

**FALASKA STATE LEGISLATURE**  
**SENATE HEALTH, EDUCATION AND SOCIAL SERVICES STANDING COMMITTEE**

March 24, 2004

1:44 p.m.

TAPE(S) 04-14&15

**MEMBERS PRESENT**

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

**MEMBERS ABSENT**

All members were present.

**COMMITTEE CALENDAR**

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

CS FOR HOUSE BILL NO. 25(JUD)

"An Act relating to health care decisions, including do not resuscitate orders, anatomical gifts, and mental health treatment decisions, and to powers of attorney relating to health care, including anatomical gifts and mental health treatment decisions; and providing for an effective date."

HEARD AND HELD

**PREVIOUS COMMITTEE ACTION**

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  
03/22/04 (S) Heard & Held  
03/22/04 (S) MINUTE(HES)  
03/24/04 (S) HES AT 1:30 PM BUTROVICH 205

BILL: HB 25

SHORT TITLE: HEALTH CARE SERVICES DIRECTIVES

SPONSOR(S): REPRESENTATIVE(S) WEYHRAUCH

01/21/03 (H) PREFILE RELEASED (1/10/03)  
01/21/03 (H) READ THE FIRST TIME - REFERRALS  
01/21/03 (H) HES, JUD, FIN  
02/13/03 (H) HES AT 3:00 PM CAPITOL 106  
02/13/03 (H) Heard & Held  
02/13/03 (H) MINUTE(HES)  
02/27/03 (H) HES AT 3:00 PM CAPITOL 106  
02/27/03 (H) Heard & Held  
02/27/03 (H) MINUTE(HES)  
03/06/03 (H) HES AT 3:00 PM CAPITOL 106  
03/06/03 (H) Moved CSHB 25(HES) Out of Committee  
03/06/03 (H) MINUTE(HES)  
03/10/03 (H) HES RPT CS(HES) NT 7DP  
03/10/03 (H) DP: GATTO, WOLF, HEINZE, SEATON,  
03/10/03 (H) CISSNA, KAPSNER, WILSON  
03/26/03 (H) JUD AT 1:00 PM CAPITOL 120  
03/26/03 (H) -- Meeting Canceled --  
03/28/03 (H) JUD AT 1:00 PM CAPITOL 120  
03/28/03 (H) Heard & Held  
03/28/03 (H) MINUTE(JUD)  
03/31/03 (H) JUD AT 1:00 PM CAPITOL 120  
03/31/03 (H) Moved CSHB 25(JUD) Out of Committee  
03/31/03 (H) MINUTE(JUD)  
04/07/03 (H) JUD RPT CS(JUD) NT 5DP  
04/07/03 (H) DP: SAMUELS, HOLM, GARA, OGG, MCGUIRE  
04/07/03 (H) FIN REFERRAL WAIVED  
05/06/03 (H) TRANSMITTED TO (S)  
05/06/03 (H) VERSION: CSHB 25(JUD)  
05/07/03 (S) READ THE FIRST TIME - REFERRALS  
05/07/03 (S) HES, JUD  
05/16/03 (S) HES AT 1:30 PM BUTROVICH 205  
05/16/03 (S) Heard & Held  
05/16/03 (S) MINUTE(HES)  
03/08/04 (S) HES AT 1:30 PM BUTROVICH 205  
03/08/04 (S) Heard & Held  
03/08/04 (S) MINUTE(HES)  
03/24/04 (S) HES AT 1:30 PM BUTROVICH 205

**WITNESS REGISTER**

Mr. Bill Hogan, Director  
Division of Behavioral Health  
Department of Health & Social Services  
PO Box 110601  
Juneau, AK 99801-0601  
**POSITION STATEMENT:** Answered questions on SB 364

Ms. Stacie Kraly  
Assistant Attorney General  
Human Services Section, Civil Division  
Department of Law  
PO Box 110300  
Juneau, AK 99811-0300  
**POSITION STATEMENT:** Answered questions on SB 364

Ms. Karleen Jackson, Deputy Commissioner  
Department of Health and Social Services (DHSS)  
PO Box 110601  
Juneau, AK 99801-0601  
**POSITION STATEMENT:** Testified on SB 364

Dr. Hopson  
Alaska Psychiatric Institute  
Anchorage, AK  
**POSITION STATEMENT:** Answered questions related to SB 364

Dr. Verner Stillner  
Bartlett Regional Hospital  
Juneau, AK  
**POSITION STATEMENT:** Seriously questioned the merit of SB 364

Sharon Lobaugh  
NAMI Juneau Representative  
Juneau, AK 99801  
**POSITION STATEMENT:** Testified on SB 364

Harold Stepp  
Juneau, AK 99801  
**POSITION STATEMENT:** Testified on SB 364

Richard Rainery  
Executive Director  
AK Mental Health Board  
431 N. Franklin St. Suite 200  
Juneau, AK 99801

**POSITION STATEMENT:** Testified on SB 364

Shawn Anderson  
Polaris House  
P.O. Box 022056  
Juneau, AK 99802

**POSITION STATEMENT:** Testified on SB 364

Jeff Jesse  
Executive Director  
AK Mental Health Trust Authority  
Anchorage, AK

**POSITION STATEMENT:** Testified on SB 364

Linda Sylvester  
Staff to Representative Bruce Weyhrauch  
Alaska State Capitol  
Juneau, AK 99801-1182

**POSITION STATEMENT:** Introduced HB 25 for the sponsor

**ACTION NARRATIVE**

**TAPE 04-14, SIDE A**

**CHAIR FRED DYSON** called the Senate Health, Education and Social Services Standing Committee meeting to order at 1:44 p.m. Present at the call to order were Senators Wilken, Davis, Guess, and Chair Dyson. Senator Green arrived shortly thereafter.

**SB 364-LIMIT STATE AID FOR MENTAL HEALTH CARE**

MR. BILL HOGAN, Director, Division of Behavioral Health, Department of Health & Social Services (DHSS), testified he was answering questions that arose in HES committee meeting of March 22. He referred to the first question ["Questions on SB 364 from 3/22/04"] in committee packet, which was:

1. Fiscal note - how to manage 24-hour notification, contract with First Health? What happens if there is a lapse by the provider in the time to report?

He said the department's intent is to work with providers to indicate there has been a change, and to educate providers on the new registration requirements. The intent is not to disallow payment because of not reporting within 24-hours; he pointed out departmental implementation would be reasonable. Regarding eligibility, there is no change, but rather a

clarification. When the patient is admitted, the department will be seeking additional information regarding mental status pertaining to being a danger to self or others, and to confirm that status as the stay is retrospectively reviewed. The cost to the division is anticipated to cost approximately \$32,000 annually, contracting with First Health to do these reviews. There were potentially 275 reviews in the current fiscal year, at \$112 per review. This would also anticipate, in addition to that initial review, reviews at the eighth day of admission. The diagnoses evaluation piece runs up to 7 days. The eighth day is when treatment begins so the reviews should be done on the eighth day of admission; that would be approximately an additional \$7,000. The cost of doing the reviews would be about \$40,000 annually, based on current volume of admissions.

MR. HOGAN told members that Dr. Hopson was available to address the second question.

SENATOR GRETCHEN GUESS asked, "Do we have a 24-hour line now?"

MR. HOGAN replied First Health Services Corporation is available 24 hours, seven days a week for Medicaid reviews. If a client or consumer calls any of our offices, there is an after-hours emergency, and if it is a mental health emergency, that person is referred to the local provider. There is no mechanism in place for departmental staff to take these calls 24 hours, seven days a week.

MR. HOGAN continued with the third question:

3. Is there a liability issue if we order an early discharge and someone is harmed due to that early discharge?

He said the department is not seeking a prior authorization process, but a retrospective review of the records with more detail about the individual's mental status while in hospital care. Additionally there will be fiscal discussions after discharge. The retrospective review versus prior authorization process will avoid most liability concerns and is only a refinement in detail over the current process. This is not anticipated to be a problem, he added.

MR. HOGAN continued with the next question:

4. What have other states one on this issue - entitlement and permissive issue?

He deferred to the Department of Law to answer this question.

MS. STACIE KRALY, Assistant Attorney General, Human Services Section, addressed the question of whether other states deal with payments for local services as an entitlement or otherwise. She responded she has been waiting for a response from other states. She noted that Alaska is different from most other states, and pointed out that in most other states - although they have local facilities and contract for local services - most are dealt with on an evaluation and stabilization basis, and then immediately go to a state hospital. There is more of a centralized provision of services in other states. Alaska is set up so that many local facilities provide evaluation and stabilization, and then regional facilities such as Bartlett or Fairbanks, or API provide treatment services. Bearing in mind that Alaska is different in terms of size and scope of services is important. She said she was still gathering information to answer this question, and it would be provided either through the Chair or further testimony.

CHAIR DYSON referenced the entitlement language and asked if the state or any other political subdivision must provide services even if they were broke or if it meant taking funds from other government services.

MS. KRALY replied this is the argument that would be made. In the circumstance of a fiscal crises, where there was no money to be paid, there are issues. If it's an entitlement program, the government is obligated to make that payment.

CHAIR DYSON asked if political subdivisions have been sued successfully for applying triage.

MS. KRALY said anecdotally, she is familiar with at least one lawsuit filed in Juneau resulting from the inability of the recipient at Bartlett to pay for his cost of care. That litigation was resolved prior to trial. Subsequently, the case was not filed, but there were overtures from attorneys in town dealing with both Bartlett and consumers, seeking reimbursement for payments they were unable to recover from folks who didn't qualify for this program, or the program wasn't in place, or didn't have third-party payor status. There is litigation on this issue.

CHAIR DYSON said this wasn't exactly his question. He was wondering if someone was refused services, or given reduced

services because of financial limitations. He questioned whether this had been litigated.

MS. KRALY said she was not familiar with any cases that have been brought, but it would be a conceivable cause of action.

CHAIR DYSON referred to folks receiving diagnostic services, and asked if most were not self-payers.

MR. HOGAN confirmed this program was designed for indigents, below 185 percent of poverty who do not have a third party payor, including Medicaid.

CHAIR DYSON asked who pays for people who come - willingly or unwillingly for diagnostic services.

MR. HOGAN reflected on his work in a mental health center, where there was a sliding fee scale for all services provided. People were expected to pay a little bit, he said.

CHAIR DYSON said if the department runs out of funds for this, the question is, "Are they going to get the service needed, and perhaps the presumption is there being attempt to recover cost from the patient and their assets, so the person wouldn't be denied the services."

CHAIR DYSON asked what happens to people who need services if the department runs out of money and is committed to not having a supplemental budget.

MR. HOGAN responded those individuals would have to go to API if in-patient services were needed even though, ideally, the person would be treated in his/her own community.

CHAIR DYSON said the default position is a more expensive one.

MR. HOGAN responded the cost at API is less expensive than services provided at community hospitals. He said this was answered on the second page of the handout.

CHAIR DYSON asked Ms. Kraly when she anticipated receiving an answer to her questions.

MS. KRALY told him she hoped to receive an answer on how other states deal with the payment issue by the end of this week or the beginning of next week.

CHAIR DYSON said another question is liability involving somebody bringing an action for not receiving services.

SENATOR LYDA GREEN clarified this wasn't the original question for number three, and asked what the question was that she was gathering information on.

MS. KRALY reiterated that Mr. Hogan had answered question number three, and she was looking into question number four.

SENATOR GREEN asked if the question was, "How many other states have this service as an entitlement?"

CHAIR DYSON said he asked, "How have other states handled it? [Do] lots of them have permissive language that we are being asked to move towards? And, what's happened with them, in terms of cost and service to the client population?"

SENATOR GREEN asked for clarification of "permissive language."

CHAIR DYSON replied it's what's in the bill. It takes out the entitlement language.

CHAIR DYSON asked about the companion bill.

MR. HOGAN told him HB 585 would be heard in House HES on Thursday afternoon at 3:00 p.m.

CHAIR DYSON asked to be kept informed of its progress because of the timing in the legislative session.

MR. HOGAN referred to the next question:

5. Wants to know what we will do if we run out of appropriated funds. [The hand out version continues with: We won't come back on a supplemental? Our response of this language in other legislation is that it is pretty much standard language in legislation on benefits (i.e. Senior Care)]

He indicated on Monday the commissioner does not intend to ask for a supplemental. He deferred to Ms. Jackson for further explanation.

MS. KARLEEN JACKSON, Deputy Commissioner, DHSS, reiterated that the objective is for no supplemental. They plan to handle the departmental budget as one unit and do what happened this year

with a net zero supplemental within the department itself, shifting funding as needed. If that is impossible, it's not inconceivable that a supplemental would be necessary, but that's not the goal.

CHAIR DYSON asked if, by inference, the goal includes that people needing services wouldn't be turned away.

MS. JACKSON confirmed the goal is to provide for the health and well being of all Alaskans.

CHAIR DYSON commented SB 364 tightens up on the controls and puts sideboards on it to get better control of costs, but not to deny services.

MS. JACKSON concurred.

SENATOR GUESS asked, if the projection is wrong. Is the administration's intent to take those funds out of other places in the budget, or to deny payment to providers, or to have that person end up at API?

MS. JACKSON responded the intent is, if there are areas within the DHSS budget to move funds from one unit to another, that would be done. The intention is to ensure people have services they need, and to ensure there are cost containment boundaries as much as possible. There are all sorts of "what if" scenarios, but until the situations are dealt with, specific responses aren't available. She reiterated the intent is to provide for the health and well being of people, while containing cost.

SENATOR GUESS asked, "The intent is not to refuse payment to a provider because there's not enough money in that BRU to pay for the services?"

MS. JACKSON said the whole purpose in doing this was to ensure there is sufficient resource to meet the need in the best possible way. The intent is not to harm providers or consumers.

SENATOR GUESS questions, "The intent is not to deny payments to providers if you run out of money?"

MS. JACKSON confirmed that is correct.

MR. HOGAN continued on page 2, question number six:

6. Do we need to note in the bill that a medical professional representing DHSS will be the one deciding with the provider?

He said "deciding" refers to whether or not the person should continue to stay within the facility. He said, as with previous questions, these will be retrospective reviews. There is a 24-hour review, and a review on the eighth day. If there is a decision the person needs to leave the facility on that eighth day, the intent is to include the medical director at API, in the decision, and particularly in the appeal process if there is a determination that the hospital feels the person should stay.

SENATOR GUESS asked if the administration's intent is to put forth an amendment clarifying this, "although it's the intent of this administration to ensure that that intent and that plan is carried out in the future."

MR. HOGAN said he believes there is a willingness to do that.

SENATOR GREEN wondered if there was any conflict with interest, with the named person.

MR. HOGAN replied a conflict was not anticipated.

SENATOR GREEN asked if, as a possible receiving facility, "Is there enough of a wall, or a third person?"

MR. HOGAN said he understood there is no financial benefit to the medical director at API, based on the number of admissions, or people coming into the facility.

SENATOR GREEN noted this would be the facility of default, and she wanted to be sure the program would be designed so that it's a clean process and that no one could say, "Of course you wanted the patient, etc." She said it wouldn't take long for it to be full, with this process in place, and wanted to be sure this wouldn't be misinterpreted.

MR. HOGAN said the intent is to manage API's census as best as possible, and a concern is there would be too many people seeking admission at API rather than not enough. He did not anticipate this being a problem. He mentioned Dr. Hopson would be available to answer questions about the evaluation process.

MR. HOGAN proceeding to question number seven:

7. How do costs compare between API and DET/S [diagnosis, evaluation, treatment and stabilization] facilities?

He referred to the hand out, listing the API daily rate as about \$670. The daily rates for the DET facilities range from about \$1,640 per day at Bartlett to as high as over \$2,000 per day at Mr. Edgumbe and Bethel.

2:12 p.m.

SENATOR GUESS asked about comparing DET, DES, and API rates.

MR. HOGAN explained the API daily rate was the rate for all patients, regardless of length of stay. If someone is there for as little as 24 hours, that is factored in with individuals who have been there for several years.

CHAIR DYSON thought the heart of the question was whether they were there for diagnostic work.

SENATOR GUESS said she presumed API does more than DET and DES. Given that, the local community's cost for DET and DES should be compared to API's cost. She was interested in comparing similar services, or "apples to apples."

MR. HOGAN said they could come up with those figures, that is, looking at the same kinds of services at different facilities.

SENATOR GREEN asked about a third alternative. She asked what a "community service would look like?"

MR. HOGAN responded the services provided in various hospitals are in patient services, provided in the various communities. The term, "community based service" connotes out of hospital, for him, that is, not in the hospital.

SENATOR GREEN asked where out-of-hospital providers comes in for someone who doesn't need to be at API, and depending on the diagnoses and stabilization diagnoses is, "What is the next lowest piece that comes after this? Because certainly these aren't the only choices."

MR. HOGAN replied there is an array of services available in a number of different communities. The next step down from hospitalization would be what used to be called partial hospitalization, or day treatment. It's possible for somebody

to participate three to four hours per day, obtaining individual or group therapy or skills development, usually three or four days per week. That would be the next intensive array of services. If a person didn't need those, there might be the more traditional hour of counseling. He said he could provide the cost for that next array of services.

SENATOR GREEN asked if this was germane to this conversation.

MR. HOGAN said he wasn't sure, as this was not a 24-hour per day, seven day per week service. The ideal is for the person to be stabilized as quickly as possible, and then return to the community with an array of behavioral health services.

SENATOR GREEN said the focus here was on the period of time before they're stabilized.

MR. HOGAN confirmed the service refers to the period of time that they're being stabilized, that is, to stabilize the individual so he/she can return to his/her own community, ideally with his/her own family.

MR. HOGAN then addressed the eighth question:

8. Do we know what the rate reduction might be, per Section 7 of the bill?

He said as indicated on Monday, the department will work out what that might look like, via regulation. There is also the possibility of running out of funds, although they would go to great lengths to ensure the basics of this service were still in place, even if it meant looking at other programs within the department.

SENATOR GUESS asked if there was a contradiction with the statement of "we don't plan to refuse payment" and the administration say, "no, it is not our intent to deal with shortfalls in that way" and having this part of Section 7 which says, "yes, we might reduce payments to providers if there is a shortfall." She said she wanted clarification of the administration's intent if there is a shortfall. Also, it seems the intent of SB 364, regardless of the administration, is to refuse payment - partial or full - to a provider.

MR. HOGAN responded the cost for providing DET services in a hospital would be somewhat less than the cost to provide services in an intensive care unit, or a medical surgical unit.

The Medicaid daily rate for services in a DET unit includes costs from those other beds. This is the hospital daily rate. The department has discussed looking at more closely determining what it actually costs to provide the service in the DET unit itself, which he thinks would be lower than an intensive care or a medical surgical bed. That would be the methodology they would like to move toward, to establish a lower rate for that particular service provision.

SENATOR GUESS said this doesn't go to whether a negotiated rate is DET or not and that you could even reduce the negotiated DET if funds were short. Given that you can't refuse a patient, a shortfall is passed on to everyone else paying at that hospital. The intent is good, but since statues are around for long periods of time, she questioned why the clause in Section 7 is there if that isn't the intent of the administration.

MR. HOGAN responded the clause is in the bill because the original intent was to manage cost better, and to ensure the person still gets the necessary service. They would like the authority to be able to negotiate a rate different than the Medicaid rate, and this would do that, he said. He said he would defer to the attorney general's office for advice regarding whether it was necessary to include that clause.

SENATOR GUESS asked if the purpose of Section 7 is to allow the department the authority to negotiate a different rate.

MR. HOGAN said it does give that authority, based on [indisc.] shortfall.

SENATOR GUESS said she doesn't read it as a negotiation, but as a percentage reduction, given the shortfall. So, the flexibility wouldn't be there to say, "maybe Bartlett does cost less but Fairbanks costs more, and we need to address these DET rates."

CHAIR DYSON declared, "That line of reasoning raises my hackles," and acknowledged he is somewhat familiar with cost shifting that goes on in medical facilities. Alaska needs to be careful that public dollars are not being used to pay for a service, and the hospital is shifting cost from other services and clients, onto the bills that are being paid for by public dollars. He said he is very interested in what the department is doing to ensure hospitals aren't doing this. He questioned how to amend the bill to make sure the negotiated rate is

available for those who are self-payers, thereby allotting them the same discount.

MR. HOGAN addressed the last question:

9. Explanation for cost increases over the last several years.

He reported the hospital cost increased has 100 percent between FY 01 and FY 03. A little over 25 percent of that increase is due to the average daily Medicaid rate going up between FY 01 and FY 03. The other increase is in the total number of bed days, again about a 25 percent increase.

CHAIR DYSON asked Dr. Hopson if the department's time constraints were adequate to stabilize a patient to the point of doing an accurate evaluation of the diagnoses. He asked what the plan is when a patient is admitted.

DR. HOPSON from Alaska Psychiatric Institute testified via teleconference. He said this would be different for every patient and every treatment or evaluation center, and this would affect the length of stay and length of treatment. Various members of the team observe the patient, complete a psychiatric evaluation, a past history, social history, substance abuse history, observe them in response to the milieu to see if the environment has a positive effect. Determine if medications are required, and if so, to observe the response to the medication, which could take 24, 48, or 72 hours. The first three days are the most critical in determining whether someone will require a length of stay longer than seven days.

CHAIR DYSON asked if some of the patients are there because they didn't take prescribed medications and if they get back on medication they usually stabilize in 24 to 72 hours.

**Tape 04-14, SIDE B**

DR HOPSON replied many patients are presenting for the first time so there might be no history to reflect on so stabilization might take longer. This means there wouldn't be a medication history and other metabolic problems that are causing the psychiatric presentation would have to be identified. These people might end up staying longer than those that have been there before.

Chronic patients are at the other end of the spectrum and have a well established pattern. They might be resistant to treatment, they might be off their medication, or their medication might not be working any longer. These patients require very creative treatment and may take longer to stabilize.

The short answer is that length of stay is specific to the presentation. The retrospective review that's being discussed would enable them to look at specific cases and observe responses and then determine appropriateness.

CHAIR DYSON restated that patients with a history might be stabilized more quickly. If a schizophrenic or bi-polar patient came in and medication was indicated, he questioned whether they could be stabilized in two or three days.

DR. HOPSON said they frequently take longer than that. A typical scenario for three to four day stabilization would be someone who had something happen in their lives to cause them to become despondent or suicidal. They would be hospitalized for evaluation and stabilization. They would be provided with support opportunities in the community and they would receive medication. Within 72 hours they are generally able to leave the hospital. That population represents a number of the patients that are under discussion, but there are a large number that fall outside that category.

CHAIR DYSON said with that information in mind, are the time limits for the diagnostic phase that the department is talking about generally sufficient?

DR. HOPSON replied he thinks so.

CHAIR DYSON asked if this legislation provides ways for patients to spend more time in the stabilization and diagnostic phase if that's what they require.

DR. HOPSON replied, "Absolutely." It's common in the managed care environment in other states, but it's new in Alaska. In the managed care environment in the Lower 48, physicians are most accustomed to working with managed care agencies and providers to assure that patients receive the appropriate level of care.

SENATOR BETTYE DAVIS noted his qualification to speak to the bill and asked what he thought about it.

DR. HOPSON replied the bill does provide for care for Alaskans and also sets a precedence to begin to manage the care.

SENATOR DAVIS asked if he was saying that hospitals would have no problem with the language in the bill.

DR. HOPSON said hospitals might have some concerns, but "if the reviews are done in a collaborative manner with the physicians, I think the overall intent is to provide improved quality of care in the least restrictive setting possible. I think an individual needs to stay in the hospital only as long as they really need to stay in the hospital. Unfortunately, in some communities without adequate community resources, that might affect the new patient length of stay. This puts forth a sort of process to kind of monitor that."

SENATOR DAVIS asked for his comments on Section 7 that talks about working out a percentage payment if there isn't sufficient money to pay for the services provided.

DR. HOPSON replied this is new to Alaska, but it's not new in the scope of medicine.

SENATOR DAVIS said it's been suggested that he would be doing evaluations and she wondered whether he felt he could do that without help.

DR. HOPSON admitted that it "could very quickly snowball into quite a process." He noted that he did previously state that as medical director for the division, he thought he would evaluate some of the retrospective reviews or consult with physicians in some cases. However, at this point, he couldn't tell how large that responsibility might be.

CHAIR DYSON asked Verner Stillner to come forward.

VERNER STILLNER testified on behalf of Bartlett Regional Hospital. He stated the following:

I think this Senate Bill has tremendous implications on the treatment of the involuntarily mentally ill individuals of Alaska and therefore I would like to put a couple of points forward to you.

First of all, there are seven facilities in the state that are diagnostic evaluation facilities and there are two outside of Anchorage that are diagnostic and

evaluation facilities. When you are a diagnostic facility, you can take someone for 72 hours involuntarily and then the disposition is either to send to another hospital or if you are diagnostic, evaluation and treatment facility, then you are able to treat the individual up to 30 days. And the State pays for this at the present time. The State designates the hospital and the hospital provides the treatment and most of the time - I can tell you I'm a Bartlett employee, I'm a psychiatrist and a member of the Alaska Psychiatric Association - their legislative representative - and so therefore I look at this from several standpoints here. Additionally, I used to have Mr. Hogan's job back in the Hammond Administration in '79 to '82. At that point we were having the history of still sending all our mentally ill from Alaska to Morningside outside of Portland Oregon. There was no facility in Alaska. Then the API came into being and we thought, well look, this is not a very good regional approach. Why not bring treatment closer to the patient's community of origin or the client's community of origin. And we said, 'Let's get the hospitals to do it.' And the hospitals said, 'Nothing doing. Unless we are reimbursed for this service, we will not provide this diagnostic evaluation or treatment facility.'

We have evolved now where we have two treatment facilities - diagnostic evaluation treatment facilities - Fairbanks Memorial and Bartlett - and we have seven evaluation facilities. I think this piece of legislation would distort and perhaps dismantle this regional approach to treatment because the way I read this bill, when the money runs out - 'Good intentions,' as my Spanish teacher used to tell me, 'pave the road to Hell.'

The legislation has a tremendous cutback in the funding - \$400,000 in its first year - which means there are going to be fewer services provided. So that the hospitals that are currently doing this - outside of the API - are going to lose their motivation for the treatment or the evaluation and treatment facility. I think that is an unfortunate thing for the mentally ill of Alaska because they are first of all, involuntarily admitted.

DR. STILLNER related an anecdotal example to show that the system is currently doing well. Patients are treated locally in outpatient clinics and they are able to remain close to their families and homes. SB 364, he said, has the potential to undo this good approach.

The API is slated for downsizing in 2005 so when there is no capacity there, the mentally ill will go to corrections. "When a judge can't find any place to put them, then Lemon Creek [Correctional Center] becomes an option for that individual and then the Division of Corrections will end up paying for them, but not treating them."

DR. STILLNER said the intentions are good here, but when you take away an individuals freedom by involuntarily hospitalizing them and then you make them pay for it, you're on soft ground and thin ice legally and he would like to hear the attorney general give an opinion on this.

In conclusion he said, "The system of designation, evaluation and treatment facilities has allowed the treatment to become closer to the community of origin for individuals and I fear that this legislation with its attempt to cut the costs of regional hospitalizations is going to shunt individuals to the API, and when the API is full, to corrections. And therefore, I would ask you to seriously consider the merits of this piece of legislation."

SENATOR GREEN acknowledged she agrees with some of his statements, but she wasn't sure about all of them. She asked whether he opposes any kind of involuntary hospitalization.

DR STILLNER assured her he is very much in favor of it because mentally ill individuals don't always realize that they're ill. He emphasized that it's a wonderful vehicle for getting those that need it into treatment. It's good for the community, the family and the individual.

SENATOR GREEN stated that it doesn't necessarily follow that someone who is committed involuntarily is unable to pay.

DR. STILLNER replied your insurance company is billed first and the State is the last resort payment.

SENATOR GREEN suggested it's not wrong to try to get payment from patients, but she's getting the impression that he's saying

it's wrong to try to get payment from individuals who are involuntarily committed and she doesn't agree with that.

DR. STILLNER advised her that many of the individuals that are committed for a 72 hour hold are indigent. If the hospital isn't reimbursed for the stay then they'll be sent to Anchorage if the transport services are available.

SENATOR GREEN questioned whether these individuals would be sent to a correctional facility.

DR. STILLNER asked her where a judge would send an individual for an evaluation.

SENATOR GREEN asked whether he was talking about incarceration.

DR. STILLNER said it's not incarceration, there's a holding area at Lemon Creek and that's been used recently.

SENATOR GREEN stated that's not like going to prison. She emphasized she doesn't want there to be the implication that someone that can't pay would go to a correctional facility.

DR. STILLNER assured her there is no intention to sent mentally ill individuals to a correctional facility, but that's where the mentally ill would ultimately land if there were no safety net treatment spectrum of services. "That's what increasingly is happening and unfortunately [it's] throughout the nation, not just Alaska, the correctional system is becoming the new asylum."

CHAIR DYSON asked him to return on Monday when the bill would be heard again. He called Sharron Lobaugh.

SHARRON LOBAUGH, NAMI Juneau representative, said she is a founder of National Alliance of the Mentally Ill (NAMI) and has been working in this area for about 30 years because her son became ill at age 15. He is now 41 and moved into his own home just last year. He's had a seriously difficult time and spent three years at API. She said she doesn't want anyone else to have to do that, which is why she has been to the Legislature many times over many years. She said she's been working to get designation and evaluation and treatment facilities close to people's homes and to establish community support programs so mentally ill people don't have to end up in API or on the street.

It's been a long struggle to get to the state of the art that's available now and she and others in the field don't want to see it regress. SB 364 tends to regress, she said.

She pointed out that there is the issue of parity here because there isn't good insurance for the mentally ill. This means that if a family doesn't have insurance that covers mental illness and if they're in the over 185 percent of poverty category, then they'd have to go into poverty to pay for their children's health care. "Mental illness is a no fault illness," she emphasized, and it's something that happens when individuals are on the cusp of becoming an adult. These individuals aren't able to go on and become income producing adults and frequently they aren't able to qualify for Medicare until they've applied two or three times.

There's no provision for appeal in this process and frequently it does become a correctional issue. The mentally ill individual may commit an infraction and if there is no other place to go, they go to jail. "This is a big step backward and I would like you to put this bill on hold for a long long time."

CHAIR DYSON asked if it's her position that State resources should be used to take care of the mentally ill rather than have families use up their resources to take care of a family member.

MS. LOBAUGH said in this kind of case she would have to say yes because families can't get insurance to cover mental illness. "If in the wisdom of the Legislature, you were able to get us a parity bill so that you required insurance companies to cover mental illness, then that might be a different story." Insurance companies treat mental illness as though it isn't part of the body, she said.

SENATOR GREEN asked whether any of the waivers provided assistance to her son.

MS. LOBAUGH said yes. Her son has both a developmental disability and a mental illness and fortunately he has a Medicaid waiver "That has kept him out of hospital as well as his medications," she said.

SENATOR GREEN said that's what a waiver is designed for.

MS. LOBAUGH pointed out that the bill caps a doctor's ability to prescribe state of the art medication and that may affect her

son. He may lose the ability to have the best medication and the consequences could be horrific.

3:00 pm

HAROLD STEPP stated he was speaking on behalf of the mentally ill to say that the bill isn't very good. Under the bill, respite would be good for just seven days and a lot of medications don't work in that amount of time so "you're in the same boat you were in before." He urged members to deal with this problem now.

RICHARD RAINERY, executive director of AK Mental Health Board (AMHB), said the board asked him to relay their position on SB 364. In general, the management tools are appropriate, he said, and in some cases they're overdue. Utilization review is good and is something everyone is trying to move toward as quickly as possible. Other than that, the AMHB has philosophic differences with the bill.

SB 364 allows mental health treatment to be a discretionary service on the part of the State and that isn't in keeping with the principles of AS 47.30.655, which says that services will be available in the least restrictive venue possible. It also says that services will be as close as possible to the community of origin of an individual. Those same principles are mirrored in the plan for the mental health system created by the board.

SENATOR GREEN asked for the statute again.

MR. RAINERY told her it's AS 47.30.655 and said the board believes that making this a discretionary service backs away from those principles.

CHAIR DYSON asked if he was saying that moving away from entitlement language makes it discretionary.

MR. RAINERY said yes, the State should pay for these services. He continued to say that the board agrees with the governor that the current environment threatens certain essential services. This is why the board is on record with the Legislature supporting a fiscal plan that provides adequate resources to protect the services that are essential to vulnerable Alaskans.

The points that make them question the bill include:

1. They don't have any idea how many individuals would be denied services if the bill becomes law. They don't know, but they surmise that if people aren't served locally, they'll be served at API.
3. API is being downsized and a key to that is that there are appropriate and adequate services across the state.
4. There are elements of DET that aren't yet in place and DET in Anchorage is part of the downsizing plan. Could that happen under this bill?
5. Other areas of the state would like to provide DET services. Could that happen with this bill?
6. The provision of DET is an alternative to API and it was a consensus decision by people interested in mental health in Alaska. The board isn't opposed to changing previous decisions, but with no clear vision of what the change would bring they are hesitant.
7. The time that is spent in a DET facility averages about five to six days. Under the downsize scenario at API, that hospital would have to deal with the most complex individuals that can't be handled at a local level. People that just need hospitalization for five or six days shouldn't be sent to API.

SHAWN ANDERSON testified that he is from Polaris House. He is a father of three and is bipolar. He got out of the hospital less than 24 hours ago and still feels vulnerable. He delayed going for help, at least partially, because he was worried about what it would cost. The consequences of SB 364 are scary to him and many others are likely to look at it the same way.

JEFF JESSE, executive director of AK Mental Health Trust Authority, said he would start by discussing the concept of entitlement. He reminded members that they were talking about people that health professionals have identified as a danger to themselves or others. These aren't people the State can avoid dealing with altogether. There's a lot of talk about which services are essential and intervention for these people has to be at the top of the list. This is a public safety issue, a health issue, and often a life and death issue. "The question isn't really the entitlement; we have to serve these people. The question is how are we going to do it."

A number of years ago a policy decision was made. There's been a progression from sending everyone to Morningside to sending them all to API and now people are treated on a local/regional basis as much as possible. Now only the people that need the longest-term treatment end up at API. "That's why we elected to build an

API that's smaller than the one we have today and it's dependant upon this designated evaluation treatment system that we're still in the process of building around the state." Building a 54 bed API facility was predicated on the assumption that 18 beds of evaluation and treatment would be built in Anchorage. That is still in process, he said.

He said they don't take issue with the cost estimate and they agree that the program needs to be managed more closely. However, he urged members to focus on the real problem of fixing the rate.

In summary he said,

The bill gives the department management tools and they would agree with those - time frames, applications, approval - that sort of thing. In my view, if you then also say, 'But you only have to manage this program until you run out of money.' you basically take away any incentive to manage. They can sit back, spend the money and when the money's gone, everybody else goes to API. I think you're better off telling them that if you have a cost overrun you're going to have to be accountable to the Legislature in a supplemental. You need to manage this program; we'll give you the tools to manage it, we'll give you the tools to set the rates where they need to be, but we need to be able to provide the service in the communities where these people come from.

CHAIR DYSON said he thinks they agree and he and Senator Guess tried to get on the record stating that people will get services and facilities will get paid.

SENATOR GREEN noted she found several other references to appropriations [AS 47.30.655] and it sounds as though it's being applied to an additional section instead of it being a new concept. She asked if that's correct.

MR. JESSE agreed, but made the point that introducing that kind of uncertainty into the financing plan is the kiss of death. He said, "One of the things I've learned in working with the Denali Commission is business plans are gold and if you set up a system where a facility cannot count on what the financing system is, not only will you jeopardize the current providers who provide service, but you can forget any expansion into Anchorage, Mat Su or any other part of the state because no reasonable provider

would get into a business where their reimbursement is so subject to the unpredictable management policies of the department."

CHAIR DYSON added or the number or people that are served.

SENATOR GREEN asked if he would get back to the committee on the question that relates to the 100 percent of hospital cost increase between FY 01 and FY 03.

CHAIR DYSON stated that he would like to apologize for using the term "nutty" in a previous discussion about mental health.

Directing his comments to those who had testified, he urged them to get together with the committee members to make sure their concerns were addressed.

CHAIR DYSON held SB 364 in committee.

#### **HB 25-HEALTH CARE SERVICES DIRECTIVES**

The committee took up CSHB 25(JUD).

SENATOR LYDA GREEN moved to adopt the committee substitute (CS), version V [labeled 23-LS0137\V, Bannister, 3/24/04] as the working document before the committee. [There being no objection, it was treated as adopted.]

CHAIR DYSON said that after Ms. Sylvester's testimony, he would run through a list of issues still being addressed that would be included in the next version of HB 25.

MS. LINDA SYLVESTER, staff to Representative Weyhrauch, explained that version V was the result of a 3/8/04 staff meeting that included the lieutenant governor's chief of staff, and Chip Wagoner from the Alaska Catholic Conference (ACC). The document they settled on had approximately 66 amendments; she said she would summarize the important ones. She began by stating that "emancipated minors" had been eliminated from HB 25. Changes were made to the role of a surrogate (noting that surrogates are a new part of HB 25) and the role of physicians was amplified in the decision-making process, when surrogates are evenly split.

CHAIR DYSON offered that this serves to bring the "best interest" of the patient into the conversation.

MS. SYLVESTER continued that regarding surrogates, the prominence of best interest was increased. The intention is to include a definition of best interest in the form, although it has not [yet] been included. She said the new language that amplifies the physician's role in detecting...

**TAPE 04-15, SIDE A**

MS. SYLVESTER continued, "... that's come forward or that's been nominated, isn't necessarily an appropriate one. The protections are in place. The physician has standing already to recommend this to go to guardianship procedures, but we just want to put that in there, so we want to direct the physician to take a more proactive role in that situation."

MS. SYLVESTER told members that most importantly there are new guidelines for surrogate decision-making when the decision involves withdrawal of life support. "We've used language from the Illinois statute. These are strict guidelines; our concern was we wanted to make sure if there was a 35-year old who was in a motorcycle accident and he was going to recover from his injuries but the spouse took the opportunity to push forward wishes of not being resuscitated, we wanted to make sure that this wouldn't happen."

CHAIR DYSON interjected, "a big estate, and she's got a boyfriend."

MS. SYLVESTER continued that regarding anatomical gifts, updates were made so that the role of the hospital was taken out somewhat, because Life Alaska has stepped into that role. Ms. Sylvester referenced Section 4 of the 1987 Uniform Anatomical Gift Act, and noted that changes had been made to verify that Alaska is not an opt-out state. If ever that were to change, a bill would need to come through the Legislature; it would be a policy decision of its own.

MS. SYLVESTER said portability was of concern; it's important that all advance directives outside of Alaska are recognized to the extent that Alaska law is not violated. The committee reviewed those Sections and regarding the "do not resuscitate (DNR)" order, one more clarification needs to be made so that it's perfectly clear that EMTs in the field who are sure there's a DNR in place can act in good faith. She gave the analogy of somebody obtaining a driver's license in Montana where the speed limit is 75 mph; although that license is valid in Alaska, that person can't drive at 75 mph.

MS. SYLVESTER said that some changes were made to the [optional] form itself. A helpful reminder was added indicating that euthanasia and mercy killing is not legal in Alaska. A change was made to the pain relief option so that space in the form is given for the principal to state his/her wishes regarding pain relief. Also, the intent is to add some critical definitions to the form, but the drafter missed those. Witness requirements were modified somewhat; "witnesses need to be in place and there are criteria for who the witnesses can be because that will be the protection that foul play isn't a part of this."

MS. SYLVESTER said that interestingly enough, HIPAA [Health Insurance Portability and Accountability] concerns were raised and have been addressed in two places: in the institution's immunity for providing medical records, to make sure that surrogates and agents have access to those records; also, hospitals sometimes cannot give medical records to individuals because of not knowing if the principal has lost capacity - it's a loop because the person needs to see the records - so that's been fixed, she said.

MS. SYLVESTER said the committee was mindful of the policy considerations; there were six, and the bulk of them have been addressed. Language has been added so that there is a presumption in favor of life in the absence of someone's stated intent that they presume to be kept alive. The role of the surrogate and the agent has been clarified regarding life support. Reciprocity has been addressed, although it still needs some work. The question, "At what point does the definition of a 'qualified patient' kick in?" has been addressed by stipulating the conditions necessary for a surrogate to make decisions relative to life support. "Anatomical gifts" has been clarified and corrected. She noted that she couldn't read her notes on the last one, number six.

CHAIR DYSON said excellent work has been done on the bill, and he understands that there is still work being done on the issue of nutrition and hydration to more clearly differentiate between persons who are unarguably terminal and those who are just injured, maybe incapacitated or comatose. There may be a little more work to do regarding surrogates, as there is still the question of limiting the authority of the decision-makers and strengthening the best interest of the patient. Also, there is the issue of reciprocity. There are ongoing discussions on those three items, he said.

DR. MARIA WALLINGTON, a medical ethicist at Providence Alaska Medical Center, said she could be available at the bill's next hearing, that she was available to answer questions.

CHAIR DYSON asked if she had a copy of the latest version.

DR. WALLINGTON said she has not seen it, but she conversed with Ms. Sylvester about it.

CHAIR DYSON suggested that she contact his office or Representative Weyhrauch to get a copy. He announced there were copies available for those wanting to see the latest version of the bill.

SENATOR GUESS noted concern about the intended timeline and asked if there would be sufficient time to ask questions pertaining to the different versions.

CHAIR DYSON assured her that there would be time for questions, saying, "We're not going to railroad this thing, it's too valuable and too sweeping." HB 25 was held in committee.

There being no further business to come before the committee, Chair Dyson adjourned the meeting at 3:28 p.m.