-Dec. 2006.

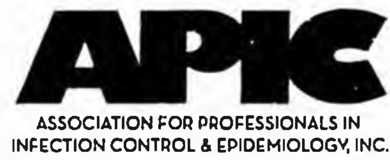
[8] Murphy, Denise and Christopher Hollenbeak, Economics of Infection Prevention, APIC Futures Summit, 2006

[9] Haley, RW et al. Am J Epidemiology 1985

[10] Pennsylvania Healthcare Cost Containment Council, PHC4 Research Brief, March 2006

[11] McGill, Doug, The Business Case for Quality, Economics of Infection Prevention APIC Futures Summit, 2006.

[12] Shannon, Richard, MD, Hospital-Acquired Infections: Meeting the challenge. American Journal of Medical Quality, Supplement to Vol. 21, No. 6, Nov-Dec. 2006.



ASSOCIATION FOR PROFESSIONALS IN
INFECTION CONTROL & EPIDEMIOLOGY, INC.

1275 K Street NW, Suite 1000
Washington, DC 20005

About APIC

APIC's mission is to improve health and patient safety by reducing risks of infection and other adverse outcomes. The Association's more than 11,000 members have primary responsibility for infection prevention, control and hospital epidemiology in health care settings around the globe, and include nurses, epidemiologists, physicians, microbiologists, clinical pathologists, laboratory technologists and public health practitioners. APIC advances its mission through education, research, collaboration, practice guidance and credentialing.

Visit APIC online at **www.apic.org**.

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/19/07

FURTHER: (Finance)

Date of 5-Day Notice: 3/1/07
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 3/12/07

Health, Education and Social Services Committee considered

SENATE BILL NO. 62

SB 62 TASK FORCE ON HEALTH CARE INFECTIONS

"An Act establishing the Advisory Committee on Public Reporting of Health Care Associated Infections; relating to reporting and dissemination of data concerning health care associated infections; and providing for an effective date."

and recommends:

[ ] be replaced with [ ] SCS or [ ] CS ______ (____)

[ ] adopt previous [ ] SCS or [ ] CS ______ (____)

[ ] attached amendment(s)

[ ] adopt ______ Letter of Intent

[ ] further referral to ______ Committee

SENATE BILL:
[ ] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#
HSS	2/8/07	✓			1

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
[signature]	Elton	✓			
[signature]	Thomas	✓			
[signature]	Dyson ✓	✓			
CHAIR: Bettye Davis	DAVIS	X			

SB
68

SFIN

FILE

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: 2
Bill Version: CSSB 68(L&C)
(S) Publish Date: 3/7/07

Revision Date/Time (Note if correction):
Title: Motor Vehicle Insurance
Sponsor: French
Requester: Senate Labor & Commerce

Dept. Affected: Commerce
RDU: Insurance (116)
Component: Insurance
Component No. 354

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES						

CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2007) cost: 0.0

Mark this box (X) if funding for this bill is included in the Governor's FY 2008 budget proposal: [ ]

POSITIONS

Full-time						
Part-time						
Temporary						

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

This legislation addresses various provisions relating to mandatory motor vehicle insurance in the Department of Administration; it does not impact the operations of the division.

Prepared by: Linda S. Hall, Director
Phone 907-269-7900
Division: Insurance
Date/Time 2/26/07 4:17 PM
Approved by: Emil R. Notti, Commissioner
Date 2/26/2007
Agency: Commerce, Community, and Economic Development

(Revised 9/18/2006 OMB)

COMMITTEE COPY

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: CSSB 68(L&C)
(S) Publish Date: 3/7/07

Revision Date/Time (Note if correction):
Dept. Affected: Administration
Title "An Act requiring motor vehicle insurers..."
RDU Division of Motor Vehicles
Component Motor Vehicles
Sponsor Sen. French
Requester (S) L&C
Component No. 2348

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Personal Services	0.0	0.0	0.0	0.0	0.0	0.0
Travel	0.0	0.0	0.0	0.0	0.0	0.0
Contractual	290.0	290.0	290.0	290.0	290.0	290.0
Supplies	0.0	0.0	0.0	0.0	0.0	0.0
Equipment	0.0	0.0	0.0	0.0	0.0	0.0
Land & Structures	0.0	0.0	0.0	0.0	0.0	0.0
Grants & Claims	0.0	0.0	0.0	0.0	0.0	0.0
Miscellaneous	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	**290.0**	**290.0**	**290.0**	**290.0**	**290.0**	**290.0**
CAPITAL EXPENDITURES	0.0	0.0	0.0	0.0	0.0	0.0
CHANGE IN REVENUES ( )	0.0	0.0	0.0	0.0	0.0	0.0

FUND SOURCE (Thousands of Dollars)

FUND SOURCE	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
1002 Federal Receipts	0.0	0.0	0.0	0.0	0.0	0.0
1003 GF Match	0.0	0.0	0.0	0.0	0.0	0.0
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts	0.0	0.0	0.0	0.0	0.0	0.0
1037 GF/Mental Health	0.0	0.0	0.0	0.0	0.0	0.0
1156 Reciept Supported Services	290.0	290.0	290.0	290.0	290.0	290.0
TOTAL	**290.0**	**290.0**	**290.0**	**290.0**	**290.0**	**290.0**

Estimate of any current year (FY2007) cost: 0.0

Mark this box (X) if funding for this bill is included in the Governor's FY 2008 budget proposal: [ ]

POSITIONS

POSITIONS	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Full-time	0	0	0	0	0	0
Part-time	0	0	0	0	0	0
Temporary	0	0	0	0	0	0

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

This legislation will allow the department to electronically verify a DMV customer's automobile insurance. The cost of this process has been estimated by adopting the same cost model used by other states with similar legislation (TX & FL). Contractually, these costs are determined by the number of vehicle records in Alaska (807,000) @ $0.03/month.

Prepared by: Duane Bannock, director
Phone 465-2200
Division: Motor Vehicles
Date/Time 2/26/2007 3.00pm
Approved by: Kevin Brooks
Date 2/27/2007 07.45am
Agency: Department of Administration

(Revised 9/18/2006 OMB)

COMMITTEE COPY

SENATE COMMITTEE REPORT

DATE: 3/7/07

FURTHER: (Finance)

DATE TURNED IN TO OFFICE: 3/30/07

Transportation Committee considered SENATE BILL NO. 68

SB 68 MOTOR VEHICLE INSURANCE

"An Act requiring motor vehicle insurers to provide to the commissioner of administration a database listing vehicle insurance policy information that will allow the commissioner to verify whether mandatory motor vehicle insurance has been obtained, limiting access to the database, establishing methods for proving that mandatory motor vehicle insurance is in place, allowing the additional penalties of suspending registration and vehicle impoundment and forfeiture for failure to have mandatory motor vehicle insurance, and authorizing hearings after suspension of registration for failure to have mandatory motor vehicle insurance."

and recommends:

[✓] be replaced with [ ] SCS or [✓] CS SB 68 (TRA)

[ ] adopt previous [ ] SCS or [ ] CS ________ (____)

[ ] attached amendment(s)

[ ] adopt ________ Letter of Intent

[ ] further referral to ________ Committee

SENATE BILL:
[ ] Same Title
[✓] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#
DCED	2/26/07			✓	2
ADM	2/27/07	✓			1

[ ] APPROPRIATION - no fiscal note

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
[signature]	Wielechowski			✓	
[signature]	Cowdery	✓			
[signature]	Olson	✓			
CHAIR: Kookesh [signature]	Kookesh	✓			

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/26/07

FURTHER: Transportation (circled)
Finance

Date of 5-Day Notice: 2/1/07
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 3/7/07

Labor and Commerce Committee considered SENATE BILL NO. 68

SB 68 MOTOR VEHICLE INSURANCE

"An Act requiring motor vehicle insurers to provide to the commissioner of administration a database listing vehicle insurance policy information that will allow the commissioner to verify whether mandatory motor vehicle insurance has been obtained, limiting access to the database, establishing methods for proving that mandatory motor vehicle insurance is in place, allowing the additional penalties of suspending registration and vehicle impoundment and forfeiture for failure to have mandatory motor vehicle insurance, and authorizing hearings after suspension of registration for failure to have mandatory motor vehicle insurance."

and recommends:

[✓] be replaced with [ ] SCS or [✓] CS FOR SB 68 (L+C)

[ ] adopt previous [ ] SCS or [ ] CS ______ (______)

[ ] attached amendment(s)

[ ] adopt ______ Letter of Intent

[ ] further referral to ______ Committee

SENATE BILL:
[ ] Same Title
[X] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#
ADMIN	2/27/07	✓ ~~190.0~~			1
COMMERCE	2/26/07			✓	2

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#

[ ] APPROPRIATION - no fiscal note

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
[signature]	Bunde		✓		
[signature]	DAVIS	X			
[signature]	STEVENS	X			
[signature]					
[signature]	Hoffman				X
CHAIR: [signature]	ELLIS	X			

SB
69

SFIN

FILE

SENATE FINANCE COMMITTEE REPORT

REPORTED OUT
MAY 0 9 2007
SENATE FINANCE COMMITTEE

DATE: 2/22/07

FURTHER:

DATE TURNED IN TO OFFICE: 9 May 2007

Finance Committee considered SENATE BILL NO. 69

SB 69 CIVIL LEGAL SERVICES FUND

"An Act relating to the creation of a civil legal services fund."

and recommends:

[✓] be replaced with [ ] SCS or [✓] CS SB 69 (FIN)

[ ] adopt previous [ ] SCS or [ ] CS CS forthcoming ( )

[ ] attached amendment(s)

[ ] adopt ______ Letter of Intent

[ ] further referral to ______ Committee

SENATE BILL:
[✓] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#
Admin.	2/5/07			✓	#1

[ ] APPROPRIATION - no fiscal note

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
[signature]	Elton	✓			
[signature]	Thomas	✓			
[signature]	Dyson	✓			
[signature]	Huggins	✓			
[signature]	Olson			✓	
CO-CHAIR: [signature]	Hoffman	✓			
CO-CHAIR: [signature]	Stedman			✓	

REPORTED OUT
MAY 0 9 2007
SENATE FINANCE COMMITTEE

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: SB 69
(S) Publish Date: 2/22/07

Revision Date/Time (Note if correction):
Title: An act relating to the creation of a civil legal services fund
Sponsor: Senator McGuire
Requester:

Dept. Affected: Administration
RDU: Centralized Admin Services
Component: Finance
Component No. 59

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Personal Services	0.0	0.0	0.0	0.0	0.0	0.0
Travel	0.0	0.0	0.0	0.0	0.0	0.0
Contractual	0.0	0.0	0.0	0.0	0.0	0.0
Supplies	0.0	0.0	0.0	0.0	0.0	0.0
Equipment	0.0	0.0	0.0	0.0	0.0	0.0
Land & Structures	0.0	0.0	0.0	0.0	0.0	0.0
Grants & Claims	0.0	0.0	0.0	0.0	0.0	0.0
Miscellaneous	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES	0.0	0.0	0.0	0.0	0.0	0.0
CHANGE IN REVENUES ( )	0.0	0.0	0.0	0.0	0.0	0.0

FUND SOURCE (Thousands of Dollars)

FUND SOURCE	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
1002 Federal Receipts	0.0	0.0	0.0	0.0	0.0	0.0
1003 GF Match	0.0	0.0	0.0	0.0	0.0	0.0
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts	0.0	0.0	0.0	0.0	0.0	0.0
1037 GF/Mental Health	0.0	0.0	0.0	0.0	0.0	0.0
Other (Specify Type--Do not abbreviate)	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2007) cost: 0.0

Mark this box (X) if funding for this bill is included in the Governor's FY 2008 budget proposal: [ ]

POSITIONS

POSITIONS						
Full-time						
Part-time						
Temporary						

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

Esablishing funds created by legislation such as this is in the normal course of business for the Division of Finance.

Prepared by: Kim Garnero
Division: Finance
Phone: 465-2200
Date/Time: 2/5/07 10:00 AM
Approved by: Kevin Brooks, Deputy Commissioner
Agency: Department of Administration
Date: 2/5/2007

COMMITTEE COPY

ALASKA STATE LEGISLATURE

Session
State Capitol Building, Room 125
Juneau, Alaska 99801-1182
Phone (907) 465-2995
Fax (907) 465-6592

Interim
716 West Fourth Avenue, Suite 430
Anchorage, Alaska 99501
Phone (907) 269-0250
Fax (907) 269-0249

Chair
Senate State Affairs
Administrative Regulation Review

Member
Senate Judiciary Committee
Senate Resources Committee

SENATOR LESIL MCGUIRE

Sponsor Statement for SB 69

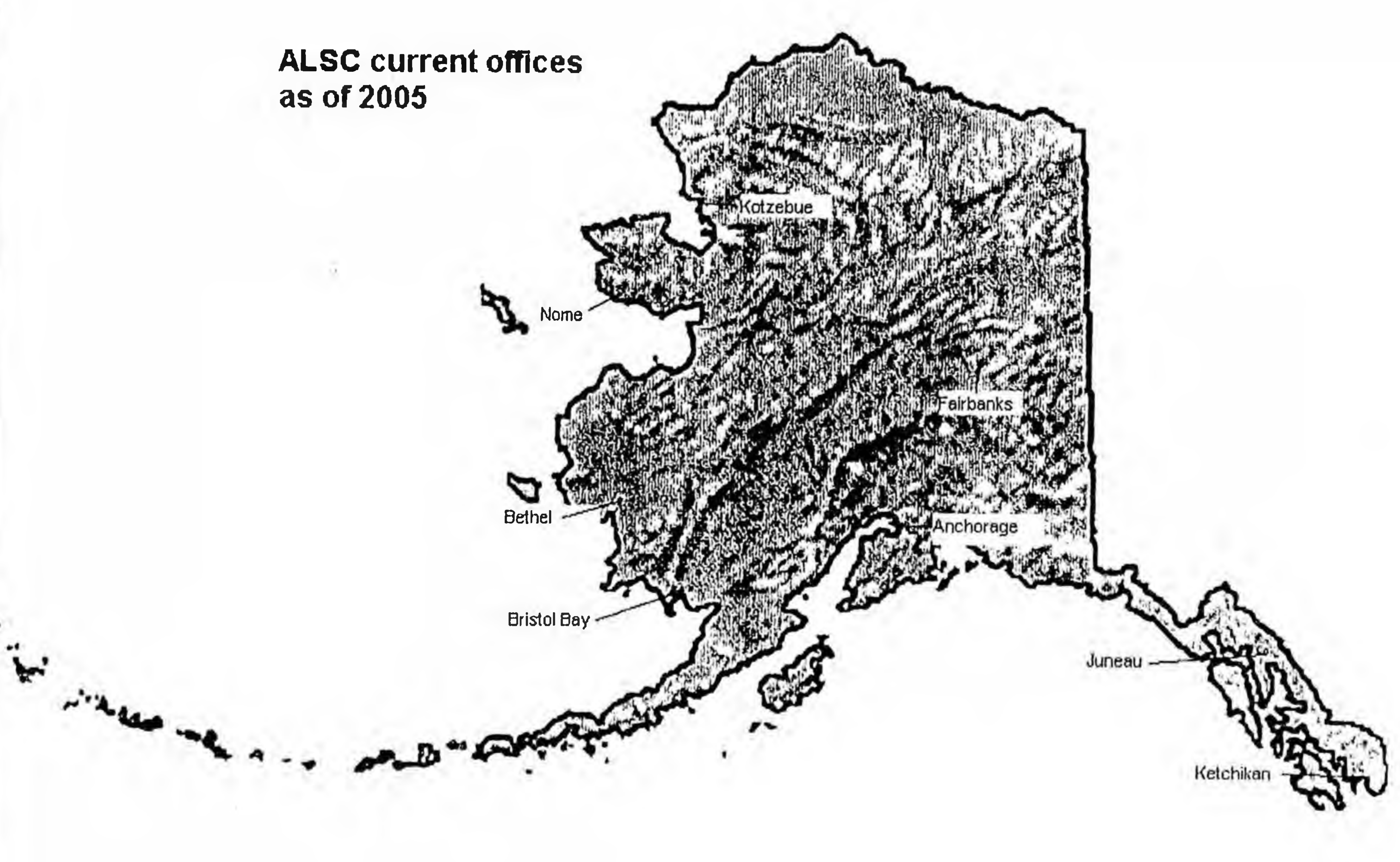
SB 69 is designed to provide a financial mechanism whereby the legislature may make appropriations to organizations that provide civil legal services to low-income Alaskans. This would be accomplished through the creation of a civil legal services account funded by provisions required under AS 09.17.020(j). This section of Alaska law requires that 50% of all punitive damage awards be turned over to the state and deposited into the general fund.

The civil legal needs of economically disadvantaged Alaskans are generally no different than anyone else's. Family law, health, will and probate issues know no socio-economic boundaries. Yet when these needs arise, self-represented litigants quite often find themselves unable to effectively represent their interests. Furthermore, these situations often place the judge in the inappropriate position of offering legal advice or even mediating between parties.

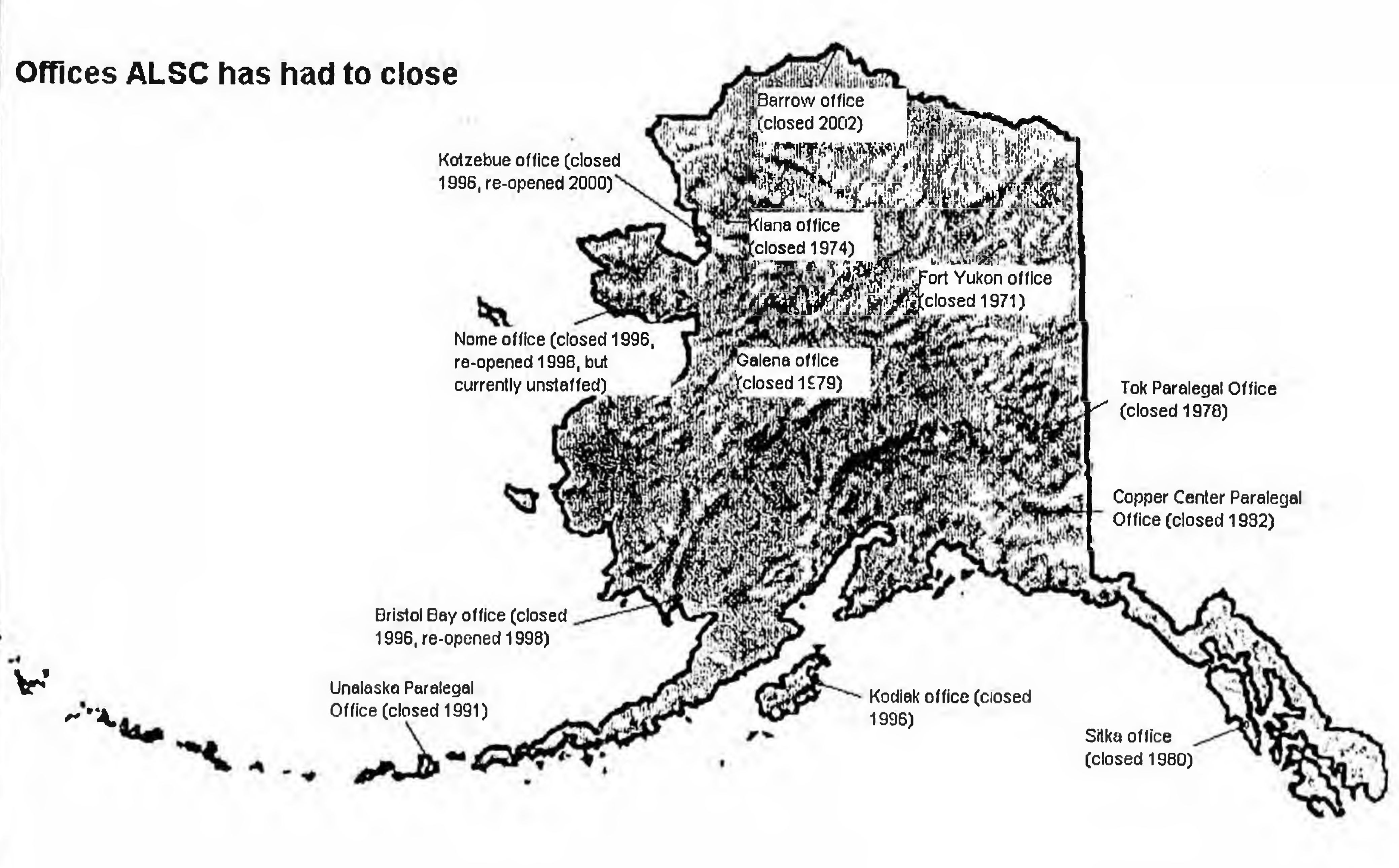
Since 1966, the Alaska Legal Services Corporation (ALSC) has assisted low-income Alaskans with their civil legal needs. The ALSC is not a state agency but rather a non-profit entity. The ALSC has been funded by a combination of state, federal and private sources. However, over the last several years these funds have been on the decline.

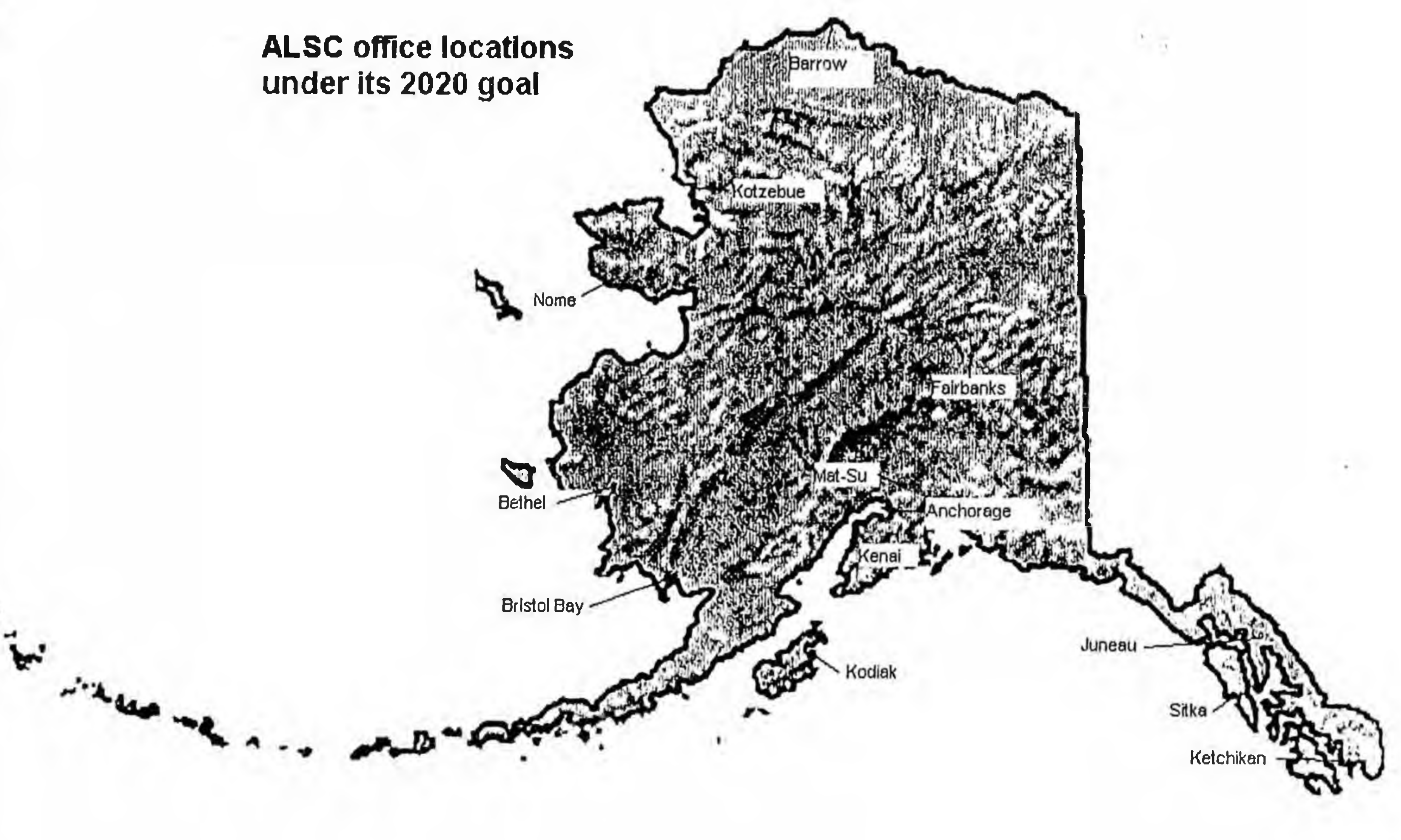
The inherent logic of SB 69 lies in the fact that the funds utilized to assist the disadvantaged in civil legal matters flow out of the civil legal system itself. High-stakes civil cases provide the funding mechanism for smaller but no less important cases impacting low-income Alaskans. Furthermore, necessary efficiencies are achieved throughout the entire process by working these cases through a non-profit entity such as ALSC.

SB 69 identifies an ongoing source of funding designed to aid the ALSC in its efforts to provide civil legal assistance to low-income Alaskans. This is accomplished through use of the state's 50% share of civil damage awards deposited to the general fund. It is important to note that SB 69 does not create a mandatory expenditure. Each legislature possesses an option to appropriate these monies to a civil legal services fund.


ALSC current offices
as of 2005
Kotzebue
Nome
Fairbanks
Bethel
Anchorage
Bristol Bay
Juneau
Ketchikan

Offices ALSC has had to close




ALSC office locations
under its 2020 goal
Barrow
Kotzebue
Nome
Fairbanks
Mat-Su
Bethel
Anchorage
Kenai
Bristol Bay
Juneau
Kodiak
Sitka
Ketchikan

Emily Stancliff

From: Andy Harrington [aharrington@alsc-law.org]
Sent: Thursday, January 18, 2007 12:14 PM
To: Emily Stancliff
Subject: Re: HB 76
Attachments: State funding.pdf

Emily, thanks for the email and for relaying the question.

The short answer is, ALSC does not receive a state appropriation, so the risk of another drop in a regular state appropriation is equal to the amount of our current state appropration, i.e., zero. A more detailed response follows.

ALSC formerly received an appropriation from the State, which had been as high as $1.2 million in FY 1984, but has not received a State appropriation since FY 2004. Most of this came through the Department of Community and Economic Development and its predecessors, for general civil work; a smaller amount came through the Department of Health and Social Services to represent individuals receiving State "Interim Assistance" in their appeals of their Social Security Disability denials. The last (FY 2004) appropriation was just through the DCED, for $125,000. The legislature had approved an appropriation in its FY 2005 budget, but then-Governor Murkowski line-item vetoed that in the summer of 2004, and ALSC has not received an appropriation since then. I'm attaching a table that shows the history of those appropriations.

Now, for the sake of completeness, you should understand that ALSC received in 2005 a total of $264,811 from funding sources which our audit classifies as State funds, but which are in actuality from local municipal grants and from the Alaska Mental Health Trust Authority.

First, ALSC received local grants from the Fairbanks North Star Borough, the Municipality of Anchorage, and the Mat-Su Borough. These are awarded by the local municipalities to local charities under a competitive grant application process, which varies from community to community. (In Anchorage, these are administered by the United Way, and are on a two-year cycle; in the North Star Borough, they are administered by a Borough Commission, and are on a one-year cycle; etc.) The funds come from a State/local match (I think in a 70/30 ratio) under the Human Services Matching Grant Program. ALSC received a total of $216,760 from the three local grants during 2005 ($123,786 from Anchorage, $55,110 from Fairbanks, and $43,740 from Mat-Su). Although these figures include both the state share and the local share, our audit reflects the entire $216,760 as state funding, notwithstanding the fact that the applications are submitted to, funding decisions made by, programs administered within, and services limited to residents of, the local municipalities.

Second, ALSC's "Beneficiary Self-Sufficiency Project" receives discretionary funding from the Alaska Mental Health Trust Authority, to focus on the civil legal needs of Trust Beneficiaries. In 2005, $42,175 came to ALSC from this source. Again, our audit reflects this as State funds. However, services funded from this source are not made available to all State residents, instead limited to Trust Beneficiaries.

The potential for a reduction in the local or AMHTA funds is quite possible. None of these is by any means "secure," and ALSC works hard every year to deliver quality services to the constituents for each of these funding sources, and submit well-prepared competitive applications to each municipality. But if ALSC does at some point in the future lose these funds, it is more likely to be a result of a low-scored municipal grant application or a decision by the AMHTA than by legislative action.

I hope this answers your question regarding state appropriations. (Maybe more than you wanted to know, but I like to err on the side of providing too much information rather than too little.) Please let me know if I can supply further information on this or any other points, and thanks again!

Andy

STATE OF ALASKA

DEPARTMENT OF LAW

OFFICE OF THE ATTORNEY GENERAL

SARAH PALIN, GOVERNOR
1031 WEST 4TH AVENUE, SUITE 200
ANCHORAGE, ALASKA 99501-3903
PHONE: (907)269-5190
FAX: (907)258-0760

January 22, 2007

The Honorable Jay Ramras
Alaska State Legislature
State Capitol, Room 104
Juneau, Alaska 99801-1182

Re: HB 76, An Act relating to the creation of a civil legal services fund.

Dear Representative Ramras:

Enclosed is a spreadsheet prepared to reflect reported awards of punitive damages and collection by the state under AS 09.17.020(j). This spreadsheet reflects awards made in 2005, 2006, or which are still pending judicial action. We received a request for this information by the Executive Director of the Alaska Legal Services Corporation requesting that the information also be provided to your office. Under Alaska Civil Rule of Procedure 78(c), the Attorney General is to be provided notice of any awards of punitive damages.

Please feel free to contact me if you have any further questions.

Sincerely,

TALIS J. COLBERG
ATTORNEY GENERAL

By: Gail T. Voigtlander
Gail T. Voigtlander
Assistant Attorney General

GTV:hrh
encl.

cc: Andy Harrington, Executive Director, ALSC
Deborah Behr
John Bitney

Awards 2005 - January 2007 or which are still judicially pending
PUNITIVE DAMAGE AWARDS

Case Name	Case Number	Case Description	Amount of Punitive Damages Awarded by Verdict (total)	Amount Collected	Verdict Date	State Move to Intervene	State's Calculation of State's Share	Credit for Rule 82 Award	Appeal Status	Notes
Rausl v. Alaska Petroleum Contractors	3KN-99-132	Employment Action	$500,000 reversed on appeal		01/11/01	Yes	Yet to be determined		Appeal concluded	Amount to the State yet to be determined by the trial court.
State of Alaska v Karen Carpenter, Westwood One, and Tom Leykis	S-10700/10739	Tort Claim Arising Out of Radio Communication	$150,000.00		2002	Yes	$75,000 minus atty fees	On appeal	Yes	On Appeal to Supreme Court. Draft circulating.
MacDonald v City of Tenakee Springs, et al.	1JU-03-228 CI	Civil Assault	$135,000.00		03/21/05	No	$67,500			Insufficient assets.
Hudson v Brandner	3AN-03-6138 CI	Personal Injury	$25,000.00		1/5/2006 Bench Trial	No	$12,500 minus atty fees			On appeal.
Lamb v. Anderson	4FA-03-02534 CI	Personal Injury	$1000 (settlement)	$333.00	04/05/06	No				Received 7/12/06
Ayuluk v. Gary Austin	3AN-01-09449 CI	Personal Injury	$6,500	None	05/06/05	No	$3,250 minus atty fees	Not yet determined	Possible	Pending trial court motion practice.
Donna Walker v. Ella Lind	3AN-03-4407 CI	Personal Injury	$100,000	None	10/02/06	No	$30,000 minus atty fees			Plaintiff plans on trying to execute against defendant's Exxon Valdez claim.
F.S. Air Service v. Casciola	3AN-02-6489 CI	Misrepresentation/ Breach of Contract	$300,000	None	02/27/02	No	$150,000 minus atty fees	?	Completed	Defendant in Florida; pending criminal charges; restitution is not likely.

EXISTING ALASKA STATUTE

Sec. 09.17.020. Punitive damages.

(a) In an action in which a claim of punitive damages is presented to the fact finder, the fact finder shall determine, concurrently with all other issues presented, whether punitive damages shall be allowed by using the standards set out in (b) of this section. If punitive damages are allowed, a separate proceeding under (c) of this section shall be conducted before the same fact finder to determine the amount of punitive damages to be awarded.

(b) The fact finder may make an award of punitive damages only if the plaintiff proves by clear and convincing evidence that the defendant's conduct

(1) was outrageous, including acts done with malice or bad motives; or

(2) evidenced reckless indifference to the interest of another person.

(c) At the separate proceeding to determine the amount of punitive damages to be awarded, the fact finder may consider

(1) the likelihood at the time of the conduct that serious harm would arise from the defendant's conduct;

(2) the degree of the defendant's awareness of the likelihood described in (1) of this subsection;

(3) the amount of financial gain the defendant gained or expected to gain as a result of the defendant's conduct;

(4) the duration of the conduct and any intentional concealment of the conduct;

(5) the attitude and conduct of the defendant upon discovery of the conduct;

(6) the financial condition of the defendant; and

(7) the total deterrence of other damages and punishment imposed on the defendant as a result of the conduct, including compensatory and punitive damages awards to persons in situations similar to those of the plaintiff and the severity of the criminal penalties to which the defendant has been or may be subjected.

(d) At the conclusion of the separate proceeding under (c) of this section, the fact finder shall determine the amount of punitive damages to be awarded, and the court shall enter judgment for that amount.

(e) Unless that evidence is relevant to another issue in the case, discovery of evidence that is relevant to the amount of punitive damages to be determined under (c)(3) or (6) of this section may not be conducted until after the fact finder has determined that an award of punitive damages is allowed under (a) and (b) of this section. The court may issue orders as necessary, including directing the parties to have the information relevant to the amount of punitive damages to be determined under (c)(3) or (6) of this section available for production immediately at the close of the initial trial in order to minimize the delay between the initial trial and the separate proceeding to determine the amount of punitive damages.

(f) Except as provided in (g) and (h) of this section, an award of punitive damages may not exceed the greater of

(1) three times the amount of compensatory damages awarded to the plaintiff in the action; or

(2) the sum of $500,000.

(g) Except as provided in (h) of this section, if the fact finder determines that the conduct proven under (b) of this section was motivated by financial gain and the adverse consequences of the conduct were actually known by the defendant or the person

responsible for making policy decisions on behalf of the defendant, it may award an amount of punitive damages not to exceed the greatest of

(1) four times the amount of compensatory damages awarded to the plaintiff in the action;

(2) four times the aggregate amount of financial gain that the defendant received as a result of the defendant's misconduct; or

(3) the sum of $7,000,000.

(h) Notwithstanding any other provision of law, in an action against an employer to recover damages for an unlawful employment practice prohibited by AS 18.80.220, the amount of punitive damages awarded by the court or jury may not exceed

(1) $200,000 if the employer has less than 100 employees in this state;

(2) $300,000 if the employer has 100 or more but less than 200 employees in this state;

(3) $400,000 if the employer has 200 or more but less than 500 employees in this state; and

(4) $500,000 if the employer has 500 or more employees in this state.

(i) Subsection (h) of this section may not be construed to allow an award of punitive damages against the state or a person immune under another provision of law. In (h) of this section, "employees" means persons employed in each of 20 or more calendar weeks in the current or preceding calendar year.

(j) If a person receives an award of punitive damages, the court shall require that 50 percent of the award be deposited into the general fund of the state. This subsection does not grant the state the right to file or join a civil action to recover punitive damages.

(k) In a civil action in which an employer is determined to be vicariously liable for the act or omission of an employee, punitive damages may not be awarded against the employer under principles of vicarious liability unless (1) the employer or the employer's managerial agent (A) authorized the act or omission and the manner in which the act was performed or omission occurred; or (B) ratified or approved the act or omission after the act or omission occurred; or (2) the employee (A) was unfit to perform the act or avoid the omission and the employer or the employer's managerial agent acted recklessly in employing or retaining the employee; or (B) was employed in a managerial capacity and was acting within the scope of employment. In this subsection, "managerial agent" means a management level employee with the stature and authority to exercise control, discretion, and independent judgment over a certain area of the employer's business and with some power to set policy for the employer.

Sec. 09.60.080. Contingent fee agreements.

If an attorney contracts for or collects a contingency fee in connection with an action for personal injury, death, or property damage and the damages awarded by a court or jury include an award of punitive damages, the contingent fee due the attorney shall be calculated **before that portion of punitive damages due the state under AS 09.17.020(j) has been deducted from the total award of damages.**

EXISTING ALASKA STATUTE

Sec. 45.50.531. Private and class actions.

(a) A person who suffers an ascertainable loss of money or property as a result of another person's act or practice declared unlawful by AS 45.50.471 may bring a civil action to recover for each unlawful act or practice three times the actual damages or $500, whichever is greater. The court may provide other relief it considers necessary and proper. Nothing in this subsection prevents a person who brings an action under this subsection from pursuing other remedies available under other law, including common law.

(b) [Repealed, Sec. 4 ch 31 SLA 1987].

(c) Upon commencement of an action brought under this section the clerk of the court shall mail a copy of the complaint or other initial pleading to the attorney general and, upon entry of an order or judgment in the action, shall mail a copy of the order or judgment to the attorney general.

(d) [Repealed, Sec. 4 ch 31 SLA 1987].

(e) A permanent injunction or final judgment against a person against whom an action was initiated under AS 45.50.501 is prima facie evidence in an action brought under this section that the person used or employed an act or practice declared unlawful by AS 45.50.471.

(f) A person may not commence an action under this section more than two years after the person discovers or reasonably should have discovered that the loss resulted from an act or practice declared unlawful by AS 45.50.471.

(g) [Repealed, Sec. 6 ch 96 SLA 1998].

(h) If the basis for the action is the fault of the manufacturer or supplier of the merchandise, the manufacturer or supplier who is at fault is liable for the damages awarded against the retailer under this section.

(i) If a person receives an award of punitive damages under (a) of this section, the court shall require that 50 percent of the award be deposited into the general fund of the state under AS 09.17.020(j). This subsection does not grant the state the right to file or join a civil action to recover punitive damages.

EXISTING ALASKA STATUTE

Sec. 37.05.146. Definition of program receipts and non-general fund program receipts.

(a) In AS 37.05.142 - 37.05.146 and AS 37.07.080, "program receipts" means fees, charges, income earned on assets, and other state money received by a state agency in connection with the performance of its functions. Unless otherwise provided in this section, program receipts are accounted for within, and appropriated from, the general fund of the state.

(b) The program receipts listed in this subsection are accounted for separately, and appropriations from these program receipts are not made from the unrestricted general fund:

(1) federal receipts;

(2) University of Alaska receipts (AS 14.40.491);

(3) designated program receipts; in this paragraph, "designated program receipts" means money received by the state from a source other than the state or federal government that is restricted to a specific use by the terms of a gift, grant, bequest, or contract;

(4) receipts of or from the trust established by AS 37.14.400 - 37.14.450, except reimbursements described in AS 37.14.410;

(5) receipts of the Alaska Fire Standards Council for which a taxpayer is allowed a credit under AS 21.89.075.

(c) The program receipts of the following are accounted for separately, and appropriations from these program receipts are not made from the unrestricted general fund:

(1) highway working capital fund (AS 44.68.210);

(2) correctional industries fund (AS 33.32.020);

(3) loan funds;

(4) international airport revenue fund (AS 37.15.430);

(5) corporate receipts earned or managed by a public corporation of the state;

(6) fish and game fund (AS 16.05.100);

(7) school fund (AS 43.50.140);

(8) training and building fund (AS 23.20.130);

(9) retirement funds (AS 14.25, AS 22.25, AS 26.05.222, AS 39.35, and former AS 39.37);

(10) permanent fund (art. IX, sec. 15, Alaska Constitution);

(11) public school trust fund (AS 37.14.110);

(12) second injury fund (AS 23.30.040);

(13) fishermen's fund (AS 23.35.060);

(14) FICA administration fund (AS 39.30.050);

(15) receipts of the employee benefits program established under AS 39.30.150 - 39.30.180;

(16) receipts of the deferred compensation program established under AS 39.45;

(17) clean air protection fund (AS 46.14.260);

(18) receipts of the group insurance programs established under AS 39.30.090;

(19) mental health trust fund (AS 37.14.031);

(20) Alaska children's trust (AS 37.14.200);

(21) commercial fisheries test fishing operations (AS 16.05.050(a)(14));

(22) Regulatory Commission of Alaska under AS 42.05 and AS 42.06;

(23) Alaska Oil and Gas Conservation Commission under AS 31.05;

(24) receipts of the Department of Commerce, Community, and Economic Development under AS 08.01.065 and from fines and penalties collected in licensing and disciplinary actions for occupations under AS 08.01.010;

(25) receipts from the seafood marketing assessment under AS 16.51.120 - 16.51.170, and receipts of the Alaska Seafood Marketing Institute;

(26) the administrative cost charge under AS 44.33.113 for the state's role in the federal community development quota program;

(27) dive fishery management assessment receipts (AS 43.76.150), salmon fishery assessment receipts (AS 43.76.220), and permit buy-back assessment receipts (AS 43.76.300);

(28) process service fees collected by the Department of Public Safety;

(29) Alaska Commercial Fisheries Entry Commission under AS 16.05.490, 16.05.530, and AS 16.43;

(30) receipts of the Alaska Vocational Technical Center;

(31) Alaska Pioneers' Home and Alaska Veterans' Home care and support receipts under AS 47.55.030;

(32) receipts of the Department of Transportation and Public Facilities from tolls charged for use of the Whittier Tunnel;

(33) receipts of the Department of Commerce, Community, and Economic Development, division of insurance, from license fees and fees for services;

(34) receipts of the Department of Commerce, Community, and Economic Development from its functions relating to banking, securities, and corporations;

(35) receipts of the Department of Corrections from the electronic prisoner monitoring program under AS 33.30.065(d);

(36) receipts of the Department of Corrections from the operation of community residential centers;

(37) receipts of the Alaska Police Standards Council;

(38) receipts of the Department of Public Safety from fees for fire and life safety plan checks under AS 18.70.080(b);

(39) receipts of the Department of Transportation and Public Facilities from the measurement standards and commercial vehicle enforcement program;

(40) receipts of the Department of Education and Early Development for teacher certification under AS 14.20.020;

(41) receipts of the Professional Teaching Practices Commission from professional certification fees;

(42) receipts of the Department of Health and Social Services, Bureau of Vital Statistics;

(43) receipts of the Department of Corrections from the inmate telephone system;

(44) receipts of the Department of Public Safety from the Alaska automated fingerprint system under AS 44.41.025(b);

(45) receipts of the Department of Administration from the boat registration program under AS 05.25.096;

(46) state land disposal program (AS 38.04.022);

(47) shore fisheries development lease program account (AS 38.05.082(f));

(48) timber receipts account (AS 38.05.110);

(49) workers' safety and compensation administration account (AS 23.05.067);

(50) receipts of fees for recording and related services of the Department of Natural Resources (AS 40.17.030(a)(10), 40.17.070; AS 44.37.025(b), 44.37.027(c); AS 45.29.303(b), 45.29.525, and 45.29.619(a));

(51) receipts described in AS 46.03.482(b)(1) and (2) received under the commercial passenger vessel environmental compliance program;

(52) receipts of the Department of Commerce, Community, and Economic Development for fees for business licenses and license endorsements under AS 43.70;

(53) receipts of fees for certain inspections deposited under AS 05.20.060, AS 18.60.360, 18.60.395, 18.60.800, and AS 18.62.030 in the building safety account created under AS 44.31.025;

(54) passenger facility charges collected at state-owned and operated airports under Federal Aviation Administration guidelines;

(55) money received by the Department of Environmental Conservation from the inspection of food under AS 17.20;

(56) fees received by the Department of Natural Resources under AS 41.21.026 for the use of state park system facilities;

(57) application and renewal fees received by the Department of Public Safety under AS 18.65.400 - 18.65.490 for licenses for security guards and security guard agencies;

(58) fees received by the Department of Public Safety under AS 18.65.700 - 18.65.790 for the issuance, renewal, and replacement of permits to carry concealed handguns;

(59) monetary recoveries by the Department of Health and Social Services of Medicaid expenditures from recipients, third parties, and providers under AS 47;

(60) the state's share of overpayments collected by the Department of Health and Social Services under AS 47.05.080;

(61) income received by the Department of Health and Social Services from a state or federal agency for children in foster care under AS 47.14.100;

(62) fees received by the Department of Health and Social Services under AS 44.29.022 for nursing and planning services provided at health centers;

(63) fees received by the Department of Health and Social Services under AS 44.29.022 for genetic screening clinics and specialty clinics;

(64) fees received by the Department of Health and Social Services under AS 18.08.080 for the certification of emergency medical technicians, emergency medical dispatchers, and emergency medical technician instructors;

(65) fees collected by the Department of Health and Social Services under AS 44.29.022 from the certification of x-ray machines;

(66) fees collected under AS 44.29.022 by the Department of Health and Social Services under the Alcohol Safety Action Program;

(67) fees received by the Department of Health and Social Services under AS 47.32;

(68) charges, rentals, and fees for airport or air navigation facility contracts, leases, and other arrangements under AS 02.15.020 and 02.15.090;

(69) fees for utility facility permits under AS 02.15.102, encroachment permits under AS 02.15.106, utility right-of-way permits under AS 19.25.010, and utility facility permits under AS 35.10.210;

(70) recoveries of repair costs for damage to highway fixtures;

(71) the state's share of child support collections for reimbursement of the cost of the Alaska temporary assistance program as provided under AS 25.27.120, 25.27.130, and AS 47.27.040;

(72) vehicle registration fees collected under AS 28.10.421 and other fees and charges collected under AS 28.10.441;

(73) fees for drivers' licenses, drivers' permits, renewals, and driver skills tests collected under AS 28.15.271;

(74) user fees and other fees collected by the Department of Education and Early Development under AS 14.57.010;

(75) student tuition and other fees related to schools that are operated by the state and collected under AS 14.07.030;

(76) receipts of fees for registration and renewal of registration for the sale of business opportunities under AS 45.66.040;

(77) emission control permit receipts account (AS 46.14.265);

(78) workers' compensation benefits guaranty fund (AS 23.30.082);

(79) receipts of the Department of Environmental Conservation from the registration of pesticides and broadcast chemicals and the licensing of pesticide applicators under AS 44.46.025;

(80) [See delayed repeal note]. the Alaska senior care fund (AS 47.45.360).

AFV labeling cost is estimated to be $258,400 ($0.38 × 680,000).

Thus, the estimated total annual non-labor cost burden associated with the Rule is $259,000 ($205 + $258,400), rounded.

William Blumenthal,
General Counsel.

[FR Doc. E7-952 Filed 1-23-07; 8:45 am]

BILLING CODE 6750-01-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Annual Update of the HHS Poverty Guidelines

AGENCY: Department of Health and Human Services.

ACTION: Notice.

SUMMARY: This notice provides an update of the HHS poverty guidelines to account for last calendar year's increase in prices as measured by the Consumer Price Index.

DATES: *Effective Date:* Date of publication, unless an office administering a program using the guidelines specifies a different effective date for that particular program.

ADDRESSES: Office of the Assistant Secretary for Planning and Evaluation, Room 404E, Humphrey Building, Department of Health and Human Services (HHS), Washington, DC 20201.

FOR FURTHER INFORMATION CONTACT: For information about how the guidelines are used or how income is defined in a particular program, contact the Federal, State, or local office that is responsible for that program. Contact information for two frequently requested programs is given below:

For information about the Hill-Burton Uncompensated Services Program (free or reduced-fee health care services at certain hospitals and other facilities for persons meeting eligibility criteria involving the poverty guidelines), contact the Office of the Director, Division of Facilities Compliance and Recovery, Health Resources and Services Administration, HHS, Room 10-105, Parklawn Building, 5600 Fishers Lane, Rockville, Maryland 20857. To speak to a person, call (301) 443-5656. To receive a Hill-Burton information package, call 1-800-638-0742 (for callers outside Maryland) or 1-800-492-0359 (for callers in Maryland). You may also visit *http://www.hrsa.gov/hillburton/default.htm.* The Division of Facilities Compliance and Recovery notes that as set by 42 CFR 124.505(b), the effective date of this update of the poverty guidelines for facilities obligated under the Hill-Burton Uncompensated Services Program is sixty days from the date of this publication.

For information about the percentage multiple of the poverty guidelines to be used on immigration forms such as USCIS Form I-864, Affidavit of Support, contact U.S. Citizenship and Immigration Services at 1-800-375-5283 or visit *http://www.uscis.gov/files/form/I-864p.pdf.*

For information about the number of people in poverty or about the Census Bureau poverty thresholds, visit the Poverty section of the Census Bureau's Web site at *http://www.census.gov/hhes/www/poverty/poverty.html* or contact the Census Bureau's Demographic Call Center Staff at (301) 763-2422 or 1-866-758-1060 (toll-free).

For general questions about the poverty guidelines themselves, contact Gordon Fisher, Office of the Assistant Secretary for Planning and Evaluation, Room 404E, Humphrey Building, Department of Health and Human Services, Washington, DC 20201—telephone: (202) 690-7507—or visit *http://aspe.hhs.gov/poverty/.*

SUPPLEMENTARY INFORMATION:

Background

Section 673(2) of the Omnibus Budget Reconciliation Act (OBRA) of 1981 (42 U.S.C. 9902(2)) requires the Secretary of the Department of Health and Human Services to update, at least annually, the poverty guidelines, which shall be used as an eligibility criterion for the Community Services Block Grant program. The poverty guidelines also are used as an eligibility criterion by a number of other Federal programs. The poverty guidelines issued here are a simplified version of the poverty thresholds that the Census Bureau uses to prepare its estimates of the number of individuals and families in poverty.

As required by law, this update is accomplished by increasing the latest published Census Bureau poverty thresholds by the relevant percentage change in the Consumer Price Index for All Urban Consumers (CPI-U). The guidelines in this 2007 notice reflect the 3.2 percent price increase between calendar years 2005 and 2006. After this inflation adjustment, the guidelines are rounded and adjusted to standardize the differences between family sizes. The same calculation procedure was used this year as in previous years. (Note that these 2007 guidelines are roughly equal to the poverty thresholds for calendar year 2006 which the Census Bureau expects to publish in final form in August 2007.) The guideline figures shown represent annual income.

2007 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA

Persons in family	Poverty guideline
1	$10,210
2	13,690
3	17,170
4	20,650
5	24,130
6	27,610
7	31,090
8	34,570

For families with more than 8 persons, add $3,480 for each additional person.

2007 POVERTY GUIDELINES FOR ALASKA

Persons in family	Poverty guideline
	$12,770
2	17,120
3	21,470
4	25,820
5	30,170
6	34,520
7	38,870
8	43,220

For families with more than 8 persons, add $4,350 for each additional person.

2007 POVERTY GUIDELINES FOR HAWAII

Persons in family	Poverty guideline
1	$11,750
2	15,750
3	19,750
4	23,750
5	27,750
6	31,750
7	35,750
8	39,750

For families with more than 8 persons, add $4,000 for each additional person.

Separate poverty guideline figures for Alaska and Hawaii reflect Office of Economic Opportunity administrative practice beginning in the 1966–1970 period. (Note that the Census Bureau poverty thresholds—the version of the poverty measure used for statistical purposes—have never had separate figures for Alaska and Hawaii.) The poverty guidelines are not defined for Puerto Rico or other outlying jurisdictions. In cases in which a

Federal program using the poverty guidelines serves any of those jurisdictions, the Federal office that administers the program is generally responsible for deciding whether to use the contiguous-states-and-DC guidelines for those jurisdictions or to follow some other procedure.

Due to confusing legislative language dating back to 1972, the poverty guidelines have sometimes been mistakenly referred to as the "OMB" (Office of Management and Budget) poverty guidelines or poverty line. In fact, OMB has never issued the guidelines; the guidelines are issued each year by the Department of Health and Human Services. The poverty guidelines may be formally referenced as "the poverty guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2)."

Some programs use a percentage multiple of the guidelines (for example, 125 percent or 185 percent of the guidelines), as noted in relevant authorizing legislation or program regulations. Non-Federal organizations that use the poverty guidelines under their own authority in non-federally-funded activities can choose to use a percentage multiple of the guidelines such as 125 percent or 185 percent.

The poverty guidelines do not make a distinction between farm and non-farm families, or between aged and non-aged units. (Only the Census Bureau poverty thresholds have separate figures for aged and non-aged one-person and two-person units.)

Note that this notice does not provide definitions of such terms as "income" or "family." This is because there is considerable variation in how different programs that use the guidelines define these terms, traceable to the different laws and regulations that govern the various programs. Therefore, questions about how a particular program applies the poverty guidelines (*e.g.*, Is income before or after taxes? Should a particular type of income be counted? Should a particular person be counted in the family or household unit?) should be directed to the organization that administers the program.

Dated: January 17, 2007.

Michael O. Leavitt,

Secretary of Health and Human Services.

[FR Doc. 07–268 Filed 1–19–07; 8:45 am]

BILLING CODE 4151–05–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Disease, Disability, and Injury Prevention and Control Special Emphasis Panel (SEP): NIOSH Occupational Health and Safety Research, Program Announcement Number (PAR) 06–484

In accordance with section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92–463), the Centers for Disease Control and Prevention (CDC) announces the aforementioned meeting.

Time and Date: 8 a.m.–5 p.m., February 9, 2007 (Closed).

Place: 1750 New York Avenue, NW., Washington, DC 20006.

Status: The meeting will be closed to the public in accordance with provisions set forth in section 552b(c)(4) and (6), Title 5 U.S.C., and the Determination of the Director, Management Analysis and Services Office, CDC, pursuant to Public Law 92–463.

Matters To Be Discussed: The SEP meeting will include the review, discussion, and evaluation of applications received in response to "NIOSH Occupational Health and Safety Research," PAR 06–484. The applications being reviewed include information of a confidential nature, including personal information concerning individuals associated with the applications.

Contact Person for More Information: Horace M. Stiles, DDS, PhD, MPH, Designated Federal Officer, 15111 Farm Market Road, Maypearl, Texas 76064–1902, telephone 404.498.2584.

The Director, Management Analysis and Services Office, has been delegated the authority to sign Federal Register notices pertaining to announcements of meetings and other committee management activities, for both CDC and the Agency for Toxic Substances and Disease Registry.

Dated: January 18, 2007.

Elaine L. Baker,

Acting Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

[FR Doc. E7–987 Filed 1–23–07; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Submission for OMB Review; Comment Request

Title: 45 CFR 1304 Head Start Program Performance Standards.

OMB No. 0970–0148.

Description: Head Start Program Performance Standards require Head Start and Early Head Start Programs and Delegate Agencies to maintain program records. The Administration for Children and Families, Office of Head Start, is proposing to renew, without changes, the authority to require certain record keeping in all programs as provided for in 45 CFR part 1304 Head Start Program Performance Standards. These standards prescribe the services that Head Start and Early Head Start programs provide to enrolled children and their families.

Respondents: Head Start and Early Head Start grantees and delegate agencies.

ANNUAL BURDEN ESTIMATES

Instrument	Number of respondents	Number of responses per respondent	Average burden hours per response	Total burden hours
Standard	2,590	16	41.8	1,732,192
Estimated Total Annual Burden Hours:				1,732,192

Additional Information: Copies of the proposed collection may be obtained by writing to the Administration for Children and Families, Office of Administration, Office of Information Services, 370 L'Enfant Promenade, SW., Washington, DC 20447, Attn: ACF Reports Clearance Officer. All requests should be identified by the title of the information collection. E-mail address: *infocollection@acf.hhs.gov.*

OMB Comment: OMB is required to make a decision concerning the collection of information between 30 and 60 days after publication of this document in the **Federal Register**. Therefore, a comment is best assured of having its full effect if OMB receives it within 30 days of publication. Written comments and recommendations for the proposed information collection should be sent directly to the following: Office of Management and Budget, Paperwork

February 17, 2006
Dr. Obermeyer:

Attached is a list of the Alaska Legal Services (ALSC) attorneys working under Bar Rule 43. There is no limit on the amount of time Rule 43 attorneys may work for ALSC. Rule 43 only applies to ALSC lawyers, and does not apply to Catholic Social Services, the Disability Law Center or the Mental Health Trust.

Also included are the Legal Interns, the Rule 43.1 (military) lawyer and the Foreign Law Consultant.

Deborah O'Regan
Executive Director
Alaska Bar Association
907-272-7469
mailto:oregan@alaskabar.org

Rule 43 Attorneys	Date Started*	Bar Admission
Denise Bakewell	9/22/04	California
Kate Burkhart	8/15/01	Tennessee
Jody Davis	6/25/95	Ohio
Judith DeMarsh	1/19/01	California
Russell LaVigne	10/28/99	Montana
Diana Lucente	1/8/02	New York
Linda Mueller	9/14/05	Ohio
Jamy Patterson	1/6/05	South Dakota
Christina Reigh	6/25/04	Washington
Carol Yeatman	5/7/99	Nevada

* no end date as long as they are employed by ALSC

Legal Interns	Expiration Date (6 month period)
Jennifer Messick	3/27/06
Tran Smith	4/7/06
Paul Hart	5/11/06

Military Attorneys Rule 43.1	Dates of Practice (2 years)
Lt. Anthony Owens	7/8/04 – 7/8/06

Foreign Legal Consultant	Waiver Date (no end date)
Nickolai Shcherbina	9/23/93

As of 2/17/06

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PART IV.

Rule 43. Waivers to Practice Law for Alaska Legal Services Corporation.

Section 1. Eligibility. A person not admitted to the practice of law in this state may receive permission to practice law in the state if such person meets all of the following conditions:

(a) The person is a graduate of a law school which was accredited or approved by the Council of Legal Education of the American Bar Association or the Association of American Law Schools when the person entered or graduated and is an attorney in good standing, licensed to practice before the courts of another state, territory or the District of Columbia, or is eligible to be admitted to practice upon taking the oath of that state, territory or the District of Columbia;

(b) The person will practice law exclusively for Alaska Legal Services Corporation on a full-time or part-time basis;

(c) The person has not failed the bar exam of this state.

Section 2. Application. Application for such permission shall be made as follows:

(a) The executive director of the Alaska Legal Services Corporation shall apply to the Board of Governors on behalf of a person eligible under Section 1;

(b) Application shall be made on forms approved by the Board of Governors;

(c) Proof shall be submitted with the application that the applicant is an attorney in good standing, licensed to practice before the courts of another state, territory or the District of Columbia, or is eligible to be admitted to practice upon taking the oath of the state, territory or the District of Columbia.

Section 3. Approval. The Board of Governors shall consider the application as soon as practicable after it has been submitted. If the board finds that the applicant meets the requirements of Section 1 above, it shall grant the application and issue a waiver to allow the applicant to practice law before all courts of the state of Alaska. The Board of Governors may delegate the power to the executive director of the Bar Association to approve such applications and issue waivers, but the Board shall review all waivers so issued at its regularly scheduled meetings.

Section 4. Conditions. A person granted such permission may practice law only as required in the course of representing clients of Alaska Legal Services Corporation, and shall be subject to the provisions of Part II of these rules to the same extent as a member of the Alaska Bar Association. Such permission shall

cease to be effective upon the failure of the person to pass the Alaska Bar examination.

(Added by Amendment No. 1 to SCO 176 effective July 1, 1974; amended by SCO 232 effective December 12, 1975; by SCO 484 effective November 2, 1981; by SCO 1153 effective July 15, 1994; by SCO 1282 effective January 15, 1998; and by SCO 1604 effective October 15, 2006)

Rule 43.1. Waivers to Practice Law Under a United States Armed Forces Expanded Legal Assistance Program.

Section 1. Eligibility. A person not admitted to the practice of law in this state may receive permission to practice law in the state for a period of not more than two years if such person meets all of the following conditions:

(a) The person is a graduate of a law school which was accredited or approved by the Council of Legal Education of the American Bar Association or the Association of American Law Schools when he entered or graduated and is an attorney in good standing, licensed to practice before the courts of another state, territory or the District of Columbia, or is eligible to be admitted to practice upon taking the oath of that state, territory or the District of Columbia;

(b) The person is an active duty member of the United States Armed Forces assigned to the Judge Advocate General's Corps or the United States Coast Guard; and

(c) The person has not failed the bar exam of this state.

Section 2. Application. Application for such permission shall be made as follows:

(a) The Staff Judge Advocate of the Military Installation to which the applicant is assigned shall apply to the Board of Governors on behalf of a person eligible under Section 1;

(b) Application shall be made on forms approved by the Board of Governors; and

(c) Proof shall be submitted with the application that the applicant is a graduate of an accredited Law School as provided in Section 1 of this rule and is an attorney in good standing, licensed to practice before the courts of another state, territory or the District of Columbia, or is eligible to practice upon taking the oath of the state, territory or the District of Columbia.

Section 3. Approval. The Board of Governors shall consider the application as soon as practicable after it has been submitted. If the Board finds that the applicant meets the requirements of Section 1 above, it shall grant the application and issue a waiver to allow the applicant to practice law before all courts of the State of Alaska. The Board of Governors may delegate the power to the Executive Director of the Bar Association to approve such applications and issue waivers, but the Board shall review all waivers so issued at its regularly scheduled meetings.

Section 4. Conditions. A person granted such permission may practice law only as required in the course of representing military clients or their dependents, or when accepting a case under the auspices of the Alaska Pro Bono Program

under this rule, and shall be subject to the provisions of Part II of these rules to the same extent as a member of the Alaska Bar Association. Such permission shall cease to be effective upon the failure of the person to pass the Alaska Bar examination.

(Added by SCO 345 effective December 18, 1978; amended by SCO 1333 effective January 15, 1999)

Rule 44. Legal Interns.

Section 1. Practice Authorized When. The Integrated Bar Act prohibits the practice of law by anyone not admitted to practice in Alaska. This rule does not authorize an intern to perform any function prohibited by that Act other than those specifically set forth herein.

Section 2. Definition of Legal Intern. A "legal intern" is any person who has on file with the Alaska Bar Association an effective permit issued by the Bar Association through its Executive Director.

Section 3. Eligibility for Intern Permit. Every applicant for an intern permit shall:

(a) File an application in the form prescribed by the Board and produce and file the evidence and documents herein required as proof of eligibility for the permit;

(b) Be a student who:

(1) Is duly enrolled in a law school which was accredited or approved by the Council of Legal Education of the American Bar Association or the Association of American Law Schools when the applicant entered, or is enrolled in a law school in which the principles of English common law are taught but which is located outside the United States and beyond the jurisdiction of the American Bar Association and the Association of American Law Schools, provided that the foreign law school in which he or she is enrolled meets the American Bar Association Council of Legal Education Standards for approval;

(2) Has successfully completed at least one-half of the course work required for a law degree;

(3) Has filed with the application a certificate from the dean or other chief administrative officer of his or her law school, stating that he or she meets the requirements as set forth in subsections (b) (1) and (b) (2); or

(c) Be a law school graduate who:

(1) Has graduated from a law school which was accredited or approved by the Council of Legal Education of the American Bar Association or the Association of American Law Schools when the applicant entered or graduated, or has graduated from a law school in which the principles of English common law are taught but which is located outside the United States and beyond the jurisdiction of the American Bar Association and the Association of American Law Schools, provided that the foreign law school from which he or she has graduated meets the American Bar Association Council of Legal Education Standards for approval;

(2) Has never failed a bar examination administered by any state of the United States, or the District of Columbia, or, despite failure, has subsequently passed such a bar examination; and

(3) Has filed with the executive director a certificate from the dean or other chief administrative officer of his or her law school which states that the legal intern applicant meets the requirements set forth in subsection (c) (1), and either

(i) A personal affidavit stating that he or she never failed a bar examination, as set forth in subsection (c) (2), or

(ii) A certificate from the supreme court of the state in which, subsequent to failure, a bar examination was passed.

Section 4. Prior Admission. Any applicant who has been admitted to practice in another jurisdiction must file a certificate of good standing from each jurisdiction in which the applicant is admitted. If not in good standing, the applicant shall submit satisfactory proof that the applicant has never been disbarred, suspended or otherwise disciplined.

Section 5. Act Authorized by Permit.

(a) A legal intern may appear and participate in all proceedings before any district or superior court of this state to the extent permitted by the judge or the presiding officer if the attorney representing the client is personally present and able to supervise the intern and has filed an entry of appearance with the court and the office of the Alaska Bar Association substantially in compliance with the form set forth in Section 9 of this rule;

(b) A legal intern may also appear and participate before any district court in small claims matters, arraignments, pleas, bail hearings, sentencings and recorded in-chambers conferences without an attorney being personally present to supervise the intern under the following conditions:

(1) If the attorney representing the client has filed an appearance in the case and with the Bar office substantially in compliance with the form set forth in Section 9 of this rule;

(2) If the supervising attorney files a certificate stating that the intern has previously been present and supervised in a similar proceeding and that the attorney believes the intern is competent to conduct such proceedings without the personal presence of the attorney ;

(3) If the client gives written consent to the appearance. A governmental body may grant approval through its attorney; and

(4) If the judge or magistrate agrees to permit the legal intern to participate in the proceedings.

Section 6. Termination of Permit. A permit shall cease to be effective upon the occurrence of one of the following events whichever occurs first:

(a) The expiration of a period of six months from date of issuance;

(b) The failure of an intern to take the first Alaska Bar examination for which the intern is eligible;

(c) The failure of an intern to pass any bar examination.

Section 7. Renewal of Expired Permit. A permit which has expired under Section 6(a) may be renewed upon compliance with the conditions for issuing an original permit, providing there has been no prior revocation of any certificate, authorization or approval required by Section 5 of this rule. No other permit shall be renewed.

Section 8. Prior Certification. All interns certified prior to the effective date of this rule must comply with the provisions of this rule within 30 days of its effective date.