

SENATE FINANCE COMMITTEE
February 25, 2016
9:06 a.m.

[9:06:51 AM](#)

CALL TO ORDER

Co-Chair MacKinnon called the Senate Finance Committee meeting to order at 9:06 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

Erin Shine, Staff, Senator Anna MacKinnon; Stacie Kraly, Assistant Attorney General, Department of Law; Heather Shaddock, Staff, Senator Pete Kelly; Valerie Davidson, Commissioner, Department of Health and Social Services; Becky Hultburg, President and CEO, Alaska State Hospital and Nursing Home Association; Jeff Jessee, Chief Executive Officer, Alaska Mental Health Trust Authority; Patrick Sidmore, Planner, Alaska Mental Health Board/ Advisory Board on Alcoholism and Drug Abuse, Juneau; Carlton Heine, Board Member, Alaska State Medical Association, Juneau; Shailee Nelson, Compliance Administrator, Yukon-Kuskokwim Health Corporation, Bethel; Pamela Watts, Executive Director, Juneau Alliance for Mental Health, Inc., Juneau; Tom Chard, Executive Director, AK Behavioral Health Assoc., Juneau.

PRESENT VIA TELECONFERENCE

Nancy Merriman, President, Alaska Primary Care Association, Anchorage; Mary Minor, Self, Anchorage; Michael Bailey, CFO, HOPE Community Resources, Anchorage; Connie Sipe, Executive Director, Center for Community, Sitka; Anne Zink, American College of Emergency Physicians, Palmer; Elizabeth Ripley, Executive Director, Mat-Su Health Foundation, Wasilla; Jeremy Gitomer, AIM, Anchorage; Kathleen Yarr, Self, Ketchikan; Robert Lane, AK Psychological Assoc., Anchorage; Andrew Peterson, Director, Medicaid Fraud, Department of Law, Anchorage; Carolyn Heyman-Layne, Health Law Attorney, Anchorage; Julia Jackson, Vice-President, Treatment Services, Volunteers of America, Anchorage; John Laux, Self, Anchorage; Deborah Brollini, Self, Anchorage.

SUMMARY

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

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

#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."

[9:07:31 AM](#)

Co-Chair Kelly MOVED to ADOPT proposed committee substitute for SB 74, Work Draft 29-LS0692\V (Glover, 2/23/16).

Co-Chair MacKinnon OBJECTED for purposes of discussion.

Co-Chair MacKinnon explained that the Senate Finance Subcommittee on Medicaid believed that there would be several issues in the bill that it expected the Senate Finance Committee to address, and the issues were not included in the work draft being considered. She expected

that the committee process would work slowly so that the members could work to gain understanding on each section.

Co-Chair Kelly asked if the sectional analysis before was the one he had previously examined.

Co-Chair MacKinnon explained that the committee was reviewing a draft document from the previous evening.

Senator Hoffman asked which members served on the Medicaid subcommittee.

Co-Chair MacKinnon specified that the subcommittee was comprised of Senator Olson, Senator Micciche, Senator Kelly, Senator Kelly, and herself.

[9:10:02 AM](#)

ERIN SHINE, STAFF, SENATOR ANNA MACKINNON, explained that the Medicaid Reform subcommittee had met 13 times to review and discuss a wide variety of topics and issues in aid of considering SB 74, as well as SB 78 (the governor's proposal for Medicaid reform). She referred to the draft sectional analysis for CSSB 74(FIN) (copy on file); specifying that portions of the bill had been amended. Additionally, sections of the original bill had remained untouched, and sections of SB 78 had been moved into the work draft for SB 74. She continued that she would point out new sections of the bill as she reviewed the CS.

Ms. Shine directed attention to page 2, Section 1, line 6; and explained that the section was part of a robust package of fraud language that the governor had proposed.

Co-Chair MacKinnon recognized legislative staff in the gallery.

STACIE KRALY, ASSISTANT ATTORNEY GENERAL, DEPARTMENT OF LAW, stated she would review initial sections in the CS related to fraud that had originally been contained in SB 78. She referred to Section 1 and 2 on page 2, which were statute of limitations provisions which amended Title IX of Alaska Statutes to identify when claims pertaining to the false claims act could be brought. Section 3 on pages 2 through 10 created a new chapter in Title IX, which was the Alaska Medical Assistance False Claim and Reporting Act.

Ms. Kraly explained that the act created a new cause of action whereby the State of Alaska, in conjunction with individuals that identified false claims or fraud in the Medicaid program, may pursue recovery of the claims through civil action. She detailed that there had been a number of new statutes established under the act:

AS 09.58.010. False claims for medical assistance; civil penalty. She explained that generally there was a list of activity that would be considered to be false claims. A full list of the activities could be found on page 2, line 26 through the end; and page 3, through line 11. The penalties for false claims would be civil penalties not less than \$5500 and not more than \$11,000, three times the amount of actual damages, reasonable attorneys' fees and costs as provided in court rules, possible reduction in penalties, and establishes corporate liability for false claims.

AS 09.58.015. Attorney General invitation; civil action. Authorizes the attorney general to investigate claims brought under this statute and to work collaboratively with DHSS on such matters.

Ms. Kraly elaborated that after an individual identified a false claim and filed a lawsuit with the Superior Court of Alaska, the action would be filed under seal and immediately served upon the attorney general's office. The attorney general's office, upon receipt of the complaint, must take 60 days to evaluate the claim; then must: take over the action, defer the action to the individual who brought the claim, or determine that the claim was without merit and dismiss the action outright.

[9:14:45 AM](#)

Co-Chair MacKinnon asked Ms. Kraly to explain the department's perspective on corporate liability versus individual liability in the case that a member of a corporation commits fraud.

Ms. Kraly stated that the general premise (which had already been in existence prior to the proposed new statute) was that a corporation was responsible for the corporate integrity of its organization through established internal controls to ensure individuals working under and

with corporate authority were acting appropriately. She clarified that AS 09.58.010 would establish that if a corporation failed to have such internal controls, it would be held liable for the activity of its employees. She reiterated the corporate liability was established outside of the false claims act.

Co-Chair MacKinnon stated that (inside the legislation) the administration had made the recommendation for audits for the companies performing medical services. She wondered if, in addition to having corporate liability, responsibility for federal dollars would be embedded in the new statutes.

Ms. Kraly answered in the affirmative, and added that there was another provision later in the bill that addressed the subject of audits.

[9:18:23 AM](#)

Ms. Kraly continued discussing provisions under the false claims act. She discussed AS 09.58.020, which dealt with how the attorney general acted as a check and balance to a claim brought under the act. She discussed AS 09.58.025, which granted the attorney general the authority to issue subpoenas in order to assist in the investigation of a claim. She addressed AS 09.58.030, which discussed the rights within the false claims provision, if an action was brought:

AS 09.58.030. Rights in fraudulent claims actions. This outlines the relative role of the parties in the event that the attorney general intervenes in a case (exclusive authority over the case/action), including moving to dismiss the case at any time or settling with the provider despite the objection of the relator. If the attorney general defers to the relator, the attorney general can ask to be served on all pleadings and intervene at any time. Further, the attorney general can ask that discovery in the case be stayed during the pendency of the criminal investigation.

Ms. Kraly described AS 09.58.030 as a "safety valve" to ensure that claims were properly prosecuted.

Co-Chair MacKinnon asked if the section included standard language from other states that specified the attorney

general would have ultimate veto authority on a case versus the judicial branch.

Ms. Kraly stated that it was general language that had been adopted after review of guidelines for program certification from the U.S. Department of Health and Human Services Office of Inspector General. She continued that the language was a general provision in most false claims acts and can be found in the federal false claims act.

Ms. Kraly addressed 09.58.040:

AS 09.58.040. Award to false or fraudulent claim plaintiff.

Outlines how the relator will be compensated in a filed claim act.

(1) If the attorney general intervenes, the relator will be awarded 15% to 25% of the total award;

(2) If the attorney general defers and allows the case to go forward, the relator receives 25% to 30% of the total award; and,

(3) Authorizes the court to limit or reduce the award if the evidence takes into account the role of the relator in bringing the case and the overall scheme.

[9:21:53 AM](#)

Senator Dunleavy asked Ms. Kraly to illustrate a brief scenario on how a fraudulent claim process might work.

Ms. Kraly described a scenario whereby an individual (an employee of an organization or a Medicaid recipient) believed something inappropriate was occurring. The individual would hire a private attorney to investigate and help determine if there was sufficient evidence to bring a false claim. If sufficient evidence was found, the attorney would file a lawsuit in the superior court. The lawsuit would be filed under seal and be sent to the superior court while contemporaneously sent to the attorney general's office. The attorney general's office would then investigate to determine the merit of the case and determine a course of action as to whether to bring the case forward and as to whom would prosecute the case. Finally, if the attorney general found no merit to the claim, the case would be dismissed. If the case went forward' a full civil trial would ensue to include discovery, depositions, and potentially a bench trial in

front of a judge. If a judge determined fraud had occurred, an award would be identified and damages would be awarded.

[9:24:12 AM](#)

Senator Dunleavy wondered if the hire of a private attorney indicated that any claim would need to be of a significant magnitude to justify the expense. He thought that most of the incidents would probably take place against institutions and entities.

Ms. Kraly stated that a claim could be against any Medicaid provider regardless of the provider's size. She added that there was a limit in the statute that stipulated one could not bring a false claim for anything less than \$5,500. She stated that he was correct in that there was a cost-benefit analysis to determine whether or not to file a claim. She thought most claims would be in excess of \$5,500.

[9:25:02 AM](#)

Senator Dunleavy asked if there could potentially be many issues below the amount of \$5,500 that over time could accumulate to a substantial sum.

Ms. Kraly answered in the affirmative.

[9:25:30 AM](#)

Senator Olson asked about potential lawsuits and wondered if the attorney general decided to dismiss the case, if there was an appeal process for the plaintiff.

Ms. Kraly understood that if DOL dismissed a case, the case would end. She assumed the decision would be appealable by the plaintiff to the Supreme Court, however was not aware of a circumstance in which it had happened before.

[9:26:32 AM](#)

Senator Bishop remarked that the attorney general possessed a lot of power in the situation, and wondered about the eventuality of new evidence being presented after case dismissal.

Ms. Kraly thought the reopening of a case to consider new evidence depended upon whether the case was dismissed with

or without prejudice. She thought some cases might be left for additional evidence to come forward, and others would be dismissed after finding insufficient evidence.

[9:27:45 AM](#)

Senator Hoffman wondered if the CS contained provisions for whistle-blower protection. He asked if there were monetary incentives for individuals to bring false claims forward.

Ms. Kraly stated that there were whistle-blower protections, and she would discuss them later in her presentation. She clarified that there was incentive through the potential of enhanced recovery - that an individual could obtain a portion of the recovery if a false claim was established.

[9:29:00 AM](#)

Ms. Kraly continued to discuss the provisions of the CS:

AS 09.58.050. Certain actions barred.
Provides a list of situations that do not constitute a false claim, such as a claim that is currently subject to a criminal or civil action by the State. (For full list page 12, line 18 - page 13, line 1).

AS 09.58.060. State not liable for attorneys' fees and other expenses. Provides that the State is not responsible for the costs and fees of a relator in bringing an action.

[9:30:18 AM](#)

Co-Chair MacKinnon asked if there was a definition of the term "relator" within the false claims act section. She thought the general public might have a different understanding of the word than how it was being employed in the bill.

Ms. Kraly clarified that a relator was the private citizen who had brought the false claim to the attention of the attorney general's office. She confirmed that the term was used in the formal statutes that governed false claims.

[9:30:58 AM](#)

Co-Chair Kelly thought the word "relator" was pronounced differently than the more commonly known word "realtor."

Ms. Kraly concurred.

[9:31:15 AM](#)

Ms. Kraly pointed out AS 09.58.070 which was the section pertaining to whistleblower protection. She discussed AS 09.58.080, which allowed for the development of regulations to implement the act. She described AS 09.58.090, which set the minimum threshold to bring a false claims act at \$5,500.

[9:31:52 AM](#)

Senator Hoffman asked how the \$5500 minimum threshold amount was established. Ms. Kraly explained that the language was drafted after a review of federal guidelines from the Office of Inspector General. By using the specific provisions, including the threshold damage amount of \$5,500; the federal government would certify the false claim act and thereby increase the state recovery match. She explained that under Medicaid there was both a federal and state match; funds from recoveries were split at 50 percent. Under the false claims act (if certified), the state would receive a 5 percent enhancement and receive 55 percent of the recoveries.

[9:32:54 AM](#)

Ms. Kraly explained that the final sections pertaining to the false claim act concerned definitions and short title.

[9:33:05 AM](#)

Ms. Shine addressed Section 4 through Section 9, which were comprised of new language neither from SB 74 or SB 78. She discussed a subcommittee meeting on the topic of opioid abuse, in which it reviewed recommendations from the Controlled Substance Advisory Committee for the Prescription Drug Monitoring Program (PDMP). She explained that the sections being discussed incorporated the nine recommendations that had been sent to the Board of Pharmacy. She detailed that in Section 4, it required the collection of dispensing data and to update the PDMP on a weekly basis.

Ms. Shine discussed Section 5:

Section 5(page 11-13) New Section

AS 17.30.200(d)

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

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

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

(8) Adds a new section to authorize PDMP database access to the State of Alaska Medicaid Drug Utilization Review Committee;

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

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

Ms. Shine explained that currently a licensed practitioner or registered pharmacist only had access to the PDMP themselves, and found the practice of checking the PDMP database before the prescribing and dispensing or prescribing an opioid to be time-prohibitive. She directed attention to the four new subsections in Section 5.

[9:35:19 AM](#)

Ms. Shine discussed Section 6:

Section 6(page 13) New Section

AS 17.30.200(e)

Amends to require all prescribers and all pharmacists to register with the Alaska PDMP. Failure to register is grounds for the board to take disciplinary action against the license or registration of the pharmacy or pharmacist.

Ms. Shine commented that the subcommittee had heard that there might be an issue regarding response time of emergency room physicians required to participate in the PDMP.

[9:36:10 AM](#)

Ms. Shine discussed Sections 7 through 9:

Section 7(page 13) New Section

AS 17.30.200(h)

Amends to require prescribers and pharmacists to review the PDMP database when prescribing or dispensing a controlled substance to a patient. Immunity for using the PDMP remains even with the change from optional to mandatory.

Section 8(page 13-14) New Section

AS 17.30.200(k)

Amends to adopt regulations to:

- (3) Set a procedure and time frame for registration;
- (4) Require prescribers and pharmacists to review the PDMP database when prescribing or dispensing a controlled substance to a patient.

Section 9(page 14) New Section

AS 17.30.200

Adding new subsections to:

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

[9:37:22 AM](#)

Co-Chair MacKinnon stated that the previously discussed sections were a departure from previous state statute, were based on a recommendation from a task force, and may be controversial. The language pertained to opioids only, and

was moving from language of "may report" to "shall report" on the prescription and use of opioids. She understand the language was in aid of understanding where the drugs were going. She referred to testimony from a physician the previous day regarding drug abuse versus drug selling. She thought the optional program had made it difficult to curb drug abuse activities, and pondered that the mandatory participation in the PDMP would help mitigate the problem. She wanted to recognize that there was a huge drug addiction issue in the state, and expressed concern for individuals who might perceive the changes as a barrier to their personal pain management. She related a personal experience in Fairbanks wherein she spoke with individuals in a public setting about their experience with opioid abuse in the community and the ease with which the general population could access opioids. She recognized that there would be different perspectives on the PDMP component of the bill, and clarified that the subcommittee made the recommendation based on what was in the best interest of the state.

[9:41:13 AM](#)

Senator Dunleavy concurred that drug abuse was an epidemic in the state, and related personal knowledge of young adults that had experienced drug addiction after being legitimately prescribed pain medication.

[9:42:08 AM](#)

Co-Chair MacKinnon discussed over-prescription of pain medication. She mentioned her experience as the former executive director of Hospice of Anchorage and discussed pain management as part of end-of-life issues. She did not want to restrict pain medication to people suffering from terminal disease or unmanageable pain.

[9:43:31 AM](#)

Senator Bishop referred to Section 9, subsection (r) and wondered who had access to the PDMP information.

Ms. Shine stated that currently access to the PDMP was limited to pharmacists and the prescribing doctor. She continued that there was a recommendation in Section 5 that would allow access to other entities such as an agent of the state or an employee of a doctor or pharmacist. She

reiterated the concern with the time necessary for providers to access the PDMP database, and thought it might have inhibited doctors from voluntarily coming to the program.

[9:45:00 AM](#)

Co-Chair MacKinnon clarified that there it was a better use of a doctor's time and more cost effective to be with patients and was a better use of an employee's time to use the PDMP database.

[9:45:26 AM](#)

Senator Bishop was concerned that drug companies may be able to access data from the PDMP for marketing purposes.

Ms. Shine confirmed that it was not the intent of the legislation to allow for such access, and she would ensure that it was not in the bill. She discussed the limited nature of access to the PDMP database.

[9:46:02 AM](#)

Co-Chair MacKinnon stated that there had been conversation about protecting privacy, and indicated that currently even the state pharmacist did not have access to detailed information in the PDMP database.

Ms. Shine added that 31 other states had added allowed access for state Medicaid pharmacists.

[9:46:58 AM](#)

Ms. Kraly addressed Section 10:

Section 10(page 14) Previously CS SB 78(FIN) Section 5 AS 37.05.146(c)

Amends 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.

[9:47:27 AM](#)

Senator Hoffman asked for the justification for not forwarding the recoveries to the GF.

Ms. Kraly understood that under statute, other Medicaid receipts were included under the non-GF designation. She stated she would look into the matter and provide Senator Hoffman with the information.

[9:48:12 AM](#)

Senator Hoffman asked what the receipts would be eligible to be utilized for. Ms. Kraly was not sure of how the funds could be used.

Co-Chair MacKinnon made note of the two questions for later discussion. She thought that the direction of the funds had to do with the state and federal funding split and the need for proper accounting. She indicated that the committee would request further information from DOL.

[9:48:52 AM](#)

Ms. Kraly reviewed Section 11:

Section 11(page 14) Previously CS SB 78(FIN) Section 6
AS 40.25.120(a)

Amends to include a new paragraph (15) a conforming amendment to include new AS.09.58.010 to existing public records statutes.

Ms. Kraly elaborated that the section had to do with protection of the filing the case under seal, and other information. Once the case went forward and was open, the matters would be public as any other civil litigation. There was a process whereby the department was investigating and determining the merits of the case, and the information needed to be maintained as confidential. She confirmed that the section would add the false claim act provisions to the Alaska Public Records Act.

[9:49:44 AM](#)

HEATHER SHADDUCK, STAFF, SENATOR PETE KELLY, discussed Section 12:

Section 12 (page 14-15) Previously CS SB 74(STA)
Section 1
AS 47.05.015

Amends by adding a new subsection to allow 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.

[9:50:30 AM](#)

Senator Hoffman asked if there was a monetary threshold that was required in the statute. He thought it did not make sense to go to competitive bid for a small amount.

Ms. Shadduck stated that there was not a monetary threshold specified - the language was acquired through an amendment made the previous session in the Senate State Affairs Committee. She clarified that the section was also left as permissive language that the department could use as a tool. She mentioned that there had been other suggestions from other groups such as the Key Campaign regarding how to purchase medical supplies, and noted that the allowance was an option rather than a requirement.

[9:51:10 AM](#)

Ms. Shadduck addressed Section 13:

Section 13(page 15-16) Previously CS SB 74(STA)
Section 2 (Amended)
AS 47.05.105 Enhanced computerized eligibility
verification system.
Amends by adding a new subsection requiring the
department to establish a computerized enhanced
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.
The annual savings must exceed the cost of
implementing the system.

Ms. Shadduck pointed out that the section would require DHSS to use a system that would complement Alaska's Resource for Integrated Eligibility Services (ARIES) system. She continued that added new subsections (c) and (d) clarified that the system was separate from ARIES (how the division of public assistance determined program eligibility); and would utilize a nation-wide system to try

and capture waste and abuse. Subsection (d) prevented a conflict of interest by stipulating that the department may not award the contract to the same entity that ran the eligibility system.

[9:52:59 AM](#)

Senator Bishop expressed appreciation for Ms. Shadduck's earlier mention of efficacy of past computer programs. He pondered that she was considering programs that had a positive track record.

Ms. Shadduck affirmed that it was the intent of the sponsors of the legislation to acquire a program with a positive track record.

[9:53:41 AM](#)

Ms. Kraly addressed Section 14:

Section 14(page 16) Previously CS SB 78(FIN) Section 8
AS 47.05.200

a) Amends 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.

Ms. Kraly detailed that Section 14 would reduce the number of audits that DHSS must contract for from 75 to 50. She discussed the state being cognizant of the multitude of other audits occurring at the federal level, and trying not to duplicate services.

[9:54:38 AM](#)

Co-Chair MacKinnon relayed that the subcommittee had communicated with the department regarding the question of a shared services agreement pertaining to audits. She understood that DHSS and the federal government were sharing audit information. She indicated that DHSS Commissioner Valerie Davidson indicated affirmatively from the gallery.

[9:55:56 AM](#)

AT EASE

[9:58:47 AM](#)

RECONVENED

Ms. Kraly addressed Section 15:

Section 15 (page 16-17) Previously CS SB 78 (FIN)
Section 9 (Amended)
AS 47.05.200(b)
Amends so that the Department may assess interest and penalties on overpayments, identified in audits conducted under this section, by calculating interest using existing statutory rates from the date of the final agency decision.

Ms. Kraly qualified that the section would mirror what happened in civil litigation and would encourage prompt repayment.

Ms. Kraly addressed Section 16:

Section 16 (page 17) Previously CS SB 78 (FIN) Section 10 (Amended)
AS 47.05.235. Duty to identify and repay self-identified overpayments.
Amends by adding a new section which requires all enrolled Medicaid providers to conduct one annual review or audit of all claims, and if overpayments are identified, to report those findings to the department within ten business days, and to establish a repayment agreement with the state.

10:00:20 AM

Co-Chair MacKinnon asked how the department was working with providers to establish safety nets for the annual review of claims.

Ms. Kraly was aware that DOL and DHSS worked with providers on a regular on-going basis to provide technical assistance pertaining to regulatory interpretation and record-keeping. She referred to webinars, trainings, and seminars provided by DHSS to assist providers with information to mitigate occurrences of overpayment.

Co-Chair MacKinnon appreciated Ms. Kraly's response. She referred to previous testimony by the department, as well as discussions about transition to a new Medicaid enrollment system. She had heard that there was a

substantial amount of money that had not been returned to the state, and wondered if interest was being charged.

Ms. Kraly was not aware of whether interest was being charged, and directed Co-Chair MacKinnon's inquiry to the department.

[10:02:37 AM](#)

Ms. Kraly discussed Section 17:

Section 17(page 17-22)

AS 47.05.250. Civil penalties. Previously CS SB 78(FIN) Section 11 (Amended)

Authorizes the department to develop regulations to impose civil fines and sets limits on the amount of the fines.

AS 47.05.260. Seizure and forfeiture of real or personal property in medical assistance fraud cases.

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 another civil or criminal action for damages resulting from alleged medical assistance fraud.

[10:04:18 AM](#)

Ms. Shadduck further discussed Section 17, and highlighted the changes to an additional section:

AS 47.05.270. Medical assistance reform program. Previously CS SB 74(STA) Section 4

Under (a), the reform program must include 11 items:

- 1) Referrals to community and social support services, including career and education training services available through the Department of Labor & Workforce Development, the University of Alaska, or other sources
- 2) Electronic distribution of benefits (EOBs) to recipients
- 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 of Medicaid under the state's home and community-based services waivers
- 6) Pharmacy initiatives
- 7) Enhanced care management
- 8) Redesigning the payment process by implementing fee agreements that include: premium payments for centers of excellence, penalties for hospital-acquired infections, readmission, and outcome failures, bundled payments, or global payments.
- 9) Stakeholder involvement in setting annual targets for quality and cost-effectiveness
- 10) Reducing travel by requiring a recipient to obtain care in their home community to the extent appropriate services are available.
- 11) Establish guidelines for health care providers to develop health care delivery models that encourage wellness and disease prevention.

New Subsection (b): Requires the department to efficiently manage a comprehensive and integrated behavioral health system that uses evidence based practices that are data driven with measureable outcomes. The department and the Alaska Mental Health

Trust Authority must provide a plan for a continuum of community based services that includes house, employment and criminal justice issues.

Subsection (c): Has the department identify the areas of the state where improvements in access to telemedicine would be most effective in reducing the costs of Medicaid. Allows the department to enter into agreements with IHS providers if necessary to improve access to telemedicine facilities and equipment.

Subsection (d): Requires the department to prepare and submit a report around reforms, savings and costs related to the Medicaid program on or before October 15 of each year.

Subsection (e): Provides a definition for telemedicine.

Ms. Shadduck detailed that item 11 was new and comprised of language from SB 78. Item 11, Subsection (b) was new and had been formulated in coordination with Jeff Jessee, Chief Executive Officer of the Alaska Mental Health Trust Authority.

Ms. Shadduck read from the bill starting on Page 20, line 24:

The goal of the program is to assist recipients of services under the program to recover by achieving the highest level of autonomy with the least dependence on state-funded services possible for each person.

Ms. Shadduck expanded that the bill was focused on continuum of care, linking individuals to community-based services, addressing housing, employment, and criminal justice.

[10:07:50 AM](#)

Senator Bishop asked to revisit Subsection (d), and wondered if the specified date of October 15 was amenable to all parties.

Ms. Shadduck conveyed that the date was chosen with the intent that the report would be delivered to the legislature with time for bills to be drafted or budget items to be prepared. She referred to comments from DHSS Commissioner Davidson regarding her work with the governor,

in the light of the departmental reporting requirement listed on Page 21, line 19 of the bill:

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

Senator Bishop supported the section, but wondered if the date allowed for ample time for the department to provide full information.

Co-Chair MacKinnon relayed that the subcommittee had allowed for brief testimony from DHSS. She relayed that the commissioner had thought that some of the dates could pose a challenge for the department to achieve. She avowed to continue working with the department to align dates and make it easier to accomplish the reporting task. She reiterated Ms. Shadduck's point about the legislature receiving information in a timely fashion prior to the legislative session in order to start work on an issue. SHE thought that if the governor chose not to advance a particular topic, he would have reasons behind his choice.

Ms. Shadduck concurred.

[10:10:35 AM](#)

Senator Bishop was supportive of Co-Chair MacKinnon's comments. He considered the newness of the program and thought it might be prudent to give more time in the first year for adjustment to the reporting schedule.

Co-Chair MacKinnon thought Senator Bishop made a valid point.

[10:10:55 AM](#)

Senator Olson referred to Page 19, line 25 of the bill:

(2) electronic distribution of an explanation of medical assistance benefits to recipients for health care services received under the program;

Senator Olson expressed support for electronic connectivity of businesses, but wondered if there were care providers that did not have access to the internet or means of complying with the section.

Ms. Shadduck understood that the distribution of explanation of benefits (EOBs) would have to be added to the current Xerox Medicaid Management Information System (MMIS). She thought it would be up to the department to comply with the requirement and ensure that individuals had access to the EOBs.

[10:12:16 AM](#)

Co-Chair Kelly thought there was nothing in the language that prohibited other types of distribution.

Senator Olson asked for confirmation that other forms of distribution were available.

Co-Chair Kelly answered in the affirmative.

[10:12:28 AM](#)

Co-Chair MacKinnon relayed that the cost of paper may have precluded the idea of printed EOBs in a cost-benefit analysis. She mentioned that one way for individuals to see if providers were over-charging was to understand the services that Medicaid was being billed for. She described the new system as a test, and thought that there would be a benefit if individual Alaskans could help monitor what providers were charging.

[10:13:35 AM](#)

Ms. Shine discussed Section 18:

Section 18 (page 22-23) Previously CS SB 78(FIN)
Section 17 (Amended)
AS 47.07.030(d)
Amends to require DHSS to implement the primary care case management system. 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.

[10:14:21 AM](#)

Ms. Shine addressed Section 19:

Section 19 (page 23-24) Previously CS SB 78(FIN)
Section 12(Amended)
AS 47.07.036

Amends by adding new subsections (d)-(f) to outline cost containment and reform measures DHSS may 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.

[10:15:16 AM](#)

Ms. Shadduck reviewed Section 20:

Section 20(page 24-27)
AS 47.07.038. Collaborative, hospital-based project to reduce use of emergency department services. Previously CS SB 74(STA) Section 6(Amended)
Requires the department to partner a statewide professional hospital organization to design and implement a demonstration project to reduce non-urgent use of emergency departments by Medicaid recipients.

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

- (1)Comprehensive primary-care-based management, including behavioral health services
- (2)Care coordination, including the assignment of a primary care provider located in the local geographic area of the recipient
- (3)Health promotion
- (4)Comprehensive transitional care and follow-up care after inpatient treatment

- (5)Referral to community and social support services, including career and education training services
- (6)Sustainability and the ability to replicate in other regions of the state
- (7)Integration and coordination of benefits and services
- (8)Local accountability for health and resource allocation

[10:16:12 AM](#)

Co-Chair Kelly thought it was important to note the requirements that had been interjected in the system: identifying frequent users, electronic exchange of patient information, dissemination of a list of frequent users, education of patients, guidelines for prescribing narcotics, and a drug monitoring program. He thought the section was a significant piece of the legislation.

[10:16:57 AM](#)

Ms. Shadduck continued to discuss the coordinated care project, which was pursuant to a subcommittee discussion regarding the proposal for a managed care program, along with the department's proposal for an accountable care organization. There had been much debate pertaining to what type of payment model or project to put forward. The CS proposed that the department should contract with one or more third-party to implement coordinated care projects, in order for the best projects to come forward to the review committee. She referred to the list of items 1 through 8.

[10:18:34 AM](#)

Ms. Shadduck gave an overview subsection (b):

AS 47.07.039(b)

Establishes a project review committee for proposals submitted under (a) of this section.

The committee is comprised of:

- 1) The DHSS commissioner or their designee
- 2) The director of the Division of Insurance, DCCED or their designee
- 3) The CEO of the Alaska Mental Health Trust Authority or their designee
- 4) Three representatives of stakeholder groups appointed by the Governor

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

Ms. Shadduck noted that the subsection listed an even number of voting members for the review committee in subsection (b) and surmised that the issue would need to be addressed in another work draft.

[10:19:21 AM](#)

Senator Hoffman asked if there was a list of the stakeholders related to the review committee. Ms. Shadduck replied that the stakeholders were not listed.

Senator Hoffman clarified that he wanted to see a list so as to know who might be appointed. Ms. Shadduck offered that the department had worked extensively with stakeholders during the interim, and offered to work with the commissioner to provide a list. She continued that stakeholders generally included the State Medical Association, the Primary Care Association, the Alaska State Hospital and Nursing Home Association, and others.

Senator Hoffman wondered how many stakeholders there might be.

Co-Chair MacKinnon confirmed that there were hundreds of stakeholders.

[10:20:26 AM](#)

Co-Chair Kelly reiterated that his office would provide Senator Hoffman with a list as soon as it could be obtained.

[10:20:49 AM](#)

Senator Hoffman asked if there would be terms of service for the committee members, and wondered how members would be replaced.

Ms. Shadduck thought that the specified members would change as did any other committee or board, and thought it might be good to specify length of terms for stakeholder

groups. It was the sponsor's intention that the project would continue on. She clarified that the committee could be used in perpetuity should the occasion arise that the Centers for Medicaid and Medicare came forward with another innovative model in the future.

[10:21:39 AM](#)

Ms. Shadduck discussed subsections (c), (d), and (e):

AS 47.07.039(c)

Grants DHSS authority to contract with third-parties to implement the demonstration projects listed under (a) of this section that include managed care organizations, primary care case managers, accountable care organizations, prepaid ambulatory health plan, or a provider-led entity. Requires a per capita fee and allows for value payment models.

AS 47.07.039(d)

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

AS 47.07.039(e)

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

Ms. Shadduck confirmed that subsection (c) included that fee structures may include global payments, bundled payments, shared savings, or other payment structures. She clarified that the intent of subsection (e) was to have good information regarding what projects should be launched in a wider regional or statewide basis.

[10:22:45 AM](#)

Ms. Shadduck reviewed subsections (f) and (g):

AS 47.07.039(f)

Directs DHSS to prepare a plan regarding regional or statewide implementation of a coordinated care project based on the results of the demonstration projects under this section. Requires DHSS on or before June 30, 2019 to submit a report to the legislature on any changes or recommendations for wider regional or statewide implementation.

AS 47.07.039(g)

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

[10:23:24 AM](#)

Ms. Shadduck continued on Section 21:

Section 21 (page 27-28) Previously CS SB 74(STA) Section 7

AS 47.07.076 Report to legislature.

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

Ms. Shadduck expanded that the section would provide the legislature with a report detailing payment error rates and other details of fraud prevention. She noted that the report would be due on October 15th of each year.

[10:24:07 AM](#)

Ms. Shine discussed Sections 22 and 23:

Section 22 (page 28) Previously CS SB 78(FIN) Section 13(Amended)

47.07.900(4)

Amends Medicaid Administration definitions, by removing the grantee status requirement for outpatient mental health clinics serving Medicaid patients.

Section 23 (page 28-29) Previously CS SB 78(FIN) Section 14 (Amended)

AS 47.07.900(17)

Amends by removing the grantee/contractor status requirement from drug and alcohol treatment centers and outpatient 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.

[10:24:46 AM](#)

Co-Chair MacKinnon stated that there was discussion in the subcommittee that removal of the word "community" in Section 23 could have an adverse effect. She stated that the subcommittee would look into the issue further through dialogue with the department. She clarified that currently in order to receive a Medicaid benefit for mental health services, a service provider must be a grantee of the state of Alaska. The legislation would allow an opportunity for other providers an opportunity to help meet the needs of the community. Ms. Shine agreed.

[10:25:29 AM](#)

Ms. Kraly commented on Section 24:

Section 24 (page 29) Previously CS SB 78(FIN) Section 15
Uncodified: Indirect Court Rule Amendments.
Adds a new section to outline court rule amendments as a result of the enactment of section 3 and 17.

Ms. Kraly explained that the section would outline the court rule amendments required with the passage of the false claims act.

Ms. Shine addressed Section 25:

Section 25(page 30) Previously CS SB 78(FIN) Section 16(Amended)
Uncodified: Implement Federal Policy on Tribal Medicaid Reimbursement.
Requires DHSS to collaborate with Alaska Tribal health organizations and the U.S. DHHS to implement new federal policy regarding 100% federal funding for services provided to Medicaid-eligible American Indian and Alaska Native individuals within six months of the rule change being finalized. Requires DHSS to report to the co-chairs of Finance the estimated savings and calculations of savings to the state general fund within thirty days of the rule being finalized.

Ms. Shine relayed that the intent of the report required in Section 25 was to gain understanding of what GF relief there might be after implementing impending new federal policy.

[10:27:03 AM](#)

Co-Chair MacKinnon relayed that the subcommittee had been told that some of the travel that happened with Indian Health Service recipients would be 100 percent reimbursable rather than the state contributing. She continued that the report would help to ensure that the department started implementation of the rules as quickly as possible.

Ms. Shine added that in addition to travel, services not available in the community or tribal health facility could potentially be covered at 100 percent.

[10:27:53 AM](#)

Co-Chair MacKinnon thought the new rules might result in significant cost savings and stated that travel for FY 15 was just under \$80 million for the Medicaid program.

[10:28:07 AM](#)

Ms. Shine discussed Section 26:

Section 26(page 30-31) Previously CS SB 78(FIN)
Section 18
Uncodified: Health Information Infrastructure Plan.
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.

[10:28:31 AM](#)

Ms. Shadduck addressed Section 27:

Section 27(page 31) Previously CS SB 74(STA) Section 9
(Amended)
Uncodified: Department of Health and Social Services Feasibility Study.
(a)Requires the department to conduct a study analyzing the feasibility of privatizing the Alaska

Pioneers' Homes and select facilities of the division of juvenile justice.

(b) Requires the Alaska Mental Health Trust Authority to conduct a study analyzing the feasibility of privatizing the Alaska Psychiatric Institute.

(c) Requires the Legislative Audit and Budget Committee to conduct a study analyzing the feasibility of creating a Health Care Authority that manages a single community-related risk pool for all State of Alaska Employees, State of Alaska retirees, Teacher retirees, Medicaid Assistance recipients, and active school district employees.

Ms. Shadduck clarified that before the state was allowed to privatize facilities that employed union employees, it was required to complete a feasibility study. She added that she thought that the language in subsection (b) would need to be adjusted slightly after collaboration with the Alaska Mental Health Trust Authority.

Ms. Shadduck discussed subsection (c) //

[10:30:36 AM](#)

Co-Chair MacKinnon referred to a report from // She thought that the state paid for approximately // Ms. Shadduck concurred //

Ms. Shadduck //

[10:31:17 AM](#)

Ms. Shadduck addressed Section 28, //

Ms. SHadduck discussed Section 29, //

Ms. SHadduck discussed SEction 30, // The section was created with Leg elgal //

Ms. SHaddauck summariazed that Section s

[10:32:32 AM](#)

Co-Chair MacKinnon conveyed that the subcommittee was explicit that the issue of Medicaid expansion was not on the table, and the CS being considered pertained solely to reform //

[10:33:07 AM](#)

Co-Chair Kelly //

[10:33:23 AM](#)

Co-Chair MacKinnon WITHDREW her objection. it was so ordered. CS SB 74(FIN) was adopted.

[10:34:35 AM](#)

VALERIE DAVIDSON, COMMISSIONER, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, complimented the work of the subcommittee. // She stated that there were versions of the bill that could benefit from enhancement. //

She referred to Section 4, page 11, line 8; that required reporting on a weekly basis. She relayed that providers had commented // She suggested adding the words "at least" to accomodate for real-time information that could be //

[10:36:50 AM](#)

Commissioner Davidson appreciated the clarification of // She asked for more clarification on the com

Commissioner Davidson section 13, page 15, lines 30 and 31, regarding enhanced computerized eligibility // All but two of the requirements //

[10:38:55 AM](#)

Co-Chair Kelly relayed that it was the intention to have //

[10:39:31 AM](#)

Co-Chair MacKinnon // SHe did not want the department to // She thought //

[10:40:07 AM](#)

Vice-Chair Micciche reiterated // Commissioner Davidson clarified that //

[10:40:47 AM](#)

Co-Chair Kelly made jokes.

[10:41:36 AM](#)

Senator Olson wondered about the cost of implementing a second system. Commissioner Davidson anticipated that the pertinent fiscal notes would be transmitted the following Monday.

[10:42:16 AM](#)

Co-Chair MacKinnon

Vice-Chair Micciche drew attention to line // Commissioner Davidson appreciated the clarification.

[10:42:58 AM](#)

Co-Chair MacKinnon //

Commissioner Davidson referred to section 17, //

on lines 8 and 9, subsection 12, requiring // The department recommended //

Commissioner Davidson referred to section // She expressed a desire for latitude to consider individuals in end of life scenarios who were //

[10:45:24 AM](#)

Senator Olson asked for the number of people that would be affected. Commissioner Davidson did not have the in

[10:45:52 AM](#)

Commissioner Davidson addressed // The department felt strongly that // and wanted the process to be ongoing // It recommended adding the language "and every year thereafter" //

Commissioner Davidson addressed // She

[10:47:29 AM](#)

Commissioner Davidson pointed out section 25, page 30, line 1 - // She // SHe pointed out

Commissioner Davidson discussed a point that was raised the previous day, referring to several references //

Commissioner Davidson expressed her thanks //

[10:49:10 AM](#)

AT EASE

[10:49:20 AM](#)

RECONVENED

BECKY HULTBURG, PRESIDENT AND CEO, ALASKA STATE HOSPITAL AND NURSING HOME ASSOCIATION, // expressed appreciation // She thought the bill // She remarked on the flexibility //

[10:52:33 AM](#)

Ms. Hultburg continued, stating that // SHe relayed the model was based on a model in Washington state //

[10:53:17 AM](#)

Ms. Hultburg highlighted areas of concern in the bill. // She commented on administrative burden brought about by // She expressed that the magnitude of the changes were difficult for the provider community to understand //

Ms. Hultburg referred to Section 3, which would incentivize frivolous lawsuits //

Ms. Hultburg suggested that the bill created a double standard, while //

[10:56:00 AM](#)

Ms. Hultburg continued, and // She expressed support for the sections pertaining to //

[10:56:44 AM](#)

Senator Hoffman thought the primary thrust of the legislation was to address fraud, and wondered if ASHNA had specific suggestions // Ms. Hultburg //

10:57:42 AM

JEFF JESSEE, CHIEF EXECUTIVE OFFICER, ALASKA MENTAL HEALTH TRUST AUTHORITY, praised the transparent, inclusive, // He expressed support for the bill, which he thought // He thought behavioral health had been recognized as a key element // He conveyed that the trustees thought the bill was the most important // He discussed internal scrutiny of funding // He expressed commitment //

11:00:41 AM

NANCY MERRIMAN, PRESIDENT, ALASKA PRIMARY CARE ASSOCIATION, ANCHORAGE (via teleconference), expressed // She expressed appreciation for the time that //

11:02:00 AM

Ms. Merriman expressed APCA's concern with //

She expressed concern with Section //

In Section 17, referring to medical assistance reform program // she suggested // She conveyed that the association would not support the //

In Section 18,

Ms. Merriman conveyed that the association //

11:04:31 AM

Ms. Merriman //

Ms. Merriman related that the association //

talking too fast...

11:05:59 AM

Senator Olson referred to // asked about other demonstration projects // Ms. Merriman referred to other states, and emphasized that Alaska presented unique //

11:07:02 AM

Senator Olson asked about the audits and administrative obstacles // He wondered if ASHNA considered the amount of required audits // Ms. Merriman understood that the 50 audits would be conducted by the state, and her concern //

[11:08:19 AM](#)

Co-Chair MacKinnon discussed the schedule for the remainder of the day //

[11:09:00 AM](#)

RECESSED

[1:09:09 PM](#)

RECONVENED

^PUBLIC TESTIMONY

[1:10:40 PM](#)

MARY MINOR, SELF, ANCHORAGE (via teleconference), testified in support of Medicaid expansion. She shared a personal medical situation. She felt that there were some items that should not be left to the private sector. She felt that the country should be healthy, and had the opportunity to enhance the nation's health.

[1:13:15 PM](#)

MICHAEL BAILEY, CFO, HOPE COMMUNITY RESOURCES, ANCHORAGE (via teleconference), testified in support of protection against continued litigation. He urged the expansion of protections against false claims. He explained that there were various organizations that conducted internal audits and reviews of compliance. He felt that an annual review and audit of all claims would be an administrated unfunded burden to providers. He looked at Section 1, page 2, and expressed concern regarding the reporting timeframe. He felt that the expanded litigation processes would be expensive, and could not withstand the exposure.

Co-Chair MacKinnon wondered if Mr. Bailey had any closing comments. Mr. Bailey replied that he was concerned with the definition of "agent", as outlined in the bill.

[1:17:47 PM](#)

CONNIE SIPE, EXECUTIVE DIRECTOR, CENTER FOR COMMUNITY, SITKA (via teleconference), echoed Mr. Bailey's comments. She expressed concern about the vagueness of the definition of "agent." She suggested additional language. She added that she was concerned about the word, "knowingly." She testified in support of the language related to over-payment. She urged separating the False Claims and Reporting Act out of the bill, to ensure that Medicaid providers were not driven out of business. She remarked that the annual audit section be clarified, because of the undue administrative burden.

[1:21:12 PM](#)

ANNE ZINK, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, PALMER (via teleconference), expressed concern regarding the database portion related to mandating the administration of medication. She further //

[1:22:19 PM](#)

Senator Olson wondered if Dr. Zink was in // Dr. Zink replied

[1:22:36 PM](#)

Senator Olson // Dr. Zink replied that page 14, lines 6 through 9 //

[1:23:46 PM](#)

Co-Chair MacKinnon // Dr. Zink replied in the affirmative.

[1:24:07 PM](#)

ELIZABETH RIPLEY, EXECUTIVE DIRECTOR, MAT-SU HEALTH FOUNDATION, WASILLA (via teleconference), testified in support of the provisions to reduce the super utilizers. She stated that there was no vision for an adequate and comprehensive behavioral health system, therefore there were many gaps within the system. She felt that the legislation would take an important step to better behavioral health care access.

[1:27:41 PM](#)

JEREMY GITOMER, AIM, ANCHORAGE (via teleconference), shared that his group had examined the opportunities within Medicaid, as related to patients admitted with a specific diagnosis. He remarked that //

[1:32:31 PM](#)

KATHLEEN YARR, SELF, KETCHIKAN (via teleconference), //

[1:32:47 PM](#)

Co-Chair MacKinnon clarified that the bill was related to Medicaid reform, not Medicaid expansion.

[1:33:10 PM](#)

Ms. Yarr expressed concern about individuals who were alcoholics, and attempted to receive care at an emergency room. She felt that individuals were treated poorly, and should not be turned away in the emergency rooms. She felt that the best place for intervention for an addict would be in the hospital. She stressed that many people would return to the hospital later, because they were not given the proper treatment at the initial visit.

[1:35:32 PM](#)

Co-Chair MacKinnon shared that Ms. Yarr's comments were relevant to the legislation.

[1:36:01 PM](#)

PATRICK SIDMORE, PLANNER, ALASKA MENTAL HEALTH BOARD/ ADVISORY BOARD ON ALCOHOLISM AND DRUG ABUSE, JUNEAU, shared that there were many aspects of the bill that were in line with his boards' constituents. He remarked that evidence-based practices were important aspects of the legislation. He understood that there was an administrative burden on // He suggested language that would allow a person to choose to be enrolled in a behavioral health provider. He supported the expansion of a broader base of behavioral health providers. He noted that there may be a required regulatory change. He suggested intent language that allowed new providers to be equal to existing providers.

[1:39:09 PM](#)

CARLTON HEINE, BOARD MEMBER, ALASKA STATE MEDICAL ASSOCIATION, JUNEAU, testified in support of // He shared that there were approximately 10 percent of people that // He stated that there were a fairly small number of people that used emergency services to receive medication for chronic pain. He felt that using //

[1:42:30 PM](#)

Vice-Chair Micciche remarked that there were some practitioners that were irresponsible. He wondered if there was value on the side of the provider. Dr. Heine replied that there were some providers that were not //

[1:44:16 PM](#)

SHAILEE NELSON, COMPLIANCE ADMINISTRATOR, YUKON-KUSKOKWIM HEALTH CORPORATION, BETHEL, looked at Section 16, and echoed the comments of some previous testifiers as related to an annual review. She stressed that auditing every claim would cause an undue administrative burden.

[1:45:48 PM](#)

PAMELA WATTS, EXECUTIVE DIRECTOR, JUNEAU ALLIANCE FOR MENTAL HEALTH, INC., JUNEAU, urged the committee to consider three points.

[1:49:26 PM](#)

Co-Chair Kelly requested the suggestions in writing. Ms. Watts agreed to provide that information.

[1:49:53 PM](#)

TOM CHARD, EXECUTIVE DIRECTOR, AK BEHAVIORAL HEALTH ASSOC., JUNEAU, supported many provisions in the bill, specifically related to behavioral health care. He hoped that the process continued to be all-inclusive. He expressed support of the fraud protection, but remarked that there should not be undue audit requirements. He stated that there were already many audit requirements. He remarked that the committee should remove the grant requirement outlined in the bill. He stated that the law should bear more thorough examination.

[1:53:30 PM](#)

Co-Chair MacKinnon wondered if the grantee language was in the governors bill in the year prior. Mr. Chard replied in the affirmative.

[1:53:46 PM](#)

Co-Chair MacKinnon // Mr. Chard replied that he had provided his comments to all

[1:54:24 PM](#)

ROBERT LANE, AK PSYCHOLOGICAL ASSOC., ANCHORAGE (via teleconference), felt that the Medicaid program should cover psychological care. He remarked that Medicaid patients should be allowed the same psychological care. He urged the committee to change the definition of "physician" to include "psychologists." He shared that many other states had crafted language to accomplish the recommendations. He stated that currently licensed psychologists could not provide the full range of services, unless supervised by a physician. He stressed that psychologists could not currently bill for services, unless supervised by a physicians. He urged the committee to allow doctoral psychological interns to bill Medicaid for testing, which would allow for better qualified providers to serve the communities.

[1:58:42 PM](#)

Co-Chair MacKinnon wondered if he should be addressed as "Dr. Lane." Dr. Lane provided in the affirmative.

[1:59:07 PM](#)

Co-Chair MacKinnon wondered if Ms. Pemberton wanted to testify.

[1:59:28 PM](#)

ANDREW PETERSON, DIRECTOR, MEDICAID FRAUD, DEPARTMENT OF LAW, ANCHORAGE (via teleconference), replied that he was available for questions.

[2:00:09 PM](#)

CAROLYN HEYMAN-LAYNE, HEALTH LAW ATTORNEY, ANCHORAGE
(via teleconference),

[2:04:23 PM](#)

Co-Chair MacKinnon requested Ms. Heyman-Layne submit her testimony in writing.

[2:04:51 PM](#)

JULIA JACKSON, VICE-PRESIDENT, TREATMENT SERVICES,
VOLUNTEERS OF AMERICA, ANCHORAGE (via teleconference),

[2:07:04 PM](#)

Co-Chair MacKinnon announced the number for individuals to call in

[2:07:47 PM](#)

JOHN LAUX, SELF, ANCHORAGE (via teleconference), expressed appreciation for Medicaid reform. He shared that he did not have any prepared comments. He encouraged the committee to provide further opportunities for public testimony. He stressed that there was nuance and detail to the legislation. He supported the language as related to behavioral and mental health.

[2:10:18 PM](#)

Co-Chair MacKinnon shared that the public had been notified of all meetings related to the legislation.

[2:10:54 PM](#)

AT EASE

[2:17:09 PM](#)

RECONVENED

[2:17:54 PM](#)

AT EASE

[2:20:29 PM](#)

RECONVENED

[2:20:49 PM](#)

DEBORAH BROLLINI, SELF, ANCHORAGE (via teleconference), expressed concern as related to Tribal Health System, and remarked that she was not eligible for Medicaid and the system would not bill her insurance. She urged the committee to examine the billing system in Medicaid, because it should not be through Chase billing.

Co-Chair MacKinnon CLOSED public testimony.

[2:24:06 PM](#)

Co-Chair MacKinnon shared that she heard from testifiers that the grantee requirement should be removed from the legislation. She felt that there would be a provider issue, and the quality of care. She furthered that the mandatory language on pharmacy and the emergency room requirement to access the PDMP database before a narcotic prescription was administered. She announced that there was also a concern for the annual audit, and the suggestion to streamline the audit.

[2:26:26 PM](#)

Senator Olson agreed with Co-Chair MacKinnon's concerns.

[2:26:35 PM](#)

Co-Chair MacKinnon asked for specific concerns as related to the audits.

[2:27:08 PM](#)

Co-Chair Kelly did not have any objection to Co-Chair MacKinnon's suggestions. He stated that the intention of the legislation was an increased quality of care, and addressing efficiencies. He felt that the highlighted concerns should be addressed. He shared that the House had a Medicaid reform bill, and furthered that the bill would be vetted throughout the legislative process.

[2:29:20 PM](#)

Co-Chair MacKinnon shared that the goal was to pass the bill at the beginning of March. She hoped that the committee substitute would be drafted //

[2:30:14 PM](#)

Co-Chair MacKinnon stated that the committee was on schedule.

[2:30:22 PM](#)

Senator Bishop felt that the public comment spoke volumes to the quality of work of the committee.

[2:30:40 PM](#)

Vice-Chair Micciche appreciated the subcommittee process. He remarked that the state budget was largely made up of the Medicaid. He appreciated the legislation. He felt that the bill provided the only substantive change to health care costs in the state.

[2:31:36 PM](#)

Co-Chair Kelly shared that Medicaid reform was essential in conducting the work required to draft the legislation.

[2:32:33 PM](#)

Co-Chair MacKinnon announced that Medicaid was \$775 million of the general fund. She stated that it also attracted \$1 billion from the federal government. She // She restated that Medicaid was a large cost driver to the state. // She remarked that the items should remain in the committee substitute, and stressed that the overutilization of the hospital stays were large cost drivers. She declared that the opioid overuse in the state should be a focus of the legislation. She thanked the efforts of Co-Chair Kelly and his staff in the work on the legislation. She stated that she would not halt the bill, so individual advocacy group could block legislation. She stressed that lobbyists were attempting to block the legislation, and hoped that the legislators would not succumb to that pressure. She exclaimed that the state was the last in the country /

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

#

ADJOURNMENT

[2:36:21 PM](#)

The meeting was adjourned at 2:36 p.m.