

SENATE FINANCE COMMITTEE  
February 29, 2016  
9:32 a.m.

9:32:03 AM

CALL TO ORDER

Co-Chair MacKinnon called the Senate Finance Committee meeting to order at 9:32 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

Karen Forrest, Deputy Commissioner, Department of Health and Social Services; Stacie Kraly, Assistant Attorney General, Department of Law; Tom Chard, Executive Director, Alaska Behavioral Health Association(ABHA); Dr. Carlton Heine, Emergency Room Doctor, Juneau; Valerie Davidson, Commissioner, Department of Health and Social Services.

PRESENT VIA TELECONFERENCE

Dr. Jay Butler, Chief Medical Officer, Department of Health and Social Services; Dr. Erin Narus, State Medicaid Pharmacist, Department of Health and Social Services; Dr. Andrew Elsborg, Emergency Medicine, Providence Alaska Medical Center, Anchorage; Doug Jones, Division of Healthcare Services, Anchorage; Becky Hultberg, President and CEO, Alaska State Hospital and Nursing Home Association, 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."

[9:32:31 AM](#)

Co-Chair MacKinnon discussed housekeeping.

[9:33:57 AM](#)

KAREN FORREST, DEPUTY COMMISSIONER, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, offered brief remarks on the language in the bill that would remove the language in the bill pertaining to the community grantee requirement. She explained that the Center for Medicare and Medicaid Services (CMS) required that the department change their practice in the area of community grantee requirement. She stated that in the last onsite evaluation, CMS had informed the department that the requirement had to be removed because the requirement that a provider be a grantee in order to bill Medicaid restricted the freedom of choice for Medicaid recipients by restricting access. She said that the department had the ability to set reasonable standards related to the qualifications of a provider; however, CMS generally questioned state established qualifications that would effectively limit services only to providers of the state's choosing. She said that the department had promised CMS to change the requirement, and in return CMS would provide technical assistance with the change. She furthered that CMS had stated that, while the department could continue its practice if it used general funds, but would not be allowed to continue to claim federal funds. Additionally, the department believed the change was needed because the current behavioral health system needed

foundational reform. She stated that some aspects of the current system no longer worked, and the requirement to be a grantee in order to bill Medicaid was one of those features. She shared that the requirement had been established 25 years ago, when behavioral health grants were first refinanced to Medicaid with the intention to avoid excessive growth in Medicaid, ensure accountability, and track outcomes. She relayed that, overtime, the department's model of the comprehensive community mental health center had eroded, and highlighted that additional providers were needed in order to address gaps. She said that the department had developed an alternative in which it provided \$100 grants in order for an agency to bill Medicaid, which had resulted in a patchwork of services across the state as well as gaps in continuum of care. She stressed that the change would be the beginning of needed reform by initiating increased access for services.

[9:37:36 AM](#)

Co-Chair MacKinnon clarified that the committee was discussing Page 28, line 22 of the bill.

[9:38:00 AM](#)

Ms. Forrest relented that, while the change would increase access; access needed to be balanced with quality and cost. She related that the vehicle for addressing the balance would be the 1115 Behavioral Health Medicaid Waiver. She explained that the purpose of the waiver was to improve care, increase efficiency, and reduce costs. She shared that once the waiver was complete the department would be evaluated by CMS on whether the waiver increased access to, and strengthened, providers and provider networks. She related that providers had expressed concern about the administrative burden placed on behavioral health grantees, and the department anticipated bringing changes before the legislature concerning the complexities in behavioral health statutes and regulations. She stressed the importance for all parties of having a coordinated and thoughtful process for discussion moving forward. She assured the committee that the department was committed to a thriving behavioral health system, and hoped that the legislature and the administration could work on the issue collectively. She said that removing the requirement for a grantee was an important first step and was foundational to

behavioral health reform, which was foundational to Medicaid reform.

[9:39:21 AM](#)

Co-Chair MacKinnon reiterated the version of bill under consideration. She explained that the word "community" had been removed from the language on Line 22 of page 28, which caused a discrepancy between the federal government and the state. She said that under current Alaska State Statute, only grantees could bill Medicaid. She solicited additional comments concerning the deletion of the word "community".

[9:40:41 AM](#)

STACIE KRALY, ASSISTANT ATTORNEY GENERAL, DEPARTMENT OF LAW, reminded the committee that she would be referencing Sections 22 and 23 of the bill. She relayed that a further edit to state statute that had been contemplated in the current bill version removed the word "community" in the two different sections. She said that the desire to examine the removal for unintended consequences had been previously discussed. She stated that after considerable review she believed that the purpose of the amendment had been to create a broader framework of what would constitute a clinic. She noted that by removing the word "community" the section of the statute that was being amended contained the definition of "clinic". She thought that the intent of the removal was to increase the number of providers that could be considered a clinic for purposes of billing Medicaid. She felt that the goal was laudable, but expressed concern that the edit would do what was intended. She furthered that Community Mental Health Clinic was already a term of art already articulated in state statute under AS 47.30.520 - 47.30.620; an entire statutory scheme existed to identify the Community Behavioral Health System, developed 25 years ago. She stressed that removal of the word "community" eliminated a term that was part of the term of art written into another provision of statute, which could create conflict and confusion as the behavior health system redesign moved forward.

[9:43:45 AM](#)

Co-Chair MacKinnon referred to a letter from the Alaska Behavioral Health Association (ABHA) (copy on file).

TOM CHARD, EXECUTIVE DIRECTOR, ALASKA BEHAVIORAL HEALTH ASSOCIATION (ABHA), testified that the association was comprised of mental health and drug and alcohol treatment centers throughout the state and was the provider association. He highlighted the letter referred to by Co-Chair MacKinnon. He expressed that the association appreciated the idea of removing the grant requirement in order to increase access, but felt that it should be balanced with quality and cost effectiveness. He relayed that the association recommended that the committee consider copying language from Section 19, pages 23 and 24, in order to balance the increased access recommended in the provisions discussed in Section 22 and 23. He spoke specifically of language in Section 19 that ensured access to healthcare without reducing the quality of care; a component for cost effectiveness should additionally be considered.

[9:46:32 AM](#)

AT EASE

[9:47:29 AM](#)

RECONVENED

Mr. Chard expressed appreciation to the committee for having the discussion, and reiterated the importance of moving with caution during this time of reform.

[9:48:11 AM](#)

Co-Chair MacKinnon stated that the committee review the proposed language compromise, and elucidated that her lead legislative staff, Erin Shine, would work with all parties involved to address concerns.

Co-Chair MacKinnon shifted the committee focus to mandatory language for prescription drugs.

[9:48:45 AM](#)

AT EASE

[9:49:17 AM](#)

RECONVENED

Co-Chair MacKinnon related that a change had been proposed to make language pertaining to a prescription drug monitoring program mandatory in response to the state's

opioid drug problem. She stated that the recommendation had received push back from physician groups that would be impacted by the reporting requirements contained in the language. She directed committee attention to Page 10, line 30, sections 4, 5, 6, 7, and 8. She added that there was an online document that spoke to the issue from DHSS, dated February 26, 2016(copy on file).

9:51:04 AM

DR. JAY BUTLER, CHIEF MEDICAL OFFICER, DEPARTMENT OF HEALTH AND SOCIAL SERVICES (via teleconference), related that the current bill version included improvement in the prescription drug monitoring program (PDMP) in keeping with recommendations of the Controlled Substances Advisory Committee. He shared that PDMPs were important communication tools for providers to get a more complete picture of a patient's recent medical history. He relayed that the changes to Alaska's PDMP were intended to strike a balance between maintaining access to opioids for appropriate use, supporting provider autonomy, and maintaining the right to patient privacy, while simultaneously assuring safe and effective utilization of drugs while minimizing the risk of drug fraud and drug diversion. He stated that opioids could be medically useful, but that the previous decade had seen an epidemic of opioid related deaths and disabilities that had highlighted the need for better management. He said that concerns from providers had been related to the language in Section 8, page 14, lines 7 through 9, which required a prescriber to check the database before dispensing, prescribing, or administering a controlled substance. He noted that other states had regulatory language that required providers to check the PDMP; however, the current language could go beyond what was necessary to address the current public health problem. He stressed that the goal was to remove barriers, and to encourage providers that did not currently use the PDMP to do so. He elucidated that the two greatest risk factors for overdose were escalation of dosage, often needed to achieve continued analgesia among persons receiving opioids over long periods of time, and co-administration with other controlled substances. He recommended providing the following exemptions to the requirements:

- an exemption in patient settings

- an exemption for anesthesia or analgesia administered immediately to during, or after, outpatient surgery
- an exemption for emergency situations - emergency medical services at scene, or during transport, or in the emergency department.
- an exemption for hospice care

Dr. Butler reminded the committee the PDMP was a communication tool for providers and dispensers, which had proven useful to reduce the misuse of opioids, and address the epidemic of dependency and overdose.

[9:54:39 AM](#)

Senator Olson expressed a concern for rural hospitals that were staffed by health aides working directly from manuals. He wondered whether the PDMP would interfere with emergency medical situations.

Mr. Butler felt that the question highlighted the need for an exemption for emergency situations. He added that emergencies often overlaid the day-to-day practice of medicine in clinics and emergency departments. He felt that this was an area that made delegation authority critical; the authority would allow the day to day practice of providing pain management, and accessing the PDMP, to be delegated to an assistant in the clinic who could provide information to the provider in a timely manner.

[9:56:41 AM](#)

Senator Olson understood that the emergency room exemption would extend to emergency patients.

Dr. Butler replied in the affirmative. He added that the intent of the emergency situations was broad, the main focus should be on limiting barriers to the administration of drugs in a timely fashion in emergency situations where opioid medication would be beneficial.

[9:57:24 AM](#)

Vice-Chair Micciche asserted that over prescription by providers could be partially responsible for the opioid problem.

Mr. Butler responded that when looking at the national data on the patterns of opioid use it had been observed that certain specialty providers did prescribe a greater proportion of opioids upon initial prescription, but the overall volume also included primary care providers; over half of all prescriptions for opioids were by general internists, family practice doctors, and advanced practice nurse practitioners. He believed that the issue was much broader than only what occurred in the emergency department. He said safeguards existed for patients that came into the emergency room on a recurrent basis, but stressed the importance of striking a balance and avoiding unintended barriers to administering opioids in emergency situations. He believed that the question was specific to emergency departments and should be further addressed.

[10:00:07 AM](#)

Vice-Chair Micciche maintained that there was a lack of accountability for providers. He understood that exemptions should be made for hospice care, but believed that there should be accountability for the opioids used to care for the hospice patient. He feared that relatives of the hospice patient could misuse prescribed opioids if the PDMP was not adequately populated and monitored. He believed the issue required further discussion.

[10:01:08 AM](#)

Co-Chair MacKinnon relayed that she had proposed an amendment to her staff regarding Section 8, page 14, line 8:

(4) that a pharmacist or practitioner shall access the database to check a patient's prescription records before dispensing, prescribing, or administering a controlled substance to the patient.

Co-Chair MacKinnon wondered whether using best practices before, and then following up and reporting the opioid after could work.

Mr. Butler thought that the amendment would be a more simplistic approach. He cautioned whether the highest risk situations would be sufficiently addressed. He explained that a person with a broken leg receiving morphine in an ambulance was probably not at risk for becoming opioid

dependent; the bigger risk factor was the patient prescribed a bottle of 100 tablets from their orthopedic surgeon upon discharge from the hospital. He asserted that focusing the PDMP on the higher risk situations should be the goal. He admitted that it would be a challenge to capture all of the at risk situations, but believed that progress could be made by working with providers and dispensers.

[10:03:50 AM](#)

Co-Chair MacKinnon clarified that the amendment that she would possibly propose would look at the word "before", while mandating the reporting.

[10:04:15 AM](#)

Vice-Chair Micciche liked the current language. He thought that if there was going to be an exemption that it should be in a subsection, and should state that only in emergency situations should a pain medication be distributed before checking the database.

Co-Chair MacKinnon simply wanted the burden to report to be placed on a lower level employee so that doctors did not have to use their time in that manner.

[10:05:18 AM](#)

Vice-Chair Micciche though that pressure should be placed on the medical community to only dispense opioids when a certain level of need had been established, rather than in anticipation of the need. He felt that medical providers were not conservative enough in their assumptions of pharmaceutical need.

[10:06:13 AM](#)

Co-Chair MacKinnon stated that her sister was a registered nurse, and that a conversation about what doctors were mandated to do in regard to prescription drugs could be had offline.

[10:06:37 AM](#)

Senator Dunleavy wondered whether a time frame of 24 or 48 hours, with a definitive end-period would help. He believed

that everyone understood the idea of the immediacy of emergency situations, and wondered at what point it became reasonable that the information would become part of the database.

Co-Chair MacKinnon agreed and thought that a doctor needed to work without regard to legislative requirements and in the best interest of the patient. She admitted that the state was suffering from a significant problem and that lenient prescription providers could be part of the problem.

[10:07:56 AM](#)

Co-Chair Kelly spoke in support of Co-Chair MacKinnon's language. He thought that an accurate database would be a useful tool for pushing back on opioid abuse.

[10:08:29 AM](#)

Co-Chair MacKinnon relayed that amendments would be due by noon of the following day.

[10:09:01 AM](#)

DR. ERIN NARUS, STATE MEDICAID PHARMACIST, DEPARTMENT OF HEALTH AND SOCIAL SERVICES (via teleconference), testified that she was available for questions.

[10:09:35 AM](#)

DR. CARLTON HEINE, EMERGENCY ROOM DOCTOR, JUNEAU, testified that he agreed 90 percent with the changes to the PDMP proposed in the legislation. He recognized that opiate addiction was a significant problem in the state that was causing numerous deaths. He asserted that there were physicians in the state that overprescribed narcotics. He expressed concern that the language in the bill attempted to address a problem, but would not be successful in its intent. He offered a background of the opioid epidemic. He shared that the epidemic had gotten worse in the late 1990s, early 2000s, after the Joint Commission asserted that pain was a 5th vital sign that was not being treated aggressively enough. He said that current patient satisfaction surveys included a question about the adequate control of pain, and that one of the quality metrics CMS held doctors to was the length of time before narcotics

were administered to a person with a long bone fracture. He felt that there was significant pressure on doctors to prescribe pain medication. He felt that finding a way to identify the providers that were overprescribing was necessary, but he did not believe that the current language in the bill would address the problem effectively, and would cause more work for the majority of patients and providers. He likened it to a "really big hammer trying to hit a small nail." He thought that work could be done to craft better language to identify the providers that were the problem. He reiterated previous testimony that the issue of addiction did not stem from a person with a broken leg receiving intravenous (IV) narcotics in an ambulance. He stated that the addiction issue stemmed from the longer term prescription of opioid for pain. He echoed previous testimony that the problem was not stemming from the administering of pain medication, but rather the prescription and dispensing of inappropriate amounts and quantities of pain medication. He explained his process for distribution of pain medication. He explained that if a patient came to him in acute pain, he administered IV or acute medication without delay. He furthered that if the injury were going to cause prolonged pain, he would write a short prescription for pain medication: 5 to 15 tablets of pain medicine. He admitted that the short prescription could lead to an addiction issue, but that it was predominately the long-term prescribing patterns that were driving addiction.

[10:14:25 AM](#)

Senator Dunleavy asked whether there was an established science that indicated how many pills a person had to take to be at risk for addiction. He wondered whether the database would help doctors to flag possible addicts.

Dr. Heine responded that the PDMP was currently used to flag over prescription. He said that the system was used to look up patients that might be receiving multiple prescriptions from multiple providers, which was a red flag for abuse. He stated that there was science available on addiction and who was at risk, as well as screening tools that had been established to give providers information concerning higher risk patients. He concluded that there was not a set number of pills or a length of time of use that lead to addiction, but characteristics of the patient that were complicated. He added that it had been documented

that high doses of pain medication administered for long-periods to terminal cancer patients had been effective, but chronic narcotic use for chronic pain had not been shown to be effective.

[10:17:37 AM](#)

Senator Bishop wondered whether opioids were always the first choice for a pain medication. He shared that he used Flexeril, a nonnarcotic, for pain management from compound fractures.

Dr. Heine replied that an opioid was not always the first choice; many different medications were considered for pain management depending upon the source of the pain. He relayed that Flexeril was a muscle relaxer that was great for chronic back pain from muscle spasms. He added that there were other situations where an over-the-counter pain medicine, or a prescription nonsteroidal anti-inflammatory drug (NSAID), could be a more appropriate pain treatment. He noted that all of the above were used, but that the latter choices were not problems and were therefore less well known.

[10:18:36 AM](#)

Co-Chair MacKinnon asked whether Dr. Heine used electronic records.

Dr. Heine replied in the affirmative.

Co-Chair MacKinnon queried whether he had the capability of making an electronic transmission of the opioid use.

Dr. Heine responded that currently the PDMP was web-based, a log on was required and then patient information needed to be entered.

Co-Chair MacKinnon interrupted asking whether he had the technology available to streamline the information.

Dr. Heine replied that he did not currently have the technology because electronic medical records had numerous firewalls. He noted that the State of Washington had a system that could be studied for potential implementation.

[10:19:48 AM](#)

Vice-Chair Micciche commented that 15 percent of the state's physicians currently used the PDMP. He said that physicians in his district had expressed concerns about over prescription of pain medication. He felt that many people could manage pain with over-the-counter pain medications. He felt that people should be encouraged to use over-the-counter drugs.

[10:21:59 AM](#)

DR. ANDREW ELSBERG, EMERGENCY MEDICINE, PROVIDENCE ALASKA MEDICAL CENTER, ANCHORAGE (via teleconference), agreed with Dr. Heine's perspective on the matter. He said that working in a busy emergency department made logging into the PDMP time intensive. He felt that mandating login before administration of drugs was unrealistic and unnecessary. He believed that prescription of pain medications was the root of the addiction problem in the state. He said that the center was working to identify repeat emergency department visitors. He reiterated that mandating a login in emergency situations would affect his ability to serve patients. He stated that he supported and information exchange that would automatically provide patient information from other providers, which he believed would take any bias out of looking up patients, and would be more efficient.

[10:25:43 AM](#)

AT EASE

[10:26:18 AM](#)

RECONVENED

Co-Chair MacKinnon discussed housekeeping.

[10:26:55 AM](#)

RECESSED

[1:35:46 PM](#)

RECONVENED

Co-Chair MacKinnon related that the committee would continue by discussing the audits.

[1:37:16 PM](#)

AT EASE

[1:37:50 PM](#)

RECONVENED

Co-Chair MacKinnon invited Ms. Kraly to the table. She directed the committee's attention to a letter from DHSS dated February 26, 2016 (copy on file):

2. Duty to identify and repay self-identified overpayments

- Section 16, Page 17, Lines 14 - 15

"An enrolled medical assistance provider shall conduct at least one annual review or audit of all claims submitted to the department..."

- For the committee's consideration: "Unless a provider is being audited under 47.05.200(a), an enrolled medical assistance provider shall conduct a biennial review or audit of a statistically valid sample of claims submitted to the department..."

[1:39:10 PM](#)

Ms. Kraly testified that concerns had arisen in previous committee meetings regarding Section 16 of the legislation. She stated that the primary concern that had been raised by providers had been a reference to the words "all claims" on line 15 of the section. She said that the language would have been unduly burdensome upon providers to have to audit all claims going forward. She relayed that in an effort to allay some of the concern the department crafted some conceptual language that would ensure that individuals that were currently under an audit under AS 47.05.200, would not have to do a self-audit that would be duplicative of that effort. She said that language was also provided that a biennial review of a statistically valid sample would be sufficient to performing an annual review of all claims. She stated that the hope was that providers would examine their records every 2 years and to review a valid sample of those claims to identify overpayments.

[1:41:10 PM](#)

DOUG JONES, DIVISION OF HEALTHCARE SERVICES, ANCHORAGE (via teleconference), shared that he was available for questions.

[1:42:02 PM](#)

BECKY HULTBERG, PRESIDENT AND CEO, ALASKA STATE HOSPITAL AND NURSING HOME ASSOCIATION, ANCHORAGE (via teleconference), believed that the language would mitigate the administrative burden that had been referenced in previous testimony. She noted that there were existing concerns related to the timing of the Medicaid Management Information System (MMIS); some claims and some categories were consistently overpaid. She did not think that the problem would be a barrier, but that audits would be "cleaner" once the system was performing better. She thought that the effective date should be beyond the point at which the system was paying timely and accurately on claims.

[1:44:07 PM](#)

Co-Chair MacKinnon reminded the committee that amendments had been due by 12pm, but that she would accept significant input from committee members for a limited time extension.

Co-Chair MacKinnon requested further discussion of the issues of fraud and false claims, which had been raised during public testimony.

Ms. Kraly stated that the Medicaid Assistance False Claim Act provisions could be found beginning in Section 1, and through Section 3, pages 2 through 10. She relayed that provider testimony from the previous week had indicated that there were concerns about the private right of action and how individuals would have the ability to potentially bring a suit. She said that the department believed that the language in current bill version properly balanced the concerns. She related that the department was comfortable with the balance provided by the legislation.

[1:46:24 PM](#)

Ms. Hultberg testified that this was a new legal framework for Alaska that had already existed on the federal level, and had resulted in significant judgements, often against institutional providers, for fraud. She pointed out that many of the cases were not for intentional wrongdoing, but from provider's running afoul of very complex federal regulatory or billing regimes. She remained concerned that the framework could result in the filing of frivolous lawsuits. She did not believe that the provision was targeted at large institutions, which were low-risk

providers, but it was likely that cases would come against them because they billed significant Medicaid dollars.

[1:47:55 PM](#)

Co-Chair MacKinnon discussed the extension of the amendment deadline for 12pm the following day.

[1:48:42 PM](#)

VALERIE DAVIDSON, COMMISSIONER, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, reiterated her comments from the previous week lauding the efforts of the subcommittee on Medicaid reform. She said that the department had spoken to all of the recommendations in the previously referenced letter.

Co-Chair MacKinnon directed attention to a letter from the U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services (CMS) dated February 26, 2016; and asked Commissioner Davidson to walk the committee through the letter and highlight any concerns.

[1:49:58 PM](#)

AT EASE

[1:50:51 PM](#)

RECONVENED

Co-Chair MacKinnon explained that she had requested DHSS view on the Indian Health Travel Policy, and how the government had responded to the state on the issue.

Commissioner Davidson explained that the letter was received the previous week, and provided more detail to the states on how to implement policy changes. She directed attention to Page 2 of the letter, which reiterated that CMS was modifying the scope of services eligible for enhanced Federal Medical Assistance Percentage (FMAP), and were expanding the meaning of contractual agent to be an enrolled Medicaid provider, which would allow state's more flexibility. She relayed that the letter also stated that flexibility would be increased for billion arrangements so that Indian Health Services (IHS)/Tribal facilities or their contractual agents could bill Medicaid directly for services.

Commissioner Davidson directed attention to Page 3, under "Permitting a Wider Scope of Services," explaining that that services that were considered through an IHS facility would be interpreted more broadly than the services that they had prior. She noted that the middle of Page 3 clarified that the Freedom of Choice requirement for Medicaid beneficiaries had not been changed. She continued to the bottom of Page 3, which reflected that CMS had indicated that there had to be a written care coordination agreement, the form of which was flexible.

Commissioner Davidson stated that Page 4 indicated that an IHS beneficiary, that was also a Medicaid beneficiary, could not self-refer to a non-IHS provider, and additionally indicated that a non-IHS provider could not self-refer.

Commissioner Davidson stated that the bottom of Page 4 described the minimum requirements for care coordination:

- (1) The IHS/Tribal facility practitioner providing a request for specific services (by electronic or other verifiable means) and relevant information about his or her patient to the non-IHS/Tribal provider;
- (2) The non-IHS/Tribal provider sending information about the care it provides to the patient, including the results of any screening, diagnostic or treatment procedures, to the IHS/Tribal facility practitioner;
- (3) The IHS/Tribal facility practitioner continuing to assume responsibility for the patient's care by assessing the information and taking appropriate action, including, when necessary, furnishing or requesting additional services; and
- (4) The IHS/Tribal facility incorporating the patient's information in the medical record through the Health Information Exchange or other agreed-upon means.

Commissioner Davidson stated that the bottom of Page 5 offered the government's willingness to be flexible in term of the form that the agreements took: a contract, a provider agreement, a memorandum of understanding or agreement; as long as the form was consistent with what an Indian health facility was in their authority to provide. She said that the department had requested the CMS have some flexibility regarding who performed the billing, and

the letter indicated that they were willing to be flexible as long as the state met the requested requirements.

1:57:05 PM

Commissioner Davidson stated that Page 6 provided clarification for that the state could claim 100 percent for care management opportunities. She relayed that CMS had indicated that they were not "willing to write states blank checks", and that the understanding should be that there was a significant amount of work that needed to be done in order for them to provide the state with 100 percent federal match. She relayed that the requirements written at the top of Page 7:

- (1) the item or service was furnished to an AI/AN patient of an IHS/Tribal facility practitioner pursuant to a request for services from the practitioner;
- (2) the requested service was within the scope of a written care coordination agreement under which the IHS/Tribal facility practitioner maintains responsibility for the patient's care;
- (3) the rate of payment is authorized under the state plan and is consistent with the requirements set forth in this letter; and
- (4) there is no duplicate billing by both the facility and the provider for the same service to the same beneficiary.

Commissioner Davidson spoke further on Page 7, and related that state expenditures for services under section 115 demonstration authority were eligible for 100 percent FMAP as long as all of the required elements of being "received through" an IHS or Tribal facility were present. She explained that the letter clarified that if there were other special enhanced matching rate, that the 100 percent FMAP matching rate would supersede other rates.

2:00:14 PM

Co-Chair MacKinnon asked whether it was possible for the department to issue a fiscal note on the issue now that the letter had been received.

Commissioner Davidson related that the department would be focusing on fiscal notes under the recognition that a

change in the system would be required by CMS, and that all parties involved would need to provide agreements for this benefit that accrued to the state, and DHSS received the benefit of 100 percent match. She noted that it would take time to craft the agreements, so the current fiscal notes had been conservative estimations that would be built up over time. She related that it would be nice to be able to claim services soon, but that it would take more time because of the system and audit requirements that CMS had placed on the department. She stressed that the fiscal notes have been conservatively estimated but that it was expected that savings would accrue.

[2:01:44 PM](#)

Co-Chair MacKinnon said that the legislature expected some of the savings to begin at the start of FY 17.

[2:02:08 PM](#)

Vice-Chair Micciche commented that the letter comprised a significant "win" for the state, and expressed appreciation for the work of any committee members who had been involved.

[2:02:41 PM](#)

Commissioner Davidson asserted that her staff had worked long hours in order to prepare information for the committee.

[2:03:04 PM](#)

Co-Chair MacKinnon reiterated that amendments were due to her office by noon the following day.

[2:04:18 PM](#)

Senator Olson queried page 14, section 8, line 7 pertaining to the requirement that pharmacists check a prescription record database before dispensing, administering, or prescribing pain medication.

Co-Chair MacKinnon shared that she was accepting amendments until noon the following day. She said that her recommendation to the committee was that it should be mandatory, period. She reiterated that Senator Olson could

bring an amendment to the contrary, but that she would be voting no on such an amendment.

[2:05:35 PM](#)

Senator Olson contended that the language addressed all controlled substances, of all schedules, and not just opioids. He said that his office would craft an amendment.

Co-Chair MacKinnon hoped that future conversation on the issue would be helpful for not overburdening doctors, which providing them the tools necessary to administer quality care.

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

#

ADJOURNMENT

[2:06:53 PM](#)

The meeting was adjourned at 2:06 p.m.