

ALASKA LEGISLATURE COMMITTEE FILES, 2003-2004 8672

10742 HOUSE HEALTH EDUCATION & SOCIAL SERVICES



# ALASKA PUBLIC HEALTH ASSOCIATION

Committed To Advancing Alaska's Public Health Since 1978

## ALPHA

FAX RE: HB 108 - SCREENING NEWBORNS FOR HEARING ABILITY <sup>MAY 05 2003</sup> May 6, 2003

Dear Representative:

HB 108: Screening Newborns for Hearing Ability is expected to be heard for the first time in (H)HESS today. On behalf of the Alaska Public Health Association, I will be presenting the following testimony.

Madame Chairman, members of the Committee, thank you for the opportunity to testify today. For the record, my name is Marie Lavigne and I am the Executive Director of the Alaska Public Health Association. I am honored to be here today representing close to two hundred public health professionals from across Alaska who are deeply committed to developing sound public health policy to improve the health of all Alaskan's.

Recognizing the importance of universal hearing screening of newborns as a critical public health intervention, the Alaska Public Health Association encourages you to support HB 108. Hearing impairment is the most common disability in newborns, impacting 2-3 children out of every thousand. Identified early, these children will not be left behind during the most critical period for speech and language development: birth to 3 years of age.

Late identification of infant hearing loss presents a significant public health problem. Without screening, children with hearing loss are usually not identified until two years of age or later, which results in significant delays in speech, language, social, cognitive, and emotional development.

Research has shown that children identified at birth with mild-to-severe hearing loss who receive intervention before they are 6 months of age fall within a normal range of language comprehension and expression as well as social development by the time they are ready to begin school. By contrast, children with hearing loss diagnosed after six months of age experience significant delays in both language and social development. The cost savings of early intervention is significant, as others will be testifying to this today.

HB 108 offers an important first step in providing newborn hearing loss screening. Yet we urge you to not stop at the hospital or birth center, as what happens after screening is also important. Families need to receive appropriate information and services following newborn hearing screening and to have their children begin receiving intervention services by six months of age. It is also critical the team working with the child measure the impact of early identification of hearing loss on development, tracking gains made and areas to develop.

To quote from Dr. Marion Downs, the world-renowned pioneer in pediatric audiology, "If a child can be identified at birth and receive immediate intervention, we have done our jobs," she said. "On the other hand, if we don't detect the hearing loss until the child reaches 2 years of age or later, that child has, in most cases, lost the opportunity to catch up with others his or her own age. *Why, with all the tools we have, would we not speed the time to establish a model for screening and early intervention in our nation's hospitals?*" That is the challenge before us in Alaska.

HB 108 takes an important step in bringing forth universal hearing, building on the success of 60% of Alaska's hospitals and birthing centers who are already voluntarily screening, to assure all newborns will be screened. With appropriate screening and follow up services, HB 108 will assure our children who are deaf or hearing impaired receive the early intervention services they need to develop their fullest potential. Thank you.

Marie J. Lavigne, Executive Director Alaska Public Health Association

P.O. Box 9-1825 Anchorage, AK 99509 907/332-1030 e-mail: publichealth@alaska.net www.alaskapublichealth.org



**FRANK H. MURKOWSKI, GOVERNOR**  
State of Alaska

**GOVERNOR'S COUNCIL ON DISABILITIES AND SPECIAL EDUCATION**

P.O. Box 240249 • Anchorage, Alaska 99524-0249 • Phone: 907-269-8990 • Fax: 907-269-8995 • Toll Free 800-708-8990

May 6, 2003

Dear Madam Chair and Members of the House HESS Committee,

On behalf of the Governor's Council on Disabilities and Special Education, I would like to indicate the Council's support for House Bill 108, the newborn hearing screening bill. This bill is critical to the development and well being of the newest Alaskans, newborn infants.

Hearing loss is the most frequently occurring birth defect in the United States. Early detection and treatment is crucial to prevent further damage. Without early screening children wait years for treatment, simply because their hearing loss is not identified until they are, on average, two and a half to three years old and in some cases until they are even as old as five or six years of age. A child who does not receive treatment for several years will have great difficulty learning basic language and social and cognitive skills, necessary for success in school and later on in life as a productive member of society.

Currently 32 states have implemented laws requiring infant hearing screening. Alaska is behind the curve. Hearing screening is relatively inexpensive (\$10-\$50 per infant), especially when compared with the long-term costs of not treating an individual with hearing loss. Studies have shown that a child whose hearing loss goes undetected in infancy, even a child with mild hearing loss, will cost a projected \$400,000 in special education costs by the time they graduate from high school. These students are 10 times as likely to be held back in school than a child with normal hearing or a child with hearing loss who received early intervention services.

In conclusion I would urge every one of you to support House Bill 108. If you have any questions or would like additional information, please feel free to contact me at 269-8992 or millie\_ryan@health.state.ak.us.

Sincerely,

A handwritten signature in cursive script that reads "Millie Ryan".

Millie Ryan, Executive Director  
Governor's Council on Disabilities and Special Education

*Creating Change That Improves The Lives Of People With Disabilities*

MAY 05 2003

**Subject: House Bill 108**

**Date: Fri, 11 Apr 2003 18:49:16 -0800**

**From: Lisa Owens <lowens@tetongravity.com>**

**To: Representative\_Richard\_Foster@legis.state.ak.us**

Hello Rep Foster,

My name is Lisa Owens and I am a speech pathologist/audiologist in Anchorage, AK. I am very interested in House Bill 108 and would like to be informed of any hearing dates. I am on the state advisory board for newborn hearing screenings and see firsthand the importance of this bill everyday in my work. I also used to live in Kotzebue and my family comes from Nome. Both these communities suffer from high incidence of hearing loss and I think that this legislation would be very important to the children of Alaska. Please let me know when you plan to send this bill to committee.

Sincerely,

Lisa Owens, M.A., CCC-SLP/A  
Speech Pathologist/Audiologist

3200 Providence Drive  
P.O. Box 196604  
Anchorage, Alaska  
99519-6604

Tel 907.562.2211



April 15, 2003

Representative Richard Foster  
State Capitol, Room 410  
Juneau, AK 99801-1182

Dear Rep. Foster,

I am writing to support your sponsorship of House Bill 108 ("Screening Newborns for Hearing Ability"). I am a pediatrician in private practice in Anchorage and Chairman of the Department of Pediatrics at Providence Alaska Medical Center and The Children's Hospital. House Bill 108 is unanimously supported and endorsed by the pediatric staff at Providence. The American Academy of Pediatrics supports the development of programs in each state for universal screening of all infants for hearing deficits at or soon after birth in order to allow for early identification and intervention of hearing impaired children in order to maximize their potential. The implications of overlooked hearing loss as well as the benefits of early detection have been well reported.

1. Hearing loss is one of the most common birth defects. One in 3000 infants are born in Alaska with permanent congenital hearing loss. Without universal newborn hearing programs, the average age of detection of even severe hearing loss is 2-3 years old
2. Hearing loss has a significant negative effect on children. This would seem obvious but many studies indicate the negative impact of hearing loss on a child's emotional and social development as well as language delays that do not seem to progress even after diagnosis, in some children, when that diagnosis is delayed. Even mild and unilateral hearing loss – problems that often defy detection much longer without an objective early hearing screen- may have long lasting negative effects to the child.
3. Early detection and intervention of hearing deficits significantly helps children. Numerous studies show that when children are diagnosed with hearing loss and appropriate intervention to augment hearing and provide appropriate communication options are started early in life, preferably before 6 months of age, significant and long lasting benefits are achieved by the children in language skills, emotional development, social and familial adjustment.

In order to achieve these benefits for children and their families, there are several benchmark steps that must occur for a successful early hearing detection and intervention program.

Each of these can be greatly aided by your bill as written:

1. Universal hearing screen for all newborns – This first step is already nearly achieved in Alaska. Due to new advancement in screening technology almost all birthing hospitals either are or soon will be screening newborns for hearing loss. By allowing non-audiologists to administer the screen and bill appropriately for this service, and asking insurance companies to cover this “standard of care” evaluation, all infants in the state can have this evaluation before they leave the hospital or birthing facility.
2. When a hearing screen is failed, they are referred for evaluation – This step may have one or two parts. A child who fails the initial screen is referred for re-screen and if still abnormal, diagnostic intervention is performed by 3 month of age. Each institution and/or the infant’s medical provider are responsible for this step. This allows for errors of omission that in some areas markedly reduce the effectiveness of the entire program. With the tracking provision of your bill, information will be shared with a state program that can make sure each infant that needs further intervention have this option provided for them. Without a state mandate, this information will have to be shared voluntarily creating a possible HIPAA confidentiality concern. When done early, many of our audiologists around the state can do this evaluation with objective testing called automated brainstem response testing. When postponed, even a few months, this test often requires testing with the infant sedated, which at present can only be done in Anchorage, and at increased expense and concern for the family.
3. Once diagnosed, in order to receive maximum benefit, parents should be presented with communication options and intervention should begin before 6 months of age. These options may include hearing aids (which are accepted by infants much better if started in early infancy), and various communication options including sign language and other visual cues. The parents and the infant’s medical provider must serve as a medical home and have information to make appropriate referrals for subspecialty evaluation and community based resources in accordance with the Individuals with Disabilities Education Act.

The physicians of The Children’s Hospital at Providence, thank you for sponsoring this bill and for the efforts that you have made toward improving the health and well being of Alaska’s children.

Sincerely,

A handwritten signature in black ink, appearing to read 'J. Demain', with a long horizontal flourish extending to the right.

Jeffrey G. Demain, MD, FAAP, FAAAAI  
Chairman, Department of Pediatrics, PAMC

April 15, 2003

Representative Richard Foster

Dear Mr. Foster:

I am writing to support your sponsorship of House Bill 108 ("Screening Newborns for Hearing Ability"). I am a pediatrician in private practice in Anchorage with 24 years of experience. I also serve as the Alaska Chapter Champion for the Early Hearing Detection and Intervention Program for the American Academy of Pediatrics. The American Academy of Pediatrics supports the development of programs in each state for universal screening of all infants for hearing deficits at or soon after birth in order to allow for early identification and intervention with hearing impaired children in order to maximize their potential. There are several reasons that this program is important:

1. Hearing loss is one of the most common birth defects. One in 3000 infants are born in Alaska with permanent congenital hearing loss. Without universal newborn hearing programs, the average age of detection or even severe hearing loss is 2-3 years old
2. Hearing loss has a significant negative effect on children. This would seem obvious but many studies indicate the negative impact of hearing loss on a child's emotional and social development as well as language delays that do not seem to progress even after diagnosis, in some children, when that diagnosis is delayed. Even mild and unilateral hearing loss – problems that often defy detection much longer without an objective early hearing screen- may have long lasting negative effects to the child.
3. Early detection and intervention of hearing deficits significantly helps children. Numerous studies show that when children are diagnosed with hearing loss and appropriate intervention to augment hearing and provide appropriate communication options are started early in life, preferably before 6 months of age, significant and long lasting benefits are achieved by the children in language skills, emotional development, social and familial adjustment.

In order to achieve these benefits for children and their families, there are several steps that must occur that are benchmarks for a successful early hearing detection and intervention program and each of these can be greatly aided by your bill as written:

1. Universal hearing screen for all newborns – This first step is already nearly achieved in Alaska. Due to new advancement in screening technology almost all birthing hospitals either are or soon will be screening newborns for hearing loss. By allowing non-audiologists to administer the screen and bill appropriately for this service, and asking insurance companies to cover this "standard of care" evaluation, all infants in the state can have this evaluation before they leave the hospital or birthing facility.
2. When a hearing screen is failed, they are referred for evaluation – This step may have one or two parts. A child who fails the initial screen is referred for re-screen and if still abnormal, diagnostic intervention is performed by 3 month of age. Each

institution and/or the infant's medical provider are responsible for this step. This allows for errors of omission that in some areas markedly reduce the effectiveness of the entire program. With the tracking provision of your bill, information will be shared with a state program that can make sure each infant that needs further intervention have this option provided for them. Without a state mandate, this information will have to be shared voluntarily creating a possible HIPAA confidentiality concern. When done early, many of our audiologists around the state can do this evaluation with objective testing called automated brainstem response testing. When postponed, even a few months, this test often requires testing with the infant sedated, which at present can only be done in Anchorage, and at increased expense and concern for the family.

3. Once diagnosed, in order to receive maximum benefit, parents should be presented with communication options and intervention should begin before 6 months of age. These options may include hearing aids (which are accepted by infants much better if started in early infancy), and various communication options including sign language and other visual cues. The parents and the infant's medical provider must serve as a medical home and have information to make appropriate referrals for subspecialty evaluation and community based resources in accordance with the Individuals with Disabilities Education Act.

Mr. Foster, thank you for sponsoring this bill that will assure that our youngest Alaskans have the opportunity to have this most common, but invisible, birth defect diagnosed early with appropriate intervention that will offer long term benefits for their future. If I can be of any assistance, please let me know.

Sincerely,

Martin F. Beals, Jr., M. D., FAAP  
Alaska AAP Chapter Champion, EHDI program

ALL ALASKA PEDIATRIC PARTNERSHIP

3<sup>RD</sup> MEDICAL GROUP \* ALASKA NATIVE CHILDREN'S CENTER \* ALASKA REGIONAL HOSPITAL  
CHILDREN'S HOSPITAL AT PROVIDENCE \* FAIRBANKS MEMORIAL HOSPITAL  
STATE OF ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES \* VALLEY HOSPITAL  
MUNICIPALITY OF ANCHORAGE DEPARTMENT OF HEALTH AND SOCIAL SERVICES

MEMO

DATE: 12/23/02

TO: Christine Hess

FM: Mary Grisco

RE: Universal Newborn Hearing Screening

Hi Christine,

Enclosed is a packet of basic information that was prepared to assist with re-introduction of structural legislation.

Reggie said to send it to you. I'm not sure if Rep. Foster will be introducing this legislation; he however has expressed great interest.

THANKS!

November 27, 2002

Dear Interested Party:

Enclosed are two model bills for Early Hearing Detection and Intervention: 1) drafted by the American Speech-Language-Hearing Association (ASHA), and 2) drafted by the American Academy of Pediatrics (AAP). Both model bills are compilations of legislation from the 37 states that currently require universal newborn hearing screening (UNHS) by law. Points of concern regarding wording throughout the two bills and implementation of mandatory universal newborn hearing screening and reporting in Alaska, include the

**ASHA Model EHD**

p. 1, Table of Content. Section 4.

Change from Early Hearing Detection & Intervention Advisory Board to EHDI Advisory Committee throughout bill.

p. 2, Section 3.

(A). Expand definition of birthing hospital to include home deliveries and births occurring in free-standing birthing centers.

p. 3, Section 5.

- (A). "There is established the Early Hearing Detection and Intervention Advisory Board..." – would want to use existing EHDI Advisory Committee.
- (B). "...newborn hearing screening must be conducted on no fewer than 85% of the newborns born in the hospitals in this State during birth admission..." – want to increase to 100% by end of 2003 or 2004.
- (D). "Every hospital shall report annually to the Board concerning the following:..."
  1. change from Board to State of Alaska, Department of Health & Social Services
  2. ensure that information collected starts with the minimum requirements requested by the Center for Disease Control and Prevention (CDC)
  3. information collected should also include a list of newborns who meet the high risk category for follow-up every six months for 3 years

p. 6, Section 7.

- (A). "In the event that 85% of newborns and infants born in this State are not being screened..., then the Department shall immediately implement a program to provide..." – State of Alaska, Department of Health & Social Services would not begin performing newborn hearing screening, but rather work with the birthing hospital, birthing facility, and/or community to remedy the situation.

- (A1). "A hearing screening test....A person properly trained and supervised by a State-licensed audiologist may perform the hearing screening test." – not necessary to be trained by a State-licensed audiologist to perform newborn hearing screening tests. An individual may perform a hearing test if authorized to do so under a protocol developed by the Department of Health and Social Services.

### AAP EHDI MODEL BILL

p. 2, Section 5.

"Perform the hearing testing...prior to the date on which he or she attains the age of three months." – Adjust to reflect an appropriate adjusted age for newborns born prematurely.

p. 3, Section 8.

"Collect performance data specified by the state Department of Health..." – Ensure that information collected begins with the minimum requirements required by CDC for all children, the minimum data set for those children who "refer", or do not pass the screening, and/or children who meet the high risk registry categories.

Thank you very much for your inquiry regarding this program. Please let me know if I can provide further information.

Sincerely,



Margaret Lanier Kessler, MPH, CHES  
EHDI Program Manager

## MINIMUM DATA ELEMENTS ONLY

Last Updated 9/30/2002

### Data Items for state-based Early Hearing Detection and Intervention (EHDI) tracking database Draft for Publication -- Produced by EHDI Data Committee

First draft created by Roy Ing, June 11, 2001; subsequent drafts updated by Data Committee during monthly conference calls, July 2001 through July 2002

#### Purpose

To create a comprehensive list of data items that can be used as a guide for building a state-based EHDI tracking system

This draft is intended as a guideline for states or facilities developing a newborn hearing program. Data items identified are classified as follows:

M= Minimum data item--data item recommended for all state data systems; the set of data items that are required for followup on universal newborn hearing screening and for full reporting on national EHDI goals.

#### Audience

State EHDI coordinators

Information systems developers interested in state-based EHDI tracking system

Facilities providing hearing screening, diagnosis, intervention, or research related to state or national EHDI programs

#### Outline

##### Information about facilities (places) and programs

Information about BIRTHING HOSPITAL OR FACILITY

Information about HEARING TESTING / EVALUATION CLINIC OR FACILITY

Information about HEARING LOSS FOLLOW-UP FACILITY

Information about HEARING LOSS FOLLOW-UP PROGRAM

Information about GENETIC TESTING LABORATORY

##### Information about providers

Information about PERSON CONDUCTING HEARING SCREENING (SCREENER)

Information about AUDIOLOGIST

Information about PHYSICIAN

Information about GENETIC COUNSELOR

Information about CASE MANAGER FOR CHILD WITH HEARING LOSS

Information about HEARING LOSS INTERVENTION SPECIALIST

##### Information about child and family

Information about FAMILY (mother, father, relative, caregiver)

Basic information about CHILD

Information about CHILD'S RISK FACTORS

##### Information about events

Information about child's BIRTH HOSPITALIZATION

Information about each SCREENING (FIRST OR RE-SCREEN) TESTS performed on child

Information about each DIAGNOSTIC HEARING EVALUATION performed on child

Information about EARLY INTERVENTION SERVICES received by each child with HEARING LOSS

Information about MEDICAL EVALUATION AND MEDICAL INTERVENTION received by each child with HEARING LOSS

Information about GENETIC TESTING of each child with HEARING LOSS and GENETIC COUNSELING for families

Information about SPEECH AND LANGUAGE DEVELOPMENT of each CHILD with HEARING LOSS

##### Information about hearing screening and follow-up status of child

#### Possible Record Type

Facility Record

Provider Record

Family Record

Child Record

Child Record

Child Record

Program Reports

Types of COMMUNICATIONS TO PARENTS AND PROVIDERS  
 Summary report of STATUS of SCREENING, EVALUATION, HEARING LOSS and INTERVENTION of child

**Abbreviations**

**Data Need categories:**

M=Minimum data item--data item recommended for all state data systems and required to report fully on national EHDl goals.

**Other Abbreviations:**

DSHPSHWA=Directors of Speech and Hearing Programs in State Health and Welfare Agencies

ICD=International Classification of Diseases; codes used to designate diagnoses, conditions of newborn, causes of death, etc.B314

JCIH=Joint Committee on Infant Hearing

UNHS=Univeral Newborn Hearing Screening

Information about BIRTHING HOSPITAL OR FACILITY					Measure Component
Data Need #	Category	Data Item description	Categories or codes	Notes	
1	M	Hospital or birthing facility (unique identifier).			EHDl 1.1; DSHPSHWA 10, 11, 13
8	M	Number of newborns screened		Provided to national or out-of-state databases without hospital identifier.	
9	M	Newborn hearing screening status	Universal / High risk infants only / Some / None	Provided to national or out-of-state databases without hospital identifier. All GA hospitals provide universal newborn hearing screening.	
10	M	Number of families that refuse screening		Provided to national or out-of-state databases without hospital identifier.	
15	M	Are alternate forms of educational materials available?	Availability for languages where 5% or more of population represented	All hospitals in Georgia have access to materials in the four most frequently spoken languages from the UNHS program; availability of materials is unknown.	EHDl 1.2

Information about HEARING TESTING / EVALUATION CLINIC OR FACILITY					Measure Component
Data Need #	Category	Data Item description	Categories or codes	Notes	

Information about HEARING LOSS FOLLOW-UP FACILITY					Measure Component
Data Need #	Category	Data Item description	Categories or codes	Notes	
				GA will not collect this information.	

Information about HEARING LOSS FOLLOW-UP PROGRAM					Measure Component
Data Need #	Category	Data Item description	Categories or codes	Notes	

Information about GENETIC TESTING LABORATORY					Measure Component
Data Need #	Category	Data Item description	Categories or codes	Notes	

Information about PERSON CONDUCTING HEARING SCREENING (SCREENER)					Measure Component
Data Need Category #	New	Data item description	Categories or codes	Notes	

Information about AUDIOLOGIST					Measure Component
Data Need Category #	New	Data item description	Categories or codes	Notes	

91	M	Does audiologist have and follow state protocols?	Yes/No	Should this and education and training be at the individual record level or maintained elsewhere in aggregate form? GA will determine this from the information collected from each diagnosis.	EHDI 2.3
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Information about PHYSICIAN					Measure Component
Data Need Category #	New	Data item description	Categories or codes	Notes	

96	M	Physician's primary board-certified specialty	Pediatrician / Family Practice / ENT / Eye / Pediatric neurologist / Plastic Surgery / Surgery / Other		EHDI 3.1
99	M	This physician represents child's Medical Home		This record must link with child's record for physician who represents medical home.	

Information about GENETIC COUNSELOR					Measure Component
Data Need Category #	New	Data item description	Categories or codes	Notes	

Information about CASE MANAGER FOR CHILD WITH HEARING LOSS					Measure Component
Data Need Category #	New	Data item description	Categories or codes	Notes	

Information about HEARING LOSS INTERVENTION SPECIALIST					Measure Component
Data Need Category #	New	Data item description	Categories or codes	Notes	

Information about FAMILY (mother, father, relative, caregiver)					Measure
Data Need Category #	New	Data item description	Categories or codes	Notes	

#	New	Data Item description	Categories or codes	Notes	Component
138	M	Child (unique identifier)			
		MOTHER INFORMATION			
143	M	Mother's date of birth			EHDI 1.3
144	M	Mother's ethnicity	Hispanic/Latino or not Hispanic		EHDI 1.3
145	M	Mothers race	American Indian or Alask Native/ Asian/ Black or African American; Native Hawaiian or Other Pacific Islander; White		EHDI 1.3
146	M	Mother's education			EHDI 1.3
147	M	Mother's language			
		FATHER INFORMATION			
		GUARDIAN INFORMATION			
		CONTACT INFORMATION			

Basic Information about CHILD					
#	New	Data Item description	Categories or codes	Notes	Measure Component
138	M	Child (unique identifier)			
205	M	Sex	Male / Female		
206	M	Ethnicity	Hispanic/Latino or not Hispanic		EHDI 1.3
207	M	Race	American Indian or Alask Native/ Asian/ Black or African American; Native Hawaiian or Other Pacific Islander; White		EHDI 1.3
208	M	Mother (identifier)			
211	M	Date of birth (birth certificate)			EHDI 6.5; DSHPSWA 3

Information about CHILD'S RISK FACTORS					
#	New	Data Item description	Categories or codes	Notes	Measure Component
138	M	Child (unique identifier)			EHDI 6.6
213	M	Family history of childhood sensorineural (permanent) hearing loss?		Wording deleted: Family history of permanent childhood hearing loss?	EHDI 6.6, JCIH-1c, JCIH-2b.
214	M	In-utero (congenital) infections?	Yes/No	Is this general item needed?	EHDI 6.6
215	M	In-utero (congenital) infection: Cytomegalovirus?	Yes/No	ICD?	EHDI 6.6, JCIH-1e, JCIH-2e.
216	M	In-utero (congenital) infection: Rubella?	Yes/No	ICD?	EHDI 6.6, JCIH-1e, JCIH-2e.
217	M	In-utero (congenital) Infection: Syphilis (although not specifically mentioned)?	Yes/No	ICD?	EHDI 6.6, JCIH-1e, JCIH-2e.
218	M	In-utero (congenital) infection: Herpes?	Yes/No	ICD?	EHDI 6.6, JCIH-1e, JCIH-2e.
219	M	In-utero (congenital) infection: Toxoplasmosis?	Yes/No	ICD?	EHDI 6.6, JCIH-1e, JCIH-2e.
220	M	In-utero (congenital) Infection: Other?	Yes/No	(specify) ICD?	EHDI 6.6, JCIH-1e, JCIH-2e.
224	M	Craniofacial anomalies, including those with morphological abnormalities of the pinna and ear canal. (JCIH-1d)		This and next risk were re-done to fit updated JCIH Risk Indicators	EHDI 6.6

227	M	Findings associated with a syndrome known to include hearing loss?	Trisomy 21 / Pierre Robin syndrome / choanal atresia / Rubinstein-Taybi syndrome / Stickler syndrome / oculo-auriculo-vertebral (OAV) spectrum (Goldenbar syndrome) / Other (specify)		EHDI 6.6, JCIH-1b.
228	M	Admitted to NICU?	Y/N		EHDI 6.6, JCIH-1a.
229	M	Days in NICU	Number of days	48 hours or more is a risk factor. Some data systems may collect risk factors (48 hours or more and more than 28 days) rather than number of days. Number of days was selected to allow for research-based changes in risk factor identification.	EHDI 6.6, JCIH-1a.
238	M	Neonatal indicators: persistent pulmonary hypertension associated with mechanical ventilation	Yes/No		JCIH-2f.
241	M	Parent or caregiver concern regarding hearing, speech, language, developmental delay or other?	Yes/No		JCIH-2a.
242	M	Stigmata or other findings with SNHL or conductive HL or Eustachian tube dysfunction?	(specify)		JCIH-2c.
243	M	Postnatal infection: Bacterial meningitis?	Yes/No	ICD?	JCIH-2d.
244	M	Postnatal infection associated with hearing loss: other?	(specify)	ICD?	JCIH-2d.
245	M	Syndromes associated with progressive hearing loss	Neurofibromatosis / Osteopetrosis / Usher Syndrome / Other (specify)	ICD?	JCIH-2g.
246	M	Neurodegenerative disorders or sensory motor neuropathies	Hunter Syndrome ? Friedreich's Ataxia / Charcot-Marie-Tooth Syndrome / Other (specify)	ICD?	JCIH-2h.
247	M	Head trauma?	Yes/No	ICD?	JCIH-2i.
248	M	Recurrent or persistent otitis media with effusion (OME) for at least 3 months?	Yes/No		JCIH-2j.

**Information about child's BIRTH HOSPITALIZATION**

Data #	Need	Category	Data item description	Categories or codes	Notes	Measure Component
138	M		Child (identifier)			EHDI 1.1; DSHPSHWA 10, 11, 13
1	M		Hospital or birthing facility (identifier)			EHDI 1.1; DSHPSHWA 4 thru 9a
259	M		Date of birth (hospital record)			EHDI 1.1; DSHPSHWA 4a, 4b
271	M		Discharge date			EHDI 1.3
273	M		Insurance / payment type for birth hospitalization	Medicaid / Medicaid-HMO / Private insurance / Private HMO / Self-Pay	Not available on GA birth cert.	

**Information about each SCREENING (FIRST OR RE-SCREEN) TEST performed on child**

Data #	Need	Category	Data item description	Categories or codes	Notes	Measure Component
282	M		Date of test		Retain screening history (e.g., retain each screening as a separate record).	EHDI 6.5; DSHPSHWA 4a, 4b, 5
138	M		Child tested (identifier)			

286	M	Facility (identifier)				EHDI 1.1
		Risk factors for hearing loss			See section on risk factors.	
289	M	Right ear: Equipment type (e.g. DPOAE, TEOAE, ABR)	OAE / ABR or more detailed codes?		Should we ask if TEOAE / DPOAE / ABR / Other?	EHDI 6.6
291	M	Right ear: Test completed successfully?	Yes/No			EHDI 6.9; DSHPSHWA 4, 4a, 4b, 5
292	M	Right ear: Test completion code	(Completed) / Could not test / Invalid / Missed / Refused / Transferred / Scheduled / Broken appointment / Deceased / Follow-up discontinued			EHDI 1.1, 6.5, 6.9
293	M	Right ear: Test results (e.g. pass/refer)	Pass / Refer / NA		Pass / Refer / Not tested	EHDI 6.9; DSHPSHWA 5, 7a, 13
294	M	Left ear: Equipment type (e.g. DPOAE, TEOAE, ABR)	OAE / ABR or more detailed codes?		Should we ask if TEOAE / DPOAE / ABR / Other?	EHDI 6.6
296	M	Left ear: Test completed successfully?	Yes/No			EHDI 6.9; DSHPSHWA 4, 4a, 4b, 5
297	M	Left ear: Test completion code	Same as Right ear			EHDI 1.1, 6.5, 6.9
298	M	Left ear: Test results (e.g. pass/refer)	Pass / Refer / NA		Pass / Refer / Not tested	EHDI 6.9; DSHPSHWA 5, 7a, 13
299	M	Disposition (eg re-screen, refer for evaluation)				EHDI 6.9; DSHPSHWA 5, 11

Information about each DIAGNOSTIC HEARING EVALUATION performed on child

Data #	Need	Category	Data item description	Categories or codes	Notes	Measure Component
308	M		Date of evaluation			EHDI 6.10; DSHPSHWA 6, 6a, 8
138	M		Child tested (unique identifier)			EHDI 6.10; DSHPSHWA 6, 6a, 8
335	M		Right ear: Evaluation completion code	(Completed) / Broken appointment / Could not test / Deceased / Invalid / Lost / Missed / No response / Refused / Scheduled / Transferred	Removed "did not do"	
345	M		Right ear: Diagnosis: Hearing loss?	PCHL?		EHDI 6.10; DSHPSHWA 6, 6a, 9, 15 DSHPSHWA 7, 7a, 9, 15
346	M		Right ear: Diagnosis: Degree of hearing loss	Mild (<=40db) / Moderate (41-60db) / Severe (61-80db) / Profound (>80db)		DSHF SHWA 15
347	M		Right ear: Diagnosis: Type of hearing loss	Fluctuating conductive / Permanent conductive / Sensorineural / Mixed / Unspecified		DSHPSHWA 15
354	M		Left ear: Evaluation completion code	(Completed) / Broken appointment / Could not test / Deceased / Invalid / Lost / Missed / No response / Refused / Scheduled / Transferred	GA will not collect this information.	
364	M		Left ear: Diagnosis: Hearing loss?	PCHL?		EHDI 6.10; DSHPSHWA 6, 6a, 9, 15 DSHPSHWA 7, 7a, 9, 15
365	M		Left ear: Diagnosis: Degree of hearing loss	Mild (<=40db) / Moderate (41-60db) / Severe (61-80db) / Profound (>80db)		DSHPSHWA 15

366 M Left ear: Diagnosis: Type of hearing loss

Fluctuating conductive / Permanent  
conductive / Sensorineural / Mixed /  
Unspecified

DSHPSHWA 15

Information about EARLY INTERVENTION SERVICES received by each child with HEARING LOSS					
Data Need #	Category	Description	Codes	Notes	Measure Component

- 138 M Child (identifier)
- 390 M Intervention service start date
- 392 M Individualized family service plan (IFSP) for child?

DSHPSHWA 9, 9a  
EHDl 6.13

Information about MEDICAL EVALUATION AND MEDICAL INTERVENTION received by each child with HEARING LOSS					
Data Need #	Category	Description	Codes	Notes	Measure Component

- 138 M Child (identifier)

Information about GENETIC TESTING of each child with HEARING LOSS and GENETIC COUNSELING for families					
Data Need #	Category	Description	Codes	Notes	Measure Component

- 138 M Child (identifier)

Information about SPEECH AND LANGUAGE DEVELOPMENT of each CHILD with HEARING LOSS					
Data Need #	Category	Description	Codes	Notes	Measure Component

- 138 M Child (identifier)
- (NEED TO ADD MEASURES OF SPEECH AND LANGUAGE)

GA - Speech and Language Development are not planned for collection in near future.

Types of COMMUNICATIONS TO PARENTS AND PROVIDERS					
Data Need #	Category	Description	Codes	Notes	Measure Component

- 138 M Child (identifier)

Summary report of STATUS of SCREENING, EVALUATION, HEARING LOSS and INTERVENTION of child					
Data Need #	Category	Description	Codes	Notes	Measure Component

- 138 M Child (identifier)
- 139 Child's mother (identifier)

156 Child's father (identifier)  
 170 Child's guardian (identifier)  
 279 Living with (identifier)

\*THE ONLY PREVIOUS QUESTION LIKE THIS IS FROM BIRTH HOSPITALIZATION - does not have id code

122 Case manager (identifier)  
 92 Child's medical doctor (identifier)

Should the medical home provider be identified here?

99 M This physician represents child's Medical Home

This record must link with the child's record for the physician who represents the medical home.

282 Initial hearing screening (date, OAE/ABR, L/R ears, results) \*SEE ORIGINAL DESCRIPTION  
 282 Rescreen hearing screening (date, OAE/ABR, L/R ears, results) \*SEE ORIGINAL DESCRIPTION

339 Diagnostic ABR (most recent date, L/R ears, results)  
 330 Behavioral assessment (most recent date, L/R ears, results)

Date is date of each exam, L/R ear information is separate, results are separate

Summary report of STATUS of SCREENING, EVALUATION, HEARING LOSS and INTERVENTION of child

Data #	Need New	Category Data Item description	Categories or codes	Notes	Measure Component
308	345/ 364	Hearing loss confirmed? (date)	Yes / No		
367	347/ 366, 346/ 365, 367	Type and degree of hearing loss (L/R ears, sound field)			
313	C	Is tester an Audiologist ?	Yes/No		
314	E	Person performing evaluation (identifier)		Change "person" to tester or audiologist	
470	III	Amplification type	Monoaural / Biaural / Unknown	/// **THIS INFORMATION DOES NOT APPEAR ANYWHERE ELSE IN THIS FORMAT; See Items 414 and 415.	
388		Date of hearing aid fitting			
471		Child's age (months) at time of hearing aid fitting	**CALCULATE, USING BIRTH DATE AND DATE OF FITTING-400		
472	III	Referral for tracking assistance		DID NOT FIND THIS / YWHERE ELSE	
367		Case referred to early intervention			
376		EI Caseworker		Is this the same as the EI Provider?	
390		Early interventions (type and dates)	Amplification / Audiology / Child-child group / Home visits / Medical / Nursing / Parent-infant group / Parent-parent group / Parent-toddler group / Parent education / Service coordination / Speech or language	Need to specify what information is required.	
473		Hearing assessment audiologist's recommendations	Diagnostic ABR / Behavioral / Medical follow-up / Risk monitoring / Locate or lost / Follow-up discontinued		
474		Recommendation date			

475

Action Due date  
(PARENT EDUCATION)  
(MEDICAL EVALUATION AND INTERVENTIONS)  
(GENETIC TESTING AND COUNSELING)  
(EARLY INTERVENTIONS)  
(SPEECH AND LANGUAGE DEVELOPMENT)



AMERICAN  
SPEECH-LANGUAGE-  
HEARING  
ASSOCIATION

75<sup>TH</sup> ANNIVERSARY  
1925-2000

## **Model Early Hearing Detection and Intervention Bill**

**Draft Revision – 2/1/02**

American Speech-Language-Hearing Association  
Contact: Charles C. Diggs, Ph.D.  
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American Speech-Language-Hearing Association  
Contact: Charles C. Diggs, Ph.D.  
Director, State & Consumer Advocacy  
Cdiggs@asha.org or 301-897-0151

**Draft Revision – 2/1/02**  
**Model Early Hearing Detection and Intervention Bill**

The original model bill (Model Universal Newborn/Infant Hearing Screening, Tracking, and Intervention Bill) was prepared in 1999 with input from the American Speech-Language-Hearing Association, the American Academy of Audiology, and the Alexander Graham Bell Association for the Deaf, Inc.

**Contents**

Section 1.	Short Title
Section 2.	Legislative Findings and Purposes
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Section 11.	Miscellaneous Provisions
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Section 13.	Effective Date

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An Act establishing a statewide Early Hearing Detection and Intervention program; establishing an advisory board; and for other purposes:

**Be it enacted by the senate and general assembly of the State of**

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**Section 1. Short Title**

This Act shall be known as the Early Hearing Detection and Intervention Act.

**Section 2. Legislative Findings and Purposes**

(A) Findings. The General Assembly finds as follows:

1. Hearing Loss occurs in newborns more frequently than any other health condition for which newborn screening is currently required;
2. Early detection of hearing loss in a child and early intervention and treatment before six months of age has been demonstrated to be highly effective in facilitating a child's healthy development in a manner consistent with the child's age and cognitive ability;
3. Eighty percent (80%) of a child's ability to learn speech, language and related cognitive skills is established by the time the child is thirty-six months of age, and hearing is vitally important to the healthy development of such language skills;
4. Children of all ages can receive reliable and valid screening for hearing loss in a cost-effective manner;
5. Appropriate screening and identification of newborns and Infants with hearing loss will facilitate early intervention and treatment in the critical time period for language development, and may therefore serve the public purposes of promoting the healthy development of children, and reducing public expenditure for health care and special education, and related services;

(B) Purposes. The purpose of this legislation is:

1. To provide early detection of hearing loss in newborn children at the birthing facility or as soon after birth as possible, to enable these children and their families/ care-givers to obtain needed multi-disciplinary evaluation, treatment, and intervention services at the earliest opportunity; and to prevent or mitigate the developmental delays and academic failures associated with late identification of hearing loss; and
2. To provide the State with the information necessary to effectively plan, establish, and evaluate a comprehensive system of appropriate services for newborns and Infants who have a hearing loss or are deaf.

### **Section 3. Definitions**

(A) The following terms used in this ACT shall have the meanings ascribed to them in this section unless expressly indicated otherwise:

"Birth Admission" means the time after birth that the Newborn remains in the hospital nursery prior to discharge.

"Board" means the State Early Hearing Detection and Intervention Advisory Board.

"Department" means the State Department of Health.

"Health Insurance Policy" means any group health insurance policy, contract, plan or any individual policy, contract or plan with dependent coverage for children, which provides medical coverage on an expense-incurred service or prepaid basis. The term includes all of the following:

1. A health insurance policy or contract issued by a nonprofit corporation or fraternal benefit society.
2. A health service plan operating as a Health Maintenance Organization, a Preferred Provider Organization, an Exclusive Provider Organization, or other managed care plan, as these terms may be defined in State law;
3. An employee welfare benefit plan as defined in section 3 of the Employee Retirement Income Security Act of 1974 (Public Law 93-406, 88 Stat. 829).

"Hearing Loss" means a hearing loss of 30 dB HL or greater in the frequency region important for speech recognition and comprehension in one or both ears (approximately 500 through 4000 Hz). However, as technology allows for changes to this definition to allow for the detection of less severe hearing loss, the Board shall have the authority to modify it by rule.

"Infant(s)" means a child 30 days to 24 months old.

"Intervention and/or Follow-up Care" means the early intervention services described in Part C of the Individuals with Disabilities Education Act (IDEA) as amended.

"Medical Assistance Program" means the State administered Medicaid program.

"Newborn(s)" means a child up to 29 days old.

"Parent(s)" means a natural parent(s), stepparent(s), adoptive parent(s), legal guardian(s) or other legal custodian of a child.

"Program" means the Early Hearing Detection and Intervention Program.

"Secretary" (Commissioner) means the Secretary (or Commissioner) of Health of this State.

#### **Section 4. Early Hearing Detection and Intervention Advisory Board**

- (A.) There is established the Early Hearing Detection and Intervention Advisory Board under the jurisdiction of the Department.

#### **Section 5. Duties and Powers of the Board**

- (A.) The Board shall advise the Secretary on issues relating to the newborn hearing screening test, diagnostic hearing evaluation, intervention, treatment, and follow-up care of newborn and infant children with a hearing loss. The Board shall act by majority vote, and as required by this State's Administrative Procedures Act. The Board shall have the authority to adopt rules to implement this Act.
- (B) By December 31, 200\_, newborn hearing screening must be conducted on no fewer than eighty-five percent (85%) of the newborns born in hospitals in this State during birth admission, using objective procedures

recommended by the Board or their equivalent. Where a newborn is delivered in a facility other than a hospital, the parents must be instructed on the merits of having the hearing screening performed and be given information to assist them in having it performed within three months of the date of the child's birth.

- (C) On or after January 1, 200\_, every hospital in this State shall educate the parents of newborns born in such hospitals of the importance of screening the hearing of newborns, and of receiving follow-up care. This educational information shall explain, in lay terms, the process of hearing screening, the likelihood of their child having a hearing loss, follow-up procedures, and community resources. The educational information also shall include a description of the normal auditory, speech, and language developmental process in children. Education shall not be considered a substitute for the hearing screening. The Board shall determine the appropriate screening venue(s) for infants who are born in facilities other than hospitals.
- (D) Every hospital shall report annually to the Board concerning the following:
1. The number of newborns born in the hospital;
  2. The number of newborns screened on birth admission;
  3. The number of newborns who passed the birth admission screening;
  4. The number of newborns who did not pass the birth admission screening;
  5. The number of newborns recommended for follow-up rescreening, diagnostic audiologic evaluation, or monitoring;
  6. The number of newborns and infants who return for follow-up rescreening, diagnostic audiologic evaluation, or monitoring;
  7. The number of newborns and infants who pass and did not pass the follow-up rescreening or diagnostic audiologic evaluation; and
  8. The number of infants referred for early intervention.
- (E) The Board shall determine which hospitals or other health care institutions in this State are administering hearing screening to newborns and infants on a voluntary basis and the number of newborns and infants screened. The Board shall report to the General Assembly by December 1, 200\_, the following:
1. The number of hospitals and other health care institutions administering voluntary screenings during birth admission;
  2. The number of newborns screened as compared to the total number of newborns born in such hospitals and institutions;
  3. The number of newborns who passed the birth admission screening;
  4. The number of newborns who did not pass the birth admission screening;
  5. The number of newborns recommended for follow-up care.

- (F) The Board shall meet as often as necessary to collect the information necessary and report to the General Assembly by December 1, 200\_, and annually thereafter. In addition, the Board shall develop and make recommendations in a sufficiently timely manner to allow for statewide early hearing detection and intervention programs by January 1, 200\_.
- (G) Subject to available appropriations, the Board shall make the report described in paragraphs E and F of this section available throughout the State, and specifically available to physicians whose practice includes the practice of obstetrics, neonatology, or the care of newborns and Infants, to consumer groups, to managed care organizations, other third party payers, and to the media.
- (H) If the number of newborns and Infants screened does not equal or exceed eighty-five percent (85%) of the total number of Newborns born in this State on or before December 31, 200\_, or falls below eighty-five percent (85%) at any time thereafter, the Department shall administer the screening of newborns and infants pursuant to this Act, and shall be reimbursed for such screenings from health insurance policies as defined herein. Notwithstanding the aforementioned, it shall be the goal of this State to achieve a one hundred percent (100%) screening rate.
- (I) The Department shall provide administrative support services required by the Board. The members of the Board shall receive no compensation for their services as members, but may receive reimbursement for travel expenses incurred as a result of their duties as members of the Board.

**Section 6. Composition of the Board**

- (A) The board shall be composed of an odd numbered membership of at least eleven members, appointed by the governor, from the following professions or organizations:

Health Professionals	Public Members	Health Care Systems/ Government
Audiologist	An adult who is deaf or hard of hearing, representing consumer organizations of deaf and hard of hearing persons	A Representative of the Health Insurance Industry
Speech-language Pathologist	Parents of children with Hearing Loss	The Secretary of Health and/or Insurance
Pediatrician/ Neonatologist	Teacher of children with Hearing Loss	A Representative from the designated

Health Professionals	Public Members	Health Care Systems/ Government
		government agency responsible for IDEA Part C.
Otolaryngologist		
Family Medical Practitioner (family doctor)		
Neonatal Nurse		

### Section 7. Universal Newborn Hearing Screening Program

- (A) In the event that eighty-five percent (85%) of Newborns and Infants born in this State are not being screened by December 31, 200\_, or if at any time after that date the number of screenings drops below eighty five percent (85%) of all newborns and infants born in this State, then the Department shall immediately implement a program to provide the following:
1. A hearing screening test that every Newborn child shall undergo for identification of newborn child Hearing Loss. A person properly trained and supervised by a State-licensed audiologist may perform the hearing screening test.
  2. The hearing screening test should be completed before discharge from a newborn nursery unit, but no later than three months after birth. The test shall include the use of at least one of the following physiologic technologies: automated or diagnostic auditory brainstem response (ABR) or otoacoustic emissions (OAE). New physiologic technologies or improvements to existing physiologic technologies that substantially enhance newborn hearing assessment should be incorporated into this program as the Board finds appropriate.

### Section 8. Intervention and Tracking Program

- (A) The Board shall establish guidelines for the provision of follow-up services for newborn children in this State who have or are at risk of developing a hearing loss and are so identified. These services shall include, but are not limited to, confirmatory pediatric audiologic assessment and diagnosis of newborns with abnormal or inconclusive test results, counseling and educational services for the parent(s), and an explanation of the potential effects of the identified hearing loss on the development of the newborn's speech, language, and cognitive skills as well as the potential benefits of early identification and intervention.

- (B) The General Assembly recognizes that it is necessary to track children identified with a hearing loss for a period of time in order to render appropriate follow-up care. Consequently, the Board is hereby authorized and directed to study and recommend to the Secretary, on or before December 31, 200\_, the preferred methods currently available to track newborns identified with a hearing loss. From the choice(s) provided by the Board, the Secretary shall then determine the most appropriate system for this State, and implement the Board's recommendation on or before December 31, 200\_. It is the purpose of this subsection to facilitate the reporting of newborns and Infants who may have or are at risk of developing a hearing loss. The reporting requirements shall be designed to be as simple as possible and easily completed by nonprofessional persons when necessary. It is the intent of the General Assembly that the tracking system, at a minimum, does the following:
1. Provide the Board, Department, and General Assembly with the information necessary to effectively plan and establish a comprehensive system of developmentally appropriate services for newborns and Infants who are deaf or hard of hearing;
  2. Reduce the likelihood of associated disabling conditions for such children; and
  3. Develop the tracking system contemplated by this section in conjunction with other similar national systems, such as the system required by Part C of the IDEA.
- (C) Once the tracking system is operational, all hospitals in the State and other providers of services that have established hearing screening procedures for newborns and infants and ages birth through three years shall report the existence of newborns and Infants who fail to pass hearing screening procedures.
- (D) The information compiled and maintained in the tracking system shall be kept confidential in accordance with the applicable requirements and provisions of Part C of IDEA. Parents of all registrants will be provided information on the availability of resources and services in the State for children with hearing loss, including those provided in accordance with IDEA through the Statewide tracking system created by this Act.
- (E) Data obtained by the establishment of the tracking system that is taken directly from the medical records of a patient is for the confidential use of the Department and the persons or public or private entities that the Department determines are necessary to carry out the intent of the tracking system. The data is privileged and may not be divulged or made public in a manner that discloses the identity of an individual whose medical records have been used for obtaining data for the registry.

Notwithstanding the above, anonymous statistical information collected under this section is public information.

1. This tracking system should be integrated with any national database or similar system developed by the federal government.
- (F) The following persons who act in compliance with this section are not civilly or criminally liable for furnishing information required by this section: a hospital, clinical laboratory or other health care facility, an audiologist, an administrator, officer or employee of a hospital or other health care facility, and a physician or employee of a physician.

#### **Section 9. Insurance Coverage**

- (A.) All health plans that are delivered, issued for delivery, renewed, extended or modified in the state, without regard to whether the issuer of the health benefit plan is located within or outside this state, must provide coverage for newborn hearing screening, necessary rescreening, audiological assessment and followup, and initial amplification or auditory programming. This section shall not apply to supplemental policies which only provide coverage for specific diseases, hospital indemnity, medicare supplement or other supplemental policies.
- (B.) Benefits for newborn hearing screening, necessary rescreening, audiological assessment and followup and initial amplification or auditory programming shall be subject to copayment and coinsurance provisions of a health insurance policy to the extent that other medical services covered by the health insurance plan are subject to such provisions. However, benefits shall be exempt from deductible or dollar limit provisions in the health insurance policy and such exemption must be explicitly provided for in the policy.
- (C.) Coverage for newborn hearing screening, necessary rescreening, audiological assessment and followup and initial amplification or auditory programming shall be provided to newborns eligible for medical assistance and the Child's Health Insurance Plan. In the absence of a third-party payor, all charges shall be paid by the state.
- (D.) All health insurance policies and health maintenance organizations shall compensate providers for the covered benefit supplemental to any previously contracted rate for services.

#### **Section 10. Medical Assistance**

- (A.) The agency responsible for the administration of this State's Medicaid program shall pay for the newborn/ Infant child hearing screening test, if the child is eligible for medical assistance as determined by State and federal law.

(B.) The Governor shall ensure that any contract for the provision of medical assistance negotiated with a managed care organization as authorized by State law, shall include payment for newborn/ infant hearing screening testing and necessary audiologic follow-up care.

**Section 11. Miscellaneous Provisions**

- (A.) No test is to be performed if the parent of a newborn dissents on the ground that the test conflicts with a personal religious belief or practice.
- (B.) The Secretary shall promulgate regulations as may be necessary to implement the provisions under Sections 4 through 11.
- (C.) The Insurance Commissioner shall promulgate regulations necessary to implement the provisions under section 9.

**Section 12. Appropriation**

- (A.) The General Assembly shall make any necessary appropriations to carry out the purposes of this Act.

**Section 13. Effective Date**

- (A.) This Act shall take effect on January 1, 200\_.

## Universal Newborn and Infant Hearing Screening Act

### A BILL TO REQUIRE THE PROVISION OF AND COVERAGE AND REIMBURSEMENT FOR NEWBORN AND INFANT HEARING SCREENING

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF \_\_\_\_\_:

*Section 1. Short title.* This Act shall be known and may be cited as the "Universal Newborn and Infant Hearing Screening Act".

*Section 2. Legislative findings and purpose.*

(a) The legislature hereby finds and declares that:

- (1) Significant hearing loss is one of the most common major abnormalities present at birth and, if undetected, will impede the child's speech, language, and cognitive development.
- (2) Screening by high-risk characteristics alone (e.g., family history of deafness) only identifies approximately 50% of newborns with significant hearing loss.
- (3) Reliance solely on physician and/or parental observation fails to identify many cases of significant hearing loss in newborns and infants.
- (4) There is evidence that children with hearing loss who are identified at birth and receive intervention services shortly thereafter, have significantly better learning capacity than children who are identified with hearing loss later than six months after birth.
- (5) Legislation is needed to provide for the early detection of hearing loss in newborns and infants and to prevent or mitigate the developmental delays associated with late identification of hearing loss.

*Section 3. Definitions.*

- (a) "Child" means a person up to 21 years of age.
- (b) "False positive rate" means the proportion of infants identified as having a significant hearing loss by the screening process who are ultimately found to not have a significant hearing loss.
- (c) "False negative rate" means the proportion of infants not identified as having a significant hearing loss by the screening process who are ultimately found to have a significant hearing loss.
- (d) "Health Care Insurer" means any entity regulated by the Insurance Commissioner, including, but not limited to, health care insurers; health, hospital or medical service plan corporations; or health maintenance organizations. Health care insurer does not include self-insured plans or groups regulated by the Employment Retirement Income Security Act of 1974 ("ERISA"), to the extent that state regulation of such plans is preempted by ERISA.
- (e) "Health Insurance Policy" means any health insurance policy, contract, plan, or evidence of coverage issued by a health care insurer, which provides medical coverage on an expense incurred, service or

prepaid basis.

(f) "Hearing screening test" means automated auditory brain stem response, otoacoustic emissions, or another appropriate screening test approved by the state Department of Health.

(g) "Hospital" means a health care facility or birthing center licensed in this state that provides obstetrical services.

(h) "Infant" means a child who is not a newborn and has not attained the age of one year.

(i) "Newborn" means a child up to 28 days old.

(j) "Parent" means a natural parent, stepparent, adoptive parents, guardian, or custodian of a newborn or infant.

(k) "Significant hearing loss" means a hearing loss equivalent to or greater than a 35-decibel hearing loss (35-dB HL) in the better ear.

#### ***Section 4. Newborn and Infant Hearing Screening Programs.***

(a) As a condition of its licensure, each hospital shall establish a Universal Newborn Hearing Screening (UNHS) program. Each UNHS program shall:

(1) In advance of any hearing screening testing, provide to the newborn's or infant's parent (s) information concerning the nature of the screening procedure, applicable costs of the screening procedure (including information concerning insurance coverage and copayment obligations), the potential risk and effects of hearing loss, and the benefits of early detection and intervention.

(2) Consistent with informed consent obtained from the parent(s) pursuant to subsection (a) (1), provide a hearing screening test for every newborn born in the hospital, for identification of hearing loss, regardless of whether or not the newborn has known risk factors suggesting hearing loss.

(3) Develop screening protocols and select screening method(s) designed to detect newborns and infants with a significant hearing loss.

(4) Provide for appropriate training and monitoring of the performance of individuals responsible for performing hearing screening tests shall be trained properly in:

(a) the performance of the tests,

(b) the risks of the tests, including psychological stress for the parent(s),

(c) infection control practices, and

(d) the general care and handling of newborns and infants in hospital settings.

(5) Perform the hearing testing prior to the newborn's discharge; if the newborn is expected to remain in the hospital for a prolonged period, testing shall be performed prior to the date on which he or she attains the age of three months.

(6) Develop and implement procedures for documenting the results of all hearing screening tests.

(7) Inform the newborn's or infant's parents and primary care physician of the results of the hearing screening test, or if the newborn or infant was not successfully tested. Whenever possible, such notification shall occur prior to discharge; if this is not possible, notification shall occur no later than ten days following the date of testing. Notification shall include information regarding appropriate follow-up for a screening failure or a missed screening, and referral information for confirmatory testing. If a hearing screening test indicates the possibility of a significant hearing loss, the hospital shall ensure that the physician or other person attending the newborn or infant is made aware of the community resources available for confirmatory testing and process of referral to early intervention services.

(8) Collect performance data specified by the state Department of Health to ensure that each UNHS program is in compliance with this section, including the number of infants born, the

proportion of all infants screened, the referral rate, the follow-up rate, the false-positive rate, and the false-negative rate.

(a) Testing Performance Standards.

- (1) Each UNHS program should have a false-positive rate of 3% or less.
- (2) Each UNHS program should have a false-negative rate of 3% or less.

(b) Oversight Responsibility. The state Department of Health shall exercise oversight responsibility for UNHS programs, including establishing a performance data set and reviewing performance data collected pursuant thereto by each hospital.

**Section 5. Civil and Criminal Immunity and Penalties.**

- (a) No physician shall be civilly or criminally liable for failure to conduct hearing screening testing.
- (b) No physician or hospital acting in compliance with this Act shall be civilly or criminally liable for any acts taken in conformity herewith, including without limitation furnishing information required to be furnished hereunder.
- (c) A hospital that has not established or implemented an UNHS program in accordance with this Act shall be subject to sanction by the Department of Health as provided by law for licensure violations.
- (d) A health care insurer that violates section 7(b) shall be subject to a civil money penalty of [up to \$25] for each affected insured who has not received the required notice.

**Section 6. Confidentiality.** The Department of Health and all other persons to whom data is submitted in accordance with this Act shall keep such information confidential. No publication or disclosure of information shall be made except in the form of statistical or other studies which do not identify individuals, except as specifically consented to in writing by the parent(s) of a tested child.

**Section 7. Coverage and Reimbursement.**

- (a) Any health insurance policy which is delivered, issued for delivery, renewed, extended, or modified in this state by any health care insurer and which provides coverage for a child shall be deemed to provide coverage for hearing loss screening tests of newborns and infants provided by a hospital before discharge.
- (b) A health care insurer delivering a health insurance policy regulated under this Act shall provide each insured with notice of the provisions of this Act upon the effective date of coverage and annually thereafter.
- (c) The amount of reimbursement for newborn or infant hearing screening provided under such a policy shall be consistent with reimbursement of other medical expenses under the policy, including the imposition of copayment, coinsurance, deductible, or any dollar limit or other cost-sharing provisions otherwise applicable under the policy.

**Section 8. Delivery of Policy.** If a health insurance policy provides coverage or benefits to a resident of this state, it shall be deemed to be delivered in this state within the meaning of this Act, regardless of whether the health care insurer issuing or delivering said policy is located inside or outside of the state.

**Section 9. Applicability.** This Act applies to health insurance policies delivered, issued for delivery, renewed, extended or modified, after the effective date of this Act.

*Section 10. Effective Date.* This act is effective upon passage and approval.

-----  
*December 2000.*

*Revised October 2001.*

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[Return to Model Bills](#)

**Subject:** [Fwd: HB 108 comment]

**Date:** Tue, 29 Apr 2003 10:38:29 -0800

**From:** Representative\_Peggy Wilson <Rep.Peggy.Wilson@legis.state.ak.us>

**Organization:** Alaska State Legislature

**To:** Jean Ellis <Jean\_Ellis@legis.state.ak.us>

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**Subject:** HB 108 comment

**Date:** Tue, 29 Apr 2003 13:15:13 -0500

**From:** "Angela Watts" <asarw4@uaa.alaska.edu>

**To:** Representative\_Richard\_Foster@legis.state.ak.us,  
Representative\_Max\_Gruenberg@legis.state.ak.us,  
Representative\_Peggy\_Wilson@legis.state.ak.us

Dear Representatives:

My name is Angela Watts. I am a junior in the Social Work Department at UAA. I have been following HB 108 for the last few months for Dr. Patrick Cunningham's Policies and Procedures class. I am impressed that this bill is being considered. It is highly important that children who are hearing impaired or deaf have access to language at a very early age. The most important time for language acquisition is within the first year. I have been studying American Sign Language and the Deaf culture as well as working with deaf and hard of hearing children for the last 3 years. The difference between the children that are diagnosed at birth and those who are not is astounding. When a child has no language until he/she is 2 or 3 years old it can cause the child to be angry and socially isolated not only from peers but from family members as well. If this bill passes it will be a giant step forward for deaf or hearing-impaired children in Alaska.

I have one concern about the writing of the bill however. The bill states that teachers of deaf children need to be certified by the Conference of Executives of American Schools of the Deaf. Yet it does not specify what if any training the social workers, doctors, nurses, or other hospital staff will need in order to properly inform the parents about the options that they now have in raising a deaf child. This step is often overlooked to great detriment to the child. Doctors inform parents incorrectly about their options such as saying that if a child learns ASL first instead of to speak English first that the child will never know English or be able to communicate through speech or written language. This however is false. If a child is born deaf and acquires his/her native language (ASL in the United States) then the child has a far higher chance of learning to read, write, and possibly speak English as a second language. It is an important part of the language acquisition for a deaf child. I would like to see the bill include a section that states that all persons who inform parents of the hearing ability of their child to be required to take a course or a Continuing Education Credit in deaf culture and the use of American Sign Language.

I appreciate that the three of you are sponsoring this bill and commend you on recognizing the importance of early detection and intervention for the well being of deaf and hard of hearing children.

Thank you for your time,

Angela Watts  
asarw4@uaa.alaska.edu

**SITE: ANCHORAGE LIO**

**COMMITTEE: HHES**

**DATE: 5-6-03**

**SUBJECT OF MEETING:**

**HB 108**

**UPDATE #: 1**

**P R I N T YOUR NAME**

**ADDRESS (MAILING & ZIP)**

**REPRESENTING**

**DO YOU WANT  
TO TESTIFY?  
Y OR N**

<b>Sara Gaar</b>		<b>AK Dual Sensory Impairment Services/Special Ed Services</b>	<b>Y-HB 108</b>
Email address:			
<b>Susan Walker</b>		<b>Parent of Deaf Child</b>	<b>Y-HB 108</b> ✓
Email address:			
<b>Mary Grisco</b>		<b>AK Pediatric Partnership</b>	<b>Y-HB 108</b> ✓
Email address:			
<b>Mary Lavigne</b>		<b>AK Public Health Assoc</b>	<b>Y-HB 108</b> ✓
Email address:			
<b>Amy Simpson</b>		<b>Early Intervention Prog</b>	<b>Y-HB 108</b>
Email address:			
Email address:			





**HB**

**135**



# Alaska State Legislature

*Representative Peggy Wilson  
Putting Alaska's Families First*

## SPONSOR STATEMENT House Bill 135

**"An act relating to marital and family therapists."**

The law that established the Board of Marital and Family Therapy has been in place for ten years. It is time to pursue the placement of updated language within the statute.

HB 135 will bring the Alaska Statutes for Marriage and Family Therapy to the same standard as the laws regarding other counseling services in the state and Marriage and Family Therapy statutes nationally.

### HB135~

- *Adds* the Board of Marital and Family Therapy to the list of boards that may request the Division of Occupational Licensing to contract for substance abuse treatment under licensed therapists,
- *Gives* the Board of Marital and Family Therapy authority to order a licensed marital and family therapist to submit to a reasonable physical or mental examination if the board has credible evidence sufficient to conclude that the therapist's physical or mental capacity to practice safely is at issue,
- *Allows* for individual client contact to be used as hours toward licensing,
- *Requires* the therapist to communicate to a potential victim or law enforcement officer if a threat of imminent serious physical harm to an identified victim has been made by a client,
- *Imposes* disciplinary sanctions with regard to therapist sexual misconduct.

HOUSE BILL 135 not only brings parity to the mental health professions in the state, it also adds additional consumer protection for Alaskans seeking professional counsel.



# Alaska State Legislature

Representative Peggy Wilson  
Putting Alaska's Families First

## Sectional analysis (HB 135)

**Section 1.** Adds the board of Marital and Family Therapists (hereafter "board") to the list of boards that may request the division of occupational licensing to contract for substance abuse treatment for licensed therapists (hereafter "licensees").

**Section 2.** Authorizes the board to require physical and mental exams of licensees.

**Section 3.** Changes a licensing requirement relating to post-degree clinical contact.

**Section 4.** Adds two more categories of circumstances when a client's communications to a licensee may be revealed to others.

**Section 5.** Adds a new ground for disciplinary sanctions

**Section 6.** Allows summary suspension of a licensee who refuses to submit to a physical or mental examination.

**Section 7.** Adds two new sections of law. One requires disclosure statements to clients. The other enacts a practice limitation.

AMENDMENT

OFFERED IN THE HOUSE

BY REPRESENTATIVE WILSON

TO: HB 135

- 1 Page 5, lines 9 - 10:
- 2 Delete "for marital and family therapy services"
- 3 Insert "by a licensed marital and family therapist"

## What is a Marriage and Family Therapist?

Marriage and Family Therapists are mental health professionals trained to diagnose and treat mental and emotional disorders. MFT's specialize in treating mental disorders in the context of marriage or family relationships. Marriage and Family Therapists work with the individual, couple or family to change behavioral patterns so that problems can be resolved.

## What types of services do Marriage and Family Therapists provide?

A fundamental tenet of marriage and family therapy is that individual problems are often best understood and treated in the context of the relationships in which the person is involved. Failure to address the marital or family environment, as part of the mental health treatment plan will result in decreased likelihood for a successful outcome. Therefore, marriage and family services are:

Brief  
Solution Focused  
Specific, with attainable goals  
Designed with the "end in mind"

Marriage and Family Therapists treat a wide range of serious clinical problems including depression, alcohol and drug abuse, anorexia, and dementia.

Clients of MFTs, according to research studies, significantly improve after treatment for problems such as: adolescent substance abuse, depression and stress by family caregivers of elderly family members, clinical depression among women in distressed marriages, general child conduct disorders, child aggression, global family problems, communication and problem solving, phobias, and psychiatric symptoms.

## Who licenses Marriage and Family Therapists?

Currently, forty-two states recognize and regulate marriage and family therapists as independent mental health providers. In addition, the Health Resources Services Administration recognizes the field of marriage and family therapy as one of the five core mental health disciplines for purposes of determining mental health shortage areas, and the healthcare program for military dependents. Champus/Tricare, recognizes and reimburses MFTs as independent health care providers.

## How are Marriage and Family Therapists educated and trained?

Marriage and family therapy is a distinct professional discipline with graduate and postgraduate programs. To become a MFT, an individual must obtain a Master's degree or complete a doctoral program in marriage and family therapy or a related field. The

American Association for Marriage and Family Therapy (AAMFT) Commission of Accreditation of Marriage and Family Therapy Education is designated by the U.S. Department of Education as the accrediting agency for academic institutions providing master's, doctoral and postgraduate training in marriage and family therapy.

Once the formal education of the MFT is completed, the individual must obtain post-graduate clinical experience in marriage and family therapy. The training of MFTs includes direct clinical supervision by experienced clinicians. When the supervision is completed, the therapist can take a state licensing exam or the national exam for MFTs conducted by the AAMFT Regulatory Board. This exam is used as a licensure requirement in most states.

## Where are MFTs employed?

While many are in private practice, MFTs can be found in schools, businesses, government agencies, hospitals and other health care facilities (i.e., community mental health centers, residential treatment facilities, legal and correctional systems and county mental health departments. In addition, many are employed in Employee Assistance Programs (EAPs).

HMOs, PPOs and other managed care companies employ and contract with MFTs for utilization review and provider screening as well as to provide mental health treatments. Insurance companies reimburse for

## Sexual Exploitation - the "Two-Year Rule"

### Issue

Enact a law to create a cause of action against a psychotherapist for engaging in sexual relations with a patient either during the therapeutic relationship or within two years following termination of therapy.

### Background

Sexual relations between a psychotherapist and his/her patient is generally prohibited by law. Violations usually result in disciplinary action by the licensing board (revocation or suspension of the license) and/or the filing of a civil action for damages by the patient. In some states, criminal penalties can be imposed on a psychotherapist who engages in sexual relations with his/her patient. Some believe that sexual relations between a psychotherapist and a patient or former patient should be prohibited in perpetuity. **This bill would instead provide that sexual relations between a psychotherapist and his/her patient are prohibited during the therapist-patient relationship and for two years following a termination of the relationship and would create a specific cause of action against a psychotherapist for a violation.**

This bill is necessary for several reasons. First, some argue or believe that a psychotherapist may have sexual relations with an ex-patient since the law only prohibits such relationships between therapist and patient. In the past, some therapists have simply terminated the therapist-patient relationship, perhaps made a referral, and then engaged in sexual relations with their "ex-patient," either moments or days later. This is clearly inappropriate and constitutes an ethical violation in most professions. Additionally, because of the power imbalance often present in the therapist-patient relationship, some reasonable amount of time must be allowed to pass before an intimate relationship should be allowed to begin.

Therapists who exploit the trust and vulnerability of patients for their own sexual gratification, especially when it can have such devastating and long-term effects upon patients, are practicing predatory psychotherapy. Imposition of a "two-year rule" will prevent therapists from avoiding the very purpose of the long-standing prohibition against therapist-patient sex by simply terminating therapy and engaging in sexual contact shortly thereafter. Establishment of a two-year rule provides for a cooling-off period that will discourage such relationships from occurring. The burden on therapists is not great, since they are free to have sexual relations with everyone except minors and ex-patients (for two years).

### Opposition

This bill could be opposed by civil libertarian groups (such as the ACLU) on the basis of the limitation of a person's right to freely associate with others. They may argue that consenting adults should be allowed to engage in sexual relations with each other regardless of their prior professional relationship. They may additionally argue that the two-year rule is an arbitrary barrier to the right of free association. Other affected professions may claim that the present law is sufficient to deal with the existing problems and that the two-year rule is excessive or unnecessary.

### Sample Language

Section 43.93 of the California Civil Code is an example of a law that creates a cause of action against a psychotherapist for engaging in sexual relations with a patient within two years following termination of therapy. Licensing law provisions that prohibit sexual relations between therapist and patient should also be amended to include the "two-year rule."

**Larry Holman M.S. LMFT  
Susitna Counseling and Associates  
2600 Denali St. Ste 450  
Anchorage, AK. 99503  
Ph. (907) 272-7002 Fax (907) 272-2851**

February 28, 2003

Representative Peggy Wilson  
State Capital Rm. 409  
Juneau, AK. 99801

Re: House Bill 135

Dear Representative Wilson,

The Regulatory Board for Licensed Marriage and Family Therapists in the State of Alaska strongly support the passage of HB 135. One of our goals for the last couple of years has been to review our laws and regulations after being licensed for about 10 years, to see if they meet current standards of practice nationally. There were several areas identified which were seen as deficient and/or not up to the standards of other mental health professions in this state and nationally. The national organization for marriage and family therapists (AAMFT) as well as the Association of Marital and Family Therapy Regulatory Board has provided us with direction and guidance in bringing our laws and regulations up to a high standard so that the Alaskan public will be protected.

House Bill 135 advances that goal in several significant ways. First and possibly foremost is the provision that addresses sexual relationships between MFTs and clients. There are no mental health professional associations of which I am aware that do not have strict sanctions and prohibitions against sexual relationships with clients and former clients. Many specify two to three years. Social Workers specify a lifetime prohibition. This provision needs to be spelled out clearly since the possible harm caused can be so egregious. Other provisions in this law are attempts to be more responsive to the public, which our Board is charged to protect. The disclosure statement section contains a description of therapist's formal education, degrees obtained and institutions attended, therapist's area of specialization, and therapist's fee schedule. We think this is an important addition to our law in that it spells out the contract between a therapist and his/her client. Many clients are not very informed about these issues and this provision clarifies them.

These are just mentioned two examples of new provisions that this law addresses. The other provisions are significant as well and we encourage you to support them vigorously as we do. The Marriage and Family Therapy Regulatory Board thanks you for your sponsorship of this bill and if there is anything we can do to support its passage please let us know.

Sincerely,

Larry Holman, LMFT, Chairperson, MFT Regulatory Board



**Alaska Association for  
Marriage and Family Therapy**

2600 Denali St., Ste 450  
Anchorage, Alaska 99503  
Ph. (907) 272-7002

February 28, 2003

Representative Peggy Wilson  
State Capital Rm 409  
Juneau, AK. 99801

Re: House Bill 135

Dear Representative Wilson,

The Alaska Association for Marriage and Family Therapy appreciates your sponsorship of House Bill 135. Our organization supports this bill and was primarily responsible for initiating it. Much of the bill is housekeeping but there are parts, which are substantial changes. The addition of sexual misconduct brings MFT standards up to other mental health care professionals in the state as well as our own National Association's standards. It requires that two years must pass before a LMFT can have a sexual relationship with a former client. Sexual misconduct is one of the most problematic issues facing mental health care providers because of the nature of the relationships that are formed in the therapeutic process. Strict boundaries are absolutely necessary because of that relationship. The disclosure statement is a new provision, which is intended to inform and protect the client as a consumer of mental health services. It is a national trend in marriage and family therapy to educate the client with regards to the professional's training and specialization. In addition, it is a commonly accepted ethical procedure to make consumers aware of fees.

Again, thanks for sponsoring this bill.

Sincerely,

Susan Arth, Division President, AkAMFT

HB

142

# ALASKA STATE HOUSE OF REPRESENTATIVES

Session

(907)-465-4930  
FAX# 465-3834  
State Capitol  
Room 416



Representative Cheryl Heinze

**ECONOMIC DEVELOPMENT, TRADE AND TOURISM**

**CHAIR  
HB 142**

## **SPONSOR STATEMENT**

The majority of eye surgery performed in the United States today is technologically advanced and is safer and more effective than ever before. The most common major eye surgery performed in the United States is cataract surgery; with more than 1.5 million cases a year. Cataract surgery has evolved to such an advanced state that many cases take less than 15 minutes to perform. The speed with which modern cataract surgery can be performed has tended to trivialize the seriousness of this surgery in the public's mind, causing patients to infer that it is risk free. No surgery is risk free, including short cases such as uncomplicated cataract surgery. However, complications do occur and can be serious. Permanent loss of vision and patient death are some of the more serious potential complications. It is important for postoperative care to be managed by an ophthalmologist familiar with the surgery and the potential complications.

Unfortunately, reduction of surgical time for cataract surgery has led to the appearance of so-called "cataract mills" where patients are referred in large numbers by an optometrist and, in return for a "co-management fee", the referring optometrist is then allowed to manage the patient postoperatively. The operating surgeon, in this setting, often meets the patient just minutes prior to surgery and takes no responsibility after surgery. In some cases this surgeon may travel from cataract mill

to cataract mill and is unavailable for any postoperative consultation or advice. The patient's follow-up care is therefore abandoned, by pre-arrangement, to the referring

Optometrist who is not qualified by training or experience to handle any serious complications resulting from the cataract surgery.

Another serious situation may arise as a result of the "cataract mill". Should the patient require hospitalization, the surgeon is unlikely to have local hospital privileges. The patient is then dumped on another ophthalmologist unfamiliar with the patient but now responsible for rendering critical care.

Co-management of eye surgery as currently practiced in Alaska is a recipe for sub-optimal patient care. House Bill 142 addresses the issue of postoperative care for eye surgery in Alaska, taking into account the unusual and sometimes-difficult medical and surgical challenges our state often poses in terms of isolation, limited medical resources and transportation difficulties.

# 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

## MEMORANDUM

March 19, 2003

**SUBJECT:** Sectional Analysis (HB 142)  
**TO:** Representative Cheryll Heinze  
**FROM:** Terri Lauterbach  
Legislative Counsel



You have requested a sectional summary of the above-described bill.

As a preliminary matter, please note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. Since you have not expressed questions about any particular aspect of the bill, this summary is brief. Let me know if you have specific questions.

Section 1. Places limits on how and when a surgeon who performs eye surgery in this state may delegate responsibility to someone else for post-operative care of the patient.

Secs. 2 - 3. Require compliance with sec. 1 of the bill by certain people who are exempt from licensing as physicians.

Sec. 4. Adds definition of "knowingly," which is a term used in secs. 1 and 3 of the bill.

Secs. 5 and 7. Allow the State Medical Board to begin the regulations process before the rest of the bill takes effect.

Sec. 6. Applies the amendments made by the bill to eye surgery occurring on or after the effective date of secs. 1 - 4 of the bill.

TML:med  
03-323.med

**Alaska Academy of Ophthalmology**

Carl Rosen, M.D.  
President  
542 W. 2<sup>nd</sup> Ave  
Anchorage, Ak 99501  
907-563-8526

MAR 7 - 2003

3/7/03  
Alaska House of Representatives  
Pouch V  
Juneau, Ak 99801

Dear Representative,

*Representative Wilson*

The Alaska and American Academy of Ophthalmology endorses HB 142(introduced by State Representative Cheryl Heinze), an act relating to provider responsibility for ocular postoperative care in Alaska, to regulate potential abuses of comanagement arrangements.

This legislation closes a patient protection loophole. Ocular care is one of the rare areas where non-physicians inappropriately perform post-operative care.

This legislation would prevent itinerant ophthalmologists from allowing non-medical personnel to provide inappropriate post-operative care after eye surgery.

It is imperative that trained physicians see patients after surgery to check for infections, other diseases, complications that might occur following surgery to prevent potential loss of vision.

It is irresponsible to permit delegation of post-operative care to an optometrist who can neither accurately diagnose nor treat complications and emergencies.

This legislation would have no fiscal impact to consumers or to health care costs. In fact, patients would receive better and safer treatment at no additional costs.

Below, please find our analysis of HB 142. We ask for your support and co-sponsorship of this important legislation.

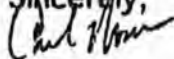
**BRIEFING: HB 142**

HB 142, an act relating to provider responsibility for ocular postoperative care in Alaska, has been introduced to regulate potential abuses of comanagement arrangements.

- HB 142 recognizes the unique challenges of practicing in Alaska. HB 142 does not prohibit legitimate comanagement. HB 142 would have no effect on responsible surgical practice in Alaska. HB 142 is consistent with the principles of the Joint Position Paper of the American Academy of Ophthalmology and the American Society of Cataract and Refractive surgery on Ophthalmic Postoperative Care.
- HB 142 provides that unless a surgeon enters into a written comanagement agreement with the patient, the bill requires a surgeon to be physically available to a patient for postoperative care in the community in which the operation was performed for 120 hours after the surgery.
- HB 142 PERMITS COMANAGEMENT if:
  - the distance the patient would have to travel to the regular office of the operating surgeon would result in an unreasonable hardship for the patient, as determined by the patient;
  - the surgeon will not be available for postoperative care as a result of the surgeon's personal travel, illness, travel to an area of the state for occasional practice of medicine, or travel to an area of a state designated as a physician shortage area; or
  - other justifiable circumstances exist, as determined by the State Medical Board.
- HB 142 PROTECTS OPHTHALMOLOGISTS AND PATIENTS by prohibiting comanagement arrangements:
  - in which a fee is paid to the person to whom the care is delegated that does not reflect the fair market value of the services performed by that person;
  - that are entered into as a matter of routine and not on a case-by-case basis;

- that are not clinically appropriate for the patient;
  - that is made with the intent to induce surgical referrals; or
  - that is based on economic considerations affecting the surgeon.
- HB 142 CONTAINS EXTRA FLEXIBILITY for the surgeon by allowing the surgeon to delegate postoperative care of a patient without a written comanagement agreement because of unanticipated circumstances that were reasonably foreseeable before the surgery was performed.

Please feel free to call me at anytime @ 907-563-8526 and I would be glad to answer any question you may have or provide you with more information.

Sincerely,  


Carl Rosen, M.D.  
Alaska Academy of Ophthalmology  
President

OLIVER M. KORSHIN, M. D.  
DISEASES AND SURGERY OF THE EYE

ALASKA MEDICAL PLAZA  
1200 AIRPORT HEIGHTS DRIVE, SUITE 310  
ANCHORAGE, ALASKA 99508  
(907) 276-8838  
FAX (907) 258-0735

March 10, 2003

Representative Pete Kott  
State Capitol  
Juneau, Alaska 99801-1182

Dear Representative Kott:

I am writing to ask your support of HB 142, a bill to regulate ocular postoperative care in Alaska. The bill is also known as the "co-management bill."

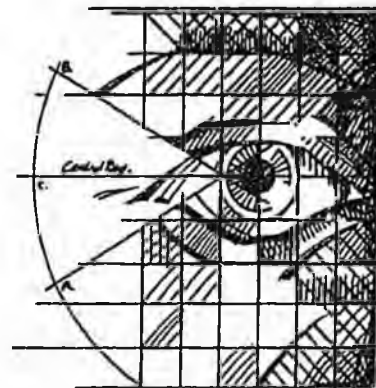
Co-management means that a practitioner other than the operating surgeon provides postoperative care. Because co-management frequently involves splitting of the surgical fee between the surgeon and the provider of postoperative care, co-management arrangements have drawn the attention of the U. S. DHHS Office of the Inspector General in an ongoing national effort to assure that such arrangements do not violate federal anti kick-back statutes.

But co-management not only poses the potential for illegal kickbacks — perhaps more important, it can harm patients. Let me explain.

Eye surgery performed in the United States today has become so technologically advanced that it is safer and more effective than ever before. This applies particularly to cataract surgery, the most common major surgery performed in our country — more than 1.5 million cases a year. Cataract surgery has become so advanced that many cases take less than fifteen minutes, using tiny incisions and foldable intraocular lens implants. Patients go home almost immediately and not infrequently are able to see 20/20 that same day.

The speed with which modern cataract surgery can be performed, as well as its astounding success rate, have unfortunately trivialized the seriousness of this surgery in the public's mind, causing patients to infer that it is risk-free. This is rather like inferring that handling a high-performance jet fighter plane is risk-free. With high-performance jet planes — as with 21<sup>st</sup> century eye surgery — increased speed and increased performance sometimes mean that things can go very wrong very quickly. And they do.

In other words, modern cataract surgery is still subject to complications, some of them serious. Although serious complications occur infrequently, they do occur with statistical regularity. When they occur, often in the first 72 hours following surgery, they must be managed by a qualified ophthalmologist who is familiar with the surgery, its potential complications and how these complications must be managed.



The reduction in the time it takes to perform cataract surgery has led to the appearance of so-called cataract mills, to which patients are referred in large numbers by optometrists, who receive a co-management fee for following the patient after surgery, including the diagnosis and treatment of short- and long-term surgical complications.

Often the surgeon in a cataract mill does not see the patient until a few minutes before surgery. After surgery, the patient may never see the surgeon again. In fact, the surgeon may leave town a shortly after surgery, traveling to another cataract mill location (which may be out-of-state). He may not return for weeks or longer, and then it is not to see his post-operative patients, but to operate on the next wave of referrals. A patient's follow-up care is therefore delegated, by *pre-arrangement*, to the referring optometrist, who is not qualified by training or experience to manage the major complications of cataract surgery, some of which require additional and sometimes complex surgery to treat.

When the co-managing optometrist is presented with a serious complication of cataract surgery that may require admission to a hospital, he must "dump" the patient into the hands of a local ophthalmologist, as the mill surgeon has left town or, if in town, may not have local hospital privileges. The new ophthalmologist is suddenly responsible for rendering critical care a very ill patient fearful of going blind, whom he has never seen before and about whom he knows nothing.

Hence, co-management of eye surgery can be a recipe for sub-optimal postoperative care. House Bill 142 addresses this important patient safety issue while taking into account the unusual and sometimes difficult medical-surgical challenges our state poses in terms of isolation, vast distances and transportation difficulties.

How do I handle cataract surgery in my own practice? I stopped all cataract surgery last year, so I refer my patients who need cataract surgery to other local ophthalmologists. I refuse to co-manage: postoperative care is the *surgeon's* responsibility. I refer only to ophthalmologists who will provide *all* my patients' postoperative care — not just for 120 hours as stipulated in this bill, but for the entire 90-day "global" postoperative period. I believe this represents sound and ethical medical practice. One hundred and twenty hours is the bare minimum.

I urge you to support HB 142.

Sincerely,

A handwritten signature in cursive script, appearing to read "Oliver Korshin".

Oliver Korshin, M. D.



March 21, 2003

Alaska State Senators and Representatives

Dear Legislators

*Representative Wilson,*

I am writing to ask for your support of HB 142 and companion bill SB 129, legislation to ensure that Alaska citizens have the necessary information regarding postoperative surgical eye care. The enactment of HB 142 and SB 129 is a positive step forward to enhance patient understanding of postoperative surgical eye care treatment.

This legislation sets forward clear rules as to the procedures that an ophthalmologist and optometrists must follow when a comanagement agreement is agreed upon. Just as importantly, this legislation informs the patient as to the type of care he or she will be receiving from each health care provider – the ophthalmologist and the optometrist. Patient protection is this legislation's objective. With enactment of HB 142 and SB 129, the ethical relationship between the ophthalmologist, the optometrist, and patient is once again paramount.

As a working pediatric ophthalmologist in Anchorage who attended the University of Alaska-Fairbanks, I have a perspective of the Alaska health care system both as a citizen and as a physician.

The delivery of quality health care is a challenge due to our state's size and rural nature. For example, I travel to our practice's satellite clinics in Wasila, Codova, Kodiak, and Homer. It is my goal to deliver quality and affordable pediatric ophthalmic care to urban and rural residents of our Great State. I have coordinated several research efforts including the 6 plus years, cooperative, charitable project to vision screen every preschool Alaskan called the "Alaska Blind Child Discovery." We have provided pre-school vision screening to over 14,000 Alaska children free of charge. I have also served as the Eye section Chief at Providence hospital for the last 11 years coordinating emergency eye call for much of the state.

>From my residency training at the Mayo Clinic and my practice in Anchorage with Ophthalmic Associates, I have learned the value of careful, open-referral and consultative medicine. Ophthalmic Associates is a subspecialty eye practice of optometrists (ODs) and ophthalmologists.

I mention referral and consultative medicine because as a legislator you must often feel that ophthalmologists and optometrists do not work well together. This is not the case. For example, Ophthalmic Associates is a subspecialty eye practice of ophthalmologists (MDs) and optometrists (ODs). We can and do work together to deliver quality patient eye care services.

However, there is what I would term a growing pressure for ophthalmologists and optometrists to enter into what is called "co-management" practice pattern in regards to postoperative surgical eye care that is not in the best interest of the patients.

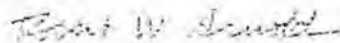
From my professional observation of the increased pressure for these types of agreements, I believe HB 142 and SB 129 are needed and are in the patient's best health care interest.

I am not against all collaborative care arrangements between Alaska's optometrists and ophthalmologists. I have and will continue to collaborate with other optometrists; family physicians and ophthalmologists in the medical and long-term postoperative care of Alaskan citizens, tourists and referred patients from the Russian Far-East (charitable surgical care).

However, you must be made aware that the current practicing environment works to destroy ethical arrangements between optometrists and ophthalmologists and fosters comanagement relationships between optometrists and ophthalmologists that are not in the best long-term interests of patients. That is why I support HB 142 and SB 129.

The enactment of HB 142/SB 129 will ensure that if a physician chooses to comanage a patient, it will be for health care considerations, not for future referrals or some other economic consideration. This legislation is a positive step forward to improve patient understanding of postoperative surgical eye care treatment.

Sincerely Yours,



Robert W. Arnold, M.D.

HB

146

# Alaska State Legislature

*Session:*  
State Capitol  
Juneau, AK 99801  
Phone: (907) 465-2995  
Fax: (907) 465-6592



*Interim:*  
716 W 4<sup>th</sup> Avenue, Suite 300  
Anchorage, AK 99501-2133  
Phone: (907) 269-0250  
Fax: (907) 269-0249

## Representative Lesil McGuire

Chair, Judiciary Committee

### MEMORANDUM

To: Rep. Peggy Wilson, Chair, House Health, Education, and Social Services Committee

From: Rep. Lesil McGuire

Date: March 5<sup>th</sup>, 2003

Re: Request for hearing of HB 146 "Repealing 'sunset' provisions for SSN reporting for CSED"

I would appreciate it if you would consider scheduling my bill, HB 146 "An Act repealing the termination date of certain provisions that require the reporting of social security numbers and automated data matching with financial institutions for child support enforcement purposes; and providing for an effective date." before your committee at your earliest possible convenience.

23-LS0705H  
Lauterbach  
3/13/03

CS FOR HOUSE BILL NO. 146( )  
IN THE LEGISLATURE OF THE STATE OF ALASKA  
TWENTY-THIRD LEGISLATURE - FIRST SESSION

BY

Offered:  
Referred:

Sponsor(s): REPRESENTATIVES MCGUIRE, Gruenberg

A BILL

FOR AN ACT ENTITLED

1 "An Act repealing the termination date of certain provisions that require the reporting  
2 of social security numbers and automated data matching with financial institutions for  
3 child support enforcement purposes; relating to social security numbers on applications  
4 for commercial fishing licenses; and providing for an effective date."

5 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

6 \* Section 1. AS 16.05.480(b) is amended to read:

7 (b) A person applying for a [RESIDENT] commercial fishing license under  
8 this section shall provide the person's social security number. A person applying for  
9 a resident commercial fishing license under this section shall also provide [AND  
10 THE] proof of residence that the department requires by regulation.

11 \* Sec. 2. AS 16.05.480(d) is amended to read:

12 (d) Upon request, the department or the Alaska Commercial Fisheries  
13 Entry Commission shall provide a social security number provided by an applicant  
14 for a license under [(a) OF] this section to the child support enforcement agency

1           created in AS 25.27.010, or the child support agency of another state, for child support  
2           purposes authorized under law.

3           \* **Sec. 3.** Sections 1 - 10, 14, and 17, ch. 54, SLA 2001, are repealed.

4           \* **Sec. 4.** This Act takes effect immediately under AS 01.10.070(c).

## **CHILD SUPPORT ENFORCEMENT 2003 "SUNSET" SUMMARY**

### **Introduction**

Sunset provisions that will take effect in 2003 were attached to legislation passed during the 2001 session. These laws support programs and activities at CSED that have resulted in a significant increase in child support payments<sup>1</sup>, and improved services to families in Alaska. If the sunsets are allowed to occur, these improvements will be diminished, and by being out of compliance with welfare reform laws Alaska will be in jeopardy of losing \$75,000,000 in federal public assistance and child support funding.

Below is an outline of key parts of the 2001 legislation, as well as a description of how the sunset provisions would affect CSED's work. Each of these segments is a requirement of federal compliance.

### **Financial Institution Data Match and Immunity from Liability**

Current statutes allow us to match the names of parents who owe arrears with the names on accounts at financial institutions. This makes it much more difficult for delinquent parents to hide their assets, simplifies the search for funds in multi-state institutions, and allows the institutions to cooperate without fear of retaliatory lawsuits. Few banks would participate in the FIDM if this protection were repealed. Searching for hidden assets would require sweeps of all banks for each and every case. For many children our ability to collect support would be seriously compromised.

CSED has had no significant complaints from parents or financial institutions regarding this statute.

### **Social Security Numbers**

Legislation passed in 2001 continued the requirement that applications for state licenses, including professional, business, occupational, driver's, recreational and marriage licenses, include the social security number of the applicant. These numbers help CSED locate parents and collect child support, and reduce the number of cases of mistaken identity. Use of Social Security numbers is critical to our New Hire Reporting, license suspension, and locate programs.

CSED is cognizant of the confidential responsibilities conferred on us through use of Social Security numbers and other items of personal information included in our files. We make confidentiality training a priority, and monitor it constantly so that no inappropriate use can be made of the parties' personal information.

Federal requirements for social security numbers on hunting and fishing licenses were waived in 2000. The waiver will expire this year, however, CSED has requested that it be extended.

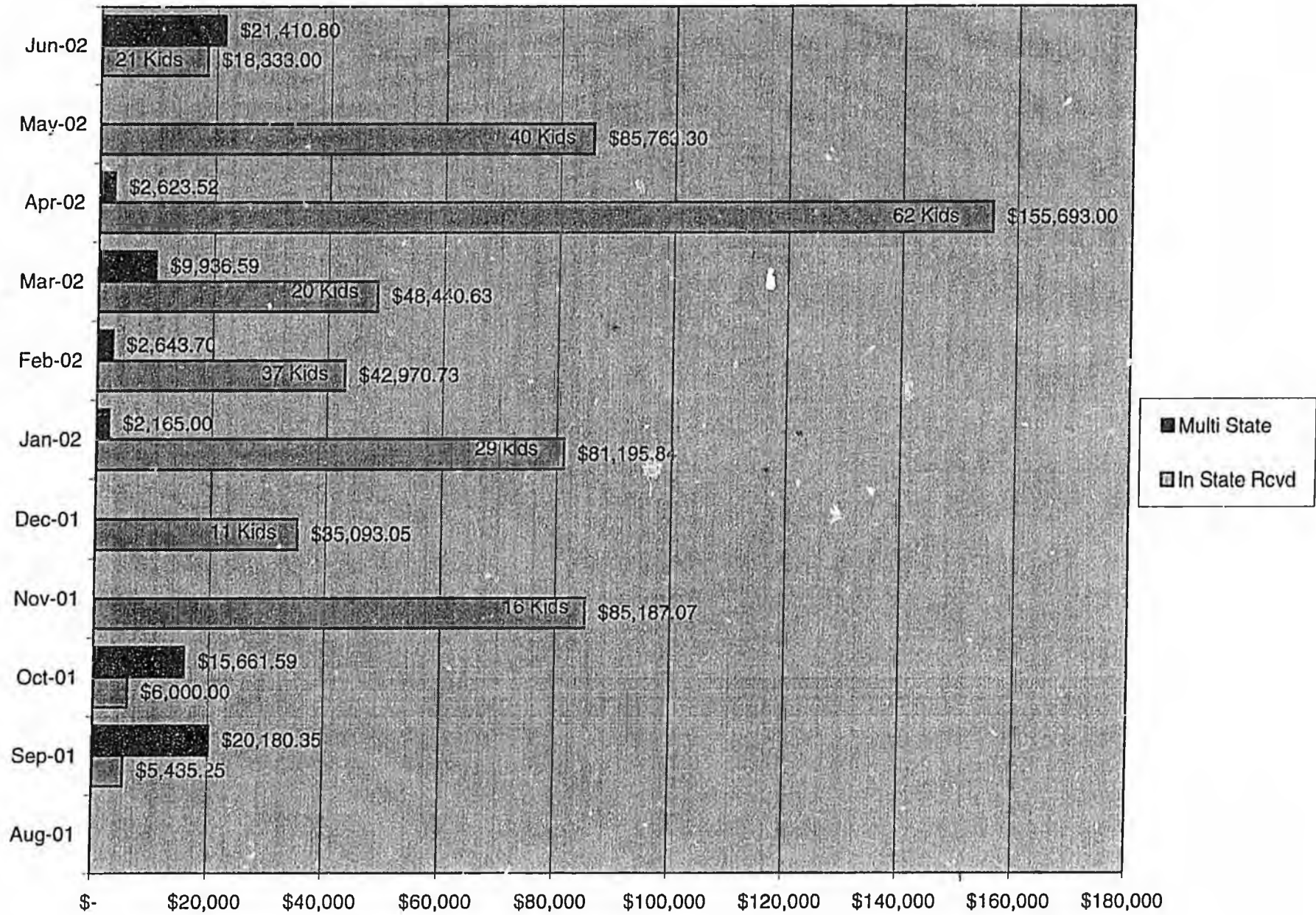
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<sup>1</sup> Since the first of these statutes was passed in 1996, child support collections in Alaska have increased from \$71 million to \$95 million, a 33% increase.

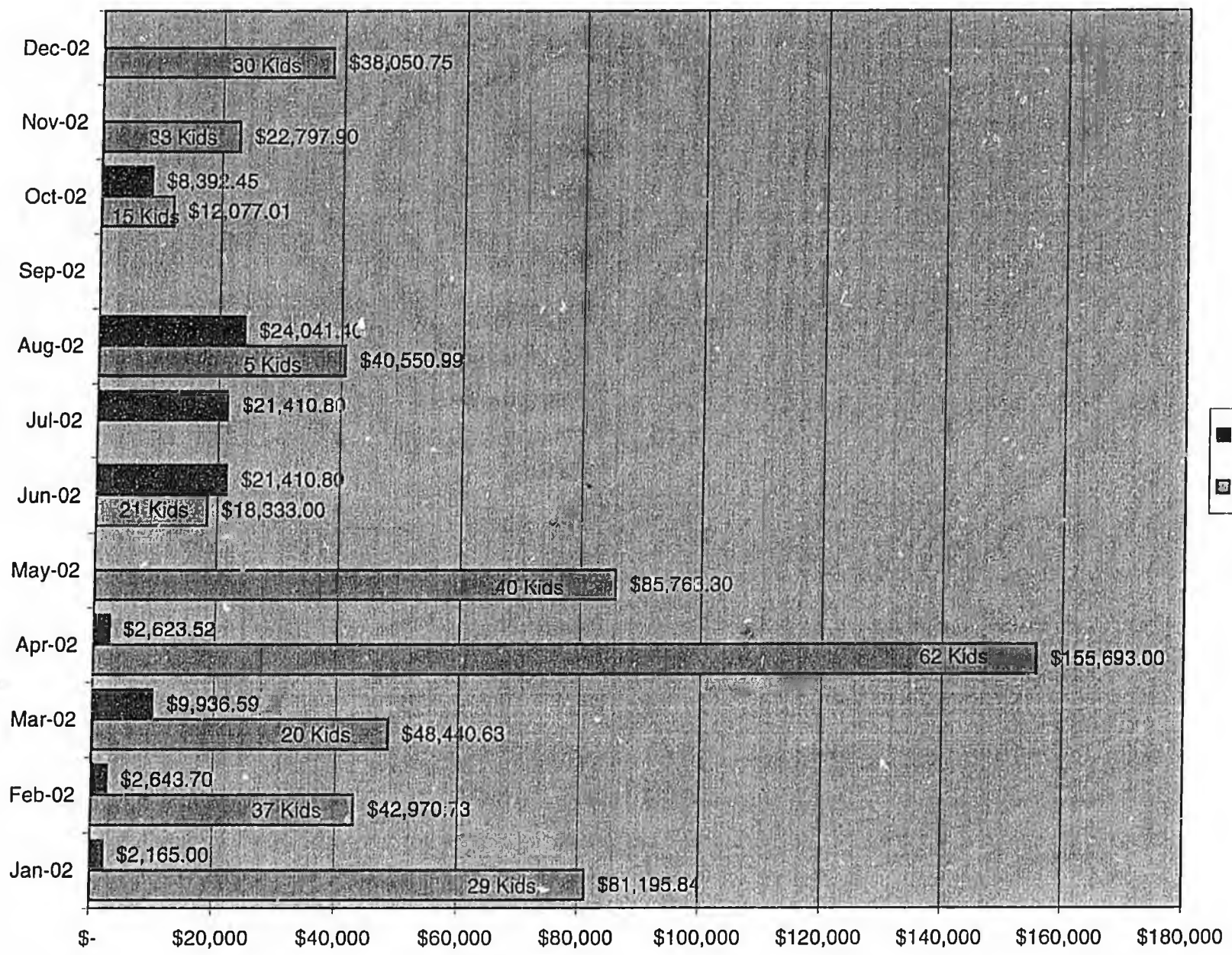
## Child Support Enforcement Division - Financial Institution Data Match Monthly Statistics: May 2001 through December 2002

Month	IN State Amount Rcvd	Multi State Amount Rcvd	# of kids	# Cases W	Case = \$	# of kids	# Cases W	Case = \$
May-01	\$ 14,313.91							
Jun-01	\$ 55,606.95							
Jul-01	\$ 53,868.55							
Aug-01	\$ -		13	12	6	0	30	0
Sep-01	\$ 5,435.25	\$ 20,180.35	12	7	7	2	17	2
Oct-01	\$ 6,000.00	\$ 15,661.59	24	23	11	0	8	0
Nov-01	\$ 85,187.07	\$ -	16	16	12	0	4	0
Dec-01	\$ 35,093.05	\$ -	6	15	4	5	4	0
Jan-02	\$ 81,195.84	\$ 2,165.00	25	27	16	4	24	2
Feb-02	\$ 42,970.73	\$ 2,643.70	37	47	24	0	13	2
Mar-02	\$ 48,440.63	\$ 9,936.59	15	21	9	5	0	0
Apr-02	\$ 155,693.00	\$ 2,623.52	62	61	36	0	24	1
May-02	\$ 85,763.30	\$ -	40	35	20	0	7	0
Jun-02	\$ 18,333.00	\$ 21,410.80	21	29	15	0	3	0
Jul-02		\$ 21,410.80	17	22	14	0	15	0
Aug-02	\$ 40,550.99	\$ 24,041.40	3	10	2	2	6	0
Sep-02		\$ -	39	31	21	0	2	1
Oct-02	\$ 12,077.01	\$ 8,392.45	13	6	5	2	5	0
Nov-02	\$ 22,797.90	\$ -	36	30	23	2	4	1
Dec-02	\$ 38,050.75	\$ -	30	30	17	0	6	0
Total Rcvd	\$ 801,377.93	\$ 128,466.20	409	422	242	22	172	9
monthly average	\$ 40,068.90	\$ 6,423.31	Collection Rate	57.35%		Collection Rate	5.23%	
Aug 01-Jun 02	\$ 564,111.87	\$ 74,621.55	271	293	160	16	134	7
monthly average	\$ 47,009.32	\$ 6,218.46	Collection Rate	54.61%		Collection Rate	5.22%	
Jan 02-Dec 02	\$ 545,873.15	\$ 92,624.26	338	349	202	15	109	7
monthly average	\$ 45,489.43	\$ 7,718.69	Collection Rate	57.88%		Collection Rate	6.42%	

## Child Support Enforcement Division - Financial Institution Data Match Collections Aug 01 - Jun 02



## Child Support Enforcement - Financial Institution Data Match Collections Jan 02 - Dec 02



Multi State  
 In State

## Child Support Enforcement Division - Financial Institution Data Match Sample Case Explanations

XZ79Y45	Case was brought current with FIDM money NCP is now current every month
XZ5X7X5	Case was brought current with FIDM money NCP is now current every month
XZ65Y67	Case paid in full with FIDM Money, now closed
XZ8948X	Case was brought current with FIDM money NCP is now current every month
XZXYZ87	NCP had two cases and owed over 45K in arrears. When FIDM /WID was issued, NCP decided to pay cases current and now pays monthly support on time each month and has been doing so since May 2002
XZ5Z4Z9	
XZX6Z36	FIDM wid paid case in full, case is being reviewed for closure
XZ764Z6	FIDM paid case in full now closed.
XZ758Y5	FIDM paid all but \$60.00 on case, there had been no payments on this case in prior three years
XZ33765	FIDM paid case in full \$5802.11
XZ74X84	FIDM paid case in full \$992.00 5/02, last payment 11/30/01
XZ5X367	FIDM payment of 3242.26 05/02, no other payments since 11/00
XXZY66Y	FIDM payment of \$27262.00 06/02 to cp, no other payments since May 2001
XZZ84YY	FIDM paid case in full 06/02, no payments since 1998 (\$2581.00
XZ76YY4	FIDM helped us collect \$22K for CP, only payments have been getting are from SSA, Bal at time of wid \$56k
XZ9ZYZ6	FIDM helped collect 12529.64 for child, no voluntary payments ever rcvd org bal 22K now 9K
XZY867Y	FIDM paid case in full now closed.
XZ5477Y	FIDM paid case in full now closed.
XZY7644	Case was brought current with FIDM money NCP is now current every month
XZ79Y45	brought case current mso now only due
XZ75873	paid case in full, only payments pfd since 8/01 (3797.44)
XZ84Y7X	Case was brought current with FIDM money NCP is now current every month
XZ39899	paid all but \$20.00 ATAP debt only case being reviewed for closure
XZ6533Z	FIDM paid case down to 6k (8278), no disbursements since 1998, ncp came in and paid remainder of case in full
XZX9Z6X	paid case in full 11/02 with no voluntary payments since 07/01

CSED WELFARE REFORM "SUNSET" SUMMARY 2003

STATUTES

**Bank & Financial Institutions**

AS 06.20.020 (b) Small Loan Act

AS 06.40.050 (a) (e) Premier Financial License

**Board of Licensing**

AS 08.01.060 (b) Professional License Application

AS 08.01.089 Certified Copy of Public Record (Professional License) per CSED request

**Alaska Bar Admission**

AS 08.08.137 Alaska Bar Admission Fingerprint submission (SSAN Required)

**Presumptive Death Certificate / SSAN Required**

AS 09.55.050

**Death Certificate / SSAN Required**

AS 18.50.230 (f)

**Professional License / SSAN Required on Application**

AS 14.20.027 Teaching Certificate

AS 16.05.450 (a) Commercial Fish Crewman License

AS 16.05.450 (a) Commercial Fishing License

AS 18.60.395 (a) Boiler Operator License

AS 18.65.410 (a) Security Guard License

AS 18.72.030 (a) Fireworks Wholesaler License

AS 21.06.255 Insurance License

**Family Judicial Processes / Vital Statistics (SSAN Required)**

AS 25.05.091 (b) Marriage License Application

AS 25.20.050 (n) Paternity Order

AS 25.24.160 (d) Court Ordered Divorce Judgement

AS 25.24.210 (f) Petition for Dissolution

AS 25.24.230 (i) Court Ordered Dissolution Judgement

**Driver's License / SSAN Required**

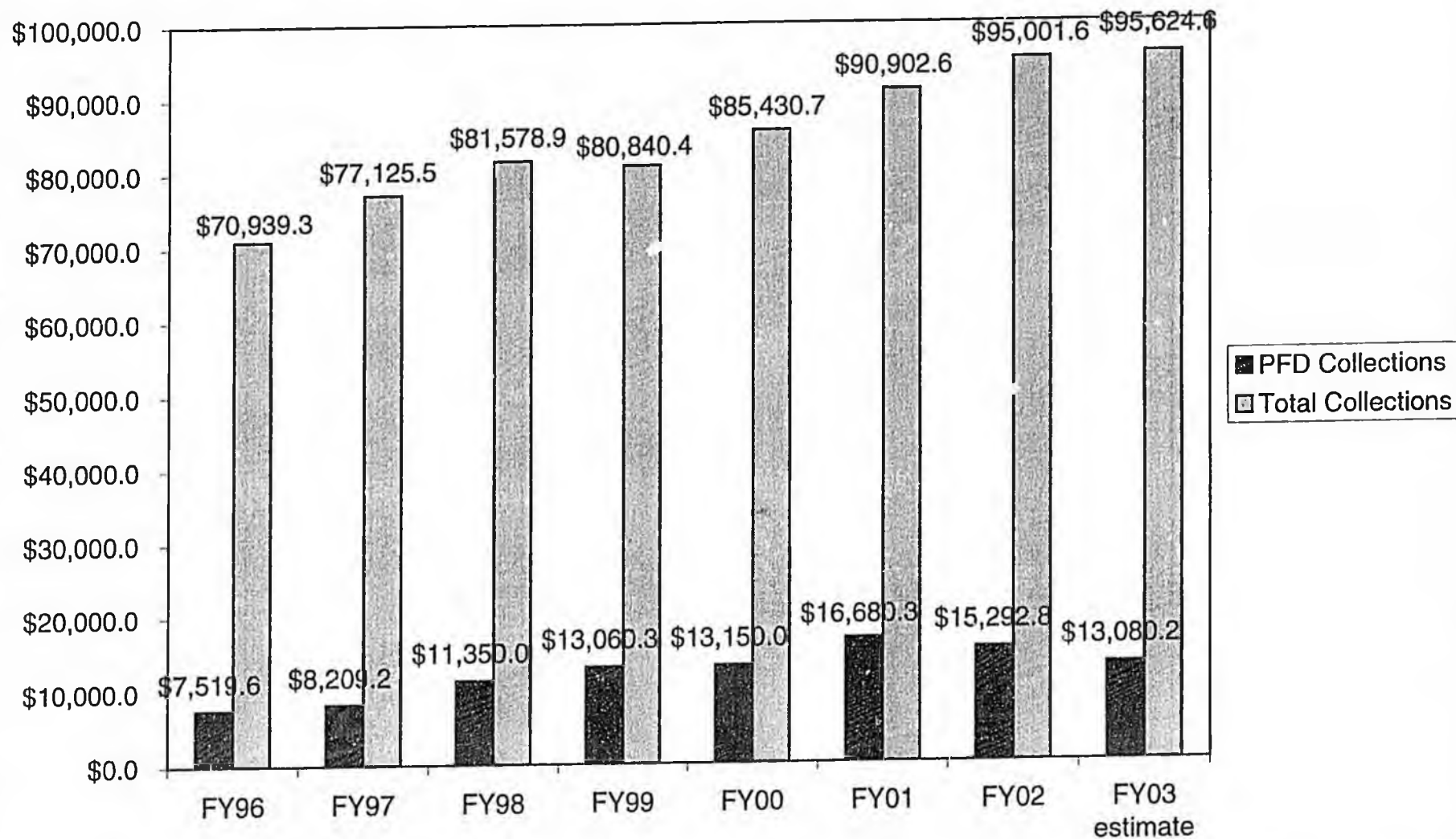
AS 28.15.061 (b) (g) Driver's License / Instruction Permit

**Financial Institution Date Match**

AS 25.27.020 (a)(2)(D) Agreements with Financial Institutions must include SSAN to facilitate automated data exchanges

### Child Support Enforcement Division PFD collections vs. Total Collections

In 000's



## Protection of Social Security Numbers

The Child Support Enforcement Division takes the security of all confidential data (including social security numbers) very seriously. The following steps are taken to protect social security numbers:

- Each new employee is given an initial comprehensive confidentiality briefing within two days of reporting to work and before they have access to the division's computer and paper files. During the more extensive employee orientation that occurs within the first several weeks of reporting to work employees are again briefed on confidentiality and shown a video produced by the federal Office of Child Support Enforcement that deals with protection of confidential information including social security numbers.
- Each employee is required to sign a confidentiality form that explains the policy and the penalties for unauthorized disclosure. These forms are signed by new employees during in processing and by other employees yearly.
- Every employee receives annual training on confidentiality to include viewing a video produced by the Internal Revenue Service. This video deals with protecting IRS information to include social security numbers.
- Only division personnel who perform casework have access to computer screens that display social security numbers.
- Caseworkers are prohibited by policy from viewing any cases that are not assigned to them. This is to prevent workers from surfing through case files and having access to confidential information on cases that they are not working.
- Social Security numbers have been removed from all forms and letters sent to parties outside the agency except where it is absolutely required to conduct business. For example the social security number is still included on the wage withholding order so employers can positively identify the individual from whom wages should be withheld.
- Any time the division is required to release information all confidential information including social security numbers are redacted.

**HB**

**152**

# STATE OF ALASKA

## DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

FRANK H. MURKOWSKI, GOVERNOR

P.O. BOX 110601  
JUNEAU, ALASKA 99811-0601  
PHONE: (907) 465-3030  
FAX: (907) 465-3068

March 6, 2003

Honorable Peggy Wilson  
Chair  
House Health, Education, and Social Services Committee  
Alaska State Capitol; Rm. 106  
Juneau, AK 99801

Dear Representative Wilson,

The Department of Health and Social Services respectfully requests a hearing in the House Health, Education, and Social Services Committee on House Bill 152 "An Act relating to payment rates under the Medicaid program for health facilities and to budgeting, accounting, and reporting requirements for those facilities; abolishing the Medicaid Rate Advisory Commission; and providing for an effective date."

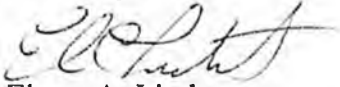
This bill will provide greater flexibility to the Department of Health and Social Services to set Medicaid payment rates for Alaska's hospitals, nursing homes and other health care facilities. Changes in federal law in the past few years providing more flexibility in rate setting have not been taken advantage of in Alaska due to our own inflexible statute.

The proposed bill would eliminate the Medicaid Rate Advisory Commission (MRAC). Since the MRAC currently acts in an advisory capacity and the Commissioner has ultimate authority to set rates, elimination of the Commission and its attendant costs is appropriate.

Passage of this legislation will allow the department to develop in regulation a more flexible, cost-effective rate setting process that will, for the first time, allow the department to explicitly take into account the appropriations made by the legislature for the Medicaid program when setting rates. A fiscal note should be on file with the committee.

Your favorable consideration of this request will be appreciated.

Sincerely,



Elmer A. Lindstrom  
Special Assistant to the Commissioner

Cc: Mike Tibbles, Legislative Director  
Office of the Governor

Virginia Stonkus, Acting Director  
Division of Medical Assistance

FRANK H. MURKOWSKI  
GOVERNOR  
GOVERNOR@GOV.STATE.AK.US



STATE OF ALASKA  
OFFICE OF THE GOVERNOR  
JUNEAU

HB152  
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WWW.GOV.STATE.AK.US

March 5, 2003

The Honorable Pete Kott  
Speaker of the House  
Alaska State Legislature  
State Capitol, Room 208  
Juneau, AK 99801-1182

Dear Speaker Kott:

Under the authority of article III, section 18, of the Alaska Constitution, I am transmitting a bill to provide greater flexibility to the Department of Health and Social Services to set Medicaid payment rates for Alaska's hospitals, nursing home and other health care facilities.

The proposed bill would eliminate the Medicaid Rate Advisory Commission and place the responsibility for calculating and setting Medicaid payment rates for health care facilities under the general authority of the Department of Health and Social Services.

Historically, the Medicaid facility rate setting process has been extremely cumbersome and costly for both the state and health care facilities. The current rate-setting process is both a barrier to effective cost containment as well as problematic for assuring adequate reimbursement for Alaska's diverse mix of health care facilities.

Passage of this legislation will allow the department to develop in regulation a more flexible, cost-effective rate setting process that will, for the first time, allow the department to explicitly take into account the appropriations made by the legislature for the Medicaid program when setting rates.

I urge your prompt and favorable action on this measure.

Sincerely,

A handwritten signature in cursive script that reads "Frank H. Murkowski".

Frank H. Murkowski  
Governor