

HOUSE FINANCE COMMITTEE  
March 23, 2016  
1:30 p.m.

1:30:54 PM

CALL TO ORDER

Co-Chair Thompson called the House Finance Committee meeting to order at 1:30 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

Heather Shadduck, Staff, Senator Pete Kelly; Becky Hultberg, Alaska State Hospital and Nursing Home Association; Carlton Heine, Past President, American College of Emergency Physicians, Alaska Chapter, Juneau; Anne Zink, President, American College of Emergency Physicians, Alaska Chapter, Mat-Su.

PRESENT VIA TELECONFERENCE

Margaret Brodie, Director, Division of Health Care Services, Department of Health and Social Services.

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 discussed the meeting agenda.

#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."

[1:31:50 PM](#)

Co-Chair Thompson noted that Commissioner Davidson was present.

HEATHER SHADDUCK, STAFF, SENATOR PETE KELLY, referred to the handout titled "SB 74 - Medicaid Reform Topic and Section Reference" that she previously distributed to the committee. She relayed that today's topics under discussion were Emergency Room Management and Super Utilizers which related to Section 29 and Section 31 of the bill. She provided a brief overview of the bill sections. She pointed to Section 29 that began on page 28, line 18. She elaborated that the section mandated primary care case management for certain Medicaid members, which was currently optional. In response to Representative Wilson's question from Monday's bill overview, she clarified that primary care case management would not initially be mandatory for all Medicaid users. She specified that the provision applied to enrollees with high hospital admissions. Over time the Department of Health and Social Services (DHSS) could add other Medicaid populations. The department believed that not all recipients required intensive case management. The provision differed from the sponsor's intent that every enrollee had an assigned primary care provider. She furthered that DHSS already engaged in primary care case management with the super utilizer population that was mostly performed telephonically.

Ms. Shadduck continued with Section 31 found on page 30, line 18 that related to the collaborative, hospital-based project to reduce inappropriate Emergency Room (ER) use. She delineated that the project had been designed after a successful model employed in Washington State. She shared that the project was recommended in the report [Recommended Medicaid Redesign And Expansion Strategies For Alaska] by Agnew Beck (copy on file) and reminded the committee that she provided two handouts related to the project titled "Seven Best Practices" (copy on file) and "Washington State Medicaid: Implementation and Impact of "ER is for Emergencies" Program (copy on file).

[1:35:20 PM](#)

Representative Wilson asked whether statute change was necessary to implement the programs. Ms. Shadduck replied that DHSS was expressly seeking a statute change for primary care case management, which did not give the identified Medicaid population a choice to opt in to the program. Representative Wilson asked whether the section defined what would happen if the recipient chose not to participate in the program. Ms. Shadduck responded in the negative. She explained that the department would implement the regulations related to Section 29. She read from an email response from the department (copy on file):

Enrollment in this program would be voluntary from the enrollee's perspective at first, except for those with multiple hospitalizations. Over time, as the department evaluates the effectiveness of the program and identifies other groups of enrollees who could benefit from this service, the department may phase in mandatory participation for additional groups.

Ms. Shadduck ascertained that the enrollee would be required to enroll in a primary care case management system under the provision in Section 29. The enrollee would initially have an option to choose their case manager. Representative Wilson asked what would happen if the recipient chose not to participate in the program. Ms. Shadduck answered that the "teeth" was the word "shall" in Section 29. Currently, DHSS did not maintain the ability to force a person to enroll but the provision made enrollment mandatory. She deferred to Margaret Brodie, (Director, Division of Health Care Services, Department of Health and Social Services) for further clarification.

[1:38:33 PM](#)

Representative Wilson was uncomfortable with changing from "may" to "shall" and forcing her Medicaid constituents into a program they might not want to participate in.

Co-Chair Neuman wanted to know how the new Medicaid reform regulations would be enforced.

Ms. Shadduck pointed to the statute AS 47.07.030 (d) and read the following:

The department may establish as an optional service a primary care case management system in which certain

eligible individuals are required to enroll and seek approval.

Vice-Chair Saddler wondered whether the new provision was a requirement or an option. He asked whether the department currently was using the optional authority. Ms. Shadduck deferred the question to the department to answer later in the presentation. She noted that the issue had been discussed thoroughly last session as a part of Medicaid redesign. She explained that optional services within Medicaid could be made optional for a certain Medicaid population. In addition, the state was able to choose the optional services it wished to participate in, within its Medicaid system. She offered that the difference made the statute language was confusing.

Representative Gara shared that when he worked for the Attorney General's office it was customary to contract outside of the state in order to utilize fewer state employees as a cost cutting measure and that it actually resulted in higher costs. He declared that in some instances hiring more department staff saved money. He noted that the super utilizer issue was not new and remembered discussing the issue with former DHSS Commissioner Bill Streur about his attempts to address the problem. He wondered why a hospital could not refer a person to another provider when someone showed up at the emergency room with a non-emergency room issue. Ms. Shadduck answered that federal law required care for anyone who went to the ER for treatment. She pointed to page 31, lines 3 through 5 of the legislation and read the following:

(4) a process for assisting users of emergency departments in making appointments with primary care or behavioral health providers within 96 hours after an emergency department visit;

Ms. Shadduck related that the former provision established the authority for ER's to refer individuals to other providers. Some individuals did not know how to access healthcare other than going to the emergency room. Representative Gara referred to the timeframe of 96 hours for an appointment and wondered why it did not also specify "immediate if feasible." He thought that 96 hours was too long a wait time for some non-emergency issues. Ms. Shadduck believed the provision was based on what other

states had done and was based on the practicality of obtaining primary care appointments. She deferred the question to the department for further detail. She revealed that the hospital association would be working with DHSS on the project. Representative Gara noted that he would like to see the timeframe amended in the bill.

1:45:30 PM

Representative Guttenberg referred to the handout titled "Washington State Medicaid: Implementation and Impact of "ER is for Emergencies" Program" (copy on file). He stated that the super utilizers were the most difficult population to deal with but the most cost effective when remedied. He asked whether more information was available regarding how to manage the super utilizer Medicaid population. Ms. Shadduck answered that a tremendous amount of information existed on the topic. She cited the Agnew Beck report she mentioned earlier and noted that an extensive explanation on the issue was provided beginning on page 69.

Representative Kawasaki asked what definition of super utilizer the state was operating under. Ms. Shadduck replied that the bill did not define the term. The department would set the guidelines along with input from the hospital association. The department would relay its current definition later in the meeting.

Representative Gara referred to Section 31 and asked whether the provisions applied to anyone who entered and ER seeking care for non-emergency issues regardless if a person was a super utilizer or not. Ms. Shadduck answered in the affirmative. She elaborated that the sponsor worked with Alaska State Hospital and Nursing Home Association (ASHNHA) in developing the provisions. The consensus was that the provisions applied to all super utilizers, Medicaid or not.

Co-Chair Neuman referred to page 28, subsection (d) of the legislation. He read from the bill:

(d) The department shall [MAY] establish as optional services a primary care case management system or a managed care organization contract in which certain eligible individuals are required to enroll and seek approval from a case manager or the managed care organization before

receiving certain services. The purpose of a primary care case management system or managed care organization contract is to increase the use of appropriate primary and preventive care by medical assistance recipients, while decreasing the unnecessary use of specialty care and hospital emergency department services.

Co-Chair Neuman reported that the legislation also addressed cost reduction. He surmised that the department would be required to do something, but the costs were unknown. He was concerned about department mandates in a fiscal crisis and a time of budget cutting. He noted that the DHSS budget was reduced in other areas. He requested further information related to the costs of the reform programs. Ms. Shadduck responded that the Senate Finance Committee members and co-chairs had taken the fiscal notes for the legislation very seriously and examined them thoroughly. However, the committee recognized that the department required adequate resources to carry out Medicaid reform. She referred to the document titled "DHSS Fiscal Impacts for CSSB074(FIN)am, version UA" (copy on file) that was distributed to members and provided a 2 page summary of fiscal impacts. She cited that the primary care case management program would cost \$30 thousand in FY 17 but, by FY 18 DHSS would save \$722 thousand and the savings would continue to grow. She offered that the Senate Finance Committee chose programs that would provide "the biggest bang for the buck" and strove to develop the most balanced options mindful of the state's fiscal situation.

Co-Chair Neuman clarified that the House was a separate body and needed to do its own due diligence. He requested any backup information regarding cost analysis.

[1:53:14 PM](#)

Representative Wilson requested information from the department concerning program mandates. Ms. Shadduck responded that the department would answer the questions.

BECKY HULTBERG, ALASKA STATE HOSPITAL AND NURSING HOME ASSOCIATION, provided brief remarks. She related that the high cost of healthcare presented a challenge to the entire nation. In particular, the high cost of Medicaid was spurring innovation in other states attempting to lower costs. Many of the projects implemented in other states

were different but shared the same themes. She reported that the themes consisted of the recognition of the role of behavioral health, primary care as the foundation for healthcare reform, and finally payment reform, which impacted the value and cost of the care. She believed the journey through reform would be arduous and involve patience and resources. She emphasized that the department would need resources to help implement some of the projects. She announced that ASHNHA wanted to be part of a solution. The association believed that the best way to help manage the challenges was for the providers to "be at the table" together with the state. She spoke to the important thematic elements beginning with behavioral health. She communicated that behavioral health presented the biggest challenges to the association's members. She referenced Section 27 and offered that the legislation framed a vision for change for the behavioral health system. She recounted that the legislation called for a system that was comprehensive, integrated, and evidence-based. Second, she remarked that primary care would serve as the "quarter back" of the healthcare team associated with the primary care case management project. She supported the elements of the legislation, which created and enabled supports for primary care providers to accomplish reform. Lastly, the fee for service model or the "do more get paid more" system was a volume based system. She remarked that people wanted a healthcare system based on value not volume; i.e., high quality care at an affordable cost. Transformation was imperative for the underlying payment mechanism that rewarded volume. She detailed that the project took a "baby step" down the transformational path by introducing a "shared savings" portion into the mix. She thought that the bill approached the volume to value transition with pilot projects. She believed the bill was the right step towards achieving payment reform by enabling broad pilot projects. She underlined that the three themes provided the backbone of reform and that reform took time to implement and produce savings. She recognized that the legislature was interested in immediate savings. She communicated that through the primary care case management project small savings were realized immediately and grew larger over time. In addition, the project greatly improved the quality of care.

[2:01:30 PM](#)

Ms. Hultberg continued by providing a brief background on the project. She communicated that ASHNHA put forward the ER project in 2014 through the Medicaid reform advisory group process. The program was included in the department's Medicaid redesign project last fall [2015]. The program was built upon a proven model from Washington State that included the implementation of the "Seven Best Practices in Emergency Room Care." She listed the practices as follows:

1. Tracking the ER visits to reduce emergency department (ED) shopping.
2. Implementing patient education efforts to redirect care to the most appropriate setting.
3. Instituting an extensive case management program to reduce inappropriate emergency department utilization by frequent users.
4. Reducing inappropriate ED visits by collaborative use of prompt visits to primary care physicians.
5. Implementing narcotic guidelines that would discourage narcotic seeking behavior.
6. Tracking data on patients prescribed controlled substances by widespread participation in the State's prescription monitoring program.
7. Use of a Feedback loop by assessing and reassessing the effectiveness of the program to ensure the steps were working.

Representative Gara stated that the presentation topic was only part of the picture and the other part was that Alaska had the highest healthcare costs in the nation.

Vice-Chair Saddler referred to Ms. Hultberg's testimony about behavioral health. He asked whether state laws, regulations, insurance companies, and the entire healthcare system was properly set up to "equalize" behavioral care with medical care. Ms. Hultberg answered that she did not have a broad enough knowledge base about other states laws to answer the question. She qualified that ASHNHA supported the "investment of resources" in behavioral health, which often resulted in reduced costs. She felt that the legislation set out a framework to move forward with healthcare system improvements.

Vice-Chair Saddler spoke to "ancillary unexpected costs" to the reform efforts regarding behavioral health improvements benefitting the healthcare system and he invited any

discussion regarding "clear ideas" on how to improve behavioral health care.

Representative Edgmon discussed that the legislation was really about "healthcare reform" and asked whether the term was a "proper distinction." Ms. Hultberg answered in the affirmative. She elaborated that Medicare and Medicaid drove reform because the programs provided a "significant portion of payment;" especially for hospitals. Medicare was moving towards value in an effort to control costs. Changes to Medicare and Medicaid would ultimately impact the entire healthcare system.

2:06:19 PM

Representative Wilson referred to a super utilizer tracking system. She wondered how the tracking system would function. Ms. Hultberg deferred to DHSS for the answer. She noted that the program would be implemented for anyone who utilized the ER. She presumed that identifying and tracking super utilizers informed the project's savings estimates. Representative Wilson asked whether a super utilizer tracking system currently existed. Ms. Hultberg responded that there would not be a tracking system. She explained that medical records, created when a person used the ER could be accessed by other ER departments for the purpose of providing better care. She characterized the system as an "information exchange." Representative Wilson provided an example of a patient using various hospitals. She asked for verification that the system would not create an information network between hospitals. Ms. Hultberg deferred the questions to the medical providers.

Representative Guttenberg noted that the healthcare costs in Alaska were astronomical and continued to increase. He wondered what would happen to the costs and the ability of the hospitals to function if nothing was done.

Ms. Hultberg answered initially about healthcare costs on a national level. She communicated that healthcare costs had been increasing as a percentage of the gross domestic product (GDP). The costs resulted in lost economic productivity in other sectors. She voiced that increased healthcare costs would have a similar effect statewide and would interfere with a "functioning economy."

Co-Chair Neuman discussed super utilizers. He assumed that the concept of having super utilizers going to primary care providers sounded beneficial. He stated that tens of thousands of individuals used the ER in Alaska. He asked how many super utilizers there were in the state and wondered whether the program was trying to fix a problem that did not exist. Ms. Hultberg did not have the data on hand, but noted it was available through the department and hospital ED's. She deferred the question to DHSS and providers. Co-Chair Neuman believed it was important to "weigh" the problems throughout the discussion. He stressed the importance of the committee's understanding of the costs by determining the size of the problem and its consequences.

[2:12:58 PM](#)

Co-Chair Thompson relayed that he had a report that showed information related to super utilizers and would distribute it to the committee.

CARLTON HEINE, PAST PRESIDENT, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, ALASKA CHAPTER, JUNEAU, relayed that beside his work in Juneau in emergency medicine he commuted to Washington to work with the University of Washington over the past six years and noted his familiarity with a similar project there and offered his perspectives. He explained that the federal Emergency Medicine Treatment and Labor Act (EMTALA) mandated that any patient that went to an ER for care had to receive a screening exam [triage] and have any emergency conditions stabilized. A screening exam always had to be carried out; therefore, "the value of triage was not always effective." He added that another provision in federal statute concerned "a prudent layperson" that defined an emergency as what a prudent layperson felt was a healthcare emergency. He exemplified that if a person came into the ER with chest pain it represented the prudent layperson's interpretation of symptoms that brought the patient to the ER.

Mr. Heine appreciated the efforts of the legislature to work on the Medicaid cost issue. He declared that changing Medicaid in ways that did not reduce care and resources to patients would be very hard and that achieving large savings would be based on difficult decisions. He delineated that a significant amount of money was spent on certain areas of healthcare without much benefit and felt efficient reform began there. He believed that the SB 74

was addressing those areas, particularly the ED super utilizer program. Alaska's high volume ER users were complicated and numbered in the thousands. The patients had complex medical problems and almost all had behavioral health or addiction issues. The individuals visited the ER "because they did not know how to do things in a different way." The current system was only "putting a band aid on the problem" and the ED was aware the patient was not receiving quality care. He surmised that a lot of money was being spent and the patient's problems were not being corrected.

[2:18:46 PM](#)

Mr. Heine related that 5 years ago the Washington state Healthcare Authority directed its Medicaid program to cut \$30 million from its super utilizer population. Because of EMTALA an ER could not merely limit the number of ER visits. The ER physicians, hospital association, and the Washington Medicaid office collaborated and created the Seven Best Practices program as a solution. He shared that the program implementation costs were low and Washington saved \$34 million in its first year. He highlighted that the program produced a significant savings without much investment while increasing the quality of care. The bill attempted to design the program to fit Alaska's needs. He addressed the key components of the legislation. One of the key components of SB 74 was related to case management and finding social work solutions to some of the problems. Another important component was the information exchange. He noted that the exchange was similar to the Washington state ER specific Healthcare Information Exchange (HIE). He explained that an ER patient would be checked against the database and the information would help ED's determine appropriate care for the individual. He favored that the information was easily accessible, contained a limited amount of data and was "quick and easy to use." He commented that one of the misconceptions was that all of the patients just needed primary care and voiced that the problem was more complex. He provided examples such as the patient who went to the ER because she was lonely and the solution was to provide a cell phone, or the patient provided transportation services because he was using the ambulance to travel to the ER. Creative solutions that helped the patients and the state save money was imperative for success. He emphasized that the program would both save

money and improve the quality of care, which were arduous solutions to find. He strongly supported of the bill.

2:23:48 PM

Representative Wilson wondered whether Washington had put its Seven Best Practices program in statute. Mr. Heine replied that some parts of the program were placed in statute but other portions were voluntary.

Representative Gattis asked about the patient information exchanges. She wondered whether patients had the same access to information and if acute care centers were considered to be an ER in terms of patient information exchanges. Mr. Heine replied that some of the nuances on how acute care was defined would depend on how the program was set up. He noted that, in general privacy laws offered some limited access. He offered that the information accessible to the ER exchanges would be limited to ER visits and not necessarily urgent care visits. The database would be designed in a way that the information was shared with the provider only if a patient met certain defined criteria.

2:27:28 PM

Representative Gattis asked whether the patient had the right to request a copy of the information. Mr. Heine answered in the affirmative.

Co-Chair Neuman asked whether patients had the right to opt out of the information exchange. Mr. Heine replied that a signed release was necessary to access a person's full medical record, but permission was not required regarding whether a patient visited another ER. Co-Chair Neuman discussed that some individuals may not want their personal information in a database. He asked whether the federal government had access to the information. Mr. Heine did not believe anyone outside of the hospitals had access to the information. Co-Chair Neuman wanted to understand how much information about the patient was shared. Mr. Heine responded that the database worked through the billing information. The amount of information was limited to number of visits and the facilities visited and would not contain all of the medical record details. In addition, the database did not produce the data unless some subjective criteria had been met such as multiple visits. A signed

medical record release would be necessary in order for the ER to access detailed records.

2:32:00 PM

Co-Chair Neuman assumed that the information would "feedback through the federal government" for any federal based medical program. Mr. Heine responded that anyone that had access to the billing system would have access to the data. Co-Chair Neuman asked for clarification. Mr. Heine answered that the federal Health Insurance Portability and Accountability Act (HIPAA) laws delineated the access certain types of providers had to various parts of patient's information. He communicated that providers had access to complete medical records and billing companies had only enough access to the medical information to do the billing portion.

Co-Chair Thompson presented a hypothetical scenario where a patient did not share the information regarding a CT scan received during one of his multiple recent visits to different ER's. The possibility then existed he could receive another scan at great cost to the system. He wondered what information was shared on the information exchange. Mr. Heine commented that that instance was a great use of the system. The system would show that the patient had received a CT scan but not the results. Beside cost reduction, the exchange offered added healthcare benefits like knowledge that a patient recently received a CT scan which protected the patient from added exposure to harmful radiation.

Representative Munoz mentioned that Mr. Heine had been active with the Front Street Clinic [public health clinic in Juneau serving the homeless population] and wondered if the clinic resulted in reduced ER visits. She also asked whether he believed there was a role for public health in reducing ER visits. Mr. Heine responded that the reason he became involved in the clinic because the ER was the population's only other access to healthcare. He was convinced that if the clinic was not in existence ER visits would increase. He described the homeless patient population as a difficult population to care for when finding providers other than ER's to deliver their healthcare and the clinic helped save the system money. Representative Munoz wondered whether he was working on the problem with the public health system throughout the state.

Mr. Heine revealed that that was the reason he was advocating the project today. He had begun discussions with Ms. Hultberg several years ago on how to expand on the ideas from Washington State for adoption in Alaska. He wanted to pilot successful programs and expand them for use in the entire state.

2:37:36 PM

Vice-Chair Saddler thought they were discussing a larger issue and viewed managed care as an answer to super utilizers and the healthcare system overall. He wondered whether the hospital based ER reduction project described in Section 31 was the same as the primary care project found in Section 29 of the legislation. Ms. Hultberg responded that the Sections described two distinct projects. Vice-Chair Saddler asked whether Washington State had enough primary care physicians to implement the Seven Best Practices program. Mr. Heine answered that problems existed because of a lack of primary care physicians. He expounded that the solutions could be broad and complex and were not purely based on primary care. Primary care follow up within a certain defined timeframe was part of the Washington program and was achieved. He understood that the primary care system in the state was "fairly robust" and the bottleneck would likely occur in behavioral healthcare where the demand outstrips the supply of providers. Vice-Chair Saddler asked whether additional liability protection was needed for ER providers who triaged the patient "if the emphasis under the super utilizer reduction became shoving people off to primary care." Mr. Heine answered that the ER would still be responsible for doing a medical screening exam and provided any needed ER care. He stated that the goal of the program was to intervene and prevent the patient's next unnecessary visit to the ER. The program wanted super utilizers to get the care they need without visiting the ER. He did not anticipate any liability problems. Vice-Chair Saddler asked what percentage of ER visits was prevented according to the Washington State data.

ANNE ZINK, PRESIDENT, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, ALASKA CHAPTER, MAT-SU, responded that the data showed a 10.7 percent reduction in super utilizers and overall 14 percent decrease in low acuity visits.

Vice-Chair Saddler asked whether the Section 29 information exchange provisions only captured ER visits or would the health information exchange contain data on primary care and urgent care visits as well.

[2:41:44 PM](#)

Mr. Heine answered that in Washington State only ER visits would populate the database because the problem resided in the excessive use of ED's. Vice-Chair Saddler pointed to Section 29 related to the super utilizer reduction program and understood that the program could either be designed and implemented by the department or contracted out to a managed care organization (MCO). He asked whether his understanding was correct. Ms. Hultberg replied in the affirmative. She deferred to the department for its interpretation.

Representative Gara spoke to a federal law requiring ERs to stabilize an individual before they were released. He asked whether a flu or bad cold required stabilization. Mr. Heine answered that if a person had a viral illness that not much could be done; however, if a person had a febrile illness like pneumonia he would prescribe antibiotics. Representative Gara informed Mr. Heine that he did significant work with underprivileged kids who did not have knowledge of the medical system and went directly to the ER for healthcare. He wondered whether there was an easier way to send a non-emergency patient to another facility that would save the system money. Mr. Heine answered that nationally ED's had been researching "triage out protocols." He detailed that an initial screening was required to make any kind of treatment assessment, which performed most of the initial triage which essentially ruled out cost savings. Public education regarding appropriate use of the ER was an important and challenging mission. He referred to causing possible problems in the reverse where individuals should have gone to the ER or doctor and decided to wait. Representative Gara asked whether the initial ER screening was avoidable.

[2:48:03 PM](#)

Mr. Heine answered that the EMTALA law made a solution difficult.

Dr. Zink provided some examples of her experiences working in an ER in an effort to clarify the issues. She referred to a super utilizer in her ED that she had established a care plan for. She notified the committee that she was prohibited from sharing the plan with other ED's. She contacted the patient's primary care provider in an attempt to obtain better care for a patient. She furthered that the patient had 32 CT scan within one year and continued to experience abdominal pain. The provider informed DR. Zink that Providence Hospital had a care plan for the patient and the patient should not be going to other hospitals. No one had been aware of the situation for three years. She judged that the underlying cause of her problems was not addressed by the current system. She remarked that the provisions in the bill would allow the hospital access to enough information to correctly care for the patient. The bill allowed for better patient care and cost savings and she strongly supported it. She provided another example of a "frequent flyer" patient who would constantly visit the ER as a way to calm her anxiety. She finally received the proper mental healthcare she needed through the mental health court subsequent to a trespassing violation. She felt that if the patient had previous access to proper behavioral healthcare, the situation could have been avoided. She voiced that many patients visiting the ER arrived because the social network failed. She believed that a true honor in working in an ER was being a safety net but if one area of healthcare was inadequate another area ballooned. She felt privileged to perform triage and help patients understand whether their issue was a perceived or real emergency and that placing the burden of "medical decisions" on the patient was a risk. She supported working with systems that allowed the provider to screen the patient and have access to a system that shared information about the patient in order to provide appropriate care. She revealed her frustration with a system that allowed over utilization of the ER and did not believe the problem would be solved without collaboration between government, insurance providers, and providers. She cautioned against creating bottlenecks when crafting a solution. She stated that different problems existed in different areas of the state and that by creating case management plans for super utilizers each community could identify its limitations and work in collaboration between public and private entities to find solutions. She shared that her care management organization in the Matanuska-Susitna Borough (Mat-Su) included the State Troopers,

Mental Health Court, Mental Health Providers, hospitals, and others. She emphasized that all members of the organization agreed that the ability for the ER to access a patient information database was helpful to all other providers. She spoke of a violent high-risk patient that had a healthcare plan. She wanted his information to be available around the state in case he travelled so providers would be informed and consistent care would be provided. She illustrated the situation as a way to describe the benefits of the legislation.

[2:56:32 PM](#)

Dr. Zink discussed the opiate addiction problem and seeing the serious health problems resulting from opiate addiction presenting in the ER. She believed there was a connection between frequent ER users and mental and behavioral health. She shared data on super utilizers from the Mat-Su Health Foundation. In 2013, one hospital in the Mat-Su received 27 thousand visits, 4429 were visits from super utilizers and 56 percent of the patients had concurrent behavioral health diagnosis. Mat-Su Regional Hospital super utilizers cost \$73.5 million for facility costs alone. She often felt like she was blind and handcuffed and unable to deal with ER patients due to the lack of accessible information about a patient. She supported the ED component of the bill, which allowed her to fully practice as an ER physician.

Representative Guttenberg referred to references made about the relationship between super utilizers, the courts, and troopers. He asked whether the courts had access to medical records. Dr. Zink replied in the negative. She explained that the patient chart notes she composed, which might include a care plan was completely protected and only shared via a patient's permission. The information was split into "different bundles;" the diagnosis, age, and other necessary bits of information were sent to billers, or Medicaid and Medicare. The billing bundle never contained the remaining information on the chart and was never shared with troopers, mental health providers, etc. She furthered that if a trooper brought a suicidal person to the ER for treatment she would have access to his care plan but not the troopers. Representative Guttenberg provided a hypothetical scenario where a mentally ill person was arrested and a judge questioned whether the person had a care plan. He wondered whether a judge or probation officer would have access to the person's care

plan. Dr. Zink answered that different care plans were written by different providers. The state would decide what care plans would be accessible. Washington State authorized ER's to write care plans. She relayed that the Mental Health Court in Wasilla asked participants to sign a HIPAA agreement releasing their records to a hospital and allow the hospital to share the information. The troopers would not have immediate access without the patient's permission. Representative Guttenberg asked for Dr. Zink's experience with the therapeutic courts. Dr. Zink replied that she became a member of a care coalition team in the Mat-Su that included troopers and the therapeutic courts a few years ago in attempts to address the issue. The court designed the HIPAA form that allowed information sharing and she discovered that numerous ER patients were involved in the therapeutic court. She voiced that the hospital had been moving forward with reform and was not waiting for the legislature to act.

[3:02:39 PM](#)

Vice-Chair Saddler asked for more information regarding record sharing and whose records would be shared. Ms. Zink believed patient privacy was a shared concern. She related that in Washington State a care plan on the database expired after 2 years. Typically, the care plans in Washington involved patient input. The majority of the plans were agreed upon between the provider and the patient. She emphasized that judging patients did not create a solution and she worked with the patient to try to find the underlying condition.

Co-Chair Thompson noted that department staff was available for questions.

Representative Edgmon thought that the legislation's approach created a better business model to provide the resources to accomplish the "low hanging fruit" of reform. He wanted to explore the idea further. He voiced that there were many areas of reform addressed in the bill. He believed that the reform situation was similar to the Medicaid expansion discussion by the need for resources in order to build a better business model that addressed all areas of reform to administer the appropriate healthcare, "at the right value." He asked whether Ms. Hultberg agreed with his summation. Ms. Hultberg responded that there were many moving parts and pieces to the legislation and she

characterized it as "dense." She communicated that the sponsor attempted to find immediate areas of savings. The ER super utilizer reduction was the one piece of SB 74 that produced savings. Other provisions in SB 74 created the building blocks of reform so that in the future the system achieved higher performance. She indicated that transforming a business model was hard. She voiced that "disruptive change was happening in healthcare all across the country." Enhancing primary care and achieving payment reform would take time and investment and results would not be seen for several years. The legislation attempted to balance the needs involved in creating a better system; invest in the long term and explore innovative ways to create some near term savings.

[3:07:58 PM](#)

Representative Edgmon referred to behavioral health. He wondered whether behavioral health had a uniform definition or "differing aspects on how it was perceived." Dr. Zink answered that when analyzing the Mat-Su health data the team "struggled" with the definition and did not think a universal definition existed. She explained how the ER addressed the issue. The ED department and the Mat-Su foundation defined a behavioral health diagnosis based on the following aspects of mental health: substance abuse, depression, suicidality, homicidality, or anxiety.

Co-Chair Neuman had read some of the information provided by Mr. Heine and cited that 85 percent of patients had serious mental health issues. He also referred to Ms. Zink's testimony about the patient with mental illness who was constantly utilizing the ER as a way to manage her anxiety. He asked whether a managed care plan would have stopped the behavior. Ms. Zink replied in the affirmative. She reminded Co-Chair Neuman that she had received a managed care program from the therapeutic courts and the behavior stopped. The hospital had only seen the woman once in the past year and not at all in the current year. She spoke to the successes the individual had as a result of the managed care plan. Co-Chair Neuman referred to Ms. Zink's other example of the women who received 32 CT scans. He thought that systems should already be in place to deal with the issue. Ms. Zink answered that she completely agreed and was frustrated every time something similar happened. She elaborated that healthcare existed in "silos" and that the ER was a fast paced environment where it was

difficult to spend the time to get all of the information. The information sharing system proposed in the bill would "push" enough information in front of her to request more complete records if warranted.

3:11:56 PM

Representative Munoz believed there needed to be fiscal restraint on the part of the hospitals as well. She thought that 32 scans were outrageous. Ms. Zink answered that part of the ER's obligation was to ensure there was not a life-threatening problem and chest or abdominal pain was a trigger for high cost intervention.

MARGARET BRODIE, DIRECTOR, DIVISION OF HEALTH CARE SERVICES, DEPARTMENT OF HEALTH AND SOCIAL SERVICES (via teleconference), relayed that the department began a program for super utilizers over two years ago. The department initially defined a super utilizer as a person who used the ER more than five times in an 18 month period. Currently, 5,155 individuals were enrolled in one super utilizer program and 19 enrollees in a different type of program. She detailed that the department employed a private contractor called MedExpert for the larger program which offered telephonic services statewide. The company provided case management services over the phone and had medical professionals available. The program was voluntary and the enormous response was unexpected. The model was geared towards serving large populations over large geographical regions. The contractor established a health baseline, resource utilization pattern, and determined whether family or community support was available for each enrollee. Medical professionals were telephonically available for the enrollees to call anytime. MedExpert staff worked with the individual and her providers to ensure that the patient was receiving the right health care in the right setting as well as providing follow up. The contractor also brought in appropriate social service agencies to assist enrollees with other aspects of life. She revealed that the program had been underway for about 1.5 years and saved \$6 million in general funds (GF) as a result.

3:16:50 PM

Ms. Brodie continued that DHSS initiated a smaller second program that involved "face to face" contact; which was

more costly; therefore, a much smaller program. She communicated that the contractor employed for the second program was Qualis Health and began in November, 2015. The investment results were not yet available. Qualis Health will eventually work with a total of 40 to 60 volunteer enrollees within the next six months. The program consisted of nurses, social workers, case workers, and a physician consultant that provided an initial screening and comprehensive assessment. The model required extensive outreach to the communities, which began by engaging in meetings with numerous stakeholders throughout the state. She remarked on the Med Expert program, which offered unique follow up by providing extensive information on the enrollee's medical condition enabling the individual to make better healthcare decisions for themselves. She spoke to Vice-Chair Saddler's questions regarding the Washington State's ER program and Medicaid. Within the first year of the program's inception, the ER visits by Medicaid patients declined by approximately 10 percent and visits resulting in prescriptions of controlled substances fell by 25 percent for the Medicaid population.

Representative Kawasaki referred to Section 29 of the bill and specified subsection d and read, "the department shall establish as optional services a primary care case management system". He wondered why the program had to be optional. Ms. Brodie answered that currently the program was optional because the initial super utilizer program called the "Care Management Program" was considered a "locked-in" program where a patient was locked into a specified provider and pharmacy and Medicaid would not pay for services if they were provided by another physician or pharmacy; the program was very restrictive for individuals. She indicated that the program's regulations required the department to obtain complete medical records to prove a patient was utilizing services much more than they should. The bill's language, explicitly the use of "shall" allowed the department to enroll a person based on over utilization of services. She qualified that the department analyzed the data to determine the causes of utilization and individuals with serious conditions that required extensive care were legitimate and ruled out. She maintained that the department considered appropriate use and did not solely rely on "statistical outliers" to enlist participants.

[3:22:53 PM](#)

Ms. Shadduck referenced page 28, subsection d, the language, "shall establish as an optional service." She recapped that the words "optional service" had to remain listed in statute in the bill. She reminded the committee that the legislature had to grant permission for any optional Medicaid service. Certain Medicaid programs were required by the federal government and some programs were optional but Alaska required legislative approval for DHSS to participate in an optional Medicaid service.

Representative Kawasaki referred to testimony by Ms. Brodie about the super utilizer program being optional for the patient and requested clarification. Ms. Brodie answered that the super utilizer programs currently in place were voluntary. She explained that many of the participants also qualified for the mandatory care management program and by volunteering for the super utilizer programs the patient was participating in a less restrictive program than the department's mandated program.

Vice-Chair Saddler noted that AS 47.07.030(d) referred to optional services and the mandatory services were in paragraph (b). He cited page 28, line 29 of the legislation, and read, "shall require recipients with multiple hospitalizations." He wondered who defined what multiple was. Ms. Brodie answered that the department established a definition of three or more visits by an individual in a 12-month period; the number totaled over 12,600 Medicaid recipients. Vice-Chair Saddler asked whether the department wanted the definition in statute rather than regulation. Ms. Brodie answered that the department would need flexibility to make changes to the definition in the future. She related that other services besides ER visits were being over utilized and the department needed to determine and address that excessive utilization over time. Vice-Chair Saddler stated the following from the legislation, "the department shall require recipients to enroll in a primary care management system." He asked what would happen if a person refused to enroll. Ms. Brodie answered that at that point the department would determine whether the individual qualified for the mandatory care management program. Vice-Chair Saddler restated the question. Ms. Brodie responded that if a patient would not enroll the state would not pay for any Medicaid services but the patient was then eligible for "fair hearing rights." She commented that most patients would enroll.

3:28:46 PM

Vice-Chair Saddler wondered about the likelihood the department would be challenged legally. He referred to page 28, lines 19 through 21 and noted that the bill allowed for either DHSS to create a managed care system or to contract with an existing MCO. He asked which was more likely and if contracting with MCO's would even be an option in Alaska. Ms. Brodie replied that the state would contract the services out if contracting was less expensive and would be the preferred option. The key was that the option had to be affordable for the state. Vice-Chair Saddler asked whether the MCO had to exist in Alaska. Ms. Brodie responded that a company could be headquartered out-of-state but would have to have a presence in state.

Representative Wilson deduced that if a recipient refused to participate in a voluntary or mandatory program the department would expel the individual from Medicaid and cause the individual to go the ER for more costly care. Ms. Brodie answered that the scenario was what currently happened with super utilizers.

3:32:10 PM

Representative Wilson surmised that the only change in the legislation was that both programs would be mandatory. She believed the end result would be the same as what was happening now because the person had no other option than to go to the ER. Ms. Brodie responded that the difference was in the number of individuals the program could serve; the new definition for super utilizer adopting 3 or more ER visits [in a twelve month Period] captured over 14 thousand more people it could steer to the appropriate healthcare provider. Representative Wilson stated that the department could currently change program parameters without statute. Ms. Brodie agreed. She detailed that the key was that the locked in care management program was only designed to serve a maximum of 300 people. Currently, over 14,000 people qualified. Representative Wilson surmised that the department already had a program. She could not figure out why statute was needed. Ms. Brodie answered that statute was necessary because if a person chose not to participate he could continue to over utilize services. She added that the additional enrollees would overwhelm the program in a short period of time. There would be 13,900 people who would

continue to over utilize services and Medicaid would be required to pay.

Representative Wilson reiterated her concerns regarding super utilizers that refuse to participate in the program frequenting the ER. Ms. Shadduck replied that if a person did not enroll the department could stop paying for Medicaid benefits. She spoke to her personal experiences working in Fairbanks with case management and related that education helped participants learn how to use appropriate services. She believed there would always be "outliers" who would refuse case management enrollment but the state would no longer pay the Medicaid benefits. She believed the programs would still save state GF money.

Co-Chair Thompson guessed that only a small number of people would refuse to participate.

Representative Gara deduced that federal law required an ER to provide care at its own expense. In addition, the use of the word, "shall" in SB 74 authorized the state to cut off Medicaid benefits upon participation refusal. Ms. Shadduck replied in the affirmative. Representative Gara asked whether there was any evidence to prove that visits to the ER were diverted by providing behavioral health to super utilizers. Ms. Brodie answered that the costs of super utilizers had been reduced by approximately \$2,400 per year per person. She indicated that providers had up to one year to bill for services so the specific data related to the Medicaid expansion population was not yet known.

[3:40:03 PM](#)

Representative Gara relayed from personal experience that there was an incentive for providers to steer patients to use expensive medical "equipment." He wondered whether the department had the authority to deny unnecessary imaging. Ms. Brodie answered that prior authorization for physician owned imaging was required by DHSS for the past three years. She clarified that imaging service rendered at an ER did not require prior authorization. Representative Gara asked whether the department could enforce inappropriate use of imaging by an ER. Ms. Brodie answered that the department could determine inappropriate use by an ER during its utilization review process within three to six months after the event happened and would direct the patient to the proper provider.

[3:42:10 PM](#)

Representative Gara hypothesized the scenario of ER abuse of the Medicaid program through overutilization of imaging services. He wondered whether the department could refuse Medicaid payment to ED's for unnecessary imaging. Ms. Brodie responded that ER's use of imaging was a medical decision and the department was not qualified to make judgements regarding medical decisions. Representative Gara asked why the department could enforce private physician overuse but not ER overuse. Ms. Brodie answered that it was due to the fact that the ER did not have time to wait for preauthorization paperwork in an emergent condition. Representative Gara wanted to know what would happen when the condition was not an emergency and the use of imaging was abused by the ER. Ms. Brodie answered that ER doctors were professionals and the department did not want to second guess their decisions.

Representative Munoz asked what the state paid for a CT scan. Ms. Brodie would follow up and provide the answers.

Vice-Chair Saddler referred to the "lock-out" program. Ms. Brodie corrected that the mandatory care management program was known as the lock-in program. Vice-Chair Saddler asked whether the lock-in program differed from the Med-Expert administered program. Ms. Brodie answered in the affirmative. Vice-Chair Saddler asked whether the Qualis Health run program was a third program. Ms. Brodie replied in the affirmative. Vice-Chair Saddler asked whether any of the described managed care efforts would be eliminated with passage of SB 74. Ms. Brodie replied that DHSS viewed passage of the bill as evolving the programs into the reform efforts. Vice-Chair Saddler asked for more detailed information about the three programs. Ms. Brodie agreed to follow up.

[3:46:52 PM](#)

Representative Wilson asked for more information regarding how many enrollees refused to participate in the case management programs. Ms. Brodie replied that she would follow up with the information.

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

Co-Chair Thompson addressed the meeting schedule for the following day.

#

ADJOURNMENT

3:49:10 PM

The meeting was adjourned at 3:49 p.m.