

HOUSE FINANCE COMMITTEE  
March 21, 2016  
1:31 p.m.

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CALL TO ORDER

Co-Chair Thompson called the House Finance Committee meeting to order at 1:31 p.m.

MEMBERS PRESENT

Representative Mark Neuman, Co-Chair  
Representative Steve Thompson, Co-Chair  
Representative Dan Saddler, Vice-Chair  
Representative Bryce Edgmon  
Representative Les Gara  
Representative Lynn Gattis  
Representative David Guttenberg  
Representative Scott Kawasaki  
Representative Cathy Munoz  
Representative Lance Pruitt  
Representative Tammie Wilson

MEMBERS ABSENT

None

ALSO PRESENT

Senator Pet Kelly, Sponsor; Heather Shaddock, Staff, Senator Pete Kelly; Stacie Kraly, Chief Assistant Attorney General, Section Supervisor Human Services, Department of Law; Representative Liz Vasquez, Representative Lora Reinbold.

SUMMARY

CSSB 74(FIN) am

MEDICAID REFORM; TELEMEDICINE; DRUG DATABASE

CSSB 74(FIN) am was HEARD and HELD in committee for further consideration.

Co-Chair Thompson planned to have the committee substitute ready and to move the bill from the House Finance Committee. His office would be providing members with a notebook of presentations and documents relating to each day's topic. He invited testifiers to the table.

Representative Kawasaki asked how questions would be handled from committee members.

Co-Chair Thompson indicated for members to hold their questions until the end.

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#sb74

CS FOR SENATE BILL NO. 74(FIN) am

"An Act relating to diagnosis, treatment, and prescription of drugs without a physical examination by a physician; relating to the delivery of services by a licensed professional counselor, marriage and family therapist, psychologist, psychological associate, and social worker by audio, video, or data communications; relating to the duties of the State Medical Board; relating to limitations of actions; establishing the Alaska Medical Assistance False Claim and Reporting Act; relating to medical assistance programs administered by the Department of Health and Social Services; relating to the controlled substance prescription database; relating to the duties of the Board of Pharmacy; relating to the duties of the Department of Commerce, Community, and Economic Development; relating to accounting for program receipts; relating to public record status of records related to the Alaska Medical Assistance False Claim and Reporting Act; establishing a telemedicine business registry; relating to competitive bidding for medical assistance products and services; relating to verification of eligibility for public assistance programs administered by the Department of Health and Social Services; relating to annual audits of state medical assistance providers; relating to reporting overpayments of medical assistance payments; establishing authority to assess civil penalties for violations of medical assistance program requirements; relating to seizure and forfeiture of property for medical assistance fraud; relating to the duties of

the Department of Health and Social Services; establishing medical assistance demonstration projects; relating to Alaska Pioneers' Homes and Alaska Veterans' Homes; relating to the duties of the Department of Administration; relating to the Alaska Mental Health Trust Authority; relating to feasibility studies for the provision of specified state services; amending Rules 4, 5, 7, 12, 24, 26, 27, 41, 77, 79, 82, and 89, Alaska Rules of Civil Procedure, and Rule 37, Alaska Rules of Criminal Procedure; and providing for an effective date."

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SENATOR PETE KELLY, SPONSOR, introduced the bill and indicated he would be leaving the meeting early. There were several people available to provide detailed information about the bill.

Co-Chair Thompson acknowledged Representative Munoz at the table.

Representative Kelly spoke of questions he had asked himself as the co-chair of finance when preparing the budget. One of his questions had to do with the growth of Medicaid. He believed the program would eat the state budget without making some changes. He conveyed a story from the 90s about Medicaid reform. At the time the legislature was dealing with an increase of \$130 million in Medicaid costs. Many people had recommended doing something about the cost because of its growth. Other Medicaid reform bills had been put forward that were different than the one before the committee. He claimed the difference was that in the past the attempt to reform Medicaid equated to restricting access rather than reforming the system. Senate Bill 74 attempted to address the system itself as opposed to limiting access. He suggested that improving the system might include looking at where best practices were not being used, finding out about the availability of technology to assist the system, and reviewing available models to operate more intelligently. He reviewed a list of other items for consideration such as telemedicine, a healthcare authority, coordinated care, the use of generic drugs, travel efficiencies and coordination, and emergency room misuse. He mentioned that there were provisions in the bill for behavioral health, which he believed had become out of control. He thought it was an interesting time when

the state administration and the majority were working together. He thanked the administration for the amount of work that it had contributed. Most of the items were agreed upon by the Senate and by the administration. He would be turning the meeting over to his staff.

Co-Chair Thompson thanked the Senator for making his presentation. He announced that Representative Edgmon and Representative Gara had joined the meeting. All committee members were present. He reminded members that there would be multiple meetings to address the many topics within the legislation.

Vice-Chair Saddler asked about areas the Senator considered but did not include in the bill.

Representative Kelly would differ to Ms. Shaddock. He relayed that he had to depart from the meeting.

Co-Chair Neuman asked Ms. Shaddock to differentiate which portions were added by the administration and which parts were originally part of the Senate's discussions. Ms. Shaddock replied that she would be happy to do so.

Co-Chair Thompson asked members to limit their questions. There would be multiple meetings and a committee substitute would be issued on April 4, 2016.

Vice-Chair Saddler withdrew his question.

HEATHER SHADDOCK, STAFF, SENATOR PETE KELLY, responded that she would be happy to answer Vice-Chair Saddler's question at the end of the meeting. She would begin the walk-through of the sectional.

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Ms. Shaddock reported that Sections 1 through 7 were related to telehealth and originated in SB 98 [Legislation introduced in 2015 - Short Title: Prescription without Phys. Exam]. She explained that when SB 98 came to Senate Finance the provisions were incorporated into SB 74. She mentioned that some of the sections opened up telehealth for the use of behavioral health:

Sections 1 - 7 - Telehealth

Section 1 - Telehealth for Licensed Professional Counselors (page 2, line 15)

Opens up behavioral health access to more individuals by broadening the provider pool. Each board still maintains licensing of their members - whether they are using telehealth or not.

Ms. Shaddock spoke for Fairbanks that there was a great shortage of providers including behavioral health practitioners. It was difficult to get psychiatrists to move and live in Fairbanks, Alaska. Opening up telehealth to behavioral health providers was one way to address the state's shortages.

Ms. Shaddock continued:

Section 2 - Telehealth for Marital and Family Therapists (page 3, line 5)

Section 3 - Telehealth for Physicians (page 3, line 21 through page 4, line 9)

- Adds to the duties of the State Medical Board that they will adopt regulations that establish guidelines for a physicians who is rendering a diagnosis, providing treatment, or prescribing, dispensing, or administering a prescription drug to a person without conducting a physical exam. These guidelines must include a nationally recognized model policy for standards of care of a patient who is at a different location than the physician.

Section 4 - Telehealth for Physicians / State Medical Board (page 4, lines 10 - 29)

- Prohibits the State Medical Board from imposing disciplinary sanctions on a physician for rendering a diagnosis, providing treatment, or prescribing, dispensing, or administering a prescription drug that is not a controlled substance without an in-person physical exam, if the physician or another licensed health care provider or a physician in the physician's group practice is available for follow-up care, and the physician follows patient consent protocols for sending medical records of the encounter to the person's primary care provider and removes the requirement that the physician is located in the state.

Ms. Shaddock added that telehealth was a tool that would open up the provider pool. It was an arbitrary barrier. The physicians would continue to be licensed and regulated by the State Medical Board. She relayed that it could also drive down the overall costs of medical care in Alaska. The state had the highest cost of care in the country. It was important to do everything possible to lower costs.

Ms. Shaddock continued:

Section 5 - Telehealth for Physicians - Controlled substances (page 4, line 30 - page 5, line 11)

- Amends by allowing a controlled substance or botulinum toxin to be prescribed dispensed or administered via telemedicine only if another appropriate licensed health care provider is physically present with the patient to assist
- Subsection d sets out that an abortion inducing drug can only be prescribed in according with AS 18.16.010 and it sets out extra patient safety by not allowing a physician to prescribe, dispense, or administer a prescription drug in response to an Internet questionnaire or electronic mail message to a person with whom the physician does not have a prior physician-patient relationship

Ms. Shaddock remarked that with some controlled drugs added sideboards were needed. She explained that the state did not want doctors from other countries or states operating in Alaska which was not the intent of the bill.

Ms. Shaddock furthered:

Section 6 - Telehealth for Psychologist & Psychological Associate Examiners (page 5, line 12)

Section 7 - Telehealth for Social Workers (page 5, line 28 through page 6, line 12)

Ms. Shaddock turned to Ms. Kraly to review the fraud provisions of the bill.

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STACIE KRALY, CHIEF ASSISTANT ATTORNEY GENERAL, SECTION SUPERVISOR HUMAN SERVICES, DEPARTMENT OF LAW, would be speaking to Sections 8 through 12 which related to the creation of a new cause of action within the State of Alaska. The name of the new cause was the Alaska Medical Assistance False Claims Reporting Act (AMAF CRA). She reviewed that Section 8 and Section 9 dealt with statute of limitations provisions related to the new cause of action:

Section 8 - Fraud Statute of Limitations  
Section 9 - Fraud time exemption

Ms. Kraly explained that Section 10 contained the bulk of the provisions:

Section 10 - Alaska Medical Assistance False Claim and Reporting Act

Ms. Kraly relayed that the provision created a state false claims act which mirrored the federal False Claims Act (FCA), a statute that had been a part of the United States code since right after the Civil War. The False Claims Act created a mechanism whereby an individual might pursue and identify fraud and waste within government programs. States were not required to have a FCA, although about 18 or 19 states had them relating to Medicaid programs. Section 10 was attempting to create one for Alaska. She highlighted that the provision would allow for an individual to come forward and identify fraud or abuse. Anyone filing a lawsuit had to have it filed by seal and served contemporaneously on the Department of Law (DOL). The department would then have 60 days to investigate the merit of any claims. At the end of 60 days DOL had 3 options. The first was to move to dismiss the case because the case was found that the claim lacked merit. The Department of Law could take over the litigation. Lastly the department could differ to the individual who had brought the case forward to pursue the claim on behalf of the State of Alaska. The premise of a FCA was when the individuals participated they received a portion of the recoveries. An individual bringing a claim forward would be entitled to 35 percent of the recovery. If the state took the claim but did not allow the individual to bring it forward the individual would still receive a recovery of 15 percent to 25 percent of the total award. If the attorney general deferred they would receive a greater recover of 25 percent to 30 percent of the award. Another provision of the FCA was that there was

a whistle blower protection within the framework that allowed an individual working for a provider to be able to report the fraud or abuse while being assured they would not be terminated from their employment.

Ms. Kraly spoke about concerns from the other body about frivolous lawsuits associated with lack of merit claims by individuals. She believed that the 3 provisions along with the ability of the attorney general to dismiss such claims was a robust protection against trivial claims. Additionally, the other body decided to sunset the whistle blower provision within 3 years. Should the bill pass the department would come back in 3 years to present evidence to the legislature about whether the claims were successful or frivolous and whether the provision should go forward. Her final point was that upon the bill passing and receiving approval from the federal government, if there was a certified FCA then the State of Alaska would be entitled to an enhanced match on the recoveries - between a 5 percent and 10 percent swing. It was a significant incentive to the state to have a FCA. The provision was in the hands of the Office of the Inspector General for review to determine if they would certify it. The department was comfortable that the state would receive certification because the provision followed federal guidelines.

Ms. Kraly indicated that the Senate identified a sunset provision to address the concerns of some providers about frivolous lawsuits. Section 11 and Section 12 contained related provisions. The two provisions related to the 60 day investigation she had mentioned earlier.

Section 11 - Subpoenas after sunset  
Section 12 - Whistleblower after sunset

Ms. Kraly continued to explain that Legislative Legal Services took the 2 sections and continued them despite the repeal or sunset to allow the sections to continue forward. It would allow DOL to have the tools available. Essentially, they were technical fixes relating to the sunset provision.

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Ms. Shadduck indicated Sections 8 through 12 came from the governor's bill, SB 78 [Legislation introduced in 2015 - Short Title: Medical Assistance Coverage; Reform] and were

incorporated into the CS for SB 74. Sections 11 and 12 were added by the Senate Finance Committee.

Ms. Shaddock indicated that Sections 13 through 19 were related to the Prescription Drug Monitoring Program (PDMP). It was added through the Senate subcommittee on Medicaid reform and then adopted by the entire Senate Finance Committee.

Ms. Shaddock continued:

Section 13 - Schedule of Drugs (page 15, line 23)

- Amends the section by only requiring data collection for prescribing, administering or dispensing II, III, and IV federal controlled substances for the controlled substance prescription database.

Ms. Shaddock elaborated that they were currently in the state schedule and the federal schedule. Through the subcommittee process it was discovered that the state schedules were not needed. They were typically used by law enforcement rather than being used by prescribers or dispensers that had a federal DEA [Drug Enforcement Administration] number. They were using just the federal schedule. In order to clean up the PDMP database, the schedule was reduced to federal schedule II, III, and IV drugs.

Section 14 - Weekly basis (page 16, line 1)

- Amends by only requiring data collection for prescribing, administering or dispensing II, III, and IV federal controlled substances for the controlled substance prescription database and amends by requiring that the database be updated on at least a weekly basis.

Ms. Shaddock provided some background information. The highest number was the most potent. Federal schedule I drugs only included drugs that had no medical use, including Marijuana. Per the ballot initiative there could not be a database on Marijuana which was the reason for excluding it. Federal schedule II, III, and IV drugs, would be collected and schedule V drugs had a very low likelihood of addiction or bad interactions and were not necessary to include.

Ms. Shaddock moved to the next section:

Section 14 - Weekly basis (page 16, line 1)

Amends by only requiring data collection for prescribing, administering or dispensing II, III, and IV federal controlled substances for the controlled substance prescription database and amends by requiring that the database be updated on at least a weekly basis.

Ms. Shaddock added that currently the database was updated on a monthly basis. Alaska was the only state that updated it infrequently. All of the recommendations in Sections 13 through 19 came from the Controlled Substance Advisory Council. She noted that there was a white paper in each of the members' packets. There would be a committee meeting exploring the topic further.

Ms. Shaddock continued to Section 15:

Section 15 - Access to database/delegated access, page 16, line 27 through page 18, line 16)

(3) Amends to authorize a licensed practitioner to delegate database access to supervised employees or clinical staff;

(4) Amends to authorize a registered pharmacists to delegate database access to supervised employees or clinical staff;

(7) Adds a new section to authorize database access to the State of Alaska Medicaid Pharmacy Program;

(8) Adds a new section to authorize database access to the State of Alaska Medicaid Drug Utilization Review Committee for utilization review of prescription drugs provided to Medicaid recipients;

(9) Adds a new section to authorize database access to the State of Alaska Medical Examiner;

(10) Adds a new section to authorize de-identified data access to the State of Alaska Department of Health and Social Services Division of Public Health. The Division of Public Health would not need access to identifiable data to fulfill public health objectives regarding controlled substances including prescription opiates.

Ms. Shaddock spoke of hearing from prescribers or dispensers that would be interested in using the database,

but felt it was timely. They suggested delegating access. She noted that the state had a Medicaid pharmacist who did not have access to the database. She mentioned that the section also authorized database access to the State of Alaska Medical Examiner who was required to perform autopsies on suspicious deaths. It would be a tool to help shed light as to whether someone was on opioids or other controlled substances potentially leading to a suspicious death. She explained that access provided to the Division of Public Health would be limited such that individuals would not be able to be identified. The provisions in the bill having to do with the division having access specifically stated that it could only be collected on a regional basis. The commissioner had assured her that it would include looking at an entire region such as the entire Bethel Region or the entire Nome Region consistent with what the division was already doing.

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Representative Gattis asked for clarification about Section 5, number 8. She heard the presenter use the term "Medicaid assistance", however, the bill stated "medical assistance". Ms. Shaddock responded that in the statutes it was referred to as a recipient of medical assistance, which was known as the Medicaid program.

Representative Gattis thanked Ms. Shaddock for the clarification.

Ms. Shadduck continued with Section 16:

Section 16 - Requires all to use PDMP (page 18, line 17)

- Amends to require all prescribers and all pharmacists to register with the controlled substance prescription database. Failure to register is grounds for the board to take disciplinary action against the license or registration of the pharmacy or pharmacist.

Ms. Shaddock discussed Section 17:

Section 17 - Civil Immunity (page 18, line 23)

- Immunity for using the PDMP remains even with the change from optional to mandatory.

- Removes the language from the statute that kept use of the PDMP optional

Ms. Shaddock moved to Section 18:

Section 18 - Board regulations/review PDMP before prescribing (page 19, line 1)

- Amends to require the Board of Pharmacy to adopt regulations to:
  - (3) set a procedure and time frame for registration;
  - (4) require prescribers and pharmacists to review the controlled substance prescription database when before prescribing, administering or dispensing a federal II, III or IV controlled substance to a patient and allows for an exemption for:
    - 1) in an inpatient setting
    - 2) at the scene of an emergency or in an ambulance
    - 3) in an emergency room,
    - 4) immediately before, during, or within the first 24 hours of surgery.

Ms. Shaddock relayed that she had heard feedback and testimony from some emergency room doctors who indicated there would be times when they would not be able to look up a patient before prescribing or dispensing. For example if someone walked into an emergency department suffering with a gunshot wound doctors would need to be able to respond immediately and prescribe pain medication. The provision did not inhibit best practices.

Ms. Shaddock referred to Section 19:

Section 19 - New subsections (page 19, line 22 through page 20, line 4) - Adding new subsections to:

- (o) Require prescribers and pharmacists to review the PDMP database when prescribing or dispensing a federal II, III or IV controlled substance to a patient.
- (p) Require notification to boards when a practitioner registers with the database.
- (q) Authorize the Board of Pharmacy to forward unsolicited notifications to prescribers and dispensers of database information about patients who may be obtaining controlled substances inconsistent with generally recognized standards of care.

(r) Collect dispensing data and update the PDMP database on at least a weekly basis.

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Ms. Kraly explained that Section 20 and Section 21 related to the AMAFCRA. Section 20 was a designation that the monetary recoveries received under the FCA would be added to AS 37.05.146c, a designated receipt fund for Medicaid money. Due to the federal match, the money did not go into the GF but into a dedicated fund.

Section 20 - Program Receipts

Ms. Kraly advanced to Section 21:

Section 21 - Medicaid False claims not public records

Ms. Kraly explained that Section 21 was an amendment to the Alaska Public Records Act. It provided protection of the information that was provided and served under seal while DOL was reviewing the merits of a claim to keep the information from being subject to a public records act. Once a lawsuit was filed or a claim was brought forward in court the protections would be lost. The actual information would be limited to a non-disclosure for a period of the investigation.

Ms. Shadduck continued to Section 22:

Section 22 - Telemedicine Business Registry (page 20, line 11)

- Establishes within the Department of Commerce, Community, and Economic Development a telemedicine business registry of businesses performing telemedicine services in the state.

Ms. Shaddock reported that the registry was added by the Senate Labor and Commerce Committee. The provision was added after some feedback from doctors and the Medical Association to make sure the state knew who was doing business in the state. It offered comfort that, if there was a telemedicine provider who was a bad actor, the state could contact their company to report the doctor.

Ms. Shaddock continued to Section 23:

Section 23 - Competitive bidding (page 20, line 26)

- Allows the Department of Health and Social Services to enter into a contract through the competitive bidding process under the State Procurement Code for durable medical equipment or specific medical services in the Medicaid program like travel.

Ms. Shaddock reported that the section was an original section to SB 74. It was added in the Senate State Affairs Committee.

Ms. Shaddock moved to Section 24:

Section 24 - Computerized edibility verification system

- Subsection (a) directs the department to establish a computerized income, asset, and identity eligibility verification system for the purposed of verifying eligibility, eliminating duplication of public assistance payments, and deterring waste and fraud in public assistance programs. This program would be separate from AIRES
- Subsection (b) directs the department to enter into a competitively bid contract with a third-party vendor for the eligibility verification system. The department may also contract with a third-party vendor to provide information to facilitate reviews of recipient eligibility conducted by the department.
- Subsection (c) requires the annual savings to the state resulting from the use of the system to exceed the cost of implementing the system
- Subsection (d) requires that the contract be awarded to a vendor that is not awarding the contract for the entire eligibility system (currently AIRES) in order to avoid a conflict of interest

Ms. Shaddock relayed that the section was part of SB 74 and was added in Senate State Affairs then was expanded on and improved in the Senate Finance Committee. It was an enhanced computerized eligibility verification system. It was a system that would complement the state's current eligibility system, AIRES, which was in the Division of Public Assistance. The system actually scanned more than

the current eligibility system. She noted that other states had been able to crack down on people that were not eligible.

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Ms. Kraly explained that Section 25 amended the current Alaska statute, AS.47.05.200, required the department to engage in not less than 75 audits per year of enrolled providers. The amendment to the statute was designed to reduce that number from 75 to 50. The reason the department was seeking the reduction was that at the time the statute went into effect there were not many audits being conducted by Medicaid providers. Since then there had been a proliferation of audits by both the federal government and private insurance companies. Providers had several audits and requirements. The department felt the number could be reduced to 50. The department worked with the federal government with their audits to avoid duplication and the state gained the benefit of the federal government's audit findings vice-versa. The idea was to reduce the burden on providers without losing the benefit of the reviews.

Ms. Kraly moved to Section 26:

Section 26 - Interest and Penalties on overpayments

Ms. Kraly mentioned that Section 26 also came from SB 78. It was an amendment to the same statutory provision which asked the legislature for the ability to assess interest and penalties on identified and established overpayments. One of the things discovered in the other body was that originally the amendment indicated that the overpayment and interest and penalties would accrue at the moment the final audit was issued. The provision was amended in the current version of the bill to allow for interest and penalties to begin accruing at the point that the audit would be appealed. If it was not appealed, then penalties and interest would accrue on that date. If appealed after the completion of the administrative hearing where they might be challenging the overpayment findings. The imposition of interest and penalties was akin to what would happen in a Superior Court litigation. If someone was challenging the overpayments, they would not be subject to interest and penalties. However, once they challenged and had lost then the penalties would begin accruing.

Ms. Kraly explained Section 27 which would require providers to self-audit their claims. Providers were being asked to identify a statistically valid sample of claims and to audit those claims. Secondly, providers were being asked to conduct self-audits on a bi-annual basis. However, providers would not be required to conduct self-audits in the same years they were being audited by the state or the federal government. The department felt that providers should be engaging in due diligence when they were not being audited. Another provision of the section was that once a provider identified an overpayment, reported it, and arranged a payment plan the department would not assess penalties and interest on the self-identified overpayment.

Ms. Kraly continued with a review of Section 28 concerning civil penalties and seizure of property. She explained that the new section provided the Department of Health and Social Services (DHSS) another tool in the tool box in dealing with program integrity and provider compliance. Under the current regulatory scheme the department had penalties ranging from termination from the program to provider education. There was really no middle ground within the sanctions. The department would like to have the authority to impose fines for different sanctionable offenses which Section 28 would allow as a means to maintain program integrity and to allow providers to remain open.

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Representative Gara asked if the legislature could constitutionally give the executive branch the power to establish penalties in a bill. He reported that by regulation they would be established between \$100 and \$25,000. He had never seen a provision where the legislature had given that power away to the executive branch.

Ms. Kraly responded that was exactly why the department was asking for the provision because absent the delegation from the legislature to the department to impose the fines and penalties under the sanction provisions the department did not believe it had the authority to do so. In light of the fact that under the administrative code there was a list of more than 60 different sanctions that asked the legislature to walk through and identify the fine. The department felt

that it could do it through regulation and provide a very nominal fine. The legislature previously provided the ability for the executive branch to impose fines in other regulatory arenas.

Representative Gara wondered if the legislature could constitutionally allow the executive branch to decide what conduct resulted in what penalty amount.

Ms. Kraly responded that the provisions already existed as to what was sanctionable. The department was asking for the ability to have a potential fine attached. The department believed that the legislature could give the authority to impose fines through a regulation.

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Ms. Kraly continued to explain that further provision of Section 26 was to identify the administrative view of an assessed fine. Certain fines of a dollar amount would be reviewed internally. A higher fine amount would go to the office administrative hearings. If there were still disputes with the lower fines, they would be forwarded to the Office of Administrative Hearings.

Ms. Kraly moved to discuss the seizure and forfeiture of real or personal property in medical assistance fraud cases. The section created a system of freezing and seizing of real or personal property to offset the cost of identified fraud. Upon the discovery of a fraud case by the Medicaid Fraud Control Unit they could seek permission from the court. The court could authorize the state to seize certain assets or to place liens on certain assets so they were not disposed of while a Medicaid fraud case was being investigated. Upon the completion of such a case DOL would have to make further evidentiary findings. If authorized by the court, the department could dispose of the assets to offset the cost of the fraud that had been established through the criminal case. The section only related to the seizure and forfeiture of claims that were brought by the Medicaid Fraud Control Unit and were limited to those types of cases.

Ms. Shaddock reviewed the remainder of Section 28:

Section 28 - Medical assistance (Medicaid) reform program (starts on page 25, line 16)

Subsection (a) directs the department to design and implement a program for reforming Medicaid. The reform program must include 11 items in this version of SB 74.

- 1) Referrals to community and social support services, including career and education training services available through the Dept. of Labor, the University of Alaska, or others
  - a. The state has a lot of training opportunities through our current network of job centers, Vocational rehabilitation offices, Workforce Investment Act programs, vocational training programs, and supports through our extensive non-profits that provide services and case management
  - b. Jobs are the path to self-sustaining and improved self-image
- 2) Electronic Distribution of an explanation of benefits to recipients
  - a. It can be another tool to allow recipients of Medicaid to check that their providers are billing the state for the actual services rendered.
- 3) Expanding the use of telemedicine for primary care, behavioral health, and urgent care
- 4) Enhancing fraud prevention, detection, and enforcement
  - a. A lot has been done under Andrew Peterson's lead at the Medicaid Fraud Control Unit; we want to encourage as much fraud prevention and enforcement as possible
- 5) Reducing the cost of behavioral health, senior, and disabilities services provided to recipients of medical assistance under the state's home and community-based services waivers (Waivers section will point to some specific waivers and options for the department to apply for)
  - a. 1915k option to serve individuals who would otherwise require an institutional level of care; enhances our FMAP from 50% to 56%
    - i. The department & their contractors are going through a rigorous process to implement these. They can also start the 1915k with just those individuals who receiving Personal Care Attendant or PCA care.

- b. 1915i option move folks currently receiving care 100% covered by the General Fund to 50% FMAP. This would be for individuals that don't require an institutional level of care, but can be independent with prompting and queuing - like Alzheimer's,
        - i. Supportive employment and housing supports
      - c. Both options Could also use telemedicine/assistive technology to check in on folks at home to remind them to take meds
- 6) Pharmacy initiatives
  - a. Expanding on what the department has already done including using generic meds, claims pricing and payment reforms, prior authorizations, etc.
- 7) Enhanced care management
  - a. This could be set up in a couple of different ways; these are methods to teach the proper use of our health care system, which can be overwhelming and not intuitive to access on your own
    - i. Primary care case management with the use of a patient centered medical home. That is where a Medicaid user (often a super-utilizer) is assigned a primary care provider to oversee their care. They have access to preventative care, primary care, vaccines, flu shots, and all other appropriate care.
    - ii. Another example is special treatment for identified needs - ex - pregnancy, diabetes, asthma, and so on.
- 8) Redesigning the payment process including free agreements for performance measures that include:
  - a. premium payments for centers of excellence
  - b. penalties for hospital acquired infections, readmissions, and failures of outcomes
  - c. Bundled payments for specific episodes of care
  - d. Global payments for a specific diagnosis or primary care managers
  - e. For example, instead of going into a hospital and getting line item charged for Advil, IVs, anesthesia, etc., there would be one rate for all things related to a knee replacement.
- 9) Stakeholder involvement in setting annual targets for quality and cost-effectiveness

- 10) Reducing travel costs by requiring a recipient to obtain medical services in the recipient's home community, to the extent appropriate services are available in the recipient's home community
  - a. We need to reduce travel where we can - use telemedicine, apply for choice waiver to restrict choice
  - b. Better coordination of travel overall - when you have a family in rural Alaska, with multiple family members receiving care through Medicaid, we should be better coordinating trips. We should be sending mom and son in on one trip for all pre-planned preventative care, instead of one trip for mom to go to the dentist and another for the son to go where the mom has to accompany the son anyway
- 11) Guidelines for health care providers to develop health care delivery models supported by evidence-based practices that encourage wellness and disease prevention

Subsection (b) starting on Page 26, line 18 requires the department to efficiently manage a comprehensive and integrated behavioral health system that uses evidence based practices that are data driven with measureable outcomes. The department and the Alaska Mental Health Trust Authority must provide a plan for a continuum of community based services that includes housing, employment and criminal justice issues.

Subsection (c) starting on Page 27, line 2 has the department identify the areas of the state where improvements in access to telemedicine would be most effective in reducing the costs of Medicaid. Also allows the department to enter into agreements with IHS providers if necessary to improve access to telemedicine facilities and equipment.

Subsection (d) starting on page 27, line 9 - Reports - this subsections require the department to annually report to the legislature on November 15

- 1) Realized cost savings related to reforms from the reform program
- 2) Savings from reform efforts undertaken by the department
- 3) A statement of whether DHSS has met annual targets for quality and cost-effectiveness

- 4) Other recommendations for the legislature including legislative changes, budget changes, impacts of federal laws, results of demonstration projects
- 5) Legal and technological barriers to the expanded use of telemedicine in Alaska, and recommendations for changes that would allow cost-effective expansion of telemedicine
- 6) Basically everything legislators want to know to continue to monitor and reform the Medicaid program. I suspect this will be very useful for our HSS and Finance committees

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Subsection (e) starting on page 28, line 13 - provides a definition for telehealth.

Ms. Shadduck continued to Section 29:

Section 29 - Primary Care Case Management (page 28, line 18, through Page 29, line 8)

- Requires DHSS to implement the primary care case management system. The purpose of this new system is to increase Medicaid enrollees' appropriate use of primary and preventive care, while decreasing the use of specialty care and hospital emergency department services. An exemption applies to recipients with chronic, acute, or terminal medical conditions.

She elaborated that the section was taken from the governor's SB 78 and it was amended in the Senate Finance Committee.

Representative Wilson asked if primary care case management would be mandated for enrollees.

Ms. Shadduck responded that on page 28, line 19 the word "Shall" was included. The intent of the department was to implement it as widespread as possible.

[2:24:01 PM](#)

Representative Wilson clarified that her question was about the recipient. She wondered if she would be required to participate if she were to enroll in Medicaid.

Ms. Shaddock responded that the intent would be that as a recipient of Medicaid she would be assigned a primary care provider. However, she would confirm her answer and get back to the representative.

Ms. Shaddock continued to Section 30:

Section 30 - Waivers (page 29, line 9)

(d) allows the department to apply for:

- 1) 1915 (i) option
- 2) 1915 (k) option
- 3) 1945 options for health homes for individuals with chronic conditions

(e) directs the department to apply for an 1115 waiver to establish one or more demonstration projects focused on innovative payment models

(f) directs the department to apply for an 1115 waiver specific to behavioral health

Ms. Shaddock explained that Section 30 came from the governor's SB 78. She highlighted that the 1915(i) option, home and community-based services, was currently funded 100 percent GF services for folks receiving grants and senior and disabilities services for things like Alzheimer's. It would move it to a 50/50 state federal match. She explained that the 1915 (k) option was a refinancing of the state's senior and disabilities services currently on the 1915 (c) waiver. It would give the state an enhanced Federal Medical Assistance Percentage (FMAP). It would move the state from a 50 percent to a 56 percent FMAP. She relayed that for the first 8 quarters the federal match for services pertaining to the 1945 option was 90 percent. She conveyed that the 1115 waiver asked the state to bend the rules on what was currently in the state's plan. The state asked Centers for Medicare and Medicaid Services (CMS) if it could do innovative things with the Alaska's Medicaid program if the state showed budget neutrality. She elaborated that some of the items related to behavioral health were specific to address the barriers that came up over the years by Alaska's fragmented behavioral health system. One of the things that was discussed extensively in the Senate Finance Committee was a 30 percent rule. A behavioral health clinic had to have psychiatric oversight by a psychiatrist 30 percent of the time which was a large burden for Alaska. Some of the items would open up regulations.

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Ms. Shadduck moved to Section 31:

Section 31 (page 30, line 18 through page 31, line 15) - Collaborative, hospital-based project to reduce the use of emergency department services.

- This would build on what the department has already done with their super-utilizer program,
- This program is modeled on a successful project in Washington State. It's about directing individuals to the right care, at the right time, in the right place.
- Number 4 on page 31, line 3 - sets how a process for a referring an ER user to a primary care provider or behavioral health provider within 96 hours after an ER visit
- Number 5 on line 6 requires a collaborated process between the department and the statewide professional hospital association to establish uniform statewide guidelines for prescribing narcotics in an emergency department

Ms. Shaddock spoke to number 4. She relayed that the project was original to SB 74. It was amended in committee and was a recommendation resulting from the Medicaid redesign process from the department's consultant, Agnew Beck Consulting. The project would be in partnership with a state professional hospital association that would be taking the lead on the project. She highlighted that there had been significant testimony and conversation about Alaska having a large opioid problem which was the reason for the provisions included around the PDMP. It was also the reason that the number was listed in the emergency room project.

Ms. Shaddock continued with the rest of Section 31:

Section 31 - Coordinated Care Demonstration Projects (page 31, line 16)

- About whole person, integrated care with payment models that move us away from fee-for-service → paying for value over volume

Ms. Shaddock noted that in the Senate Finance Committee and in the Medicaid reform subcommittee there was a lot of discussion about options including managed care

organizations, accountable care organizations, coordinated care organizations, etc. The coordinated care project was the result of those conversations as a way of bringing forward the best projects and proposals for the State of Alaska.

[2:30:14 PM](#)

Ms. Shaddock continued with Section 32:

AS 47.07.039 (a) - Line 16, through page 32, line 16)  
Requires DHSS to solicit and contract with one or more third-party entities for coordinated care demonstration projects for individuals who qualify for Medicaid benefits on or before December 31, 2016. DHSS may use an innovative procurement process as described under AS 36.30.308. A proposal for consideration must include three or more of the following:

- 1) Comprehensive primary-care-based management, including behavioral health services and coordination of long-term services and support;
- 2) Care coordination, including the assignment of a primary care provider located in the local geographic area of the recipient;
- 3) Health promotion;
- 4) Comprehensive transitional care and follow-up care after inpatient treatment;
- 5) Referral to community and social support services, including career and education training services;
- 6) Sustainability and the ability to replicate in other regions of the state;
- 7) Integration and coordination of benefits, services, and utilization management;
- 8) Local accountability for health and resource allocation.

AS 47.07.039(b) (page 32, line 17)  
Establishes a project review committee for proposals submitted under (a) of this section. The committee is comprised of:

- 1) The Commissioner of DHSS or their designee;
- 2) The Commissioner of Administration or their designee;
- 3) The CEO of the Alaska Mental Health Trust Authority or their designee;
- 4) Two representatives of stakeholder groups, appointed by the Governor for staggered three-year terms;

- 5) A Non-voting member of the Senate appointed by the Senate President; and
- 6) A Non-voting member of the House of Representatives appointed by the Speaker of the House of Representatives.

AS 47.07.039(c) (page 33, line 1)

Grants DHSS authority to contract with third-parties to implement the demonstration projects listed under (a) of this section that include managed care organizations, primary care case managers, accountable care organizations, prepaid ambulatory health plan, or a provider-led entity. Allows for fee structures including but not limited to global payments, bundled payments, capitated payments, and shared savings and risk. Requires DHSS to work with the division of insurance, DCCED to streamline the application process for a company to obtain a certificate of authority as needed to participate in a demonstration project.

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AS 47.07.039(d) (page 33, line 10)

Requires any project under (a) to include cost-saving measures including the expanded use of telehealth for primary care, urgent care, and behavioral health services.

AS 47.07.039(e) (page 33, line 17)

Requires DHSS to contract with a third-party actuary to review demonstration projects after one year of implementation and make recommendations for the implementation of a similar project on a statewide basis. On or before December 31, 2018, and each year thereafter, the actuary shall submit a final report to the DHSS for any project that has been in operation for at least one year.

AS 47.07.039(f) (page 33, line 26)

Directs DHSS to prepare a plan regarding regional or statewide implementation of a coordinated care project based on the results of the demonstration projects under this section. Requires DHSS on or before November 15, 2019 to submit a report to the legislature on any changes or recommendations for wider regional or statewide implementation.

AS 47.07.039(g) (page 34, line 4)

Refers to the definition of telehealth in AS 47.05.270(e)

Ms. Shaddock indicated that the project would continue on. If CMS came up with a new demonstration project or some other innovative method, the department could continue to run the projects through the same project review committee and use the same process.

Ms. Shaddock moved on to Section 32:

Section 32 (Page 34, line 5)

- Requires the department and the attorney general to annually prepare a report regarding fraud prevention, abuse, prosecution, and vulnerabilities in the Medicaid program.

Ms. Shaddock reviewed Section 33 and Section 34:

Section 33 (page 35, line 2) Removal of Grantee Requirement

AS 47.07.900(4) Amends Medicaid Administration definitions, by removing the grantee status requirement for outpatient community mental health clinics serving Medicaid patients.

Section 34 (page 35, line 7) Removal of Grantee Requirement

AS 47.07.900(17) Amends by removing the grantee/contractor status requirement from drug and alcohol treatment centers and outpatient community mental health clinics. This change, and the one in the previous section, allows mental health and drug treatment service providers who do not receive grants from the department to become enrolled Medicaid providers and deliver services to Medicaid recipients.

Ms. Shaddock conveyed that the provisions would align the state with requirements by the federal government to provide these services. The federal government required that the state remove the grantee requirements or they would start withholding behavioral health Medicaid funds. It would help to address the state's shortage of behavioral health providers across the state.

[2:35:38 PM](#)

Ms. Shadduck addressed Section 35:

Section 35 (page 35, line 15) Alaska Pioneer Home Payment Assistance

- Requires individuals applying for Pioneer Home payment assistance to show proof of having applied to Medicaid. HB 30 audits - will save around \$1 million a year

Ms. Kraly noted that Section 36 and Section 37 related back to the Medicaid False Claims and Reporting Act. She reported that Section 36 contained the repealer provisions of the sunset provisions for the private plaintiff relator individuals.

Ms. Kraly indicated that Section 37 related to the indirect and direct court rule amendments that needed to take place as a result of the new cause of action. She referenced page 35, line 28 through page 37.

Ms. Shadduck spoke to Section 38:

Section 38 - Implement Federal Policy on Tribal Medicaid Reimbursement (page 37, line 2)

- Requires DHSS to collaborate with Alaska Tribal health organizations and the U.S. DHHS to implement new federal policy regarding 100% federal funding for services provided to Medicaid-eligible American Indian and Alaska Native individuals within six months of the rule change being finalized. Requires DHSS to report to the co-chairs of Finance the estimated savings and calculations of savings to the state general fund within thirty days of the rule being finalized.
- Savings have been reflected in both the House and Senate budgets as part of the overall package of Medicaid Reform

Ms. Shaddock was aware that finance committee members had significant discussions around the rule change put out by the CMS concerning services being received through an Indian Health Service (IHS), a tribal facility, and those being reimbursed 100 percent. The section asked that the department fully implement the provision within 6 months of the rule being finalized and to submit a report to the co-

chairs of the House and Senate Finance Committees on the savings.

Ms. Shaddock continued to Section 39:

Section 39 - Health Information Infrastructure Plan (page 39, line 20)

- One result of the Medicaid Redesign process the Dept. has taken
- Requires DHSS to develop a plan to strengthen the health information infrastructure, including health data analytics capability, to support transformation of the health system in Alaska.

Ms. Shaddock reported that the section came from the governor's SB 78. She remarked that the state had a long way to go to improve its data analytics. The department was determined to implement the plan correctly and aggressively.

Ms. Shaddock moved to Section 40:

Section 40 - Feasibility Studies (page 38, line 4) - Required before any state service can be privatized

(a) Alaska Pioneer Homes and Select DJJ facilities - procured by DHSS

- Wouldn't look the same for each facility
- For DJJ Facilities - RPTC - residential psychiatric treatment centers that could be run by Tribes like in Nome. They could provide culturally relevant care close to home.
- All of these 24/7 facilities represent 1,192 state employees

(B) Alaska Psychiatric Institute - DHSS in conjunction with the Trust

- Private psychiatric hospitals in other states

(c) Health Care Authority (line 22)

- Requires the Department of Administration in collaboration with the House and Senate Finance Committees to conduct a study analyzing the feasibility of creating a health care Authority to coordinate health care plans and consolidate purchasing effectiveness for all state employees,

retired state employees, retired teachers, Medicaid Assistance recipients, University of Alaska employees, employees of state corporations, and school district employees.

- Other states like Washington State and Oregon have used these very effectively

Ms. Shaddock conveyed that Section 40 was original to SB 74 and it had been expanded. She noted that other states had leveraged all of the health care that their state was paying for. In looking at the contracts with state employees, the cost of healthcare continued to rise in Alaska. Large changes would need to be made. Section 40 outlined one tool to study how to pool all of them, leverage the state's purchasing effectiveness, hopefully bend the curve, and maybe even bend the curve of the cost of healthcare in Alaska.

[2:41:00 PM](#)

Ms. Shaddock spoke on Section 41:

Section 41 (page 39, line 17)

- Requires the department to amend the state Medicaid plan and apply for any waivers necessary to implement the projects and programs described in the bill.

Ms. Shaddock advanced to Section 42:

Section 42 - Transitions: Regulations (page 39, line 28)

- Allows the department and the Board of Pharmacy to adopt regulations necessary to implement the changes made by the Act. The regulations may not take effect before the dates the relevant provision of the Act takes effect.

Ms. Shaddock continued to Section 43:

Section 43 - Conditional effects (Page 40, line 7)

- This protects the Department from having to follow a law on the books if the federal government won't approve state plan amendments or waivers needed to implement the law.

- Subsection (e) on line 27 is specific to the provisions of the false claims act that are amending court rules and require a 2/3 vote.

Ms. Shaddock reviewed Sections 44-47:

Sections 44-47 (page 41, starting on line 1)

- Provides for effective dates for provisions that require waiver and state plan amendment approvals from the United States Department of Health and Human Services.

Ms. Shaddock reviewed Section 48:

Section 48 (line 13)

- Effective Dates - Provides an immediate effective date for Sections 40, 41, 42(a), and 43.

Section 49 (line 15)

- Effective Dates - Provides for a July 1, 2017 effective date for Sections 13-19 relating to the Prescription Drug Monitoring Program (PDMP).

Section 50 (line 16)

- Effective Dates - Provides an effective date of July 1, 2016 for Section 42(b).

Section 51 (line 17)

- Effective Dates - Provides a delayed effective date of July 1, 2019 for Sections 11 and 12 to conform to the sunset provisions in Section 36.

[2:43:02 PM](#)

Co-Chair Thompson acknowledged that there had been a significant amount of information to digest.

Vice-Chair Saddler corrected Ms. Shaddock regarding the effective date of Section 49. Ms. Shaddock had indicated the date of July 1. The correct date was January 1, 2017.

Ms. Shaddock happily stood corrected.

[2:43:32 PM](#)

Representative Wilson asked if the state already allowed telemedicine services within its own insurance.

Ms. Shadduck was not sure what state insurance currently allowed. She was aware of health plans offered by private companies in the state that wanted to use the telehealth option. However, the in-state requirement had limited that use.

Representative Wilson was in support of the use of telehealth medicine. She thought it was a great idea for private insurance as well as for the whole state. She did not understand why it would be limited to Medicaid.

Representative Wilson mentioned having discussions in the House Finance Committee about optional benefits. She wondered if they had been discussed and, if so, asked why they had not been part of the presentation. She requested a written response.

Ms. Shadduck responded that the provisions about telehealth and telemedicine were specific to the use across the state. It was not specific to the Medicaid program. She responded to Representative Saddler's question about optional benefits. The topic was discussed in committee and privately. It was found that the optional benefits saved the state money. She spoke to having Legislative Research update a report about primary care attendants and home and community-based services. They saved the State of Alaska a significant amount of money. All of the individuals that were receiving care needed an institutional level of care. If they were not receiving care at home the state would have to care for them in an institution. It meant the state would have to put money in the capital budget to build nursing homes. Some of the optional benefits included pharmacy, hospital ER use, and others. They would show up as costs elsewhere if the state did not provide them. She would provide the research piece to Representative Wilson.

Representative Wilson appreciated Ms. Shadduck's response.

Co-Chair Thompson ran through a list of other people available to answer questions.

[2:47:00 PM](#)

Co-Chair Neuman had concerns with the prescription drug database. He had asked the chair for a few minutes to share his concerns with the committee on the subject. He first came across the issue when he became the chairman of the House Finance subcommittee for DHSS. One of the things that got his attention was \$40 million in rebates to DHSS. He had wondered where the money came from. The Department of Administration (DOA) had also received \$20 million in rebates from pharmaceutical companies. At the time of his discovery he was unclear about what was going on. He found out that there was a federal regulation that allowed pharmaceutical companies to charge more than the actual cost of prescription drugs under the guise of covering the costs for Medicaid patients (about \$1 million per week). He thought the practice was very wrong. He reported that when talking to Alaskans they were unaware and uncomfortable that the State of Alaska kept a database on controlled drug prescriptions. He was informed that databases within Alaska have commonly been hacked. He pondered what could happen if there was a breach allowing for access to personal information. He suggested that the information would be appealing to drug gangs. He explained that when someone brought in a prescription that the pharmacy staff felt was an inappropriate or illegal prescription they were required to destroy them or not give them back. He continued that there was no enforcement behind the requirement except for a pharmacist or a pharmacy technician like his wife. He was very concerned about retribution from drug addicts who had a prescription that could be worth thousands or tens of thousands of dollars from not getting them back.

Co-Chair Neuman reported that SB 74 allowed additional access to the database. Some people with access could dispense the information to people who were not upstanding Alaskans. He told of some seniors in Big Lake who were robbed of their prescription drugs and murdered. He posed the question to other legislators, "Do you feel comfortable knowing that somebody could give access to your personal information?" He posed a hypothetical scenario in which someone broke a leg and the doctor issued a prescription for 100 Percocet to manage their pain. The information could be given to someone including an address. His constituents were not very comfortable.

Co-Chair Neuman furthered that he had worked as hard as anyone on drug and alcohol abuse. Three years prior he had placed intent language in the operating budget that allowed

for the Recidivism Reduction Group to form. Born out of that group was the Recidivism Reduction Plan which was the basis for much of the substance abuse treatments in Alaska. He also noted that the House took action in the current year to address the substance abuse issue.

Co-Chair Neuman continued to discuss the issue of the prescription drug database. He found that the state provided doctors with a preferred drug list. He suspected that the state received the largest rebates from the drugs on the list. He thought there was an opportunity for the state to stick its nose in between a doctor and patient based on how much money the state received in rebates. He thought that if it was not happening, it could. He admitted that presently he did not have proof. He understood how hard people were trying to find money in the state to support their budgets. He brought the subject up because of his great concerns for opioid overdose. There was a movement to try to deal with the problem. He had spoken with a doctor from Wasilla who had issues because he was losing patients. He mentioned doctor requirements in the states of Washington and California. He thought primary care providers should talk to their patients about the effects of opioids or any drugs they took including the benefits and the risks to a person's health. He noted that primary care doctors were no longer allowed to talk to long established patients about certain drugs. Instead, a patient had to go to a specialty doctor to provide long-term care and to dispense pain medication or classified drugs. The cost of a visit to a specialty doctor was upwards of \$550 per office visit. He wondered how many of the Medicaid or Medicare patient visits were causing the state's budget to increase. He believed it would only be about \$150 per visit for a patient to see their primary care provider, someone familiar with their medical history.

[2:56:02 PM](#)

Co-Chair Neuman wondered about doctors being required to participate [in the PDMP] and, if they chose not to, potentially losing their DEA license which enabled them to prescribe drugs. He continued that most doctor's visits were 15 minute increments averaging about 4 appointments per hour. He suggested that the doctors would have to expand their visits because of having to look at the database. He relayed that most doctors did not go into a back office to look at a prescription drug database and

then meet with their patients. He noted having talked to several people that worked in specialty clinics dispensing prescription drugs who have indicated they did not use the database. He pondered why. Although he did not have access to the database, it was his understanding that there were 7 pages of federal regulations. They [doctors] had to print the pages out and sign each one acknowledging they completely understood the information. The doctors he had spoken with did not comprehend how anyone could understand 7 pages of federal regulations. If any doctor did not sign each page they would lose their DEA license and their ability to write prescriptions. Rather than signing the form the doctors just did not use the database. He could understand why a doctor might want access to the database in an emergency situation. Generally, emergency rooms were used for triage - to get a patient through the weekend, to get a patient to their primary care provider. He opined that in the emergency room doctors were not writing prescriptions for large amounts.

Co-Chair Neuman reiterated that he had huge concerns about the State of Alaska keeping a database. He had spoken with Alaska's federal delegation about federal regulations allowing for about \$60 million in rebates to the state. He was unclear what the pharmaceutical companies received for their administrative fee but he suspected they received as much as they could. I suggested that Alaska was spending at least \$60 million extra for Alaskan's prescription drug that came back in rebates for the State of Alaska. He opined that it was the largest crime in America currently. The State of Alaska voluntarily entered into a program with the federal government that allowed the federal government to give the money back to the State of Alaska. The State of Alaska would rather have the money as an increment in its operating budget to cover its costs. The federal government also had access to the records in the database. He would be happy to further discuss the issue with members. He wanted to make sure the public was aware of the issue.

[3:00:13 PM](#)

Co-Chair Thompson indicated that each subject would be handled separately and that a schedule of topics and corresponding committee meeting times would be given out to committee members.

[3:00:39 PM](#)

Representative Kawasaki asked about Sections 1 through 7 related to telehealth. He noted that each section specifically prohibited the State Medical Board from imposing sanctions for rendering a diagnosis. He wondered about the liability of a physician if they did something wrong and whether the board would have the ability to sanction them if they committed a criminal act.

[3:01:16 PM](#)

Ms. Shadduck clarified that each of the sections were related to their specific board and who they oversaw. Only three of them were specific to the State Medical Board. How it was worded meant that they could not impose sanctions purely using telehealth. They could still regulate bad medical behavior and bad practice. However, they could not go after a doctor for simply practicing via telehealth.

[3:01:48 PM](#)

Representative Kawasaki asked about how to prevent having a "Doc-In-A-Box" or from physicians out-of-state that became licensed. He wondered about physicians, psychologists, or social workers being out-of-state, licensed within Alaska to practice, and able to practice via telehealth.

Ms. Shadduck stated that the only board specifically called out the in-state and out-of-state provision was the State Medical Board. It was the only board that had not allowed individuals to perform telehealth via out-of-state. She furthered that the other boards did not currently outline in their provisions whether they allowed telehealth. They would be allowed to have telehealth but the decision was left with the decision as to whether the individuals would be in-state or out-of-state to the boards.

Representative Kawasaki asked her to speak to how it would become an issue if hiring a provider at a cost savings that would be using a telehealth bridge. He wanted more information concerning difficulties in the recruitment of providers. He wondered if the issue had been discussed in the other body.

Ms. Shadduck indicated that some of the conversations around the provisions were bringing the rest of the state in line with what was already being done within IHS. Alaska

Native Tribal Health Consortium (ANTHC) and other IHS providers were extensively using telehealth. They currently could have providers operating from out-of-state. They were trying to true up to allow the same availability for everyone else. There were communities that were unlikely to attract a fulltime doctor. Telehealth was a means to address provider issues. She did not see telehealth completely eliminating the need for individuals to have hands-on primary care. She supposed that because she was from a younger generation she would be more likely to use the telehealth option. She continued that someone like her Mom who was in her 50s would not be comfortable using it. She did not see telehealth completely taking away hands-on primary care. She was uncertain if there was a discussion about whether the cost would drive providers out. She would follow-up with the initial bill sponsor and have them get back to his office.

Representative Kawasaki referred to Section 28 which dealt with civil asset forfeiture. He wondered if it was outlined in the same way non-medical fraud cases were handled. He pointed to page 23 of the bill.

Ms. Kraly asked Representative Kawasaki to repeat his question.

Representative Kawasaki wondered if civil asset forfeitures were handled the same within the state.

Ms. Kraly asked if he was referring to the seizure and forfeiture of real and personal property. Representative Kawasaki responded affirmatively.

Ms. Kraly responded that the answer to his question was both yes and no. She explained that the state did not have a civil forfeiture provision within the State of Alaska besides what was currently used with Fish and Game. She reported having looked at those provisions when drafting the section. She indicated that the specific sections came from other states that had a more robust civil forfeiture provision for broader schemes. It was a little bit of both. She did some civil forfeiture for Fish and Game violations. The template from the provision being discussed was broader than just Alaska.

Representative Kawasaki commented that just reading the plain view in the sectional and the bill on page 23, it

talked about the real property that could be subject to seizure including bank accounts and inventory dealing specifically with the fraud. It also listed a bunch of other things including automobiles, boats, airplanes, and stocks and bonds.

Ms. Kraly explained that part of the reason the section he read was as broad as it was, was that it was borne out of experience. It would be discussed further in the following day during the presentation on fraud and false claims provisions. She added that the Medicaid Fraud Unit has had some difficulty in recovering fines. Some people charged with crimes transferred their assets to avoid state seizure of them. The Medicaid Fraud director could speak more to the subject in the following day.

Co-Chair Thompson relayed fraud would be the topic for the following day.

[3:07:56 PM](#)

Vice-Chair Saddler asked if a report that had been referenced earlier in the meeting could be provided. He was unclear if it was something the department had done or if it was an assessment of the Agnew Beck report.

Ms. Shadduck stated that the report was about the cost of optional services for Alaska's primary care and home and community-based services. She would submit the report to the chair for distribution.

Vice-Chair Saddler referred to page 9 of the sectional analysis there was reference to AS.47.05.270b where the department was directed to work with the Alaska Mental Health Trust Authority regarding community-based services. In subparagraph "c" the department was asked to identify areas where telehealth would be affective to reduce Medicaid costs. He recalled a comment made about ANTHC being experts but the department did not work with the entity. He wondered why.

Ms. Shadduck reported that Line 7 and 8 of the bill specifically stated the department could enter into agreements with IHS providers, the more appropriate name in statute for a group like ANTHC.

Vice-Chair Saddler asked Ms. Shaddock to characterize the involvement the Senate Finance subcommittee had with stakeholders in developing the bill. He had read the Agnew Beck report and seen their extensive list of people they consulted with.

Ms. Shaddock responded that the sponsor had heard from many different people when creating each section of the bill. There had been testimony from Agnew Beck as the department's contractors as well as the Menges Group, the legislature's contractors. A significant amount of feedback was received from Becky Hultberg with the Alaska State Hospital and Nursing Home Association, Jeff Jesse with the Alaska Mental Health Trust Authority, Tom Chard with the Alaska Behavioral Health Association, Kate Burkhart with the Alaska Mental Health Board and the Advisory Board on Alcoholism and Drug Abuse, the Dental Society, the Alaska Primary Care Association, the Psychological Association, and the South Central Foundation. She offered to provide a complete list of organizations she had heard from. The list was exhaustive and extensive. She indicated that if someone had reached out to the bill sponsor, they offered to hear from them. She mentioned that she and Ms. Erin Shine, Staff to Senator Anna MacKinnon, worked one-on-one with as many folks as possible.

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Vice-Chair Saddler asked Ms. Shaddock to provide the list as well as contact information. He mentioned that throughout the bill that required reports to the legislature on various dates. He wanted a list of the reports, due dates, and the person that generated them.

Ms. Shaddock responded that she had been asked to create a master table that listed the large topics and the provisions in the bill. She could certainly include the reports in the document. She noted that all of the reports were due on the same date.

Representative Gattis had presented a bill on telehealth medicine a couple of years prior. The current bill tweaked some of the things she did not think was possible before the advancement of technology. She had become aware that IHS had a federal exemption that kept them from being sanctioned. She thought the bill was allowing everyone else

outside of that from being sanctioned by the medical board. She wondered if she was accurate.

Ms. Shaddock confirmed that Representative Gattis was correct.

Representative Gattis stated that telehealth was offered to state employees but the necessary doctors were not available. She explained that the legislature passed a bill that required doctors to be licensed in Alaska and to reside in Alaska. The state was currently unable to utilize its technology because although providers from other places were licensed in Alaska, they did not reside in the state. The state's insurance showed that telemedicine was an option but could not be used because they were unable to get people to Alaska. She thought the opportunity was being opened up.

Representative Gara was impressed with Ms. Shaddock's presentation of the bill. He highlighted the first line of the third paragraph of the sponsor statement that indicated Alaska had some of the highest Medicaid rates in the nation. He furthered that Alaska had not executed some of the rate innovations implemented by other states and Medicare. He had not heard anything that touched on the issue. He was concerned with Medicaid reimbursement rates not being high enough to attract physicians. Medicare rates had been particularly troubling for physicians leading them to decide not to take Medicare patients. He asked if there was a provision in the bill that lowered Medicaid rates to those of Medicare. If so, he would be concerned about patient access.

Ms. Shaddock explained that in the Medicaid provisions where she discusses redesigning the payment process, number 8, there had been a significant amount of conversation about rates. Questions had been sent back and forth between the subcommittee to the commissioner inquiring about the state's rates being inadequate, not in line with Medicare, and provider's not taking Medicaid because of rates. She furthered that rate setting was an art form, trying to move the entire system away from fee-for-service. In order to make this change the committee redesigned the payment process to include some of the innovative rates. She noted it was the main intention behind the coordinated care projects, starting to see what kind of innovative rate structures and pier coordination would work on a global

basis. There was a fiscal note from the Office of Rate Review to discuss implementing the two sections. Setting rates required the state to use an actuarial analysis and, the extensive process required those to go before the providers for public comment. She added that it was difficult to mess with the entire process and, they were trying to move the entire system away from fee-for-service. She explained that copays were not addressed because of hearing from providers that they ended up eating the cost. There were provisions that were set by the federal government about what could be charged for copays. She thought Director Margret Brodie could provide additional information. She continued that adding in things such as copays when trying to move the structure away from fee-for-service could be counter intuitive. She also noted that the state's technology might not work or would cost more to collect a very nominal amount.

[3:18:17 PM](#)

Representative Gara agreed that copays were often more costly than trying to collect them. He continued that he did not want to do what was done in Medicare such as doctors receiving only \$65 for a primary care visit. Physicians had reported that the amount was completely inadequate for them to want to serve the Medicare population. If they served Medicare patients they did it out of a sense of obligation. He noted that there had been discussion about reducing the cost for home and community-based care. He suggested that those who provided respite care and personal care attendants already received a very low level of pay. He wondered if, by reducing the cost for home and community-based care, it would put pressure on the state to lower the pay for attendants.

Ms. Shadduck suggested that the intention was to use innovative methods such as telemedicine. For instance regarding home and community-based services, instead of having to send someone out to a patient's home every day, an iPad could be placed in a patient's home and Facetime could be used to check in with a patient about their medications and to answer any questions. She reported that Section 30, referring to waivers, was the location in the bill where the department was asked to implement the 1915i and 1915k options as well as the 1945 health homes. They did not reduce services but helped shift what the state was receiving from the federal government.

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Representative Gara was aware that the department was moving ahead with a number of waivers. He was unclear why it was included in the bill. He suggested the department wanted the legislature's blessing that it was moving ahead.

Ms. Shaddock responded that he was correct. The department wanted to make sure there was legislative approval in place before applying for the waivers. She reported having a conversation with Deputy Commissioner Sherwood on the matter.

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Co-Chair Neuman referred to Section 23 which had to do with competitive bidding for durable medical equipment. The section discussed that a Medicaid service provider could go through a program that could be delivered on a statewide basis. He wondered if it meant that only providers that worked on a statewide basis could enter into a contract with the state for the competitive bidding process.

Ms. Shaddock responded that it could be done regionally. The bill was specific about the type of things that would be allowed to be handled in a competitive bidding process such as durable medical equipment, wheelchairs, travel, and other items. She reported being approached about considering other things that the committee was comfortable with. She stressed that it was in no way to mean that one provider needed to do it entirely statewide.

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He asked about the number of audits per year listed at 50 in Section 25. He wondered why the state would specify a number without knowing costs.

Ms. Kraly answered that currently in statute it required the department to conduct 75 audits. There was a contract with Myers and Stauffer to conduct the state's audits. She could provide Co-Chair Neuman with a copy of the state's contract with them. It outlined how it was reimbursed. The department determined to reduce the number of audits to 50 to offset the costs of multiple audits. Providers had a significant amount of audits at the federal, local, and

state levels. The department would experience the same impact without doing as many audits.

Co-Chair Neuman referred to Section 30 which talked about outlining cost containment. He wondered about the current value of the waivers if the state accepted all of those that were available. He saw that there was a limit of 6 months to apply. He did not understand why the state would want to put a time limit on applying. He wanted the information from the department. He also wanted a legal opinion on the authority of the department to develop regulations and post fines.

Co-Chair Thompson assured Co-Chair Neuman that a request would be made.

Representative Edgmon would ask his question at a later time.

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Representative Munoz, commented that Board of Pharmacy oversaw the PDMP. The focus was really on the patient and trying to track patients that shopped around or who had sought more than one prescription in a short period of time. There was a provision that the board would notify the pharmacist or practitioner. She wondered if the bill committee had contemplated how the database might be used to monitor the prescriptive practices of certain physicians who tended to over prescribe narcotics.

Ms. Shadduck responded that since that had been brought to her attention in a meeting with Representative Munoz she had sent a question to the Director of Corporations, Boards, and Licensing to get some feedback. She also noted that there was a PDMP technical assistance center in the US. She sent a feeler out to them and they had already responded. She would be happy to share more information. The other question could be addressed by the director on the day focusing on the PDMP.

Representative Munoz also asked whether previous committees had contemplated the State Board of Medicine being involved in the monitoring of prescriptive practices.

Ms. Shadduck responded that as a board if they were sanctioning someone they could not use the database. There

were protections to avoid the information being used incorrectly. There were provisions that were Class A misdemeanors and Class C felonies. She continued that through a legal action there could be a subpoena to look up information but was very restrictive on who had access to the database. Currently, the method the Senate chose was those unsolicited notifications to prescribers. She added that requiring the use of the database would allow an education level to increase about how much controlled substances prescribers were prescribing. It was more on the educational side than a complete aggressive hammer.

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Representative Munoz asked about the types of drugs included on Schedules II, III, and IV. She noted that Schedule II and III drugs was more addictive in nature than Schedule IV drugs. Her concern was that the inclusion of Schedule IV drugs would create a great amount of workload on the part of practitioners. She thought it was the information about the narcotics represented in Schedule II and III that was most important. She wondered if the discussion had come up in previous committees.

Ms. Shadduck realyed that there had been much discussion about what schedules to include. Schedule IV included Benzodiazepines which potentially interacted badly with Schedule II and III drugs. The group felt that it was important to include Schedule IV drugs. She clarified that the only folks that enter information in the database were pharmacists and pharmacy employees at the time of dispensing. The day prior to the bill passing on the floor the US Senate passed SB 524, the Comprehensive Addiction and Drug Recovery Act of 2016, which included (in Section 601) a use of the PDMP that would be required for prescribers and dispensers to look up federal schedule II, III, and IV drugs. The prescribers would have to look up all three schedules before they prescribed. It was something that was co-sponsored by Senator Sullivan and passed by both of Alaska's Senators. If the bill became federal law, then the federal government would have a higher threshold and, they would be linked to federal grants and other things.

Representative Munoz asked if a false claim could be placed against the State of Alaska or one of its affiliates such as the Pioneer Home or the Juvenile Justice System. She

also wondered if a false claim could be applied in another way such as an underpayment or overpayment by the state reimbursement of a payment.

Ms. Kraly would have to look more closely. She noted that state agencies like the Pioneer Home were subject to audit requirements. They did identify overpayments and had to reconcile those issues. She believed there was a provision regarding state employees and state agents in terms of the FCA. She would follow up with additional details.

Co-Chair Thompson thanked Ms. Shadduck for the amount of work she had put into the bill.

Ms. Shadduck looked forward to the committee making the bill a better bill.

CSSB 74(FIN) am was HEARD and HELD in committee for further consideration.

Co-Chair Thompson reviewed the agenda for the following day.

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ADJOURNMENT

[3:32:11 PM](#)

The meeting was adjourned at 3:32 p.m.