OBJECTIVES, SCOPE, AND METHODOLOGY

In accordance with the intent of Titles 24 and 44 of the Alaska Statutes, we have reviewed the activities of the Board of Dispensing Opticians (BDO) to determine if the termination date for the board should be extended. As required by AS 44.66.050(a), the legislative committee of reference shall consider this report as part of the oversight process in determining if BDO should be reestablished. Currently, AS 08.03.010(c)(9) specifies that BDO will terminate on June 30, 2004. If no action is taken by the legislature, the board will have one year from that date to conclude its administrative operations.

Objectives

Central, interrelated objectives of our report are:

1. To determine if the termination date of the board should be extended.
2. To determine if the board is operating in the public interest.
3. To determine if the board has exercised appropriate regulatory oversight of licensed opticians.
4. To assess and report on the board's response to legislative concerns regarding use of, and alternatives to, a practical examination for licensing applicants as opticians.
5. To assess and report on actions taken in response to legislative concerns about charging licensees adequate licensure fees to cover the operating expenses of board.

The assessment of the operations and performance of the board was based on criteria set out in AS 44.66.050(c). Criteria set out in this statute relate to the determination of a demonstrated public need for the board.

Scope and Methodology

Under the direction and supervision of the Division of Legislative Audit, another auditor conducted the majority of this review. We followed professional standards to determine that the other auditor was independent and their work was competent and sufficient.

The major areas of our review were board proceedings, licensing, complaint investigation, and resolution functions. During the course of our examination we reviewed and evaluated the following:

- Applicable statutes and regulations.
- Compliance with statutes and regulations related to the licensing of Dispensing Opticians and the registration of optician apprentices.
- Files and documentation related to individuals licensed as dispensing opticians and dispensing optician apprentices.
- Files and documentation related to individuals who applied for licensure as a dispensing optician.
- Minutes of board meetings, budget documents, and annual reports related to, or issued by, BDO.
- Annual reports issued by the board.
- Complaints filed with the Division of Occupational Licensing.

Additionally, we conducted interviews with Division of Occupational Licensing staff, a program manager with the U.S. Department of Labor, and members of the board, including the current board chair.

ORGANIZATION AND FUNCTION

Alaska Statute 08.71.010 establishes the Board of Dispensing Opticians (BDO). The board consists of five members, specified in statute to be made up of four licensed opticians and one public member appointed by the governor.

The board regulates the practice of Opticianry. BDO sets the minimum standards to practice in Alaska by:

1. Registering dispensing optician apprentices.
2. Licensing opticians through examination or credentials.
3. Establishing, amending, or eliminating regulations that affect the standards of professional opticianry practice.

BOARD OF DISPENSING OPTICIANS
(As of June 30, 2003)

James D. Rothmeyer, Optician, Chair

Larry E. Harper, Optician

David G. Matthews, Optician

Roberta (Bobbie) Rawcliffe, Public Member

Cindy S. Tidd, Optician

4. Taking disciplinary actions in accordance with the Administrative Procedures Act when a person has violated dispensing opticians' statutes or regulations.

Licensed dispensing opticians, from a commercial perspective, are somewhat uniquely situated. The optician provides services that also can be provided by two other licensed professionals – optometrists and ophthalmologists (the latter being a licensed physician specializing in care of the eyes). State law specifies the rights, privileges, and obligations of dispensing opticians are designed not to *"limit or restrict a licensed physician or optometrist from the practices enumerated"* in the dispensing optician statutes. Additionally, statute provides that *"each licensed physician and optometrist has all the rights and privileges which may accrue under [statute] to a Dispensing Optician licensed [under state law]."*

Opticians provide services to the public that also can be provided by individuals associated and supervised by optometrists and ophthalmologists. Some opticians work independently while others are affiliated with optometrists or ophthalmologists.

Department of Community and Economic Development (DCED), Division of Occupational Licensing (OccLic)

The Department of Community and Economic Development (DCED), Division of Occupational Licensing (OccLic), provides administrative and investigative assistance to the Board of Dispensing Opticians. This includes budgetary services and functions such as: collecting fees, maintaining files, receiving and issuing application forms, and publishing notice of examinations and meetings.

Alaska Statute 08.01.065 mandates DCED, with the concurrence of the board, to adopt regulations establishing the amount and manner of payment for application fees, examination fees, license fees, registration fees, permit fees, investigation fees, and all other fees as appropriate for the occupations covered by the statute.

Alaska Statute 08.01.087 empowers OccLic with the authority to act on its own initiative or in response to a complaint. The division may:

1. Conduct an investigation if it appears a person is engaged in, or is about to engage in, a prohibited professional practice.

2. Bring an action in superior court to enjoin the act.

3. Examine the books and records of an individual.

4. Issue subpoenas for the attendance of witnesses and records.

REPORT CONCLUSIONS

In 2002 the legislature extended the termination date of the Board of Dispensing Opticians (BDO) for only two years to June 30, 2004. This reflected the legislature's concern regarding various aspects of the board's operations and enabling statutes. These concerns were set out in both the 2002 legislation extending the termination date of the board and a letter of intent from the House Labor and Commerce Committee. We incorporated these issues into the scope of this sunset review and present conclusions regarding how the board responded to these specific legislative concerns.

As discussed in the box below, the legislature was concerned about the board not setting fees high enough to cover operating costs. Additionally, the legislature wanted BDO to research and report on options for conducting a practical examination for licensure as a dispensing optician.

Practical examination eliminated

A BDO subcommittee researched and analyzed alternatives for the practical examination. In addition to revising the state practical exam to make it more objective, the subcommittee reviewed other alternatives including the purchase of exam and grading services from a private sector contractor.

Eventually, consideration of these alternatives was abandoned. BDO essentially decided to acquiesce to the legislature's decision when it repealed the requirement of applicants to pass a practical examination for optician licensure. This action was taken as part of the 2002 sunset extension legislation. No final report was completed for submission to the Chair of the House Labor and Commerce Committee or the Legislative Auditor – as was required in the original letter of intent.

In place of the state practical exam, dispensing optician candidates now must pass, with a score acceptable to the board, the National Contact Lens Examiners (to dispense contacts) and the National Opticianry Competency exam (to dispense spectacles).

Legislature Concerned about Fees, Costs, and Examination Requirements

Section 1 of Chapter 58, SLA 2002 set out the following legislative findings and intent:

a. The legislature finds that the Board of Dispensing Opticians has not collected sufficient fees to cover its costs and may not have been complying properly with AS 08.01.065(c).

b. It is the intent of the legislature that during the next review of the board under AS 44.66.050, an analysis and determination be made about the extent to which the board is complying with AS 08.01.065(c) and what factors, if any, hamper the board's ability to cover its costs with fee collections.

A letter of intent issued by the House Labor Commerce Committee and attached to the legislation specified the:

Board of Dispensing Opticians research the options for conducting a practical examination for licensure as a dispensing optician. ...

Despite large fee increases, BDO is currently, and prospectively will remain, in deficit

The board has been in a deficit position since FY 98. As reflected by the schedule on page 18 of this report, at the end of FY 03 the cumulative deficit was over $22,000.[1]

In recent years, relatively large increases in costs identified as "contractual" have had a significant impact to the continuing deficit. Most recently in FY03, BDO spent over $3,800 for one-time examination fees to the National Academy of Opticianry and the Contact Lens Society of America. In the same fiscal year, the board spent almost $3,000 on advertising and printing services which were primarily due to changes made in the regulations. Significant changes of this sort typify the unpredictable nature of contractual costs thus making fee setting difficult.

The department and board took action to reduce the cumulative deficit by increasing biennial licensing fees for both dispensing opticians and optician apprentices.[2] For the renewal period starting July 2003, fees for dispensing opticians and optician apprentices increased by $210 (55%) and $150 (300%), respectively. The FY 03 license renewal fees for opticians were $590, up from the previous level of $380. Prospectively, at this time BDO is facing renewal fees ranging from $800-$1,000 for the upcoming renewal cycle in June 2005 to eliminate the deficit and cover annual board operating costs.

Optimistically assuming that revenues for the next two years remain the same, and expenditures are reduced by 20%, BDO will still be facing a substantial continuing deficit at the end of the next biennial renewal period (2005). Given this conservative projection the Division of Occupational Licensing (OccLic), in conjunction with BDO, will need to increase fees to come into compliance with AS 08.01.065(c). For further discussion of this concern, see Recommendation No. 2.

Registration and reliance on national examination may be a viable licensing alternative

Under AS 44.66.050(d)(4) part of a sunset review is to provide *"an assessment of alternative methods of achieving the purposes of the program."* In the prior audit we considered the

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[1] Since licenses are renewed every two years, revenues generated by renewal fees alternate between high and low years. In license renewal years, the board does cover its operating costs, although the cumulative deficit continues. In the low revenue, non-renewal, years the costs are such that the deficit grows. Prior to the collection of biennial licensing renewal fees in FY 03, the board's cumulative deficit was $38,700.

[2] The cumulative deficit decreased by approximately $16,300 from FY 02 to FY 03.

merits of regulating opticians through a registration process and placing primary reliance on the successful completion of nationally recognized examinations to ensure competency.[3]

Most states do not "regulate" or license opticians at all. According to the Opticians Association of America, only 22 states license dispensing opticians.[4] Texas has a voluntary registration program – which allows the individual to advertise as a "registered optician" if they have met certain established criteria related to competency.[5] Such an approach may be a viable alternative for Alaska.

Under this approach an individual could advertise as being a registered optician, once they provided proof to OccLic that they had met the necessary testing and continuing education requirements. Presumably, such designation would have some commercial advantages, assuring consumers the practitioner had met an established standard of competency.

Changing over to a registration, rather than licensing, process would not necessarily result in the disappearance of the optician profession and its related services. The scope of practice for opticians, to a large extent if not completely, falls within the purview and scope of optometrist and ophthalmologist professions.[6] Given such circumstances, jurisdictions in which opticians are not licensed or registered still have opticians working – often in conjunction with licensed optometrists.

Termination date for the board should not be extended

BDO is serving a public purpose by promoting the competent and safe practice of opticianry. The board does this by: establishing standards for licensed professionals; monitoring the manner in which they practice; and, has carried out these responsibilities in a satisfactory manner. A licensed optician provides enhanced quality control in the dispensing of spectacles and contact lenses. Having an individual with the training to evaluate the

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[3] The American Board of Opticianry (ABO) and the National Contact Lens Examiners are national, nonprofit organizations which conduct voluntary certification programs for dispensing opticians. The examination given by ABO measures the basic knowledge required to dispense eyeglasses safely and effectively. While there are no prerequisites to take the examination, the ABO comments that candidates with two to three years of full-time, board-based, hands-on experience, or with formal optical schooling, are more successful in passing the examination.

[4] Information from the internet website maintained by the Opticians Association of America is at: http://www.oaa.org/navbar/4oaamembers/8license/index.htm (September 13, 2003)

[5] An individual is allowed to register as an optician upon demonstrating they have seven classroom hours of recognized training prior to submitting a registration application and they had taken and passed, either or both, of the ABO examination or the National Contact Lens Examiners examination. See: http://www.tdh.state.tx.us/hcqs/plc/optician.htm#requirements (September 13, 2003)

[6] This situation is explicitly recognized in state law at AS 08.71.230(1) which states no part of the optician licensing statute is to be construed as limiting or restricting *"a licensed physician or optometrist from the practices enumerated in [the opticianry statutes], and each licensed physician and optometrist has all the rights and privileges which may accrue under [the statutes] to dispensing opticians...."*

prescription of lenses – either eyeglasses or contact lens – and assisting in the proper fitting is a valuable, though not essential, service to the public.

As reflected in both the Auditor Comments and Findings and Recommendations sections of this report, the future operational viability of the board is questionable. In the long term, the number of new applicants seeking licensure as opticians may be reduced significantly due to creation of the optician assistant designation. Combined with fiscal instability involving operating costs, the long-term viability of the board is problematic. Given these concerns, we recommend the legislature not extend the termination date for the board.

In our view, the public can be adequately protected by competition in the marketplace, ongoing supervision of assistants, or professional standards already established for practicing opticians and ophthalmologists.

By not passing any extension legislation, BDO would go into a wrap-up phase. In the one-year wrap-up period, we recommend that the board formally recognize the U.S. Department of Labor (USDOL) apprentice program in regulation – as a means for individuals to continue training to be opticians – under the supervision of practicing opticians.

Additionally, during this wrap-up period, the legislature may want to consider putting a registration system in place. Such a process would allow individuals who have passed one or both of the national licensing examinations to show proof and obtain an "endorsement" from the State of Alaska – allowing them to advertise as a registered optician. The statute could require the optician to renew their registration every two years by showing proof they have obtained a required amount of continuing professional education.

AUDITOR'S COMMENTS

In 2002 the legislature, in the process of extending the termination date of BDO, made a small but important change to the opticianry statutes. The legislature created a statutory designation of optician assistant, in addition to the paraprofessional optician apprentice that was already recognized in law.

Previously, eyewear salespersons, termed stylists, had to register as an apprentice

The number of individuals registered as optician apprentices have always been very disproportionate to the number of apprentices who eventually sought licensure as opticians. In recent years, there have been almost 200 registered apprentices on record at the Division of Occupational Licensing (OccLic); but, each year only four or five, at most, would apply to take the optician licensing examination.

This situation developed from the statutory requirement that all nonlicensed personnel, involved in fitting eyewear in optical shops, had to be registered as an optician's apprentice. This registration was required whether the customer sales representative, or as they are often referred to as "stylists," worked for an optician, optometrist, ophthalmologist, or a large nationally-affiliated chain store. As a result, individuals who had little or no interest in becoming a licensed optician had to register as an apprentice.[7]

Key distinction between apprentices and assistants involve standards of supervision

BDO wanted to be sure apprentices were supervised appropriately. The general intent of this public policy was apprentices would someday be licensed opticians and it was important they be appropriately supervised by whatever professional was responsible for providing the oversight. Accordingly, BDO adopted specific requirements[8] about supervision, requiring the professional involved:

> *(1) be physically present at the same site as the apprentice at least once per day and not be absent for more than two hours while the apprentice is performing dispensing optician tasks;*

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[7] The statutory designation of an optician assistant has had an immediate impact on the number of individuals registering as a dispensing optician apprentice. In FY 00 through FY 02, the number of individuals registering as apprentices averaged 35 each year. In FY 03 the number of individuals registering as an apprentice decreased to eleven (11). The decrease of registered apprentices is substantial, but the financial impact will be minimal because of higher apprentice registration fees.

[8] See regulations at 12 AAC 30.125.

(2) frequently observe and review performance of assigned tasks; and,

(3) ensure correct performance of assigned tasks.

These requirements, especially the regulation requiring the supervising professional to be physically present on the premises for a specific period of time, are much more restrictive than the standards applicable to the new optician assistant designation.

Under the 2002 amendments to the opticianry statutes, assistants must be supervised to the extent necessary to provide *"needed direction, control, consultation, instruction, evaluation and personal inspection of the work performed."*[9] This statutory language gives the supervising professional much more discretion in the supervision of assistants than they have under BDO regulations for apprentices.

Relaxed supervision standards may lead to less demand for opticians, devaluing licensure

Most licensed opticians in Alaska are employed by, or are a contractor with, other eye care professionals – optometrists and ophthalmologists. A current board member has estimated that as many as 80% of opticians work for, or in conjunction with, these other two eye care professionals. One reason that many of these opticians are employed in such settings is this arrangement allows an optometrist or ophthalmologist to meet supervision requirements for apprentices in the selling and fitting of eyeglasses and contact lenses.

Under the new state law, an optometrist or ophthalmologist can employ and designate stylists and customer service representatives as assistants while reasonably asserting they provide the necessary *"direction, control, consultation, instruction..."* over the phone, by e-mail, or with intermittent face-to-face contact. Such an arrangement eliminates the need to be physically present or to rely on another qualified supervising professional such as an optician. As a result, optometrists and ophthalmologists have less incentive to hire or contract with an optician.

Less demand and high licensing fees may lead to many opticians opting out of licensure

The creation of the optician assistant designation will likely serve to undercut the need for apprentices and, in the long run, may substantially reduce the number of people seeking to be licensed as a dispensing optician. The reduced supervision standards for assistants, coupled with the prospect of continued large increases in licensing fees, may lead to a situation where currently-licensed opticians no longer see the value of remaining licensed. Additionally, in the long term, such disincentives would further discourage interested individuals from enrolling in apprentice programs – further reducing the prospective number of individuals seeking licensure.

[9]These supervision standards are set out in state law at AS 08.71.240(4).

Optician license devaluation seems to have little adverse effect on public health and welfare

Given the scenario previously discussed, our overarching concern is what impact, if any, does the opticianry statute changes have on the health, safety, and welfare of the public. Based on the number and type of complaints often made to OccLic, there is no obvious direct impact. We reviewed investigative case-file summaries for both the Board of Dispensing Opticians and the Board of Optometric Examiners for FY 02 and FY 03. There is no evidence showing that a minimally-supervised assistant's services as being inferior to those services provided by licensed opticians or registered apprentices.

The harm that unlicensed opticians can potentially cause the public does not appear to warrant state licensure. The presence of licensed opticians and well-supervised apprentices can save the public from loss of time, money, and general aggravation involved with making return visits to a prescribing professional to remedy improperly fitted glasses. However, the avoidance of these costs, discomforts, and hassles does not necessarily warrant state licensure and oversight.

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necessary for licensure and significantly reduced the amount of apprentice training time required. Compared to the previous apprentice training requirement of 6,000 hours that the board had in place prior to FY 03 and the apprenticeship periods found in other jurisdictions, we agree the 3,600 hour requirement for both endorsements is a reasonable requirement.

The wording of the current statute does not clearly specify that 1,800 hours are required for **each** license endorsement. This leads to situations where the statute and the regulation are not congruently matched. The board should adopt language to clarify the apprenticeship training requirement, especially as it relates to the minimum number of training hours necessary for each type of endorsement.

2. Modification of apprentice registration requirements at AS 08.71.160. The creation of the optician assistant has had a significant impact on the opticianry profession. The impetus behind the change was to reduce the number of registered apprentices and associated board costs. The optician assistant position helped to accomplish those goals by segregating individuals who previously registered because it was a job requirement from those seeking professional licensure. The anticipated results from the statutory changes were evidenced by the immediate decrease in numbers of registered apprentices (66%) and a reduction of associated board costs, albeit slight. However, the continuing, apprentice registration requirements result in unnecessary administrative duties and costs to the board. This is especially true in light of the development of the U.S. Department of Labor (USDOL) optician apprenticeship program.

Since the 2002 legislative changes to the opticianry statutes, the board, in conjunction with USDOL officials, has developed and implemented a dispensing optician apprentice program. USDOL administers the program; the Opticians Association of Alaska is the sponsor. The program was designed specifically to meet Alaska's dispensing optician statutory and regulatory requirements. There are many advantages of the apprentice program including specific training guidance for individuals seeking licensure as a dispensing optician, better prepared optician candidates, and for employers, access to federal grants to help offset the cost of the apprentice. Currently, individuals must register with the state; however, USDOL registration and participation in the apprenticeship program is optional.

The board should modify the apprentice registration statute by adding a requirement in the opticianry regulations that apprentices register with USDOL and complete the optician apprenticeship program. Implementation of such changes will eliminate all administrative duties and costs to the board relating to apprentice registration. The USDOL program has been designed to meet the state's statutory and regulatory requirements. Additionally, the structure of the newly-designed apprentice program will facilitate a better prepared and more competent dispensing optician candidate. It should be a requirement that apprentices register with and participate in the USDOL program and the state requirement for apprentices to register should be eliminated.

3. Recognition, in statute, of a process to license individuals from other jurisdictions. Currently, an individual from another jurisdiction with licensing requirement experience that is less than Alaska requires, can only obtain licensure by participating in the state's apprenticeship process. This puts an undue burden on qualified individuals, new to the state, who worked in the profession for several years.

   BDO has suggested that if individuals pass the American Board of Opticianry (ABO) master-level examination, the board would be willing to license these individuals to practice in Alaska. This testing is appropriate for individuals who possess dispensing optician experience gained in another jurisdiction that has licensing requirements less stringent than those required in Alaska.

   Since more than half of the states do not license opticians, many individuals practicing in these states are often permitted to call themselves opticians by virtue of passing a national licensing examination. Because these individuals would not easily qualify for licensure in Alaska under the current statute, this represents a significant barrier for entry into the profession. Allowing these individuals to be licensed, by virtue of successfully completing the ABO advanced exam, BDO can make the profession more accessible while ensuring the individual possesses the necessary competence to practice.

Recommendation No. 2

The Division of Occupational Licensing (OccLic), in conjunction with the board, should increase optician's licensing fees to eliminate the cumulative deficit.

As discussed in the report conclusions section of this report, it is clear another increase in opticianry licensing fees is necessary to eliminate the cumulative deficit and meet annual operating costs of the board. Licenses are renewed every two years; therefore, the revenue generated in the renewal year must be sufficient to fund most of the board's costs for the nonrenewal or subsequent year. The recent increase in licensing renewal fees for dispensing opticians and optician's apprentices appears to be sufficient to cover the board's costs for the two-year period. Depending on the amount of revenue collected in the nonrenewal year, the increase licensing fee may also reduce a small portion of the board's continuing deficit.

BDO members object to some of the charges made to the board by Department of Law (DOL). In recent years DOL charged BDO with litigation costs it incurred relating to a national contact lenses distribution case. BDO reports DOL pursued this matter unilaterally, with no direction or request from the board. Although these charges to the board may have been services not approved by the board, they do not contribute significantly to the cumulative deficit.[11] The major contributing factor to the deficit is board costs have exceeded license renewal fees without BDO instituting necessary fee adjustments to cover costs. As a result, the deficit has continued to grow for several years.

[11] In FY 00 and FY 01, there were no charges from the Department of Law. In FY 02 and FY 03, legal costs were approximately $5,500 and $1,100, respectively.

Without further increases to the renewal licensing fee for dispensing opticians, the cumulative deficit will remain and the board will likely meet annual operating costs – only.

Alaska Statute 08.01.065(c) requires fees for an occupation be set to approximate the regulatory costs for the occupation. We recommend that the board and OccLic review the regulatory costs and licensing fees to ensure that BDO licensing fees are sufficient eliminate the cumulative deficit and to meet annual operating costs.

ANALYSIS OF PUBLIC NEED

The following analyses of board activities relate to the public need factors defined in AS 44.66.050(c). These analyses are not intended to be comprehensive, but address those areas we were able to cover within the scope of our review.

The extent to which the board, commission, or program has operated in the public interest.

The Board of Dispensing Opticians (BDO), by implementation of prior audit recommendations, has operated in the public interest. The current BDO is responsive to outside suggestions and is conscientious of its fiduciary responsibilities. Further, BDO, in conjunction with USDOL, has developed and implemented an optician apprenticeship program. As discussed in Recommendation No. 1 we encourage the board to mandate adoption of the USDOL apprenticeship program to replace the current state apprentice registration process.

The extent to which the operation of the board, commission, or agency program has been impeded or enhanced by existing statutes, procedures, and practices that it has adopted, and any other matter, including budgetary, resource, and personnel matters.

Most of BDO's revenue is from certification, licensing, and renewal fees. Renewals are conducted on a biennial basis. This creates a two-year cycle in board revenues, with BDO receiving most of its revenues during the renewal period. We reviewed the internal records maintained by the OccLic for revenues and expenditures associated with BDO. We did not audit this information, but present it below for general information purposes.

Alaska Statute 08.01.065(c) requires *"...that the total amount of fees collected for an occupation approximately equals the actual regulatory costs for the occupation."* As the schedule on the next page reflects, the board was running a substantial deficit at the end of FY 03. As discussed in Recommendation No. 2, the Division of Occupational Licensing should increase fees substantially to bring BDO into compliance with state law.

State of Alaska
Board of Dispensing Opticians
Schedule of License Revenues and Board Expenditures
FY 00 - FY 03
(Unaudited)

	FY 03	FY 02	FY 01	FY 00
Revenue	$ 46,500	$ 17,300	$ 32,700	$ 11,800
Direct Expenses				
Personal Services	13,900	19,200	14,200	16,500
Travel	1,300	2,600	3,400	4,800
Contractual	9,300	8,900	2,900	2,300
Supplies	200	-	100	-
Equipment	-	-	-	-
Total Expenses	24,700	30,700	20,600	23,600
Indirect Expense	5,500	3,800	4,900	5,000
Total Expenses	30,200	34,500	25,500	28,600
Annual Surplus (Deficit)	16,300	(17,200)	7,200	(16,800)
Beginning Cumulative Surplus (Deficit)	(38,700)	(21,500)	(28,700)	(11,900)
Unallocated Administrative Indirect Revenue	-	-	-	-
Ending Cumulative Surplus (Deficit)	$ (22,400)	$ (38,700)	$ (21,500)	$ (28,700)

The extent to which the board, commission, or agency has encouraged interested persons to report to it concerning the effect of its regulations and decisions on the effectiveness of service, economy of service, and availability of service that it has provided.

All of BDO's board meetings had time available for public comment.

The extent to which the board, commission, or agency has recommended statutory changes that are generally of benefit to the public interest.

BDO, while not necessarily endorsing the statutory changes made by the 2002 legislature, did work constructively with legislative staff to develop changes in state law related to the opticianry profession.

The extent to which the board, commission, or agency has encouraged public participation in the making of its regulations and decisions.

The location, date, and time of upcoming meetings and exams were advertised in Alaskan newspapers, as well as on the Board of Dispensing Opticians' web page with adequate time for interested individuals to attend or to submit written comment for review. The board's meeting agenda sets aside suitable time for the board to receive public comment. Minutes from the meetings of the board reflect public participation at various meetings.

The efficiency with which public inquiries or complaints regarding the activities of the board, commission, or agency filed with it, with the department to which a board or commission is administratively assigned, or with the office of victims' rights or the office of the ombudsman have been processed and resolved.

During the 48-month period from July 1, 1999 through June 30, 2003, OccLic opened eight investigative cases related to individuals certified by the board. None of the cases involved complaints made by clients or individuals from the general public. Six of the complaints were opened by OccLic as a result of a site visit/shop inspection. One of the complaints was made by an optometrist. Only one complaint appears to have originated from a member of the general public. Five of the complaints involved unlicensed practice by dispensing opticians, three of which were optician apprentices.

Of the seven cases closed as of the date of our review, two resulted in licensure action involving Memorandums of Agreement. Of the remaining cases, one was closed finding no violation, three were closed with warnings issued by BDO, and one by compliance. The one case not closed, as of the date of our review, is still being actively investigated even though it was opened in May 2001.

We have reviewed the nature and extent of complaints filed involving dispensing opticians. In our view OccLic, in conjunction with the BDO, has proceeded in a manner consistent with the potential threat the complaints posed to the public welfare.

There were no complaints filed with the Office of the Ombudsman or the Office of Victims' Rights for the period under review.

The extent to which a board or commission that regulates entry into an occupation or profession has presented qualified applicants to serve the public.

The table below summarizes licensing activity for the prior four fiscal years, listing the number of new licenses issued each year for each license type, as well as the total number of current certificates. The number of individuals registering as dispensing opticians has remained stable, while the number of apprentice registrants has decreased significantly as a result of Chapter 58 SLA 2002 (see discussion in both Auditor Comments and Report Conclusions section of this report).

	New Licenses Issued				**Total Current Licensees/ Registrants**
	FY 00	**FY 01**	**FY 02**	**FY 03**	
Dispensing Optician	2	3	3	4	107
Apprentice	40	32	34	11	191

Once an individual registers as an apprentice, they remain registered with OccLic indefinitely; there is no renewal requirement for the apprentice license. Apprentices are required to file any supervisory changes and submit the appropriate fee.

The extent to which state personnel practices, including affirmative action requirements, have been complied with by the board, commission, or agency to its own activities and the area of activity or interest.

We did not find any evidence that BDO was not complying with state personnel practices, including affirmative action in qualifying applicants. In no instances has the board denied an applicant a license based on personal attributes.

The extent to which statutory, regulatory, budgeting, or other changes are necessary to enable the agency, board, or commission to better serve the interest of the public and to comply with the factors enumerated in AS 44.66.050.

As discussed in Recommendation No. 1, legislation is needed to clarify various aspects of the opticianry statutes. Changes needing to be addressed:

1. The discrepancy between statute and regulation suggests that applicants may become licensed opticians with only 1,800 hours of registered practical experience. For an individual to be licensed as a dispensing optician with an endorsement to dispense both eyeglasses and contact lenses, they would need 3,600 hours of experience. Currently, this distinction is not made clear in state law.

2. The need for apprentices to continue registering with the Division of Occupational Licensing. With the creation of the optician assistant classification and establishment of an apprenticeship program administered by USDOL, the need for individuals to formally register as apprentices with the Division of Occupational Licensing is no longer necessary. Rather, as a condition for being licensed as a dispensing optician the statute should be modified to require applicants to complete a board-recognized apprenticeship program. Further, opticianry regulations should be developed requiring apprentices to register with USDOL and complete the optician apprenticeship program.

3. The need to recognize in statute a procedure available for individuals, who practiced as a dispensing optician in other states with licensing requirements less stringent than Alaska, to be licensed as dispensing opticians through the successful completion of a national "masters" examination.

   As discussed in Recommendation No. 2, fees should again be increased to come into compliance with state law.

House Resolution —

Fairness of Contact Lenses Act —

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November 17, 2003

Pat Davidson, Legislative Auditor
Division of Legislative Audit
PO Box 113300
Juneau, AK 99811-3300

Re: BOARD OF DISPENSING OPTICIANS – PRELIMINARY AUDIT

Dear Ms. Davidson:

Thank you for the opportunity to comment on your preliminary audit report of the Board of Dispensing Opticians.

The department concurs with the findings in your report. Specifically, we share your concerns with viability of the board and support the recommendation that the board not be extended.

The department recommends the legislature amend the law to provide for mandatory registration of Dispensing Opticians, through a registration program administered by the department. We recommend the registration be for the Dispensing Optician level only and that apprentices not be registered.

FINDINGS AND RECOMMENDATIONS

If the legislature decides to extend the termination date for the Board of Dispensing Opticians (BDO), we believe it is important for the board to take the following actions.

Recommendation No. 1
The board should develop and propose legislation to clarify statutes related to the various aspects of dispensing opticians.

The department concurs with the concerns raised in items 1-3 referenced under this recommendation. If the legislature decides to extend the termination of the board, the Board should be requested to assist with developing and proposing conceptual language

for legislation. However, we believe the legislature has the staff and expertise to draft legislation.

Recommendation No. 2
The Division of Occupational Licensing (OccLic), in conjunction with the board, should increase optician's licensing fees to eliminate the cumulative deficit.

The department recently increased the Dispensing Optician biennial license fee from $380 to $590. Although we concur that the board needs to be self-sufficient, we are concerned that as the fees continue to increase fewer licensees will chose to renew, thus creating a larger deficit. Licensing programs that show a significant deficit have been allowed to recoup the deficit over two biennial periods; this approach has provided incremental increase in fees and gives the profession time to reduce its operating costs where applicable. The department has attempted to apply this process consistently to all licensing programs, and will continue to work with professions in reducing their operating costs while also reducing their deficit. We believe by eliminating the board and creating a registration system administered by the department, reduction in operating costs can be realized.

We appreciate the thoroughness of your review and the opportunity to comment.

Sincerely,

Edgar Blatchford
Commissioner

Cc: Rick Urion, Director
Division of Occupational Licensing

November 10, 2002

Pat Davidson, Legislative Auditor
Alaska State Legislature
Legislative Budget and Audit Committee
P. O. Box 113300
Juneau, Ak. 99811-3300

Re: Audit Control Number 08-20022-03
Board of Dispensing Opticians Sunset Review
October 2, 2003

Dear Pat Davidson:

I received your Preliminary Audit Report and wish to thank you for an opportunity to respond.

Response to the recommendations in your October 29, 2003 letter follow:

- Recommendation No. 1 - "The board should develop and propose legislation to clarify statutes related to the various aspects of dispensing optician licensing." Item #1, #2 and #3 were addressed in my response, dated September 26, 2003, to the "management letter #1". dated September 18, 2003 from audit manager Mr.Jim Griffin. The legislative bill we propose (which was attached) would clarify these areas. This bill will be presented in the 2004 legislature.

- Recommendation No. 2 - "The Division of Occupational Licensing, in conjunction with the board, should increase optician's licensing fees to eliminate the cumulative deficit." The Schedule of License Revenues and Board Expenditures included in your report is information on FY2003 that had not been provided to the Board. I formally request a more detailed breakdown of FY2003 expenses and revenues. As to the recommendation, I refer to my response in my September 26, 2003 letter stating I do not believe there will need to be a substantial increase in licensing fees in 2005 because of cost cutting changes we are implementing and the passing of our 2004 legislative bill.

There are some short and long term consequences of de-licensing that should be considered:

- Short Term Consequences

1. Licensed Opticians (spectacles). There is little likelihood that any portion of the present deficit, $22,000, will be paid by individuals being de-licensed, or sunsetted. Economic revenue and activity from registration of apprentices will disappear as "entry"

into an occupation that has such a decreased level of economic opportunity with the prospect of wages being decreased by one half will no longer be attractive.

2. Licensed Opticians (contact lenses). This area will be addressed by another board member.

- Long Term Consequences

There are relative few licensed opticians in the State, approximately 100. These opticians and their families have enjoyed the opportunity to work for a "living wage". You mentioned the state of Texas voluntary registration program as a viable alternative for Alaska. I have enclosed a wage comparison report that shows Texas median wages for opticians to be 56% of what Alaska, a licensed state is. De-licensing will mean no longer having "portable credentials" that distinguishes an educated and trained professional from anyone off the street. It will devalue the occupation and effectively close the door on what has been an alternative occupation and trade for someone unable to obtain a college education.

- Comments

On page #7 footnote #3 your report states " The examination given by ABO measures the basic knowledge required to dispense eyeglasses safely and effectively." This an opinion, not a fact, and it is an opinion not supported by this Board or the professional optical community. To rely on the written ABO exam alone for competency can be likened to relying on a written DMV test for competency to operate a motor vehicle. There is much more involved in the fitting and dispensing of spectacles and contact lenses than the current entry level written test from ABO or NCLE alone can evaluate.

- Conclusion

The State of Alaska has a skilled, educated and trained workforce providing professional services in the fitting and dispensing of spectacles and contacts. What is proposed by this Legislative Budget Audit is to dismantle this profession by de-licensing. I feel it is in the best interest of the public to maintain licensure of Dispensing Opticians. Thank you for your consideration.

Other board members may be responding to this preliminary audit report. My hard copy response will contain a copy of my response to "letter No. 1, dated September 26, 2003, for your reference. Thank you for your time and consideration.

Sincerely,

James Rothmeyer, Chair
Board of Dispensing Opticians.

(2)

September 26, 2003

Mr. Jim Griffin
Alaska State Legislature
Legislative Budget and Audit Committee
Division of Legislative Audit
P. O. Box 113300
Juneau, Ak. 99811-3300

Re: Letter Sept. 18, 2003

Dear Mr. Griffin:

I received management letter No. 1 on September 23, 2003, thank you. I will try to respond as briefly and the best I can.

Just for clarification the Board does not set renewal fees. They are set by the Department of Commerce, Division of Occupational Licensing .

The notion that untrained, uneducated persons perform to the standards of practice as those who have spent hundreds of hours and thousands of dollars in educational courses and training , is in my opinion not a sensible argument.

Ensuring the individual dispenser/optician has the education and training to sort and select the appropriate and safe combination of eyewear and lenses from the complex and extensive variety of products on the market is not just a valuable service it is essential to the publics safety. This is amply documented by the numerous warnings and vision safety notices that are part of every set of lenses from optical laboratories. Concern for "vision safety" has never been more acute than now. The wide choices of sport, safety and dress eyewear can lead to mistakes and have caused the loss of sight (see attached documents). The need for educated and trained contact lens fitters and dispensers is even more important as permanent harm can be caused by patients not having professional advice regarding their contact lenses. (see attached)

The Board has reviewed the 2002 changes in statutes that were vague and inconsistent. The Board had a bill to remedy this in 2002. That bill never made it into the legislation because the lobbyist for the Opticians Association of Alaska thought the timing to introduce the bill was wrong and then it became to late in the legislative session for consideration. The Board will have this introduced in the 2003 legislation. (see attached draft).

The Board did research and give recommendations to the then licensing examiner and the Director of the Division of Occupational Licensing for a practical exam from a private sector contractor. One alternative, Dr. Ferguson's The Learning Curve could of been procured and administrated at no cost to the Department. This information was a part of the 2001 audit report (Sept. 2001). The "acquiescence" to the 2002 legislatures bill SB 270 (no practical) was the best alternative available to us at the time as we were told it would take at least 2 years and a large sum of money for a "request for proposal" bid for a practical test.

(3)

Deficit - The current deficit began in 1998 when the board was informed of an "accounting error" which caused a deficit. In the next two years our licensing examiner was new and spent probably more time than necessary getting up to speed. From documented time sheets, she spent about one half of her time on the apprentice program. In 2002, $5,500 was billed to the Board by the Department of Law for litigation from a class action law suit regarding contact lenses. This constitutes 22%of our current deficit and these charges should be reversed. The Board has yet to received a breakdown of the $9300.00 "contractual " charges for 2003.

RECOMMENDATIONS

I agree with your recommendations for clarifying training hours, licensing individuals from other jurisdictions and transferring apprentice registration and administration to the U.S.D.O.L. See attached "draft bill".

I feel that there is no need to increase licensing fees. I have been in contact with the licensing examiner, Denise Williams, and she states that if there is no apprentice program to administer, she will spend less than 5% of her time on BDO activities annually. With no other unforeseen bills from the Department of Law, this should bring our expenses to a manageable figure and reduce our deficit to the point we will be in compliance.

The Board respectfully request that you extend the Board of Dispensing Opticians for another 6 years. The Board has made great strides to comply with recommendations and work with the Optometrist and Ophthalmologists.

The fact that of the 83% of the licensed opticians in the state, renewed their license even with the increased fees, shows that the profession feels the need to hold themselves up to a higher standard of performance and education then stylists, assistants or sales persons. The Licensed Optician whether licensed in spectacles, contacts or in both is continually working to insure the health, safety and welfare of the public through education and training.

Thank you for your time and consideration.

Sincerely,

James Rothmeyer

James Rothmeyer
Chair. Board of Dispensing Opticians

4

Corrected Copy

A BILL
FOR AN ACT ENTITLED

"An act relating to dispensing Opticians and dispensing Opticians apprentices"
BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

- Section 08.71.080 License required is amended to read;
- Sec. 08.71.080 License required. A person may not act as a dispensing optician in the state unless that person is licensed under this chapter. A license shall be issued for (1) the fitting and dispensing of contact lenses, or (2) the fitting and dispensing of other lenses, eyeglasses, spectacles, artificial eyes and their appurtenances, or (3) both.

*Sec. 08.71.090. Examination requirement is amended to read;

Sec.08.71.090 Examination requirement. To be licensed to fit and dispense contact lenses, a person, unless eligible for licensing under AS 08.71.145, shall document to the board that the person has passed the contact lens registry exam offered by the National Contact Lens Examiners with a score acceptable to the board. In order to be licensed to fit and dispense other lenses, eyeglasses, spectacles, artificial eyes, and their appurtenances, a person, unless eligible for licensing under AS 08.71.145, shall document to the board that the person has passed the national opticianry competency examination offered by the American Board of Opticianry with a score acceptable to the board. An applicant for licensure in both areas shall document having received a score acceptable to the board on both examinations. The board shall by regulation, establish the scores that will be acceptable for the examinations described in this section.

*Section 1. AS08.71.110(a) is amended to read:

(a) The board may issue a license to a person who
(1) has [HAD EDUCATION EQUIVALENT TO FOURS YEARS ATTENDANCE AT] a high school diploma or its equivalent;
(2) Has either
(A) completed at least 1,800 hours of training for spectacles and/or 1,800 hours for contact lenses as an apprentice after registering with the US Dept. of Labor as an apprentice; or
(B) been engaged for at least 1,800 hours practice as a dispensing optician in spectacles and /or 1,800

(5)

hours practice in contact lenses, in a state, territory, district, or possession of the ~~Un~~ United States;

(3) has passed the applicable examination required under AS08.71.090 with a score acceptable to the board;
(4) has passed a course designated in the board's regulations as being acceptable; and
(5) has paid the required license fee.

*Sec. 2 AS 08.71.145 is amended to read:

08.71.145. Licensure by credentials. A person with a valid license as a dispensing optician from another state, territory, district, or possession of the United States with licensing requirements substantially equivalent to or higher than those of this state shall, without further examination, be issued a license under this chapter for those professional areas in which the person is licensed in the other jurisdiction upon payment of any fee and documentation that the board may require by regulation.

*Sec.3 AS 08.71.145 is amended by adding a new subsection to read:

(b) A person who is designated by the American Board of Opticianry as a Master Optician or as an individual certified as an Advanced Certified optician may be issued a license authorizing that person to be a licensed dispensing optician with respect to spectacles upon payment of the appropriate fee and submission of the documentation that the board may require by regulation.;
(c) A person who is designated a Fellow of the Contact Lens Society of America, or who is designated by the National Contact Lens Examiners as an Advanced Certified Contact Lens Fitter may be issued a license authorizing that person to be a licensed dispensing optician with respect to contact lenses upon payment of the appropriate fees and submission of the documentation that the board may require by regulation.

(6)

*Sec. 4. AS. 08.71.160 (a) is amended to read:

(a) A person may be employed by [OR SERVE UNDER] a licensed Physician, optometrist, or dispensing optician as an apprentice for dispensing optician tasks. An apprentice shall register with the U.S. Department of Labor [DEPARTMENT] before beginning employment [OR SERVICE] as an apprentice[,SHALL BE DSIGNATED AS SUCH IN THE RECORDS OF THE BOARD] and shall be in training under the supervision of the [a] licensed physician, optometrist, or dispensing optician. Notwithstanding AS 08.71.180, a registered apprentice may perform dispensing opticians tasks that are delegated by and performed under the regular supervision of the licensed physician, optometrist, or dispensing optician and may use the title "dispensing optician apprentice".

*Sec. 5 AS 08.71.200 is amended to read:

Sec. 08.71.200 Contact lenses. Contact lenses shall be fitted in conjunction with and under the supervision of a licensed physician or an optometrist using [AND WITH] a written contact lens fitting authorization that (1) shows the powers of the sphere , cylinder and axis location; (2) includes an authorization to fit; and (3) states a requirement that the patient return to the prescriber for a final recheck after the contact fitting has been completed.[PRESCRIPTION SHOWING THAT THE PRESCRIPTION MY BE FILLED FOR CONTACT LENSES AND REQUIRING THAT THE PATIENT RETURN TO SEE THE PRESCRIBING PHYSICIAN OR OPTOMETRIST]. In no case may contact lenses be prepared by neutralizing a persons eyeglasses or spectacles. Duplicated contact lenses may be dispensed, mailed to, or otherwise delivered to a patient from a written contact lens prescription that shows the exact specifications and parameters needed to exactly duplicate the patients previous contact lenses. Notwithstanding other provisions of this section, contact lenses may not be provided to a patient at a time that is after the expiration of the most recent prescription for the patient unless authorized in writing or orally by the person who issued the prescription.

*Sec. 6 AS 08.71.230 is amended to read:

(7)

Sec. 08.71.230 Exemptions from and limitations on the application of this chapter. This chapter may not be construed to

(1) limit or restrict a licensed physician or optometrist from the practices enumerated in this chapter, and each licensed physician and optometrist has all the rights and privileges which may accrue under this chapter to dispensing opticians licensed under it;

(2) prohibit an unlicensed person from performing mechanical work upon inert matter in an optical office, laboratory or shop;

(3) prohibit an unlicensed person from engaging in the sale of eyeglasses, spectacles, magnifying glasses, goggles, sunglasses, telescopes, binoculars, or any like articles which are completely preassembled and sold only as merchandise; however, the exemption in this paragraph does not authorize an unlicensed person to sell contact lenses of any type.

(4) authorize or permit a licensee under this chapter to hold out as being able to, or to offer to, or to attempt by any means, to refract or exercise eyes, diagnose, treat, correct, relieve, operate or prescribe for any human ailment, deficiency, deformity, disease or injury.

(8)

"Duty To Warn" – A Growing Responsibility

It has been seven years since the Optical Laboratories Association (OLA) issued its first "Duty To Warn" kit. To appreciate why this subject has become so important to the whole industry, it might help to review how laboratories first became involved in a problem that seems to be more a concern of those who deal directly with patients at the retail level.

When retail offices are involved in litigation resulting from broken eyewear, manufacturers and laboratories used in making the glasses are usually brought into the action so that, no matter who ends up with the blame, that person will be involved in the lawsuit. What brought "duty to warn" into prominence in recent years has been the emergence of polycarbonate as a viable lens material for dress eyewear.

The first recorded court case occurred in 1981 when a Wyoming rancher wearing photochromic lenses in a dress frame, sustained an injury while roping. No award was granted on the basis that polycarbonate was so new a product, it was only available from one source at the time the glasses were dispensed. The case did, however, alert the Optical Laboratories Association to the problem and their concern led directly to the development of the OLA "Duty To Warn" kit.

Since that time, polycarbonate lenses have matured and are now readily available in almost any type of lens design. At the same time, there has been additional litigation in which the courts consistently ruled that "failure to warn" patients about their options regarding lens materials justifies damage claims. This places a considerable burden on everyone dispensing eyewear to the public. The OLA is attempting to answer that concern with their program. They have just revised their kit and reissued it with a number of improvements and additions.

Among the new items included in the revised kit are the following:

Practitioner Forms. One of the most persistent requests from retail offices during the last few years has been for office forms that would help establish that patients had been properly informed regarding lens materials. They particularly asked for a Patient Rejection Form. Three new practitioner forms are now included in the kit.

Refractionist's Duty and Script. A concise examination of the refractionist's obligations under "Duty To Warn" is provided along with a suggested script for the doctor to follow.

Dispenser's Duty and Script. Just as the refractionist has a "duty to warn", so do dispensers, whether they work in the refractionist's office or in an outside office. These duties are clearly outlined.

Lens Menu. The Lens Menu patient brochure is a key component in the "Duty To Warn" process. A sample Lens Menu and an order form are included.

Safety Warnings. Every pair of eyeglasses dispensed must be accompanied by a printed Safety Warning. Offices that order finished eyewear from an OLA laboratory usually receive this important form with each pair of finished eyewear they order. Offices doing their own edging have the obligation of providing their own Safety Warnings to pass on with the eyewear they dispense. Camera-ready artwork for each Safety Warning form (dress eyewear and safety eyewear) is part of the kit.

In-Office Edging. Edging lenses in a retail office imposes special responsibilities under the "Duty To Warn". In the eyes of the FDA and OSHA, these offices become the eyewear manufacturer and, as a consequence, assume the same legal responsibilities as laboratories. To help them meet these obligations, a brochure titled "Impact Testing of Ophthalmic Dress Lenses" is included in the kit.

A variety of other background material is also included so that retail offices have everything they need to set up a "Duty To Warn" process in their office. Today's economic climate makes compliance with the duty to warn process as important as maintaining proper fire insurance.

The OLA is making these kits available at minimal cost ($14.95). They are available through most OLA laboratories. If you need information on OLA laboratories in your area, you may call 1-800-477-5652 for the names.

— Joe Bruneni

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Informing The Patient

An Increasingly Important Professional Responsibility

by
Pamela Joyce Miller, O.D., F.A.A.O., J.D.

Published as a public service
to the Eyecare Professions by the

Optical Laboratories Association

(10)

Informing The Patient — An Increasingly Important Professional Responsibility

by Pamela Miller, O.D.,F.A.A.O., J.D.

It was not until the mid1980's that this industry began to realize that there were some potential problems regarding the impact resistance of lens materials. The subject first arose when a Wyoming lawsuit was filed over a broken lens. The suit claimed one lens material was more impact resistant than any other and the company selling the glasses should have informed the patient about polycarbonate.

In that case, the patient was a cowboy wearing glasses while performing in a rodeo. While twirling a rope, his glasses broke and an eye injury resulted. Fortunately for the dispenser, the court ruled that, while the dispenser had a duty to inform the patient about polycarbonate, these lenses were not yet readily available or in general use at that time. The Court issued no award, but the subject did receive close attention from the industry. It illuminated a subject to which few eyecare professionals had given much thought.

The Optical Laboratories Association (OLA) immediately set up a study group to establish how laboratories and their customers could best deal with the legal, professional, moral and business issues involved. The result of this study was the development of a practical program to meet these new responsibilities of retailers and laboratories.

The study concluded that dispensers and doctors have a legal and professional responsibility to make sure patients have all the information required to make an informed decision about lens materials and frames. **Because of these legal responsibilities, the duty to warn must be part of every dispensing transaction.** To help professionals comply with this new responsibility, the OLA published a "DUTY TO WARN" kit, with sections fully documenting the responsibilities of the doctor, the dispenser and the manufacturing laboratory. It provided specific details on how to discharge the professional's "duty to warn" and included sample forms for setting up a "Duty to Warn" system for retailers and for laboratories.

Issued in 1988, the OLA has distributed thousands of these guides through member labs and made them available to O.A.A. and A.O.A. members. That, however, was six years ago and concerns about the doctor/dispenser's responsibilities and "DUTY TO WARN" were gradually forgotten.

A recent lawsuit in Minnesota reminded the professions of the importance of this duty to warn patients regarding choice of lens material. A youngster suffered an eye injury while wearing conventional plastic lenses. The court ruled the retailer did not adequately inform the patient about a safer lens material. The award was for $73,610.93.

The OLA has now revised the original "Duty to Warn" kit and again made it available through OLA members for $14.95. One issue is clear. The only way to make sure every patient is properly informed regarding lens materials is to set up a standard office routine and follow it for every patient. The "Duty to Warn" kit provides camera ready copies of various forms to be used for this purpose. It's always best when the dispenser *(or doctor)* personally discusses the options for polycarbonate lenses with each patient. This is sometimes difficult and it only takes one omission to lay the groundwork for potential problems.

The OLA recently revised their popular "Lens Menu", an attractive four color patient brochure that explains each lens option available to persons ordering eyewear. This latest revision adds a powerful "Vision Safety Notice" to the back panel. Verbiage in this important section was taken in whole from the OLA "Duty to Warn" kit. **Now, offices who provide the Lens Menu to each patient going through their office will be subtly reinforcing their professional responsibility to fully inform patients regarding lens materials.**

The obligation to inform buyers of a product's inherent dangers is nothing new. Nearly every product today is accompanied by warnings of one type or another. When someone is involved in recommending a product, they assume certain liabilities based on those recommendations. It's important to remember that eyeglass manufacturers and/or laboratories cannot get their warning message to the purchaser until after the patient has selected a lens material and a frame.

Because of this, doctors and dispensers have a legal and professional responsibility to make sure patients understand the risks involved in wearing eyeglasses and the relative safety of each lens material or frame style. This doesn't mean every patient must order polycarbonate. It just means that each lens material must be explained, along with the relative risks of each material. It's important to establish a program in your office that makes sure every patient is fully informed about lens materials. Some offices take this so seriously they insist every patient sign a document indicating that they have been told about the safety issues involved. There is some question whether this really does much good and it does have the potential of upsetting some patients. The best procedure is to set up a standard routine that makes sure every patient is informed of safety issues with the doctor or dispenser noting on the patient's file that the patient was so informed.

Do this and you can be secure you are fulfilling your "duty to warn".

Pamela Joyce Miller holds a doctorate in both Optometry and Jurisprudence. She has a solo practice in Highland, California and is a widely known practice management consultant who lectures and publishes worldwide. She has authored over 100 articles, including THE VISION CARE ASSISTANT, a guide for new paraoptometrics, published by Vision Extension in Santa Ana, California.

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LITIGATION YOU SHOULD KNOW ABOUT

by Pamela Joyce Miller, O.D., F.A.A.O., J.D.

January, 1981

January, 1981 saw one of the first significant cases involving Polycarbonate lenses. In essence, a Wyoming farmer, wearing photochromic lenses in a dress frame, suffered an injury resulting in a cataract, when his lens shattered during a roping accident. The basic claim was that the doctor should have prescribed polycarbonate lenses in view of the fact that the patient was involved in an active and dangerous endeavor. The jury concluded *(based on expert testimony)* that the accident would not have been prevented with polycarbonate lenses, although polycarbonate was a new product and only available from one source at the time of the dispensing.

1982

A 1982 case in Louisiana involved a high school student who suffered a severe eye and lower lid cut during a volleyball game, while wearing glass lenses. The patient claimed that no one had told him that scratched lenses had a greater propensity toward shattering. Although the case was settled, it was alleged that the dispenser failed to warn of the risks associated with wearing the glasses in sporting events. A claim for contribution against the school board was also filed by the dispenser *(to defray the costs of settlement)*.

January, 1993

A January, 1993 jury ruling involved a Minnesota optical chain that failed to warn a customer sufficiently about his spectacle lens options. A 13 year old boy purchased a metal semi-rimless frame with CR 39 lenses in November, 1986. Some 6 months later, he was hit in the eye, and the lens shattered resulting in permanent eye damage. The case centered on the "FAILURE TO WARN" issue. The case resulted in a settlement *(not to exceed $73,610.93)*, with the amount and the jury proceedings sealed in the court records.

The Present

"Duty to Warn"

The trend is obviously toward an emphasis on the dispenser's or doctor's "duty to warn" or failure to advise a patient of their options. Greater responsibility is placed on patient education, informed consent, and documentation of the information given to a patient *(or the parent or guardian)*.

Your Duty

You have a clear cut duty to the patient. A breach of that duty, which results in harm to the patient, could result an action for Negligence. The result may be lengthy and costly litigation against the dispenser, the laboratory, and the lens manufacturer. If you elect to have an in-office laboratory, your liability may be substantially increased.

Your Responsibility

In essence, the last person to work on the lens may be regarded as the manufacturer in a Product Liability case. The concept of professional responsibility is growing and with that growth comes your responsibility to document what was advised and provided to every patient.

o The continued impact resistance of your lenses depends on how well you protect them from physical shocks and abuse. For your own protection, scratched or pitted lenses should be replaced immediately.

o If your occupational or recreational activities expose you to the risk of flying objects or physical impacts , your eye safety requires special safety spectacles with safety lenses, side shields, goggles and/or a full face shield.

o Federal Regulation 29 CFR 1910.133 states that your employer shall make available eye protection suitable for your work, and that you shall use such protectors. For more information, consult your safety officer or supervisor.

Your vision specialist can provide more information and help you select the proper eyewear to meet these vision safety needs.

Sports Eyewear

Many sports present unique eye safety risks. Industrial safety eyeglasses are not designed to protect against these special risks. As a result, special eyewear designs have been developed for a number of sports. The standards for such eyewear vary according to the sport for which they are designed, so it is important to base your selection on how the eyewear will be used.

Optical Laboratories Association
Post Office Box 2000
Merrifield, VA 22116-2000

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• The continued impact resistance of your lenses depends on how well you protect them from physical shocks and abuse. For your own protection, scratched or pitted lenses should be replaced immediately.

• If your occupational or recreational activities expose you to the risk of flying objects or physical impacts, your eye safety requires special safety spectacles with safety lenses, side shields, goggles and/or a full face shield.

Your vision specialist can provide more information and help you select the proper eyewear to meet these vision safety needs.

Sports Eyewear

Many sports present unique eye safety risks. Neither dress eyewear nor industrial safety eyewear are designed to protect against these special risks. As a result, special eyewear designs have been developed for a number of sports. The standards for such eyewear vary according to the sport for which they are designed, so it is important to base your selection on how the eyewear will be used.

Optical Laboratories Association
Post Office Box 2000
Merrifield, VA 22116-2000

Dispenser: Safety spectacles with polycarbonate lenses must not be dispensed without this warning.

Important!

Read this notice before using your new safety eyewear.

Proper selection and use of eyewear is critical to your eye safety. No single pair of eyeglasses is best for all situations, so make sure you consider how your eyeglasses will be used before deciding whether to wear dress, safety or sports eyewear.

Vision Safety Notice:

o The polycarbonate lenses in these safety spectacles have been prepared in accordance with the order of your plant safety officer or vision specialist. The lenses meet or exceed American National Standard Z87.1 and the requirements of the Occupational Safety and Health Administration, but they are not unbreakable or shatterproof.

o If struck with sufficient force, the lenses can break into sharp pieces that can cause serious injury to the eye, or blindness. Even if the lenses do not break, the force of impact may cause the lenses or spectacle frame to contact the eye or surrounding area, causing injury.

o For tasks requiring additional impact protection, polycarbonate lenses should be used. Of all the materials that lenses can be made from, polycarbonate is the most impact resistant.

Dispenser: Dress eyewear must not be dispensed without this warning.

(14)

Important!

Read this notice before using your new eyewear.

Proper selection and use of eyewear is critical to your eye safety. No single pair of eyeglasses is best for all situations, so make sure you consider how your eyeglasses will be used before deciding whether to wear dress, safety or sports eyewear.

Vision Safety Notice:

• Your new eyeglasses are dress eyewear, not safety spectacles.

• The type and style of the spectacle frame is an important factor in determining how much protection your eyeglasses will provide. Many frames are fragile and are designed for appearance—not for protection.

• Your lenses meet or exceed American National Standard Z80.1 and FDA requirement 21 CFR Sec 801.410 for impact resistance, but they are not unbreakable or shatterproof. Of all the materials that lenses can be made from, polycarbonate is the most impact resistant.

• If struck with sufficient force, the lenses can break into sharp pieces that can cause serious injury to the eye, or blindness. Even if the lenses do not break, the force of impact may cause the lenses or spectacle frame to contact the eye or surrounding area, causing injury.

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March 11, 2004

Representative Jim Holm
State Capital, Room 416
Juneau, Alaska 99801

OAA
Opticians Association of Alaska

Representative Holm,

Thank you for your letter requesting more information about the potential effects of HB 502, which you have introduced.

You ask what the current problem is, if the current level of training is directly affecting consumers, and if the increased requirement will have an impact on prices. There are several problems with the opticianry statute resulting from legislation passed a few years ago, though we are not proposing that they all be dealt with in HB 502.

From the time it was originally passed in 1973 until just a few years ago Alaska statute required 6000 hours of apprenticeship training to become a licensed optician. In 2002 the level was lowered to 1800 hours in SB 270, which also repealed our practical exam, leaving us with no way to evaluate the technical qualifications of our apprentices. HB 502 strengthens the training that an apprentice will receive by re-establishing some of the hours we lost. Simply put, SB 270 went too far. In HB 502 we are simply asking for some balance between entry into the field of opticianry and the quality of care optical patients receive.

To directly answer your question, the first problem is that we can not properly train new entrants into our field in 1800 hours. Is the current level of training affecting consumers? Not yet, because the people training under this new, lower standard aren't in the field yet. Please understand that when consumers do have a problem, they rarely report it to the state. Instead, they come to my office on Old Steese, and to the other offices of qualified, licensed opticians, for proper care. You ask if increasing the hours of training will cause prices to rise. No, it won't. No more than decreasing the hours would have caused prices to drop (which they did not). Opticianry in Alaska is highly competitive and that competition determines the price paid by consumers.

HB 502 also formally transfers our apprenticeship program to the US Department of Labor. DOL requires training in both spectacles and contact lenses to become an optician. Major changes to SB 270 were added in House Rules, quite late in the session, under the 24-hour rule, and quite late in the day. Unfortunately, the result is that not only is the requirement for training inadequate, it is unclear. Legislative auditors recently made the same observation. Under current law we do not meet the training threshold for the DOL program. If for no other reason, and there are many, HB 502 should be passed to rectify this problem.

You ask about training and the state exam. SB 270 repealed our state exam; we now rely on the American Board of Opticianry (ABO) exam as the written test for spectacles and the National Contact Lens Examiners Certifying (NCLEC) exam for contacts. These tests are used nationwide to evaluate the basic knowledge needed by an optician; however they do not evaluate hands-on competency or technical acumen. Only a formal training program can guarantee that the apprentice is getting the skills needed to go out into the labor force and properly fit Alaska's consumers with glasses or contacts.

HB 502 sets out the requirements for selling contact lenses. This is especially important since a contact lens is a medical device and rests directly on the cornea. Improper fitting can lead to many adverse complications which could lead to scarring, infection and even blindness. Anyone selling or fitting contact lenses should be highly trained and licensed.

HB 502 also retains the Career Progression Plan (CPP) as the distance learning portion of the apprenticeship, this course was developed by the National Academy of Opticianry to provide the apprentice and the mentor with a step by step process to follow as they work through the apprenticeship program. The CPP is given in three sections with an exam at the end of each section. Upon completion of the CPP, the ABO and NCLEC exams, 4000 hours of documented apprenticeship for spectacles and an additional 2000 hours in apprentice training for contacts an applicant can submit all the required paperwork and fees to the State for licensing.

Opticians are like a pharmacist to the eye doctor. We are trained to take the prescription, make recommendations based on power, lens availability, visual task needs and other factors. Each prescription is individual; there are many aspects involved in taking those numbers written by the doctor and incorporating them into a visual remedy for patients.
With the expanse of ever changing technology and information about new and improved materials available today the trained licensed optician is always learning new and improved ways to help the consumer with their individual visual needs. We attend continuing education seminars yearly to learn all we can about our ever-changing field.

I am aware that certain groups, who lobby nationally against basic standards for opticianry, may oppose HB 502. They represent large corporate chains who would like to employ entry level clerks and call them opticians. As an eyeglass wearer I hope you realize that outside corporate executives cannot simply put a white lab coat on someone and expect that they will know all the aspects of opticianry. In sponsoring HB 502 I hope you will lead the Alaska Legislature in taking a stand against this dumbing down of Alaska's opticians by implementing HB502 and continuing licensure in Alaska.

The Opticians Association of Alaska supports HB502 and we ask that you protect Alaska's consumers by requiring that anyone who presents themselves as an optician is properly trained and licensed.

Sincerely,

Christi Brand, President
Opticians Association of Alaska

HB

511

REPRESENTATIVE RALPH SAMUELS

HOUSE DISTRICT 29

House Bill 511
Sponsor Statement

""An Act relating to the certificate of need program for health care facilities; and providing for an effective date."

The Certificate of Need review process, which is administered by the Department of Health and Social Services, establishes a set of statutory criteria to guide the development of new healthcare facilities and services in Alaska. Among the objectives of the program are ensuring reasonable access to needed healthcare services throughout the state without unnecessary service duplication and assuring that the need, cost, type, level, quality, and feasibility of providing any new health services be subject to review and assessment prior to any offering or development. In that process, a focus is placed on managing growth in capital expenditures in order to ensure that the new services will provide high-quality services in a cost-effective manner.

With the demand for healthcare services constantly evolving and technology rapidly changing, the resulting impact on the state's existing statutes must be addressed from time to time. It is in that vein that I am sponsoring this piece of legislation. Current state law governing this program requires any person wishing to expend $1,000,000 or more to construct a health care facility, alter the bed capacity of a health care facility, or add a category of health services provided by a health care facility, must apply for a Certificate of Need. That law leaves a gaping hole in state oversight in that any person who wishes to establish or alter a health care facility or related service may circumvent the Certificate of Need process by simply leasing space and equipment. This legislation seeks to "level the playing field" by subjecting all those seeking to provide these services to the same rules.

Additionally, the number of Alaska's children and youth who are sent out of state for residential psychiatric treatment has skyrocketed from 83 children in FY98 to 528 children in FY02. The state infrastructure must be developed to provide a comprehensive system of behavioral health care. However, uncontrolled growth could result in a system focused on the most intensive care, not necessarily the most effective or needed care. While the state is anxious to build up the necessary in-state capacity needed to serve Alaskan children with in-state care, without safeguards in place, secure care could quickly be overbuilt. Since all children and youth served by residential psychiatric treatment centers (RPTCs) are paid for by Medicaid after 30 days in an out-of-home placement, this becomes a Medicaid issue. Adding secure residential psychiatric treatment facilities to the Certificate of Need (CON) program would be an advantage to the state in managing the way in which the service delivery system is developed.

Email: Representative_Ralph_Samuels@legis.state.ak.us
Session: Alaska State Capitol, Juneau, Alaska 99801-1182 • Phone: (907) 465-2095 Fax: (907) 465-3810
Interim: 716 W. 4th Ave., Anchorage, Alaska 99501-2133 • Phone: (907) 269-0240 Fax: (907) 269-0242

Amendment # 1 Adopted 3/04/04
HB 511
Offered House HESS

Page 2, line 8, 12, 16, 19, 21, 24, 27, 29, and 31, delete [SECURE]

Page 3, line 3, 7, and 15, delete [SECURE]

Page 3, line 26, after "of" delete [ADMINISTRATION] and insert **Health and Social Services**

Page 3, line 30 and 31, delete all material and insert

(10) Residential psychiatric treatment center (RPTC) means therapeutically appropriate and medically necessary diagnostic, evaluation and treatment services provided by a secure or semi-secure psychiatric facility, or inpatient program in a psychiatric facility, which are

1. under the direction of a physician;
2. include active treatment of a professionally developed and supervised individual plan of care designed to achieve the recipient's discharge from inpatient status at the earliest possible time that must be intensively and collaboratively delivered by an interdisciplinary team involving medical, mental health, educational, and social service components.
3. are provided 24 hour days for children with severe emotional or behavioral disorders; and,
4. licensed by the Department of Health and Social Services.

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF ADMINISTRATIVE SERVICES

FRANK H. MURKOWSKI, GOVERNOR

P.O. BOX 110650
JUNEAU, ALASKA 99811-0650
PHONE: (907) 465-3082
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March 15, 2004

The Honorable Peggy Wilson, Chair
The Honorable Carl Gatto, Vice-Chair
House HESS Committee
State Capitol, Room 104 and 411
Juneau, AK 99801-1182

Dear Representatives Wilson and Gatto:

Recently, members of the House Health Education and Social Services (HESS) Committee received correspondence from Tanana Valley Clinic regarding HB 511-Certificate of Need Bill. The correspondence alleges that the Certificate of Need program has approved 99% of all the projects submitted for CON consideration, which is not accurate.

To clear up any confusion on the subject, the department completed an analysis of Certificate of Need approvals, disapprovals, etc. and in *Attachment #1* have provided the analysis.

Also attached for your information, in *Attachment #2*, is a summary of Questions and Answers related to Certificate of Need.

We have also had questions concerning the number and activity of "competing applications", *Attachment #3* includes information on this subject.

I hope this information is useful to all members of the House HESS Committee. If you have any further questions I will be available on Thursday March 18, 2004 to testify on HB 511 you can also contact me at 465-1630.

Sincerely,

Janet Clarke

Janet Clarke
Assistant Commissioner

cc: Representative John Coghill, Capitol Building 204
Representative Paul Seaton, Capitol Building, Room 428
Representative Kelly Wolf, Capitol Building, Room 418
Representative Sharon Cissna, Capitol Building, Room 420
Representative Mary Kapsner, Capitol Building, Room 424
Joel Gilbertson, Commissioner
Sherry Hill, Special Assistant

RESPONSE TO TVC ASSERTIONS

Tanana Valley Clinic has asserted that 1) the CON review process automatically "rubber stamps" hospital projects; 2) none of the non-hospital CONs are approved; 3) that the true purpose of the CON program is to protect hospitals from competition; and 4) that 99% of applicants are approved, which indicates that CON is an unnecessary and expensive process. The clinic urges that the program be eliminated.

1) Rubber Stamping: There are 5 possible outcomes to a certificate of need review 1) approval as requested; 2) denial; 3) partial approval (which could be considered partial denial); 4) approval but with special conditions; and 5) withdrawal of an application. The Commissioner has the authority to approve an application, but may attach special conditions such as allowing an activity to be shelled in but delaying full implementation until a certain use rate is reached.

The Department has reviewed 36 certificate of need applications since 1996; 61% were approved as requested and 39% were not approved as requested. Of those not approved as requested, 11% were denied, 11% partially approved, 6% withdrawn and 14% were given special conditions that had to be met. (See attached chart. Percentages are more than 100% because a decision may include both a special condition and partial approval).

Of the 39% that were not approved as requested: 50% of the denials or partial approval/denials were for hospitals or collocated facilities (hospital and nursing home together), 38% were for Ambulatory Surgery Centers; and 12% were freestanding nursing home beds. 50% of withdrawn applications were for nursing home beds and 50% for acute inpatient psych beds. 60% of the special conditions were for acute hospitals and 40% for acute inpatient psych beds. ***The fact that only 61% of all applications are approved as requested, that hospitals and nursing homes are denied or given conditional approval shows that there is no "rubber stamping" going on.***

2) Non-hospital CON approval: Most of the approved CON applications are from acute care hospitals, nursing homes and kidney dialysis centers because they are required to go through the CON process while other organizations are not required to go through the process or can avoid the process in some way. Most ambulatory surgery centers are able to lease equipment or space in a building and avoid CON. Only 6 CON applications for freestanding ambulatory surgery centers have been received since the inception of the CON program 27 years ago. Fifty percent of these were approved. Independent diagnostic testing facilities are not required to go through the CON process, so no applications have ever been received from them. Other non-acute care hospital facilities that have had CON applications approved include free-standing nursing home facilities, freestanding psychiatric hospitals, and kidney dialysis centers. Although there are no longer any Intermediate Care facilities for the Mentally Retarded in the Alaska, the CON applications for these services were approved in the past.

3) The CON program protect's hospitals from competition: It is difficult to imagine that the CON program is protecting hospitals from competition since many ambulatory surgery centers are able to avoid CON and independent diagnostic centers are not covered by CON. Since 1996 a number of freestanding facilities in Anchorage, Wasilla and Kenai have been built without a CON that would have required a CON if built by a hospital. For example, Alaska Open

imaging has opened facilities in Wasilla, Anchorage and Soldotna without a CON and purchased a PET scanner. Providence had to go through the CON process to get approval for a PET scanner. Anchorage Fracture Clinic purchased an MRI, and several ASCs in Anchorage were able to develop projects without a CON that hospitals would have to go through the CON process to build of buy the equipment. A private group of physicians built a cardiac cath lab without a CON. Also, if the Department's goal is to protect hospitals from competition, why do hospitals appeal our decisions?

4) 99% of applicants are approved, which indicates that CON is unnecessary:
This is not true. As can be seen from the data supplied on the attached page ***only 61% of the applications were approved as requested*** and overall, ***11% of the applications were denied outright***. The fact that most applications are approved is exhibited as proof that the program has little or no effect. If the number of projects denied is the benchmark for showing how well certificate of need is working, then the more projects denied the better, and the very best program would deny all applications. This obviously isn't true. Over time, healthcare providers gain expertise in writing applications and the CON process and gain an understanding of the trends in healthcare. They avoid the time and expense of applying for projects that are unlikely to be approved. Technical assistance and current state plans produced by senior services and behavioral health help eliminate poorly conceived and marginal projects before submission of a CON application. Development of new review criteria and standards in the new State Health Systems Plan will help even more. In the regulation of healthcare, just as in the promotion of health, prevention is by far the most effective strategy.

Projects that are denied may be few and far between, but the ongoing cost of one poorly planned project will last for many years. As someone once said, build it and they will come. Over the 28-year life of one CON program in a sparsely populated state, 573 nursing home beds, 468 acute care hospital beds, 9 ambulatory surgery suites, 144 substance abuse beds, 60 psych beds, and 30 rehab beds were denied. This resulted in the avoidance of nearly $200 million in construction costs alone and an additional $240 million in annual operating costs. Also, going through the CON process has resulted in improved project planning for many facilities. The brief information that TVC gathered from the internet to develop their assertions does not present the whole picture. For example, the 1996 Providence-Seward Medical Center project looks like it was a blanket approval as requested, and it was. However, the Department spent years working with the applicant and informed them that a 35-bed facility recommended by outside consultants was not feasible and had a poor chance of being approved. As a result, they submitted an approvable application.

Certificate of need programs have assisted other agencies in promoting changes in service delivery methods. In particular, it has been helpful in changing the direction of the long-term care industry and psychiatric care in Alaska and other states. It has been a tool used to slow nursing home bed growth to allow development of home and community based alternatives to nursing homes. Since many patients can be served in either a hospital or residential setting, the CON program has been helpful in defining the continuum of care.

The cost of Medicaid is a serious problem facing Alaska. Commissioner Gilbertson is working to contain that. CON is only one of the tools needed to contain costs, but it is an important one.

CERTIFICATE OF NEED DECISIONS FROM 1996-2003

	No. of CON Decisions*	Approved as Requested	CONs Denied	Partial** Approval	Withdrawn	Special Conditions	Shape Helped by CON***
2003	6	4	0	1	0	1	0
2002	6	4	0	0	0	2	2
2001	3	2	0	1	0	0	1
2000	1	1	0	0	0	0	0
1999	9	3	3	1	1	1	0
1998	5	3	1	1	0	1	1
1997	4	3	0	0	1	0	1
1996	2	2	0	0	0	0	1
Total	36	22	4	4	2	5	6
%	100%	61%	11%	11%	6%	14%	17%

*Number of CON applications approved, denied or withdrawn in that year.

Other CONs may have been in progress, but not finished.

** Partial approval means that part of the project was approved and part denied.

*** CON efforts influenced shape or scope of project before it was submitted or helped outcome.

CON Influences Project or Assists by being there:		
1996	PSMC	Number of beds reduced from 20 to 6 - a change from prior proposals
1997	Valley Hosp	CON influenced the withdrawel ofapplication after assisting with moratorium
1998	WFC	Included adult day and 10 assisted living beds
1999	API	Withdrew due to planning prob, need for alternatives CON gave time
2001	BRH	Included Kidney Dialysis in CON App
2002	PAMC	Psych design included Single Pt of entry & DET
2002	Valdez	No of acute & NH beds influenced

Special Conditions:		
1998	ARH	May not convert Surg Suite to OHC for 5 years.
1999	PAMC	Open Heart shelled, not avail for 5 yrs.
2002	PAMC	8 Psych Beds Shelled until higher use
2002	API	8 Beds shelled until higher use
2003	MSVMC	Conditions for shelled space and Cath Lab

Partial Approval/Denial or Complete Denial:		
1998	SPH	10 Nursing home beds not approved/delayed
1998	FSC	Denied an extension or modification due to lack of need
1999	FBKS Surg	3 denials, TVC, McGuire & FMH
1999	SPH	Partial Denial - only 5 NH Beds approved
2001	FMH	Partial Denial - Reduced acute beds, healing garden
2003	WFC	Denied conversion but offered 5 -bed unit.

Certificate of Need Questions & Answers

Question: What types of projects are required to submit a certificate of need application and go through the review process?

Answer: Any health care facility project that involves the expenditure of $1 million or more for construction, renovation or the purchase of new equipment, and any project, regardless of cost, that converts space into nursing home beds is required to submit a certificate of need application.

Question: Are there any types of "health care facility" projects that are currently exempt from the certificate of need program?

Answer: Projects are exempt from certificate of need if: 1) the project cost is under the $1 million threshold; 2) the project is for routine maintenance or routine replacement regardless of the cost; 3) the project is for specifically exempted Pioneer Homes, private physicians' offices, or dentists' offices; or 4) the project is not included in the definition of "health care facility."

Question: Will the definition of a "health care facility" change if HB 511 passes?

Answer: Yes. If HB 511 passes, two additional types of facilities will be added to the list of those projects that may be required to go through the CON process: 1) Residential Psychiatric Treatment Centers (RPTCs), and 2) independent diagnostic testing facilities.

Question: Are all projects exempt from certificate of need if they fall below the dollar threshold?

Answer: All projects that fall below $1 million are exempt from certificate of need except for space converted to nursing home beds, which must submit a CON application regardless of the cost.

Question: What are the components of the certificate of need (CON) process?

- Submission of a letter of intent - (includes who, what, where, how large, the cost and timeline);
- Letter of intent (LOI) determination - a decision is made as to whether a CON is required;
- 60-Day wait - A CON application may be submitted 60 day after the LOI determination;
- Completeness Check - The application is checked for completeness, and more information is requested if the application is incomplete. The applicant has 60-days to submit information;
- Review Period - The analysis document must be submitted to the Commissioner in 90 days;
- Public Notice & Public Comment – Public notice is given at the beginning of a review and the public comment period runs concurrently with the review,
- Commissioner's Decision - The Commissioner makes the decision, which is published, and
- Appeal - The applicant has 30 days to appeal if dissatisfied.

Question: If I apply for a certificate of need, how long will it take for a decision?

Answer: Once your application is received and declared complete, a review document must be submitted to the Commissioner for a decision within 90 days. The Commissioner does not have a timeline to make a decision, but generally makes one in about two weeks

Question: How much does it cost to prepare a certificate of need application?

Answer: That depends on the size of the project, its complexity and whether it is controversial. A rule of thumb is that a certificate of need application should not cost more than 1% of the total project cost with a maximum of $25,000. Health Facilities Planning and Development, a consulting firm that writes approximately 70% of all CON applications for facilities in Washington State and has done at least 4 applications in Alaska, charges approximately $15,000 per application, regardless of the size of the facility.

History of Concurrent (Competing) Certificate of Need Reviews

There have been only 6 concurrent reviews since the inception of the CON program in 1976. Only 8.2% of all applications since 1990 were reviewed concurrently. 7 AAC 07.060(a), states: "In the commissioner's discretion, the agency shall defer commencement of the review process for a period not to exceed 60 days after the determination that the application is complete to enable the state agency and the appropriate health systems agency to receive and consider concurrently applications from each person who has submitted a letter of intent... proposing an activity within the appropriate health service area which is similar to the activity proposed by the applicant." ***Key Points: A letter of intent must be in hand from a competing project in order for a concurrent review to be allowed and a competing application must be submitted within 60 days after the first application has been declared complete.*** The six concurrent reviews are:

1982	**Charter Medical Corporation submitted a CON to construct a $12.2 million 80-bed psychiatric/alcohol/drug abuse hospital in Anchorage. An application for a 34-bed, $3.4 million alcohol/drug hospital was received from Advanced Health Systems/Raleigh Hills. Comprehensive Care Corporation submitted a letter of intent for $5.5 million, 50-bed alcohol/drug treatment hospital but did not submit an application. Charter and Advanced Health Systems were approved.**
1982	**Providence Hospital submitted a CON application for an $80 million, 150-bed addition and Humana Hospital (now Alaska Regional) submitted a CON for a $21.6 million, 93-bed addition. The projects were approved, but reduced to 53 additional beds and 39 additional beds respectively.**
1985	**Heritage Place (Soldotna) and South Peninsula Hospital (Homer) submitted CON applications for 60 nursing home beds. Heritage Place was approved for 45 nursing beds and a shelled in space for 15 additional beds to be opened later when use increased. South Peninsula's request for 60 beds was denied.**
1985	**Camai Care Center, Palmer; Careage Nursing Center, Wasilla; and Cook Inlet Housing Development Corporation submitted CON applications for 90-bed nursing facilities. Cook Inlet Housing Development Corporation was approved to build a 60-bed facility and 30 assisted living beds at a cost of $8.8 million. This facility was named the Mary Conrad Center. Careage was denied, Camai Care approved, but was later denied a time extension due to lack of process.**
1995	**Fairbanks Memorial Hospital (FMH) submitted a CON application for outpatient services including ambulatory surgery, and Fairbanks Surgery Center (FSC) submitted a CON for a freestanding ambulatory surgery center. Only the surgery portion of the FMH CON was reviewed concurrently with the FSC CON. Both were approved. FSC was later denied due to lack of progress.**
1999	**Tanana Valley Clinic, Fairbanks Surgery Center, Inc. and Fairbanks Memorial Hospital submitted CON applications for 5 surgery suites and 4 procedure rooms costing $11 million. None of the applicants were approved.**

Attachment #3

Alaska State Hospital & Nursing Home Association

We're helping people care for people!

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February 27, 2004

Representative Peggy Wilson
Chair, House Health & Social Services Committee
Alaska State Legislature
State Capitol Building, Room 104
Juneau AK 99801-1182

Dear Representative Wilson:

Unfortunately I am unable to attend Tuesday's hearing on HB 511, " An Act Relating to Certificate of Need", but I wanted to make certain that the Alaska State Hospital and Nursing Home Association, ASHNHA, expressed its support for passage of this important legislation.

HB 511 strengthens the Department of Health & Social Services ability to guard against overdevelopment of Alaska's critical health care infrastructure. Of particular importance to ASHNHA are the following two provisions:

- **Section 2, lines 4 and 5 amending AS 18.07.031**:
  This new language clarifying that the "net present value of a lease for space occupied by or the equipment required for a health care facility" is included in the meaning of the term "expenditure".

  This language is important because it removes the potential for health care developers to circumvent CON law by leasing rather than purchasing needed space or equipment. ASHNHA sees this language as vital to preserving a level playing field for all in a very competitive health care market place.

- **Section 4, lines 20, 21 and 22 amending AS 18.07.111(8):**
  This new language adds additional health care provider types to the definition of "health care facility". ASHNHA strongly supports this change as it recognizes that an independent diagnostic testing facility is another health care category that, if not monitored, can lead to excess capacity in the community.

ASHNHA appreciates the opportunity to submit these comments in support of HB 511. Alaska's health care market already faces economic challenge from an increasing number of uninsured Alaskans that current providers must serve. Existing capacity in the health care system must be used fully to enable Alaska's providers to offset this largely uncompensated care. To allow capacity to grow in a community without giving the Department an opportunity to assess the need for this additional investment invites serious problems. Questions such as the sustainability of all providers already in the

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market, and the impact on overall cost of care as developers expand profitable parts of the health care system without a commensurate requirement to assume a proportionate share of the uncompensated care, are examples of questions that the department must address to assure a level playing field for all providers, and to assure sustainability of the health care system as a whole.

ASHNHA's many members hope your Committee will agree with this analysis and pass HB 511 from your Committee favorably. Thank you.

Sincerely,

Rod Betit

Rod L. Betit
President/CEO

Cc: Representative Ralph Samuels

Health care regulation and Alaska
An Overview

Prepared by Mike Powers, CEO/Administrator, Fairbanks Memorial Hospital
and Denali Center
February, 2004

Regulation is pervasive in healthcare and serves many good purposes. Physician licensure is an easy example of a case where the rule of law confers benefits greater than those of the marketplace. Furthermore, effective regulation is highly specific. This limits, at times, the lessons that can be learned from the experiences of other states in addressing the common problem of ensuring the greatest possible degree of consumer choice consistent with overall public benefit. For, as in so may other areas, Alaska differs dramatically from the rest of the United States in its health care.

Special considerations in the Alaskan market:

1. Alaska has an extremely low population density, resulting in a uniquely high proportion of sole community providers.

2. There are significant physician shortages in psychiatry, internal medicine, and obstetrics. In Ohio, 14 delivery programs have closed since repeal of CON in 1996. Could that happen here, as profits dwindle and recruitment costs rise? The competitive model suffers pervasive physician supply shortages since they work to concentrate physician power to an extent not witnessed in the lower 48.

3. Even where physician shortages do not exist, certain specialties are highly concentrated. One cardiology group handles the whole state. One radiation therapy group services the whole state. There is only one ophthalmologist in Fairbanks.

4. Tertiary services are unusually distant. Most tertiary services are available only in Anchorage, a six to seven hour drive from Fairbanks; even air transport requires three hours including the time taken to arrange logistical support.

5. Not all tertiary/quaternary services are available in Alaska and residents sometimes must travel to the lower 48. Over 500 children currently receive inpatient psychiatric treatment out-of-state.

6. Alaska's demographics are skewed toward younger populations, and the State has a higher proportion of males.

7. Labor turnover is extremely high. This is party due to the fact that many health care workers are military dependants. Fairbanks experiences a 25% turnover in labor annually.

8. Many expenses are unusually high. Construction costs are inflated by sub-arctic construction seasons, and the need for special construction materials.

9. The State has a high proportion of Alaska Natives; who use, to some extent, their own system of healthcare.

10. The State has an unusually high percentage of charge-based payers, including Medicaid.

11. There is no managed care in the State and no rate setting.

12. An uncommonly high level of commercial insurance leads to high potential for moral hazard, for both provider and patient.

Many of these factors combine to make cherry-picking unusually attractive. Sole community providers are responsible for the spectrum of local care. Since they are necessarily monopolies, cross-subsidies are possible. They are social institutions that accept responsibilities other than marketplace gain, thus making cross-subsidies unavoidable if any measure of charity care is going to be provided. The high-margin services providing the subsidies are attractive targets for opportunists, who do not use the profits to subsidize other services. They can easily under-price the monopoly and still collect windfall profits, or as economists say, "rents."

This does not create competition. It merely exploits the social mission of the monopoly by converting a community benefit to a shareholder benefit. Cross-subsidies are a public good with positive social "spillovers." Allowing predatory entry reduces the ability to cross-subsidize and converts a portion of the subsidy to private profit. The cost of the subsidy will not be eliminated from the system altogether, however. It provides the majority of the entrant's profits, and rates are not monitored by the state apart from CON reviews. Certificate of Need is one means of recognizing and dealing with these unusual features.

Loss of Cross-Subsidy

Under deregulation, cross-subsidies become excess profits. Eliminating cross-subsidies while allowing excess profits does not lower the cost of health care. Transforming cross-subsidies into excess profits, that is, moving funds from public-use to private-use, does not address the issue of how the community will continue to provide subsidized services when the subsidy is reduced. An understanding of this dynamic explains the social benefit of shielding community providers from predatory entrants.

Deregulation will not reduce costs because as deregulation reduces the supply of cross-subsidy funds from certain individual services, providers will react. They may try to increase the utilization of other well-insured areas to make up the loss, thereby shifting the lost subsidy to other payers, as has been observed in other markets. This is more easily accomplished in a state without managed care and its incentives for utilization

review, like Alaska. Therefore, for these reasons alone, usage rates can be expected to increase with capacity. Furthermore, in a state without rate review, rates themselves will also increase.

Eventually, the cross-subsidies lost to new entrants will be replaced by higher prices and increased usage elsewhere. This dynamic itself creates new opportunities for rent-seeking entrepreneurs and the cycle begins again. Total costs shift and rise overall, in an ever-tighter spiral of increasing costs until the system of subsidies collapses altogether.

Competition

In the lower 48, managed care brings insurance into the heart of the medical decision-making process. It does it with explicit concern for costs. This doesn't happen in Alaska since there is no managed care; physicians enjoy a degree of decision-making latitude long since extinguished elsewhere.

In the lower 48, managed care companies often make the facility choice for patients by restricting their options. This process allows hospitals to become involved in patient-directing behaviors through their managed care contracts, and makes price a part of the referral decision. In the lower 48, managed care companies often play a negotiating role, weakening the physician referral autonomy and introducing a measure of price competition. This doesn't happen here and managed care is unlikely to enter the market.

Without managed care as a vehicle, hospitals in Alaska have a greatly reduced ability to compete with physicians for patient flow. This differential market power makes a mockery of the notion of a level playing field where marginal utility equals marginal cost and to determine the amount consumed. Hospitals simply don't, and won't, have access to the only medical decision-making process in Alaska – that of the physician. Therefore, for example, Alaskan hospitals would inevitably lose business to a captive surgeon-owned surgery center. Not because they're more expensive, not because they're less convenient, not because they're less efficient – but because they don't have the same power over the decision-making as physicians. That is, "physician self-referral puts the hospital at a potentially significant disadvantage when it competes for patients with surgeon-owned ASCs."[1]

Managed care companies in the lower 48 also employ extensive utilization review mechanisms to reduce moral hazard. These curbs are also significantly absent in Alaska, so the problem of moral hazard is severe, and moral hazard is a powerful factor in escalating health care costs, especially when combined with physician ownership of facilities.

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[1] William J. Lynk and Carina S. Longley. *The Effect of Physician-Owned Surgery Centers on Hospital Outpatient Surgery*. Health Affairs. Vol. 21 Number 4. July August 2002: Page 219.

For these reason, and others, the growth of managed care in the lower 48 led to decreased reliance on CON as a cost and utilization control mechanism in many states. For along with their onerous choice-limiting mechanisms, they do bring a measure of price-based market discipline to the health care marketplace. We do not advocate the establishment of managed care in Alaska, even if it could be made to work here. There are other ways to achieve its benefits while avoiding its limitations.

What we do advocate is an understanding of the intricate market dynamics at work in Alaskan healthcare and the necessity for a measure of government oversight and regulation greater than that required to ensure free, informed choice in the markets for other goods and services. Leveling the playing field in Certificate of Need regulations is a good place to start.

GAO
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United States General Accounting Office
Washington, DC 20548

April 18, 2003

The Honorable Bill Thomas
Chairman
Committee on Ways and Means
House of Representatives

The Honorable Jerry Kleczka
House of Representatives

Subject: *Specialty Hospitals: Information on National Market Share, Physician Ownership, and Patients Served*

Specialty hospitals represent a small but growing segment of the health care industry. These hospitals specialize in providing care for certain conditions, such as cardiac care, or performing certain procedures, such as orthopedic surgery. Specialty hospitals are not an entirely new phenomenon, as children's and other types of specialty hospitals have existed for decades. Consequently, it is challenging to distinguish between the old and new types of specialty hospitals. One aspect that sets apart the newer genre of specialty hospitals is that many are owned, in part, by the physicians who work in them.

Advocates contend that, because of their focused mission, specialty hospitals can provide high-quality specialty services more efficiently than general hospitals. Because specialty hospitals can tailor their facilities and resources to best fit the needs of certain types of patients, individuals treated in such hospitals may enjoy relatively greater convenience and comfort. Specialty hospitals may also offer physicians financial and work environment advantages. Advocates have stated that the focused mission and dedicated resources of specialty hospitals allow physicians to treat more patients than they could in general hospitals. Physicians may gain financially from this increased productivity. If they are part owners, physicians may also share in the financial gains that accrue to the hospital. Physicians in specialty hospitals may also have more control over patient scheduling and the purchasing of desired equipment.

However, concerns have been raised by general hospitals and others in the health care community that specialty hospitals are siphoning off the most financially rewarding portions of general hospitals' business. Representatives of general hospitals contend that specialty hospitals concentrate on the most profitable procedures and serve patients that have fewer complicating conditions—leaving general hospitals with a sicker, higher-cost patient population. Part of the concern is that physician ownership in specialty hospitals creates incentives to concentrate on

patients who are less sick than other patients with the same diagnosis, as a hospital is typically paid a fixed, lump-sum amount for treating someone with a given diagnosis. Hospitals can benefit financially by treating a disproportionate share of less ill patients because the payment amounts for these patients are not reduced to reflect the fact that fewer services are needed. Critics contend that this practice of drawing away a more favorable selection of patients makes it more financially difficult for general hospitals to fulfill their broad mission to serve all of a community's needs, including charity care, emergency services, and stand-by capacity to respond to community-wide disasters.

A federal law, known as the Stark anti-self-referral law, generally prohibits physicians from referring Medicare patients to facilities in which they (or their immediate family members) have financial interests.[1] The law was enacted after several studies found that physicians with ownership interests in separate clinical laboratories, diagnostic imaging centers, or physical therapy providers tended to make more referrals to them and order substantially more services at higher costs.[2] The Stark self-referral prohibitions do not apply in the case of specialty hospitals, however, because the law does not prohibit physicians who have ownership in an entire hospital from referring patients to that hospital.[3] It is likely that any referral or decision made by a physician who has a stake in an entire general hospital would produce little personal economic gain because such hospitals tend to provide a diverse and large group of services. However, the Stark law does prohibit physicians who have an ownership interest only in a hospital subdivision from referring patients to that subdivision. Concern exists with respect to specialty hospitals, that since they are usually much smaller in size and scope than general hospitals and closer in size to hospital departments, that their physician owners could influence their hospitals'—and therefore their own—financial gain through practice patterns and referrals.

In light of these concerns, you asked us to provide information on the prevalence of specialty hospitals, their characteristics in terms of ownership and patients treated, and the effect specialty hospitals have on the greater hospital communities in which they operate. We are preparing a comprehensive report to be issued later this year that will address these issues. This report provides available information on the

- share of the national hospital market comprising specialty hospitals,
- extent to which physicians have ownership interests in specialty hospitals, and
- patients served by specialty hospitals compared with those served by general hospitals, in terms of illness severity.

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[1] 42 U.S.C. § 1395nn(a)(1)(A) (2000).

[2] U.S. General Accounting Office, *Medicare: Referrals to Physician-Owned Imaging Facilities Warrant HCFA's Scrutiny*, GAO/HEHS-95-2 (Washington, D.C.: Oct. 20, 1994). Jean Mitchell and Elton Scott, "Physician Ownership of Physical Therapy Services," *Journal of the American Medical Association*, vol. 268 (Oct. 21, 1992). For additional discussion of the topic, see Jennifer O'Sullivan, *Health Care: Physician Self-Referrals "Stark I and II,"* Congressional Research Service 97-5 EPW (Dec. 6, 1996).

[3] 42 U.S.C. § 1395nn(d)(3) (2000).

Our work focused on hospitals that tended to treat patients for a limited group of diseases or conditions or that tended to perform surgical procedures. Specifically, we considered a hospital to be a specialty hospital if the diagnosis-related group (DRG) classification for two-thirds of its Medicare patients (or two-thirds of all of its patients where such data were available) fell into no more than two major diagnosis categories, such as diseases of the circulatory system (cardiac), or if at least two-thirds of its patients were classified in surgical DRGs. We excluded hospitals that specialized in providing long-term care or otherwise had missions that were largely distinct from the missions of short-term, acute care general hospitals.[4] We classified the hospitals that fit these criteria into five specialty types—cardiac, orthopedic, surgical, women's, and other specialty. Because the other-specialty category contained a diverse set of hospitals that could not be compared to one another, we excluded hospitals in that category.[5] The information in this report is derived from our analysis of hospital inpatient discharge data, various administrative databases, and responses to our survey of specialty hospitals. We analyzed Medicare inpatient discharge data from all hospitals nationwide to help identify specialty hospitals. We also obtained Healthcare Cost and Utilization Project (HCUP) data on all patient discharges in 2000 from hospitals located in six states.[6] These states contained 26 urban specialty hospitals, slightly more than one-fourth of the existing specialty hospitals we identified. The all-patient discharge data from hospitals in these states were used to help identify specialty hospitals and analyze the relative illness severity among patients at specialty and general hospitals. For more detail regarding our specialty hospital criteria and analysis methodology, see the enclosure at the end of this report. Our work was performed from September 2002 through April 2003 in accordance with generally accepted government auditing standards.

Results in Brief

Specialty hospitals represent a small but growing share of the national market. In February 2003, the 92 cardiac, orthopedic, surgical, and women's hospitals that we identified and were open for business accounted for less than 2 percent of the short-term, acute care hospitals nationwide. Recent growth in specialty hospitals has been rapid—the number of facilities has tripled since 1990 and another 20 facilities are under development. Because specialty hospitals tend to be relatively small, they account for a somewhat low share of inpatient spending relative to their share of hospitals. The specialty hospitals in existence in fiscal year 2000 accounted for about 1 percent of Medicare spending for inpatient services.

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[4]Thus, we excluded hospitals that specialized in providing rehabilitation or in treating mental disorders, alcohol or drug problems, respiratory conditions, or newborns and children.

[5]The other-specialty category contained 18 hospitals that specialized in a variety of other areas, such as eye and ear, nose, and throat procedures.

[6]Data were from all hospitals in Arizona, California, New Jersey, New York, and North Carolina and the hospitals located in three regions of Texas.

About 70 percent of the specialty hospitals in existence or under development had some physician owners, according to our 2003 specialty hospital survey results. Among these hospitals, total physician ownership averaged slightly more than 50 percent. The average share owned by an individual physician was more than 2 percent at half the hospitals, while it was less than 2 percent at the other half. In about one-fifth of the hospitals with some degree of physician ownership, the largest share owned by an individual physician was at least 15 percent. Nearly all specialty hospitals with physician owners reported that some of the owners were members of a single group practice. The largest share owned by physicians in a single group practice was more than 25 percent at half the hospitals and less than 25 percent at the other half. In about 1 out of 10 specialty hospitals with physician owners, physicians in a single group practice owned 80 percent or more of the hospital.

We found that patients at specialty hospitals tended to be less sick than patients with the same diagnoses at general hospitals, although we did not determine the clinical and economic importance of this finding. Our analysis of all inpatient discharge data from the 25 urban specialty hospitals for which these data were available—about one-fourth of all specialty hospitals we identified nationwide—showed that 21 of the 25 specialty hospitals treated lower proportions of severely ill patients than did area general hospitals. For example, at an urban cardiac hospital in Arizona, about 17 percent of patients with the most commonly treated diagnoses were severely ill, whereas at 26 general hospitals in the same urban area, about 22 percent of patients treated for the same diagnoses were severely ill. For all four specialty hospital types included in our study—cardiac, orthopedic, surgical, and women's—the median percentage of severely ill patients treated was lower than that for general hospitals. Four of the 25 specialty hospitals were exceptions, as they had treated patients that were as sick, or sicker, than the patients at general hospitals.

The American Surgical Hospital Association and two major specialty hospital chains—MedCath Corporation and National Surgical Hospitals—provided comments on a draft of this report. Representatives from these groups stated that physician ownership of specialty hospitals did not affect physician referral behavior and that our physician ownership discussion was potentially misleading. Our report provides information on the extent of physician ownership of specialty hospitals but, because of data limitations, we did not attempt to analyze the relationship between ownership and referral patterns. The specialty hospital representatives also questioned the extent to which the illness severity differences we reported might apply to specialty hospitals not in our sample and the economic significance of these differences. The illness severity differences that we report are based on an analysis of thousands of claims from more than one-fourth of the specialty hospitals that we identified. We did not attempt to assess the economic significance of these differences. A more complete summary of their comments and our evaluation of their comments is included at the end of this report.

Background

The fixed-rate, lump-sum payments that health care payers typically make to hospitals for inpatient care for patients with a given diagnosis, regardless of the costs of serving particular patients, are designed to promote efficiency by discouraging hospitals from providing unnecessary services as a way to boost revenues. However, these lump-sum payments foster undesirable incentives, as hospitals may gain financially by serving a disproportionate share of low-cost patients. The mechanics of Medicare's hospital payment system illustrate this principle.

Under its system of prospective payments, Medicare pays a predetermined rate for each hospital discharge, based on the patient's diagnosis and whether the patient received surgery. In other words, the payments reflect an average bundle of services that the beneficiary is expected to receive as an inpatient for a particular diagnosis. Discharges are classified according to a list of DRGs. DRG payment rates are based on the expected cost of the diagnosis group's typical case compared with the cost for all Medicare inpatient cases. The DRG payment is not adjusted for within-DRG differences in severity of illness.[7] Therefore, hospitals have a financial incentive to treat as many patients as possible whose costs are low relative to the average patient in each DRG.

Specialty Hospitals Represent a Small but Growing Share of the National Market

In February 2003, there were 17 cardiac, 36 orthopedic, 22 surgical, and 17 women's hospitals that met our specialty hospital definition and were open for business.[8] These 92 hospitals represent about 2 percent of all short-term, acute care hospitals nationwide. (See fig. 1.) The most recent Medicare discharge data indicate that the 80 specialty hospitals in existence in 2001 accounted for slightly less than 1 percent of Medicare spending for inpatient services.

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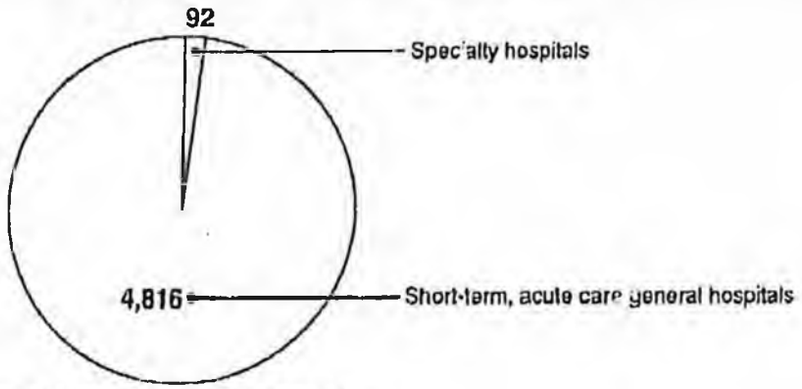
[7]An "outlier" policy exists to make additional payments to hospitals when their costs for a particular patient are extraordinarily high compared with the DRG rate for that patient's diagnosis group.

[8]Although we used several methods to identify specialty hospitals, the counts included in this report should not be interpreted as a complete census of the specialty hospitals in existence or under development. In particular, it is likely that our estimate of the number of women's hospitals is low. See the enclosure for a discussion of this issue.

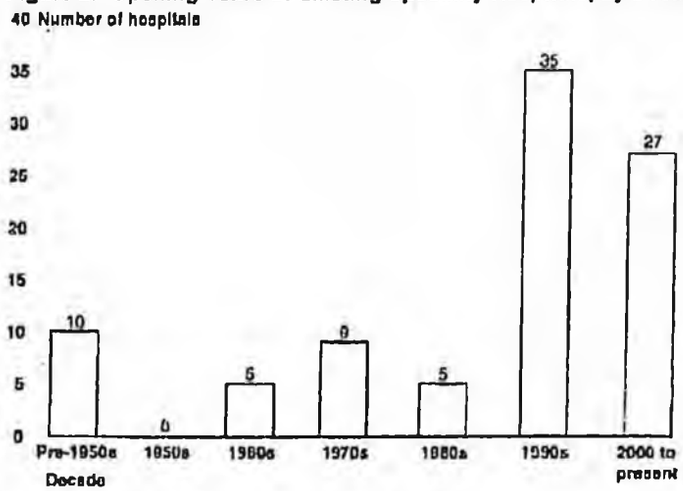
Figure 1: Number of Specialty Hospitals Relative to All Short-term, Acute Care General Hospitals, 2003



Sources: GAO and American Hospital Association (AHA).

The number of these facilities has grown rapidly in recent years—as of March 2003, the number of specialty hospitals had tripled from the 29 that existed in 1990. (See fig. 2.)

Figure 2: Opening Years of Existing Specialty Hospitals, by Decade

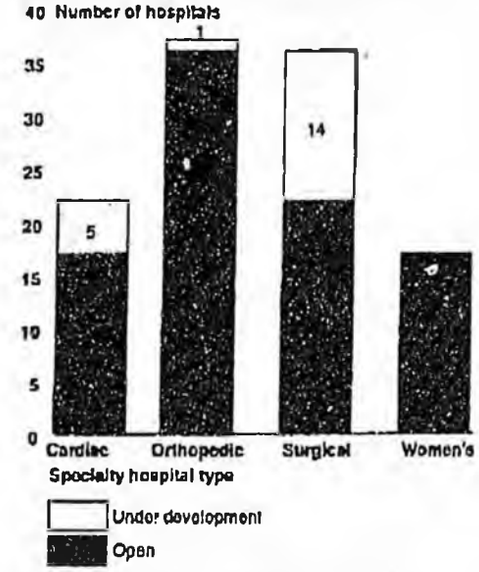


Sources: GAO and Centers for Medicare and Medicaid Services (CMS).

Note: Data are from the GAO specialty hospital universe file (2003) and the CMS Medicare Providers of Service file (2002).

An additional 20 specialty hospitals are now under development, most of which specialize in surgical care. (See fig. 3.)

Figure 3: Number of Specialty Hospitals Open and Under Development, by Specialty Type

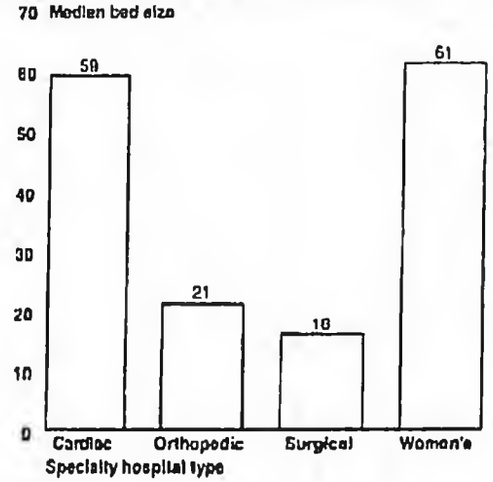


Sources: HCUP, CMS, industry groups, and hospital chains.

Note: Data are from HCUP (2000) and CMS Medicare Provider Analysis and Review (MedPar) file (2001). Data on the number of women's hospitals under development were not readily available.

In terms of beds, specialty hospitals are relatively small. In our study, surgical care facilities were the smallest, with a median of 16 beds, compared with a median of 61 beds for women's hospitals. (See fig. 4.) In contrast, the average short-term general hospital had approximately 170 beds.

Figure 4: Median Number of Beds in Specialty Hospitals, by Specialty Type



Source: GAO.

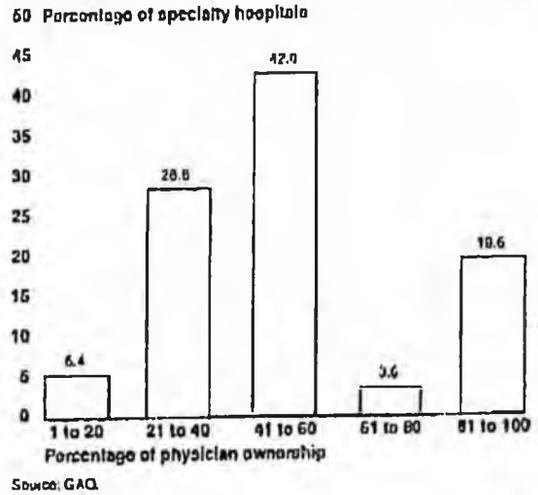
Note: Data are from GAO's specialty hospital survey (2003).

Physician Ownership of Specialty Hospitals Is Common, but Shares Owned by Individual Physicians or Physician Group Practices Vary Widely

Our survey of the more than 100 specialty hospitals in existence or under development indicates that about 70 percent of specialty hospitals had some physician owners.[b] Of the specialty hospitals with any degree of physician ownership, physicians' combined ownership shares averaged slightly more than 50 percent of the hospital. About one-fifth of specialty hospitals were owned entirely, or nearly so, by physicians. (See fig 5.) Physicians owned 20 percent or less of the hospital in relatively few specialty hospitals.

[b]Approximately 80 percent of specialty hospitals returned our survey, although the response rate on certain questions was somewhat lower. Physician ownership information was self-reported by hospitals and does not reflect ownership by physician family members.

Figure 5: Specialty Hospitals by Extent of Physician Ownership

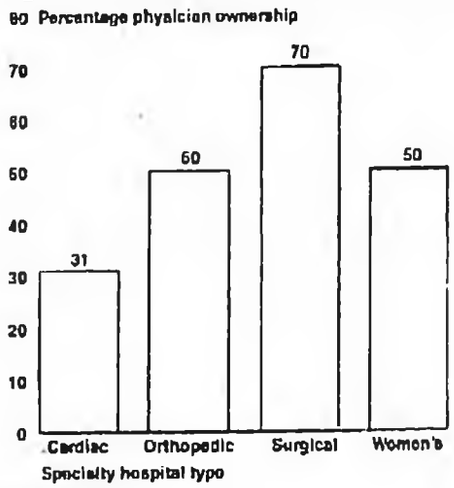


Source: GAO.

Note: Data are from GAO's specialty hospital survey (2003). Data include the approximately 70 percent of specialty hospitals that reported some degree of physician ownership.

Physicians tended to own somewhat smaller percentages of cardiac hospitals and larger percentages of surgical hospitals. (See fig 6.)

Figure 6: Median Percentage of Hospital Owned by Physicians, by Specialty Type

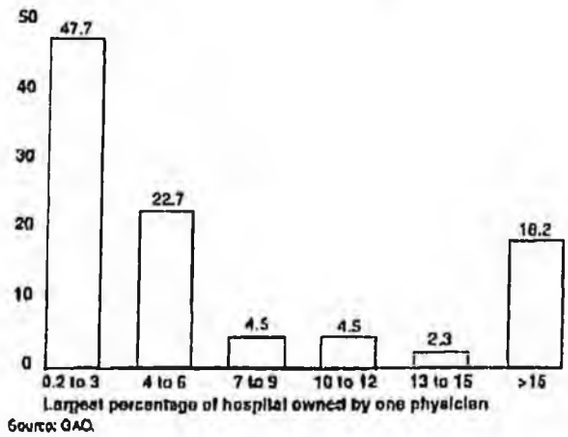


Source: GAO.

Note: Data are from GAO's specialty hospital survey (2003). Data include the approximately 70 percent of specialty hospitals that reported some degree of physician ownership.

On average, individual physicians owned relatively small shares of their hospitals. At half the specialty hospitals with physician ownership, the average individual share was less than 2 percent; at the other half, it was greater than 2 percent. Some physicians owned substantially larger shares. In nearly one-fifth of the specialty hospitals with some physician ownership, the largest share owned by a single physician was 15 percent or greater. (See fig. 7.)

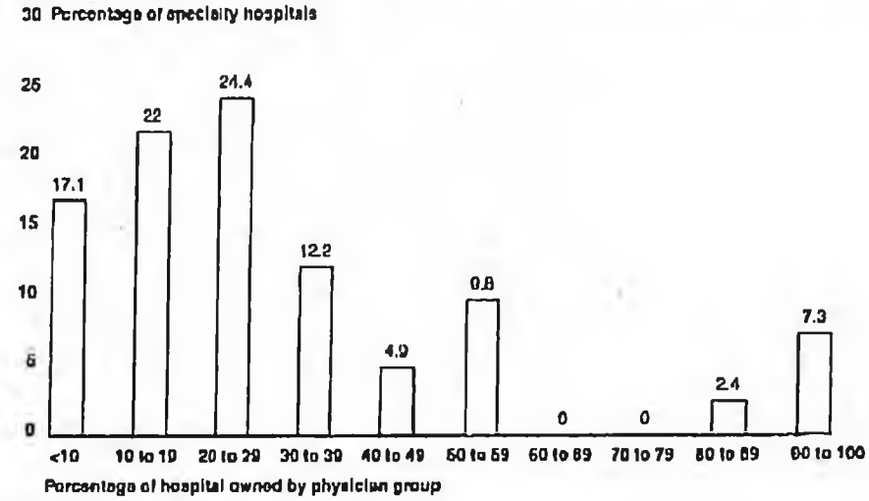
Figure 7: Largest Share of Specialty Hospital Owned by an Individual Physician



Note: Data are from GAO's specialty hospital survey (2003). Data include the approximately 70 percent of specialty hospitals that reported some degree of physician ownership.

Nearly all specialty hospitals with physician owners reported that some of the owners were members of a single group practice. The largest percentage of each hospital owned by physicians in a single group varied widely—at half the hospitals the largest percentage was more than 25 percent and at the other half it was less than 25 percent. In about 1 in 10 specialty hospitals, physicians in a single group practice owned 80 percent or more of the hospital. (See fig 8.)

Figure 8: Largest Ownership Share by Physicians in a Single Group Practice at Specialty Hospitals



Source: GAO.

Note: Data are from GAO's specialty hospital survey (2003). Data include the approximately 70 percent of specialty hospitals that reported some degree of physician ownership.

Specialty Hospitals Tend to Treat a Lower Percentage of Severely Ill Patients than General Hospitals

Some patients are more severely ill than others—even when compared to individuals who have the same principal diagnosis. Differences in age, secondary diagnosis, and other complicating conditions can affect the severity of patients' illnesses and the amount and cost of the resources required for their treatment.

To determine whether there were differences in illness severity between the patients treated at specialty hospitals and the patients treated at general hospitals, we analyzed calendar year 2000 patient discharge data at 25 specialty hospitals. These hospitals were located in 18 urban areas in six states: Arizona, California, New Jersey, New York, North Carolina, and Texas.[10] Our group of comparison hospitals consisted of the 396 general hospitals located in the same 18 urban areas. Our comparisons included only those general hospitals that provided short-term, acute care. We used a widely recognized system, known as All Payer Refined-Diagnosis Related Groups (APR-DRG), to assign an illness severity level to each patient on the basis of the information contained in the discharge data. This system, which is frequently used by hospitals and private insurers, groups patients into one of 355 diagnosis categories and assigns one of four severity levels (minor, moderate, major, or extreme) to each patient based on patient diagnosis, age, sex, and procedure. While we examined

[10]Data on all inpatient discharges were obtained from HCUP, a federal-state-industry partnership sponsored by the Agency for Healthcare Research and Quality.

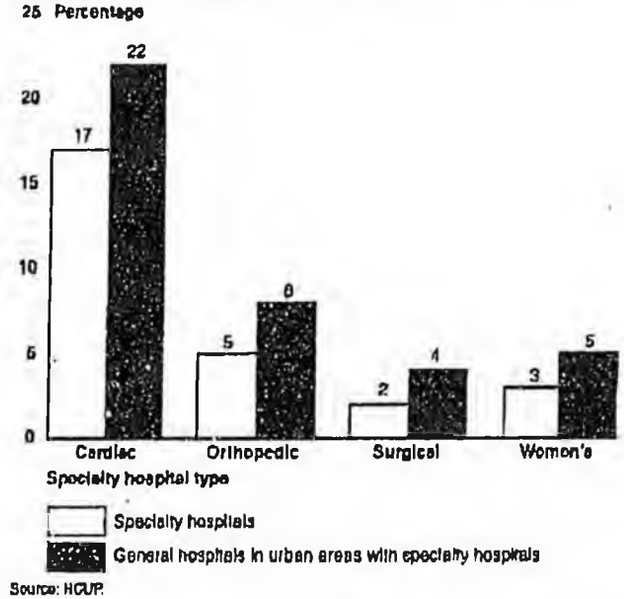
illness severity differences between specialty and general hospitals, we did not determine the clinical or economic importance of these differences."

The vast majority of specialty hospitals with HCUP data available to us—21 out of 25—treated a lower percentage of patients who were severely ill—that is, assigned to the major or extreme severity levels by the APR-DGR system—relative to patients in the same diagnosis categories treated at general hospitals in the same urban areas. For example, 3 percent of the patients in the 10 most common diagnosis categories at one Texas orthopedic hospital were classified as severely ill. A higher proportion—8 percent—of the patients in the same diagnosis categories were classified as severely ill at the 51 general hospitals in the same urban area. A cardiac hospital in Arizona provides a similar example. About 17 percent of the patients in that hospital's most common diagnosis categories were classified as severely ill. In contrast, 22 percent of the patients in the same diagnosis categories who were treated at the 26 general hospitals in the same urban area were classified as severely ill. Not all specialty hospitals treated patients who were, by comparison, less sick. Two of the 25 specialty hospitals treated a higher percentage of severely ill patients and two others treated about the same percentage as area general hospitals.

For all four specialty hospital categories—cardiac, orthopedic, surgical, and women's—the median share of severely ill patients treated was lower than the median share of severely ill patients in the same diagnostic categories treated at the corresponding general hospitals. (See fig 9.) For example, the median orthopedic hospital, in terms of patient illness severity, had 6 percent of patients in its most common diagnosis group classified as severely ill. The median general hospital in the urban areas with orthopedic hospitals had 8 percent of patients in the same diagnosis groups classified as severely ill.

"Average inpatient costs may be substantially higher for sicker individuals. In its March 2000 report to Congress, the Medicare Payment Review Advisory Commission (MedPAC) illustrated this relationship with several examples, including one for patients diagnosed with intracranial hemorrhage (APR-DRG 44). MedPAC found, based on its analysis of fiscal year 1997 Medicare data, that the estimated inpatient cost was $3,195 for patients whose illness severity was classified as minor. The estimated costs were higher for patients with the same diagnosis who were classified as more severely ill: $4,214 for moderate severity, $5,464 for major severity, and $11,255 for extreme severity. MedPAC noted that illness severity cost differences were smaller for some diagnoses and larger for others. In June 2000, MedPAC recommended that Medicare's hospital inpatient payment system be improved by accounting for illness severity differences within DRGs.

Figure 9: Median Percentage of Severely Ill Patients Treated in Specialty Hospitals and General Hospitals, by Specialty Hospital Category



Source: HCUP.

Note: Data are from HCUP (2000).

Comments Obtained from Organizations Representing Specialty Hospitals and Our Evaluation

We obtained comments from officials representing the American Surgical Hospital Association—a specialty hospital association—and from officials representing MedCath Corporation and National Surgical Hospitals—two major specialty hospital chains. Their comments, summarized below, primarily focused on physician ownership issues and our illness severity analysis. Unless otherwise noted, the following comments reflect the positions of all three organizations.

The specialty hospital representatives said that our report provided an inadequate, and potentially misleading, discussion of the financial incentives facing the physician owners of specialty hospitals. The officials believe that the average physician who invests in a specialty hospital owns such a small share that the theoretical incentive to steer relatively sick patients away from the facility is very weak. Instead, they believe that there is a strong incentive for physicians to treat patients in specialty hospitals because high-quality care can be provided efficiently in such facilities. According the representatives, our report did not sufficiently discuss the efficiency gains achieved by specialty hospitals. The representatives also noted that many physicians who work in specialty hospitals are completely unaffected by investor-related financial incentives because they have no ownership stake in the facilities.

The representatives stated that our illness severity analysis had several potential limitations and that our results may not apply to all specialty hospitals. The representatives said that our results are based on a sample that is too small to be representative of all specialty hospitals. MedCath representatives noted that Medicare data were available for most of the 92 specialty hospitals that we identified and that we could have increased our sample size if our illness severity analysis had been based on Medicare data. Representatives from the three specialty hospital organizations suggested that we might have obtained different results if we had analyzed more claims from the hospitals that we did include. They also stressed that our reported differences in illness severity could be misleading because we did not analyze the economic or clinical implications of the differences.

Our report discusses the concerns that some have raised regarding physician ownership of specialty hospitals and the potential effect on referrals. Data were not available on the identity of physician owners and therefore we could not determine if there was a relationship between physician ownership and referral behavior. Instead, our report provides descriptive information on the extent to which physicians own specialty hospitals. Our results show that many physicians who invest in specialty hospitals own relatively small shares. In about half the specialty hospitals the average share was 2 percent or less. However, our results also show that some physicians own considerably larger shares of 15 percent or more. Furthermore, the combined share owned by physicians who are members of a single group practice represents the majority ownership in some hospitals.

We disagree with the criticisms of our illness severity analysis. The 25 specialty hospitals included represent more than one-fourth of the facilities that we identified as meeting our criteria for a specialty hospital. We analyzed data pertaining to nearly 75,000 specialty hospital patients and approximately 900,000 general hospital patients. By focusing on the 10 most common diagnoses at each specialty hospital, we included nearly two-thirds of all patients treated at the specialty hospitals in our sample. Although an analysis of Medicare patients alone would have allowed us to increase the number of hospitals in our sample, it would have provided much less comprehensive information on the patients treated at each hospital. As we stated in our report, we did not attempt to determine the economic implications of the illness severity differences we observed between specialty and general hospitals. Research by MedPAC suggests that average treatment costs tend to rise with illness severity, as classified by the APR-DRG system, but we did not quantify the cost differences for the specific diagnoses we analyzed.

We plan no further distribution of this report until 30 days after the letter's date. At that time, we will send copies of this report to appropriate congressional committees and other interested parties. We will also make copies available to others upon request. This report will be available at no charge on GAO's Web site at http://www.gao.gov.

If you or your staffs have any questions, please call me at (202) 512-7119 or James Cosgrove at (202) 512-7029. Other contributors to this report include Hannah Fein, Zachary Gaumer, and Ariel Hill.

A. Bruce Steinwald

A. Bruce Steinwald
Director, Health Care—Economic
and Payment Issues

Enclosure

Scope and Methodology

This enclosure provides additional information on three key aspects of our analysis. First, it lists the criteria we used to define specialty hospitals and the process we followed to identify them. Second, it discusses the survey used to collect physician ownership information. Finally, it describes the data and methodological approach used to compare patient illness severity at specialty and general hospitals.

Specialty Hospital Definition and Identification

Although a standard definition for a specialty hospital does not exist, a reasonable approach is to define specialty hospitals as those that predominately treat certain diagnoses or perform certain procedures. For this report, we classified a hospital as a specialty hospital if the data indicated that

- two-thirds or more of its inpatient claims were in one or two major diagnosis categories (MDC) or
- two-thirds or more of its inpatient claims were for surgical diagnosis-related groups (DRGs).

Because our study focused on private, short-term, acute care hospitals, we eliminated from consideration hospitals that were government-owned and those that tended to provide long-term care or otherwise had missions very different from those of short-term, acute care general hospitals. Thus, we excluded

- government-owned hospitals;
- hospitals where the majority of inpatient claims were for MDCs that related to rehabilitation, psychiatry, alcohol and drug treatment, children, or newborns; and
- hospitals with fewer than 10 claims per bed per year.

Of the hospitals that met our criteria, 92 could be classified into four specialization categories: cardiac, orthopedic, surgical, and women's.[13] An additional 18 hospitals specialized in a variety of other areas, such as eye and ear, nose, and throat procedures. For this report, we focused on the specialty hospitals in the four major categories listed above.

We applied our criteria to inpatient discharge data from two different data sources: the 2001 Medicare Provider Analysis Review file and the 2000 Healthcare Cost and Utilization Project (HCUP) data set. Medicare and HCUP data both have distinct advantages and disadvantages. Medicare data contain patient information from virtually all of the nation's hospitals, but only for Medicare patients. Patients covered by Medicare are predominately age 65 or older. Consequently, some conditions—such as those that affect women of childbearing age—may be underrepresented, or

[13]This number does not include hospitals that initially appeared to be specialty hospitals, but informed us through our survey that they did not meet our criteria for a specialty hospital.

not represented at all, in Medicare data. Thus, it is likely that an identification based on Medicare data may undercount the number of hospitals that specialize in treating such conditions.

In contrast to Medicare, HCUP data provide information on all of a hospital's patients. However, HCUP data are only available for hospitals in 29 states and each state's data must be purchased separately. We obtained HCUP data from the following six states: Arizona, California, New Jersey, New York, North Carolina, and Texas.[13] These states were selected because Medicare data identified them as having potentially large concentrations of specialty hospitals.

To identify specialty hospitals that opened too recently to be included in the Medicare or HCUP data, we obtained information from the American Surgical Hospital Association and two national specialty hospital chains: MedCath Corporation and National Surgical Hospitals. These three organizations also provided information on specialty hospitals that are under development.

Source of Physician Ownership Information

To obtain information on physician ownership of specialty hospitals, we surveyed the more than 100 cardiac, orthopedic, surgical, and women's hospitals that we identified as in existence or under development. Among other questions, hospital representatives were asked about the number of physician owners, the overall percentage of the hospital owned by physicians, the largest share owned by a single physician, and the largest combined percentage of the hospital owned by physicians in a single revenue-sharing group practice. The survey was conducted from January through March 2003. Approximately 80 percent of the hospitals responded to our survey.

Severity of Illness Analysis

To compare patient illness severity at specialty and general hospitals, we analyzed 2000 HCUP data from Arizona, California, New Jersey, New York, North Carolina, and Texas. An analysis of HCUP data for these six states identified 25 specialty hospitals in 18 urban areas.[14] Patients at each specialty hospital were compared to patients in the same diagnosis categories at short-term, acute care general hospitals in the same urban area. (See table 1.) A total of 396 general hospitals were used in the comparisons.

[13]We obtained HCUP data on hospitals in three of Texas's five regions. .
[14]One specialty hospital was excluded because it was located in a rural area and we could not readily identify a set of general hospitals that should serve as the comparison group.

Table 1: Number of Urban Specialty Hospitals and Comparison General Hospitals Used in Patient Illness Severity Analysis, by Specialty Hospital Type

Specialty hospital type	Number of urban specialty hospitals	Number of urban areas	Number of general hospitals in urban areas (range)
Cardiac	7	7	5 to 26
Orthopedic	8	6	10 to 87
Surgical	3	3	2 to 51
Women's	7	7	7 to 87

Source: HCUP.

Note: Data are from HCUP (2000).

We used All Payer Refined Diagnosis Related Groups (APR-DRG), a widely recognized patient classification system developed by 3M Health Information Systems, to assign an illness-severity level (minor, moderate, major, or extreme) to each patient on the basis of the DRG information contained in the HCUP discharge data. The system, which is frequently used by hospitals and private insurers, groups patients into one of 355 diagnosis categories and assigns a severity level based on patient diagnosis, age, sex, discharge status, and procedure.

Based on numbers of patients treated, we identified the 10 most common diagnosis categories at each specialty hospital and computed the percentage of patients in each of those categories determined to be severely ill (that is, assigned to the major or extreme severity level by the APR-DRG system). We then determined the percentage of severely ill patients in the same 10 diagnostic categories treated at general hospitals located in the same urban area and used the result as a benchmark against which to compare the specialty hospitals. We repeated this process for each specialty hospital. This ensured that we compared illness severity among the types of patients typically treated at each specialty hospital to the illness severity for similar types of patients treated at area general hospitals.

(290181)

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HB

535

Historical HB 535

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STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

March 5, 2004

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 related to the mental health treatment assistance program. The bill would give the Department of Health and Social Services additional tools to control costs. Costs would be controlled by limiting financial assistance to persons meeting the eligibility criteria after registration. Registration would require contacting the department in a timely manner and supplying information on medical and financial need. The department would also gain some flexibility to reduce rates when there is a shortfall of funds.

I urge your support of this important bill.

Sincerely yours,

Frank H. Murkowski
Governor

Enclosure

ATTACHMENT
DESIGNATED EVALUATION AND TREATMENT PROGRAM

Beginning in the late 1970s, the Designated Evaluation and Treatment Program provided funding on a fee-for-service basis to local community hospitals and specialty hospitals. This funding covered psychiatric inpatient care to certain persons, enabling them to receive care close to home and family. The population initially served by the program was anyone who did not have the means to pay the bill for hospital and related services. The budget, while limited, enabled the program to compensate hospitals for psychiatric inpatient care provided to "indigent" persons, without any further restrictions.

Growth in the program and increases in hospital rates pushed program costs beyond the available budget, and the first restriction was imposed. The program policy was changed to provide payment only for persons who were under civil commitment. A task force, appointed to resolve payment issues, recommended that the hospitals be paid at the Medicaid rate.

The Designated Evaluation and Treatment Program has become a vital part of the necessary array of community services that must be in place before the Alaska Psychiatric Institute can assume its role as the tertiary care facility for Alaska. It provides acute hospital psychiatric care treatment close to ones home community and support network.

In 1998, the federal government made funds available to assist low-income individuals in paying for evaluation and treatment services in designated mental health facilities. The funding was available through FY 01. During the 21st session of the Alaska State Legislature, Senate Bill 97 became law. It created the Mental Health Treatment Assistance Program (AS 47.31.005 – 47.31.100) and directed the department to adopt regulations to implement the program (after consulting with the Alaska Mental Health Trust Authority).

23-GH2080\H
Mischel
4/26/04

CS FOR HOUSE BILL NO. 535(HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-THIRD LEGISLATURE - SECOND SESSION

BY THE HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): HOUSE RULES COMMITTEE BY REQUEST OF THE GOVERNOR

A BILL

FOR AN ACT ENTITLED

"An Act relating to liability for expenses of placement in certain mental health facilities; relating to the mental health treatment assistance program; and providing for an effective date."

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

*** Section 1.** AS 47.30.910(a) is amended to read:

(a) A patient, the patient's spouse, or the patient's parent if the patient is under 18 years of age shall pay the charges for the care, transportation, and treatment of the patient when the patient is hospitalized under AS 47.30.670 - 47.30.915 at a state-operated facility, an evaluation facility, or a designated treatment facility providing services under AS 47.30.670 - 47.30.915. The patient, the patient's spouse, or the patient's parent if the patient is under 18 years of age shall make arrangements with a state-operated facility, an evaluation facility, or a designated treatment facility for payment of charges, including providing income information necessary to determine eligibility for benefits under AS 47.31. Charges assessed for services provided under

AS 47.30.670 - 47.30.915 when a patient is hospitalized at a state-operated facility may not exceed the actual cost of care and treatment. The department may, when assessing charges for services provided at a state-operated facility, consider the ability to pay of a patient, a patient's spouse, or a patient's parent if the patient is under 18 years of age. In order to impose liability for a patient's cost of care at a state-operated facility, the department shall issue an order for payment within six months after the date on which the charge was incurred. The order remains in effect unless modified by subsequent court order or department order. The department may not impose liability for a patient's cost of care at a state-operated facility if the patient would **be eligible for financial assistance under** [OTHERWISE MEET THE ELIGIBILITY CRITERIA, OTHER THAN LOCATION OF SERVICE, IN] AS 47.31.010 **if the care were provided by an evaluation facility or a designated treatment facility**.

*** Sec. 2.** AS 47.31 is amended by adding a new section to read:

Sec. 47.31.007. Limitation on financial assistance and appeals due to lack of appropriations; notification. (a) Notwithstanding any contrary provision of this chapter, financial assistance under this chapter is subject to appropriation by the legislature. Nothing in this chapter creates an entitlement to financial assistance under this chapter. Notwithstanding any contrary provision of this chapter, a denial of financial assistance under this chapter due to lack of appropriations is not appealable under AS 47.31.035.

(b) If the department projects, based on registrations, that the need for financial assistance under this chapter will exceed the amount of appropriations made for financial assistance under this chapter, the department shall

(1) post notification of the projection on the department's Internet website and provide electronic notice to evaluation facilities and designated treatment facilities that have previously served patients who received assistance under this chapter; and

(2) as necessary and as the patient's condition permits, assist affected facilities in transferring patients to the Alaska Psychiatric Institute or to a community-based program approved by the department.

*** Sec. 3.** AS 47.31.010 is amended to read:

Sec. 47.31.010. Eligibility for assistance. (a) The department shall provide financial assistance under this chapter to a patient who

(1) does not have the available means to pay or substantially contribute to the payment of charges assessed by a facility;

(2) has no **insurance or** other **third-party resources, including Medicaid or Medicare,** [THIRD PARTY] to pay for the evaluation or treatment provided under AS 47.30; [AND]

(3) **has been registered under AS 47.37.012; and**

(4) meets the criteria in this chapter.

(b) To be eligible for assistance under this chapter, a patient must have

(1) been admitted for inpatient evaluation or treatment at an evaluation facility or a designated treatment facility other than a state-operated hospital after either

(A) an involuntary commitment under AS 47.30.700 - 47.30.915; or

(B) a voluntary admission chosen by the patient after a determination by the patient's treating physician that the patient meets the involuntary commitment criteria in AS 47.30.700 - 47.30.915 and that involuntary commitment proceedings would be initiated if the patient did not choose to be admitted voluntarily; [AND]

(2) a gross monthly household income that does not exceed 185 percent of the federal poverty guideline for this state for the calendar month in which service was provided**;**

(3) no insurance or other third-party resources, including Medicaid or Medicare, to pay for the cost of evaluation or treatment;

(4) been timely registered under AS 47.31.012; and

(5) not become eligible for discharge under AS 47.30.780 during the period for which financial assistance is requested.

* **Sec. 4.** AS 47.31 is amended by adding a new section to read:

Sec. 47.31.012. Registration of eligibility for assistance. (a) Notwithstanding any contrary provision of this chapter, the department may not

provide financial assistance under this chapter unless the patient has been registered under this chapter. The registration must be received by the department within 24 hours after the patient's admission to the facility. The registration may be made by telephone call, electronic message, or other means approved by the department. In order to register, information specified by the department by regulation must be supplied to demonstrate the patient's eligibility for assistance.

(b) Registration under (a) of this section must be made for each admission.

(c) Following registration for each admission, a complete application for assistance must be submitted in accordance with AS 47.31.015 and evaluated by the department for eligibility under this chapter.

* **Sec. 5.** AS 47.31.015(a) is amended to read:

(a) To receive assistance under this chapter, a patient or a patient's legal representative must apply in writing on a form provided by the department. A patient must apply for assistance within **90** [180] days after the date of **admission to** [DISCHARGE FROM] the facility.

* **Sec. 6.** AS 47.31.015(b) is amended to read:

(b) A patient is considered to have applied for assistance under (a) of this section if the evaluation facility or designated treatment facility notifies the department on a form provided by the department that there is good cause to believe that the patient would be eligible for assistance under this chapter and

(1) the patient, the patient's spouse, or the patient's parent if the patient is under 18 years of age failed, within **60** [150] days after the date of **admission to** [DISCHARGE FROM] the facility, to make arrangements to pay the evaluation facility or designated treatment facility; or

(2) the patient lacks the mental capacity to apply for benefits under this chapter.

* **Sec. 7.** AS 47.31.035(a) is amended read:

(a) **Except as provided in (d) of this section, a** [A] patient or the patient's legal representative may appeal a denial of assistance by sending written notice of objection to the department within 30 days after the date of the notice of denial. The written notice of objection must include an explanation of the reasons for the objection