SENATE FINANCE COMMITTEE
January 27, 2016
9:03 a.m.

9:03:32 AM

CALL TO ORDER

Co-Chair MacKinnon called the Senate Finance Committee meeting to order at 9:03 a.m.

MEMBERS PRESENT

Senator Anna MacKinnon, Co-Chair
Senator Pete Kelly, Co-Chair
Senator Peter Micciche, Vice-Chair
Senator Click Bishop
Senator Mike Dunleavy
Senator Lyman Hoffman
Senator Donny Olson

MEMBERS ABSENT

None

ALSO PRESENT

Valerie Davidson, Commissioner, Department of Health and Social Services; Jon Sherwood, Deputy Commissioner, Medicaid and Health Care Policy, Department of Health and Social Services; Heather Shadduck, Staff, Senator Pete Kelly.

PRESENT VIA TELECONFERENCE

SUMMARY

SB 74 MEDICAID REFORM/PFD/HSAS/ER USE/STUDIES

SB 74 was HEARD and HELD in committee for further consideration.

SB 78 MEDICAL ASSISTANCE COVERAGE; REFORM

SB 78 was HEARD and HELD in committee for further consideration.

#sb78

SENATE BILL NO. 78

"An Act relating to medical assistance reform measures; relating to eligibility for medical assistance coverage; relating to medical assistance cost containment measures by the Department of Health and Social Services; and providing for an effective date."

9:04:23 AM

Co-Chair MacKinnon explained that the Medicaid reform bill had been before the committee in the previous session. She relayed that the CS currently before the committee carried with it the support of the administration.

VALERIE DAVIDSON, COMMISSIONER, DEPARTMENT OF HEALTH AND SOCIAL SERVICES (DHSS), concurred.

Co-Chair Kelly MOVED to ADOPT proposed committee substitute for SB 78(FIN), Work Draft 29-GS1055\H (Glover, 1/25/16).

There being NO OBJECTION, it was so ordered.

9:05:43 AM

Co-Chair MacKinnon referred to a letter dated January 25, 2016, from the Senate Finance Committee to the Department of Health and Social Services, which contained the following five questions (copy on file):

1. Is the Medicaid software system certified? If not, when did we apply for certification and when will it be certified?

2. In April you had identified 100 defects in the software system. What defects remain? How many errors are we still aware of? Who do the errors affect? Are the defects critical, high, moderate, or low?

3. How quickly are applications being processed?

4. How quickly are providers being paid?

5. What is the legal status of our lawsuit with Xerox? Have other states in legal challenges with Xerox systems been certified? Has Xerox completed their

> corrective action plan? Is there a financial award? If so, how much are we requesting as compensation?

Co-Chair MacKinnon said that it was not the intent of the committee to discuss policy issues contained in the legislation, but to have a brief discussion about where the state was in the reform process.

Commissioner Davidson stated that she was prepared to speak to the 5 questions put forth by the committee.

Co-Chair MacKinnon hoped that the administration could explain the specific changes in the current version of legislation, and how each section of the bill would work to address the issue of Medicaid reform in the state.

Commissioner Davidson testified that the state's Medicaid program, in its current form, was not sustainable and that reform was essential. She addressed question 1, submitted by the committee:

> Is the Medicaid software system certified? If not, when did we apply for certification and when will it be certified?

Commissioner Davidson explained that in December the department had met with the Centers for Medicare and Medicaid Services (CMS) (who provide system certification) and their contractor. She shared that the next meeting with CMS, and their contractor, was scheduled for February 1, 2016.

9:08:17 AM

Senator Dunleavy understood that the system was not currently certified.

Commissioner Davidson replied in the affirmative.

9:08:32 AM

Co-Chair MacKinnon clarified that deeper discussions of the questions contained in the letter would happen in subcommittee. She highlighted that there had been a delay in the certification process, but hoped the present discussion on the matter would be brief.

Commissioner Davidson admitted that certification had been delayed, and relayed that the department was working toward certification.

9:09:32 AM

Commissioner Davidson addressed question 2:

> In April you had identified 100 defects in the software system. What defects remain? How many errors are we still aware of? Who do the errors affect? Are the defects critical, high, moderate, or low?

Commissioner Davidson enumerated that there were currently 121 defects in the system. She said that most of the defects were new; as old defects were fixed, new defects were created in the coding. She relayed that 1 critical defect, 6 high defects, 111 moderate defects, and 3 low defects had been discovered in the system. She said that the defects were affecting 3 different service categories: prior authorization for services - behavioral health prior authorization for approved units of service, prior authorization units of service for enhanced adult dental services, and car coordination services for enrollees on the Tax Equity and Fiscal Responsibility Act (TEFRA) Waiver.

9:10:57 AM

Co-Chair Kelly queried the definition of "defect" as it applied to the software system.

Commissioner Davidson explained that the defect classification was based on the level of impact it had on the payment system. She noted that there had been defects in the old legacy system previously used by the state. She asserted that no software system would be 100 percent defect-free. She shared that the goal was to minimize the defect number.

9:12:04 AM

Co-Chair Kelly understood that a defect was essentially a glitch that misdirected data in the system.

Commissioner Davidson answered in the affirmative. She reiterated that the defects considered critical, or high,

were those that impacted payments to providers for services rendered.

9:12:43 AM

Co-Chair Kelly asked for the definition of a "unit of service".

JON SHERWOOD, DEPUTY COMMISSIONER, MEDICAID AND HEALTH CARE POLICY, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, explained that a unit of service varied according to the type of service. Typically, professional services were listed under numerous procedure codes; submitted claims identified the service provided, and the number of service units provided.

9:14:01 AM

Co-Chair MacKinnon noted that a written hard copy of the answers to the questions that the committee had submitted to the department was anticipated.

Commissioner Davidson addressed question 3:

> How quickly are applications being processed?

Commissioner Davidson relayed that that the department processed 8,107 Medicaid application in December 2016, over 20 percent of which were processed within a week of submission. He furthered that 62 percent were 60 days old, or less; 38 percent were over 60 days old.

9:14:58 AM

Commissioner Davidson addressed question 4:

> How quickly are providers being paid?

Commissioner Davidson responded that provided were paid in the same week that claims were submitted, or the week after, with the exception of the 3 defects previously mentioned. She stated that the department paid an average of 107,000 claims per week worth approximately $30 million. She spoke to repayment of advance payments that the department made to providers when the system was particularly dysfunctional. She said that providers had repaid a total of $81.6 million, and the state had

approximately $83.7 million in outstanding payments. Provider repayments were ongoing.

9:16:25 AM

Co-Chair MacKinnon asserted that the state had extended advance payments totaling $164 million.

Commissioner Davidson concurred.

9:16:43 AM

Senator Hoffman queried the total dollar amount for the number of claims that were 60 days overdue.

Commissioner Davidson clarified that it was the applications for eligibility that had been overdue, not the payments. She offered to provide the information regarding the payments.

9:17:11 AM

Commissioner Davidson addressed question 5:

> What is the legal status of our lawsuit with Xerox? Have other states in legal challenges with Xerox systems been certified? Has Xerox completed their corrective action plan? Is there a financial award? If so, how much are we requesting as compensation?

Commissioner Davidson explained that case before the Office of Administrative Hearings was currently suspended. She said that a mediation with Xerox was scheduled for February 9, 2016. She stated that compensation would be a topic of discussion during the mediation. She relayed that some providers had filed their own class-action suits against Xerox. She said that the department was unaware of other states engaged in litigation with Xerox over their MMIS System. She shared that North Dakota and New Hampshire had certified systems in 2015, but Alaska's system was different because Alaska was a fee-for-service state. She highlighted that Xerox had 5 items remaining on their corrective action plan that needed to be completed:

- an Edit 8040
- TEFRA care coordination services claim processing
- MRO14 Report (Medicaid cost reporting)

- National Correct Coding Initiative Report
- Mass Adjustment Reprocessing

9:21:30 AM

Vice-Chair Micciche spoke to the assumption how much the department would be required to run and populate the system, prior to moving to the Xerox MMIS system. He queried the level of labor insensitivity prior to going live.

Commissioner Davidson stated that the early implementation was much more labor intensive than anticipated. She contended the new system was more efficient than the old legacy system, and there had been an increase in the total amount of total average weekly claims paid.

9:23:02 AM

Co-Chair MacKinnon reminded the committee that the bill would be moving to subcommittee and that policy inquiries should presently be limited.

Co-Chair MacKinnon expressed concern that using an uncertified system put Alaska at risk. She wondered how far back in time claims could be submitted to the federal government.

9:24:11 AM

Senator Olson observed that due to systemic defects, the number of providers available for Medicare patients was dwindling. He wondered whether Medicaid expansion had affected the number of providers.

Commissioner Davidson responded that in Alaska, Medicaid paid more than Medicare; the department had not seen providers discontinuing their participation in Medicaid. She said a "refresh" of Medicaid providers had been conducted by the department in 2015; providers had been asked to re-enroll as Medicaid providers because there were Medicaid providers in the old system who were no longer providing services.

9:25:50 AM

Senator Dunleavy asked what the current version of the bill was meant to accomplish.

Commissioner Davidson asserted that the department took reform very seriously, and many of the changes that had been incorporated into the committee substitute were new reform opportunities that had been identified over the interim. She added that research had included looking to other states for guidance and taking advantage of the best ideas.

Senator Dunleavy asked what the bill would cost the state, and did the department hope to recoup monies as a result of the reforms.

Co-Chair MacKinnon asked Commissioner Davidson to contain remarks to a high-level overview, and restated that the policy discussions would occur in subcommittee.

Commissioner Davidson stated that the department would provide fiscal notes for more detail, but did expect reform opportunities to provide better services for less cost.

9:27:48 AM

Commissioner Davidson relayed that the department had identified reform efforts already existing and ongoing in the department in 2015, including the "over-utilizer" of emergency services. She furthered that pharmacy reform and utilization control initiatives had been priorities. She stated that additional reforms had been included in the original bill introduced by the governor. Ove the interim, the department had undertaken an effort to bring national health policy expertise and actuarial analysis to the process. She shared that the resulting report of the work by the department and Agnew Beck Consulting had been released and could be found at: dhss.alaska.gov/HealthyAlaska/Pages/Medicaid_Redesign.aspx.

Commissioner Davidson stated that the bill focused on, and created, an Alaska Medicaid False Claims Act, which mirrored the federal statute and provided financial incentives for individual Alaskans who brought fraud to the attention of the Attorney General. This would allow the state to recover losses from fraud and overpayments. She relayed that the bill proposed a number of reform

opportunities that had not been included in pervious bill versions, such as, primary care initiatives, and increased 1115 Waiver opportunities. She stressed that not investing in a decent behavioral health system impacted the state in three different ways: increased incarceration, increased child-maltreatment rates, and increased emergency room overutilization. She continued that the bill would create the public/private opportunity to address the non-urgent use of emergency room departments, and the opportunity to work with the tribal health system in order to maximize 100 percent federal match opportunities. One of those opportunities included finalizing a national policy change issued by Secretary Burwell, of the United States Department of Health and Human Services, in which it had been proposed to allow states like Alaska to recoup travel and accommodation services, under certain conditions, at 100 percent federal match. Another opportunity was to expand referred services from a tribal organization to a service not provided in the tribal system to be considered for a 100 percent federal match.

9:32:45 AM

Senator Hoffman asked whether the increased travel reimbursement included Medivac support in rural Alaska.

Commissioner Davis replied in the affirmative.

9:33:06 AM

Co-Chair MacKinnon asked Mr. Sherwood to address the sectional analysis.

9:33:52 AM

Mr. Sherwood discussed the sectional analysis for CSSB 78(FIN):

> Section 1 Adopts intent language related to the need to redesign the state's Medicaid program to provide financial sustainability, and sets out goals for redesign of the program.
>
> Section 2 Adopts AS 09.10.075, which establishes time limits in which a person may or may not bring an action under new sections AS 09.58.010-09.58.950, the Alaska Medicaid False Claims Act, and a statute of

limitations. An action may be brought within six years of when the act or omission was committed, or three years after the date when the act or omission was known or reasonably should have been known by the attorney general and department, but no action may be brought for a violation more than ten years after the date of violation.

Section 3 Amends AS 09.10.120(a) to include reference to new subsection AS 09.10.075, creating an exception for Medicaid fraud action time limits.

Section 4 Adopts AS 09.58, which establishes Alaska Medicaid False Claim and Reporting Act (AFMCA). This section includes several subsections related to liability for certain acts and omissions, civil actions, rights of participants in such actions, awards allowed, actions that are not allowed, limits state liability, and outlines whistleblower protections. This section identifies the fraudulent or false acts that can be committed by a Medicaid provider, a corporation, partnership or individual, or recipient in effort to defraud the State. This section also outlines provisions by which a recipient or provider may reduce the amount of liability from actual damages.

This section also allows a private citizen to pursue a false claim action in the superior court, outlines the provision by which they may file a suit or an extension of time in which to bring an action, and the responsibilities and time-line in which the attorney general must investigate and respond to the claim. This section also identifies the options available to private persons, should the attorney general dismiss the case due to lack of evidence, including pursuing the suit of their own accord. Throughout the process, this section states that the attorney general holds the rights to intervene, settle, dismiss the case, request investigation assistance from the department and bring civil action in superior court.

This section further allows the attorney general to issue subpoenas to compel records in connection with an investigation, and outlines the courts' authority to issue an order to comply and punishments if the

Medicaid provider or recipient(s) fail or refuse to comply with the courts order. Further, by this section the attorney general may elect to interview and file or amend a new complaint based on conduct, transactions or acts set out in the complaint.

Further, this section provides protections for the private person acting as a whistleblower and limit the liability of the state and outlines time limits for bringing action.

Finally, this section includes department regulatory authority, identifies the limits of punitive damages, and provides definitions related to this section.

Section 5 Amends AS 37.05.146(c) to include a new paragraph (88) adding monetary recoveries from the Alaska Medicaid False Claims Act to the program and non-general fund program receipts definitions.

Section 6 Amends AS 40.25.120, a conforming amendment to include new AS.09.58.010 to existing public records statutes.

Section 7 Amends AS 47.05.010 to include a requirement that DHSS develop a health care delivery model that encourages wellness and disease prevention.

Section 8 Amends AS 47.05.200, Medicaid Audits statute, changes the number of program audits to no less than fifty per year and adding that the state shall attempt to minimize concurrent state or federal audits.

Section 9 Adopts AS 47.05.200 that the Department may assess interest and penalties on overpayments, calculating interest using existing statutory rates.

Section 10 Adopts AS 47.05.235, which applies the duty of enrolled Medicaid providers to conduct one annual review, identify overpayment and report findings to the department within ten business days, and create a repayment agreement with the state.

Section 11 Adopts AS 47.05.250, which authorizes the department to develop regulations to impose civil fines and sets limits on the amount of the fines.

Adopts AS 47.05.260, which authorizes the department, after application to the court and a finding of probable cause, to seize certain real or personal property of a medical assistance provider who has committed or is committing medical assistance fraud, to offset the cost of the alleged fraud. The court may authorize seizure of real or personal property to cover the cost of the alleged fraud.

This section provides a list of possible real or personal properties, including bank accounts, automobiles, boats, airplanes, stocks and bonds, and inventory.

This section, upon issuance of the court order of seizure, prohibits the owners of property from disposing of the property, with a provision of good faith in the event property is sold without written permission of the court.

This section further authorizes the forfeiture of any seized property if the Medicaid provider is eventually convicted of medical assistance fraud. This section provides instructions to the state to sell or return properties, and depositing funds from disposal of seized properties.

This section also allows for the action of forfeiture to be joined with any alternative civil or criminal action for damages.

9:39:57 AM

Mr. Sherwood continued with the sectional analysis:

Section 12 Amends AS 47.07.036 by adding new subsections (d) – (f) to outline cost containment and reform measures DHSS must undertake, including seeking demonstration waivers related to innovative service delivery models, applying for other options under the Social Security Act to obtain or increase federal match, and improving telemedicine for Medicaid recipients. This section also requires DHSS to apply

for an 1115 waiver for a demonstration project for one or more groups of Medicaid recipients in one or more geographic area. The demonstration project may include managed care organizations, community care organizations, patient-centered medical homes, or other innovative payment models.

Section 13 Amends 47.07.900 (4), Medicaid Administration definitions, by removing the grantee status requirement for outpatient community mental health clinics serving Medicaid patients.

Section 14 Amends AS 47.07.900 (17) by removing the grantee/contractor status requirement from drug and alcohol treatment centers and outpatient community mental health clinics. This change, and the one in the previous section, allows mental health and drug treatment service providers who do not receive grants from the department to become enrolled Medicaid providers and deliver services to Medicaid recipients.

Section 15 Adds a new section to outline court rule amendments as a result of enactment of “section 2, 3, and 4 ” (AMFCA) of this Act.

Section 16 Requires DHSS to collaborate with Alaska Tribal health organizations and the U.S. DHHS to implement new federal policy regarding 100% federal funding for services provided to Medicaid-eligible American Indian and Alaska Native individuals.

Section 17 Requires DHSS to implement the primary care case management system authorized under AS 47.07.030(d). The purpose of this new system is to increase Medicaid enrollees’ use of primary and preventive care, while decreasing the use of specialty care and hospital emergency department services.

Section 18 Requires DHSS to develop a plan to strengthen the health information infrastructure, including health data analytics capability, to support transformation of the health system in Alaska.

Section 19 Authorizes DHSS to support one or more private initiatives designed to reduce nonurgent use of emergency departments by Medicaid recipients.

Section 20 Authorizes DHSS to contract with one or more accountable care organizations to demonstrate the use of local, provider-led coordinated care entities that agree to monitor care across multiple care settings, and that will be accountable to DHSS for the overall cost and quality of care. DHSS is authorized to participate in public-private partnerships with other purchasers of health care services, and is required to implement an evaluation plan to measure the success of this demonstration project.

Section 21 Instructs DHSS to immediately amend the Medicaid state plan to be consistent with this Act, and submit the amendments to the federal government for approval.

Section 22 Authorizes DHSS to adopt regulations to implement provisions of this Act.

Section 23 Provides that Section 4 is effective conditional on Section 15 receiving a two-thirds majority vote. The new sections of law creating the civil Medicaid false claims act do not take effect unless the indirect court rule change sections of the bill receive the necessary two-thirds vote.

Section 24 Provides that Section 22 is effective immediately under AS 01.10.070(c).

Section 25 Provides that, except for Section 22, the provisions of this Act take effect on July 1, 2016.

9:44:08 AM

Senator Hoffman asked about Section 14, and wondered how it changed the current system and care for individuals on the FASD spectrum.

Mr. Sherwood explained that the principal effect the section would bring more substance abuse treatment providers into the Medicaid system. He suggested that it would make substance abuse treatment more readily available, with shorter wait times.

Senator Hoffman asked whether the legislation offered any other preventative measures.

Mr. Sherwood referred to Section 7 of the bill, which addressed the duties of the department, which required the department to develop a health care delivery model and encourage wellness and disease prevention.

Co-Chair MacKinnon directed attention to Page 13, line 16 of the legislation.

9:47:10 AM

Commissioner Davidson stated that one critical component included in the Agnew-Beck report was a demonstration project that would be allowed under the proposed legislation for accountable care organization demonstration projects. She said that accountable care organizations were a way to be able to manage the care of a defined population.

9:49:08 AM

Senator Olson wondered how many groups provided input in the crafting of the legislation.

Commissioner Davidson responded that the Agnew-Beck report listed all of the participants in the Appendix and included tribal health providers. She added that the webinars that had been provided were available on the department's website.

Senator Olson asked why the provider would be penalized for overpayments as well as an interest payment.

9:51:27 AM

Co-Chair MacKinnon articulated that she was going to send both Medicaid reform bills to a subcommittee consisting of the following lawmakers:

Co-Chair MacKinnon, Chair
Co-Chair Kelly
Vice-Chair Micciche
Senator Olson
Senator Cathy Giessel

Co-Chair MacKinnon said that Senator Olson and Senator Giessel both had expertise in the medical field that would supply additional insight into the bills. She requested

that Senator Olson submit his previous question to the department in written form.

9:54:26 AM

Vice-Chair Micciche wanted 2 questions on the record, but did not need them to be answered.

Co-Chair MacKinnon asserted that the subcommittee was created with geographic and regional sensitivities in mind. She added that the subcommittee would meet at 1:30pm on Monday, Wednesday, and Friday into the future.

9:55:48 AM

Vice-Chair Micciche commented that the department was the second highest cost-driver in the state, and shared that he was very focused on false claims. He believed that it was a fairness issue for all Alaskans. He asked about the statute of limitations for the reporting of false claims. He asked for further explanation of Sections 2 and 3. He asked about the change of the word "relator" to "person", and whether the definition included state employees.

9:57:37 AM

Co-Chair MacKinnon referred to Section 4, and asked about the difference between "false" and "fraud". She asked about Section 8, and wondered if the state would have a memorandum of understanding (MOU) with the federal government to receive federal audit finding results. She spoke to Section 13, and queried the role of the grantee.

9:58:41 AM

Co-Chair MacKinnon directed the public to www.akleg.gov/BASIS for meeting documents. She referred to the sectional analysis and a memo from Legislative Legal. She announced that all legislative staff was welcome to attend the SB 78 subcommittee meetings.

SB 78 was HEARD and HELD in committee for further consideration.

9:59:54 AM
AT EASE

10:01:29 AM
RECONVENED

#sb74
SENATE BILL NO. 74

"An Act relating to permanent fund dividends; relating to a medical assistance reform program; establishing a personal health savings account program for medical assistance recipients; relating to the duties of the Department of Health and Social Services; establishing medical assistance demonstration projects; and relating to a study by the Department of Health and Social Services."

10:01:41 AM

Co-Chair Kelly stated that Medicaid had become unsustainable in its current form and needed to be reformed. He noted that his office had hired a private contractor to draft a Medicaid reform bill over the interim, the result of which was SB 74. He relayed that the heart of the bill was the case management system, otherwise called managed care, and added that Alaska was one of only 12 systems that did not have a case management system. He relayed that through a case management system the state could regulate emergency facility use, make sure that people were using cheaper, generic prescription drugs as much as possible, restrict travel for care, and to keep recipients from engaging in self-referral to specialists when primary care physicians were sufficient. He said that the bill contained a feasibility study that would direct the administration toward privatization. He added that the bill contained language on fraud prevention and recovery.

10:06:38 AM

Co-Chair MacKinnon pointed out to the committee that there were individuals available online for questions.

10:07:22 AM

HEATHER SHADDUCK, STAFF, SENATOR PETE KELLY, began the sectional analysis.

10:08:20 AM
AT EASE

10:11:55 AM
RECONVENED

Ms. Shadduck continued discussing the Sectional Analysis for CSSB 74:

Section 1: Allows the Department of Health and Social Services (DHSS) to enter into a contract through the competitive bidding process under the State Procurement Code for durable medical equipment or specific medical services provided in the Medicaid program.

Section 2: Requires the department to establish a computerized eligibility verification system to verify eligibility and to deter waste and fraud. It also requires DHSS enter into a competitively bid contract with a third-party vendor for the eligibility verification system.

Section 3: Adds new sections establishing civil penalties for false claims for medical assistance and authorizing the Department of Health and Social Services (the department) to assess civil penalties against medical assistance providers.

Section 4: Requires DHSS to design, adopt, and implement a medical assistance (Medicaid) reform program. Requires the department to prepare and submit a report about reforms, savings, and costs related to the Medicaid program. Provides for a definition of "telemedicine."

Ms. Shadduck discussed the sub-sections related to Section 4:

(1) referrals to community and social support services, including career and education training services available through the Department of Labor and Workforce Development under AS 23.15, the University of Alaska, or other sources;
(2) distribution of an explanation of medical assistance benefits to recipients for health care services received under the program;
(3) expanding the use of telemedicine for primary care, behavioral health, and urgent care;

(4) enhancing fraud prevention, detection, and enforcement;
(5) reducing the cost of behavioral health, senior, and disabilities services provided to recipients of medical assistance under the state's home and community-based services waiver under AS 47.07.045;
(6) pharmacy initiatives;
(7) enhanced care management;
(8) redesigning the payment process by implementing fee agreements that include
(A) premium payments for centers of excellence;
(B) penalties for hospital-acquired infections, readmissions, and outcome failures;
(C) bundled payments for specific episodes of care; and
(D) global payments for contracted payers, primary care managers, and case managers for a recipient or for care related to a specific diagnosis;
(9) stakeholder involvement in setting annual targets for quality and cost-effectiveness;
(10) to the extent consistent with federal law, reducing travel costs by requiring a recipient to obtain medical services in the recipient's home community, to the extent appropriate services are available in the recipient's home community.

(b) The department shall identify the areas of the state where improvements in access to telemedicine would be most effective in reducing the costs of medical assistance and improving access to health care services for medical assistance recipients. The department shall make efforts to improve access to telemedicine for recipients in those locations. The department may enter into agreements with Indian
Health Service providers, if necessary, to improve access by medical assistance recipients to telemedicine facilities and equipment.

(c) On or before October 15 of each year, the Department of Health and Social Services shall prepare a report and submit the report

to the senate secretary and the chief clerk of the House of Representatives and notify the legislature that the report is available. The report must include

(1) realized cost savings related to reform efforts under this section;

(2) realized cost savings related to medical assistance reform efforts undertaken by the department other than the reform efforts described in this Act;

(3) a statement of whether the Department of Health and Social Services has met annual targets for quality and cost-effectiveness;

(4) recommendations for legislative or budgetary changes related to medical assistance reforms during the next fiscal year;

(5) changes in federal laws that the department expects will result in a cost or savings to the state of more than $1,000,000;

(6) a description of any medical assistance grants, options, or waivers the department applied for in the previous fiscal year;

(7) the results of demonstration projects the department has implemented;

(8) legal and technological barriers to the expanded use of telemedicine, improvements in the use of telemedicine in the state, and recommendations for changes or investments that would allow cost-effective expansion of telemedicine;

(9) the percentage decrease in costs of travel for medical assistance recipients compared to the previous fiscal year;

(10) the percentage decrease in the number of medical assistance recipients identified as frequent users of emergency departments compared to the previous fiscal year;

(11) the percentage increase or decrease in the number of hospital readmissions within 30 days after a hospital stay for medical assistance recipients compared to the previous fiscal year;

(12) the percentage increase or decrease in average state general fund spending for each medical assistance recipient compared to the previous fiscal year;

(13) the percentage increase or decrease in uncompensated care costs incurred by medical assistance providers compared to the percentage change in private health insurance premiums for individual and small group health insurance;

(14) the cost, in state and federal funds, for providing optional services under AS 47.07.030(b).

(d) In this section, "telemedicine" means the practice of health care delivery, evaluation, diagnosis, consultation, or treatment, using the transfer of medical data through audio, visual, or data communications that are performed over two or more locations between providers who are physically separated from the recipient or from each other.

Section 5: Requires the legislature to approve any new additional groups added to the Medicaid program on or after March 23, 2010.

Section 6: Requires the department to design and implement a demonstration project to reduce nonurgent use of emergency departments by Medicaid recipients.

Ms. Shadduck spoke to subsection 5 of Section 6:

(5) a process for assisting frequent users with plans of care and for assisting patients in making appointments with primary care providers within 96 hours after an emergency department visit;

10:20:49 AM

Ms. Shadduck continued with the sectional analysis:

Section 7: Requires the department and the attorney general to annually prepare a report regarding fraud prevention, abuse, prosecution, and vulnerabilities in the Medicaid program.

Section 8: Requires the department to develop one or more managed care or case management demonstration projects through a contract with a third party. The managed care program would be for individuals enrolled in all Medicaid programs.

Ms. Shadduck spoke to the subsections in Section 8:

> (b) The department shall enter into contracts with one or more third-party primary care case managers, managed care organizations, prepaid ambulatory health plans, or prepaid inpatient health plans to implement the project established under this section. The contract must provide for a fee based on a per capita expense that is fair and economical. The department or administrator shall develop a comprehensive system of prior authorizations for payment of services under the project. However, prior authorization may not be required for mental health or primary care services.
> (c) The department or a third-party administrator shall designate health care providers or one or more teams of health care providers to provide services that are primary care and patient centered as described by the department for purposes of a project under this section. The department or a third-party administrator shall enter into necessary provider and fee agreements. For primary care case managers, the fee agreement must include an incentive-based management fee system. The fee agreements may not be based on a fee for service but must be based on performance measures, as determined by the department.
> (d) A project under this section must include additional cost-saving measures that include innovations to
>
> (1) reduce travel through the expanded use of telemedicine for primary care, urgent care, and behavioral health services; to the extent legal barriers prevent the expanded use of

telemedicine, the department shall identify those barriers;

(2) simplify administrative procedures for providers, including streamlined audit, payment, and stakeholder engagement procedures.

(e) In this section, "department" means the Department of Health and Social Services.

10:23:20 AM

Section 9: Requires the department to conduct a study analyzing the feasibility of privatizing certain services.

Ms. Shadduck explained that the studies would vary from item to item; exploration into privatizing the Alaska Psychiatric Institute was one plan, another was be to privatize certain divisions of juvenile justice facilities, and certain pioneer homes.

Section 10: Requires the department to amend the state Medicaid plan and apply for any waivers necessary to implement the projects and programs described in the bill. Requires the Commissioner of Health and Social Services to certify to the revisor of statutes federal approval of specified measures.

Section 11: Allows the department to adopt regulations necessary to implement the changes made by the Act. The regulations may not take effect before the dates the relevant provision of the Act takes effect.

Section 12: Conditional effects.

Sections 13 - 17: Provides for effective dates for provisions that require waiver and state plan amendment approvals from the United States Department of Health and Human Services.

Section 18: Provides an immediate effective date for sections 9 – 12.

10:25:29 AM

Senator Olson asked about Section 8. He asked whether any private entities had expressed interest in taking over healthcare facilities in the state.

Ms. Shadduck answered in the affirmative. She said that there was a lot of interest and excitement from the private sector.

Senator Olson wondered whether the interest was coming from national corporations, as opposed to an Alaska based private company.

Ms. Shadduck replied that the process was legally prescribed. The study would simply reveal feasibility on the matter. She assumed that privatization would follow state procurement code.

10:27:19 AM

Vice-Chair Micciche observed the fiscal notes attached to the bill reflected savings beginning in FY18.

Ms. Shadduck responded that the fiscal notes had been prepared by the administration in 2015 and could not speak to why savings would not begin until FY18.

10:28:15 AM

Co-Chair Kelly encouraged the scrutinizing of the bill in subcommittee. He said that there had been recent developments that would result in serious savings in 2017, that would impact the FY18 budget process. He furthered that the finance committee would move quickly and reserve substantive policy debates for subcommittee. He asserted that Medicaid was a huge cost driver for the state, which suggested that the state was doing a poor job in providing the service. He concluded that the legislation would deliver savings and better care.

10:31:07 AM

Vice-Chair Micciche felt that the effort would take teamwork.

10:31:59 AM

Senator Olson asked about Section 6. He wondered how the bill addressed the problem of the prescription of narcotics in the emergency room.

Ms. Shadduck replied that there was currently a prescription drug database, which would continue to receive funding under the bill.

10:33:36 AM

Co-Chair MacKinnon assigned SB 74 a subcommittee comprised of:

Co-Chair MacKinnon
Co-Chair Kelly
Vice-Chair Micciche
Senator Olson
Senator Geissel

Co-Chair MacKinnon clarified that both SB 78 and SB 74 were being referred to the same subcommittee. She asserted that the subcommittee would examine valuable pieces and components of each in order to come up with a single recommendation for the committee to consider. She offered that the timeline was expected to be one month.

SB 74 was HEARD and HELD in committee for further consideration.

Co-Chair MacKinnon discussed housekeeping.

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ADJOURNMENT
10:35:33 AM

The meeting was adjourned at 10:35 a.m.