HOUSE FINANCE COMMITTEE
March 30, 2016
1:32 p.m.

1:32:04 PM

CALL TO ORDER

Co-Chair Thompson called the House Finance Committee meeting to order at 1:32 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

Stewart Ferguson, Chief Technology Officer, Alaska Native Tribal Health Consortium; Heather Shadduck, Staff, Senator Pete Kelly; Doctor Jay Butler, Chief Medical Officer, Department of Health and Social Services; Janey Hovenden, Director, Division of Corporations, Business and Professional Licensing, Department of Commerce, Community and Economic Development; Sara Chambers, Administrative Operations Manager, Division of Corporations, Business and Professional Licensing, Department of Commerce, Community and Economic Development; Valerie Davidson, Commissioner, Department of Health and Social Services; Senator Pete Kelly; Representative Liz Vasquez.

PRESENT VIA TELECONFERENCE

Rebecca Madison, Executive Director, Alaska E-Health Network and Board Member, Northwest Telehealth; Doctor Henry DePhillips, Chief Medical Officer, Teladoc, Nashville, Tennessee; Wallace Adamson, Vice President, Anthem, Inc., Columbus, Ohio; Melinda Rathkopf, President, Alaska State Medical Association, Wasilla; Erin Narus, Lead State Pharmacist, State Medicaid Pharmacist Healthcare Services, Department of Health and Social Services; Brian Howes, Program Manager, Prescription Drug Monitoring Program, 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."

1:33:07 PM

Co-Chair Thompson relayed that the committee would begin with the telemedicine portion of the legislation.

STEWART FERGUSON, CHIEF TECHNOLOGY OFFICER, ALASKA NATIVE TRIBAL HEALTH CONSORTIUM (ANTHC), addressed a PowerPoint presentation titled "Better Care. Lower Costs. Impacts and Outcomes of Telehealth in Alaska" (copy on file). He communicated that ANTHC had been operating a telehealth system in Alaska for almost two decades. He planned to speak to outcomes from about 250,000 telehealth cases. He clarified that ANTHC used the terms telehealth and telemedicine interchangeably (slide 2). The American Telemedicine Association (the largest body in the world dedicated to telemedicine) treated the words as synonymous; the terms referred to the use of telecommunications to exchange information that could be done through medical records, audio, video, or a combination of the two in order to care for patients.

Mr. Ferguson highlighted the different types of telemedicine. The most common type of telemedicine in the Lower 48 was video-teleconferencing or synchronous telemedicine where the patient and provider were both participating at the same time from different locations. When ANTHC began building telemedicine in the late 1990s it did not have the bandwidth to support live

videoconferencing so it had begun building its system based on store-and-forward technology, which involved capturing data and sending it. The system captured images, heart and lung sounds, pressure-wave forms of the ear, and other. He believed ANTHC was currently one of the world's leading authorities on the specific technology; it used the system for about 40,000 to 50,000 cases per year. Home telehealth was the third type of telemedicine. The system was not commonly used in Alaska, but he believed it should be considered. The system tried to care for chronically ill patients in their home setting by monitoring weight, glucose, blood pressure, and other. He turned to slide 4 and discussed that telemedicine was extremely prevalent throughout the U.S. and worldwide. The side included a chart showing that in 2011 there had been over 200 networks throughout the U.S. - of which the Alaska Federal Health Care Access Network (AFHCAN) was one - with almost 4,000 service sites; at that time over half the U.S. hospitals used telemedicine, which was currently a standard of care delivery throughout North America.

1:36:00 PM

Mr. Ferguson relayed that his presentation would address the evidence gained, primarily in the Alaska Tribal Health System (slide 5). He shared that he worked for ANTHC, which co-managed the Alaska Native Medical Center (the largest Native hospital in the U.S.) with Southcentral Foundation to provide primary care services. The tribal health system also had six regional hospitals (including Mount Edgecumbe Hospital in Sitka); multi-physician health centers; sub-regional centers staffed by nurses, physician assistants, and in some cases doctors; and the "bread and butter" of providing care was the use of village clinics in very remote settings where community health aides delivered care. Alaska's tribal health system had been designed to serve all of the facilities, to work in remote settings, and to meet primary care needs. He turned to slide 6 and shared that in FY 15 the system had about 43,000 cases, 1,500 providers, and 26,000 patients. He highlighted that 26,000 patients represented about 18 percent of the Alaska Native population. He did not believe another system existed anywhere in the world where 18 percent of its patients were involved in telehealth on an annual basis. The 43,000 cases represented about 3 percent of all outpatient encounters in the tribal health system. He believed a person would be hard pressed to find any other

healthcare system with that level of penetration. He relayed that growth could increase significantly, but the current system was well utilized throughout the entire tribal health system. Slide 6 included the system's store-and-forward data representing how often the system captured and sent data.

Mr. Ferguson turned to slide 7 and spoke to specialty healthcare clinics available by video teleconference. He shared that the system had a growing use of video-teleconferencing, primarily because it now had the necessary bandwidth out to most village clinics through the expansion efforts of a number of telecommunication carriers. The slide provided a list of various specialty clinics offered by the Alaska Native Medical Center. He pointed out that telemedicine offered by the center was not strictly contained within Alaska's borders. He detailed there were many areas where specialists were not available in Alaska. For example, in adolescent medicine many pediatric specialists were located in the Lower 48 (some at Seattle Children's Hospital). The center tried to screen women at a high risk of developing breast cancer and conducted regular telehealth consultations between the patients and the Mayo Clinic in Rochester, Minnesota. One of the beauties of telehealth was the ability to bring providers and patients together independent of distance.

1:38:54 PM

Mr. Ferguson shared that one of the benefits of having developed the system in Alaska was a built-in evaluation component. He detailed that every time someone did a telemedicine case in Alaska, the center asked questions about whether the service improved the quality of care, educated the patient, made the provider's job more fun, etcetera. Slide 8 included two questions community health aides were asked in the village: whether telemedicine improved the quality of care and whether it improved patient satisfaction. He relayed that three-quarters of the almost 12,000 responses showed that telemedicine had improved the quality of care and about two-thirds of the time they believed it improved patient satisfaction. He drew the committee's attention to two images on the slide: the lower left image showed a cochlear implant. He specified that a higher percentage of babies were born deaf in the tribal health system compared to the general population. He elaborated that traditionally the patients

could either remain deaf or travel to the Lower 48 for a cochlear implant and remain in the Lower 48 for about 12 months of intensive speech therapy. However, telehealth had enabled the cochlear implants to be done in Anchorage, the patient could return to their home, and all of the speech therapy was conducted by telehealth. He stressed that the system could now do things that had never been possible before.

Mr. Ferguson pointed to the image of a diabetic retina shown on the lower right of slide 8. He detailed that diabetic patients could start to have problems with the microvasculature of the blood vessels in the retina; when those vessels started to bleed or clog it caused blindness. However, the affliction was easily treatable if diagnosed. Several years back the center had done a pilot study where it sent the equipment out to the villages and screened all the diabetics it could find. The three-month effort had reversed a seven-year decline in the percent of annual eye exams for diabetics. Additionally, 100 of the 300 patients screened had needed follow up and care - they had been on a path to blindness. Telehealth allowed ANTHC to take care out to the patients and enabled patients to remain in their homes. He addressed that telehealth saved money, primarily in patient travel (slide 9). They estimated that most of the time if travel was saved it was only saved to the nearest regional hospital (not necessarily to Anchorage) and that not all cases prevented travel; however, ANTHC estimated that annually about $10 million was saved per year in patient travel. He underscored that for every $1.00 reimbursed for Medicaid about $10 to $11 was saved in patient travel.

1:41:43 PM

Mr. Ferguson addressed improving patient access to care on slide 10. He explained that it was very difficult to measure access and improvements to access in a healthcare system. He relayed that Dr. Phil Hofstetter based out of Nome had looked at the number of new referrals to specialists between 1991 and 2007; he had discovered that prior to telemedicine for a span of about 11 years, 47 percent of the patients waited 5 months or more to see a doctor in person. Once telemedicine began to be utilized to screen the patients to decide who needed to be flown to Anchorage and who could wait, the number had dropped to 8 percent and 3 years later it dropped to 3 percent. The

takeaways were that telemedicine enabled patient screening to make decisions and get patients to care faster and that the impact of telehealth did not happen immediately. He elaborated that it had taken 3 years for the number to drop from 8 percent to 3 percent; some of the things required process change. He moved to slide 11 titled "ANMC Turnaround Time" and shared that telehealth also helped improve how long it took for a patient to get a specialty consult. He detailed that the medical center currently turned around 25 percent of the health consults in 60 minutes or less. He explained a parent living in a remote village there was a 1 in 4 chance of having a specialty consult and treatment plan before leaving the village clinic. He explained it was a better level of care and higher turnaround than a person could get if they lived in Anchorage and went to their family physician or pediatrician. Additionally, about two-thirds of the cases were turned around in one day.

Mr. Ferguson addressed the bigger picture of telehealth and how it related to the changing world of healthcare (slide 12). The healthcare world was moving away from fees based on procedures to a performance and quality based payment structure; therefore, it was necessary to think about how to change the delivery of care. He detailed that the vast majority of the center's patients were low risk (care could be provided when a person was sick and then they left the system). High risk patients were at the other end of the pyramid (patients with complex diseases and comorbidities) and constituted 5 percent of the center's patients; the group accounted for a low percentage of the center's patients, but consumed a significant percentage of its costs. He continued that the center had known for years that one of the ways to treat the patients was to shift to care management models to care for the patients. He guaranteed increased care management was necessary if the desire was to manage the expense of patients and to keep them healthier.

Mr. Ferguson detailed that the center had conducted a pilot study several months back where it tried to bring all of the people involved in caring for its patients in two of the most remote villages into a video session to determine whether good care management could be done over telehealth (slide 13). He elaborated that the center worked with patients in Gambell and Savoonga out on St. Lawrence Island; the locations had been selected because Norton

Sound Health Corporation based out of Nome was heavily focused on a patient-centered medical home model with the goal of keeping patients in the village. The trouble was the case managers were typically in Nome and not in the villages and the case managers for the specialists were in Anchorage. The only way to implement the model was through the use of telecommunications. He expounded that the center had conducted a three-way virtual field clinic with a case manager in Nome and Anchorage, a specialist in Anchorage, and the patients in Gambell and Savoonga. The center believed it was one of the ways it could help to manage the more expensive patients.

1:45:31 PM

Mr. Ferguson stated the bottom line was the fact telemedicine enabled the center to deliver care to the patients in their homes. Additionally, the center could start trying to predict the trajectory of its patients and to use telehealth to manage them before they necessarily enter the system. The center had done a study several years back where it had looked at infants who were the most expensive and vulnerable Medicaid population (slide 14). He elaborated that they were typically infants who had entered a neonatal intensive care unit (NICU). He pointed to a chart on slide 14 and relayed that most of these children would cost between $40,000 and $80,000 in the first year of their lives. He continued that the infants would be returned to a village clinic with no specialists, doctors, and potentially no nurses. He furthered that if an infant went into a NICU with a diagnosis of respiratory disease, congenital anomalies, or both, they were almost guaranteed to be an expensive patient for several years to come. The center proposed wrapping a "whole umbrella of telehealth services around these children." The minute the infants were discharged from the NICU there were pediatric specialists willing to be involved and case managers to support them. He explained that parents suddenly had access to resources throughout Alaska and the Lower 48. The center estimated the model could save about 37 percent of the overall patient cost through fewer emergency department visits, fewer hospitalizations, and other. He explained that telehealth could provide day-to-day care for the center's patients and it could be part of a much more complex, solution focused way to take care of patients through proper analytics.

1:47:26 PM

Vice-Chair Saddler asked for the terminology for an in-person consultation. Mr. Ferguson replied that it was "in person."

Vice-Chair Saddler had heard from providers that while telemedicine allowed improved access, there were challenges with the non-standard charting. He explained providers received chart notes and could not interpret them. He asked if there were chart note standards.

Mr. Ferguson replied that one of the challenges in telehealth had always been to make sure to have a complete patient record in front of the remote site. The center was addressing the issue in a couple of ways. He explained that the tribal health system was moving to a shared electronic health record, which did help. He elaborated that when the center utilized telehealth, especially store-and-forward, it trained the providers to put the relevant information into the telehealth consult to send to the provider. The center was currently in the process of integrating telehealth back into the electronic health records so things were appropriately logged and charted within the patient's chart.

Vice-Chair Saddler asked if the level of care was qualitatively the same for telehealth versus in person. Mr. Ferguson believed center clinicians would say the level of care was as good or better [via telehealth]. The trick was to avoid doing things that were not possible through telehealth. He elaborated that the center's providers were trained to immediately suggest a patient be seen in person if the provider could not treat the patient, recognize what they were looking at, or could not care for the patient.

Vice-Chair Saddler asked what could not be done by telemedicine.

Mr. Ferguson answered that services provided via telehealth were broad. He explained that procedures requiring skills to touch a patient could not be done via telehealth. There were certain things where perhaps the appropriate data could not be captured. For example, if a provider was testing heart and lung sounds and could not hear exactly what they needed, it would require an in person visit. He relayed that ANTHC had done a study for the Indian Health

Service (IHS) about five years earlier where it had addressed the percentage of healthcare that could be done through telehealth and what percentage could not. As part of the study ANTHC had interviewed about 10 different specialists including dermatologists and cardiologists. The general answer had been that it varied from about 10 to 80 percent depending on the specialty. He elaborated that a high percentage of dermatology could be done through imagery, whereas things like behavioral and mental health required live video.

Vice-Chair Saddler asked if the practice of telemedicine had been hindered by technological limitations (i.e. end-user equipment or broadband access between the provider and telehealth consult) in Alaska.

Mr. Ferguson answered that about 12 to 15 years ago bandwidth had not been sufficient, but it was no longer a challenge. He detailed that although about half the sites were on satellite, which introduced a delay, it was not really a hindrance to telehealth at present.

1:51:02 PM

Representative Guttenberg quoted from a speech given by the Federal Communications Commission (FCC) Commissioner Jessica Rosenworcel to the American Telephone Association several years earlier "In Alaska, under the leadership of Dr. Stewart Ferguson, I saw how village clinics well beyond the last road mile, so remote that they can only be assessed by telephone, can nevertheless provide first-class care using a mix of broadband and store forward technology." He thanked Dr. Ferguson for his work at the forefront of delivering telehealth services. He was involved in broadband issues because he lived in Fairbanks and did not have the service; everything was buffered. He referred to healthcare pilot program charts done a few years earlier by the FCC and a presentation provided by FCC Chairman Kevin Martin. He referenced dots on the presentation representing villages across Alaska. He was astounded all of the places across Alaska had broadband capabilities for telemedicine. He added that he was delighted, but astounded. He had been in villages where all of the kids and the village council were huddled around the library taking broadband off the routers because the service was not available elsewhere or it was very expensive. He asked if the clinics had dedicated broadband

accessibilities that was only available to rural health clinics as part of the pilot program. He asked about costs that were exorbitant many places in Alaska. He noted that costs were driven down by e-rate in some places. He stated that for medicine, regardless of the costs, may be efficiencies. He asked if they were factors or whether the program was so far along they were integrated into a success.

Mr. Ferguson answered that the clinics depended heavily on the Universal Services Fund (USF) for access to bandwidth. He explained that the fund was a federally subsidized program (paid for with funds brought in from telephone bill tax), which enabled rural healthcare facilities (village clinics and sub-regional hospitals in Alaska) to buy bandwidth at no more than the cost in the nearest municipality or city of 50,000 (i.e. Anchorage). For example, connectivity could be bought from Savoonga into Anchorage or Nome for the same cost he would personally pay to get from his hospital across to Providence in Anchorage. He relayed that a T1 satellite link of 1.5 megabits per second ran about $8,000 per month; in Anchorage the cost was $180 per month. He explained that it meant the clinic in Savoonga would pay $180 per month and USF would cover the remaining cost of the $8,000. He elaborated that because of the high cost of satellite in Alaska, the state consumed about 60 percent of the entire national subsidy for USF. Most of the tribal system's village clinics had between two and four T1s, which gave them enough bandwidth to do multiple videoconferencing sessions, electronic health records, store-and-forward, phone and fax, and other. He continued that the electronic capability was due to USF. He added that he met with the FCC whenever it came to Alaska due to the critical importance of continuing the program; without the program the tribal health system could not afford the connectivity.

1:56:16 PM

Representative Guttenberg believed he had part of a plan in place [related to bandwidth], but he noted it was a subject for a different time. He stated that the bill included very little dialogue about doing reports on broadband availability. He asked if the bill needed to include language specifying that telemedicine programs were eligible for USF. Alternatively, he asked if the programs

were already eligible for the funds under the rural healthcare programs.

Mr. Ferguson answered that almost all rural healthcare facilities (e.g. doctor offices, public health, and other) were eligible to apply for USF. He did not believe it was necessary for the state to take any action.

Representative Edgmon remarked that SB 74 was an omnibus reform bill for healthcare, which devoted a number of sections to telehealth and attempted to facilitate increased telehealth opportunities in primary care, behavioral health, and urgent care. He asked whether one of the areas may be a priority in terms of expanded opportunities.

Mr. Ferguson replied that he could not prioritize the areas, which were all huge for Alaska. The state did not do anywhere near the amount of behavioral and mental health services it could be providing to patients in Alaska. He stressed the tremendous need and relayed that the services were one of the easiest to provide via telehealth. He detailed that most telehealth programs in the Lower 48 started with tele-mental health and tele-behavioral health; therefore it was easily done - the infrastructure and bandwidth were available. He believed looking for opportunities to expand the area was great. He specified that the death by trauma rate had been 5 times the national average in Alaska. He continued that the state had incredible emergent emergency department needs throughout; therefore, the ability to connect with someone via telehealth to determine whether a patient needed to be flown to a hospital or stabilized was potentially huge for the state. He noted that ANTHC had started some pilot programs, which had been very successful. He remarked that the system did a significant amount of primary care telehealth, but he did not believe it was utilized at the level it could be. Additionally, he believed care management was the secret to helping manage costs going forward and telehealth was a substantial part of that.

Representative Edgmon relayed that he had spoken with Robert Clark at the Bristol Bay Area Health Corporation (BBAHC) who had communicated that the Bristol Bay Hospital did a significant amount of behavioral health services [via telehealth]. He asked if Mr. Ferguson believed the bill

went far enough to aid what ANTHC and other regional providers were attempting to do with telehealth.

Mr. Ferguson believed from a telehealth perspective the bill was pretty much right on. One of the challenges was determining what the system wanted to do with telehealth; the service did not merely happen on its own. He believed the state and tribal health system needed to determine where to put the focus and how to do it. He understood that part of the legislation was to work on that level of planning. He believed the bill focused on the areas of need and the obvious areas of opportunity. He did not believe ANTHC or he personally, would be asking for anything in addition to the current bill language.

2:01:44 PM

Representative Edgmon asked if the bill would open up opportunities for accessing providers residing out of state. He wondered if the opportunities would be hugely significant or a good compliment to current services offered to patients. He referred to Mr. Ferguson's earlier testimony that the majority of the tribal health system's patients fell into the lower risk category.

Mr. Ferguson replied that there were different kinds of telehealth. Telehealth provided by some other companies was a direct to consumer service, which he believed had value. He believed the committee would hear from the company Teladoc later in the meeting. He elaborated that there were plenty of consumers who would like to have the ability to talk to a doctor at night. The telehealth offered by the tribal health system was primarily provider to provider or care management and often times involved complex cases. The system made every effort to ensure it was fully integrated into the electronic health record, which was an important piece of what the system did. There was room for all of the various types of telehealth services, which were not all the same. He relayed that no matter what kind of telehealth an entity used, there was a growing need to reach outside the state's borders. He detailed that many pediatric specialists simply did not exist in Alaska - many had moved out of Alaska based on changes that occurred at Providence Hospital and other places. Efforts were always underway to make it work; therefore, anything to help with the effort was beneficial.

2:03:35 PM

Representative Gara expressed appreciation Mr. Ferguson's work. He understood what the bill did in terms of making it more permissive to do telehealth for behavioral health treatment, but he was unsure how the bill expanded the ability for more telehealth services. He observed that the tribal health system was already offering a substantial amount of services. Apart from the behavioral health area, he wondered what else the bill was doing to expand telehealth outside of the behavioral health services.

Mr. Ferguson answered that the bill included some provisions to support new models working directly with IHS and tribal facilities to expand telehealth. One of the challenges was in aligning the payment model with the cost of providing telehealth. He detailed that sometimes telehealth cost more than traditional healthcare, but it became beneficial when factoring in money saved on travel and identifying disease earlier. Part of what the bill offered was the conversation with the state to consider what else could be done and how to model the associated costs.

Vice-Chair Saddler asked if other states had the same requirement as Alaska that telehealth providers must be licensed in the same state as the patients resided.

Mr. Ferguson replied that it varied across the U.S. For example, Minnesota specified that a licensed provider with good standing in any state could provide care to Minnesotans, whereas New Mexico required a $10 separate license to provide telehealth, which was easily attainable. The American Telemedicine Association identified the issue as one of the greatest barriers to telemedicine because it made it hard for physicians to know what they needed in different states.

Vice-Chair Saddler asked if there was any place telemedicine had expanded too far and it had been necessary to pull back from something not working as anticipated. Mr. Ferguson was not aware of any. He stated that in his experience of running and building a couple of different programs, he had observed the opposite problem. He elaborated that it took significant effort to build the programs and many times it was necessary to continue work on the program to keep it going; therefore, programs did

not typically get to a point where they ran amok. He added that he was not aware of any other programs that had.

2:07:17 PM

Representative Guttenberg highlighted that several years earlier a broadband taskforce had determined the standard for the state should be 100 megabits, which was clearly not the case. He noted the standard speed had been lowered to 10 megabits. He was concerned about chasing the technology and reasoned it would not be possible to run a program on a 10-year-old computer. He asked if the telemedicine community was planning for future capabilities. He reasoned that a program in the development phase may not run on a computer in a rural area. He detailed that programs would be pushing technology due to increasing capabilities. He wondered if there was a planning group observing the situation. He asked how the interconnectivity worked with someone in a rural community interacting with a doctor in Anchorage who needed a specialist in another state. He asked if the capability existed.

Mr. Ferguson agreed that the technology was changing at a rapid rate, which impacted telemedicine in a number of ways. There were a number of lower cost, high performing devices, which made it necessary for the tribal health system to do the appropriate level of testing to determine whether they were good enough for clinicians to use. Some of the devices available were not diagnostic quality - the items may be sufficient for a quick image, but not something a specialist could use. He relayed that Alaska had the world's only National Telehealth Technology Assessment Center, which had been federally funded and in operation for about six years. He elaborated that the center assessed about six different technologies on an annual basis (e.g. stethoscopes, other scopes, and etcetera). The challenge was to locate funding or work with organizations to pay to put the technologies out into the field, but it was done with the ANTHC's tribal partners. Additionally, they were looking at some mobile devices available. He detailed that the system's telehealth platform had gone from computer-based to IPad, IPhone, and Android - providers used the tools when doing consults. He elaborated that the system did videoconferencing on IPhones out to village sites. He shared that in the past the system had used an otoscope to take a still image, but it could now beam the image live to the doctor. The system mixed

store-and-forward and live telehealth capabilities. He spoke to involving other providers and relayed that the system had gone to a desktop videoconferencing solution called Vidyo. He detailed that the system liked the service, which enabled people to join a secure room; other clinicians could be invited and it enabled the sharing of images and live feeds from medical devices.

2:11:08 PM

Representative Edgmon asked about fiber optic cable. He referred to an article about the company Quintillion breaking ground in Nome. He believed there was future prospect of fiber optic cable paralleling the outer coast of Alaska to get services out to the Aleutians, the North Slope, and higher services to Kodiak. He remarked on the significant difference between fiber optic cable service and the traditional TERRA Southwest service provided in Southwest Alaska. He noted Southwest Alaska was very grateful for the TERRA Southwest service provided through GCI. He asked about ways the services could be further expanded once the fiber optic cable was more fully in place.

Mr. Ferguson answered that fiber allowed a transition from satellite to terrestrial, which significantly decreased delays. Additionally it provided much bigger bandwidth, which was the biggest issue. The most significant impact of the Quintillion fiber would be to bring terrestrial connectivity to the villages along the North Slope (especially to Barrow where the tribal health center had a regional hospital). Once Barrow was off of satellite the hospital would have the ability to access an electronic health record shared in Kansas City, which was not possible over satellite (he noted it was possible at a clinic, but not at a hospital). The increased service would enable the tribal health facilities to all be on one medical record and higher bandwidth videoconferencing would be possible. He remarked that the upgrade would change everything for the remote villages. He believed once TERRA reached Nome, Dillingham, and Kotzebue it huge impact on healthcare. When TERRA had reached the villages the tribal health system had put Nome on the same electronic health record and the system had increased tribal health in the areas.

2:13:23 PM

Co-Chair Neuman believed the most recent cost estimates of expanding fiber optics statewide was over $2 billion. He asked if the amount was accurate. Mr. Ferguson answered that he did not know the cost, but it would be huge.

Co-Chair Neuman remarked on Mr. Ferguson's testimony about many of the wonderful capabilities of telemedicine. He had not received information specifying opportunities available for Southwestern Alaska with specific internet services or the connectivity that could be used regionally. He understood that technology changed daily. He wondered if there was a way to get a better idea of what could be used and what could not be used throughout the state. He asked about technology available in Alaska.

Mr. Ferguson replied that the tribal health system tracked what the current connectivity was to its 200-plus sites. As a general rule, the system did not find that the delays introduced by satellite prohibited it sufficiently from utilizing telemedicine. The largest issue was how much bandwidth the villages had (even over a satellite link). Most of the system's sites had sufficient bandwidth; the system was not limited to providing the services it wanted to provide related to store-and-forward, live videoconferencing, electronic health records, and integrating the villages into its other services provided. He added that the tribal health system even utilized tele-pharmacy to dispense medications at remote sites. The tribal health system was almost past the point of being limited by bandwidth or satellite. He relayed that terrestrial connectivity did help for large facilities like hospitals. He concluded that at present there was not a kind of telehealth the system could not do because a place was on satellite or lower bandwidth.

2:16:08 PM

Co-Chair Thompson thanked Mr. Ferguson for the tremendous work he did. He remarked how surprising the technology capabilities were at present.

REBECCA MADISON, EXECUTIVE DIRECTOR, ALASKA E-HEALTH NETWORK AND BOARD MEMBER, NORTHWEST TELEHEALTH (via teleconference), spoke from prepared remarks:

> Thank you for inviting me to address your committee. My name is Rebecca Madison. I am the Executive

Director of the Alaska eHealth Network and am on the Executive board of the Alaska Telemedicine and Telehealth Collaborative. Both are non-profit organizations dedicated to decreasing healthcare costs through effective use of technologies. I also served as chairman of the Alaska Federal Healthcare Access Network for 9 years as that group developed telemedicine technology for the Alaska Native health system.

I would like to speak to the strong need for telemedicine, prescription drug monitoring, and health information exchange as they apply to Medicaid Reform starting with some real world examples from other states.

- Mississippi implemented a home based telemedicine program directed at diabetes and other chronic conditions. The program saved Mississippi Medicaid $189 million in its first year and was so successful that Texas has begun implementation of the same program in Austin.
- Maine showed a cost savings of $2 million dollars in one 60 day period for 162 patients by using telemedicine for patient follow up, thus reducing hospital re-admissions.
- New Mexico implemented a hospital-level care program in patient homes. Patients showed comparable or better clinical outcomes and the program achieved savings of 19 percent over costs for similar in-patients. Cost savings came through less time in the hospital and fewer tests performed.
- A study in Michigan showed a 59 percent and 67 percent reduction in CT scans and chest x-rays respectively, when providers used health information exchange services to review radiology results.

2:18:38 PM

Ms. Madison continued to read from prepared remarks:

And savings aren't just to Medicaid. Departments of Justice and Corrections also have shown significant savings:

- The University of Texas Medical Branch conducted over 250,000 telemedicine consultations with prison inmates at a net savings to taxpayers of $780 million dollars.
- The Colorado Department of Corrections reported savings of $450 per telemedicine intervention, about $100,000 per year through transportation and security cost reductions.

In our own state of Alaska, Providence Health and Services provides eICU services to Critical Access Hospitals statewide keeping patients and families in their communities.

You also heard from Stewart Ferguson on the Tribal Health system travel savings and the impact on wait times.

SCL Health, a private corporation with services in Montana, Colorado and Kansas saw a combined savings across all payors of $226.7 million by implementing clinician to clinician specialty consults, clinician to patient virtual visits and consumer mobile self-tracking services.

Telemedicine, opioid monitoring and health information exchange without a doubt are definitely becoming mainstream and are no longer specialized projects. One major issue is that much of this data was siloe'd in the past and required providers to sign into many different systems to get the information they needed. This silo'ing of data systems means that many providers don't use the systems because they don't have time or knowledge to search through multiple databases for all the patient data they need.

In Alaska, we can now leverage the health information exchange infrastructure to provide a single point of entry into health data from many systems – from electronic health records, to telemedicine systems, to drug databases and a host of other services. This single point of entry can further streamline and produce savings to both Medicaid and providers statewide.

2:20:58 PM

Ms. Madison continued to address a written statement:

> Cost savings are accomplished through healthier patients. By putting data in the hands of providers and, yes, also in the hands of patients, we can ensure a healthier population. It takes a team of payers, providers and patients to lower healthcare costs.
>
> Of course, there is also a significant impact on patients and patient care, particularly those patients with chronic conditions, which we could also discuss at length. But in light of our current fiscal situation, I felt it is important today to stress the financial impact which coordinated access to telehealth and other healthcare data has on the healthcare system in general and Medicaid, in particular. We must stem the rising cost of healthcare. We have the systems and the will to do so. Medicaid reform can leverage these systems, in place today, to give all Alaskans an opportunity to receive better care at a lower cost.

2:22:12 PM

Co-Chair Neuman referred to Ms. Madison's testimony about the abilities of other states to use telemedicine, much of which he believed sounded wonderful. He asked how much of the technology was available in Alaska.

Ms. Madison replied that all of the technology could be made available, there was no reason Alaska could not use the same technologies as other states. Some may be cost prohibitive because of the size and number of patients, but a business case could be done for those things.

Co-Chair Neuman asked if Ms. Madison believed Alaska was doing everything possible in the telemedicine industry to support and utilize its current programs. Ms. Madison replied that she believed the state was doing all it could to use its current programs. However, she did not believe everything possible was being done to reach the patients. She believed it was important to include the patients in the healthcare through their care managers.

Co-Chair Neuman believed Ms. Madison had testified that Alaska had the ability to purchase the technology to acquire some of the things other states were doing. He asked for verification that Alaska currently did not have the necessary technology. Ms. Madison answered that there was sufficient technology in Alaska to do much of the work, but there were some things that could not be done (e.g. the state was not currently set up for some of the home telehealth programs). She concluded that the state had significant technology to provide many of the telehealth services.

Co-Chair Neuman requested an update from the Department of Health and Social Services (DHSS) on telemedicine services currently provided. Additionally, he was interested in services the state did not provide and whether they could be offered.

Co-Chair Thompson noted his office would try to get the information from DHSS.

2:24:52 PM

Vice-Chair Saddler referred to page 20 of Ms. Madison's presentation on Live Health Online (LHO), which made the notation that the patient's copay was the same for an LHO visit as it would be for an in person visit [note: the presentation referred to was provided by a presenter later in the meeting]. He understood that the access was easier timewise. He asked if there was a disincentive to using telemedicine if the cost was the same. He asked if there was any advantage to the patient if the cost was the same.

Ms. Madison replied that she had provided several references and was uncertain which document Vice-Chair Saddler was referring to. She stated that the bill began the process to use the items to determine how to best contain costs; it started the discussion for things like parity and what the cost of a telemedicine visit should be versus the cost of an office visit. She believed the topic was another discussion that needed to be looked at by Medicaid and the current administration.

Representative Guttenberg referred to Ms. Madison's testimony that Alaska was not doing enough to reach out to the patients. He asked if she differentiated between rural and urban on the issue. He believed the state had taken on

rural healthcare first because it included the largest savings. He remarked that in other communities the savings may not be much, but they may be considerable relatively speaking. He asked her to be more specific on her statement.

Ms. Madison clarified that she had not meant the state did not reach out. She explained that as providers there was still not the direct patient in-the-home connectivity that would benefit the patients. For example, Mississippi had done a home-based telemedicine program that had involved screening every patient discharged from the hospital to determine whether the patient should use telehealth from home. Subsequently, the patients on telehealth had been monitored in their homes (e.g. if a person were at risk of falling they would be monitored by video and if a patient was diabetic they would be monitored with equipment measuring glucose and other various tests). She detailed that monitoring the individuals at home had eliminated the need for readmission and had brought many of the chronic conditions under control because the patients had not previously had sufficient interaction with providers. She elaborated that much medical follow up could be done with nurses at a much lower cost.

Co-Chair Thompson clarified that the presentation currently shown on a projector screen in the committee room was for a later presenter.

2:29:09 PM

DOCTOR HENRY DEPHILLIPS, CHIEF MEDICAL OFFICER, TELADOC, NASHVILLE, TENNESSEE (via teleconference), relayed he had been pleased to hear Dr. Ferguson's testimony. He lauded Dr. Ferguson for doing a phenomenal job with a phenomenal program. He remarked that legislation the prior year (HB 281) had moved the State of Alaska forward significantly in the world of telemedicine. He discussed that Teladoc had worked with the Alaska State Medical Association (ASMA) on HB 281 and in deference to ASMA, bill sponsors had incorporated a provision requiring a physician rendering telemedicine care be licensed in Alaska and an Alaska resident. He referred Dr. Ferguson's response to an earlier question that licensing requirements varied in the U.S. He did not want to speak for Dr. Ferguson, but he believed the doctor had probably been referencing the federal telemedicine programs, which he believed the tribal health

system was a part of (the Veterans Administration system and many others were also a part of the federal system). At the state level (i.e. private companies and people under state government programs) where the state legislation and regulations apply there was actually substantial uniformity. To do a telemedicine consultation in any state a provider was required to have a license in that state. He elaborated that only Alaska-licensed physicians in the private sector and state government were allowed to do telemedicine consultations for the citizens of Alaska.

2:31:41 PM

Mr. DePhillips returned to discussing HB 281 (from the prior year) and the ASMA. He relayed that after the bill had passed and Teladoc went to recruit positions to offer telemedicine services in Alaska, it had quickly discovered that the supply and demand challenge was much more acute than it had thought. He continued it was very difficult to ask doctors in Alaska to do additional work via telehealth or other because they were already stressed to or beyond capacity. Subsequently, a group (including Teladoc) had come together in the current year to discuss removing the residency requirement. He detailed that for decades the Alaska State Medical Board responsible for credentialing and licensing physicians to render services to Alaskans had been issuing licenses to physicians resident in Alaska as well as physicians outside the state (primarily in the State of Washington, but other states as well) to render services to Alaskans. He highlighted his intent to speak to the provision in SB 74 that removed the in-state residency requirement to allow Alaska licensed physicians (certified by the state's medical board) to render telemedicine and other services to Alaskans. He communicated that Alaska was the only state with a residency requirement encapsulated in legislation.

2:33:12 PM

Mr. DePhillips relayed that telemedicine had existed for a bit and Teladoc had built its program around primary care telemedicine for common uncomplicated medical issues. Teladoc had been established in 2002 and was coming up on 1.5 million e-visits across all 50 states. From a patient safety standpoint, across the country for in person care for about every 1 million visits there were 17 medical malpractice cases filed and carried through to completion

where an award was made (the average award was $248,000). Teladoc was approaching 1.5 million visits and had never had a medical malpractice go through to completion and awarded, filed with its carrier, or litigated. He believed the record was a reasonably good marker for patient safety. From an oversight perspective, a comprehensive electronic health record embedded in a technology platform provided the ability to do very intense quality oversight, which was not available in a private practice brick and mortar setting. Teladoc looked at the data including prescribing patterns, appropriate prescribing, and other. He relayed that the company did not allow any Drug Enforcement Agency (DEA) controlled substances or lifestyle drugs in the program. The company's overall prescribing rate was currently running at 77 percent of all consult requests; the brick and mortar average as reported on the Center for Disease Control (CDC) website was currently 82 percent. He detailed that based on the company's volume, its overall prescribing was statistically significantly below the national average.

Mr. DePhillips discussed the comprehensive electronic health record shared between the patient and physician prior to the visit, completed during the visit, and shared with the patient's primary care physician after the visit. He referred to a committee member's earlier comment about concern related to the quality of medical records. He believed that because of the platform approach and quality oversight that the quality of the clinical record was quite strong compared to charts in the in person setting where there was less oversight. The company wanted care to be local; Teladoc had built a five minute lead time into the platform that gave a licensed and resident physician the opportunity to respond to the consult before a non-resident physician could respond. The company actually preferred for care to be given by licensed and resident physicians (they had to be licensed by law), but the capacity was not sufficient to service the clients.

2:36:41 PM

Mr. DePhillips addressed cost savings and referenced well-done third-party studies. He shared that a Harvard Medical School researcher had studied claims in the population of a national home improvement retailer - He noted the company did not want its name used in the study, but he added that its logo was orange. He shared that for every consult done

by one of the company's 150,000 employees (including those in Alaska), for the self-insured employer responsible for the cost of medical care across the individuals who used the service and their independents who did not use the service there was a savings per consult of $1,157. He stressed that the savings was much higher than he had expected. He believed it indicated the shortage of the provision of primary care services. Before the individuals in the study had the telemedicine benefit they had used the emergency room for non-emergency common, uncomplicated medical issues. He relayed that Teladoc had worked with ASMA on SB 74 and he believed the entity's concerns were understandable. He referred to the credible nature of Teladoc's program. The association had vocalized concern about other companies that may come up if things were legislated. The company recommended that the standard of care for any medical issue needed to be met regardless of the modality of treatment (i.e. whether in person or remote) and the standard must be the same. Additionally, Teladoc recommended a technology neutral approach. He referred to the two prior testifiers who had specified technology was moving extremely quickly. He did not believe any legislature in the country should be in the business of assessing and determining what technology was appropriate in healthcare. He believed the issue should be left up to practicing physicians to decide how they collect information and what information they need to meet the standard of care.

Mr. DePhillips addressed three modalities offered by Teladoc including audio-videoconferencing; uploading of high definition photographs, which were probably superior to video (smart phone still cameras had about seven to nine times the resolution of the video camera) for things like skin lesions, pink eye, and other; and a subset of medical issues could be handled by telephone. He elaborated that the ability to diagnose issues (e.g. bronchitis, sinusitis, urinary tract infections, and other) over the phone helped with the bandwidth issue and the diagnosis could be safely done after the medical record was shared via store-and-forward. He relayed that no data indicated any of the modalities were either superior or inferior to any of the others, which was the reason Teladoc continued to offer all three options. He added that if data emerged showing one of the modalities was superior, the company would go with that option. He communicated that Teladoc was currently servicing GCI, Alaska Airlines, Fred Meyer, and Aetna,

Premera, Lowes, Costco, BP, Shell, and other. He noted Aetna would love to bring the program to state employees. The company would love to have the ability to allow Alaska licensed physicians residing in other states to render services in Alaska to the employees of the entities he had listed.

2:40:47 PM

Representative Munoz asked if Teladoc's fees were the same across state lines. Mr. DePhillips answered in the affirmative. For example, for a company doing business in all 50 states, Teladoc charged the company the same price to offer the service in each state. There was also a uniform fee schedule for reimbursement going out to the board certified physicians rendering care. There were a couple of minor, few and far between exceptions, but the company tried hard to have a uniform fee schedule.

Representative Munoz asked if the fees were published and whether the patient knew the fees prior to services being rendered. Mr. DePhillips answered that the cost of the visit was $45.00. He detailed that the sponsor (i.e. the employer or health plan) would pick up a portion of the amount (some sponsors covered the entire amount). He referred to an earlier question by a committee member about why the service would be utilized if an in person visit cost the same. The data was clear that unlike most medical benefits it was a benefit a company should want employees to use more and not less because it provided a safe access to care option for patients to use rather than being faced with going to the emergency room or utilizing more expensive options. The companies paying the entire $45 had four times the utilization of the companies pitching in nothing. He furthered that the ROI [return on investment] for the company responsible for the cost of care went from 5 to 1 on the $45 patient copay to 20 to 1 on the zero patient copay.

2:42:51 PM

Vice-Chair Saddler asked if there was any area of telehealth that was not providing the results he hoped to see. He asked if there were areas in which Mr. DePhillips would advise against using telehealth.

Mr. DePhillips answered that behavioral health was an "absolute slam dunk" for telehealth. He pointed to short supply of behavioral health services, especially in the pediatric population. He mentioned dermatology as another area where telemedicine provided a good option. He stressed the conservative nature of the industry and relayed that when interviewed for his position at Teladoc he had interviewed all board members and senior management and had asked what they would choose if they had to decide between patient safety and profit. He would not have taken the job if the answer had not been patient safety every step of the way. The bottom line was no one in the industry could afford an article on the front page of the Wall Street Journal saying that the industry had done too much, gone too far, and had a bad result; the situation would be bad for the specific company and for the industry as a whole. He reiterated that the industry had been very conservative and had good clinical guardrails in place around the programs. He believed all of its direct competitors also had a clean medical liability history. He stressed that the industry had not gone too far. He believed it had intentionally been very conservative in the rollout of services because they all wanted to ensure clinical quality was the first priority.

Vice-Chair Saddler referred to testimony about the malpractice rate. He asked about the liability and insurance implications for a physician offering services via telemedicine.

Mr. DePhillips replied that the problem had been solved by using an insurance carrier that insured all of the physicians who worked in the Teladoc and other programs. Teladoc provided the medical malpractice insurance for all of the doctors. Second, Teladoc's agreements with the physicians included a hold harmless clause specifying if an issue occurred, Teladoc would take responsibility on behalf of the physician.

2:45:20 PM

WALLACE ADAMSON, VICE PRESIDENT, ANTHEM, INC., COLUMBUS, OHIO (via teleconference), spoke in support of SB 74. He shared that he was a family physician and had worked in various business capacities over the past 16 years for Anthem. Anthem was a health insurance company with approximately 36 million members operating Blue Cross and

Blue Shield plans in 14 states and Medicaid plans in 20 states through its Amerigroup subsidiary. He currently led the physician strategy for Anthem's telehealth solution LiveHealth Online. He addressed a PowerPoint presentation titled "Introducing LiveHealth Online" (copy on file). He explained that LiveHealth Online allowed consumers to have live face-to-face real time visits with the physician of their choice. In addition to the consumer option, the system also offered LiveHealth Online to physicians for use in their practices, which enabled them to offer telehealth opportunities to their own patient populations. He relayed that the wait time for a visit on LiveHealth Online averaged 10 minutes or less. The program targeted minor health problems of a somewhat urgent nature (i.e. sinus infections, ear aches, and other). Visits were available 24 hours per day, 7 days a week, and 365 days per year.

Mr. Adamson moved to slide 3 that included a map of the United States. He detailed that the program was currently offered to 16 million Anthem members in 47 states and the District of Columbia (shown in green). The company did not operate in Alaska, Texas, and Arkansas due to the local regulatory and legislative environments (shown in gray). California was shown in a darker green because its program included a Spanish language offering of LiveHealth Online called Cuidado Medico. Indiana was shown in light green to indicate that the state recently had a statute change that would allow prescribing via telehealth effective July 1 [2016].

Mr. Adamson relayed that Anthem offered a real time video visit giving patients access to the board certified physician of their choice. The company had also rolled out a LiveHealth Online psychology. He noted that behavioral health was a natural fit for telehealth and worked very well. He spoke to the importance of telehealth from the employer prospective. He detailed the company had national employers including Wells Fargo, FedEx, Safeway that offered LiveHealth Online to their employees (excluding Alaska).

2:49:39 PM

Mr. Adamson relayed that Anthem's primary reason for providing the service was related to access and cost of care. The company preferred for individuals to see their own physician and believed patients could get the highest

quality care from the ongoing relationship with the doctor they had chosen. Unfortunately, many individuals did not have the benefit of that type of relationship; the majority of Anthem members did not have an ongoing relationship with a primary care physician. He addressed the busy schedules doctors held and referred to earlier testimony about the demands on Alaska physicians. He detailed that the company liked to be available as the backup (e.g. at 10:00 p.m. on a Friday night or Sunday morning at 7:00 a.m.) if someone was in need of care. He turned to slide 5 titled "HealthCore study results are promising" and spoke to cost-savings. The company had conducted an extensive study of Anthem results from its claims data on people using the program. The study had compared LiveHealth Online users living in the same state with the same health problem. For example, the study had looked compared Anthem members living in Ohio who received treatment for a sinus infection through LiveHealth Online, urgent care, a clinic, the emergency room, and a primary care visit. The study had looked at a three-week period, which included costs for follow up, imaging, pharmacy, and other; it had concluded there was a savings of approximately $201 to $202 per visit with LiveHealth Online. The study had also determined that the patterns of care were very comparable to the other locations. For example, follow up visits and prescribing were very closely aligned between the different treatment settings. He communicated that the program was valued by consumers; 90 percent of individuals who used the program specified they would use it again and 85 percent reported that their medical problem was completely resolved.

Mr. Adamson addressed an earlier question about the benefits of telemedicine even if the cost differential was the same. Anthem had heard loud and clear from consumers about the time savings telemedicine provided. He believed the time savings would only be amplified in Alaska given its landscape and geography. He detailed that most people in the Lower 48 reported they saved two to three hours of time using telemedicine versus an in person doctor visit. He noted the value to employers when they were able to keep people in the workplace.

2:53:29 PM

Vice-Chair Saddler referred to language on slide 20 of the presentation specifying that the copay for each consultation was a flat $49, which was the same as a

doctor's visit. He asked if it was a disincentive to use telehealth if the cost was the same as an in person visit.

Mr. Adamson answered that the total cost of a visit was $49, which included the health plan's contribution and the individual's copay (some people had copay and others had coinsurance). When Anthem had implemented the program in 2013 there had been a "spirited" discussion on what to do with copays compared to primary care. The company had decided the least disruptive strategy at the time was to be equal with the primary care component. The company wanted the program to be neutral and did not want to stimulate excess demand or create a disincentive for its use. With a couple of years under its belt, the company heard from consumers that the price was very fair, especially for individuals with a health savings account and a high deductible plan ($49 for a visit was much better than the rate at a local urgent care or an emergency room). Anthem spoke to many different companies that set the benefits and different companies did different things. He detailed that some companies wanted to offer low copays to individuals to encourage them to use the service, whereas other companies had higher copays because they believed the service would be over-utilized.

Vice-Chair Saddler asked if Anthem experienced any problem with the over-prescription of opioids via telehealth. Mr. Adamson answered that opioids and lifestyle drugs were blocked on LiveHealth Online; therefore, it was not a problem for the company. He believed the same was true for most of the major telehealth companies.

2:56:34 PM

Representative Gattis relayed that she had offered a bill related to telehealth in the past; she was a big proponent of technology and telehealth. She spoke to the significant amount of time it took parents to take a sick child to the doctor, which included driving and wait time. Additionally, she believed waiting in a waiting room with other sick children had to factor in to the convenience factor of using telemedicine. She remarked on the advances of technology over time. She believed telemedicine added to convenience, cost-savings, and provided another option for parents.

Co-Chair Thompson thanked Mr. Adamson for his testimony. He spoke to advances in technology and reasoned the legislature would eventually have teleconferencing to see the testifiers.

2:58:21 PM

HEATHER SHADDUCK, STAFF, SENATOR PETE KELLY, relayed that Sections 13 through 19 of the legislation dealt with the Prescription Drug Monitoring Program (PDMP), beginning on page 15, line 23. Section 13 was amended by only requiring data collection for the database or dispensing for federal Schedule II, III or IV controlled substances. Section 14, page 16, line 1 amends by only requiring data collection for prescribing, administering, or dispensing federal Schedule II, III, or IV drugs. The section updated data collection to a minimum of once a week (line 11). Currently the PDMP was updated on a monthly basis.

Ms. Shadduck addressed changes in Section 15, which added additional access to the database (page 16, line 27 through page 18, line 16). The first change was in number 3 on page 17, line 9 where the bill amended law to authorize a licensed practitioner to delegate database access to a supervised employee or clinical staff. The second change started on line 14 and would authorize a registered pharmacist to delegate database access to supervised employees or clinical staff. The third change was in number 7 on line 29; a new section was added to authorize database access to the State of Alaska Medicaid pharmacy program. The fourth change appeared in number 8 on page 18, line 3; a new section was added to authorize database access to the State of Alaska Medicaid Drug Utilization Review Committee for utilization review of prescription drugs provided to Medicaid recipients. Number 9 on line 8 added a new section to authorize database access to the State of Alaska medical examiner. Number 10 added a new section to authorized de-identified data access to the State of Alaska DHSS Division of Public Health. The division would not need access to identifiable data to fulfill public health objectives regarding controlled substances.

Ms. Shadduck addressed the change in Section 16 beginning on page 18, line 17. The change removed optional use and maintained immunity for individuals using PDMP. Section 18 on page 19 related to board regulations and review of PDMP. Number 3 was added to the section to set a procedure and

timeframe for registration for the PDMP. Number 4 required prescribers and pharmacists to review the controlled substance prescription database before prescribing, administering, or dispensing a federal Schedule II, III, or IV controlled substance to a patient. Some exemptions had been added in based on some public testimony in the Senate including: a) for those in an inpatient setting; b) at the scene of an emergency or in an ambulance; c) in an emergency room; d) immediately before, during, or within the first 24 hours after surgery. Section 19 included new subsections: o) required prescribers and pharmacists to review the PDMP database when prescribing or dispensing a federal Schedule II, III, or IV controlled substance to a patient; p) required notifications to boards when a practitioner registered with the database; q) authorized 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; and r) collect dispensing data and update the PDMP database on at least a weekly basis. She relayed that most of the items were conforming to clean up changes in the other sections. She reminded the committee that the recommendations had come from the Controlled Substance Advisory Committee, which had been reported to the governor prior to the start of the current session.

3:03:59 PM

Representative Guttenberg stated that the pharmacists had a concern about the redundancy of the requirement mandating them to check the database before filling a prescription because a doctor was also required to check the database when writing a prescription. He asked for Ms. Shadduck's feedback on the issue.

Ms. Shadduck replied that the sponsor had worked with others in the Senate and with DHSS on the issue. She explained that the pharmacists were responsible for populating the database. She believed it made sense not to require pharmacists to check the database before dispensing, but they had to populate it. The requirement for physicians to check the database prior to writing a prescription would remain. She explained the change would alleviate some of the problems where the pharmacists feel they had to enforce the issue, when it should really be the doctor's responsibility to know whether it was wise to

prescribe a controlled substance. She furthered that doctors would be the most equipped to consider whether an addiction problem was present.

Representative Guttenberg remarked that the discussion was only about individuals the system had problems with. He surmised that most of the population was fine. He spoke about individuals shopping for doctors to receive prescriptions. He asked for verification that doctors would have the ability to see what other doctors had prescribed to a patient.

Ms. Shadduck replied that it was what the sponsor wanted. Part of the information came from the white paper she had provided from the Controlled Substances Advisory Committee [State of Alaska Controlled Substances Advisory Committee "White Paper: Increasing the Effectiveness of Alaska's Prescription Drug Monitoring Program (Alaska's PDMP)" dated January 29, 2016 (copy on file)]; currently only 13.5 percent of prescribers and 40 percent of dispensers were using the database as an optional database. She furthered that by making use of the database mandatory would give doctors access to the information. She knew DHSS had worked hard to improve the database; the intent of requiring database updates at least once a week that it would be updated more frequently. The goal was to provide flexibility for pharmacies that were ready to update the database on a daily basis (some small pharmacies were not ready for that). The intent was for doctors to have the ability to see if a person was doctor shopping. She noted that Doctors Inc. had given great testimony about the emergency room project - once they had the data they could identify individuals who were doctor shopping.

3:07:58 PM

Co-Chair Thompson noted that Senator Pete Kelly and Representative Liz Vasquez were present in the room.

MELINDA RATHKOPF, PRESIDENT, ALASKA STATE MEDICAL ASSOCIATION, WASILLA (via teleconference), spoke to ASMA's position on the PDMP. The association's goal was care for patients in Alaska and determining the best way to provide the care. The association was supportive of the PDMP (it had been working with the legislature and administration and recognized the national and global problem with opioid abuse) and of looking at ways to improve the problem of

opioid abuse in Alaska. The association appreciated some of the language included in the bill about ways to utilize the database to its fullest potential without being overly burdensome to the provider. She relayed that ASMA had requested that Schedule IV be dropped from the mandatory pre-lookup. She detailed that ASMA saw the need to include Schedule II and III (opioids and drugs more likely to have a higher abuse potential), but it felt that Schedule IV (that by nature had a lower abuse potential) was potentially very burdensome on providers on a day-to-day basis. She referred to the exception made for instances within the first 24 hours after surgery and requested to add "or procedure" to the exemption. She explained that often it was not necessarily a surgery, but a procedure where a doctor may be prescribing a short-term substance pre-procedure. She relayed that ASMA wanted to work with the legislature and strongly supported the idea of the database, but wanted to look at ways to make the system more usable for the provider and to determine the best way to deal with the overall problem.

3:11:20 PM

Representative Gara asked about the current prescription drugs doctors were required to look up. Dr. Rathkopf answered that there was currently no requirement for a pre-lookup. At present providers were using the database when they had concerns about over-prescribing or about a patient who may be doctor shopping and getting prescriptions elsewhere.

Vice-Chair Saddler asked if Dr. Rathkopf had any information about breeches of privacy in the current PDMP. Dr. Rathkopf answered that she had not heard of any. She elaborated that the ASMA had not discussed or had as many issues with the privacy concerns. She explained that as providers they were looking at the utilization of the database on a patient level; at that level providers already assumed patients were sharing personal information and providing access to their prior medications. She believed the biggest concern was giving doctors a way to look up patients' prescriptions in case they were not forthcoming about medications they were taking. She detailed that when patients saw doctors on a one-on-one basis they had already waived their rights for some of those issues. She concluded that the privacy issue had not

come out of the provider side and it had not been brought up by physicians that she was aware of.

Vice-Chair Saddler asked how long it took to check the database. Dr. Rathkopf answered that she was a pediatric allergist/immunologist and prescribed very little opioids and narcotics; therefore, she did not utilize the database in her own day-to-day patient care. Other providers in the emergency room and pain specialists had told her the check could take up to 10 minutes. She had registered for the database to see how difficult the registration process was.

Representative Gara looked at the emergency room treatment exception in the bill where pre-lookup in the database was not required. He did not want to provide prescription access to a person seeking extra narcotics. He assumed that unless a person was suffering a real injury a person would not have the ability to walk into the emergency room to obtain a prescription. He asked whether Dr. Rathkopf saw any room for abuse in the area.

Dr. Rathkopf replied that the purpose of the exemption was that ASMA did not want to delay response to a person in critical condition. She believed the database was utilized most frequently by pain specialists and emergency room doctors; they already saw the utility of the database. She was not saying that an emergency room doctor would not consult the database if someone was being discharged in stable condition with a prescription for Schedule II or III drugs. The primary concern was about having to halt patient care until the mandatory pre-lookup was done.

3:15:50 PM

Representative Gara understood the reason for the exception. He could not envision a circumstance where the emergency room exemption would make it possible for a person to get extra prescriptions they did not need. He asked if there was any danger he was missing.

Dr. Rathkopf answered that she did not believe so. She expounded that the idea was to ensure that patient care was not hindered. The emergency room providers were already using the database and individuals who were seen as a high risk of seeking multiple prescriptions would be looked up in the system.

Co-Chair Neuman asked what it took to get on and enter into the database. Dr. Rathkopf answered that she had registered the prior day. She detailed that the database was a separate site not tied to licensing or anything else. The initial registration took about five minutes, but then it required the registrant to download a form requiring a notary. She relayed that fortunately she had a notary in her office, but most providers did not. The process included finding a notary, scanning the document, resubmitting it. Once all of the information was submitted, it took overnight to get approval.

Co-Chair Neuman relayed that he had spoken to other doctors about the topic. He had asked DHSS for information about the topic, but had not yet received it. He asked for verification that the registrant was required to read and sign 7 pages of regulations.

Ms. Rathkopf answered that there were some documents she had read, which required the registrant to agree to the terms. Subsequently, the registrant was sent the additional paperwork. The registrant was required to have a DEA number, provider number, and state license number. The reason for the notary requirement was to show proof the person registering for the database was who they claimed to be. She had not found the initial registration particularly cumbersome other than the notary requirement. She reiterated that after completing the registration it had taken overnight to get the approval. She had not had the need to look up a patient for an opioid narcotic so she could not personally attest to how long that part took. She had heard reports that the process took an average of 10 minutes.

Co-Chair Neuman had heard concerns from other doctors that they were hesitant to sign that they had read and fully understood all of the regulations. He referred to the confusing nature of federal documents. The doctors were concerned they could lose their DEA license because it was essentially perjury if a doctor did not fully understand what they read. He asked Dr. Rathkopf if she would feel comfortable signing the documents.

3:19:46 PM

Ms. Rathkopf answered that she had read many of the documents in her role on ASMA and surmised that perhaps she

was more comfortable reading through the documents. She was much more familiar with the system than she had been a year ago before she had become president of ASMA. The requirements did not stand out as bothersome or concerning, but it may be because she was more prepared going into it based on her experience on ASMA.

Co-Chair Neuman asked Dr. Rathkopf believed general practitioners (the bulk of the state's family doctors) would feel comfortable signing each of the federal documents. He remarked that individuals who signed the agreement, but did not understand it could potentially lose their DEA license.

Ms. Rathkopf responded that it was difficult to generalize across a spectrum of providers. She specified that some individuals could be more concerned and read things in more detail and there were others who did not and were more comfortable.

Co-Chair Neuman had spoken to several doctors, one of whom was from a pain clinic, who had refused to sign the documents because of the concern. He remarked that the bill also allowed assistants or people who worked for a doctor to access the database. He asked if Dr. Rathkopf would allow her employees to access the database.

Ms. Rathkopf replied that she believed the provision, which enabled a doctor to have a designee, was very favorable. She could see there could be concerns about giving an unlicensed person the ability to do something on the doctor's behalf, however, doctors would be selective in who they chose. She furthered that most likely the doctor would select a medical assistant or nurse who had some medical training. The board supported the addition of the delegate account. She relayed that it had been identified nationally as a best practice of prescription drug management programs.

3:22:55 PM

Co-Chair Neuman stated he had spoken with doctors who relayed that doctors tended to know, particularly in smaller communities like Juneau and Mat-Su, which doctors tended to over-write prescriptions. He asked if Dr. Rathkopf felt the same.

Ms. Rathkopf believed it was one of the things doctors thought they knew. She stated it was like the proverbial "you think your neighbor has a problem, but you don't have a problem." She furthered that it was hard to say because it was not possible to be in the other person's shoes or to know their patients. She elaborated that a person may see a lot of prescriptions were coming from a certain provider, but she did not know of any doctors over prescribing. She knew both pain specialists and emergency room doctors, who by volume probably prescribed more than doctors not in those specific fields. She concluded it was very difficult to make that generalization without being in the room with the individual patients, knew the indications, and how many prescriptions the doctor was prescribing. She believed it was a hard generalization to make.

Co-Chair Neuman referred to Dr. Rathkopf's remarks. He surmised doctors and pharmacists had a moral or ethical oath to notify the state medical or doctor's boards if they felt one of their peers was possibly writing too many prescriptions.

Dr. Rathkopf believed if a provider witnessed provider care that was harmful to a patient they had some responsibility to address the provider personally or through other means. She had not had to take that action at a provider level [note: due to a poor phone connection some testimony was inaudible], but at a pharmacy level she had reported to the pharmacy board when she thought inappropriate care was given. She replied that if she witnessed an instance [of inappropriate care] she would put it under the same type of moral obligation or ethical category.

3:26:29 PM

Co-Chair Neuman asked Dr. Rathkopf if she or a pharmacist suspected a person of over writing prescriptions that there was a moral obligation to report the person.

Ms. Rathkopf replied that her answer reflected her personal belief, but she could not answer for every provider because the question pertained to what a person believed was moral and ethical. She explained what was normal for a pain specialist to prescribe was a much higher threshold than what was normal for her to prescribe.

Co-Chair Neuman believed there were already systems in place. He surmised that if there was more than one doctor in a community they generally knew who tended to over prescribe. He opined they would have a moral duty to report the issue to the Alaska State Medical Board. He continued that the board would question why the reporting doctor believed another doctor was over-prescribing. Subsequently, the board would take action if they believed the doctor was over-prescribing. He believed there were already systems in place to stop the over prescribing of opioids. He believed the system was already managed by doctors and the medical board. He asked if the state needed more intrusive laws into people's lives.

Ms. Rathkopf answered that the country was still facing a national problem [with opioid use]. She detailed that other states with prescription drug database programs had shown decreases in opioid prescriptions. There were best practice models in certain states, which had shown decreases in prescriptions for opioid narcotics with the use of a prescription database.

3:29:02 PM

Representative Gara asked Ms. Shadduck if the bill included a requirement for a physician to submit a list of the drugs they prescribed to the board and the database.

Ms. Shadduck answered in the negative. The bill required the prescriber to check the database prior to dispensing a prescription. The population of the database was done by the pharmacist.

Representative Gara asked for verification the bill required a weekly report to be sent to the state medical board. Ms. Shadduck replied in the affirmative. She pointed to Section 14, page 16, line 11, which required the database to be updated a minimum of once a week.

Representative Gara referenced Ms. Shadduck's statement that only pharmacists would enter data into the PDMP. He provided a personal example where he had received a prescription medication at the emergency room after breaking some ribs the previous year. He assumed his doctor had prescribed the medication, which was provided at the hospital. He wondered if emergency room prescriptions did not get entered into the database.

Ms. Shadduck answered in the negative. She clarified that the pharmacist filling the prescription entered the information into the PDMP. She explained that every written prescription should not be entered into the database. For example, a doctor could prescribe a narcotic to a patient, but the patient could decide not to get the prescription filled. The point was to prevent including prescriptions in the PDMP that had never been filled. Under the current system, if the pharmacist who filled Representative Gara's prescription was one of the 40 percent who used the database, they would have entered the information into the system.

Representative Gara asked if pharmacists always filled prescriptions. He wondered if a prescription could be filled in an emergency room by a physician. Ms. Shadduck deferred the question to DHSS.

3:32:42 PM
AT EASE

3:43:35 PM
RECONVENED

Co-Chair Thompson introduced the following testifiers who would continue to address the PDMP.

DOCTOR JAY BUTLER, CHIEF MEDICAL OFFICER, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, expressed his intent to provide context on the PDMP portion of the bill. He shared that in 2015 more than 80 Alaskans had died following an opioid overdose. He remarked that while heroin use had dominated the news headlines, it was important to remember that almost twice as many deaths occurred due to overdose of prescription opioids. Of the 36 individuals who had died of a heroin overdose, more than half had also been taking prescription opioids at the time of death. He considered how to stop the situation from continuing. He asked the committee to think about the opportunities for prevention surrounding an Alaskan who had died of an overdose. He shared that after an overdose was taken and a person's breathing stopped, Naloxone could have been administered to reverse the depressive respiratory effects and a life could have been saved. One of the barriers to that opportunity had been removed with the passage of SB 23 [legislation passed in 2016 related to the prescribing of opioids]. When

considering the individual's life it would most likely be discovered that opioid dependency had led to the overdose. At that stage, prevention included screening and diagnosis of dependency as a chronic health issue in order for the problem to be destigmatized and treated. Traveling further back in time in the person's life may reveal a tendency to self-medicate. He elaborated that self-medication often started with an otherwise healthy person living with a combination and an addictive substance (the demand and supply side of the equation).

Dr. Butler continued to discuss the scenario. He explained that increasing resiliency and wellness early in life by decreasing the impact of adverse childhood experiences and improving emotional wellness later in life were important measures for preventing traumatic stress and mitigating the impact in reducing demand. To address the role of the addictive substance in the case of opioids, it was necessary to address the supply by reducing the flood of opioids into the state's communities through more rational pain management strategies and prevention of diversion. The effort could in part be addressed by utilization of the PDMP. He stressed that the PDMP was not a Panacea, but it was an important part of the overall strategy when considering the entire flow of events leading to an overdose death. He relayed that deaths were just the tip of the iceberg; it was estimated that for every person who died of an opioid overdose, 12 more were hospitalized and 25 were admitted in the emergency department. The number of opioid prescriptions in the U.S. quadrupled between 1990 and 2010; the number of opioid deaths had also quadrupled during the same period.

Dr. Butler discussed that a number of drivers had contributed to the substantial increase in opioid use. He explained there was really no evidence that the prevalence of pain increased four-fold during 1990 and 2010. He emphasized that Americans consumed roughly 80 percent of the world's supply of opioids. He questioned whether the U.S. really had that much more pain than the rest of the world. He detailed that 19,000 Americans had died in 2014 of prescription opioid overdose and 10,000 more had died of heroin overdose. He furthered that the two epidemics were closely related; 80 percent of heroin users started by using opioid pain killers. Additionally, many heroin users also supplemented with opioid pain killers. Two major risk factors for opioid overdose are: higher doses, which can be

common when opioids were used for long periods to control chronic pain (dosages could become very high when medications were obtained from multiple providers); and co-administration with benzodiazepines (e.g. Valium and Xanax). The PDMP helped providers to monitor total dosages dispensed from all sources and to identify potentially dangerous combinations. He believed the vast majority of prescriptions were well intentioned, but too often led to misuse, particularly when the opioids were dispensed in larger-than-needed quantities.

3:50:02 PM

Doctor Butler discussed that benzodiazepines were Schedule IV drugs. Under best practices, often Schedule IV drugs were included in the required PDMP lookup. He had spoken with providers who utilize the PDMP - one provider who had seen a patient for the first time, accessed the PDMP and had been surprised to find the person had been prescribed 1,200 opioids in the past year and 1,000 benzodiazepines. He furthered that about half of the prescriptions were from one provider. He remarked that the question about what to do about that was very pertinent. He continued that Provider A had contacted Provider B, who had responded that they had no idea they had prescribed that much. He stated that the database not only helped providers know what other people were doing; it was also a reminder to individual providers about what they prescribed. The Alaska PDMP was underutilized that needed to be used more if it was going to be used.

Dr. Butler addressed that recommendations incorporated into SB 74 included components of the nine broad recommendations from the Controlled Substances Advisory Committee. A number of the recommendations were controversial to various people. The two recommendations that had given him the greatest pause were the required registration and lookup. He shared that it had taken him 15 minutes to register, which had involved locating his DEA number and other information. He only remembered having to get a single page notarized. He acknowledged that finding a notary could be burdensome to some people. He would prefer to remove barriers to make the right choice the easy choice, instead of putting mandates in place. He believed there were opportunities to make registration easier. He reasoned that if registration was tied to license renewal the notarization requirement could potentially be eliminated.

He deferred to the Department of Commerce, Community and Economic Development (DCCED) to address the feasibility of the idea. He was initially opposed to the mandatory lookup. He detailed that more than 20 states required a mandatory lookup in some form. He elaborated that the bill sponsor had worked to determine how to implement the requirement while striking the appropriate balance between access to care, patient and provider autonomy, patient privacy, quality of care, and addressing the opioid epidemic.

3:53:38 PM

Dr. Butler communicated that he rarely used the term epidemic, but he was comfortable calling the four-fold rise in the rate of death from one specific cause over a less than one decade an epidemic. He pointed out that young people accounted for many of the deaths. Thus, when considering the years of potential life lost or work lost to the state, the impact in Alaska was fairly large.

Co-Chair Neuman remarked it had been wonderful working with Dr. Butler on reform packages over the past four years. He added he had first met Valerie Davidson, Commissioner, Department of Health and Social Services during work on recidivism reduction. He asked how many of the 80 opioid overdose deaths in Alaska [in 2015] had been prescribed by a doctor.

Dr. Butler replied that providing access to the PDMP for the state medical examiner as well as de-identified data for epidemiological analysis would help answer those types of questions. He added that those were the critical types of questions to be able to address the challenge.

Co-Chair Neuman surmised that it was highly likely that the drugs had been over-prescribed by the person's doctor. He surmised that a person may have depression issues due to excess chronic pain and overdosed because they did not want to live any longer. He asked about the likelihood of the scenario.

Dr. Butler answered that roughly 1 in 10 deaths had some evidence of suicidal intent. There was some overlap as a cause of death, but it was important to recognize that the vast majority of the evidence was that the overdoses were accidental. He addressed national studies on where people obtained prescription opioids without a prescription. The

broad majority obtained the drugs from a friend or relative. He guessed that most people at the table had at some point had opioids in their medicine cabinet at home because the prescription sizes had increased over the past 10 years. He explained that there really was a ready available supply. He reiterated his earlier statement that the PDMP was not a cure-all, but it was a way to track prescriptions so individual providers could know what was going on with an individual patient. Additionally, providers would have the ability to look have visibility into where medications were coming from for a patient or potentially to a family. In terms of other sources, it was interesting that theft and purchasing only accounted for about 5 percent. Nationally, about 5 percent of all prescriptions came through emergency departments, whereas about 50 percent came from primary care providers (i.e. internal medicine physicians, family practice, and advanced practice nurse practitioners). He noted there was no visibility into the issue for Alaska on its own. He explained that the statistic did not mean primary care providers were writing a large percentage of opioid prescriptions; the number reflected that the group of providers saw a high number of patients and did often did prescribe opioids for chronic pain.

3:58:33 PM

Dr. Butler continued to answer the question. He relayed that proposed changes in the bill aligned with a number of the national best practices and with the recently published national guideline co-published by the American Medical Association (AMA) Journal and the CDC on March 15 [2016]. The best practices recommended a provider to check the PDMP prior to writing a new prescription for an opioid and to recheck the PDMP at regular intervals if the provider was prescribing opioids for chronic long-term pain management.

Co-Chair Neuman discussed that his family doctor knew everything about him because he wanted to live a long life. He elaborated that he did not eat right and his cholesterol was slightly high. He surmised all doctors should talk with their patients about the cause and effect prior to prescribing medications. He surmised doctors considered how multiple medications worked together and what the cause would be of taking or not taking them, which was the reason doctors told patients to take their prescriptions as specified. He reasoned that prescriptions were not to give

to a person's friend, neighbor, or loved one. He followed the directions of his doctor when receiving prescriptions. He thought all doctors should have that relationship with their patients.

Dr. Butler agreed that the scenario described by Co-Chair Neuman should happen. He shared that he had experienced a medical issue and a provider had insisted on subscribing some Percocet even though he did not personally feel he needed them. He heard from a number of people that they were raised to take their medicine as instructed - if a person was prescribed 50 Percocet they may feel the need to take them - the problem was especially prevalent for older people who just added it to the list of medications they took. What Co-Chair Neuman was describing was the ideal and the PDMP should help to facilitate the relationship. He stressed that the situation did not just involve bad people - people were all just human. He referred to a new medication his father had started, which he noticed was contradictory to a medication his father was already taking. His father communicated that the doctor had not asked about other medications. Subsequently his father told the doctor about the other prescriptions and the doctor immediately canceled the new medication. He explained that often the ideal of everyone communicating did not happen. Part of the goal of the PDMP was for all providers to understand what was being prescribed.

Co-Chair Neuman discussed that it was the job of the pharmacy to interpret one drug's interaction with another. He believed when the pharmacy filled the prescription they would have noted the new medication was not compatible with others being taken by Dr. Butler's father. He thought there were already things in place to catch the issue.

Dr. Butler answered that it would be great if the person went to the same pharmacy for all of the medications, but it was not what happened.

Co-Chair Neuman thought Medicaid or Medicare billing would catch the issue at the end of a billing period.

Doctor Butler replied that Medicaid was an important example. He detailed that currently the Medicaid pharmacist did not have any visibility on medications without a Medicaid claim. He furthered that a very robust business model was to get some opioids through the Medicaid program,

sell them for cash, use the cash to visit another provider, get more opioids, and so on. He explained that the practice had been documented in other states. He did not know whether it was happening in Alaska, but there was no way of currently knowing because the Medicaid pharmacist did not have access to the PDMP.

Co-Chair Neuman stated that he had asked the pharmacist about the issue. He relayed that generally when prescriptions were paid for in cash the pharmacist called the prescribing doctor to let them know. He believed the pharmacies were pretty aware of what was going on. He opined that pharmacies and doctors had a tight relationship in Alaska.

Vice-Chair Saddler referred to Dr. Butler's testimony that the PDMP was a part of the solution. He asked for the other elements of the solution.

4:05:31 PM

Dr. Butler replied that he thought in terms of infectious diseases, trains of transmission, and the opportunities to interrupt transmission. He thought about how a person who ultimately died of an overdose had started as healthy as anyone in the room at one point in time. He specified that often when people became addicted to opioids it started with a prescription for an acute injury. He continued that the situation resulted in no problem for most people. He added that most people using opioids recreationally did not go on to heroin, but a significant portion did. When tracing how a person became addicted, receiving a prescription for an injury was one of the contributing risk factors. He believed that apart from intervening on the supply of opioids in the community through the PDMP, better pain management, limiting the number of pills dispensed, and looking for other modalities of management in the case of chronic pain were all important. Additionally, he believed addressing behavioral health was critically important as understanding of how early childhood trauma increased the risk of self-medication later in life. He referred to a study in England suggesting nearly 60 percent of heroin and crack/cocaine use was attributable to adverse childhood experiences. Also important was being able to recognize addiction and to intervene with treatment; treatment opportunities included medication assisted therapy (e.g. Buprenorphine). He believed there was

currently a big inequality in the 900,000 American providers that could write prescriptions for Schedule II opioids with only 34,000 qualified to write prescriptions for Buprenorphine. Methadone was another option and Naltrexone was a very promising approach for individuals who had gotten through withdrawal and were off opioids and who wanted to take extra steps to ensure they could remain clean.

4:08:11 PM

Vice-Chair Saddler asked if the opioid epidemic could be controlled without increased use of the PDMP. Dr. Butler answered that if he was convinced it made no difference at all he would not be sitting before the committee. The seven states recognized as doing the largest portion of the nationally recognized best practices (Tennessee, Kentucky, Ohio, Wisconsin, New York, Connecticut, and Massachusetts) had seen declines in the total number of prescriptions for opioids, a decline in the number of high dose opioids, a very significant decline in the amount of doctor shopping, and increases in the number of Buprenorphine prescriptions. He submitted it was a sign there were more people seeking treatment once they were recognized as opioid dependent.

Vice-Chair Saddler asked for clarification. Dr. Butler replied that they were not discussing something like a flu vaccine that he could specify was 60 percent effective. Evidence had shown the PDMP had helped in other states. He believed it was more probable the system would help in Alaska than not.

Vice-Chair Saddler asked for the reason behind the high prescription of opioids. He asked if there was a profit to the pharmacist or pharmaceutical companies. Alternatively, he asked if it was defensive medicine or patient satisfaction.

Dr. Butler answered that during the early part of the 20th Century as everyone responded to the first opioid epidemics occurring in the late 19th Century, there had been a tendency to avoid opioids and there had not been a multitude of other options. As a result, he believed pain had probably been under managed. By the time he had started his training there had been good progression - he recalled specifically being told if he had a patient dying of cancer, to make them comfortable and not worry about that

patient being addicted to morphine. In the 1990s particularly with the Federal Drug Administration (FDA) approval of Oxycodone, things had changed. He specified that there had been a perfect storm of an aggressively marketed opioid combined with a flawed philosophy (i.e. pain was the fifth vital sign). The philosophy was still part of the way Center for Medicaid and Medicare Services (CMS) did reimbursements based on patient satisfaction. He was included in a number of people working to push the federal government to change the practice, which he believed created an unreasonable impetus to make sure people answer the question that everything was done to manage their pain. There had been some very large fines, particularly against one manufacturer, for marketing that did not address the emerging risk of addiction and overdose with their product. He believed the country was finally beginning to get away from the concept of the fifth vital sign. He detailed that pain was very subjective, it was not like blood pressure, temperature, pulse, or respiratory rate that was easy to measure.

4:12:32 PM

Representative Gara spoke from his perspective as a spouse of a health professional and believed there were physicians who over prescribed opioids. He referred to a growing pain medicine practice he found troubling, which the bill would not impact. He wanted to ensure that all of the required prescriptions were entered into the database. He referenced his earlier question about whether pharmacists always filled prescriptions in the emergency room. He asked for verification that a pharmacist entered the information into the PDMP.

Dr. Butler answered most likely. He specified that the program was currently voluntary; therefore, whether the data was entered into the PDMP depended on whether the pharmacist participated in the program. The participation was much higher among pharmacists than by providers. In the ideal situation the prescriber assessed a person's controlled substance history using the PDMP, wrote and filled a prescription if there were no issues; the information was then recorded in the database. He explained that in terms of the scenario described by Representative Gara, it depended on where a patient went for treatment. He reiterated that the program was currently voluntary.

Representative Gara wanted to ensure that all of the prescriptions were entered into the database. He remarked that the legislation currently required pharmacists to enter the data into the PDMP. He asked if there was always a pharmacist in the emergency room or whether it was necessary to add specific language to the bill related to the emergency room setting.

Doctor Butler answered that it depended on where a patient went. In general a patient would receive a prescription from the emergency room to take to a pharmacy, which may be in the hospital. He had not experienced a situation where a doctor brought the filled prescription directly to a patient in the emergency room.

Representative Gara stated that he did not know the difference between Schedule II, III, IV, or V drugs. He asked for verification that the bill currently applied to Schedule II and III drugs.

Doctor Butler answered that the bill also included Schedule IV drugs. He explained that Schedule I included illegal substances the FDA specified had no recognized medical value. Schedule II tended to be opioids as well as some stimulants such as Attention Deficit and Hyperactivity Disorder (ADHD) drugs. Schedule III included things like anabolic steroids. Schedule IV included benzodiazepines - he remarked it was a bit of a conundrum because the medications were much more frequently prescribed, but based on an analysis of Veterans Administration data, really potentiated the risk of death when an opioid was co-prescribed. He did not have an easy answer to make the requirements easy, while also reducing the risk of an adverse event. Schedule V drugs included Codeine containing cough syrups; there was a risk of abuse, but probably not as high. Schedule IV also included drugs like Tramadol, which was an analgesic. He reported he was receiving increased calls asking about abuse of Tramadol or diversion. He currently did not know. He explained it was where the de-identified access for public health was useful in order to further understand prescribing patterns. It was not currently known whether something was coming in from another country and if it was being prescribed in Alaska. He explained that the office of the medical examiner was primarily to give healthcare providers statewide a heads up when a substance started to be seen more in the state (e.g. such as synthetic cannabinoids the past year). He remarked

that a Tramadol overdose was particularly nasty and tended to include seizures and low blood sugars. He believed being able to recognize the symptoms was important for providers.

4:18:25 PM

Representative Gara surmised there may be an amendment to remove Schedule IV drugs from the bill. He asked if there was an easily identifiable small group of Schedule IV drugs that should be left in the bill.

Dr. Butler answered that if the list had to be whittled down he would include drugs that were currently a problem such as benzodiazepines and Tramadol. The problem was the situation was always dynamic. For example, he questioned how to handle a situation when new drugs arose in the future - he asked if it would be changed through regulation or whether it would require a statute change. He noted the State Controlled Substances list currently required a statutory change; there was currently a bill before the legislature that would add Tramadol to the list, which he believed had not been scheduled for a hearing.

Representative Gara repeated drugs mentioned by Dr. Butler including benzodiazepines, Tramadol, and some definition that would describe other drugs by regulation the state did not currently know how to write. He reasoned it was the legislature's job to figure out. He had looked into writing a bill to limit the amount of some of the more dangerous opioids that could be prescribed, but he had been told as a matter of federal law that the limits on the number of opioid pills that could be prescribed were stringent. He asked if a person could get addicted to opioids on a few pills or whether it took a multitude of pills. Additionally, he asked if existing law prevented doctors from prescribing an addictive amount of opioids.

Doctor Butler answered that he was not aware of what the limits were. He had heard from a number of people over the past several months talking about receiving 100 pills at one time. He had personally received a prescription for 50 pills after oral surgery, which he believed was a high amount - particularly when the drugs were dispensed as a "just in case" precaution. He had never run into a problem with a patient with terminal pain requiring continual refilling because you could dispense a fairly large amount if needed. He was not familiar with that being an issue.

Representative Gara stated if there was something meaningful that could be done to limit the number of opioids that could be prescribed he would not mind considering it.

4:21:56 PM

Representative Pruitt surmised that the database started to resemble medical reform as opposed to Medicaid reform. There was some concern about the privacy of having the information exist on a database. He thought there was a timeframe from which the information was removed from the database, which he believed made sense. He asked if it was the case.

Doctor Butler responded that the timeframe was two years.

Representative Pruitt remarked that the bill focused on Medicaid reform; however, he believed the database fell into the medical reform category. He referred to some concern about the privacy related to people's information in the database in perpetuity. He believed the information was only on the database for a certain period of time. He used the Division of Motor Vehicles as an example and explained that at a certain point some old offences dropped off a person's record. He believed it made sense for the information to be removed from the database after a certain period of time. He reasoned that people who had not used an opioid for two or three years were not the people the bill was aiming to address. He asked for verification of the accuracy of his statements. He wanted to put some of the privacy concerns about maintaining a database with a long-term record of a person's usage of prescription drugs.

Dr. Butler commented on the critical importance of the question. He believed the information was maintained on the PDMP for two years before being deleted.

Representative Pruitt saw the database and conversations related to behavioral health as chasing the problem in many cases. He opined that the root cause had yet to be focused on. He referred to Dr. Butler's testimony about the root cause going back into the 1990s and making sure cancer patients did not have pain. He noted certain committee members had faced that challenge. He relayed that he had spoken with Dr. Rathkopf who had highlighted that the CDC

had recently come out with new recommendations that he believed may assist in the current discussion. He referenced that the CDC's 6th recommendation highlighted that long-term opioid use began with treatment of acute pain ["CDC Guideline for Prescribing Opioids for Chronic Pain - United States, 2016" (copy on file)]. The recommendation noted that in most cases [medication for] three days or less would often be sufficient and more than seven days would rarely be needed. He asked whether there was a current opportunity to facilitate a conversation with the state medical board or other mechanism about utilizing the CDC recommendations to put them into regular use. He spoke to beginning to address the root cause of the problem in some capacity by utilizing the CDC recommendations. He asked if the bill needed to contain language giving the state the mechanisms to take action by working with providers to limit the amount prescribed (to prevent a person from receiving 30 to 50 days' worth of medication).

4:26:20 PM

Dr. Butler answered that a number of things came to mind. He relayed numerous provider surveys and individuals he had spoken to (including medical students) reported they had not had significant training in pain management or addiction medicine. He believed it was the point historically where physical health had not been integrated with behavioral health as it should be. He believed promulgating the guidelines would be very helpful because he heard from providers who were not sure what to do. The common situation the recommendations did not address thoroughly was the patient who had already been on opioids for several months and the need to get them off the drugs. He concluded that the recommendations were not a complete educational package yet, but they represented a huge step forward. The recommendations also used data he had referenced earlier highlighting the risks when a person got above a certain dose and associating doses often times connected with more prolonged periods of therapy as well as the co-administration with benzodiazepines. He specified that every state had a requirement for a certain amount of continuing medical education credits. A number of states required the education to be in pain management and/or addiction medicine. He had met with the state medical board once, which had been loath to have any kind of requirement for training; however, it was an option pursued in other states. He added that it was now required for the federal

healthcare workforce. He relayed there were a number of approaches, which could be used.

Representative Pruitt remarked on earlier testimony that doctors sometimes believed other doctors were over-prescribing medication. He detailed that sometimes it sounded like doctors were not aware of the amount they were prescribing. He hoped over-prescribing was limited in terms of negligence. He remarked that training was one component. He asked if there was still a need for something firmer than guidelines.

Dr. Butler answered that sometimes it required "a stick as well as a carrot" to make that happen, which was where things like requiring a PDMP lookup before writing a prescription could help. He suggested an amendment which could be considered would be an exemption to the lookup for quantities less than three-day supply (the number in the CDC guidelines).

4:30:05 PM

Representative Pruitt asked if there was an opportunity to engage some of the providers with the State Medical Board to facilitate the conversation within the provider community with the ultimate goal of providing recommendations (taking the CDC guidelines into account) to the legislature. He remarked that the legislature could decide whether it thought the recommendations should be put in statute or Dr. Butler could decide whether a regulatory change was needed. He stated that some great providers had provided feedback; however, they were not talking to all of the providers. He wondered if there was an opportunity to get providers more engaged. He noted that currently the AMA and the state had not specified the CDC recommendations should go forward. He wanted to make sure the guidelines were addressed. He referred back to working to address the root cause of the [opioid] problem. He asked if there was something the legislature could do at present or whether Dr. Butler and DHSS could do to help facilitate the conversation.

Dr. Butler answered that he did not believe any of the work should be done without engaging providers. One of the best opportunities to engage providers was through the various professional societies. He detailed there was significant interest in the topic; he had personally been asked to

speak to the Academy of Family Practice, ASMA, and the Alaska Nurse Practitioner Association. He stressed that the groups provided marvelous input. He agreed with Dr. Rathkopf's testimony that the perspective of the primary care provider was desperately needed. He added that Dr. Rathkopf was a pediatric allergist had a different perspective; he personally was an infectious disease provider and opioids were the last thing his patients needed because opioids led to the reason they were seeing him. He elaborated that providers all had different points of view; therefore, input from as many people as possible and through the organizations was important. He explained that the way the CDC and AMA worked was fairly collegial; the entities operated to put out guidelines and information. He believed the AMA had recently published the guidelines the same day as the CDC to get the information out to their providers. He noted that all of the guidelines related back to an assumption there was a functioning PDMP. He agreed it was a part of healthcare reform, although the bill included a very specific piece related to the Medicaid program in terms of access for the Medicaid pharmacist to the PDMP.

4:33:57 PM

Representative Gattis had received emails from a couple of providers who had a problem with the PDMP. The providers stated that the PDMP excluded the emergency room and surgeons who dispense 90 percent of the narcotics by volume. Alternatively, she thought Dr. Butler had specified the number was about 5 percent. She asked Dr. Butler to comment on the figures and discrepancy.

Dr. Butler would be happy to provide the background publications where the numbers had been derived; it was an issue of the total number of prescriptions. He explained that when looking at surgeons or ER physicians as a proportion of all the prescriptions they write, the higher percentage was for opioids, but the total number was actually smaller. The primary care providers, which made up a larger group, wrote a larger number of prescriptions.

Representative Munoz had a concern about opioids in the hands of young people below the age of 20 or 21. She asked if there was any evidence that addiction was greater in a younger person than in a much older person.

Dr. Butler answered that it was a good question, but he was not sure he was the best person to answer. He referred to an emerging science in neurodevelopment suggesting the adolescent brain was susceptible to addiction to a wide variety of substances (more so than the brain of someone 25 years of age or older). He added that a person's youth was definitely a time of high risk in terms of experimentation. He believed people struggled with a perception that opioids were merely "granny's pills" and they were perfectly safe. He believed everyone in the room had heard some of the heartbreaking stories in Juneau about how pills had led to worse things and ultimately to overdose.

Representative Munoz asked if other states were able to limit the availability of pain narcotics to a younger population with a prescription limit of three days, seven days, or other.

Dr. Butler answered that he was not aware of any states that had implemented age limits related to the number of pills prescribed. The pediatric component was one of the gaps in the recommendations; it was not addressed in the CDC guideline and had been a criticism from the American Academy of Pediatrics. He knew the pediatric community recognized the issue of one that needed to be addressed.

Representative Munoz asked if Dr. Butler believed the participation of all prescribers in the database would prevent or deter over prescriptive tendencies. Dr. Butler answered that all he could do was look at the other states to see that the number of prescriptions had declined when participation in the PDMP was required. The data was in fairly early stages, but there was no evidence there had been worse pain control because of fewer number of prescriptions.

Representative Munoz asked how much Medicaid was spending on pain narcotics in Alaska. Dr. Butler did not personally know, but he believed a colleague would know (Erin Narus, Lead State Pharmacist, State Medicaid Pharmacist Healthcare Services, Department of Health and Social Services).

Co-Chair Thompson noted that Dr. Narus would testify next.

4:39:01 PM

Co-Chair Neuman believed he had spent more time on the issue than anyone in the building. He added that he went back several years with Dr. Butler and others on the topic. He expressed concerns about the topic. He relayed that his wife was a pharmacy technician, and there was currently no enforcement except by pharmacy technicians and pharmacists. He believed when prescriptions were altered to increase the amount on a prescription it was done in the time between a doctor office and the pharmacy. He noted that his wife had been faced with telling an individual the pharmacy believed the written prescription was illegal it would be destroyed. He was scared that his wife had to tell a drug addict or distributor she would not fill a prescription. He stressed that retribution could be high and extreme. He recalled that several years back a senior couple had been murdered in Big Lake within a half mile from his house; the offender had stolen the couple's prescription drugs. He had concerns about who was responsible for telling drug addicts their prescription may be illegal. He emphasized that the issue had to be addressed. He remarked on calling the troopers who emailed a report - he added that the troopers did not respond to the issue. He detailed there were fewer troopers in Alaska at present than at any time in the past.

4:42:05 PM

Co-Chair Neuman continued to discuss his concerns, citing pharmacy theft, which was prevalent. He specified that pharmacies were very concerned about the issue and most had security cameras. He reasoned that people who work in pharmacies or have access to drugs were human and stole the drugs - some to take care of their own habits and others sold the drugs. He believed the bill was creating an opportunity to increase access to information in the database. He surmised that the database would show who had received prescriptions, the amounts, and the address of the individual. He stated that most people he had spoken with about the issue were very concerned. He relayed that people were surprised to find out about the PDMP that contained information about a person and their prescriptions. He understood the database helped emergency room doctors, but he believed emergency room doctors were triage and there to get a person to a primary care provider as soon as possible - generally within one or two days. He was greatly bothered the government was keeping track of all the prescription drugs people took. He reiterated his opposition to giving others access to the database.

Co-Chair Neuman relayed an anecdotal story about a pharmacy technician who was addicted to drugs and who gave out information about people in the database. He surmised the people who received the information could potentially rob a person's house. He was extremely bothered that when the Medicaid bill had been before the legislature and the state had not spoken to Medicaid patients. He emphasized people dealing with the issues were faced with real problems.

4:45:09 PM

Co-Chair Neuman discussed information he had heard from his family doctor, who was losing patients. He detailed that his doctor had insurance out of California or Washington and those two states had implemented new insurance regulations requiring patients to go to a pain clinic when receiving medication for long-term pain management. He stated the costs were $550 per visit compared to $125. He reasoned that a person would be faced with leaving their family doctor to see someone different who did not know their medical history. He added that more and more people were signing up for Medicaid; he wondered what it did to the cost of the Medicaid program. He asked what the change did to the cost of prescriptions for Medicaid. He referred to his past chairmanship of the DHSS budget subcommittee. He recalled that DHSS had been getting about $40 million from the federal government and the Department of Administration had been receiving $20 million in rebates from pharmaceutical companies. He stated that the companies were charging more for prescriptions than their actual cost.

Co-Chair Neuman continued that Alaska's 700,000 residents were currently spending over $60 million plus administrative fees, which he thought easily accounted for another $10 million to pharmaceutical companies. He stated that Alaskans were spending more for the cost of drugs so companies could get the money back under the guise of covering the cost of prescription drugs for Medicaid, which was about $1 million per week. He questioned whether more government in people's lives made it right. He did not believe so. He remarked that a state board produced a preferred drug list. He believed it was plausible that the drugs on the list were from companies who provided higher rebates. He had huge concerns about the issue. He opined that if the scenario was possible, the state should be taking a hard look. He spoke to the concerns about the

invasion of privacy. He remarked that the database could be accessed by the federal government. He continued that the federal government was taking long strides to take away guns from honest people. He thought the federal government could use the database to identify people it believed should not have guns. He did not support taking guns away from individuals. He could live with the current PDMP, which pharmacists, primary care and ER doctors could access if they needed.

4:50:07 PM

Co-Chair Neuman could not believe the legislature was considering making it mandatory for doctors to use the database. He reasoned a person could be long-term patient, but would still be included in the database. He believed not all doctors would want to delegate authority to someone in their office to write scripts. He spoke to cost drivers and did not know how much it would cost to update the database weekly. He emphasized that the database was currently updated on a monthly basis. He believed it was essentially worthless. He had been told weekly updates would be expensive by the director of boards and commissions. He understood the problem of opioid abuse and overdoses, which was the reason he had worked hard to address the issue. He mentioned an earlier question about addressing the problem. He stressed the legislature had included $30 million ($10 million per year for three years) to start treating the problem - to treat Alaskans with addiction problems without current access to treatment. He remarked it had been specified in a gap analysis he had worked on with Dr. Butler. He believed the best thing the state could do was to try to treat the problem and the addicts in the state. He opined it was the cheapest and least intrusive method. He continued it would keep people from trying to break into homes to steal prescription drugs. The people he talked to wanted less government in their lives. He stressed that the PDMP requirement was not less government. He emphasized the personal nature of the information.

Co-Chair Neuman continued to address his concerns about expanding access to the database. He asked people to imagine what a drug gang would do with the information. He did not know anyone who felt comfortable with the issue. He stressed that other databases got hacked and so could state databases. He wondered what an insurance company would do

with the information if they got the data. He added that every doctor who had called in during public testimony had specified various points that needed to be amended.

4:54:50 PM

Co-Chair Neuman continued to speak to his concern about the issue. He referred to discussion during the meeting about limiting the amount of pills a doctor could prescribe. He asked if that was really where people wanted government to go. He understood it saved lives. He stated that there had been over 1 million prescriptions in the PDMP the previous year. He questioned whether the committee was asking to erode the personal rights of more Alaskans. He understood that people overdosed on drugs. He referred to his earlier question about whether the 80 Alaskans who had overdosed had been getting prescription drugs by their doctor who had not been prescribing correctly. He recalled that Dr. Butler had agreed for the majority of the cases it was probable. He reiterated that he could live with the current system. He believed the topic needed much more discussion before leaving the committee. He was upset at the idea of more intrusion into people's rights, which he believed was not the government's role. He remarked that the requirement would increase the cost of government; he thought the bill would require an increase of 5 or 6 new state positions for enforcement. He reiterated his other concerns. He had spoken with a doctor at a pain clinic who had specified he would not access the database. He restated earlier testimony. The doctor had specified that if he saw the name of one of his patients on the list he may not be able to treat the person. He wondered how many other doctors in Alaska would feel the same way. He mentioned the shortage of doctors in Alaska.

4:58:19 PM

Representative Guttenberg remarked that SB 74 was a Medicaid reform bill, which he believed was about the process of medicine. He surmised the conversation seemed to be "walking back and forth" over the practice of medicine. He furthered that one of the goals was to create efficiencies and to reduce the escalating costs of medicine, which were out of control. He added that the costs were out of control in Alaska even with the expansion of Medicare. He reasoned the bill was about taking control of those costs. He continued that the state had more

control over the Medicare environment than it did over anyone else. He did not want to get into the practice and reasoned that the state had almost no control over the area. He elaborated that it was not possible to tell a physician what to do. He stressed that the state did not want government in the room telling a physician how to practice medicine. He believed the PDMP would enable the discovery of things as a "side version of what that is," whether it was about prescribing things that should not be prescribed in certain amounts to certain people. He mentioned efficiencies in telemedicine and other areas. He addressed the issue of privacy. He discussed when he walked into a clinic he saw schedulers, people filling out insurance forms, and filing. He reasoned there were national HIPAA [Health Insurance Portability and Accountability Act] laws dealing with the issues. He asked if there was a history of abuse, prosecutions, or behavior that was out of the norm that the committee should be concerned about. He referenced expanding for individuals in a pharmacy or doctor's office to access the database (outside of the pharmacist or doctor). He always questioned who had access to what in a doctor's office. He asked if the issue had been a problem.

Dr. Butler answered that the security issue was critically important. He had spoken with DCCED and state troopers about whether or not there had been breeches in the Alaska PDMP. He was particularly concerned about linking the PDMP to homicides and releases of data because the troopers were not aware of this. He stressed that if people were aware of crimes of that nature they needed to report them to law enforcement. The national experience had been that disclosures occasionally occurred - he was aware of two occurrences. The first involved a law enforcement official in a state with open access to law enforcement, which was not listed among the best practices and was not a good idea. The second occurrence involved a healthcare provider with access to the medical record who had tried to get information on an ex-spouse in Ohio. He was not aware of any similar issues occurring in Alaska based on the conversations he had with DCCED and the state troopers. He encouraged other department officials available to testify to weigh in on the issue if they had something to add.

Dr. Butler continued that the concern about hacking into private information was valid (the same went for financial institutions), but no national experts were aware of any

occurrences where data from the PDMP had been used to target people for robberies. He stated that "it gets to that question of just how prevalent opioids are in the community because you don't really need to do that." He detailed that a number of the larger national relators had issued advisories to their agents to make them aware that people often times showed up at open houses and asked to use the restroom because it was a chance to pilfer the medicine cabinet. He stressed that the PDMP was not needed to find those opportunities. He continued that a person could monitor the obituaries to look for someone who died at home after a long illness and could break in during the person's memorial service. There were all kinds of ways for crimes to be committed that did not involve the PDMP. He had not been able to find documentation of crimes that had been proposed involving the PDMP. He stressed that security was critical and he deferred to DCCED or other for further detail into security precautions against hacking into the PDMP. He was curious how the precautions compared to those for the Alaska Permanent Fund Corporation and other. He provided a scenario about online hacking to steal money. He reasoned those hacking interests would not care about the PDMP.

5:05:35 PM

Representative Guttenberg asked if troopers had access to the database. Dr. Butler clarified that troopers did not have access to the database without a subpoena or search warrant. He had asked state troopers whether they had ever investigated a crime related to release of information from the PDMP.

Representative Edgmon asked about the genesis of the bill section. Dr. Butler believed the section had been added in a Medicaid Reform Subcommittee in Senate Finance. He noted confirmation from the sponsor.

Representative Edgmon remarked on the compelling viewpoints from both sides of the issue. He asked if the discussion was at the nascent stage. He wondered if the issue had not been thought through about cost to the provider and issues of privacy infringements versus the greater good of not having a centralized database.

5:07:38 PM

Dr. Butler replied that if part of the question was about why he was speaking to the issue, the answer was he was not actually sure. He reasoned the program was not in his department. He answered that the process was ongoing and the state's PDMP was not new. He continued that it had been one of the topics of discussion in looking at healthcare reform as a quality of care issue by the healthcare commission before it had been disbanded. Some of the discussion had been fulfilling the will of the House Finance Committee to implement the recommendations of the healthcare commission. He explained the discussion was not new.

Representative Edgmon referred to Dr. Butler's testimony that the state did not have the ability to compile numbers or meaningful statistics on opioid addictions or possible overdoses. He asked for verification that Dr. Butler believed the state was hindered because it did not have a centralized drug database.

Dr. Butler responded that the state was able to monitor overdose deaths and to some degree hospitalizations for overdose. He noted those issues did not relate to the PDMP. The discussion was about considering how to do more than the testing and count the numbers. For example, addressing questions like treatment. The discussion was also about how to reduce the number of people requiring treatment. He considered whether it would be sustainable to continue to pour funding into treatment if there was an opportunity to address the problem at its root cause, which was often related to the combination of stress and the availability of an addictive substance. In terms of the utility of data in the PDMP it was primarily as a communication tool among providers. He speculated that part of the reason the subject had been added to SB 74 was its involvement in the Medicaid program - the access for the Medicaid pharmacist was part of stewardship for public funding that went to Medicaid beneficiaries - in order to reduce fraud and provide improved care. Access to the database was concerning because privacy was critically important; however, he believed the limited expansions and access were on a need-to-know basis (similar to a national security issue) in terms of who was currently unable to make important decisions that would improve the health of Alaskans absent the data in the PDMP.

5:11:18 PM

Representative Edgmon believed the vastness of the issue was engendered more discussion. He vocalized his interest in hearing from the bill sponsor on the benefits of the provision, which seemed to be apparent. He added there were also costs and implications that may not be fully understood. He was trying to weigh both sides of the issue.

Co-Chair Thompson thanked Dr. Butler for his testimony.

5:12:26 PM

ERIN NARUS, LEAD STATE PHARMACIST, STATE MEDICAID PHARMACIST HEALTHCARE SERVICES, DEPARTMENT OF HEALTH AND SOCIAL SERVICES (via teleconference), relayed that most of the points she had planned to address had been covered by Dr. Butler. She provided a brief overview of the one the role of the Alaska Medicaid drug utilization review process. Currently under federal law the nation's Medicaid programs were required to provide for a drug utilization review program for covered outpatient drugs. The requirement was primarily to ensure that prescriptions were appropriate, medically necessary, and not likely to result in adverse medical results. The federally mandated drug use review program had two broad components. The first component was a prospective drug utilization review program, which looked at the point of sale of prescriptions. She detailed that when an individual filled a prescription at the pharmacy there were rules within the claims adjudication system to help the pharmacy to be aware of other medications the patient may currently be taking. After being entered into the point of sale the claim was sent to the Medicaid claims processing system. The second component was a retrospective drug utilization review. She specified her office worked with the drug utilization review committee - an interdisciplinary committee of practitioners throughout Alaska (e.g. physicians, mid-level practitioners, and pharmacists) - and reviewed trends of medications and looked for ways to reduce fraud and abuse and to guide clinical prescribing utilizing evidence-based medicine tenets.

Representative Pruitt asked if Dr. Narus saw the database as a key part in helping the state to save money on pharmaceuticals in the Medicaid program. Dr. Narus answered that access to the PDMP by licensed pharmacists within the Alaska Medicaid program was critical in order to prevent

hospitalizations and to ensure the appropriate utilization of funds.

5:16:12 PM

Representative Pruitt believed the answer was "yes." He thanked Dr. Narus for her response.

Representative Munoz asked about the cost spent on narcotics in the Medicaid program. Dr. Narus replied that she did not have the specific number, but she could provide it. She added that in December [2015], narcotic analgesics had been the top number of claims in the Alaska Medicaid system.

Representative Munoz asked for the total cost of all Medicaid pharmaceuticals had been during that month. Dr. Narus replied that she would follow up with the information.

Co-Chair Thompson thanked Dr. Narus for her testimony.

5:18:25 PM
AT EASE

5:30:16 PM
RECONVENED

Co-Chair Thompson asked DCCED to address the committee.

JANEY HOVENDEN, DIRECTOR, DIVISION OF CORPORATIONS, BUSINESS AND PROFESSIONAL LICENSING, DEPARTMENT OF COMMERCE, COMMUNITY AND ECONOMIC DEVELOPMENT, introduced herself and other department staff available to testify. She clarified that the department's fiscal note included the cost for telemedicine and the PDMP expansion; the PDMP only accounted for one-fifth of the fiscal note, which would fund a program coordinator and a small amount of travel for the coordinator to attend Board of Pharmacy meetings. She relayed that the cost to update the PDMP weekly or daily (instead of monthly) would be $2,175 per year.

Co-Chair Thompson asked for clarification.

Ms. Hovenden replied that for the division to update the PDMP weekly or daily with information received from

pharmacists it would cost $2,175 annually. Currently the database was updated monthly.

Co-Chair Thompson asked for verification the cost was associated with updating the database weekly versus monthly. Ms. Hovenden answered in the affirmative and explained it was a software issue.

SARA CHAMBERS, ADMINISTRATIVE OPERATIONS MANAGER, DIVISION OF CORPORATIONS, BUSINESS AND PROFESSIONAL LICENSING, DEPARTMENT OF COMMERCE, COMMUNITY AND ECONOMIC DEVELOPMENT, spoke to questions and concerns that had been raised earlier. She clarified that the PDMP had been in existence for several years; a list of people receiving opioid prescriptions currently existed and was purged every two years. She detailed that the information was accessible by a very limited number of licensed prescribers and providers in the state and the authority could not currently be delegated to anyone (e.g. a pharmacy technician, or other office personnel). She stated that the ability to delegate the authority was included in the current bill. She furthered that what the provision would look like and what side rails may be included to achieve some of the protections concerns was certainly open for discussion. Federal government access to the PDMP was restricted to licensed medical providers with a right to access specific patient data (their own patients). She noted that the Veterans Administration (VA) and IHS would have a different definition than in the State of Alaska, but it would boil down to what the federal and state licensing requirements were for qualified doctors and pharmacists. She referenced the seven-page signature form [mentioned earlier by Co-Chair Neuman] and relayed the division was working with Co-Chair Neuman to determine what the form may be. She detailed that it did not appear to be a PDMP form; it was perhaps a DEA form. The division was dedicated to increased efficiencies - all of its licensing programs had moved to online renewal capability in the current year. She noted the division had received significant positive feedback from licensees.

5:36:02 PM

Ms. Chambers relayed that the division had worked with Doctor Butler; she thanked him profusely for his assistance and education on the subject. Additionally, the division had worked with the bill sponsor to continue its commitment

to making the processes as efficient as possible for providers.

Co-Chair Thompson referred to an earlier question that he did not believe had been answered. He asked if the PDMP data on patients with opioid prescriptions shared with the federal government.

Ms. Chambers answered that access to the PDMP was currently available to the federal government only when an agent of the federal government was a qualified licensed medical provider; those individuals had the ability to the data regarding their own patients just like any other non-government private doctor. Additionally, the information was available to law enforcement through a subpoena or warrant issued in a court order process. She was not aware of any other current or proposed federal government access.

Vice-Chair Saddler spoke to a letter from the Board of Pharmacy [dated February 11, 2016 (copy on file)] indicating the federal funding for the PDMP ended August 31, 2013. He continued that currently there was another grant DHSS was receiving. He asked what the funding source would be past 2021. He asked Ms. Hovenden for details on the current cost of the PDMP and what the cost would be after the expansion.

Ms. Hovenden replied that the cost was approximately $100,000 for the PDMP expansion. The cost included one personnel and some travel costs.

Vice-Chair Saddler asked for the current cost. Ms. Hovenden replied that the cost was currently $85,000.

Vice-Chair Saddler surmised that the total cost would be $185,000. Ms. Hovenden affirmed.

Vice-Chair Saddler asked if the funding was available through a federal grant up to 2021. Ms. Hovenden replied in the affirmative.

Ms. Chambers clarified that currently the division received $120,000 annually through federal funding. The funds paid for the database at approximately $80,000 to $85,000 [per year]. The additional funding was set aside to pay support staff assisting with the PDMP. She explained the division did not receive the grant money if it was not utilized. The

division received adequate funding for the PDMP at present. She detailed that the division had applied in a partnership with DHSS for another grant, but it had not quite made the cut. Subsequently, the division had been working with Dr. Butler and his team on enhancing the grant. She detailed that if received, the grants would cover the additional expenses anticipated in the fiscal note; therefore, the cost would be fully funded by a grant, which she understood was the original legislative intent for the PDMP. The funding would prevent the division from being in the quandary of having to go to its licensees or registered users to charge a licensing fee. The division had been very active in partnership with DHSS to continue to seek grant opportunities; the grant opportunities moved the PDMP from a list of numbers and data - which was critically important, especially to grant access to Medicaid - into a robust statewide opioid control program.

5:41:27 PM

Vice-Chair Saddler pointed to the letter mentioning legislative intent put in by former Senator Lyda Green specifying it was not the intent of the legislature for professional users of the database to absorb the cost; it was the intent that the PDMP would be funded by federal grants and state appropriations. He asked if it was the legislation that had created the database.

Ms. Chambers answered in the affirmative.

Representative Pruitt returned to the discussion about federal government access to the database. He spoke to concern about people who were not doctors accessing the database. He asked if a federal law required the state to give the federal government access to the PDMP through a subpoena. Alternatively, he asked if the state felt it needed to provide the data in those circumstances.

Ms. Chambers answered that the law was currently in state statute.

Representative Pruitt surmised that the state's own statute could be changed in order to appease some concerns about giving the federal government access to information. He suggested prohibiting the transfer or cooperation with the federal government on access to the database.

Ms. Chambers answered she would need to review the statute to determine exactly how law enforcement was clarified. She tended to agree with the tone mentioned by Dr. Butler that the state's own Department of Public Safety and troopers would have that level of access. She could not say without researching the statute, whether it allowed or prohibited federal law enforcement to have access to the information. She would look into the issue.

Representative Gara understood the purpose of the database, which would enable one physician to see if an individual was shopping around and seeking large amounts of prescription drugs. He referred to page 16 of the bill and wondered why the pharmacist had to send a list of individuals they prescribed drugs to the board. He wondered about the purpose.

Ms. Hovenden replied that the board administered the PDMP. The information was not literally sent directly to the board; it went to the PDMP, which was managed by the board.

Representative Gara asked for verification that the language requiring pharmacists to submit information to the board meant the pharmacists were to submit the information into the database. Ms. Hovenden replied in the affirmative.

Representative Gara referred to the provision requiring pharmacists to submit the information a minimum of once a week. He thought there had been a provision requiring a pharmacist to enter the information quicker. He asked for verification that the submittal of information was required on a weekly basis. Ms. Hovenden replied in the affirmative.

5:46:18 PM

Representative Munoz referred to testimony from the prior evening by a pharmacist who was concerned about having to recheck the database after the initial prescribing doctor had checked the database. She wondered if it would be appropriate to have the Board of Pharmacy overseeing the program if the state only required the prescribing doctor to check the database. She wondered if it would be more appropriately housed in the State Medical Board.

Ms. Chambers answered that the division oversaw all professional licensing boards including the Board of Pharmacy and the State Medical Board. She detailed that it

was "six of one, half dozen of another" - any particular board may be given the statutory authority by the legislature to govern the process, but the division administered the program from a day-to-day standpoint.

Representative Munoz asked if the PDMP was managed currently by the Board of Pharmacy. Ms. Chambers answered in the affirmative.

Representative Edgmon asked if the concept flowed through the Board of Pharmacy and State Medical Board. Ms. Chambers answered that the idea of expanding the PDMP had been generated outside of the division; the proposed expansion had not initiated by the Board of Pharmacy or State Medical Board. She furthered that the division had become involved in answering technical and impact types of questions when the legislation had been drafted.

5:48:28 PM

Representative Edgmon asked discussing the issue as a policy measure would be in the normal course of business for the board.

Ms. Chambers answered in the affirmative. She detailed the Board of Pharmacy discussed the PDMP regularly and was an engaged partner in its governance and administration. She specified that because the State Medical Board was not responsible for governance of the PDMP, it had not to her knowledge had such a robust discussion; however, it had thoroughly discussed the telemedicine aspect of the bill.

Vice-Chair Saddler asked if there had ever been a breach of the integrity of the PDMP. Ms. Hovenden replied in the negative.

Vice-Chair Saddler asked what the practical effect would be if the pharmacist was removed from the redundant task of doing a pre-check of the database. He asked if it would tend to diminish the effectiveness of the database. Ms. Chambers answered that the conversation was a result of testimony the heard by the committee. She detailed the conversation was being held with the bill sponsor, Dr. Butler, and other engaged personnel.

Co-Chair Neuman asked if there had never been a breach of information that was obtained from the PDMP. Ms. Hovenden deferred the question to the database manager.

Co-Chair Neuman believed there was no way to know if someone with access to the database told someone else about the information.

5:52:01 PM

Co-Chair Thompson asked the database manager to address the question related to system security.

BRIAN HOWES, PROGRAM MANAGER, PRESCRIPTION DRUG MONITORING PROGRAM, DEPARTMENT OF HEALTH AND SOCIAL SERVICES (via teleconference), relayed that there had been no breach of the database; the data had not been shared to his knowledge. He relayed there had never been a complaint regarding a breach. He explained that someone would have to make a complaint that the data had been obtained illegally. He furthered that through different complaint processes the division could have the ability to determine who had accessed the information and whether or not it was used inappropriately.

Co-Chair Thompson surmised that if there was a breach it would have been by someone with legal access to the PDMP involving printing off the data and passing it on to someone illegally. Mr. Howes answered in the affirmative.

Vice-Chair Saddler stated that there may not have been a breach of the database there may have been a non-technical human breach. Mr. Howes answered in the affirmative.

5:54:00 PM

Representative Guttenberg surmised the state would not know if there was or was not a breach. He wondered how the state would know either way. Mr. Howes replied that it would require a complaint that data had been shared with someone else. He furthered at that point the division would determine which provider had looked up the patient. There was an audit trail within the program, which would enable a lookup of the information. From that point, they would go through an interview process to determine what had happened and what the person had done with the data.

Representative Guttenberg asked how many complaints there had been. Mr. Howes replied there had been no complaints.

Representative Guttenberg asked if that was throughout the history of the database. Mr. Howes answered in the affirmative.

Representative Edgmon asked referred to testimony there had been no breaches or sharing of the data from the PDMP. He referred to the human intelligence factor. He remarked on federal access by qualified medical agents and law enforcement. He asked who had state access to the PDMP outside the division.

Mr. Howes answered that any access was by a licensed prescriber or dispenser regarding a patient or a patient they anticipated seeing. The statute specified that federal, state, and local law enforcement may receive printouts from the database based on a court order or search warrant demonstrating probable cause for the action.

Representative Edgmon asked if currently every provider had to participate. Mr. Howes answered that there was currently no requirement for providers to look at the database.

Representative Edgmon asked how many practitioners used the database. Mr. Howes answered the percentage was low. Approximately 700 to 800 out of the 6,400 prescribers used the database. He detailed that whether a prescriber needed to access the system depended on their type of practice.

5:57:23 PM

Representative Edgmon surmised that the characterization that the database was centralized was not accurate. He believed the bill sponsor wanted the database to fully encapsulate the providers and dispensers.

Co-Chair Thompson surmised that 10 percent of the providers were registered and utilizing the database.

Ms. Hovenden answered that currently a low percentage of the users would be correct.

Ms. Chambers clarified that the bill would make the shift from what could arguably be termed a pilot program into a centralized repository of data to connect providers and

prescribers across the state and to shift into a robust opioid control program. The connection to Medicaid was to provide DHSS and Medicaid personnel the opportunity to save Medicaid costs and better manage those elements through a small sliver of a wider Medicaid reform bill. She believed the intent was to move from a voluntary, not widely used program, to a more official program that would provide more reliable data to accomplish the variety of goals.

6:00:00 PM

Representative Gara remarked that he did not particularly have a concern about the security of the database; however, he surmised there was no signal to specify if a breach did occur. He referred to testimony the division would not know if there was a breach unless someone knew their information had been breached and they complained to the division. He believed that would not happen. He opined that the fact the division would not know if a breach occurred would have been a fairer response to Co-Chair Neuman's earlier question. He reasoned it mattered how good the system's security was.

Vice-Chair Saddler asked if having a mandatory database was likely to be a condition of any existing or future federal benefit or funding. He remarked there had been a number of provisions from the Affordable Care Act with delayed implementation. He could imagine the federal government may want the data.

Ms. Chambers deferred the question to DHSS and was not aware of anything of that nature coming down the pike.

6:02:20 PM

Ms. Shadduck spoke to the question asked by Vice-Chair Saddler. She discussed that on March 10, 2016 the U.S. Senate had passed the comprehensive Addiction and Recovery Act (SB 524). She detailed that Alaska's two senators had voted in support of the act. She furthered that Section 601 of the bill included language requiring states to use a PDMP in order for states to access the federal grants to combat opioid and other addiction problems; it would also be required for prescribers to look up federal Schedule II, III, and IV drugs before prescribing and dispensers would be required to input the same data. Some of the

recommendations had been reinforced by the passage of U.S. Senate Bill 524.

Co-Chair Thompson asked if the required the state to share access to the information with the federal government. Ms. Shadduck did not believe so, but she would follow up.

Ms. Shadduck relayed that based on the testimony, the bill sponsor was very willing to work with the committee on final tweaks to the sections under discussion. The sponsor realized there were concerns and was open to some of them.

Representative Gara referred to the concept of sharing state savings with emergency rooms. He spoke to concerns about people going to an emergency room for care when they did not need an emergency room. He addressed the expensive nature of the care. He continued that part of SB 74 helped solve the problem, which would result in fewer people going to the emergency room for inappropriate care. He wondered why the state would pay hospitals money for the reduced number of patients, especially when the state had a $4.4 billion deficit.

VALERIE DAVIDSON, COMMISSIONER, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, replied that the program included in the bill was modelled after a Washington State program. During the last and current budget processes, DHSS had heard from the Ketchikan hospital that it had applied for an innovation grant from CMS. She believed the hospital had spent $700,000 to decrease its ER overutilization, but it had cost $1.5 million in lost revenue if those same patients had come to the ER. The hospital had communicated there was not much financial incentive for providers to look at the ER overutilization when it ended up costing them money. The program in Washington State had been a public private partnership between several parties; SB 74 included the same concept making sure all parties worked as hard as possible to be able to achieve the savings. She reiterated that the Ketchikan hospital had reported it spent $700,000 to lose $1.5 million, which was not much incentive for facilities to change the way they did business. She surmised if there was a way to change the way healthcare was delivered in a more appropriate way and to have the opportunity to share the savings, perhaps the savings shared could be applied more appropriately in other settings (e.g. developing better partnerships with primary care providers, utilizing support services, and other).

6:08:58 PM

Representative Gara stated that the loss was based on hospitals not receiving very large charges in the ER for non-emergency care. He surmised the hospitals were not getting the higher amount of money because they were not able to charge non-ER patients with ER rates. He was not convinced by the argument. He continued that hospitals would benefit in the ER setting by having Medicaid reform cover people who they had not previously been receiving compensation for (people without children and the expanded Medicaid population). He asked for verification the hospitals were receiving much more money for ER care through Medicaid expansion.

Commissioner Davidson answered in the affirmative. The goal was to make sure people were using the ER appropriately - for ER care. The challenge was that under the current federal EMTALA [Emergency Medical Treatment and Labor Act] emergency rooms did not have a choice when it came to letting a person in the door; emergency rooms were required to provide a certain level of care prior to sending individuals on their way.

Representative Gara reasoned that individuals would either receive coverage through private insurance or Medicaid expansion. He spoke to the concept of no incentive for hospitals to reduce ER care. He stated that a significant part of the bill was about creating a managed care plan and establishing people with a primary physician in order to avoid using the ER [for inappropriate reasons]. He believed that even without incentives to the hospital, the bill was intended to steer people away from the ER. He did not buy the lack of incentive as a justification to ask the state to compensate emergency rooms for no longer treating people who should not be in an ER.

Vice-Chair Saddler asked if Commissioner Davidson saw any other situations in which the federal government would require the state to have mandatory PDMP reporting as a condition of a federal payment, grant, benefit, or participation.

Commissioner Davidson answered that she was not aware of any additional requirements.

6:12:09 PM

Representative Edgmon asked if there was an existing model that could help the state reform Medicaid that did not involve a public private sector relationship.

Commissioner Davidson asked if the question was specific to ER overutilization or broader.

Representative Edgmon discussed whether the state went through a managed care and/or accountable care organizations. He surmised that it appeared necessary to have the private sector involved in terms of being able to make Medicaid more efficient and cutting down on ER super-utilizers that cost the program more. He reasoned that the ER was a business entity; therefore, if they were given some incentive they would comply accordingly. Likewise, if the incentive was removed, the need to comply dissipated.

Commissioner Davidson answered that the department appreciated the bill's broad flexibility and the options available for DHSS to work with providers and stakeholders on ways to test certain theories. She pointed to the broad demonstration authority described in the bill as an example, such as a public private partnership for the ER overutilization project. The department could opt to do some of the things on its own, but she did not believe it achieved the right result. She wanted to ensure providers giving good and appropriate care to patients could continue to do so. She did not have all of the answers, but she believed the bill provided more tools to work with people in Alaska to design a healthcare system that worked for everyone. She continued that there were lessons the state could learn from other states, but some may not necessarily work in Alaska. The state could elect to use a model from another state, but the challenge was selecting a model that worked for Alaska, for as many people as possible, and that met the state's unique challenges. She pointed issues such as access to care (travel would always be a concern). She continued that during certain times of the year in certain regions, infants and children were impacted by respiratory syncytial virus, which would result in increased ER utilization and Medivacs. She noted her daughter had fallen into the category when she was an infant. She spoke to improving the delivery of healthcare, while recognizing efficiencies were necessary to continue to provide healthcare into the future. She believed everyone

recognized that Medicaid was not sustainable in its current form. She stressed the need to reform Medicaid and believed the state's best opportunity to implement reform was with its partners.

6:16:56 PM

Representative Guttenberg asked about the ER-shared reimbursement. He understood the issue in the short-term and that hospitals would change their business models. He asked if it would be appropriate to put a five-year timeline on the shared reimbursement. He reasoned that after five years the hospitals would have changed their business model. He detailed that reform to the system included efficiencies the hospitals recognized were needed as well. He spoke to providing incentives for several years for hospitals to remodel, retooling, changing processes, and other. He wondered if a timeline was appropriate to allow hospitals time to transition.

Ms. Shadduck replied that one of the parts of Section 31 required the Alaska State Hospital and Nursing Home Association (ASHNHA) to report back on the successes and challenges. She did not want to put an arbitrary end to the shared savings, but she surmised that ASHNHA could also be asked to report on the processes and shared savings. Section 28 on Medicaid reform asked the department to report on savings based on reforms implemented by the bill. She detailed there were a couple of reporting mechanisms throughout the bill. She did not want to speak on behalf of emergency rooms and their doctors because she did not know their business practices inside and out.

Co-Chair Thompson relayed that amendments to the bill should be submitted to his office by April 1, 2016 at 5:00 p.m.

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

Co-Chair Thompson discussed the schedule for the following day.

#
ADJOURNMENT

6:20:27 PM

The meeting was adjourned at 6:20 p.m.