

ALASKA STATE LEGISLATURE
SENATE HEALTH, EDUCATION AND SOCIAL SERVICES STANDING COMMITTEE

March 22, 2004

1:31 p.m.

TAPE (S) 04-13

MEMBERS PRESENT

Senator Fred Dyson, Chair
Senator Lyda Green, Vice Chair
Senator Gary Wilken
Senator Bettye Davis
Senator Gretchen Guess

MEMBERS ABSENT

None

COMMITTEE CALENDAR

SENATE BILL NO. 373

"An Act relating to residency and internship permits issued by the State Medical Board; and providing for an effective date."

MOVED SB 373 OUT OF COMMITTEE

SENATE BILL NO. 364

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

HEARD AND HELD

PREVIOUS COMMITTEE ACTION

BILL: SB 373

SHORT TITLE: PHYSICIAN INTERNS AND RESIDENTS

SPONSOR(S): HEALTH, EDUCATION & SOCIAL SERVICES

03/19/04	(S)	READ THE FIRST TIME - REFERRALS
03/19/04	(S)	HES
03/22/04	(S)	HES AT 1:30 PM BUTROVICH 205

BILL: SB 364

SHORT TITLE: LIMIT STATE AID FOR MENTAL HEALTH CARE

SPONSOR(s): RULES BY REQUEST OF THE GOVERNOR

03/08/04	(S)	READ THE FIRST TIME - REFERRALS
03/08/04	(S)	HES, FIN
03/19/04	(S)	HES AT 1:30 PM BUTROVICH 205
03/19/04	(S)	-- Meeting Canceled --
03/22/04	(S)	HES AT 1:30 PM BUTROVICH 205

WITNESS REGISTER

Dr. HAROLD JOHNSTON
Director, Family Practice Residency
Providence Alaska Medical Center
POSITION STATEMENT: Provided information on SB 373.

MR. BILL HOGAN
Director, Division of Behavioral Health
Department of Health &
Social Services
PO Box 110601
Juneau, AK 99801-0601
POSITION STATEMENT: Presented SB 364.

MR. ROBERT HAMMAKER
Treatment and Recovery Section
Division of Behavioral Health
Department of Health & Social Services
PO Box 110601
Juneau, AK 99801-0601
POSITION STATEMENT: Answered questions pertaining to SB 364.

MS. STACIE KRALY
Senior Assistant Attorney General
Human Services Section, Civil Division (Juneau)
Department of Law (DOL)
PO Box 110300
Juneau, AK 99811-0300
POSITION STATEMENT: Provided information on SB 364.

ACTION NARRATIVE

TAPE 04-13, SIDE A

CHAIR FRED DYSON called the Senate Health, Education and Social Services Standing Committee meeting to order at 1:31 p.m. Present at the call to order were Senators Wilken, Guess, and

Chair Dyson. Senators Davis and Green arrived while the meeting was in progress.

SB 373-PHYSICIAN INTERNS AND RESIDENTS

The committee took up SB 373.

CHAIR DYSON presented the sponsor statement as follows:

Current Alaska statutes require that all residents participating in the WAMI/Family Practice Residency program receive a permit by the State Medical Board for a period not to exceed 18 months after the date of issue. Renewal permits to continue residency [or internship] are also issued by the board, for a period not to exceed 18 months after the date of renewal.

Given that the program is a three-year program, all residents are required to get the renewal. The renewal process has been fraught with problems. Residents have needed to interrupt their training on multiple occasions because the renewed permits were not issued efficiently. This legislation would extend the period from 18 to 36 months.

CHAIR DYSON indicated that Senators Davis and Green had joined the meeting.

DR. HAROLD JOHNSTON, a family physician, and director of Providence Alaska's family practice residency in Anchorage, testified via teleconference that this bill extends the initial permit length for resident physicians from 18 months to three years so that it corresponds with the length of the training program. Family physicians are required to have a total of three years of residency training in order to be board certified. Current law allows the permit for a maximum of 18 months. This requires that the residents renew their permits half way through the training program; this poses problems for the Division of Occupational Licensing. The processing of the licensing renewal requests has created difficulties on several occasions, which has almost caused residents to stop their training.

DR. JOHNSTON explained that when the 18-month requirement was originally established, physicians in Alaska only needed to have one year of training before being eligible for a full license. The 18-month term for resident permits allowed residents to

complete the first year of training and still have an additional six months to get paperwork processed for the regular license. Several years ago the state law changed, requiring physicians to have two years of residency before obtaining an unrestricted license, which means the 18-month permit is inadequate to get the resident through his/her initial licensing period. The ideal situation would be for permits to be issued for a three-year period from the start of training because in this scenario, there would be no requirement for a renewal.

CHAIR DYSON asked if there was anybody present from the administration or the [Division of Occupational Licensing] to speak to the bill. Hearing no response, he then asked, "Do you have any idea, Dr. Johnston, how we got into this remarkable fix?"

DR. JOHNSTON re-stated that it was because the law had changed. Originally the 18-month permit was fine because only one year of training was required before getting an unrestricted license. About two or three years ago, the Legislature changed the requirement, and now physicians need to have at least two years - and sometimes three years - of training before getting an unrestricted license. He said he has worked with the State Medical Board on this issue, and at the January meeting after some considerable debate, a resolution unanimously passed in support of changing this to 36 months.

SENATOR GARY WILKEN moved to report SB 373 out of committee with individual recommendations.

CHAIR DYSON asked if there was any objection. Seeing and hearing none, it was so ordered.

1:40 p.m.

SB 364-LIMIT STATE AID FOR MENTAL HEALTH CARE

MR. BILL HOGAN, Director of the Division of Behavioral Health, Department of Health and Social Services (DHSS) provided background to members that diagnosis, evaluation and treatment (DET) is an important component of Alaska's current mental health care system. A number of hospitals in the state, particularly in Fairbanks, Juneau, Ketchikan, Cordova, Homer, Valdez, Sitka, Bethel, and Kodiak provide beds for individuals who are experiencing a psychiatric emergency or who are in psychiatric crises. The two primary providers are Fairbanks Memorial Hospital (20 beds) and Bartlett Regional Hospital in

Juneau (12 beds). In many of the other communities listed, there are usually only one or two beds used for this purpose. The concept is that by stabilizing a person in his/her community hospital, he/she would not have to enter Alaska Psychiatric Institute (API) in Anchorage but could be served in his/her own community.

MR. HOGAN continued that historically the division - formerly known as Mental Health - has received bills from DET providers. The division has scrutinized situations to determine if admissions were appropriate and has monitored stays in various hospitals; however, under current statute, the division doesn't have the authority to actively manage those stays. SB 364 proposes that [the division] have the authority to proactively manage such stays in these various facilities. The bill stipulates that within 24 hours, hospitals will be required to notify the division of the rationale for an admission and to then work with the division (over time) to ensure that a patient's length of stay is appropriate. The bill also establishes the provision that DET services are not entitlements, and that payment for services can only be for up to the amount appropriated by the Legislature; the department is under no obligation to pay once those dollars have been exhausted. The department proposes to work collaboratively with DET providers and is not suggesting that the number of beds in communities be reduced.

MR. HOGAN referred to an outline in the committee packet and highlighted that in FY 00, approximately \$1,901,480 was spent on this service. Through FY 03, an increasing number of dollars was spent, with the amount in FY 03 at approximately \$3,384,430; the cost for services has grown substantially. There is less money available in the FY 04 budget, and even fewer dollars are proposed in the FY 05 budget. He said one stipulation is that a portion of this service is funded through DSH (disproportionate share hospital) payments, which are payments that hospitals receive to offset the cost of providing services to indigent individuals. He said that at Senator Davis's request, he has included the number of individuals served in each facility from FY 00 through FY 03; the summary also includes the average length of stay and the cost of providing those services.

CHAIR DYSON asked if the savings to the state was \$100,000.

MR. HOGAN confirmed that savings would be approximately \$100,000 minimum, once the bill is initiated.

CHAIR DYSON asked why the costs went up and then down approximately \$1,000,000 in FY 04 and then another \$435,000 in FY 05.

MR. HOGAN explained that the amount went up because of the division's inability to effectively manage the program. The number of people served in FY 03 is lower than the previous fiscal year's, "So I cannot say to you or say to committee members that the cost has gone up because we're serving more people, because that is not the case."

CHAIR DYSON questioned if it was possible that even though there wasn't an increase in the number of people being served, that more intense needs and more comprehensive treatment drove those costs up.

MR. HOGAN confirmed that an increase in the length of stay could be one rationale.

CHAIR DYSON referred to Mr. Hogan's previous comment - "the department didn't manage" - and asked if the inference was that individuals were receiving inappropriate treatment, or receiving more treatment than was appropriate.

MR. HOGAN responded this may be inferred, however, "until we have the capacity or the capability to effectively manage, I am just not sure at this point."

SENATOR GRETCHEN GUESS asked who, under this proposal, would manage the stays. She questioned who would be making the decisions at the end of the day whether or not a person should be discharged.

MR. HOGAN replied this needs to be developed and that specifics on how to manage would be in regulation. It is the division's intent to use Dr. Hopson, API's Medical Director, who is a psychiatrist and who directed the Fairbanks unit before working for the division at API. He said if there is contention concerning a patient's admission or discharge, that discussion needs to take place between two physicians; therefore regulation would include a process to include Dr. Hobson in the discussion.

SENATOR GUESS asked, "Who trumps? The medical director at API or the physician on the ground?"

MR. HOGAN replied that this was not included in the bill's intent, and it is certainly something the division would

consider. He said that ultimately the state trumps since the state is paying for the service.

SENATOR GUESS asked what happens to the institution and to the patient if the state does not get notified within 24 hours; how would such 24-hour notification be managed.

MR. HOGAN responded this would be more clearly defined in regulation. He said this would involve a lot of work and he was not suggesting that division staff manage this; First Health Services Corporation currently does this for children in residential psychiatric facilities and may possibly be used.

SENATOR GUESS said there was no mention in the fiscal note of contract labor with First Health. She gave the hypothetical example of admitting someone at the Fairbanks facility, and inadvertently not reporting this within the 24-hour period. She asked if the provider would then not get paid because connection with the state was not made within 24 hours.

MR. HOGAN said the division would be flexible and would understand extenuating circumstances, as the desire would be to continue collaborating with providers and not to set up adversarial relationships. "We clearly need a mechanism to be able to more closely monitor these stays."

SENATOR GUESS said, "You said in here that you wanted to make sure it's not an entitlement, and you moved a 'shall' to a 'may'." She asked what happens to a patient in a situation in which there is no more money in the budget and the decision is made to not pay anymore; can the hospital not take the person because the state has run out of money or does the hospital still have to take that patient. She asked how this works, and if costs are then born by others who use that hospital.

MR. HOGAN said it was his understanding that if someone appears in the emergency room, that hospital is obligated to ensure that the individual gets to the right kind of service, which in this case would be API. This would be unfortunate because, even though API provides excellent service, it defeats the intention of being close to home; API would be out of the individual's community. The other option might be attempting to stabilize the person outside of the hospital setting, and the hospital would work with community providers to devise alternatives.

SENATOR GUESS said if this were an in-hospital stay, the idea would be to get that person out of the hospital as soon as

possible and into one of the community service providers. She asked if the cost per patient at these facilities was higher or lower than at API.

MR. HOGAN said the cost was higher than at API.

CHAIR DYSON referred to the average number of days, and asked if this was for people who were involuntarily committed.

MR. HOGAN replied that this was not absolutely necessary.

CHAIR DYSON ascertained that people are evaluated, voluntarily or not, at one of these resources, and in looking at the number of days, there seems to be a fair amount of disparity between the different institutions. He suggested that someone testify on how professionals proceed with the evaluation, and in particular, address the length of time that is reasonable. He suggested that people with multiple diagnoses would require a longer period of time as would people with mental health problems who had been traumatized and/or who have chemical dependency issues needing to be stabilized.

SENATOR LYDA GREEN asked about DES/DET.

MR. HOGAN replied that DES (diagnoses, evaluation, and stabilization) usually refers to shorter term - three to seven days - while "treatment" is longer term.

SENATOR GREEN asked about a discussion in the Legislature several years ago regarding the DET process, and recalled that the purpose was to stop direct entry into API and keep people situated throughout the state.

MR. HOGAN confirmed that this was the intention.

SENATOR GREEN asked if this was in statute or in policy. She received a response [from an unidentified person in the audience] that this was in statute.

2:00 p.m.

SENATOR GREEN asked if "Fairbanks" and "Bartlett" were treatment facilities whereas the others were DES facilities; she received confirmation from Mr. Hogan that this was the case. She said if this detracts from the original purpose of handling things closer to home, and "by pro-rating and saying we don't have enough money to keep doing this at the going rate, therefore

we're cutting the rate or discontinuing it" then most people in crisis will go to API "which has another whole set of problems for us." She asked if there was a way to evaluate whether people were being enrolled correctly and getting into the correct services immediately, a way in which each facility would need to be responsible for this. She questioned whether any facility or population would be advantaged by this change or grandfathered-in, and asked, "Are certain people going to be at the top of the pecking order?"

MR. HOGAN responded that there is a movement towards standardized screening and assessment so that the same instrument would be used statewide to stipulate the level of care required for the person being assessed, but it's not currently in place. The division will actively work with providers to ensure that people actually need a certain level of service and the specified length of stay, but it ultimately comes down to one person's opinion against another's. The intent is to ensure that people are getting the required care, while at the same time containing the costs of service. The division intends to continue working with communities, such as Palmer, to develop at least a couple of [DET] beds. However, there would be serious reservations about the state paying for a large (16 - 20 bed) facility, as there isn't money to pay for the current level of DET services.

SENATOR GREEN asked where the dollars come from that are being used for this.

MR. HOGAN replied that it was general fund dollars with some DSH dollars.

SENATOR GREEN asked if DSH was a form of Medicaid.

MR. HOGAN said it was not Medicaid, but was federal dollars. He explained that DSH assists hospitals in providing services to indigent individuals - those without insurance or Medicaid - as those costs are born by the hospitals.

SENATOR GREEN asked if anyone who wasn't indigent was included in these figures.

MR. HOGAN replied that if someone has Medicaid or third-party insurance, obviously the service is paid for in that way. This is designed for individuals without Medicaid or any insurance, that is, there is no third-party payor.

SENATOR GREEN added, "and under 185 percent poverty." She asked if this was a new or current qualifier.

MR. HOGAN replied he didn't know, and deferred to Mr. Hammaker.

MR. ROBERT HAMMAKER, Manager of the Treatment and Recovery Section, Division of Behavioral Health, DH&SS, stated that the 185 percent poverty level is current and will continue.

CHAIR DYSON asked about the state's or a DET center's liability if there is a misdiagnosis.

MR. HOGAN said he wasn't sure and would be happy to research that question.

CHAIR DYSON continued with the hypothetical example of someone who is dangerous to self or others being misdiagnosed and then doing harm. He asked if the state would be in danger of being sued. In this situation the state, in efforts to responsibly reduce the length of stay, ends up in court with a person saying, 'because of the complexity of the problem, that was too short a time, and the state in its efforts to control cost, forced an inadequate evaluation period' and then this person goes out and murders somebody. He emphasized that his interest was in the patient receiving the best treatment appropriate for him/her, and expressed reluctance to switch this responsibility away from the primary caregiver, who ought to be a very qualified professional. He asked what other states have done, inquiring as to whether other states have entitlement language - as Alaska does - or if the language was more permissive, such as what is being proposed.

MR. HOGAN said he didn't know but could research this.

CHAIR DYSON referred to people living on the street who might be homeless, who have mental health problems or substance issues and who are dangerous to self or others, people going through an involuntary commitment process. He said this process has saved quite a few lives and in the long term, some costs. He asked what percentage of this population is in the system, versus people who are referred by DPS, family members, or mental health workers.

MR. HOGAN restated the question for clarification, asking if what was wanted was the number or percentage of individuals served through DET who may have been homeless and who are involuntarily committed.

CHAIR DYSON confirmed he was asking about people who "kind of come from that population; I'm sure I'm not doing a good job of defining it."

SENATOR GUESS then asked if a community could not handle a case, does it currently go to API anyway; she received nonverbal confirmation that this was correct. She continued by asking about the cost per bed day for DES, DET, API, and non-API.

MR. HOGAN said he could access that information.

SENATOR GUESS suggested that if discussion on treatment was going to be between the medical director of API and the hospital, to include it in the bill so that "we don't get into a situation where we have a bureaucrat at the state level telling a doctor in Valdez that they have to let someone go."

MR. HAMMAKER responded that a patient would be discharged to API or to an acceptable community program; he/she doesn't go from a local hospital to having no services.

SENATOR GUESS said that whether it's discharged to the community or remains in the facility, the conversation should be between two people who are knowledgeable rather than between a doctor and a deputy commissioner or a head of a division, that is, someone without the medical background.

SENATOR DAVIS said, "You want to establish that this is not an entitlement and you said there was a ruling or an opinion, and you were going to get a copy to me which I did not get."

MR. HOGAN responded that he had determined about an hour ago, that this was oral tradition within the division, meaning that prior to his coming to the division, he was told (until very recently) that there had been an attorney general's opinion indicating that DET was an entitlement; however, there has never been such a formal, written opinion, he said.

MS. STACIE KRALY, Senior Assistant Attorney General, Human Services Section, Civil Division (Juneau), Department of Law (DOL), testified that there is no attorney general's opinion dealing with the entitlement issue with respect to the DET program. Historically, about when DET statutes were amended to create Title 47, Chapter 31, there was litigation in Juneau pertaining to an individual who had been involuntarily committed, received a bill from Bartlett, and wasn't happy about

having to pay it. Through the settlement of that issue, Title 47, Chapter 31 was drafted and amended to address some of these payment issues. She referred to the language of Sec. 47.31.010 - Eligibility for assistance - subsection (a), "The department shall provide financial assistance under this chapter..." and surmised that there was at least an argument or a discussion regarding taking the leap from the word "shall" and turning it into an entitlement argument on the part of an attorney or a recipient of services, to say, "you shall provide assistance for me." She said the argument could be made - but it has never been DOL's position or past administrations' - despite information that Mr. Hogan may have received when he came onboard.

SENATOR BETTYE DAVIS said, even though there was nothing stated in writing that this was an entitlement, "you haven't done anything to follow up on that since you found out that it was orally ... just an opinion."

MR. HOGAN repeated that he had just confirmed this with Ms. Kraly at today's hearing, and it is something that he will be following-up on.

CHAIR DYSON said the reference to "the department doesn't need to spend more money than the legislature appropriates" indicates there is no control regarding people who come in the door of this process. More has to do with people who need help and need evaluation. "What we appropriate will be based upon [your] recommendation, and some consideration for the state's financial situation." He asked if, by that language, a commitment is being made not to have a supplemental budget if the number of intakes for the process accelerates for some reason.

MR. HOGAN responded that he understood that DHSS Commissioner Gilbertson is not interested in a supplemental at this time.

SENATOR GREEN asked how facilities determine the rates, that is, are the rates negotiated or the same across the state.

MR. HOGAN said rates are determined according to a cost-based Medicare rate.

TAPE 04-13, SIDE B

MR. HOGAN continued that rates vary from hospital to hospital, depending on the cost of providing services at that hospital.

SENATOR GREEN asked if this was the only way to determine the rate.

MR. HOGAN responded that he wasn't sure, but this was the current determination.

SENATOR GREEN asked if federal law requires the state to do this.

MR. HOGAN said not to his knowledge.

SENATOR GREEN considered that there were no federal matching funds to soften what the state does, other than DSH.

MR. HOGAN agreed that the use of DSH dollars was the way to soften the cost to the state.

SENATOR GREEN referred to Sec. 7, "if the department determines that the amount of appropriations ... is less than ... and the department has given notice ... the department may reduce the rates calculated..." and asked, "so you could go off the Medicare rate at that point?"

MR. HOGAN responded this would be an option. He said the answer to the question of what this might look like had not yet been determined.

CHAIR DYSON asked what enabled the savings of \$1,050,000 between the FY 03 and FY 04 budgets.

MR. HOGAN said that part of the problem is that the department would like providers to submit bills within 90 days of the end of the fiscal year. Currently providers can submit bills for FY 03, through December of FY 03, so six months after the fact, bills are still being received from the previous fiscal year. Therefore, these dollar amounts are for what's been expended during those fiscal years, because bills are received through the end of the calendar year. He said he wished he had the confidence that all of the FY 03 payments were for the FY 03 expenditures, adding that nothing has been done to limit the cost or to limit expenditures.

CHAIR DYSON clarified that the columns on the spreadsheet should be shifted somewhat to the right. He asked if the difference between FY 03 and FY 04 was a billing/timing problem, rather than there being less people requiring services or that the services were more efficient.

MR. HOGAN agreed this was true.

CHAIR DYSON asked if the additional savings of \$435,000 would result from better management due to the department's oversight, and from the facilities doing better.

MR. HOGAN confirmed this to be so.

SENATOR GREEN asked if the department typically experienced such billing delays regarding medical receipts.

MR. HOGAN responded that other providers could bill Medicaid for up to one year after the provision of service. From that perspective, six months could be considered as reasonable. The department maintains that the six-month delay is difficult to manage; that's why a 90-day maximum submission time for bills is being requested.

CHAIR DYSON stated for the record that he has a perceived conflict of interest; his wife is a licensed public health mental health provider and has the authority to have people involuntarily committed. He then suggested that Commissioner Gilbertson or someone speaking on the commissioner's behalf speak to the issue of, once the more intense management and efficient use of resources is achieved, what will be done if there are still more people needing the services, and "you all are hard and fast on not coming back with a supplement." He said he appreciates the efforts at getting control of costs, as that could make more money available to serve greater needs.

CHAIR DYSON held SB 364 in committee.

There being no further business to come before the committee, CHAIR DYSON adjourned the Senate Health, Education and Social Services Standing committee meeting at 2:30 p.m.