

HOUSE FINANCE COMMITTEE

April 12, 2018

9:07 a.m.

9:07:58 AM

CALL TO ORDER

Co-Chair Foster called the House Finance Committee meeting to order at 9:07 a.m.

MEMBERS PRESENT

Representative Neal Foster, Co-Chair
Representative Paul Seaton, Co-Chair
Representative Les Gara, Vice-Chair
Representative Jason Grenn
Representative David Guttenberg
Representative Scott Kawasaki
Representative Dan Ortiz
Representative Steve Thompson
Representative Cathy Tilton
Representative Tammie Wilson

MEMBERS ABSENT

Representative Lance Pruitt

ALSO PRESENT

Juli Lucky, Staff, Senator Anna MacKinnon; Janey McCullough, Director, Division of Corporations, Business and Professional Licensing, Department of Commerce, Community and Economic Development; Senator David Wilson, Sponsor; Representative Ivy Spohnholz; Gary Zepp, Staff, Senator David Wilson.

PRESENT VIA TELECONFERENCE

Dr. Jeff Moore, Orthopedic Surgeon, Anchorage; Debora Stovern, Executive Administrator, State Medical Board, Division of Corporations, Business and Professional Licensing, Department of Commerce, Community and Economic Development; Ken McCarty, past president, Board of Marital and Family Therapists, Eagle River; Margaret Brodie, Director, Division of Health Care Services, Department of Health and Social Services; Rick Calcote, Chief, Risk and

Research Management, Division of Behavioral Health, Department of Health and Social Services; Ken McCarty, Marital and Family Therapist, Eagle River; Melissa Kemberling, Director Of Programs, Mat-Su Health Foundation, Matanuska-Susitna Borough; Amy Spargo, Assistant Superintendent, Matanuska-Susitna Borough School District, Palmer; Ben Shelton, President, Alaska American College of Emergency Physicians, Anchorage; Laura Evans, State Government Affairs Manager, American Association for Marriage and Family Therapy, Virginia; Jon Zasada, Policy Integration Director, Alaska Primary Care Association, Anchorage.

SUMMARY

CSSB 105 (FIN)

MARITAL/FAMILY THERAPY LIC & MED SERVICES

SB 105 was HEARD and HELD in committee for further consideration.

SB 126 VISITING PHYSICIANS WITH SPORTS TEAMS

SB 126 was REPORTED out of committee with a "do pass" recommendation and with one previously published fiscal impact note: FN1 (CED).

SB 158 OIL/HAZARDOUS SUB.:CLEANUP/REIMBURSEMENT

SB 158 was SCHEDULED but not HEARD.

Co-Chair Foster reviewed the agenda.

#sb126

SENATE BILL NO. 126

"An Act providing for an exception to the regulation of the practice of medicine for a physician who provides medical services to an athletic team from another state."

[9:08:52 AM](#)

Co-Chair Foster reported that it was the first time the bill was heard in committee.

JULI LUCKY, STAFF, SENATOR ANNA MACKINNON, shared that the bill had been brought to the chair by a constituent who was

an orthopedic surgeon and member of the National Council of Orthopedic Surgery and Spots Medicine. She explained that the bill was part of a nationwide effort to provide certainty for sports teams' physicians that were licensed in another state and traveling with the team in other states. The bill would add an exemption for state licensure for the physicians traveling with sports teams. The physician would have to be licensed to practice medicine in another state, under a written contract to provide care to an athletic team in that state and would be limited to providing services to members of the team while they were traveling or participating in a sporting event in Alaska. The sponsor believed that the exemption was very specific. She added that the first section of the bill dealt with the exemption and the second section was a conforming amendment that renumbered exemptions in existing statute.

Representative Wilson asked if the physicians would be required to fill out any paperwork. Ms. Lucky answered that the individuals would not have to fill out any additional paperwork. She clarified that the bill did not allow any hospital privileges. She relayed that the bill addressed common concerns like an athlete who was without an asthma inhaler and the student otherwise would have to go to a clinic, which would be time consuming.

[9:12:31 AM](#)

Representative Thompson asked how other states handled the issue. Ms. Lucky answered that the effort included getting the measure passed in all 50 states. She reported that 48 states had either introduced or passed the legislation.

Representative Ortiz asked for the reason the constituent had brought the issue forward. Ms. Lucky deferred to the constituent to answer the question.

DR. JEFF MOORE, ORTHOPEDIC SURGEON, ANCHORAGE (via teleconference), replied that he was the national delegate for the American Orthopedic Society for Sports Medicine and the bill was a national program for the society. He concurred that the bill was currently passed in 35 states and was pending in 14 states and only allowed authority to treat "simple" health issues.

Representative Ortiz deduced that the legislation was a national effort to standardize the rights for visiting physicians. Mr. Moore answered in the affirmative.

[9:15:23 AM](#)

Representative Guttenberg thought the bill seemed simple and positive but wondered about the "mechanics". He provided a scenario of a team member that lost their asthma inhaler and the team doctor wrote a prescription, but the pharmacist recognized that the physician was from out of state. He asked how the situation would work. Mr. Moore replied that without the bill, typically the traveling team doctor could not prescribe out of state and would need to call a local physician to get a prescription filled. He reiterated that the bill precluded surgery. Representative Guttenberg asked how the Alaskan pharmacist would know the traveling physician had the authority. Mr. Moore answered that the pharmacist would need a national "DEA" number [Drug Enforcement Administration Registration Number].

Representative Kawasaki asked if a physician would have the ability to write an order for an X-Ray. Mr. Moore answered that the physicians would not have any inpatient privileges and would not be able to order an x-ray.

Co-Chair Foster OPENED public testimony.

Co-Chair Foster CLOSED public testimony.

Vice-Chair Gara reviewed the previously published fiscal impact note from the Department of Commerce, Community and Economic Development (DCCED) FN1 (CED). He noted the one-time \$2,500 for regulatory costs.

[9:20:52 AM](#)

Representative Guttenberg remarked that the committee saw a variety of trivial fiscal notes. He asked what the \$2,500 represented. Ms. Lucky deferred to DCCED.

DEBORA STOVERN, EXECUTIVE ADMINISTRATOR, STATE MEDICAL BOARD, DIVISION OF CORPORATE, BUSINESS, AND PROFESSIONAL LICENSING, DEPARTMENT OF COMMERCE, COMMUNITY AND ECONOMIC DEVELOPMENT (via teleconference), replied that the fiscal note represented the cost for the board to adopt regulations to implement the statute change. Representative

Guttenberg voiced that the answer did not address his question.

JANEY MCCULLOUGH, DIRECTOR, DIVISION OF CORPORATIONS, BUSINESS AND PROFESSIONAL LICENSING, DEPARTMENT OF COMMERCE, COMMUNITY AND ECONOMIC DEVELOPMENT, answered that the division estimated the costs to adopt regulations from other similar previous regulation projects. The fiscal note authorized the division to spend the money on behalf of the licensees. Representative Guttenberg asked for further clarification. Ms. McCullough replied that regulation project costs did vary depending on the number of interested parties that needed mail notification. She stated that 731 people would be affected by the regulation change. She pointed out that one newspaper ad was \$772.

Ms. Lucky pointed out that the funds were receipt supported services and General Fund (GF) was not used in updating regulations.

Co-Chair Seaton MOVED to REPORT SB 126 out of committee with individual recommendations and the accompanying fiscal note. There being NO OBJECTION, it was so ordered.

SB 126 was REPORTED out of committee with a "do pass" recommendation and with one previously published fiscal impact note: FN1 (CED).

[9:25:50 AM](#)

AT EASE

[9:26:15 AM](#)

RECONVENED

#sb105

CS FOR SENATE BILL NO. 105 (FIN)

"An Act relating to the licensure of marital and family therapists; relating to medical assistance for marital and family therapy services; and providing for an effective date."

[9:26:22 AM](#)

Co-Chair Foster indicated that Representative Ivy Spohnholz carried the companion bill, HB 353 Marital & Family Therapy Lic. & Services.

REPRESENTATIVE IVY SPOHNHOLZ, explained that the bill updated and clarified the supervisory requirements for a licensed Marital and Family Therapist (LMFT). The updated requirements would allow the therapists to become eligible for Medicaid reimbursement. The purpose of the bill was to increase the access to behavioral health care, which currently the state had a shortage of providers. She indicated that the fiscal note was "modest" and would reduce costs over the "mid-term" by allowing more people struggling with behavioral health issues access to health care before the condition was acute. She qualified that the bill was not an expansion of Medicaid and was a "step in the right direction" to increase access to behavioral health care.

[9:28:35 AM](#)

SENATOR DAVID WILSON, SPONSOR, spoke to the legislation. He explained that the bill involved the professional application of assessments, treatments, and psychotherapy services to individuals, families, and couples for the purposes of treating and diagnosing emotional and mental disorders. Currently, LMFTs were only allowed to provide services in community health clinics or physician mental health clinics, which limited the number of willing providers. The legislation expanded medical assistance reimbursement services to cover those services provided directly and independently by LMFTs. He delineated that SB 105 specifically defined the supervision training hours and requirements for an Associate Marital & Family Therapist, expanded the list of approved healthcare professionals that can provide group supervision of an Associate Marital & Family Therapist and, added Marital & Family Therapy services as eligible to render and bill for Medicaid-funded services as independent practitioners under Alaska Statute 47.07.030 (b). He furthered that SB 105 "dovetailed" with SB 169 (Medicaid: Behavioral Health Coverage) [Senator Giessel - Adopted Both Bodies 05/04/2018] which removed 30 percent of onsite requirement for supervision and provided for a telecommunication device option. He voiced that the bill dealt with the shortage of behavioral health care professionals that was addressed in SB 74 (Medicaid Reform;Telemedicine;Drug Databas)[CHAPTER 25 SLA 16 - 06/21/2016] but was accidentally omitted during regulation drafting by the Department of Health and Social Services (DHSS). The department also discovered that the necessary statute that would allow the regulations did not exist and

the bill also provided "clean-up" language for SB 74. Finally, the bill also fit together with the departments federal 1115 waiver [Allowed a state to use federal Medicaid funds in ways that are not otherwise allowed.] that authorized expansion of behavioral health services. He related that DHSS's experienced challenges in extending behavioral health services throughout the state due to the geographic nature of the state and problems with recruitment and retention of a behavioral health care work force. He spoke to the cost of recruiting a licensed clinical social worker of up to \$100 thousand, which took up to 6 months to fill versus recruiting a LMFT at a cost of up to \$40 thousand. The LMFTs were equally trained and more plentiful.

[9:31:57 AM](#)

GARY ZEPP, STAFF, SENATOR DAVID WILSON, reviewed the PowerPoint presentation titled "CCSB 105(FIN) - Marital/Family Therapy" (copy on file). He reviewed items on slide 1:

What is Behavioral Health?

The term "behavioral health" is the umbrella that encompasses all contributions to mental wellness, including substance abuse, behavior health disorders, schizophrenia, bipolar disorder, and other mental health concerns.

Behavioral health promotes well-being by preventing or intervening in mental illness, such as depression or anxiety, but also aims to prevent or intervene in substance abuse or other addictions.

One in four Americans experience a mental illness or substance use disorder each year, and the majority of these people also have a co-occurring physical health condition, according to the American Hospital Association.

National Behavioral Health Needs:

- 20% of inmates in jails suffer from a serious mental illness;
- 60% of inmates suffer from substance abuse conditions;

- 80% of people who suffer from mental illness are unemployed;
- 26% of all homeless shelter residents suffer from severe mental illness;
- 34% of homeless people also have chronic substance abuse issues.

Source: US National Library of Medicine/National Institutes of Health; National Association of State Mental Health Program Directors

Mr. Zepp believed that early intervention prevented an emergency room (ER) crisis, incarceration, and institutionalizing and individual with behavioral health issues. He noted that ER visits costs were much higher than therapy sessions. He moved to slide 2:

Alaska's Behavioral Health Needs:

- Alaska's suicide rate is 21.8 per 100,000 people, the national rate is 11.5 per 100,000 people;
- Approximately 145,790 Alaskans need mental and behavioral health services; Of those, only 19% receive behavioral health services;
- It's estimated that 65% of Alaska prisoners suffer from some form of mental health issues and 80% have drug or alcohol addictions;
- In 2016, the Mat-Su Regional Emergency Department spent \$43.8 million for patients with behavioral health diagnoses for 3,443 patients;
- This does not include additional costs for law enforcement, dispatch, and ambulance services.

Source: Arctic Mental Health Working Group; Alaska Behavioral Health Systems Assessment Final Report; Alaska Dispatch News; Treatment Advocacy Center

Alaska's Behavioral Health Care Shortages - Psychiatrists:

- Alaska needs approximately 106 additional psychiatrists to meet the national standard, per 100,000 adults;
- Alaska is 20% - 54% below the estimated need for psychiatrists in Alaska, as compared to national standards;

- 2.9 years = average retention time for mental health care providers in Alaska;
- The ratio of vacant mental health provider positions in rural Alaska is 1 in 5 as compared to 1 in 10 in urban Alaska.

Source: Arctic Mental Health Working Group

[9:35:43 AM](#)

Mr. Zepp addressed slide 3:

What is CSSB 105(FIN)?

If enacted, the proposed legislation would add licensed Marital and Family Therapists to the list of independent practitioners to address the shortage of Medicaid-eligible behavioral health providers in the state, afford more options for beneficiaries, and increase access to behavioral health care.

Currently, licensed Marital and Family Therapists are only allowed to provide services in community health clinics or physician mental health clinics, which limits the number of willing providers. CSSB 105(FIN) expands medical assistance reimbursement services to cover those services provided directly/independently by licensed marital & family therapists.

Specifically, CSSB 105(FIN):

Defines the supervision training hours and requirements for an Associate Marital & Family Therapists. This will create a path for an associate to become a fully licensed marital & family therapist. This in turn creates more fully licensed marital & family therapists and increases the capacity of behavioral health services in our state!

Expands the list of approved health care professionals that can provide group supervision of an Associate Marital & Family Therapist; and Adds Marital & Family Therapy services as eligible to render and bill for Medicaid funded services as independent practitioners under AS 47.07.030(b).

[9:37:43 AM](#)

Mr. Zepp specified that the bill mandated 1,700 hours of clinical contact and of that amount 100 hours were individual supervision and 100 hours of group supervision. He delineated that Section 2, page 3, lines 5 through 13, of the bill expanded the list of providers to 6 different mental health care providers who could deliver group supervision to the associates who were attempting to reach the level of LMFT. He added that currently all supervisors had to meet board approval. He moved to slide 4:

Benefits of CSSB 105(FIN) and how does it help Alaskans?

- By expanding Medicaid optional services to include licensed marital & family therapy, it provides an opportunity to intervene early to help Alaskans, so they don't end up in an expensive emergency room setting or in a costly institutional setting;
- Example: Private clinical hourly cost = \$150 per hour vs. \$4,370 average one-time emergency room behavioral health cost
- By increasing the number of health care professionals available to provide services for those who cannot currently receive services or are on a waiting list for behavioral health services, both in urban and rural areas of our state;
- Improve behavioral health care services to Alaskans improves their health outcomes and reduces spending on physical health issues;
- Add additional health care professionals to the group supervision of an associate licensed marital & family therapist should enable more associates to become a fully licensed marital & family therapy;
- Better access to behavioral health care leads to positive outcomes and likely avoids expensive emergency room care, correctional incarceration, or psychiatric institutionalization.

[9:39:35 AM](#)

Mr. Zepp concluded on slide 5:

Acknowledgment and Thanks!

Thank you for your support of CSSB 105(FIN)

"An Act relating to the licensure of marital and family therapists; relating to medical assistance for marital and family therapy services; and providing for an effective date."

CSSB 105(FIN) is supported by:

- Alaska Board of Marital & Family Therapy;
- American Association for Marriage and Family Therapy;
- Mat-Su Health Foundation;
- American College of Emergency Physicians/Alaska Chapter;
- Alaska Emergency Room Physicians

Representative Guttenberg understood the need for the legislation. He asked who set the standards for the hours. He wondered where the requirements came from. Mr. Zepp replied the hours had been established by the Board of Marital and Family Therapists. Representative Guttenberg asked if there had been any feedback from licensees. Mr. Zepp deferred the answer to the past president of the board.

KEN MCCARTY, PAST PRESIDENT, BOARD OF MARITAL AND FAMILY THERAPISTS, EAGLE RIVER (via teleconference), voiced that he was on the regulatory board for 6 years. He replied that the language clarified the standard of 1,500 hours of clinical time with 200 hours of supervised clinical time; 100 hours for individual and 100 hours for group. He reported that the way the statute currently read caused confusion. He furthered that the provision broadened the supervisory role and was included due to the difficulty of finding a licensed LMFT supervisor in areas of the state like Utqiaqvik, Nome, Kotzebue, and even Seward. The board noted that the supervisory shortage caused LMFT trainees to pursue a different career. Other professionals lead clinical groups in the areas noted therefore, the opportunity was available for others to gain the certification by allowing other behavioral health care professionals to supervise LMFT trainees.

[9:44:37 AM](#)

Representative Guttenberg wanted to ensure potential licensees did not consider that the hours were too high or a barrier to entry. Mr. McCarty replied that he was a licensed supervisor and had the ability to provide the 100 hours of individual supervision through an associate under contract agreements in places like Utqiaqvik but could not do a group in the same manner. The bill allowed the trainee from a place like Utqiaqvik to capture the supervision.

Representative Spohnholz clarified that the bill did not change the hours it took to become a LMFT. The bill clarified the requirement statute and also allowed supervisors from other professions to provide supervision. She believed the provision would increase the number of qualified LMFTs and had not heard any negative feedback relating to the change.

Representative Tilton welcomed the students, parents, and teachers from Academy Charter School in the Matanuska-Susitna Borough in the audience.

Co-Chair Foster also welcomed the students.

[9:48:11 AM](#)

Representative Wilson remarked that the bill was adding another optional service. She pointed to Section 3, page 3, of the bill and read the following "... the department may offer only the following optional services..." and listed the LMFT category. Representative Spohnholz replied that they were not adding an optional service. The bill only added LMFTs to the range of options. Representative Wilson believed it was an option.

Senator Wilson clarified that SB 105 merely added the LMFTs to the list of professionals who had the ability to bill individually for optional Medicaid services. Otherwise, the LMFT would only be able to provide the services as part of a community mental health clinic. Representative Wilson stated that without the language they would not be authorized to bill Medicaid and thought it was the whole reason for the bill. She expressed concern over the \$1 million fiscal note [FN4 (DHS)]. She noted that federal receipts were in the amount of \$660.5 million [thousand] and the GF match was \$340.3 thousand [FY 2020]. She

referred to the analysis on page 2 and read the following "\$1,581 annual per recipient cost times 633 recipients equaled \$1,000,773." She wondered where the number of 633 recipients had come from.

Mr. Zepp deferred to DHSS for the answer.

MARGARET BRODIE, DIRECTOR, DIVISION OF HEALTH CARE SERVICES, DEPARTMENT OF HEALTH AND SOCIAL SERVICES (via teleconference), answered that the Division of Behavioral Health prepared the fiscal note.

Co-Chair Seaton asked whether Ms. Brodie could answer the question of whether the bill added an optional service and the explain the difference between mandatory and optional services. Ms. Brodie replied that the service was already covered under the duly eligible recipients, which was covered under Medicaid and Medicare. The bill added a provider to a currently covered service.

[9:52:42 AM](#)

Representative Wilson did not understand the answer. She wondered why it had to be added to AS 47.07.030 (b) if it was not adding to the optional services list.

Senator Wilson deferred the answer to Mr. Calcote.

RICK CALCOTE, CHIEF, RISK AND RESEARCH MANAGEMENT, DIVISION OF BEHAVIORAL HEALTH, DEPARTMENT OF HEALTH AND SOCIAL SERVICES (via teleconference), replied that SB 74 expanded the list of licensed providers who could bill Medicaid independently for Medicaid services. Under the statute, LMFTs were not included on the list and the bill allowed LMFTs to become independent providers for Medicaid services.

[9:55:17 AM](#)

Representative Wilson stated it had been her exact point that the bill added to the list of providers. She asked whether the 633 individuals were currently receiving services in a clinical setting and would switch to a private setting and for the current number of providers that would be able to bill Medicaid individually. She stated that Medicaid "was one of the fastest growing areas" and the bill was adding services, which was concerning to

her. Mr. Calcote responded that the fiscal note assumed that a number of individuals were currently in the Medicaid system and were receiving behavioral health treatment through physicians' offices, mental health physician clinics, and community behavioral health centers. He delineated that by expanding the number of providers the division assumed that individuals not currently being seen within the Medicaid system would be served. The division based the fiscal note on projected figures derived from Medicaid prevalence data that indicated there were a number of unserved recipients who were eligible but did not seek services. In addition, the division used the national average number of unserved recipients that was approximately 10 percent. The division employed the greatest number of participants that could possibly be served (633) by expanding the new provider set. He indicated that most likely the number would be fewer than 633. Representative Wilson asked how many providers were currently unable to bill Medicaid. Mr. Calcote was unable to answer the question accurately. He detailed that he lacked the necessary data.

[9:59:02 AM](#)

Representative Wilson asked how many providers it would take to service 633 participants.

Senator Wilson replied that currently there were roughly 85 LMFTs in the state. The numbers were currently unknown because the choice to become a LMFT was personal. Some businesses like the Federally Qualified Health Centers would more likely pursue LMFTs to be able to bill Medicaid for them. He emphasized that the bill was not "necessarily" adding recipients to Medicaid, the recipients were underserved, and the bill would "open the door" to provide more access to mental health services. He suggested that current LMFTs providing testimony could better answer the question. Representative Wilson stated that she would wait for public testimony to provide the answer.

Vice-Chair Gara remarked that leaving family problems untreated was not "free". He noted that the state had the highest rate of repeat child abuse and drug and alcohol abuse, which affected children and families. He voiced that fiscal notes do not report the amount of expenditures avoided as a result of expanding services and thought the

information would be useful. He believed that not expanding the services would cost the state more.

[10:02:40 AM](#)

Representative Kawasaki mentioned that currently clinical social work services was part of the provider list. He asked whether clinical social workers provided marital and family advice for a patient. Senator Wilson was unsure of the numbers and deferred the answer to providers. However, he acknowledged that the number of clinical social workers were much fewer and cost more to hire because their services were in demand for other practices and services. Representative Kawasaki returned to the question of whether the bill was adding an optional service. He referred to the fiscal note analysis on page 2 and read the following:

This fiscal note reflects the fact that licensed marriage and family therapist services have been added to the AS 47.07.030 list of Medicaid optional services for which the State will reimburse.

Representative Kawasaki alluded to the conflicted testimony regarding the optional service and felt that it was a policy decision. He wanted a definitive statement regarding whether the legislation was adding another optional service that could potentially cost the state more in the future.

[10:05:45 AM](#)

Mr. Calcote responded that the addition of the LMFT provider in statute would certainly allow them to bill Medicaid services directly. The providers would no longer have to bill through a community or behavioral health clinic. He assumed that a small percentage of the Medicaid population might seek the services of a LMFT independent practitioner for extended treatment. He was unclear how much the Medicaid bill would be affected. The fiscal note was the division's best estimate and was in the "outside range" of probability. The department would know more after the bill took effect. Representative Kawasaki stated that the current number of LMFTs were known and thought it was a yes or no answer. He stressed that the bill offered a new optional service to LMFTs who otherwise was unable to bill Medicaid "prior to the bill passing". He asked whether he was correct. Mr. Calcote replied in the affirmative. He deferred to the sponsor for further answers.

Mr. Zepp replied that it was also his understanding that LMFTs were currently eligible through community or physicians' behavioral health clinics billing and the bill authorized coverage for LMFTs to bill directly through an independent practice.

Co-Chair Seaton wanted to gain clarity on the bill. He asked if the bill was a "two-way street". The LMFT could bill for a service listed under the Medicaid optional or mandatory services and anyone who is qualified could bill for marital and family therapy services. He asked whether he was correct. Mr. Calcote clarified that family psychotherapy was already an existing Medicaid billable service and anyone qualified to provide the service may do so. He restated that by changing the statute the bill merely allowed LMFT to bill for Medicaid services. Co-Chair Seaton asked if anyone else qualified could also bill for marital and family therapy services.

[10:12:42 AM](#)

Mr. Calcote replied in the affirmative. Anyone licensed in the state and was a qualified Medicaid provider of marital and family therapy could provide the service.

Representative Thompson cited the presentation and surmised that there was a severe shortage of family therapists in the state. He deduced that the bill was attempting to increase the number of providers covered under Medicaid. He thought the untreated individuals could end up in the emergency room (ER) or incarcerated. He viewed the bill "as a cost avoidance in some fashion." He asked whether he was correct. Senator Wilson answered in the affirmative.

Mr. Zepp interjected that the costs of ER services was "astronomically higher" than treatment in a clinical setting. He reported that according to DHSS 2016 data, \$621 million was spent in ER billing and 53.9 percent were Medicaid clients. He determined that the state already bore the costs because the first 23 hours in an ER was covered by Medicaid and after that the hospital assumed the costs.

Representative Kawasaki supported the bill. He knew that LMFTs would like the ability to bill Medicaid. He spoke about arguments in other sectors of the medical field that felt expanding services "cut into the market" of the established licensees. He wondered if any behavioral health

care providers that currently billed Medicaid were opposed to the bill. Senator Wilson replied in the negative.

Representative Guttenberg asked Ms. Brodie if there had ever been reports done on avoidance costs. He thought it would be interesting to see the difference between individuals getting expanded coverage versus going to the ER and if any previous data existed.

[10:17:43 AM](#)

Ms. Brodie responded in the negative. She elaborated that the issue spread across other departments and divisions. She exemplified the costs related to the Office of Children Services (OCS) removing children from the home and the state paying for therapy that was required to allow them to return home coupled with the Department of Corrections (DOC) involvement and the costs related to the use of ERs. Representative Guttenberg recognized that costs were far reaching to other agencies and institutions as well. He would do some research on the national level.

Senator Wilson replied that an all claims database was necessary to gather the data. Lacking the data base, it would be difficult to extrapolate the data; the department did not have the capability to perform the study.

Co-Chair Seaton referenced the fiscal note from DHSS. He read the following from the last paragraph on page 2 "... some of those professionals are already billing for their services under the umbrella of a mental health physician clinic." He inquired whether mental health physician clinics were currently providing marriage and family therapist services and were able to bill for the services without the service listed as an optional service or if the clinics billed under another service such as psychological services.

[10:20:07 AM](#)

Ms. Brodie answered that all behavioral health services were optional services. Co-Chair Seaton was trying to determine the current system. He asked whether some other behavioral health providers were billing for marriage and family therapist services under a different category. Ms. Brodie deferred to Mr. Calcote.

Mr. Calcote replied that Co-Chair Seaton was correct. Currently community behavioral health centers and mental health physician clinics were able to bill any behavioral health Medicaid clinic service that included individual, group, or family psychotherapy. He expounded that any qualified providers working in the provider agencies who were able to deliver the services billed Medicaid with the psychiatrist provider identification billing number. Co-Chair Seaton asked if the bill would require a "plan amendment" and whether it was in the fiscal note. Mr. Calcote understood that the expansion did not require a state plan amendment.

Representative Wilson pointed to the following on page 2 of the fiscal note:

FY2019 General Fund Match in the Services Line: \$50.0 for development of business rules in the Medicaid Management Information System [(MMIS)] detailing the parameters for services/reimbursement.

Representative Wilson thought the \$50,000 cost seemed high and inquired how the cost was derived. Ms. Brodie answered that the expenditure was for the development of the business rules. She elaborated that currently the system was only able to accept claims from Medicare and had to accept Medicaid only claims as well. The system development for the MMIS was extremely expensive. Representative Wilson was very uncomfortable with the fiscal note and how it was developed. She agreed with the services the bill wanted to provide and she thought most recipients were currently receiving the services. She was not certain amending the bill would help with the fiscal note. She thought the fiscal note was "one-sided" and she wanted to see the "cost shifting advantages."

[10:24:18 AM](#)

Co-Chair Foster noted there was a forthcoming amendment and the bill would not report out of committee during the current meeting. He asked the department to further examine the fiscal note.

Vice-Chair Gara asked whether Mr. Calcote considered two countervailing factors when writing the fiscal note. He deduced that the number of recipients receiving the service from more expensive providers who would switch to the LMFT

would reduce costs, but the state recession was increasing Medicaid enrollment. Mr. Calcote answered that many variables could not be completely quantified. The precise number of LMFTs who would provide service to Medicaid clients was unknown. The national 10 percent underserved figure matched the states historic data. He elaborated that even though the state may have 633 new people seek services, the division did not know how many of the individuals would seek services from an independent provider versus a clinic and did not know how many individuals would terminate services within a calendar year.

[10:27:01 AM](#)

Vice-Chair Gara ascertained that Mr. Calote stated factors that may lower the fiscal note yet other issues may increase the fiscal note, like a prolonged recession. He guessed that the department had developed a fiscal note based on all factors "to the best of its ability". Mr. Calcote replied in the affirmative.

Co-Chair Foster asked to hear from invited testimony.

Mr. McCarty testified in support of the bill. He stressed that the state did not have enough providers. He had conducted a survey in 2013 and had found that over 35 percent of the providers were working for agencies that already billed for their services. He discovered that only 8 percent of LMFTs wanted to bill Medicaid directly, but at least 8 percent more providers would be available. He indicated that regarding addiction, morphine treatment was only effective with psychotherapy. He had been concerned over the fiscal note and in 2013 when SB 74 was being deliberated he examined what happened in other states when they included LMFTs as providers. He had found there was no increase to the budget in other states and they experienced reductions due to decreased visits to places like ERs, mental institutions, or other intrusive interventions due to early treatment.

Representative Kawasaki asked Mr. McCarty for the typical hourly rate for LFMT services. Mr. McCarty replied that the hourly rate and what the insurance would pay was different. The hourly rate was \$215 and typically insurance paid 80 percent of the rate.

10:32:54 AM

Representative Kawasaki asked whether Mr. McCarty was aware of the audit and billing requirements for Medicaid and if would he offer the service for Medicaid recipients. Mr. McCarty answered that he had already done what was necessary to become a Medicaid provider including spending "tens of thousands of dollars." He expected that other behavioral health "agencies" would demonstrate they were a "trustworthy entity" and want to bill Medicaid.

10:33:50 AM

DR. MELISSA KEMBERLING, DIRECTOR OF PROGRAMS, MAT-SU HEALTH FOUNDATION, MATANUSKA-SUSITNA BOROUGH (via teleconference), spoke in support of the bill. She shared that the foundation shared ownership in Mat-Su Regional Medical Center. She elaborated that the foundation was "very in touch" with Mat-Su residents. The foundation conducted a community health needs assessment every three years. The top challenges were related to behavioral health; alcohol and substance abuse, childhood trauma, depression and suicide, domestic violence and sexual assault, and lack of access to behavioral health care. The bill would help increase the number of providers available to clients. She related that school nurses had conveyed to the foundation that lack of access to behavioral health service was a challenge due to a 4 to 8 months wait list for individuals and families to see a counselor who accepted Medicaid. The borough only had one behavioral health provider for every 860 residents versus one provider to every 330 residents in other communities in the country. She informed the committee that the Mat-Su Regional Medical Center had no behavioral health treatment so an individual who went to the ER with a behavioral health crisis would be stabilized for a cost of \$4,370. and most of those individuals went to the ER 5 or more times per year. She indicated that in Mat-Su roughly 300 individuals had behavioral health needs. She offered that LMFT visits cost \$150 per visit. She voiced that the opioid crisis increased the need for behavioral health and the foundation was attempting to build a behavioral health continuum of care staffed with caring professionals through investing in non-profits and providing scholarships to train new behavioral health providers. The effort was aimed at keeping individuals out of institutional and ER care and was providing local jobs.

She believed that SB 105 would help the foundation accomplish building its continuum of care.

Co-Chair Seaton was not finding that the bill authorized marital and family therapists to do anything. He thought that the bill provided for any qualified professional could provide marital and family therapy services. He wondered if there was another category of behavioral health or if the idea of the bill was that marital and family therapy services was not sufficiently covered. Ms. Kemberling observed that in the Mat-Su a "handful of agencies" had counselors including LMFTs that were able to bill Medicaid, but individual providers were prohibited from billing Medicaid. The clinics and agencies that billed Medicaid had a significant shortage of staff. She concluded that if private providers could bill Medicaid the result would provide more access to families needing behavioral health care.

[10:41:03 AM](#)

Co-Chair Seaton asked whether LMFTs would only be able to bill Medicaid for marriage and family therapy services under the bill. Ms. Kemberling answered that what the bill allowed independent LMFTs to bill Medicaid. Co-Chair Seaton asked for what services. He wondered if it was limited to marital and family therapy.

Senator Wilson interjected that a marital and family therapist was a designated licensure that was qualified through educational experience and going through the licensure process that made the licensee eligible to bill for a myriad of therapies. He added that the therapy was not limited to marriage and family issues per say but included psychotherapy services and treating and diagnosing mental disorders. Co-Chair Seaton asked Senator Wilson to follow up with the definitions.

Representative Wilson ascertained that currently an independent LMFT could not bill Medicaid but if the bill passed a LMFT could bill for all services under the parameters of the professional qualifications and licensure. She asked if she was correct. Senator Wilson replied in the affirmative.

[10:44:36 AM](#)

AMY SPARGO, ASSISTANT SUPERINTENDENT, MAT-SU BOROUGH SCHOOL DISTRICT, PALMER (via teleconference), spoke in support of the bill. She shared that her focus was on school safety and advocated for increasing access to behavioral health services for students in crisis and preventative health for students who were experiencing trauma. The school district engaged in a pilot program with the Mat-Su Health Foundation. Five of the district's schools, through behavioral health wellness grants, partnered with community providers to work part-time in the schools and address the behavioral health needs of the students and families. In order to provide the services, the program needed Medicaid eligible providers to give equal access to all families. She discovered that there were not enough Medicaid eligible providers in the borough. The bill allowed more private providers to be eligible under the plan. She referenced the conversation about how to quantify preventative work. She related a 2015 study by the Center for Benefit Cost Studies in Education from Columbia University that determined each dollar spent on prevention returned the equivalent of \$11 to students and society later. She noted the connection between social and emotional learning and increased academic performance.

[10:47:48 AM](#)

Co-Chair Foster OPENED public testimony.

BEN SHELTON, PRESIDENT, ALASKA AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, ANCHORAGE (via teleconference), spoke in support of the bill. He related that as an ER physician he cared for patients daily that were in crisis with mental health conditions who were not able to access timely outpatient care, which lead to the crisis. He believed that timely outpatient care could have prevented their condition from deteriorating into a crisis. He restated his support for the bill.

LAURA EVANS, STATE GOVERNMENT AFFAIRS MANAGER, AMERICAN ASSOCIATION FOR MARRIAGE AND FAMILY THERAPY, VIRGINIA (via teleconference), spoke in support of the bill. The organization represented approximately 62 thousand LMFTs. She believed that the bill would expand access to mental health services that were already covered and simply allow more provider choice. She offered that a study showed a decrease of about 21.5 percent ER utilization after 6 months of marital and family therapy and that patients

were taking better care of their health generally. Regarding the fiscal note, she believed the costs would be minimal because the services were already covered, but simply offered an additional provider to address the 10 percent increase in recipients. She indicated that the 10 percent increase would happen whether or not marital and family therapy was part of the program because Medicaid was an entitlement program. She noted that Alaskan LMFTs were clinical providers and licensees could diagnose and provide treatment for mental and behavioral disorders. The LMFT therapy differed from other methods by employing a holistic or systemic perspective and believed that the needs did not occur in a vacuum and the individual's relationship dynamic affected a person's mental or behavioral disorder. However, the services provided were all clinical and able to be billed via Medicaid. She stressed that the bill was not providing for other services or non-clinical services to be added to Medicaid reimbursement.

Vice-Chair Gara asked if the definition of family therapy included treatment of a child or one parent individually. Ms. Evans replied that LMFTs saw individuals and families and thought the scenario merely related to the billing code.

[10:55:38 AM](#)

JON ZASADA, POLICY INTEGRATION DIRECTOR, ALASKA PRIMARY CARE ASSOCIATION, ANCHORAGE (via teleconference), testified in support of the bill. He related that the association represented Alaska's federally qualified health centers that provided behavioral health care integrated with medical services. The centers operated outside of the community behavioral health centers and could not currently bill for services provided by LMFTs. He voiced that expanding the Medicaid billable labor force was the number one priority for the association and it supported the bill. He emphasized the chronic and serious shortage of billable providers and some positions in the centers were open for up to one year. Adding LMFTs to the list of providers would enable the centers to serve a wide variety of patients. He would submit additional written testimony.

Co-Chair Foster set an amendment deadline for the following day at 9:00 a.m. He intended to hear the bill on Friday, April 13, 2018.

SB 105 was HEARD and HELD in committee for further consideration.

Co-Chair Foster reviewed the schedule for the following meeting.

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ADJOURNMENT

[10:59:16 AM](#)

The meeting was adjourned at 10:59 a.m.