FISCAL NOTE

STATE OF ALASKA
2008 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: CS SB 245 (HES)
() Publish Date:

ID(File name) SB245CS(HES)-DHSS-HPI-03-28-08
Dept. Affected: Health & Social Services
Title HEALTH CARE: PLAN/COMMISSION/FACILITIES
RDU Departmental Support Services
Component Health Planning & Infrastucture

Sponsor RULES BY REQUEST OF THE GOVERNOR
Requester SENATE HES
Component No. 2765

Expenditures/Revenues (Thousands of Dollars)

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

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2009**	**FY 2009**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims	*		*	*	*	*	*
Miscellaneous							
TOTAL OPERATING	*	0.0	*	*	*	*	*
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (0)							

FUND SOURCE (Thousands of Dollars)

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

Estimate of any current year (FY2008) cost: _____

POSITIONS

Full-time							
Part-time							
Temporary							

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

This bill would exclude diagnostic imaging centers from Certificate of Need (CON) requirements in certain circumstances.

The potential impact on the CON program in Health Planning and Infrastructure is indeterminate (*). CON fees for some imaging centers would not be collected because CON applications would not be necessary. However, this loss of fees would not appear to be enough to affect staffing needs and costs.

Prepared by: Jay C. Butler, Chief Medical Officer
Phone 269-8045
Division Public Health
Date/Time 03/28/2008
Approved by: Karleen Jackson, Commissioner
Date 03/28/2008
Agency Department of Health and Social Services

(Revised 11/19/2007 OMB)

FISCAL NOTE

STATE OF ALASKA
2008 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: CS SB 245 (HES)
() Publish Date:

ID(File name) SB245CS(HES)-DHSS-CO-03-28-08
Dept. Affected: Health & Social Services
Title HEALTH CARE: PLAN/COMMISSION/FACILITIES
RDU Departmental Support Services
Component Commissioner's Office
Sponsor RULES BY REQUEST OF THE GOVERNOR
Requester SENATE HES
Component No. 317

Expenditures/Revenues (Thousands of Dollars)

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

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2009**	**FY 2009**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**
Personal Services							
Travel							
Contractual	325.0						
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**325.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (0)							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF	325.0						
1037 GF/Mental Health							
Other(Specify Type-do not abbreviate)							
Other(Specify Type-do not abbreviate)							
TOTAL	**325.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2008) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

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

CS SB245 (HES) requires the Department of Health and Social Services (DHSS) to contract for an independent study of the efficacy of the Certificate of Need (CON) program in Alaska. This fiscal note is an estimate based on two recent studies contracted out by the department. It is assumed the contractor would interact with the CON program to receive data and other pertinent information -- and that no work for the actual study would be conducted in DHSS. It is assumed the study would be completed in FY2009. One example study was a comprehensive rate-setting study for home and community-based services costing $325.0, which included a review of regulations and statutes, development of a new rate-setting system and assisting with the transition. The other was a Request for Proposal (RFP) for a Long Term Care Plan, requiring a contractor with extensive experience in analyzing health care systems at a state or regional level. The $320.0 RFP has generated several responsive bids.

Prepared by: Jay C. Butler, Chief Medical Officer
Phone 269-8045
Division Public Health
Date/Time 03/21/2008
Approved by: Karleen Jackson, Commissioner
Date 03/28/2008
Agency Department of Health and Social Services

(Revised 11/19/2007 OMB)

Alaska State Medical Association

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March 14, 2008

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

Transmitted by email: Senator_Bettye_Davis@legis.state.ak.us

RE: Work Draft CS for SB245 (version 0) - Alaska Health Care Commission and Alaska Health Care Information Office

Dear Senator Davis:

The Alaska State Medical Association (ASMA) represents physicians statewide and is primarily concerned with the health of all Alaskans.

ASMA supports the concept of the establishment of the Alaska Health Care Commission (AHCC). However, ASMA might recommend that more than one seat be slotted for physicians. ASMA believes the AHCC purpose would be better served by physician members from diverse geographic areas as well as physicians representing different medical specialties.

ASMA appreciates and understands what SB245 is attempting to accomplish by the formation of the Alaska Health Care Information Office (AHCIO) and with the establishment of the internet based information database. However, ASMA can not support the provisions in SB245 creating the AHCIO and the data base for a host of reasons including drafting created questions, scope of its application, practical issues, and potential serious legal issues. Those concerns are summarized as follows:

- **Drafting/Definition Issues**
  - **No definition of "physician office"**
  - **"physician office" included in the definition of a facility which creates confusion in applicable provisions**
  - **No definition of a "medical procedure" (i.e. no common nomenclature such as CPT codes)**
  - **No definition of "health care providers"**
  - **No definition of "Types" of insurance**
  - **No definition of "amounts" of insurance**
  - **No definition of "actions" taken by Regulatory Agencies (e.g. after formal adjudication?)**
- **Legal Issues**
  - **Impairment of Contract**
  - **ERISA Pre-emption**
  - **Equal Application (e.g. dentists, chiropractors, advanced nurse practitioners, and optometrists not covered by SB245)**
  - **Confidentiality of Underlying Data which is reported**
- **Practical and Cost Issues**
  - **Frequency of Required Reporting May Impact Cost to Physicians as well as the Department**
  - **Unclear what "the costs to consumer" actually means (Does "actual" mean the actual cost after deductibles, co-pays, or other limitations in the insurance coverage?)**

(ASMA's comments will generally apply to physicians but some may be applicable to other health care professionals as well.)

The more detailed comments relating to the above summary follow.

First, the way in which the provisions creating AS18.09.100 through AS18.09.990, by including in the definitions of "health care facility" (AS18.09.990 (4)) a "physician's office" (AS18.09.990 (4)(F)), creates non-sensical practical situations. For example, what does it mean in AS18.09.120 (a) (1) (p.10 lines 9-10) regarding a physician office to split costs between a facility component and a physician component. This is a provision more suited to in-patient hospital care. Please also note the term "physician office" is not defined. Does this mean each individual physician practice, each individual licensed physician, etc?

AS18.09.110 (a) (p.8 lines 11-12) states the Department "may" require health care facilities to report data. This states the Department has discretion. Yet AS18.09.120 (a) (p.10 lines 6-7) requires mandatory reporting beginning July 1, 2009. Does this mean the Department has discretion only between July 1, 2008 and July 2, 2009 as far as requiring reporting of the required data? It would also seem to be a daunting task for the Department to review the data individually with each physician licensed in this state.

AS18.09.110 (b) (2) (E) (p.8 lines 25-27) requires that the data base has a listing of all licensed "health care providers" in the State. The term "health care providers" is not defined but could include those not covered by the provisions of this bill. For example, dentists, advance nurse practitioners, chiropractors, optometrists, etc. could fall in this category. Why would these health care providers not be covered by the requirements of SB245 while others are by being defined as a "health care facility"? This would also appear to be an unequal application of the law should SB245 be passed in its current form, and may not provide for the collection of data from other health care professionals that could be important to the consumers of health care.

AS18.09.110 (b) (4) (p.9 - lines 2-5) requires that the data base include a list of the 100 most commonly conducted medical procedures. The terms "medical procedure" is not defined and needs to be so common nomenclature is used - for example CPT codes for physicians. It is not specified but it is presumed that the reporting health care facilities, as defined, would need to report data on all the medical procedures provided. It could be the most commonly conducted procedures would be the lowest cost procedures. Potentially, the most expensive, least conducted, rare procedures would never be included in the data base. Another requirement of this provision, as well as AS18.09.120 (a) (2) (p.10 line 12), requires respectively that the data base include and the health care facility provide the "cash" and "negotiated" price of a procedure. A "negotiated" price may, indeed, be the result of a contract entered into by a physician and a health insurance company. For competitive reasons, neither the physician nor the health insurance company may not want the terms of such documents disclosed. (Due to the small size of the health care community in Alaska, de-identified data may not solve this problem). This could provide for a legal issue surrounding impairment of contract. At a minimum, it could also result in a physician opting not to provide the data and have the department post on the data base that physician's failure to provide the information. (It is also possible that the terms of the contract could prohibit such disclosure). Another more serious issue is also raised.

The presumption, in the absence of any specific language in SB245, is that a physician would be required to report the "negotiated" price pursuant to a contract with a health insurer for fully insured plans as well as with self-insured plans. Having such a requirement apply to self-insured plans may be pre-empted by federal law and could not apply. The federal law is the Employee Retirement Income Security Act of 1974 (commonly known as ERISA). ERISA pre-emption issues are very complex and ASMA is not aware of any attorneys who are experts who live in Alaska. If ERISA pre-empts such reporting for physicians for self-insured plans, the data base's value would seemingly be greatly diminished, as reportedly a significant number of Alaskan's have health plans that are self-insured.

AS18.09.110 (b) (12) (p.9 lines 25-26) requires that actions taken by state of federal agencies be included in the data base. It is not clear if this requirement means that "actions" are those that are after final adjudication or if this includes initial allegations. It is recommended that a reported "action" be an action that has been fully adjudicated.

AS18.09.120 (a) (p.10, lines 5-7) addresses a reporting schedule set by the Department. The costs of reporting this data will vary with how often the data must be reported. Legislative guidance would be welcomed as to frequency of reporting. Should it be monthly, quarterly, semi-annually, annually, or whenever any price changes? The frequency also impacts the Department costs as well in part because it is required to review the data that goes onto the web site with those persons who provided it.

AS18.09.120 (a) (1) (p.10 lines 9-10) requires that physicians report "costs to and bills payable by the consumer...". AS18.09.990 (2) defines "costs to the consumer" as the actual price paid by the consumer. This language is unclear as to exactly what would need to be reported. Does this mean that what the consumer pays after the health plan pays (i.e. out of pocket after deductibles, co-pays, limitations, etc)? If so, this could be a daunting if not impossible task for the physician to determine because the amount owed changes as deductibles are met, co-pays decreased, to include just a few of the variables.

AS18.09.120 (a) (2) (p.10, lines 11-12). This provision requires a physician to report the "...types and amounts of insurance..." accepted. The "types" of insurance should probably be defined even though it appears to be clear what is meant - private health insurance, Medicaid, Medicare, Worker's Compensation, etc. What is not known and needs definition is the term "amounts of insurance". Perhaps the insurance industry may provide you guidance in this area as ASMA has no idea of what this means.

Generally, there is no language that addresses the confidentiality of the underlying data - de-identified or not. Obviously the data on the internet would be available for all to see. But, the question remains if the underlying data in the Department's possession is subject to public inspection via a freedom of information request or other means. Transparency is usually a good element but it must not be at the cost of appropriate privacy and constitutional protection.

Due to the complex legal and practical issues raised, ASMA believes a great deal of work is necessary. ASMA does not see how these issues can be thoroughly researched and addressed in the time remaining in this session. ASMA would support the creation of the Alaska Health Care Commission and would commit to providing the names of a sufficient number of physicians to accomplish its work. Furthermore, it is recommended that the Alaska Health Information Office and the development of an appropriate data base not be addressed at this time in legislation. ASMA would suggest that the Alaska Health Care Commission itself be given the direct charge to develop a recommendation as to the formation of the Alaska Health Information Office and the development of a database in a manner that addresses the issues raised by ASMA and, certainly, other stakeholders.

Sincerely,

By: J. Ross Tanner, DO, President
For: The Alaska State Medical Association

Alaska State Legislature

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Senator Bettye Davis
Senate HESS Committee

Senate Bill No. 245

"An Act establishing the Alaska Health Care Commission and the Alaska health care information office; relating to health care planning and information; repealing the certificate of need program for certain health care facilities and relating to the repeal; annulling certain regulations required for implementation of the certificate of need program for certain health care facilities; and providing for an effective date."

Work Drafts

1/19/08	
25-GS2050\A –	Governor's Bill with Amendments, Sectional Analysis and Fiscal Notes
1/29/08	
25-GS2050\C –	Senate CS to incorporate Governor's Amendments
1/30/08	
25-GH2050\E -	CS for House Bill 337(HES) with notes from HSS
2/5/08	
25-GS2050\M -	Senate CS amending "E" version and adding 2 more public members
2/08/08	
GS2050K -	Senate CS amending "M" version with changes
2/11/08	
GS2050\L -	Senate CS amending "K" version with changes
3/05/08	
25-GS2050\O -	"O" version amending "L" and L.3 Amendment
3/20/08	
25-GS2050\V -	"V" version adding Study by Dept
3/06/08	
25-LS1599\A -	Senate Bill 300 removed CON sect., leaves Commission; info office; information
3/28/08 -	"N" Voted out of Committee with amendments is final "HESS" version

25-GS2050\L
Mischel
2/11/08

CS FOR SENATE BILL NO. 245( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIFTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

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

A BILL

FOR AN ACT ENTITLED

"An Act establishing the Alaska Health Care Commission and the Alaska health care information office; relating to health care planning and information; amending the certificate of need requirements to exclude expenditures for diagnostic imaging equipment in certain circumstances; and providing for an effective date."

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

*** Section 1.** AS 18.05.010(b) is amended to read.

(b) In performing its duties under this chapter, **AS 18.09,** and AS 18.15.355 - 18.15.395, the department may

(1) flexibly use the broad range of powers set out in this title assigned to the department to protect and promote the public health;

(2) provide public health information programs or messages to the public that promote healthy behaviors or lifestyles or educate individuals about health issues;

(3) promote efforts among public and private sector partners to

develop and finance programs or initiatives that identify and ameliorate health problems;

(4) establish, finance, provide, or endorse performance management standards for the public health system;

(5) develop, adopt, and implement

(A) a statewide health plan under AS 18.09 based on recommendations of the Alaska Health Care Commission established in AS 18.09.010; and

(B) public health plans and formal policies through regulations adopted under AS 44.62 or collaborative recommendations that guide or support individual and community public health efforts;

(6) establish formal or informal relationships with public or private sector partners within the public health system;

(7) identify, assess, prevent, and ameliorate conditions of public health importance through surveillance; epidemiological tracking, program evaluation, and monitoring; testing and screening programs; treatment; administrative inspections; or other techniques;

(8) promote the availability and accessibility of quality health care services through health care facilities or providers;

(9) promote availability of and access to preventive and primary health care when not otherwise available through the private sector, including acute and episodic care, prenatal and postpartum care, child health, family planning, school health, chronic disease prevention, child and adult immunization, testing and screening services, dental health, nutrition, and health education and promotion services;

(10) systematically and regularly review the public health system and recommend modifications in its structure or other features to improve public health outcomes; and

(11) collaborate with public and private sector partners, including municipalities, Alaska Native organizations, health care providers, and health insurers, within the public health system to achieve the mission of public health.

* **Sec. 2.** AS 18.07.031(a) is amended to read:

(a) Except as provided in **(e), (d), and (f)** [(c) AND (d)] of this section, a person may not make an expenditure of $1,000,000 or more for any of the following unless authorized under the terms of a certificate of need issued by the department:

(1) construction of a health care facility;

(2) alteration of the bed capacity of a health care facility; or

(3) addition of a category of health services provided by a health care facility

*** Sec. 3.** AS 18.07.031(e) is amended to read:

(e) In

(1) (a) of this section, "expenditure" includes the purchase of property occupied by or the equipment required for the health care facility and the net present value of a lease for space occupied by or the equipment required for the health care facility; "expenditure" does not include costs associated with routine maintenance and replacement of equipment at an existing health care facility;

(2) (f) of this section, "critical access hospital" refers to a facility designated as a critical access hospital by the department by regulatory authority exercised under AS 18.05 or AS 18.20.

*** Sec. 4.** AS 18.07.031 is amended by adding a new subsection to read:

(f) Notwithstanding the limitations in (a) of this section, a person may make an expenditure of $1,000,000 or more for diagnostic imaging equipment without authorization under the terms of a certificate of need issued by the department if the equipment is used in a health care facility that

(1) is located in a

(A) borough with a population of 60,000 or more; and

(B) a city that does not have a facility designated by the department as a critical access hospital; and

(2) has at least a 50 percent ownership by one or more physicians licensed in the state who are qualified to interpret, and actually interpret, diagnostic images produced by the equipment in the facility

*** Sec. 5.** AS 18 is amended by adding a new chapter to read:

Chapter 09. Statewide Health Care Planning and Information.

Article 1. Alaska Health Care Commission; State Health Plan.

Sec. 18.09.010. Alaska Health Care Commission. The Alaska Health Care Commission is established in the Department of Health and Social Services. The purposes of the commission are

(1) to provide recommendations for and foster the development of a statewide plan to address the quality, accessibility, and availability of health care for all citizens of the state; and

(2) to review and approve facility health care information for placement on the department's Internet database established under AS 18.09.110.

Sec. 18.09.020. Composition; chair. (a) The commission consists of 13 members as follows:

(1) the state officer assigned the duties of medical director for the department;

(2) one member representing the Department of Administration, appointed by the commissioner of administration;

(3) one member representing the Department of Commerce, Community, and Economic Development, appointed by the commissioner of commerce, community, and economic development;

(4) one member representing the Department of Labor and Workforce Development, appointed by the commissioner of labor and workforce development;

(5) six public members, appointed by the governor; one of the members appointed under this paragraph must be a small business owner in the state;

(6) one member from the house of representatives, appointed by the speaker of the house;

(7) one member from the senate, appointed by the president of the senate; and

(8) one member representing the Office of the Governor.

(b) The department's representative appointed under (a)(1) of this section shall serve as chair of the commission.

Sec. 18.09.030. Term of office. (a) Public members of the commission appointed under AS 18.09.020(a)(5) serve for staggered terms of three years.

(b) If a vacancy occurs in a public member's seat on the commission, the governor shall make an appointment for the unexpired portion of that member's term.

(c) The governor may remove a public member of the commission from office only for cause.

Sec. 18.09.040. Executive director. The commission shall employ an executive director who may not be a member of the commission. The executive director serves at the pleasure of the commission. The commission shall establish the duties of the executive director. The executive director is in the partially exempt service under AS 39.25 (State Personnel Act).

Sec. 18.09.050. Staff. The department may assign employees of the department to serve as staff to the commission. The commission shall prescribe the duties of the commission staff.

Sec. 18.09.060. Bylaws. The commission, on approval of a majority of its membership and consistent with state law, shall adopt and amend bylaws governing proceedings and other activities, including provisions concerning a quorum to transact commission business and other aspects of procedure; frequency and location of meetings; and establishment, functions, and membership of committees.

Sec. 18.09.070. Duties of the commission. (a) The commission shall serve as the state health planning and coordinating body. Consistent with state and federal law, the commission shall provide recommendations for and foster the development of a statewide health plan containing the following:

(1) a comprehensive statewide health care policy;

(2) a strategy for

(A) encouraging personal responsibility in prevention and healthy living for all residents of the state;

(B) reducing health care costs for all residents of the state to below the national average;

(C) ensuring access in communities to safe water and wastewater systems;

(D) developing a sustainable health care workforce in the state;

(E) ensuring access to quality health care for all residents of the

state; and

(F) increasing the number of residents of the state who are covered by insurance for health care services.

(b) The commission shall review and approve health care information for placement on the department's database developed under AS 18.09.110 and establish a schedule for implementation of the database and reporting requirements under AS 18.09.120.

(c) The commission shall submit to the governor and the legislature by January 15 of each year an annual report regarding the commission's recommendations and activities.

Sec. 18.09.080. Compensation, per diem, and expenses. A public member appointed to the commission under AS 18.09.020(a)(5) is not entitled to a salary, but is entitled to per diem, reimbursement for travel, and other expenses authorized by law for boards and commissions under AS 39.20.180.

Article 2. Alaska Health Care Information Office.

Sec. 18.09.100. Office. The Alaska health care information office is established in the department. The purpose of the office is to improve access by residents of the state to consistently updated

(1) information about health care facilities to aid consumers of health care services of health care facilities in the state; and

(2) information to encourage personal responsibility in prevention and healthy living.

Sec. 18.09.110. Dissemination of information. (a) The department shall establish and maintain an information database on the Internet of information about all health care facilities in the state to provide objective, unbiased, and factually based information on health care facilities in the state. The department may require those health care facilities to provide information in a standard form or format to the department for placement in the database. Before information is placed on the database, the commission shall review the information for accuracy.

(b) The database developed under (a) of this section must include the following

(1) a list of preferred drugs approved by the department for reimbursement by the department;

(2) a complete list, organized by region and address, of

(A) health facilities located in the state;

(B) licensed pharmacists and pharmacies located in the state;

(C) emergency and urgent care facilities located in the state;

(D) health insurance companies offering coverage in the state;

(E) health care providers licensed in the state, including the provider license number, type, and expiration date along with disciplinary actions, if any;

(F) long-term, in-home, and hospice care providers located in the state;

(G) public assistance offices of the department;

(3) a list of the 100 most commonly prescribed medications in the state and the source and price, updated monthly, of the medications;

(4) a list of the 100 most commonly conducted medical procedures in the state, organized by the cash and negotiated price of the procedure at available providers and insurers, updated annually; the list must include medical procedures covered by workers' compensation under AS 23.30;

(5) available hospital ratings, including the rates of hospital acquired infections and mortality occurring at each hospital located in the state;

(6) consumer education information on topics that include body mass index, diet and nutrition, exercise, smoking cessation, and alcohol and drug addictions, that includes the location of available sites that provide care and treatment related to those issues;

(7) a list of procedures approved by state agencies for emergency response and treatment;

(8) disease management support information;

(9) insurance information that includes

(A) a navigator to determine insurance eligibility using a matrix of available insurers;

(B) links to Internet websites for purchasing insurance policies;

(C) an explanation of mandatory and optional insurance coverage;

(10) a list of primary care clinics that cater to uninsured and self-pay patients; and

(11) information on the quality of health care facilities, including any actions taken by state or federal agencies related to

(A) licensure and accreditation of a health care facility; or

(B) a licensed professional practicing in a health care facility.

(c) The department may contract with a private entity to provide services and information required under (a) of this section.

(d) The department shall develop and consistently update an Internet website to provide residents of the state timely and accurate information regarding prevention and healthy living.

(e) The department shall post and make available information related to the commission, including the commission's annual reports under AS 18.09.070(e).

Sec. 18.09.120. Mandatory reporting. (a) A health care facility shall provide to the department, based on a schedule set by the commission under AS 18.09.070(b), the following information related to the facility's health care services for placement in the database developed under AS 18.09.110:

(1) information on costs to the consumer for health care services;

(2) types of insurance and payment accepted by the health care facility for health care services;

(3) each location where the health care facility operates, and the hours of operation;

(4) the types and scope of health care services offered at the health care facility;

(5) the Internet address of any Internet website of the health care facility the purpose of which is to provide factual information to aid the consumer;

(6) any other readily accessible information that the department determines would help the consumer to make informed decisions about the health care

facility's services.

(b) The department shall develop a standard form or format for reporting the information required in (a) of this section. The department shall adopt regulations specifying the timing and frequency of the reporting of the information required by (a) of this section.

(c) The department shall notify the health care facility of a failure to report under (a) of this section and give the health care facility an opportunity to contest or cure the failure. If the health care facility does not promptly cure the failure, the department shall post the notice of failure on the database developed under AS 18.09.110.

Sec. 18.09.130. Coordination of departments. The Department of Administration, the Department of Commerce, Community, and Economic Development, the Department of Labor and Workforce Development, and the Department of Law shall

(1) provide to the commission for placement on the database developed under AS 18.09.110 information regarding an adverse action taken against a health care facility in the state or against a licensed professional practicing in a health care facility in the state; and

(2) cooperate with the commission in the performance of its duties.

Article 3. General Provisions.

Sec. 18.09.900. Regulations. The department may adopt regulations under AS 44.62 (Administrative Procedure Act) to carry out the purposes of this chapter.

Sec. 18.09.990. Definitions. In this chapter,

(1) "commission" means the Alaska Health Care Commission established in AS 18.09.010;

(2) "costs to the consumer" means actual price paid by the consumer for health care services;

(3) "department" means the Department of Health and Social Services;

(4) "health care facility" means

(A) a facility licensed under AS 47.32;

(B) an independent diagnostic testing facility providing

services in the state;

(C) a provider of a home and community based waiver service that is certified under regulations adopted by the department;

(D) a provider of personal care services that is certified under regulations adopted by the department.

*** Sec. 6.** AS 39.25.120(e)(7) is amended to read:

(7) the principal executive officer of the following boards, councils, or commissions:

(A) Alaska Public Broadcasting Commission;

(B) Professional Teaching Practices Commission;

(C) Parole Board;

(D) Board of Nursing;

(E) Real Estate Commission;

(F) Alaska Royalty Oil and Gas Development Advisory Board;

(G) Alaska State Council on the Arts;

(H) Alaska Police Standards Council;

(I) Alaska Commission on Aging;

(J) Alaska Mental Health Board;

(K) State Medical Board;

(L) Governor's Council on Disabilities and Special Education;

(M) Advisory Board on Alcoholism and Drug Abuse;

(N) Statewide Suicide Prevention Council;

(O) the State Board of Registration for Architect, Engineers, and Land Surveyors;

(P) Alaska Health Care Commission;

*** Sec. 7.** The uncodified law of the State of Alaska is amended by adding a new section to read:

APPLICABILITY. Sections 2 - 4 of this Act apply to health care facilities in existence or proposed on or after the effective date of this Act. A decision of the Department of Health and Social Services made before the effective date of this Act denying or granting a certificate of need that was applied for or issued for a health care facility described in AS 18.07.031(f),

added by sec. 4 of this Act, shall be void and unnecessary. A pending application for a certificate of need for a health care facility described in AS 18.07.031(f), added by sec. 4 of this Act, shall be returned to the applicant.

*** Sec. 8.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: REGULATIONS. The Department of Health and Social Services may proceed to adopt regulations necessary to implement the changes made by this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not before the effective date of the statutory change.

*** Sec. 9.** Section 8 of this Act takes effect immediately under AS 01.10.070(c).

*** Sec. 10.** Except as provided in sec. 9 of this Act, this Act takes effect July 1, 2008.

25-GS2050\O
Mischel
3/5/08

CS FOR SENATE BILL NO. 245( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIFTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

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

A BILL

FOR AN ACT ENTITLED

"An Act establishing the Alaska Health Care Commission and the Alaska health care information office; relating to health care planning and information; amending the certificate of need requirements to exclude expenditures for diagnostic imaging equipment in certain circumstances; and providing for an effective date."

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

*** Section 1.** AS 18.05.010(b) is amended to read:

(b) In performing its duties under this chapter, **AS 18.09,** and AS 18.15.355 - 18.15.395, the department may

(1) flexibly use the broad range of powers set out in this title assigned to the department to protect and promote the public health;

(2) provide public health information programs or messages to the public that promote healthy behaviors or lifestyles or educate individuals about health issues;

(3) promote efforts among public and private sector partners to

develop and finance programs or initiatives that identify and ameliorate health problems;

(4) establish, finance, provide, or endorse performance management standards for the public health system;

(5) develop, adopt, and implement

(A) a statewide health plan under AS 18.09 based on recommendations of the Alaska Health Care Commission established in AS 18.09.010; and

(B) public health plans and formal policies through regulations adopted under AS 44.62 or collaborative recommendations that guide or support individual and community public health efforts;

(6) establish formal or informal relationships with public or private sector partners within the public health system;

(7) identify, assess, prevent, and ameliorate conditions of public health importance through surveillance; epidemiological tracking, program evaluation, and monitoring; testing and screening programs; treatment; administrative inspections; or other techniques;

(8) promote the availability and accessibility of quality health care services through health care facilities or providers;

(9) promote availability of and access to preventive and primary health care when not otherwise available through the private sector, including acute and episodic care, prenatal and postpartum care, child health, family planning, school health, chronic disease prevention, child and adult immunization, testing and screening services, dental health, nutrition, and health education and promotion services;

(10) systematically and regularly review the public health system and recommend modifications in its structure or other features to improve public health outcomes; and

(11) collaborate with public and private sector partners, including municipalities, Alaska Native organizations, health care providers, and health insurers, within the public health system to achieve the mission of public health.

*** Sec. 2.** AS 18.05.010(b), as amended by sec. 1 of this Act, is amended to read:

(b) In performing its duties under this chapter, AS 18.09, and AS 18.15.355 - 18.15.395, the department may

(1) flexibly use the broad range of powers set out in this title assigned to the department to protect and promote the public health;

(2) provide public health information programs or messages to the public that promote healthy behaviors or lifestyles or educate individuals about health issues;

(3) promote efforts among public and private sector partners to develop and finance programs or initiatives that identify and ameliorate health problems;

(4) establish, finance, provide, or endorse performance management standards for the public health system;

(5) develop, adopt, and implement

(A) a statewide health plan under AS 18.09 [BASED ON RECOMMENDATIONS OF THE ALASKA HEALTH CARE COMMISSION ESTABLISHED IN AS 18.09.010]; and

(B) public health plans and formal policies through regulations adopted under AS 44.62 or collaborative recommendations that guide or support individual and community public health efforts;

(6) establish formal or informal relationships with public or private sector partners within the public health system;

(7) identify. assess, prevent, and ameliorate conditions of public health importance through surveillance; epidemiological tracking, program evaluation, and monitoring; testing and screening programs; treatment; administrative inspections; or other techniques;

(8) promote the availability and accessibility of quality health care services through health care facilities or providers;

(9) promote availability of and access to preventive and primary health care when not otherwise available through the private sector, including acute and episodic care, prenatal and postpartum care, child health, family planning, school health, chronic disease prevention, child and adult immunization, testing and screening

services, dental health, nutrition, and health education and promotion services;

(10) systematically and regularly review the public health system and recommend modifications in its structure or other features to improve public health outcomes; and

(11) collaborate with public and private sector partners, including municipalities, Alaska Native organizations, health care providers, and health insurers, within the public health system to achieve the mission of public health.

*** Sec. 3.** AS 18.07.031(a) is amended to read:

(a) Except as provided in **(c), (d), and (f)** [(c) AND (d)] of this section, a person may not make an expenditure of $1,000,000 or more for any of the following unless authorized under the terms of a certificate of need issued by the department:

(1) construction of a health care facility;

(2) alteration of the bed capacity of a health care facility; or

(3) addition of a category of health services provided by a health care facility.

*** Sec. 4.** AS 18.07.031(e) is amended to read:

(e) In [(a) OF] this section,

(1) "expenditure" includes the purchase of property occupied by or the equipment required for the health care facility and the net present value of a lease for space occupied by or the equipment required for the health care facility; "expenditure" does not include costs associated with routine maintenance and replacement of equipment at an existing health care facility**;**

(2) "critical access hospital" means a facility designated as a critical access hospital by the department by regulatory authority exercised under AS 18.05 or AS 18.20.

*** Sec. 5.** AS 18.07.031 is amended by adding a new subsection to read:

(f) Notwithstanding the limitations in (a) of this section, a person may make an expenditure of $1,000,000 or more for diagnostic imaging equipment without authorization under the terms of a certificate of need issued by the department if the equipment is used in a health care facility that

(1) is located in a

(A) borough with a population of 60,000 or more; and

(B) a city that does not have a facility designated by the department as a critical access hospital; and

(2) has at least a 50 percent ownership by one or more physicians licensed in the state who are qualified to interpret, and actually interpret, diagnostic images produced by the equipment in the facility.

*** Sec. 6.** AS 18 is amended by adding a new chapter to read:

Chapter 09. Statewide Health Care Planning and Information.

Article 1. Alaska Health Care Commission; State Health Plan.

Sec. 18.09.010. Alaska Health Care Commission. The Alaska Health Care Commission is established in the Department of Health and Social Services. The purposes of the commission are

(1) to provide recommendations for and foster the development of a statewide plan to address the quality, accessibility, and availability of health care for all citizens of the state;

(2) to review and approve the department's plan for a reporting data system, including the type of reporting entity or person, and the timing of reporting; and

(3) to review and approve facility health care information for placement on the department's Internet database established under AS 18.09.110.

Sec. 18.09.020. Composition; chair. (a) The commission consists of 15 members, as follows:

(1) the state officer assigned the duties of medical director for the department;

(2) one member representing the governor and appointed by the governor;

(3) one member who is a member of the Alaska Commission on Aging;

(4) three public members, in addition to members appointed under (5), (8), and (9) of this subsection, appointed by the governor; one of the members appointed under this paragraph must be a small business owner in the state;

(5) three public members who are health care providers, appointed by the governor, as follows: one representing hospitals, one representing physicians, and one representing mental health;

(6) two members from the house of representatives appointed by the speaker of the house of representatives;

(7) two members from the senate appointed by the president of the senate;

(8) one public member representing the Alaska tribal health care system appointed by the governor; and

(9) one public member representing health care insurers appointed by the governor.

(b) The medical director appointed under (a)(1) of this section shall serve as chair of the commission.

Sec. 18.09.030. Term of office. (a) Public members of the commission appointed under AS 18.09.020(a)(4), (5), (8), and (9) serve for staggered terms of five years.

(b) If a vacancy occurs in a public member's seat on the commission, the governor shall make an appointment for the unexpired portion of that member's term.

(c) The governor may remove a public member of the commission from office only for cause.

Sec. 18.09.040. Executive director. The commission shall employ an executive director with appropriate health care policy experience who may not be a member of the commission. The executive director serves at the pleasure of the commission. The commission shall establish the duties of the executive director. The executive director is in the partially exempt service under AS 39.25 (State Personnel Act).

Sec. 18.09.050. Staff. The department may assign employees of the department to serve as staff to the commission. The commission shall prescribe the duties of the commission staff.

Sec. 18.09.060. Bylaws. The commission, on approval of a majority of its membership and consistent with state law, shall adopt and amend bylaws governing

proceedings and other activities, including provisions concerning a quorum to transact commission business and other aspects of procedure; frequency and location of meetings; and establishment, functions, and membership of committees.

Sec. 18.09.070. Duties of the commission. (a) The commission shall serve as the state health planning and coordinating body. Consistent with state and federal law, the commission shall provide recommendations for and foster the development of a statewide health plan containing the following:

(1) a comprehensive statewide health care policy;

(2) a strategy for

(A) encouraging personal responsibility in prevention and healthy living for all residents of the state;

(B) reducing the rate of growth in health care costs for all residents of the state;

(C) improving access in communities to safe water and wastewater systems;

(D) developing a sustainable health care workforce in the state;

(E) improving access to quality health care for all residents of the state and increasing the number of residents of the state who are covered by insurance for health care services.

(b) The commission shall review and approve health care information for placement on the department's database developed under AS 18.09.110 and establish a schedule for implementation of the database and reporting requirements under AS 18.09.120.

(c) The commission shall submit to the governor and the legislature by January 15 of each year an annual report regarding the commission's recommendations and activities.

Sec. 18.09.080. Compensation, per diem, and expenses. A public member appointed to the commission under AS 18.09.020(a)(4), (5), (8), or (9) is not entitled to a salary, but is entitled to per diem, reimbursement for travel, and other expenses authorized by law for boards and commissions under AS 39.20.180.

Article 2. Alaska Health Care Information Office.

Sec. 18.09.100. Office. The Alaska health care information office is established in the department. The purpose of the office is to improve access by residents of the state to consistently updated

(1) information about health care services, price, and quality to aid consumers in making health care decisions; and

(2) information to encourage personal responsibility in prevention and healthy living.

Sec. 18.09.110. Dissemination of information. (a) The department shall establish and maintain an information database on the Internet of information about health care facilities in the state to provide objective, unbiased, and factually based information on health care services in the state. The department may require those health care facilities to provide information in a standard form or format to the department for placement in the database. Before information is placed on the database, the department shall review the information with the health care facility for accuracy.

(b) The database developed under (a) of this section must include the following:

(1) a list of preferred drugs approved by the department for reimbursement by the department;

(2) a complete list, organized by region and address, of

(A) health care facilities located in the state;

(B) licensed pharmacists and pharmacies located in the state;

(C) emergency and urgent care facilities located in the state;

(D) health insurance companies offering coverage in the state;

(E) health care providers licensed in the state, including the provider license number, type, and expiration date along with disciplinary actions, if any;

(F) long-term, in-home, and hospice care providers located in the state;

(G) public assistance offices of the department;

(3) a list of the 100 most commonly prescribed medications in the state

and the source and price, updated monthly, of the medications;

(4) a list of the 100 most commonly conducted medical procedures in the state, organized by the cash and negotiated price of the procedure at available providers and insurers, updated annually; the list must include medical procedures covered by workers' compensation under AS 23.30;

(5) available hospital ratings, including the rates of hospital acquired infections and mortality occurring at each hospital located in the state;

(6) consumer education information on topics that include body mass index, diet and nutrition, exercise, smoking cessation, and alcohol and drug addictions, that includes the location of available sites that provide care and treatment related to those issues;

(7) a list of procedures approved by state agencies for emergency response and treatment;

(8) disease management support information;

(9) insurance information that includes

(A) a navigator to determine insurance eligibility using a matrix of available insurers;

(B) links to Internet websites for purchasing insurance policies;

(C) an explanation of mandatory and optional insurance coverage;

(10) a list of primary care clinics that cater to uninsured and self-pay patients;

(11) a list of physicians who accept patients with Medicare coverage; and

(12) information on the quality of health care facilities, including any actions taken by state or federal agencies related to

(A) licensure and accreditation of a health care facility; or

(B) a licensed professional practicing in a health care facility.

(c) The department may contract with a private entity to provide services and information required under (a) of this section.

(d) The department shall develop and consistently update an Internet website

to provide residents of the state timely and accurate information regarding prevention and healthy living.

(e) The department shall post and make available information related to the commission, including the commission's annual reports under AS 18.09.070(c).

Sec. 18.09.120. Mandatory reporting. (a) Beginning July 1, 2009, a health care facility shall provide to the department, based on a schedule set by the department, the following information related to the facility's health care services for placement in the database developed under AS 18.09.110:

(1) information on costs to and bills payable by the consumer for health care services that include both facility and physician components of care;

(2) types and amounts of insurance and other payments accepted by the health care facility for health care services, including cash and negotiated prices;

(3) each location where the health care facility operates, and the hours of operation;

(4) the types and scope of health care services offered at the health care facility;

(5) the Internet address of any Internet website of the health care facility the purpose of which is to provide factual information to aid the consumer;

(6) any other readily accessible information that the department determines would help the consumer to make informed decisions about the health care facility's services.

(b) The department shall develop a standard form or format for reporting the information required in (a) of this section. The department shall adopt regulations specifying the timing and frequency of the reporting of the information required by (a) of this section.

(c) The department shall notify the health care facility of a failure to report under (a) of this section and give the health care facility an opportunity to contest or cure the failure. If the health care facility does not promptly cure the failure, the department shall post the notice of failure on the database developed under AS 18.09.110.

Sec. 18.09.130. Coordination of departments. The Department of

Administration, the Department of Commerce, Community, and Economic Development, the Department of Labor and Workforce Development, and the Department of Law shall

(1) provide to the department for placement on the database developed under AS 18.09.110 information regarding an adverse action taken against a health care facility in the state or against a licensed professional practicing in a health care facility in the state; and

(2) cooperate with the commission in the performance of its duties.

Article 3. General Provisions.

Sec. 18.09.900. Regulations. The department may adopt regulations under AS 44.62 (Administrative Procedure Act) to carry out the purposes of this chapter.

Sec. 18.09.990. Definitions. In this chapter,

(1) "commission" means the Alaska Health Care Commission established in AS 18.09.010;

(2) "costs to the consumer" means actual price paid by the consumer for health care services;

(3) "department" means the Department of Health and Social Services;

(4) "health care facility" means

(A) a facility licensed under AS 47.32;

(B) an independent diagnostic testing facility providing services in the state;

(C) a provider of a home and community based waiver service that is certified under regulations adopted by the department;

(D) a provider of personal care services that is certified under regulations adopted by the department;

(E) a licensed pharmacy; and

(F) a physician's office.

* **Sec. 7.** AS 39.25.120(c)(7) is amended to read:

(7) the principal executive officer of the following boards, councils, or commissions:

(A) Alaska Public Broadcasting Commission;

(B) Professional Teaching Practices Commission;

(C) Parole Board;

(D) Board of Nursing;

(E) Real Estate Commission;

(F) Alaska Royalty Oil and Gas Development Advisory Board;

(G) Alaska State Council on the Arts;

(H) Alaska Police Standards Council;

(I) Alaska Commission on Aging;

(J) Alaska Mental Health Board;

(K) State Medical Board;

(L) Governor's Council on Disabilities and Special Education;

(M) Advisory Board on Alcoholism and Drug Abuse;

(N) Statewide Suicide Prevention Council;

(O) the State Board of Registration for Architect, Engineers, and Land Surveyors;

(P) Alaska Health Care Commission;

*** Sec. 8.** AS 18.09.010, 18.09.020, 18.09.030, 18.09.040, 18.09.050, 18.09.060, 18.09.070, 18.09.080, 18.09.110(e), 18.09.130(2), 18.09.990(1); and AS 39.25.120(c)(7)(P) are repealed July 1, 2013.

*** Sec. 9.** The uncodified law of the State of Alaska is amended by adding a new section to read:

APPLICABILITY. Sections 3 - 5 of this Act apply to health care facilities in existence or proposed on or after the effective date of secs. 3 - 5 of this Act. A decision of the Department of Health and Social Services made before the effective date of secs. 3 - 5 this Act denying or granting a certificate of need that was applied for or issued for a health care facility described in AS 18.07.031(f), added by sec. 5 of this Act, shall be void and unnecessary. A pending application for a certificate of need for a health care facility described in AS 18.07.031(f), added by sec. 5 of this Act, shall be returned to the applicant.

*** Sec. 10.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: REGULATIONS. The Department of Health and Social Services may

proceed to adopt regulations necessary to implement the changes made by this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not before the effective date of the statutory change.

*** Sec. 11.** Section 2 of this Act takes effect July 1, 2013.

*** Sec. 12.** Sections 3 - 5, 9, and 10 of this Act take effect immediately under AS 01.10.070(c).

*** Sec. 13.** Except as provided in secs. 11 and 12 of this Act, this Act takes effect July 1, 2008.

25-GS2050\V
Mischel
3/20/08

CS FOR SENATE BILL NO. 245( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIFTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

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

A BILL

FOR AN ACT ENTITLED

"An Act establishing the Alaska Health Care Commission and the Alaska health care information office; relating to health care planning and information; amending the certificate of need requirements to exclude expenditures for diagnostic imaging equipment in certain circumstances; providing for a study of the certificate of need program; and providing for an effective date."

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

*** Section 1.** AS 18.05.010(b) is amended to read:

(b) In performing its duties under this chapter, **AS 18.09,** and AS 18.15.355 - 18.15.395, the department may

(1) flexibly use the broad range of powers set out in this title assigned to the department to protect and promote the public health;

(2) provide public health information programs or messages to the public that promote healthy behaviors or lifestyles or educate individuals about health

issues;

(3) promote efforts among public and private sector partners to develop and finance programs or initiatives that identify and ameliorate health problems;

(4) establish, finance, provide, or endorse performance management standards for the public health system;

(5) develop, adopt, and implement

(A) a statewide health plan under AS 18.09 based on recommendations of the Alaska Health Care Commission established in AS 18.09.010; and

(B) public health plans and formal policies through regulations adopted under AS 44.62 or collaborative recommendations that guide or support individual and community public health efforts;

(6) establish formal or informal relationships with public or private sector partners within the public health system;

(7) identify, assess, prevent, and ameliorate conditions of public health importance through surveillance; epidemiological tracking, program evaluation, and monitoring; testing and screening programs; treatment; administrative inspections; or other techniques;

(8) promote the availability and accessibility of quality health care services through health care facilities or providers;

(9) promote availability of and access to preventive and primary health care when not otherwise available through the private sector, including acute and episodic care, prenatal and postpartum care, child health, family planning, school health, chronic disease prevention, child and adult immunization, testing and screening services, dental health, nutrition, and health education and promotion services;

(10) systematically and regularly review the public health system and recommend modifications in its structure or other features to improve public health outcomes; and

(11) collaborate with public and private sector partners, including municipalities, Alaska Native organizations, health care providers, and health insurers,

within the public health system to achieve the mission of public health.

* **Sec. 2.** AS 18.05.010(b), as amended by sec. 1 of this Act, is amended to read:

(b) In performing its duties under this chapter, AS 18.09, and AS 18.15.355 - 18.15.395, the department may

(1) flexibly use the broad range of powers set out in this title assigned to the department to protect and promote the public health;

(2) provide public health information programs or messages to the public that promote healthy behaviors or lifestyles or educate individuals about health issues;

(3) promote efforts among public and private sector partners to develop and finance programs or initiatives that identify and ameliorate health problems;

(4) establish, finance, provide, or endorse performance management standards for the public health system;

(5) develop, adopt, and implement

(A) a statewide health plan under AS 18.09 [BASED ON RECOMMENDATIONS OF THE ALASKA HEALTH CARE COMMISSION ESTABLISHED IN AS 18.09.010]; and

(B) public health plans and formal policies through regulations adopted under AS 44.62 or collaborative recommendations that guide or support individual and community public health efforts;

(6) establish formal or informal relationships with public or private sector partners within the public health system;

(7) identify, assess, prevent, and ameliorate conditions of public health importance through surveillance; epidemiological tracking, program evaluation, and monitoring; testing and screening programs; treatment; administrative inspections; or other techniques;

(8) promote the availability and accessibility of quality health care services through health care facilities or providers;

(9) promote availability of and access to preventive and primary health care when not otherwise available through the private sector, including acute and

episodic care, prenatal and postpartum care, child health, family planning, school health, chronic disease prevention, child and adult immunization, testing and screening services, dental health, nutrition, and health education and promotion services;

(10) systematically and regularly review the public health system and recommend modifications in its structure or other features to improve public health outcomes; and

(11) collaborate with public and private sector partners, including municipalities, Alaska Native organizations, health care providers, and health insurers, within the public health system to achieve the mission of public health.

*** Sec. 3.** AS 18.07.031(a) is amended to read:

(a) Except as provided in **(c), (d), and (f)** [(c) AND (d)] of this section, a person may not make an expenditure of $1,000,000 or more for any of the following unless authorized under the terms of a certificate of need issued by the department:

(1) construction of a health care facility;

(2) alteration of the bed capacity of a health care facility; or

(3) addition of a category of health services provided by a health care facility.

*** Sec. 4.** AS 18.07.031(e) is amended to read:

(e) In [(a) OF] this section,

(1) "expenditure" includes the purchase of property occupied by or the equipment required for the health care facility and the net present value of a lease for space occupied by or the equipment required for the health care facility; "expenditure" does not include costs associated with routine maintenance and replacement of equipment at an existing health care facility;

(2) "critical access hospital" means a facility designated as a critical access hospital by the department by regulatory authority exercised under AS 18.05 or AS 18.20.

*** Sec. 5.** AS 18.07.031 is amended by adding a new subsection to read:

(f) Notwithstanding the limitations in (a) of this section, a person may make an expenditure of $1,000,000 or more for diagnostic imaging equipment without authorization under the terms of a certificate of need issued by the department if the

equipment is used in a health care facility that

(1) is located in a

(A) borough with a population of 60,000 or more; and

(B) a city that does not have a facility designated by the department as a critical access hospital; and

(2) has at least a 50 percent ownership by one or more physicians licensed in the state who are qualified to interpret, and actually interpret, diagnostic images produced by the equipment in the facility.

* **Sec. 6.** AS 18 is amended by adding a new chapter to read:

Chapter 09. Statewide Health Care Planning and Information.

Article 1. Alaska Health Care Commission; State Health Plan.

Sec. 18.09.010. Alaska Health Care Commission. The Alaska Health Care Commission is established in the Department of Health and Social Services. The purposes of the commission are

(1) to provide recommendations for and foster the development of a statewide plan to address the quality, accessibility, and availability of health care for all citizens of the state;

(2) to review and approve the department's plan for a reporting data system, including the type of reporting entity or person, and the timing of reporting; and

(3) to review and approve facility health care information for placement on the department's Internet database established under AS 18.09.110.

Sec. 18.09.020. Composition; chair. (a) The commission consists of 15 members, as follows:

(1) the state officer assigned the duties of medical director for the department;

(2) one member representing the governor and appointed by the governor;

(3) one member who is a member of the Alaska Commission on Aging;

(4) three public members, in addition to members appointed under (5),

(8), and (9) of this subsection, appointed by the governor; one of the members appointed under this paragraph must be a small business owner in the state;

(5) three public members who are health care providers, appointed by the governor, as follows: one representing hospitals, one representing physicians, and one representing mental health;

(6) two members from the house of representatives appointed by the speaker of the house of representatives;

(7) two members from the senate appointed by the president of the senate;

(8) one public member representing the Alaska tribal health care system appointed by the governor; and

(9) one public member representing health care insurers appointed by the governor.

(b) The medical director appointed under (a)(1) of this section shall serve as chair of the commission.

Sec. 18.09.030. Term of office. (a) Public members of the commission appointed under AS 18.09.020(a)(4), (5), (8), and (9) serve for staggered terms of five years.

(b) If a vacancy occurs in a public member's seat on the commission, the governor shall make an appointment for the unexpired portion of that member's term.

(c) The governor may remove a public member of the commission from office only for cause.

Sec. 18.09.040. Executive director. The commission shall employ an executive director with appropriate health care policy experience who may not be a member of the commission. The executive director serves at the pleasure of the commission. The commission shall establish the duties of the executive director. The executive director is in the partially exempt service under AS 39.25 (State Personnel Act).

Sec. 18.09.050. Staff. The department may assign employees of the department to serve as staff to the commission. The commission shall prescribe the duties of the commission staff.

Sec. 18.09.060. Bylaws. The commission, on approval of a majority of its membership and consistent with state law, shall adopt and amend bylaws governing proceedings and other activities, including provisions concerning a quorum to transact commission business and other aspects of procedure; frequency and location of meetings; and establishment, functions, and membership of committees.

Sec. 18.09.070. Duties of the commission. (a) The commission shall serve as the state health planning and coordinating body. Consistent with state and federal law, the commission shall provide recommendations for and foster the development of a statewide health plan containing the following:

(1) a comprehensive statewide health care policy;

(2) a strategy for

(A) encouraging personal responsibility in prevention and healthy living for all residents of the state;

(B) reducing the rate of growth in health care costs for all residents of the state;

(C) improving access in communities to safe water and wastewater systems;

(D) developing a sustainable health care workforce in the state;

(E) improving access to quality health care for all residents of the state and increasing the number of residents of the state who are covered by insurance for health care services.

(b) The commission shall review and approve health care information for placement on the department's database developed under AS 18.09.110 and establish a schedule for implementation of the database and reporting requirements under AS 18.09.120.

(c) The commission shall submit to the governor and the legislature by January 15 of each year an annual report regarding the commission's recommendations and activities.

Sec. 18.09.080. Compensation, per diem, and expenses. A public member appointed to the commission under AS 18.09.020(a)(4), (5), (8), or (9) is not entitled to a salary, but is entitled to per diem, reimbursement for travel, and other expenses

authorized by law for boards and commissions under AS 39.20.180.

Article 2. Alaska Health Care Information Office.

Sec. 18.09.100. Office. The Alaska health care information office is established in the department. The purpose of the office is to improve access by residents of the state to consistently updated

(1) information about health care services, price, and quality to aid consumers in making health care decisions; and

(2) information to encourage personal responsibility in prevention and healthy living.

Sec. 18.09.110. Dissemination of information. (a) The department shall establish and maintain an information database on the Internet of information about health care facilities in the state to provide objective, unbiased, and factually based information on health care services in the state. The department may require those health care facilities to provide information in a standard form or format to the department for placement in the database. Before information is placed on the database, the department shall review the information with the health care facility for accuracy.

(b) The database developed under (a) of this section must include the following:

(1) a list of preferred drugs approved by the department for reimbursement by the department;

(2) a complete list, organized by region and address, of

(A) health care facilities located in the state;

(B) licensed pharmacists and pharmacies located in the state;

(C) emergency and urgent care facilities located in the state;

(D) health insurance companies offering coverage in the state;

(E) health care providers licensed in the state, including the provider license number, type, and expiration date along with disciplinary actions, if any;

(F) long-term, in-home, and hospice care providers located in the state;

(G) public assistance offices of the department;

(3) a list of the 100 most commonly prescribed medications in the state and the source and price, updated monthly, of the medications;

(4) a list of the 100 most commonly conducted medical procedures in the state, organized by the cash and negotiated price of the procedure at available providers and insurers, updated annually; the list must include medical procedures covered by workers' compensation under AS 23.30;

(5) available hospital ratings, including the rates of hospital acquired infections and mortality occurring at each hospital located in the state;

(6) consumer education information on topics that include body mass index, diet and nutrition, exercise, smoking cessation, and alcohol and drug addictions, that includes the location of available sites that provide care and treatment related to those issues;

(7) a list of procedures approved by state agencies for emergency response and treatment;

(8) disease management support information;

(9) insurance information that includes

(A) a navigator to determine insurance eligibility using a matrix of available insurers;

(B) links to Internet websites for purchasing insurance policies;

(C) an explanation of mandatory and optional insurance coverage;

(10) a list of primary care clinics that cater to uninsured and self-pay patients;

(11) a list of physicians who accept patients with Medicare coverage; and

(12) information on the quality of health care facilities, including any actions taken by state or federal agencies related to

(A) licensure and accreditation of a health care facility; or

(B) a licensed professional practicing in a health care facility.

(c) The department may contract with a private entity to provide services and

information required under (a) of this section.

(d) The department shall develop and consistently update an Internet website to provide residents of the state timely and accurate information regarding prevention and healthy living.

(e) The department shall post and make available information related to the commission, including the commission's annual reports under AS 18.09.070(c).

Sec. 18.09.120. Mandatory reporting. (a) Beginning July 1, 2009, a health care facility shall provide to the department, based on a schedule set by the department, the following information related to the facility's health care services for placement in the database developed under AS 18.09.110:

(1) information on costs to and bills payable by the consumer for health care services that include both facility and physician components of care;

(2) types and amounts of insurance and other payments accepted by the health care facility for health care services, including cash and negotiated prices;

(3) each location where the health care facility operates, and the hours of operation;

(4) the types and scope of health care services offered at the health care facility;

(5) the Internet address of any Internet website of the health care facility the purpose of which is to provide factual information to aid the consumer;

(6) any other readily accessible information that the department determines would help the consumer to make informed decisions about the health care facility's services.

(b) The department shall develop a standard form or format for reporting the information required in (a) of this section. The department shall adopt regulations specifying the timing and frequency of the reporting of the information required by (a) of this section.

(c) The department shall notify the health care facility of a failure to report under (a) of this section and give the health care facility an opportunity to contest or cure the failure. If the health care facility does not promptly cure the failure, the department shall post the notice of failure on the database developed under

AS 18.09.110.

Sec. 18.09.130. Coordination of departments. The Department of Administration, the Department of Commerce, Community, and Economic Development, the Department of Labor and Workforce Development, and the Department of Law shall

(1) provide to the department for placement on the database developed under AS 18.09.110 information regarding an adverse action taken against a health care facility in the state or against a licensed professional practicing in a health care facility in the state; and

(2) cooperate with the commission in the performance of its duties.

Article 3. General Provisions.

Sec. 18.09.900. Regulations. The department may adopt regulations under AS 44.62 (Administrative Procedure Act) to carry out the purposes of this chapter.

Sec. 18.09.990. Definitions. In this chapter,

(1) "commission" means the Alaska Health Care Commission established in AS 18.09.010;

(2) "costs to the consumer" means actual price paid by the consumer for health care services;

(3) "department" means the Department of Health and Social Services;

(4) "health care facility" means

(A) a facility licensed under AS 47.32;

(B) an independent diagnostic testing facility providing services in the state;

(C) a provider of a home and community based waiver service that is certified under regulations adopted by the department;

(D) a provider of personal care services that is certified under regulations adopted by the department;

(E) a licensed pharmacy; and

(F) a physician's office.

* **Sec. 7.** AS 39.25.120(c)(7) is amended to read:

(7) the principal executive officer of the following boards, councils, or

commissions:

(A) Alaska Public Broadcasting Commission;

(B) Professional Teaching Practices Commission;

(C) Parole Board;

(D) Board of Nursing;

(E) Real Estate Commission;

(F) Alaska Royalty Oil and Gas Development Advisory Board;

(G) Alaska State Council on the Arts;

(H) Alaska Police Standards Council;

(I) Alaska Commission on Aging;

(J) Alaska Mental Health Board;

(K) State Medical Board;

(L) Governor's Council on Disabilities and Special Education;

(M) Advisory Board on Alcoholism and Drug Abuse;

(N) Statewide Suicide Prevention Council;

(O) the State Board of Registration for Architect, Engineers, and Land Surveyors;

(P) Alaska Health Care Commission:

*** Sec. 8.** AS 18.09.010, 18.09.020, 18.09.030, 18.09.040, 18.09.050, 18.09.060, 18.09.070, 18.09.080, 18.09.110(e), 18.09.130(2), 18.09.990(1); and AS 39.25.120(c)(7)(P) are repealed July 1, 2013.

*** Sec. 9.** The uncodified law of the State of Alaska is amended by adding a new section to read:

APPLICABILITY. Sections 3 - 5 of this Act apply to health care facilities in existence or proposed on or after the effective date of secs. 3 - 5 of this Act. A decision of the Department of Health and Social Services made before the effective date of secs. 3 - 5 this Act denying or granting a certificate of need that was applied for or issued for a health care facility described in AS 18.07.031(f), added by sec. 5 of this Act, shall be void and unnecessary. A pending application for a certificate of need for a health care facility described in AS 18.07.031(f), added by sec. 5 of this Act, shall be returned to the applicant.

*** Sec. 10.** The uncodified law of the State of Alaska is amended by adding a new section to

read:

TRANSITION: REGULATIONS. The Department of Health and Social Services may proceed to adopt regulations necessary to implement the changes made by this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not before the effective date of the statutory change.

*** Sec. 11.** The uncodified law of the State of Alaska is amended by adding a new section to read:

CERTIFICATE OF NEED STUDY. The Department of Health and Social Services shall contract with an entity that has no financial interest in health care services to conduct a comprehensive study of the effects of the certificate of need program in the state. The department shall provide a copy of the study to the legislature.

*** Sec. 12.** Section 2 of this Act takes effect July 1, 2013.

*** Sec. 13.** Sections 3 - 5, 9, 10, and 11 of this Act take effect immediately under AS 01.10.070(c).

*** Sec. 14.** Except as provided in secs. 12 and 13 of this Act, this Act takes effect July 1, 2008.

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/19/08

FURTHER: Finance

Date of 5-Day Notice: 1/17/08
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 3/31/08

Health, Education and Social Services Committee considered

SENATE BILL NO. 245

SB 245 HEALTH CARE: PLAN/COMMISSION/FACILITIES

"An Act establishing the Alaska Health Care Commission and the Alaska health care information office; relating to health care planning and information; repealing the certificate of need program for certain health care facilities and relating to the repeal; annulling certain regulations required for implementation of the certificate of need program for certain health care facilities; and providing for an effective date."

and recommends:

[✓] be **replaced** with [ ] **SCS** or [✓] **CS** SB 245 (HES)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

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

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

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#
DHSS/2077	3/28/08		✓		
DHSS/2786	3/28/08		✓		
DHSS/317	3/28/08	✓			

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#
HSS (2894)	1/17/08	✓			2
HSS (2900)	1/18	✓			1

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS	PRINTED LAST NAME	DO PASS	DO NOT PASS	DO REC	AMEND
	Elton			✓	
	Thomas	✓			
	Dyson			✓	
	Coghill		✓		
CHAIR: Betty Davis	DAVIS	✓			

SB

267

Alaska State Legislature

Interim (Mar - Dec)
716 W 4th Ave
Anchorage, AK 99501
Phone (907) 269-0144
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Senator_Bettye_Davis@legis.state.ak.us
http://www.aksenate.org

Senator Bettye Davis

Sponsor Statement

SB 267 mandates that health care professionals record an infant's pre-natal exposure to alcohol, if consent is given by the mother, in the infant's medical file. This information is desired to assist with early FASD diagnosis's when applicable. The benefits of early detection of FASD are immeasurable in comparison to late detection, misdiagnosis, or possible failure to diagnose. Early diagnosis and intervention has shown to reduce the risk of developing "secondary disabilities" such as difficulty in school, trouble maintaining employment, mental health problems, drug an/or alcohol addiction, etc.

Due to the ambiguous nature of many of the symptoms of FASD, misdiagnoses are common. In the cases of misdiagnosis, the benefits of early intervention are rendered ineffectual. A documentation of pre-natal alcohol exposure in the child's medical file will assist medical professionals in making more accurate diagnoses.

This bill limits use of information pertaining to prenatal alcohol use by the mother to purposes of diagnosis, treatment, or care. This legislation comports with the FAS Surveillance Project recommendations found in *Fetal Alcohol Syndrome Prevalence in Alaska:* "Health care providers should be encouraged to document the details of maternal alcohol use during pregnancy in the child's medical chart."

FISCAL NOTE

STATE OF ALASKA
2008 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB 267
() Publish Date:

ID(File name) SB267-DHSS-BHA-02-22-08
Dept. Affected: Health & Social Services
Title DOCUMENT PRENATAL ALCOHOL EXPOSURE
RDU Behavioral Health
Component Behavioral Health Administration

Sponsor DAVIS
Requester SENATE HES
Component No. 2665

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2009**	**FY 2009**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (0)							

FUND SOURCE (Thousands of Dollars)

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

Estimate of any current year (FY2008) cost: _____

POSITIONS

Full-time							
Part-time							
Temporary							

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

The intent of this legislation is to improve and enhance the ability of service providers to identify, screen, assess and diagnose individuals impacted by prenatal exposure to alcohol. This will be accomplished by requiring certain persons licensed by the State Medical boards to document an infant's prenatal exposure to alcohol in the infant's medical file. This has no fiscal impact on the Div'sion of Behavioral Health.

Prepared by Melissa Stone, Director
Phone 269-3410
Division Behavioral Health
Date/Time 02/21/2008
Approved by Karleen Jackson, Commissioner
Date 02/22/2008
Agency Department of Health and Social Services

Don Burrell

From: Rutherdale, Jan A (LAW) [jan.rutherdale@alaska.gov]
Sent: Sunday, February 24, 2008 4:01 PM
To: Thomas Obermeyer
Cc: Laughlin, Wilda J (HSS); Sen. Bettye Davis
Subject: DOL comments to SB 267

Tom,
As noted in my earlier email to you, I understand from Mike Ford that you would like an outline of what concerns the Department of Law has with SB 267. Below is a recap of what the bill is trying to accomplish and our position that it does not accomplish that result; in practice, it may accomplish the opposite. In addition, since this issue has already been addressed in a 2006 addition to the reporting statutes, we don't believe that there is a need for this bill.

1. Problem sought to be addressed:

SB 267 requires that a health care professional record an infant's pre-natal exposure to alcohol, if the mother so consents, in the infant's medical file. According to the sponsor statement, "This information is desired to assist with early FASD diagnosis's when applicable . . . A documentation of pre-natal alcohol exposure in the child's medical file will assist medical professionals in making more accurate diagnoses. . . . This legislation comports with the FAS Surveillance Project recommendations found in Fetal Alcohol Syndrome Prevalence in Alaska: "Health care providers should be encouraged to document the details of maternal alcohol use during pregnancy in the child's medical chart."

There is no question that documentation is important in diagnosing FASD. In my experience, the FASD evaluators will not even begin an assessment of a child or adult suspected to have FASD unless there is some sort of documentation that the mother of the person to be evaluated drank during pregnancy. For example, if someone saw the mother drinking during pregnancy or if the mother admits to drinking during pregnancy, the evaluators would want this fact documented, such as in a letter or records of some kind, including medical, police or OCS records.

Usually, FASD symptoms don't appear until the child is in school or older. The biggest problems of documentation arise when the child is an adult and 20-30 years have passed since the pregnancy. This bill tries to ensure that a health professional documents drinking behavior when the child is still an infant.

2. This bill does not solve the need for increased documentation because it allows the mother to prevent such documentation:

Instead of providing more documentation, this bill may have the unintended effect of making it more likely that the documentation of pre-natal exposure to alcohol exposure will not be made. If, as the sponsor statement states, it is important that the documentation is made in the first place, asking the mother and giving her veto power over this documentation creates a possibility that the documentation will not be made. The file is the infant's and this would prevent the doctor to do what is best for the infant. In other words, if making the documentation is good medical practice, the documentation should be made regardless of the mother's wishes.

3. AS 47.17.024 already addresses this issue:

AS 47.17.024, enacted in 2006, requires a "practitioner of the healing arts" (which includes a doctor) involved in the delivery or care of an infant to make a report to OCS if the practitioner determines that the infant has been exposed to alcohol. If the doctor makes a report of harm the doctor

will undoubtedly note this fact in the infant's file. Therefore, there is no need for this bill, since the documentation is already being made. In addition, given the reporting statute, OCS is going to have this prenatal exposure documented in their files, which will be helpful in later making an FASD diagnosis (at least when OCS is involved, which is often the case).

4. This bill may create confusion for doctors who are trying to follow AS 47.17.024.

If the mother objects to any documentation about prenatal exposure in the infant's file, the doctor is still obligated to make a report of harm under AS 47.17.024. but if the mother refuses to allow documentation, the doctor may be under the false impression that he/she does not have to comply with AS 47.17.024. Alternatively, the lack of documentation due to mother's refusal may make it more likely that the doctor will forget to make a report to OCS, or it will require the doctor to create a filing system apart from the infant's file so that the doctor can honor the mother's request but still keep a record that he made the report of harm pursuant to AS 47.17.024.

5. This bill is a departure from normal licensing requirements.

Normally, the state does not legislate best practices for a doctor. If it is good practice for doctors to document exposure to alcohol, the doctors will probably already be doing this. If more education is needed for doctors, there are better ways to satisfy this need than by legislation.

Thank you for providing this opportunity to share my concerns about this bill. Please feel free to call or email me if you have any questions are wish to discuss this matter further.

Jan Rutherdale
Deputy Section Chief
Child Protection Section
Attorney General's Office
(907)465-3608
Fax: (907)465-3019

Secondary Disabilities

Other problems, or secondary disabilities, arise when needs go unmet for children with alcohol-related birth defects.

In a 1996 study of 415 FAS/FAE patients ranging in age from 6 to 51 years, Dr. Ann Streissguth of the University of Washington identified a number of secondary disabilities that a person is not necessarily born with. These include:

- 90% had mental health problems
- 80% of those over 21 were dependent on others for daily needs
- 80% (21 and older) had employment problems
- 60% (12 and older) were expelled or dropped out of school
- 60% (12 and older) had trouble with the law
- 50% (12 and older) inappropriate sexual behavior
- 50% (12 and older) were incarcerated or confined for mental health reasons
- 30% (12 and older) had alcohol or drug problems

This study also identified several universal "protective factors" that - if addressed early on and consistently - helped minimize the secondary disabilities.

- Living in a stable nurturing home for over 72% of life
- Being diagnosed before the age of six years
- Never having experienced violence against oneself
- Staying in each living situation for an average of more than 2.8 years
- Experiencing a good quality home from age six to twelve years
- Having applied for and been found eligible for Developmental Disability Services
- Having a diagnosis of FAS rather than FAE
- Having basic needs met for at least 13% of life

Family Health Dataline

IN THIS ISSUE:

- Approximately 126 infants born each year in Alaska are identified as having been affected by maternal alcohol use during pregnancy.
- During 1995 through 1998, an average of 14 Alaskan infants per year were born with Fetal Alcohol Syndrome (1.4 per 1000 live births).
- FAS surveillance resulted in higher FAS prevalence findings than previously reported for Alaska Natives - 4.8 per 1000 live births for children born in 1995 through 1998.
- Women 30 years of age or older are significantly more likely to have an FAS child than younger women.

Fetal Alcohol Syndrome Prevalence in Alaska: New Findings From The FAS Surveillance Project

Background

Fetal Alcohol Syndrome (FAS) was first identified as a clinical condition in 1973. FAS has drawn considerable attention in Alaska. During the 1980's, the Alaska Area Native Health Service of the Indian Health Service began FAS surveillance among beneficiaries. In 1990, the Alaska Area Native Health Service joined the Alaska Department of Health and Social Services and the Centers for Disease Control and Prevention in establishing the Alaska FAS Prevention Project. The Alaska FAS Prevention Project developed methods for FAS case identification from multiple data sources, documented issues associated with improved FAS surveillance and published the first population-based FAS prevalence for the state[1].

The Section of Maternal, Child and Family Health established the Alaska Fetal Alcohol Syndrome Surveillance Project in 1998. The Surveillance Project is part of a collaborative effort with the Centers for Disease Control and Prevention (CDC) and four other states (NY, WI, CO, AZ). These five states make up the National FAS Surveillance Network (FASSNet). FASSNet has developed a standardized surveillance case definition for FAS surveillance[2]. Participating states (with the exception of Wisconsin) use the same case definition and the same case abstraction methods; however, each of the five states uses varying methodologies for identifying potential FAS cases. FASSNet will soon publish surveillance findings for birth years 1995-97 in the CDC's Morbidity and Mortality Weekly Report. This issue of the Dataline summarizes FAS prevalence in Alaska for birth years 1995 through 1998.

Methods

FAS surveillance in Alaska is based on reports to the Alaska Birth Defects Registry. The Alaska Birth Defects Registry is population-based and uses a multiple source methodology for recording all reportable birth defects. The FAS Surveillance Project and the Alaska Birth Defects Registry are housed in the Division of Public Health's Section of Maternal Child and Family Health, MCH Epidemiology Unit.

Children reported to the Alaska Birth Defects Registry with the International Classification of Diseases, 9th revision (ICD-9) code 760.71 (infant affected by prenatal alcohc exposure) or 742.1 (child with microcephaly) are considered to be potential cases of FAS. Trained medical record abstractors review the medical records of each potential case. Extensive medical and risk factor information abstracted from medical records for each reported child is entered into standardized abstraction software developed by the CDC FASSNet group.

FAS surveillance case definitions were developed by FASSNet, in consultation with a committee of dysmorphologists, pediatricians, psychologists, epidemiologists, and public health officials. The FASSNet database uses an algorithm for determining FAS case status based on abstracted information. The case categories established by FASSNet are:

- Confirmed FAS phenotype with or without confirmed maternal alcohol exposure
- Probable FAS phenotype with or without confirmed maternal alcohol exposure; and
- Suspect FAS (reported children who do not meet the criteria for a confirmed or probable case).

To meet the criteria for confirmed FAS phenotype, a child must have medical record documentation of the following: facial features associated with FAS (small palpebral fissures, thin upper lip and smooth/abnormal philtrum); central nervous system impairment, either structural or functional (head circumference less than or equal to the 10th percentile at birth, low intellectual functioning, developmental delay, mental retardation, or attention deficit disorder); and height, weight or weight for height below the 10th percentile for age. Probable FAS phenotype differs from the confirmed FAS phenotype in that a child may have either central nervous system impairment, or height and weight below the 10th percentile in addition to the facial features associated with FAS.

In this report all children who were reported to the Alaska Birth Defects Registry with ICD-9 codes 760.71 or 742.1, and for whom a medical chart review was conducted, are described as "at risk of FAS." An "FAS case" is defined as a child who was classified as confirmed or probable according to the definitions above.

Records of children identified as being at risk for FAS were linked to birth certificates to eliminate duplicate cases and to obtain additional epidemiological information. Birth certificate data were used to compute rate ratios (rr) for potential maternal risk factors and to compare the prevalence of adverse birth outcomes among FAS cases with other Alaskan children born during the study period (1995 through 1998).

Results

As of July 1, 2001, 543 Alaska children, born in 1995-98, were reported to the Alaska Birth Defects Registry as potential FAS cases. Of the 543 children, 505 (93%), had at least one medical chart abstraction. Among these 505 children, 55 met the FAS surveillance case definition for either a confirmed or probable case.

Table 1. FAS Surveillance Case Finding Results, by Birth Year, Alaska, 1995-98.

Birth Year	Children At Risk of FAS	Confirmed FAS Cases	Probable FAS Cases	Total FAS Cases	Percent of At Risk Children with FAS
1995	67	9	6	15	22.4
1996	126	14	4	18	14.3
1997	138	9	4	13	9.4
1998	174	6	3	9	5.3
Total	505	38	17	55	10.9

Table 2. FAS Prevalence by Mother's Race, Alaska, 1995-98.

Mother's Race	Children At Risk of FAS			Children with FAS		
	n	Rate per 1000 Live Births	95% Confidence Interval	n	Rate per 1000 Live Births	95% Confidence Interval
White	74	2.7	(2.1, 3.4)	5	0.2	(0.0, 0.3)
Alaska Native	390	40.9	(36.9, 45.0)	46	4.8	(3.4, 6.2)
African American	5	2.9	(0.4, 5.4)	0	-	-
Asian/Pacific Islander	9	4.6	(1.6, 7.5)	0	-	-
Unknown	27	-	-	4	-	-
Total	505	12.6	(11.5, 13.6)	55	1.4	(1.0, 1.7)

The proportion of children reported "at risk of FAS" who met the case definition decreased for each subsequent birth year (Table 1). The overall FAS prevalence for Alaska, for children born in 1995-98, was 1.4 per thousand live births (95% C.I.: 1.0 – 1.7).

All races were represented among children who were reported "at risk of FAS", but only whites and Alaska Natives met the FAS surveillance case definition. Children born to Alaska Native women were significantly more likely to be reported to the Alaska Birth Defects Registry as having an alcohol related birth defect than children of other races. Among the 55 children with confirmed or probable FAS, 84% were Alaska Natives and 9.1% were white (Table 2).

Maternal characteristics (as indicated on the birth certificate) that were associated with having a child with FAS were: alcohol use during pregnancy, cigarette smoking during pregnancy, Alaska Native race, maternal age of 30 or more years, and 12 or fewer years of education. Maternal residence in Anchorage or Fairbanks, the two census areas in Alaska with the largest populations, was not associated with FAS (Table 3).

Twenty-two percent of children with FAS were born at less than 33 weeks gestation and 25% were born between 33 and 37 weeks of gestation. Fifty percent of children with FAS were born with low birth weight. The prevalence of low birth weight and prematurity were significantly higher among children with FAS than other infants born over the study period (relative prevalence = 8.9 (95% CI: 6.7,11.9) and 4.8 (95% CI: 3.6, 6.4) respectively). FAS was not associated with sex of the child.

Discussion

The statewide FAS rate presented in this report (1.4 per 1000 children born in 1995-98) is higher than that found previously by the Alaska FAS Prevention Project (0.8 per 1000 children born in 1977-92)[1]. Differences in the case finding methodology used by the two projects may have contributed to the higher rate found by the Alaska FAS Surveillance Project. Routine public health surveillance provides a system for identification of all potential cases based on standardized surveillance protocols. Ongoing surveillance also provides for systematic updates to the FAS prevalence for any given birth cohort. Children may not be diagnosed with FAS or reported "at risk of FAS" until they are as old as six years; additionally, future medical chart abstractions on children previously reported to the registry may change case status findings. Because of this, the Alaska FAS Surveillance Project may report higher FAS prevalence in the future as the birth cohort ages.

Our surveillance findings substantiate previous reports that Alaska Natives have a vastly higher reported prevalence of FAS than other races[3,4,5]. Increased awareness of maternal alcohol use and excellent documentation by Alaska Native health organizations may result in more vigilant reporting of potential cases of FAS. Diagnostic bias may also play a role in explaining the high FAS rate for Alaska Natives: growth curves for Yup'ik Eskimos, one of the largest Alaska Native groups, indicate that this group tends to have shorter stature than the standard US population (State of Alaska, unpublished data). Furthermore, some Yup'ik Eskimo facial features resemble those characteristic of FAS, such as small palpebral fissure.

Another finding of this study that is substantiated by previous reports is the association of older maternal age with FAS. This

study demonstrates that while the association holds true for FAS cases, there is no significant association with maternal age among children who are reported to the Alaska Birth Defects Registry as "at risk" for FAS. These findings suggest that maternal age may be a co-factor in the risk of developing symptoms consistent with FAS. Further study of the interaction between risk factors, such as age, race and maternal alcohol use during pregnancy is needed. Continued collection and analysis of FAS surveillance data over time will increase the power of risk factor analysis.

This analysis showed that children whose birth certificate's recorded maternal alcohol use during pregnancy were 51 times more likely to have FAS. The birth certificates of 15 of the children who met the case definition for FAS did not record maternal alcohol use. Retrospective assessment of maternal alcohol use is difficult; birth certificate information may be unsubstantiated and often, the medical charts of children reported to be at risk of FAS do not contain adequate information on maternal drinking. Interestingly, data from a population based survey of women who have recently had a live birth in Alaska show 3.7% of Alaska Native women reported drinking during the last three months of pregnancy compared to 4.6% of white women.[6]

Because the FAS rates reported here are derived from surveillance data, they are affected by the degree to which health care providers comply with birth defects reporting requirements. It is important to recognize that the

Table 3. FAS Risk Ratios (rr) for Selected Maternal Characteristics, from Linked Birth Certificate Information, Alaska, 1995-98.

Potential Risk Factor	Children with FAS		
	n	Rate per 1,000 Live Births	rr (95% CI)
Maternal Race			
Alaska Native	46	4.8	29.6 (11.76, 74.42)*
Non-Native	5	0.2	ref.
Maternal Age			
>= 30 years	37	2.6	4.9 (2.68, 9.15)*
< 30 years	14	0.5	ref.
Maternal Residence			
Anchorage or Fairbanks	27	1.6	1.5 (0.89, 2.66)
Other Regions	24	1.0	ref.
Maternal Education			
High School or less	38	1.7	5.0 (2.1, 11.7)*
More than High School	6	0.4	ref.
Smoked during Pregnancy			
Yes	39	5.0	16.2 (8.1, 32.5)*
No	10	0.3	ref.
Alcohol Use During Pregnancy			
Yes	32	19.9	50.6 (27.5, 93.2)*
No	15	0.4	ref.

*Statistically significant

ICD-9 code 760.71 is not specific to FAS. This code means only that an infant has been identified as having been prenatally affected by maternal alcohol exposure, and may or may not be identified at birth or in later years as a child with FAS. The relative interpretation of which cases to report under ICD-9 code 760.71 effects the sensitivity and specificity of FAS surveillance. Efforts to increase awareness and understanding of mandated birth defects reporting should be continued.

The proportion of FAS cases among children reported as "at risk of FAS" decreased for each successive birth year under study. Children reported at birth with maternal alcohol exposure may not initially meet the FASSNet case criteria, but may meet the definition later in life. Many tests and assessments for developmental delay may not be effective until after a child has reached the age of three or older. Since most children with FAS are diagnosed between ages 3 and 5, the prevalence of FAS for any given birth year may increase as the birth cohort ages. This illustrates the importance of abstracting medical data over time for children reported with prenatal alcohol exposure. An important feature of the Alaska FAS

Surveillance Project is our ability to continue medical chart abstraction for all children reported at risk of FAS up to the sixth birthday. Completion of medical chart abstractions for all reported children and follow-up abstractions on suspect cases is a central component of on-going FAS surveillance.

FAS prevalence in Alaska is higher than in other FASSNet regions.[7] In the first FASSNet report on FAS prevalence, estimates of FAS prevalence for birth years 1995-97 ranged from 0.26 per 1000 in the Denver-Boulder metropolitan area, to 1.5 per 1000 in Alaska. For Alaska Natives the FAS prevalence is 5.6 per 1000 live births for birth years 1995-97. We found a similar overall FAS prevalence in our analysis of children born in 1995-98 (1.4 per 1000) but a lower prevalence for Alaska Natives (4.8 per 1000). The higher race-specific finding in our FASSNet report for birth years 1995-97 illustrates how case ascertainment may be more complete for older birth cohorts.

Alaska's high FAS prevalence and the presence of ongoing surveillance provide the opportunity to implement and monitor intervention programs. The relatively small number of women who give birth to children with FAS may make targeted intervention programs the most cost-effective method of decreasing FAS prevalence. Future analysis of FAS surveillance data on maternal characteristics of mothers of children with FAS will help to focus these efforts.

Recommendations

- The Alaska Birth Defects Registry should continue provider education efforts to encourage consistent and timely compliance with birth defects reporting requirements.
- Health care providers should be encouraged to document the details of maternal alcohol use during pregnancy in the child's medical chart.
- The Fetal Alcohol Syndrome Surveillance Project should implement a plan for completion of medical chart abstractions for all reported children and for routine and follow-up abstractions on suspect cases.
- The Section of Maternal Child and Family Health should conduct further study of the interaction between FAS risk factors.
- The Section of Maternal Child and Family will monitor trends in FAS prevalence through periodic analysis of FAS surveillance data.
- The Section of Maternal Child and Family Health should work with the Office of FAS to develop mechanisms to make FAS surveillance findings widely available to prevention programs for use in planning and evaluation.

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